Introduction

In the first quarter of the 20th century in Australia and elsewhere there was a strong perception that venereal diseases were spreading in epidemic proportions, and ricocheting across class and gender boundaries: that they constituted a ‘red plague.’ This opinion was fueled by wartime anxieties related to productivity and defence and led to a fear that venereal diseases were spreading virulently through populations, stripping the new Australian nation of its health and vitality. Such views prompted impassioned debates throughout the period about the most appropriate methods for monitoring, treating and preventing venereal diseases. At their most fundamental, these debates centred on the relationship between the government of self, the government of others, and the government of the state, and the modes of rule considered necessary to maintain the health of populations. I argue that in New South Wales (NSW) from Federation in 1901, through the first three decades of the 20th century, there was a perceptible shift in modes of rule that related to the management of venereal diseases. At the beginning of the 20th century, a medico-penal and coercive approach was central to the management of venereal diseases, and so-called ‘case-hardened’ prostitutes, in brothels, were believed to be the most dangerous transmitters of transmission. By 1925, persuasion and ‘responsibilisation’ were becoming important modes for the management of venereal diseases, and young people, in a range of settings including homes and workplaces, were assessed as being a venereal risk. At its core, then, this thesis is concerned with examining these shifting modes of rule.

This study focuses in detail on specific records and institutions in NSW between 1901 and c. 1925. It examines medical records from Sydney’s Royal Prince Alfred (RPA) Hospital Venereal Wards and Outpatient Clinique, weekly statistical returns on the prevalence of syphilis and gonorrhoea submitted to the New South Wales (NSW) Venereology, 2001:14: pp. 69-81

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2 Responsibilisation is a term used to describe the various ways in which governments develop legislation and policies aimed at inculcating a culture of self-discipline or surveillance of the self, by the self. In the context of the management of venereal diseases, this meant that citizens were encouraged to monitor their own venereal health, seek authorized treatment and agree to surveillance and notification procedures. See Scott, J., ‘The Management of Venereal Diseases in New South Wales, 1871 to 1916’, Venereology, 2001:14: pp. 69-81
Department of Public Health by both Sydney and RPA Hospitals, the publications of various charitable and non-government organisations involved in the prevention of venereal diseases, and medical texts and journals which described aetiological, pharmacological and medico-political developments in the management of venereal diseases. Framing this period were three important political and legislative changes which I closely examine: the NSW Prisoners Detention Act 1909, the NSW Select Committee on the Prevalence of Venereal Diseases 1915 and the NSW Venereal Diseases Act 1918. I place these legislative interventions in broader national and international contexts, and argue that developments in the management of venereal diseases in NSW were at times incongruent. On the basis of this core of data and this framework of legislation I analyse three of the most fundamental aspects of the management of venereal diseases: treatment, epidemiology and prevention.

There are compelling medico-cultural, microbiological, biopolitical and social reasons to study venereal diseases in NSW between 1901 and 1925. In the late 19th century, the organism responsible for gonorrhoea was identified. In the first decade of the twentieth century, the organism that caused syphilis was isolated. These discoveries allowed for ongoing investigations into the nature and sequelae of these infections, and the development of therapeutic responses. In 1909 a procedure for diagnosing syphilis was patented by Gustav Wasserman: the Wasserman reaction. In 1910, Paul Ehrlich and his assistants marketed a preparation called ‘606,’ or ‘Salvarsan,’ as a

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3 In 1879, Albert Ludwig Sigesmund Neisser (1855–1916) discovered the organism *gonococcus nesseria*, responsible for gonorrhoea. Neisser’s discovery occurred in the wake of rapid developments in the field of bacteriology, and was made possible by utilising Koch’s smear tests for bacteria, and the new Zeiss microscope, based on the condensor and oil immersion system. In 1892, based on his own design, he established a dermatological clinic in Leipzig. He worked for a time with Ehrlich on the syphilis microorganism, but in 1910 he was publicly censured for a series of syphilis experiments with children, in which they were inoculated with syphilitic serum (See Ligon, B. L., ‘Albert Ludwig Sigesmund Neisser: The Discoverer of the Cause of Gonorrhoea,’ Seminar Pediatric Infectious Diseases, 2005: 16: 4: pp. 336–41).

4 Hideyo Noguchi (1876–1928) and Simon Flexner (1863–1946) discovered the bacteria that was the cause of syphilis, *Treponema pallidum*, confirming the earlier discovery made by F. R. Schaudinn (1871–1906) and E. Hoffman in 1905 (See Kampmeier R. H., ‘The Demonstration of Spirochetes in Syphilis Lesions by F Schaudinn and E Hoffman,’ Sexually Transmitted Diseases, 1979: 6:1: pp. 25–27). In his ongoing work on syphilis, Noguchi was able to modify the Wasserman test, the purpose of which was the detection of syphilis, as well as to prove that general paralysis of the insane and *tabes dorsalis* were the late stages of syphilis, as Fournier had argued. Noguchi also discovered that syphilis had delayed effects on the nervous system that did not become apparent until 10 to 20 years after the original infection. Hall remarks that ‘the sense of the pervasiveness and insidiousness of syphilis was only confirmed and extended when the guilty micro-organism was finally identified’ (Hall, L., ‘‘The Great Scourge’: Syphilis as a Medical Problem and Moral Metaphor, 1880–1916,’ Courtauld Institute Symposium, May 1998 – URL http://homepages.primex.co.uk/~lesleyah/webdoc3.htm).
treatment for syphilis.\(^5\) As a result of these changes and other advances in the field of microbiology, and because of the interest of both the Commonwealth of Australia, and the NSW Department of Public Health, there were significant debates about treatment options for venereal diseases. Treatment debates focused on the relative merits of inpatient and outpatient services, and the values of public and private treatments *vis-à-vis* indigent and well-to-do patients. There was also a lengthy and inflammatory debate about how best to prevent venereal infections, whilst not inadvertently arousing sexual desire. Advocates in these debates argued from ‘purity,’ ‘hygiene’ and ‘sex-education’ perspectives. Considerable argument about the most appropriate legislative responses to the management of venereal diseases occurred, and correspondents in medical journals argued for and against notification and compulsory or voluntary treatment. With the support of the Commonwealth, venereal diseases legislation was passed in most states in Australia between c. 1901 and 1925. In NSW, the Venereal Diseases Act passed in 1918, and subsequent Regulations were gazetted in November 1919. This followed the Prisoners Detention Act 1909 and the aforementioned Select Committee on the Prevalence of Venereal Diseases of 1915. In this period, as well, the Great War was being waged, necessitating a global movement of soldiers and the consequent globalisation of venereal infections.\(^6\)

This broad set of medico-cultural shifts meant that new terminologies were needed to understand and describe the impact of venereal diseases. Ways of naming, defining and understanding syphilis and the broader category of venereal diseases changed over the course of the 19\(^{th}\) and into the 20\(^{th}\) century. In the mid 19th century, particularly in France, three theories related to venereal diseases were prominent: the orthodox theory of the unity of gonorrhoea and syphilis; the Broussais theory which denied the existence of such a disease; and the Ricord theory which made a distinction

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\(^5\) By 1926, Ehrlich had been immortalised, along with other significant scientists who investigated germs and related theories, in *Microbe Hunters* (Orlando, 1926) by Paul de Kruif. De Kruif wrote an entertaining and hagiographic account of important early virologists, microbiologists and immunologists like Koch, Pasteur, Metchnikoff, Ros, Grassi and Ehrlich. Ehrlich was possibly apocryphally described as saying that ‘we must learn to shoot microbes with magic bullets’.

\(^6\) Most broad-ranging histories of venereal diseases take it as axiomatic that the prevalence of venereal diseases increases during, and as a result of, war. See Brandt, A., *No Magic Bullet: A Social History of Venereal Diseases in US since 1880*, Oxford, 1985; Oriel, J. D., *The Scars of Venus: a History of Venereology*, London, 1994; Cassel, J., *The Secret Plague: Venereal Disease in Canada, 1838–1939*, Toronto, 1987. It should be noted that the perception that venereal diseases increased during, and as a result of war, is also true: there were, and are, many interests to be served in inflaming the perception of a ‘red plague.’
between gonorrhoea and syphilis. Dracobly argues that such theoretical arguments were closely linked to therapeutic developments. Remnants of these theoretical debates continued into the 20th century, and were reflected in the way in which legislators chose to name venereal diseases. ‘Venereal disease’ as a term emerged gradually in legal and medical parlance, replacing the earlier and sometimes more obfuscatory ‘contagious diseases.’ ‘Contagious diseases’ as an epithet has its roots in contagion, a complex and laden word which at times referred to venereal and at other times to other diseases, including cholera, leprosy and smallpox. It is worth noting that sometimes the usage was the singular ‘venereal disease’: gonorrhoea, syphilis and chancroid could be referred to as one disease, reflecting the mid-19th century orthodox theory. This was very different to the way in which other communicable diseases were defined, like tuberculosis, smallpox or diphtheria. By the early 20th century other organisms and infections were being categorized as venereal infections. Although primary sources from the early 20th century mostly

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8 Only in the last decade have medical and other associated experts in the health sector decided to alter the nomenclature of ‘sexually transmitted diseases’ to ‘sexually transmissible infections.’ The health sector now talks about STIs, as opposed to STDs. The differences are subtle. It is clear, however, that an infection is perceived to be less threatening than a disease, and that ‘transmissible’ carries only the potential for infection, as opposed to the more certain ‘transmitted.’
9 Throughout the later part of the 19th century, legislation related to venereal diseases was always referred to as contagious diseases legislation. This was often to disguise the real intent of the legislation, given the controversies which surrounded its introduction. Even in 1909, with the NSW Prisoners Detention Act, ‘contagious disease’ was the preferred appellation throughout the Parliamentary debates.
10 Chancroid is an STI caused by Haemophilus ducreyi, and is characterised by a painful primary ulcer at the site of inoculation, usually on the external genitalia, associated with regional lymphadenitis. In this period it was often referred to as soft chancre, soft sore or soft ulcer.
12 There were in fact more than three organisms that were sometimes suggested to be venereal diseases. Medical texts of the time, for instance, refer to other genital infections that could be considered sexually transmitted. McDonagh, J. E. R., in the Biology and Treatment of Venereal Diseases, London, 1915, refers to herpes genitalis, molluscum contagiosum, granuloma inguinale and pediculosis pubis. Harrison, L. W., in The Diagnosis and Treatment of Venereal Diseases in General Practice, London, 1918, refers to Balanitis, Papillomata (genital warts), Itch, herpes and molluscum contagiosum. These conditions were excluded from venereal diseases legislation because it was not conclusively accepted that they were venereal diseases. McDonagh argued that herpes genitalis ‘was most common in patients who have suffered from a venereal disease, especially from gonorrhoea, but it may occur in those who have not’ (p. 469). Harrison argued that infections like scabies and pediculosis could ‘result from connection with unclean, impure or diseased persons…and that the proof of non-specificity of a disorder of the genital organs does not disprove its origins in venery’ (p. 426).
use the terms ‘venereal disease’ or ‘venereal diseases,’ I will introduce somewhat new concepts. I will discuss venerealism and venerealisation. I will parse the venereal, and identify how attitudes, beliefs and values were actively used to construct the category of the ‘venereal’ – a category that included the venereal patient, institution, population and discourse. For this reason I will refer throughout to ‘venereal’ patients, and not patients with venereal diseases; to the ‘venereal’ count, and not prevalence of venereal diseases; and to ‘venereal’ treatments, and not treatment for venereal disease. Other words and phrases have changed since the early 20th century. In the period that this thesis covers, consumers were called patients and sexual health physicians were called either venereologists or syphilologists. The process of populations becoming infected with syphilis was called syphilisation (rhetorically related to civilization) and when fear of being infected with syphilis became pathological, it was sometimes called syphilophobia. When venereal diseases were discussed, the references were usually only to gonorrhoea (and the chronic gonorrhoeal condition, gleet), syphilis or chancroid: nowadays, sexually transmissible infections include a veritable armory of bacteria, viruses and protozoa.

The management of syphilis and other venereal diseases between c.1901–1925 was coterminous with broader public health trends and categorisations concerned with regulating communicable diseases and with developments in bacteriology, but was in some ways quite different to responses to other communicable diseases. The legal and institutional segregation of particular groups of patients based on infections was characteristic of this period. Isolation was a technique used broadly in regulating

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13 Bradford, D., in V. D. in Australia, Melbourne, 1981, p. 6, writing just before the onset of the AIDS epidemic in Australia, argued that ‘VD is a name which has stuck, and is the name best known to most people…other names are sexually transmitted diseases, communicable diseases, social diseases, genital disease and even plain infectious disease.’

14 The Report of the Committee investigating venereal diseases in New Zealand in 1922 suggested that ‘syphilization follows civilization, and syphilis is an important factor in the extermination of aboriginal races’ (Committee of the New Zealand Board of Health, Venereal Diseases in New Zealand: Report of the Special Committee of the Board of Health appointed by the Hon. Minister of Health, Wellington, 1922).


16 A range of infectious diseases were colour coded, creating a spectrum of infections: the red plague (venereal diseases), the black plague (bubonic plague), the white plague (tuberculosis) and the yellow plague (smallpox), although these ‘colours’ referred to very different phenomena (Lewis, M., Thorns on the Rose, pp. 142–143). Similarly, treatment facilities for particular infections were given specific titles: sanatoria for tuberculosis, lazarets for leprosy, asylums for mental illness and cliniques or lock hospitals for venereal diseases.
communicable diseases. Smallpox, scarlet fever and leprosy were all examples of communicable diseases for which isolationist policies were developed, usually at a significantly earlier time than similar responses for venereal diseases. I will argue, however, that the coupling of isolation with the venereal stigma placed venereal diseases in a very different field. In the parliamentary debates which preceded the introduction of the NSW Venereal Diseases Act in 1918, the Hon. Dr Nash argued that: ‘venereal diseases stand in a class apart, and it is this standing in a class apart that makes the difficulty in dealing with them in a legislative way. The ordinary diseases which are notifiable, such as smallpox, consumption and others, have with them no stigma.’ Contact, with its corollary of segregation, and space, with its corollary isolation, placed the treatment of venereal diseases in a broad public health response to communicable diseases. Avoidance and exclusion, based on a stigma


20 In other contexts, both internationally and in other states of Australia, segregation of the ‘venereal’ generally preceded isolation practices for other infectious diseases. NSW was a notable and interesting exception, with attempts to introduce isolationist contagious diseases legislation failing in the 1870s, and only succeeding with the NSW Prisoners Detention Act 1909.

21 NSW Parliamentary Debates, session 1918, 9 George V, vol. LXXXIV, p. 3500. Others agreed with Nash’s view. L. W. Harrison, a medical practitioner with considerable wartime experience of venereal diseases, argued in 1918 that any form of communicable disease, from scabies to leprosy, could be sexually transmitted. He further argued that the sexual communication of predominantly non-sexual diseases carried ‘no slur, or stigma’ and it was only the communication of the so-called venereal diseases that carried stigma (Harrison, L. W., The Diagnosis and Treatment of Venereal Diseases in General Practice, London, 1918, pp. 424–426).
associated with sex and sexuality, placed venereal diseases in a discourse of their own.

Notwithstanding these important terminological and categorical changes, perhaps the most significant change over this period was the way in which the NSW government perceived itself as having a role in the management of venereal diseases. In the early 20th century governments all over the world were questioning the impact of venereal diseases on individuals and populations, and changing perceptions of venereal populations led to the deployment of specific apparatus and techniques to monitor the conduct of these populations. Treatments, legislative responses, preventative approaches, hospital facilities, patient numbers and ways of monitoring them, medical records, individual behaviours: all changed in this period, and at the heart of these changes was a reconceptualisation of the role of government itself.

There were two clear rationales for the government’s role in the management of venereal diseases, which I characterise, following the work of Michel Foucault, as the ‘medical gaze’ and the ‘watchful eye.’ 22 I use the medical gaze to describe not only the individual patient attending a hospital and the body of the person diagnosed with syphilis and/or gonorrhoea, but most importantly to describe the power relationship between the medical practitioner and the patient. I use the watchful eye in a more overarching way to suggest the suite of techniques and apparatus deployed by government to monitor and regulate the venereal body politic, both the populations perceived to be posing a venereal risk, and populations at risk of venereal infection. I argue that the NSW Venereal Diseases Act 1918 conflated these rationales: empowering, and enforcing individual medical practitioners and their collective bodies to maintain a watchful eye on the body politic.

In the first quarter of the 20th century in NSW, governments themselves came to embody the ‘medical gaze’; they increasingly funded public hospitals to employ medical practitioners to provide venereal treatment for the indigent poor, so as to monitor their sexual and reproductive conduct. Foucault’s notion of the medical gaze

provides a set of metaphors and an ensemble of relationships which assist in understanding historical changes in the relationships between medical practitioners and patients. According to Foucault, the ‘abstracted patient,’ with a totalising ‘concrete disease,’ and the institutional setting, existed in fluid relationship with each other, and in the context of the empirical clinic, or the teaching hospital, produced the experience and expression of medicine. Foucault argued that for clinical experience to become a form of knowledge, with a new language based on the correlation between the invisible and the expressible disease, ‘a re-organisation of the hospital field, a new definition of the status of the patient in society, and the establishment of a certain relationship between public assistance and medical experience, between help and knowledge, became necessary.’ It was in the hospital, and as a result of the hospital, that clinical experience became possible as a form of knowledge. In this thesis I interrogate evidence that sheds light on the nature of the medical gaze as it was practised at a number of hospitals in Sydney in the early part of the 20th century, and how clinical practice assisted in the production of venereal categories and knowledge.

The second and closely related governmental rationale was the maintenance of a ‘watchful eye:’ governments were increasingly interested in documenting and monitoring the sexual and reproductive conduct of specific venereal populations. To do this, governments deployed and exercised a range of technologies of power, and the Foucauldian notion of ‘panopticon’ is a useful tool for understanding these technologies. Foucault used the Benthamite notion of the panopticon to describe historical renditions of power and surveillance in a range of settings from the 18th century. The ‘panopticon’ was not so much an architectural model that embodied power as a means for the operation of power in space. The metaphor is particularly useful in understanding changing historical approaches to keeping a ‘watchful eye’ on people with venereal diseases: ranging from quarantine, detention and isolation in ‘lock’ settings, to more diffuse and sophisticated surveillance mechanisms involving large numbers of health bureaucrats and medical practitioners. I will expand on both the ‘medical gaze’ and the ‘watchful eye,’ and their Foucauldian resonances, in chapter 4 and chapter 6, in relation to both venereal treatments and epidemiology, and associated legislation.

In interrogating the medical gaze and the watchful eye, I argue that during this period there was a gradual, uneven and complex biopolitical shift from government to self-government in the management of venereal diseases in NSW. I use ‘government’ to refer both to Commonwealth and State departments of public health, and the practices, knowledges, techniques and institutions that shaped public health. I use ‘self-government’ to denote the movement towards individual responsibilisation and an internalized desire for health, and the government’s role in promoting these responsibilist approaches, based on education and prevention. The shift from government to self-government involved a shift in the sites and practices of rule, which in itself involved a change ‘in the focus and controls of public health from issues of sanitation and the natural environment to patterns of social contact and transmission.’

I use the Foucauldian framework of biopolitics to argue two connected theses. Firstly, in the management of venereal diseases, questions of individual sexual and reproductive contact and conduct intersected with issues of national policy and power. For example, powerful organising ideas like eugenics impacted upon the conduct of men and women in relation to sexual activity, marriage and childbirth. As the century progressed the government’s interest in the conduct of individuals became more focused on facilitating the role of the individual, the self, in regulating their own health. In relation to the management of venereal diseases this meant that older paradigms of coercion, detention, isolation and segregation slowly gave way to newer paradigms of prevention, persuasion, education and self-regulation.

Secondly, I characterise biopolitics as the diffusion of power through a range of practices, apparatuses and policies, in conjunction with experts, with the intention of consolidating government and enhancing self-government. As Foucault suggested, government and self-government are interrelated, and act upon each other: the movement towards self-government is in itself a major instrument of government power. Similarly, self-government is conceptually realisable in the context of populations: governments are interested in promoting self-government precisely

because individuals are the basic units of populations, populations communicate and inter-relate, and populations can be monitored, studied, reported upon and categorised. Government and self-government will not be examined as simple oppositions however: instead, I will propose that there was a complex movement in the practice and techniques of power in this period. Techniques of domination and techniques of self-regulation were intensely and regularly interrogated, and different techniques were variously tried, resisted, abandoned, modified, outlawed and normalised. Public health techniques throughout the period included detention, coercion, notification, isolation, persuasion, education, responsibilisation, consent and propaganda, all terms that I will discuss and explain. These were the biopolitical tools of public health, and these tools were used extensively in the management of ‘colonialism, nationalism, and in the interwar period, racial hygiene and eugenics.’

The NSW Venereal Diseases Act 1918 (and subsequent Regulations) was a significant moment in this shift from government to self-government. The Act itself was not a watershed, with immediate differences in techniques of power on either side of the divide. For example I will provide evidence for the rise of self-government in the period prior to 1918, and then evidence the curiously, and awkwardly, coercive nature of the Venereal Diseases Act 1918. I will also provide evidence to suggest that over this period power slowly became more dispersed through a range of practices and sites. Prior to 1918, key sites for the exercise of control over the venereal population in NSW were both the venereal wards and the outpatient clinics at Royal Prince Alfred and other hospitals and pieces of key legislation for ensuring detention and compulsory treatment such as the Prisoners Detention Act 1909. Key structures in the deployment of this power were the Department of Public Health, and the medical profession. I investigate the spaces, structures and relationships of all these bodies. After 1918, key sites for the exercise of control of the venereal population were workplaces, schools, community based organisations and people’s homes: self-regulation necessitated a dispersal of power through practices which allowed for a focus on social contacts and transmission. I will investigate this diffusion of power in all three domains: treatment, epidemiology and prevention.

My analysis of the biopolitics of venereal diseases in NSW is both informed by, and departs from, existing historiography. Current historiography clusters around two significant periods: the mid- to late-19th century introduction, circulation and repeal of contagious diseases legislation and the early 20th century relationship between medical technology and legislation. Across and beyond both these periods, the most recent historiography has focused on trans-national and imperial developments and inter-connections in the management of venereal diseases, including the diffusion of ideas and theories related to venereal diseases.\textsuperscript{26} Berridge has indicated that in the historiography of venereal diseases the cross-national approach is one way forward.\textsuperscript{27} Notwithstanding the historiographical need for international comparisons, I focus intensively on the second and third decades of the 20th century, at a particular site in Sydney, NSW. There is a need for localised, micro-histories of venereal diseases, where evidence and data related to specific hospitals, medical practitioners and individuals are examined. To a large extent, this is what this thesis is about: the patients who attended the Outpatient Clinique and Venereal Wards at RPA Hospital between 1901 and 1925, the medical practitioners who treated them, the public health officials who developed policies, and the politicians who implemented legislation.

What is it about the lives of people with venereal infections that is historically relevant, or about the relationship between people with venereal infections, medical experts and governments, that has meaning to historians? The significance of venereal patients lies in their liminality and marginality. People with venereal diseases had complex and cathartic relationships with medical practitioners, hospitals and governments: their treatments were punishing, their diagnoses were doubtful, the surveillance of their lives invasive, the consequences of their contact with the medical profession were probably traumatising, distressing and fraught, and they have often


been stereotyped as non-compliant and irresponsible, and therefore not worthy of treatment. In this period as well they were confronted with new treatments, which publicity and word-of-mouth suggested were either ‘magic bullets’ or toxic killers. Porter argues that social historians generally ‘have given the sick a wide berth’ and that if people were to become the subjects, and not just the objects of social history, then historians of sickness needed to create a history ‘from below.’ In the historiography of venereal diseases, a focus on individual patients at particular hospitals who lived with venereal diseases is somewhat new, as suggested by Davidson. Part of my thesis aims to locate the voices of venereal patients ‘from below’ usually when they intersected with medical practitioners at the Royal Prince Alfred and other hospitals in NSW. Using this approach, I also aim to tunnel under the ‘enormous burden of metaphorical representation’ and ‘over-signification’ which has characterised much venereal diseases historiography.

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28 Evidence presented by most of the medical practitioners to the NSW Select Committee on the Prevalence of Venereal Diseases 1915 (Legislative Assembly of NSW, Minutes of Evidence taken before the Select Committee on the Prevalence of Venereal Diseases, Progress Report, Sydney, 1915) suggested that they perceived their venereal patients to be reckless, irresponsible and non-compliant with treatment regimes. The evidence of Dr G. W. Bray and The Hon. Frederick Flowers is the only evidence presented to the committee which suggested that venereal patients were responsible, compliant and grateful.


32 Davidson, R., ‘Venereal Diseases, Sexual Morality and Public Health in Inter War Scotland,’ Journal of the History of Sexuality, 1994: 5:2: p. 268. Davidson argues that much research ‘has centred on socio-medico politics at a national level, and for Britain in particular, there is a lack of regional and local studies of the VD services that provide traction on these issues at the interface between the health authorities and dispensaries and those in the society who were venereally infected.’


A significant proportion of venereal diseases historiography is focused on the causes and consequences of venereal infection in soldiers, sailors and/or prostitutes. The connection between prostitution and the armed forces, whether army or navy, generally centred on contained environments like naval ports and garrison towns, is explored to some extent in most histories of venereal diseases and prostitution.\textsuperscript{35} This focus resulted from the attention that has been paid to histories of contagious diseases legislation in the 1860s in the UK, and in the later 19\textsuperscript{th} century in other parts of the British Empire. Much of this historiography is concerned with the role that feminists played in resisting such legislation, and the implications of this struggle in understanding regulatory approaches to women’s bodies. There is also a significant historiography centred on prostitution, feminism and the military which relates to other European countries.\textsuperscript{36} This broad historiography provides an important backdrop to this thesis, and McHugh, Hall, Walkowitz, Bashford and Levine all explore the regulation of women’s bodies through moral and legislative injunctions related to prostitution.\textsuperscript{37} McHugh, for instance, traces the development of Contagious Diseases legislation in England, and the development of prostitution around garrison towns. Levine traces the pattern of contagious diseases legislation between Britain and various colonial settlements, including Queensland. Davidson points to the return journey which often happened with the export of contagious diseases legislation: constructions of sexuality fed back into venereal diseases policy in the UK with

\textsuperscript{35} Sea ports were perceived to be a major entry point for venereal diseases in sovereign territory. Sailors clearly visited a range of countries and territories, and their connection with prostitutes was seen to place them at risk of venereal infection. In the United States and Canada, marine hospitals and clinics were built around sea ports. This idea was eventually taken up internationally, in 1924, when 42 countries signed the Brussels Agreement. ‘This established no-paying treatment clinics in the various ports of signatory countries, and these clinics offered therapy for seamen with actual or suspected venereal infection’ (Felstein, I., Sexual Pollution: The Fall and Rise of Venereal Diseases, London, 1974, p. 28).


‘concepts such as sexual atavism conflating fears of native and female sexuality.’

Levine’s analysis of the development and deployment of contagious diseases legislation in Queensland has served as an important platform for my discussion of similar legislation, the NSW Prisoners Detention Act 1909, in NSW. Similarly, Hart has provided important statistical information related to the treatment of venereal diseases in South Australia in the first quarter of the 20th century.

There are three further strands of venereal diseases historiography: regional, national and international histories; histories which place venereal diseases in the context of sex and sexuality; and histories which explore the connection between venereal diseases and race, with a particular emphasis on eugenics. Of course, many histories cover all three strands, particularly social histories which investigate the connections between national agenda, social constructions of sexuality, and race. National and international histories examine broad themes and policy directions, and position venereal diseases in a long history which encompasses comments on ancient and medieval conceptions of the venereal and shorter sections related to the discovery of the syphilis spirochete and the gonorrhoea gonococcus. Brandt, Cassel and Oriel provide three such examples. Both of these histories are qualitative studies that attempt to investigate the social and cultural construction of venereal diseases at a national level. These investigations are mostly undertaken through an examination of government policy, and its impact on populations. Both of these histories, at the macro level, effectively demonstrate the extent to which social and cultural agendas dominated medical and public efforts to control and regulate venereal diseases. In this thesis, I have taken a micro-level approach, substantially locating my investigation in the practices and techniques of one hospital, in one city, in a limited period.

39 See also Levine’s ‘Public Health, Venereal Disease and Colonial Medicine in the Later Nineteenth Century’ in Davidson, R. and Hall, L., Sex, Sin and Suffering.
Lundberg has made an innovative contribution to the genre of national histories, with her analysis of a demographic database in Sweden. Lundberg examines medical and political perceptions of venereal diseases in Sweden in the period 1785-1903, but also studies the lives of patients with venereal diseases. Using demographic data related to patients with venereal diseases, analysed against a control group of patients without venereal infection, Lundberg concluded that although patients with venereal disease belonged to a cross-section of Swedish society, most were from the indigent or working class. Lundberg also concluded that adult mortality rates and marriage rates were not significantly different for the venereal and non-venereal populations, and therefore that life and familial expectations were not abnormal or reduced. I too have analysed specific demographic data, embodied in the weekly venereal statistical returns to the NSW Department of Public Health from Sydney and RPA Hospitals. These data are significantly more localised than Lundberg’s, but it does shed light on gender and infection profiles in Sydney between 1910 and 1920.

Lewis provides another example of this national genre, in his history of venereal diseases in Australia, which also places that history in the context of Britain and the United States, ‘because historically Australia was a political dependant of Britain and a cultural dependant of Britain, Europe and the United States.’ With the important exception of Levine, Lewis provides, in fact, one of the few histories that span three continents, and compares policies and practices across this geography. He examines examples of the social construction of venereal diseases, but is avowedly concerned with ‘a larger project – the identification of the social, economic, political, cultural and medical factors shaping both the historical pattern of STDs and the collective (government and community) response to that pattern.’ Given his aim to discern patterns, Lewis utilises quantitative data far more readily than either Cassel or Brandt, and often to compelling effect. I will utilise Lewis’s data on treatment defaulters after the introduction of notification in NSW in 1918 in this thesis, but will also challenge

46 Levine, P., Prostitution, Race and Politics: Policing Venereal Disease in the British Empire.
47 Lewis, Thorns on the Rose, p. X111.
some general conclusions about the nature and extent of default in NSW.\footnote{Ibid., pp. 213–215.} Lewis’s description of the use of notification in all Australian states as a regulatory tool in the inter-war years, and the comparison with Great Britain, where there was a reliance on voluntary attendance at public VD clinics, allows for an assessment of the value and benefit of both public health approaches. The broad comparative approach is not the goal of this thesis however: rather the reverse.\footnote{There is certainly a gap in the literature which examines the development of international linkages and networks for the management of venereal diseases across the 20\textsuperscript{th} century. This would include an analysis of the role of the League of Nations, the United Nations, World Health Organisation, and international unions and societies formed to combat venereal diseases. This could also include an analysis of those international agreements, like the Brussels Agreement 1924, developed so as to ensure consistency of treatment for merchant seamen across the world’s ports (\textit{World Directory of Venereal-Disease Treatment Centres at Ports}, Geneva, 1961). One article which addresses international coordination is Weindling, P., ‘The Politics of International Coordination to Combat Sexually Transmitted Diseases, 1900–1980,’ in Berridge, V., and Strong, P., (eds), \textit{AIDS and Contemporary History}, London, 1993.} In as much as quantitative data is analysed in this thesis, it is in the context of specific outpatient occasion-of-service data from particular clinics at Sydney Hospital and RPA Hospital.

Davidson and Hall provide a variation on this comparative national genre with their collection of essays that examine the history of the management of venereal diseases across Europe from 1870.\footnote{Davidson and Hall (eds), \textit{Sex, Sin and Suffering}.} Chapters in this book demonstrate that in this period public health responses to the management of venereal diseases were varied and no single template that positioned technological change leading to legislative intervention was apparent across Europe. The British model, which passed from promulgation of contagious diseases legislation in the 1860s, and their later repeal, through to the Royal Commission of 1916 and the post-war development of voluntary, confidential clinics, was not paralleled elsewhere in Europe. Aisenberg demonstrates that the regulation of prostitution lasted until the 1960s in France.\footnote{Aisenberg, A., ‘Syphilis and Prostitution: a Regulatory Couplet in Nineteenth Century France,’ in Davidson, R. and Hall, L., \textit{Sex, Sin and Suffering: Venereal Disease and European Society since 1870}, London, 2001.} Castejon-Bolea demonstrates that the abolition of regulation and medicalisation did not occur in Spain until the Second Republic in the 1930s.\footnote{Castejon-Bolea, R., ‘Doctors, Social Medicine and VD in Late 19\textsuperscript{th} and Early 20\textsuperscript{th} Century Spain,’ in Davidson, R. and Hall, L., \textit{Sex, Sin and Suffering: Venereal Disease and European Society since 1870}, London, 2001.} Similarly, approaches to the management of venereal diseases were focused on health education in early
communist Russia.\cite{53} Models in Australia somewhat resembled the British template, but not exclusively. Whilst there was a clear shift from medical regulation to self-regulation over the period, most venereal diseases legislation introduced between 1915 and 1920 at the behest of the Commonwealth of Australia, including legislation in NSW, did not enact voluntary treatment. These state-based pieces of legislation did however institute a system of free, confidential public clinics. Lewis, Bamber and Waugh provide a similar comparative study of venereal diseases in the Asia/Pacific region.\cite{54}

Davidson has also contributed significantly to the national genre, whilst interrogating information and interpretations of venereal diseases in Scotland across the 20th century.\cite{55} He explores the role of venereal diseases in shaping perceptions of sexuality in twentieth-century Scotland. He is interested in the extent to which anxieties related to the ‘hidden scourge’ (another contemporary term for the ‘red plague’) and their impacts on public morality affected medical and political developments, during times of both peace and war. Davidson acknowledges that the ‘understandable preoccupation of feminist historians with the sexual discrimination underpinning VD measures’ has now been supplemented by other studies focusing on the importance of class, generation and race.\cite{56} His study covers treatment, epidemiology and prevention issues in Scotland, and provides important information on venereal propaganda, through both text and images, that was distributed by government in interwar Scotland. Much of this prevention education material was produced by the British Social Hygiene Council in the 1920s. In chapter 6 I examine some of the textual prevention education material produced in NSW by equivalent organizations, including the Australian Association for Fighting Venereal Diseases.

\cite{53} Bernstein, F., ‘Visions of Sexual Health and Illness in Revolutionary Russia,’ in Davidson and Hall, Sex, Sin and Suffering.
\cite{54} Lewis, M., Bamber, S., and Waugh, M., (eds), Sex, Disease and Society: A Comparative History of Sexually Transmitted Diseases and HIV/AIDS in Asia and the Pacific, Sydney, 1997.
\cite{55} Davidson, R., Dangerous Liaisons: A Social History of Venereal Diseases in Twentieth Century Scotland, Amsterdam, 2000.
\cite{56} Ibid., p. 1.
The second category of venereal diseases histories may take a national or a local view, but they position venereal diseases firmly in the field of sex and sexuality. Such relationships are in one sense mundane: venereal diseases are after all sexually transmitted. On another level, however, sex, sexuality and sexual infections are related in the same way that the medical gaze is related to the watchful eye: as Foucault remarks, ‘the political significance of the problem of sex is due to the fact that sex is located at the point of intersection of the discipline of the body and the control of the population.’ There are clear and important associations between sexuality, desire, risk and infection, as they affect the body and the body politic, and much recent analysis of sexuality has examined these associations in relation to HIV/AIDS. Davenport-Hines for example set out to write ‘a history of English sexuality from the standpoint of the AIDS crisis.’ He states that his ‘themes are sex, dirt, fear and punishment,’ and in particular the long history of the association between homosexuals and venereal diseases. Davenport-Hines’ powerful evocation of ‘AIDS as a Copernican event in the history of sexuality’ does not imply that his history is about AIDS: rather, it is written in response to it. Davenport-Hines recounts social and medical perceptions of venereal diseases in England over four centuries, together with political and administrative responses, and charts perceptions of homosexuality over the same period. Levine’s study of colonialism and contagious diseases demonstrates how important the regulation of sexuality was to

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57 See also Freund, M., ‘Women VD and the Control of Female Sexuality in Post-war Hamburg,’ and Wanrooij, B., ‘The Thorns of Love: Sexuality, Syphilis and Social Control in Modern Italy’ in Davidson and Hall, Sex, Sin and Suffering.


59 Davenport-Hines, R., Sex, Death and Punishment: Attitudes to Sex and Sexuality in Britain since the Renaissance, Sydney, 1990.

60 Ibid., p. 3.

61 See also Amstey, M. S., ‘The Political History of Syphilis and its Application to the AIDS Epidemic,’ Women’s Health Issues, 1994: 4: pp. 16–19. Amstey argues that to control the HIV epidemic, control measures used for syphilis (before penicillin) are needed – including contact tracing and partner notification.

62 This thesis will not examine the connection between venereal diseases and homosexuality in the first quarter of the 20th century in NSW, but there is a wide contemporary literature which examines AIDS in relation to homosexuality in NSW at the end of the 20th century. Notable examples include the work of McInnes (McInnes, Hurley, Prestage, Hendry, Enacting Sexual Contexts: Negotiating the Self, Sex and Risk in Sex on Premises Venues, University of Western Sydney, 2001); Rosengarten (Rosengarten, Race and Kippax, ‘Touch Wood, Everything Will be OK’: Gay Men’s Understandings of Clinical Markers in Sexual Practice, University of NSW, 2000); Davis, Dowsett, Connell, Ariss, Carrigan and Chapple, Class, Homosexuality and AIDS Prevention, Macquarie University, 1993); and Lambevski (Lambevski, Kippax, Crawford, Abelson, Bartos, Mischewski, Living as Men: ‘It’s Like Being in a Washing Machine’: Masculinities in Contemporary Urban Australia, University of New South Wales, 2001).
late 19th century British governments, and colonial governments. Davidson’s analysis of interwar Scotland argues that venereal diseases ‘provided a powerful justification for the social construction and proscription of dangerous sexualities.’ Others, including Waldby, and Weeks, have addressed the relationship between medical discourse and sexual politics. In the context of the biopolitics of venereal diseases, sexuality is crucial because it is the hinge that links an ‘anatamo-politics’ of the human body with a biopolitics of the human population, as Foucault suggests.

The final category in venereal diseases historiography examines the relationship between race and venereal diseases. Jones provides a good example of this literature with his history concentrating on a particular experiment conducted in the United States, in which African-American men were deliberately inoculated with syphilis, and over a number of years denied treatment, so as to observe the effect of untreated syphilis. This experiment was consistent with a long line of eugenic approaches which included sterilisation of the unfit and medical certificates of health and freedom from infection for those proposing marriage. This localised history is relatively uncommon in the literature, but there is a significant literature which positions venereal diseases in the broader context of eugenics. Towards the end of the 19th century, and partially in response to imperialist ventures, the ‘spectre’ of racial degeneration was raised in Australia and across the globe. This organising idea was a national imperative that informed policy and practice around the management of venereal diseases. Porter, Lowe and Bashford examine eugenics in relation to public health, and Bashford in particular demonstrates how eugenics was ‘grafted’ onto public health. I argue that the organising idea of race, and the practice of eugenics,

63 Levine, P., Prostitution, Race and Politics.
64 Davidson, R., Dangerous Liaisons, p. 1.
68 There is a growing historiography on the impact of venereal diseases on Aboriginal communities. See Jebb, M., ‘The Lock Hospitals Experiment: Europeans, Aborigines and Venereal Disease,’ European-Aboriginal Relations in Western Australian History, 1984: 8: pp. 68–87; Jebb, M. A., Blood,
were fundamental ways of understanding venereal populations, along with class and gender, and that between 1901 and 1925, such concepts were perceived as central for regulating the sexual and reproductive health of the nation.

In examining organising ideas of race, class and gender, and investigating the biopolitics of venereal diseases in NSW between 1901 and 1925, I have taken RPA Hospital in Sydney as my focus. There are two major sets of unpublished primary evidence which have provided significant sets of data for this investigation: the surviving medical records of the venereal wards and clinics at RPA Hospital for the period 1910–1925 and the surviving occasions of service for the outpatient venereal Clinique at RPA Hospital 1917 –1921, and Sydney Hospital 1918–1919. The medical records from the venereal wards and clinics at RPA Hospital are located in the secondary repository of the Archives Department at RPA Hospital. These records allow for the partial reconstruction of the medical lives of the male and female patients who attended for diagnosis and/or treatment for either syphilis or gonorrhoea. These records coincide almost exactly with the important technological changes I have noted earlier. The vast majority relate to poor, young women who lived in the industrial suburbs around Camperdown. They comprise physicians’ notes, nurses’ charts, graphs, pathology requests and results and cover-sheets related to individuals who attended the venereal wards. It should be noted that prior to 1950, in NSW, individual patient records, in separate files, were not archived separately. The usual practice prior to 1950 was to have all patients with similar diseases or conditions recorded in a ‘disease log,’ which was a formatted, triplicated log book which allowed for the grouping of patients by disease. Consequently, log books survive, amongst others, for ‘migraine,’ ‘varicose veins,’ ‘abortion’ and ‘syphilis.’ This was known as the Bertillion system. This grouping clearly supports Foucault’s theory of the patient

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Davidson argues that venereal diseases policies were equally determined by gender and class considerations. He suggests that in the final analysis it was ‘primarily working class female sexuality that was scrutinized by public health and police authorities’ (Davidson, R., Dangerous Liaisons, p. 2).

These records were located in the secondary repository of the Medical Records section of RPA Hospital. Given the confidential nature of these medical records, and the possibility that some patients may still be alive, ethical approval was sought and obtained from the Ethics Committee at RPA Hospital.
being abstracted by the disease, and the medical records themselves allow for a careful consideration of the object and nature of the medical gaze.

The unpublished weekly returns on the number of patients attending the Outpatient Clinique at RPA Hospital are located in the NSW State Archives. They comprise some hundreds of handwritten and typed half-page statements from the Registrars at RPA Hospital to the Minister of Public Health. These batches of weekly returns comprehensively cover the period from 1 January 1917, to September 1921, and for most of that period, they include data on the Outpatient Clinique at Sydney Hospital as well. This permits useful comparative data analysis. Sample copies of the weekly returns are included in chapter 4. The weekly returns are statements which include raw data on the number of patients attending for the week, including a breakdown according to gender, and the number of new cases of syphilis and gonorrhoea diagnosed, again broken down according to gender. As returns were submitted to the Minister for Public Health, receipt of these returns was acknowledged by a series of signatures by senior public health officials, and by the Minister himself. The Minister always interrogated slight variations, particularly decreases in the number of patients attending, and correspondence was entered into with the Registrar at RPA Hospital to ascertain reasons for any decrease. These weekly returns were scrutinised closely, and they were also distributed to a range of newspapers, both metropolitan, and provincial, for publication. The weekly returns were pulled together annually to create a picture of total attendances and total diagnoses per year.

Other important sets of primary evidence are the reports, books, booklets and articles by prominent public health politicians, medical practitioners or bureaucrats, both in Australia and overseas. I have examined the evidence of four key contemporary Australian commentators whose careers were integrally concerned with the management of venereal diseases, public health administration and eugenics: John Howard Lidgett Cumpston (1880–1954), the first Commonwealth Director-General of Health of the Federal Health Department; Dr Richard Arthur (1865–1932), whose career as both a politician and a medical practitioner spanned the Boer War and World War 1, the Prisoners Detention Act 1909, to which he was vehemently opposed and the Venereal Diseases Act 1918, which he helped draft; George Black (1854–1936), Chief Secretary and Minister for Public Health in NSW for a short time from April to
November in 1916, and a prominent Labor Party politician; and The Hon. Fred Flowers (1864–1928), Minister for Public Instruction in 1911–12 and Minister for Public Health from 1914 to 1915. Flowers was also a Director of RPA Hospital between 1916 and 1918. These commentators were all at some stage either Ministers of Public Health in NSW, or bureaucrats in the Commonwealth Department of Health, and as such regularly commented and reported upon arrangements for the management of venereal diseases in NSW. I have also examined the evidence provided by the most noted international venereologist of the period, Dr Alfred Fournier (1832–1914), whose publications and views were well known in NSW.

The major primary evidence examined for this thesis permits me to undertake a qualitative and quantitative examination of the treatment, epidemiology and prevention of venereal diseases, as they relate to both the venereal body and the venereal body politic. In chapter 1, I describe in detail the geography of venereal diseases management in NSW, with particular reference to the changing role of government in relation to hospitals, through the Department of Public Health. I will chart a governmental line through the Prisoners Detention Act 1909, the Select Committee on the Prevalence of Venereal Diseases 1915 and the Venereal Diseases Act 1918. In chapter 2, I will describe venereal spaces at RPA Hospital, with particular reference to wards, outpatient clinics and a proposed purpose-built Venereal Block, and to the staff who worked in these spaces. In chapter 3 I will look at treatment. I argue that there was a widespread ambivalence towards treating venereal patients, and that treatment of venereal diseases was painful, prolonged and punitive precisely because of the moral sickness perceived to be at the heart of venereal infection.71 Mounting these arguments will involve a description of diagnostic and treatment regimes, and an examination of the patients who presented at the wards and clinics, based on their medical records. I will argue that in their conduct, venereal patients were often compliant, conscientious and responsible, despite some evidence relating to those patients who in the 1920s ‘defaulted’ from compulsory treatment.

71 Davidson, R., ‘Venereal Diseases, Sexual Morality and Public Health in Inter war Scotland,’ Journal of the History of Sexuality, 1994: 5:2: p. 289. Davidson remarks that ‘the lingering belief, despite protestations to the contrary, that venereal disease was the penalty for vice and sexual irresponsibility and that treatment for venereal infection should be neither too easy nor too accessible also explains in part the penitential regime operating in the clinics in inter war Scotland.’
In chapter 4 I examine epidemiology. I suggest that there was a discernible shift towards assessments of risk based on external factors, and a shift away from conceptualisations of danger as being inherent and individual in the management of venereal diseases. These shifts permitted and necessitated a focus on the factors affecting populations, as opposed to the factors affecting individuals. Governmental perceptions of venereal populations led to the deployment of various apparatuses and techniques to monitor the conduct of these populations. One of the key factors which characterised this concentration on populations was the enhanced capacity to count, and through counting, monitor populations. I suggest that statistical methodologies applied after the NSW Venereal Diseases Act 1918 allowed for the creation of two important new ‘venereal’ categories: the ‘notified person’ and the ‘defaulter,’ both categories which came to permeate renditions of venereal patients throughout the 20th century. In chapter 5 I focus on prevention. I argue that preventative approaches to venereal diseases became increasingly complex, and operated in three domains – preventative medicine, public health prevention and prevention education. I suggest that in the domain of prevention education, a plethora of community-based organizations emerged which ensured that sociologies and pedagogies related to prevention challenged the dominant medical discourses.

Between 1901 and 1925 in NSW there was an uneven and complicated shift from government to self-government, in prevention, treatment and epidemiological domains. Using familiar military metaphors to describe the war against syphilis, just after World War 1 a social commentator, pamphleteer and sex hygiene advocate, Mrs Francis Anderson, captured this shift when she argued:

The battle will be, not against Germans and Turks, of whom we know little, but against the foes of our own households, against our own habits, our own customs, our own silence on the subjects we would rather ignore, and our own blindness to the evil we would prefer not to see. 72

In the chapters which follow it will become evident just how much this ‘silence’ was articulated, and this ‘evil’ watched.

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Chapter 1
Administering Health and Venereal Diseases in New South Wales c. 1901 – 1925

Considerable change was taking place in the broad field of public health administration in the state of NSW in the period 1901–1925. Government was seeing itself as playing a more significant role in the management of a range of diseases, and hospitals were evolving from charitable or philanthropic establishments to institutions with firmer ties to government. Governments were questioning their own role in the provision of health services, and venereal diseases presented a real conundrum. On the one hand, venereal diseases were communicable, and governments in NSW and elsewhere had long played a significant role in the management of outbreaks of communicable diseases, particularly the series of smallpox and plague epidemics in Sydney in NSW between 1880 and 1920. On the other hand, syphilis and gonorrhoea were infectious diseases that had periods of latent symptomatology and could also be characterised as chronic infections, albeit with serious sequelae. Although understandable as chronic diseases, venereal infections also carried with them the ‘burden of stigma’, a phenomenon which was also played a part in the development of services. These issues played out in a number of challenges related to venereal service provision: the necessity for inpatient as opposed to outpatient services, the capacity to develop gender-specific services and the extent to which venereal services should be located in general or specialist hospitals were significant topics of debate. Syphilis and gonorrhoea were also perceived to have differential impacts on particular populations, and governments interrogated and juggled their responses at both the level of individual treatment in hospitals and regulatory approaches at the level of population. Both syphilis and gonorrhoea, however, were only two of a significant number of health issues in which governments saw themselves as having an increasingly interventionist role.

In this chapter I will examine how health was administered between 1901 and 1925 in a rapidly changing system in NSW, what sort of changes were occurring in the period, and what these changes indicated about prevailing conceptions of health in general, and RPA Hospital in particular. I will ask why the NSW government, and government in general, was interested in developing responses to venereal diseases. This will
involve an analysis of the paradigms that existed for the management of venereal diseases in public health frameworks (including lock hospitals) and an outline of the significant moments that characterised governmental responses to the management of venereal diseases in NSW. I will trace a line through late nineteenth century advocacy for contagious diseases legislation in NSW, the Prisoners Detention Act 1909, the Select Committee on the Prevalence of Venereal Diseases 1915 and the VD Act 1918 and its subsequent Regulations – all significant moments in the administration of venereal diseases. I will conclude by counterposing two contemporaneous discourses on venereal diseases treatments, and draw from these discourses observations on the shifting modes of rule that characterised the management of venereal diseases.

**Health administration in NSW**

Between 1901 and 1925, after NSW became a state rather than a colony, and as the Commonwealth government widened its purview, the administration of health underwent major changes. These changes reflected shifts in the very notion of health. Although the NSW Board of Health existed from as early as 1881, the Public Health Act of 1896 was a significant moment that established the Board of Health as the foremost instrument of public health administration in NSW. The Board of Health had the power to institute inquiries on its own initiative, report any government authority and ‘the capacity to make its own regulations unfettered by Ministerial approval.’ The Public Health Act 1896 also provided for notification of infectious diseases, although venereal diseases were not listed, for control of unhealthy buildings, and unwholesome food, drink or drugs, and for the registration and control of dairies and dairy products. With this set of inclusions, the Public Health Act was integrally concerned with sanitation and environmental health, and as such can be placed in a long tradition of similar legislation in the UK and Europe. Between 1896 and 1904, the administration of these aspects of public health was shared between the Department of the Colonial Secretary and the Department of the Colonial Treasurer.

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73 Allen argues in the context of similar changes in state benevolence and state power which were occurring in Germany that feminist organisations and feminist movements played a significant role in conceptualising new administrative paradigms in public health (Allen, A.T., ‘Feminism, Venereal Diseases and the State in Germany, 1890–1918,’ *Journal of the History of Sexuality*, 1993: 4:1.

In 1904, however, the Department of Public Health was established as a formal sub-department of the Department of the Colonial Secretary.

The growing diversification of the Department of Public Health between 1904 and 1913 is highlighted by the increasing range of its functions, and by the nomenclature of its head. Between 1904 and 1913 the head of the Department Dr Ashburton Thompson was referred to as the Chief Medical Officer. Cummins argues that under Thompson’s administration, issues related to quarantine became more settled, and that this allowed for a greater concentration on infectious diseases, including typhoid fever, diphtheria, venereal diseases and influenza. It was in this period that the NSW PD Act, the first contagious, or venereal, diseases legislation in NSW was introduced in 1909. From 1913, the head of the Department of Public Health was referred to as the Director-General of Public Health, with Dr Robert Paton the first health bureaucrat to operate under this title. Paton served as Director-General until 1921, during a period when, as Cummins indicates, ‘recruitment of professional staff was impeded by the priorities of the Armed Services during World War I.’ Paton was also the first Commissioner appointed under the VD Act 1918, and oversaw the introduction of this legislation. Paton was also instrumental in developing strategies to combat the smallpox epidemic of 1913 and the pandemic of influenza in 1919.

Coincident with the appointment of Dr Paton as Director-General of Public Health was the appointment of the first Minister of Health in 1913, with the Hon. Frederick Flowers serving as Minister between 1913 and 1915. By 1915, the Department of

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75 Ibid., p. 85.
76 The Hon. Fred Flowers (1864–1928) was an important Labor Party politician in the early decades of the twentieth century who held a number of important posts within government. Flowers was Minister for Public Instruction in 1911–12, Colonial Secretary from 1913–14 and Minister for Public Health from 1913 to 1915. Flowers was also a Director of RPA Hospital between 1916 and 1918. He was progressive in the domain of public health, and as early as 1897 had been one of the originators of the Labor Party’s policy to nationalise medicine. Flowers’ evidence to the NSW Select Committee on the Prevalence of Venereal Diseases on Tuesday 21 September 1915 provided some graphic and specific insights into public health modes of rule, the operations of the Outpatient Clinique, broader treatment issues, and techniques of prevention. Flowers’ evidence ranged freely across a number of public health techniques, including coercion, consent, compulsion, and detention, and Flowers also referred often to the evidence presented to the Royal Commission into Venereal Diseases in 1913–1916 in England, quoting selectively from the more progressive evidence of that Commission. (For views of the UK Royal Commission 1913–1916 see Lewis, M., The People’s Health: Public Health in Australia, 1788–1950, Westport, 2003 and Bashford, A., in Caine, B., (ed.), The Woman Question in England and Australia, Sydney Studies in History, no. 5, Dept. of History, University of Sydney, 1994, p. 58. Flowers’ major themes were stigma and shame, privacy and confidentiality, and how these provided the pivot between improved prevention and therefore decreased treatment needs.) Flowers was also interested in the relationship between the private practice of medicine, and public funding of hospitals.
Public Health encompassed the sanitation and infectious diseases services, the Pure Food Branch, the Private Hospitals Branch, the public health laboratories, gaol medical services and the Hospitals Admissions Depot, and the administration of Health Acts, health institutions and services were unified in the one departmental structure.  

Within the Department of Public Health, the development of Health Districts, Divisions and Branches also reflected the growing diversification of health administration, and to an extent, shifting notions of health. The Public Health Act of 1896 had mandated the establishment of the Hunter River Combined Health District (1898) and the Metropolitan Combined Health District (1898). Until the creation of the Broken Hill Health District in 1916, Hunter and Metropolitan covered all of NSW. The Metropolitan Health District extended as far west as ‘Parramatta in the west, Vaucluse in the east, Hurstville in the South and Willoughby in the north.’ The initial Health Districts were based on the UK model, and were supervised by a Medical Officer of Health. The central administration of the Department of Public Health also comprised separate administrative branches and divisions, which were usually created to provide a service component or to ‘meet a deficit in medical services which was not provided by the medical profession, the general hospitals or voluntary or other agencies.’ The Sanitation (Health Inspection) Branch and the Government Analysts Branch were examples of this type of development. Other Branches were established to administer specific legislation, and the Division of Venereal Diseases was a direct result of the VD Act of 1918. Cummins has remarked that from 1918 to 1929 the main functions of the Division of Venereal Diseases were ‘the collation of notifications and some educational material…treatment being carried out at general hospitals or by private

He saw an obligation on public hospitals to provide non-discriminatory treatment, but knew as well that medical practitioners had their private practices, and these had to be protected to enlist the support of medical practitioners. There is no inkling in the evidence as to what motivated Flowers’ passion for this subject although a clear guiding principle was equality of access to treatment for all classes of society. Nairn has argued that Flowers’ ‘interest and advancing expertise in medical and hospital development gave depth and form to Labor Party policy in 1897–1911 and his administrative flair conditioned practical progress in 1911–1915.’ (Nairn, B., Australian Dictionary of Biography, p. 530). Cummins, A History of Medical Administration, p. 133.

Ibid., p. 93.

Ibid., p. 97.

In 1954 the Division of Venereal Diseases became the Division of Epidemiology. In 1977 the Branch reverted to the Venereal Diseases Branch, and from the mid 1990s the Branch has been known as the AID/Infectious Diseases Branch.
venereologists. In the context of shifting priorities in health, it is worth noting that in 1926, the Publicity Branch was established, which later transformed into the Health Education Branch in 1964. The role of the Publicity Branch was ‘to provide continuous health propaganda by means of press or radio, posters, exhibitions and leaflets for mass issue.’

Throughout the period 1901–1925, the relationship between hospitals in NSW and the Department of Public Health changed considerably, with an increasing emphasis on both government funding and government control. Cummins delineates four types of hospitals that operated in NSW in this period: general hospitals, private hospitals, state hospitals and specific hospitals dedicated to discrete health issues, for example, maternity hospitals, convalescent homes and tuberculosis sanatoria. General hospitals, including Sydney Hospital and RPA Hospital, had developed as voluntary charities for the indigent poor and in the colonial period relied largely on subscriptions and received limited government assistance. In 1913 formal supervision of these hospitals came under the Director-General of Public Health, and in 1918 the Hospital Advisory Board was created, but this Board had little effective control over these institutions. It was not until the passing of the Public Hospitals Act in 1929, whilst Dr Richard Arthur was Minister for Public Health, that a

81 Cummins, A History of Medical Administration, p. 177.
82 Ibid., p. 174. Between 1896 and 1926 the following divisions or branches were established within the Department of Public Health: Government Analysts’ Branch, Division of Industrial Hygiene, the Government Medical Officer, a dental branch affiliated with both the Department of Public Health and the Department of Public Instruction, Publicity Branch, the Director of Tuberculosis, Division of Venereal Diseases, Division of Maternal and Baby Welfare, Private Hospitals Branch, Pure Food Branch, Health Inspection Branch and the Microbiological Laboratories.
83 Although hospitals were becomingly increasingly tied to government funding, there remained a significant number of subscription activities. For example, in 1906, William Epps, Honorary Secretary of the Board of Directors of RPA Hospital, undertook a study tour of overseas hospitals, and arrived home with ideas for new subscription and fundraising initiatives. These included: ‘a Hospital Sunday, collection groups in country areas, a greater share of Naval patients, payment by outpatients to the order of three pence for a bottle of medicine and two pence for each dressing’ (Maddox, K., Schlink of Prince Alfred, Sydney, 1978, p. 28).
84 Cummins, C. J., A History of Medical Administration, p. 136.
86 Cummins, A History of Medical Administration, p. 136.
87 Dr Richard Arthur’s (1865–1932) career as both a politician and a medical practitioner spanned the Boer War and World War 1, the PD Act 1909, to which he was vehemently opposed and the VD Act 1918, which he helped draft, and a significant number of parliamentary inquiries into subjects as diverse as venereal diseases (1915), child endowment (1917), health insurance, (1925) and education for mental defectives (1923) (Roe, M., Nine Australian Progressives: Vitalism in Bourgeois Social Thought 1890–1960, Brisbane, 1984). Arthur’s career is useful to examine because from the early 1890s to the late 1920s Arthur was significantly involved in prevention, treatment and epidemiological practices. Arthur chaired the NSW Select Committee on the Prevalence of Venereal Diseases, and
Hospitals Commission was established, which exercised effective control over general
hospitals. Throughout the period, the NSW government became incrementally more
significant in the administration of general hospitals.

One significant marker of the increasing role of government in the practices of
general hospitals in NSW was the growth of the Hospital Admissions Depot (HAD) in
Macquarie St, Sydney. Patients attended this Depot in person, were examined,
classified and dispatched to various hospitals. The Depot operated from at least 1906,
and was one of a number of health facilities that responded to a request for
information on venereal prevalence from the Board of Health in that year. In 1906,
462 venereal patients were dispatched to various hospitals, including 442 males and

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wrote the Report on the Existing Facilities for the Treatment of Venereal Diseases in New South
Wales, with Recommendations for their Extension and Improvement in 1919 (Government Printer,
Sydney, 1919). Arthur is described by Lewis as a leading progressivist, who combined the ‘social
gospel of Protestantism and the modern scientific outlook of progressivism’ (Lewis, M., Thorns on
the Rose, New Haven, 1998, p. 130). Perhaps it was this combination that saw Arthur take a leading role in
the Eugenics Society of NSW, becoming its first President in 1911, and also saw Arthur become a
leading proponent of the White Australia policy. Arthur wrote his Report on Existing Treatment
Facilities in that period between the passing and the gazetting of the VD Act, between 1918 and 1921,
so, as opposed to Cumpston, Arthur was not looking forward to the passing of the legislation, but to its
gazetting and operationalisation. Arthur suggested that his original intention for the Report was to
‘incorporate…suggestions for legislative enactments’ (Arthur, R., Existing Facilities for the Treatment
of Venereal Diseases in New South Wales, p. 1), but since the legislation had already passed, complete
with many of the suggestions Arthur said that he himself had proposed through the University Society
for Combating Venereal Disease, there was no need. Arthur stressed that the report ‘will therefore be
concerned only with the measures which it is expedient that the Government should adopt at once in
order to prevent the recently passed legislation becoming a dead letter.’ From Arthur’s chairing of the
NSW Select Committee on the Prevalence of Venereal Diseases in 1915, to his stint as a Minister for
Public Health between 1927 and 1930, Arthur was keenly interested in the prevention of venereal
diseases. He attended the WEA Sex Hygiene conference in 1916. He was involved in the formation of
the University of Sydney Society for Combating Venereal Disease in 1917. In 1923, Arthur chaired a
parliamentary inquiry into lunacy law and administration, and argued that we should ‘eliminate prison-
like features wherever possible’ and then in 1923 supported eugenic birth control for the ‘feeble-
minded.’ In 1923, as well, Arthur was arguing that the VD Act had lost potency because it was not
being strictly applied, and in response Arthur formed the Australian Association for fighting Venereal
Diseases. In the same year Arthur became the foundation President of the Father and Son’s Welfare
Movement, an organisation with long roots in purity philosophy. As Minister for Public Health
between 1927 and 1930, Arthur appointed the first, and much delayed, Director of Venereal Diseases
Division (J. Cooper Booth), and as Roe suggests, ‘the enforcement of the 1918 Act quickened’ (Roe,
M., Nine Australian Progressives, p. 176). In 1929 he became patron of the Racial Hygiene
Association, attended its Congress, and actively supported contraception. This would have been an
unthinkable proposition earlier in his career. Arthur’s career spanned significant changes in the
administration of public health and venereal diseases, and aspects of his career reflect these changes.

Collins provides a brief overview of the first Head of the NSW Hospitals Commission, Robert James
Love, with some early history about the bureaucratic struggles over the role of the Hospitals
Commission (Collins, Y., ‘Love’s Labours Lost – Bureaucratic Independence Versus Ministerial Control,’
Individuals and Institutions in the History of Medicine, Conference Proceedings, Sydney, 2000).

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88 Collins provides a brief overview of the first Head of the NSW Hospitals Commission, Robert James
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20 females, and 322 cases of gonorrhoea and 140 cases of syphilis and chancroid.\textsuperscript{89} Often patients were issued with a rail pass to Parramatta, Lidcombe or Liverpool stations, where a hospital orderly met them. Following an analysis of the Hospitals Admissions Depot report for 1916, Cummins calculated that of over 12,000 persons who were examined for admission ‘3420 were diverted to the Coast hospital, 436 to the RPA Hospital, 267 to Sydney Hospital, 172 to the Women’s Hospital Crown Street and 117 to the Hospice for the Dying.’\textsuperscript{90} During the 1920s the Hospital Admissions Depot played a continuing role in referring venereal patients to hospitals, but by about 1925, hospitals were referring venereal patients back to the Depot because they were unable to cope with the avalanche of attendances.\textsuperscript{91} It is clear from evidence presented in subsequent chapters however that venereal patients, both before and after 1916, were able to present directly to either Sydney Hospital or RPA Hospital.

In this context there was one key issue that was debated regularly, heatedly and specifically in relation to the management of venereal diseases. This debate centred on the necessary and complex relationships between medical practitioners in private practice, and medical practitioners working in public hospitals. At a time when government was consolidating its role in the administration of health, medical practitioners, and their representative organisations, were arguing for the preservation of their interests, practices and livelihoods. In the early part of the twentieth century there was a clear distinction between public patients, seen in a range of charitable institutions and hospitals, and private patients, seen by medical practitioners in private practices and at patient’s homes. On the one hand, public hospitals and the resident medical officers attached to them, provided services for the poor, for the indigent and for the unemployed. Public hospitals were only partially state-funded until 1929: some of their funding was raised through subscriptions and donations, and hospitals were therefore still strongly charitable in nature. On the other hand, medical practitioners saw moneyed patients privately, and the patient/doctor relationship, particularly in this circumstance, was perceived to be sacrosanct. Notification of

\textsuperscript{89} ‘Patient returns for Hospital Admissions Depot,’ Containment and prevention of venereal diseases 1906–1916, container 5/5300, NSW Archives, Kingswood.
\textsuperscript{90} Cummins, A History of Medical Administration, p. 136.
\textsuperscript{91} ‘Memorandum from Under Secretary to Director-General of Public Health, 7/1/1921,’ Establishment of Venereal Diseases Clinics, NSW State Archives, Box no. 10/43028, folio 34/26.
venereal diseases from private medical practitioners was resisted, and more successfully because no government funds supported their tenure or employment at a hospital. Mooney identifies some of the tensions between public and private practice in the context of venereal diseases in late nineteenth century Britain.\textsuperscript{92} He argues that the instigation of national legislation for the compulsory notification of infectious diseases was most effectively ‘hampered by opposition from the private medical profession – family practitioners – who maintained that notification jeopardised their confidential relationship with their patient.’\textsuperscript{93} As today, between 1901 and 1925 there was no easy fit and balance between the provision of private and public health services.

There were a number of settings in which medical practitioners could undertake their training, and a number of ways in which medical practitioners could receive incomes. Private medical practitioners provided services for the upper and middle classes, usually in private consulting rooms. The elite amongst them also served as honorary medical officers, attached to public or less frequently private hospitals. Private medical practitioners were relatively well paid, but avoided paid work in public hospitals or friendly societies or lodges because it did not improve their status.\textsuperscript{94} As part of their training, however, many medical practitioners worked for a time as salaried officers in public hospital settings. This combination of factors meant that many medical practitioners struggled for status and income. To work with poor people as a salaried medical officer was not the most prestigious of positions, so to be employed as either a resident medical officer in a public hospital, or as a doctor with a friendly society, club or lodge, did little to enhance a medical practitioner’s career.\textsuperscript{95} As noted by Martyr, medical practitioners regularly dealt with ‘defaulting customers,

\textsuperscript{93} Ibid., p. 239.
\textsuperscript{95} Friendly societies were groups of 30 or more individuals or families who banded together to employ a medical practitioner to cater to their health needs. Often the treatment of venereal diseases was specifically excluded from Friendly Society medical coverage (Tibbits, D. R., ‘VD Behind Bars,’ \textit{Proceedings of the Fourth Biennial Conference of the Australian Society of the History of Medicine}, 1995, p. 157).
\textsuperscript{96} Martyr, \textit{Paradise of Quacks}, p. 136.
lodge exploitation and closed-shop hospital appointments. Honorary medical officers within public hospitals fared considerably better: they worked for several hours free-of-charge in the public hospital, survived financially on private practice, and these positions were held in considerable prestige. Martyr goes some way to estimating average income for medical practitioners when she argues that salaried classes earned in general between 200 pounds and 500 pounds a year, whereas the ‘majority of medical practitioners in active practice make from 350 pounds to 1200 pounds a year.’ J. H. L Cumpston pointed to the difference between salaried medical practitioners at public hospitals, and medical practitioners in private practice, with particular reference to the treatment of venereal patients, arguing that:

The hospitals are required by law to provide an efficient system of diagnosis and treatment, but no compulsion has been contemplated in respect of the methods by medical practitioners in their private practice. While the professional conscience of the medical profession remains at its present high

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97 The lodge refers to the Friendly Society, or other consumer organisation, and the most extensive history of these organisations is Green, D. and Cromwell, L., Mutual Aid or Welfare State? Australia’s Friendly Societies, Sydney, 1984, p. 134.
98 Martyr, Paradise of Quacks, p. 134.
99 John Howard Lidgett Cumpston (1880–1954) was the first Commonwealth Director-General of Health of the Federal Health Department founded in 1921. Cumpston wrote Venereal Disease in Australia, and from as early as 1910 attempted to influence the provision, by the States, of health services for venereal diseases (Commonwealth of Australia, Quarantine Service, 1919, p. 29). In the early years of the Commonwealth, federal responsibilities in relation to health were limited, but infectious diseases were one area where the Commonwealth attempted to exert some pressure through funding. Milton Lewis in his Introduction to Cumpston’s Health and Disease in Australia, describes Cumpston ‘as undoubtedly the most important figure in public health in Australia this century’ (Lewis, M., in Cumpston, J. H. L. Venereal Disease in Australia, p. 1). Described by Lewis also as ‘a historically oriented epidemiologist of great ability and a considerable scholar who made many original contributions to the history of medicine in Australia,’ Cumpston’s Health and Disease in Australia was completed in 1928. Lewis remarks that although there was a long established tradition of writings on public health and epidemiology in Australia, including those by both James Jamieson and John Ashburton Thompson, Cumpston’s work was the first ‘history and geography of diseases from the beginning of European settlement in 1788 to 1928’ (Lewis, M., in Cumpston, J. H. L. Venereal Disease in Australia, p. 3). Lewis also remarks that Cumpston was a leading exponent of progressivism in health, progressivism being defined as social and legislative reform to improve national efficiency, and as a person who ‘identified the science of public health as a significant source of power for the modern state’ (Lewis, M., Thorns on the Rose, p. 128). Apart from his broader interest in public health, Cumpston also had a particular interest in the treatment and prevention of venereal diseases. In his Venereal Disease in Australia, published by the Quarantine Service (of which he was Director) in 1919, Cumpston provided a comprehensive overview of treatment, prevention and epidemiological issues related to venereal infection. Cumpston’s key goal in this short booklet was to review existing services for people with venereal infection in every state of Australia, with an emphasis on the actual and potential role of the Commonwealth in assisting the development of legislation which could best control the ‘plague.’ The booklet contains evidence related to the treatment of venereal infection that will be valuable in the qualitative analysis of treatment regimes and facilities in chapter 3 (For further information on Cumpston see also Hyslop, A., ‘A Question of Identity: J.H.L. Cumpston and Spanish Influenza, 1918-1919’, Australian Cultural History, 1997-1998:16: pp. 77-95
level, there is probably no necessity for penalties or compulsion in respect of methods of treatment.\textsuperscript{100}

**Administration of RPA Hospital**

As hospitals developed closer links with government, their administration became increasingly complex, particularly in relation to management, subsidies and the connections between honorary medical practitioners, nursing staff and Boards of Directors. RPA Hospital exemplifies these developments. In the early twentieth century there were two bodies which played a significant role in the administration of RPA Hospital: the Board of Directors and the Medical Board. The Prince Alfred Hospital Act of 1873\textsuperscript{101} provided for a Board of 15 members,\textsuperscript{102} of whom three were nominated by the government,\textsuperscript{103} ten represented the subscribers, and two were ex-officio. Into the twentieth century, the majority of Board members were elected by, and from, the subscribers. The Hon. E. Deas-Thomson, Chancellor of Sydney University, was elected the first Chair of the Board of Directors in 1873. The Hon. Edward Knox succeeded Deas-Thomson, holding the position of Chair until 1901. Medical doctor Sir Thomas Anderson Stuart became Chair of the Board in 1901, a position he held until his death in 1920.\textsuperscript{104} The roles of the Board of Directors were, and often remain, unclear, although it was understood generally that the Board had a

\textsuperscript{100} Cumpston, J. H. L., Venereal Disease in Australia, p. 29.

\textsuperscript{101} The event that precipitated the founding of RPA Hospital was the attempted assassination of His Royal Highness Prince Alfred, Duke of Edinburgh on 12 March 1868, at Clontarf, by Feinian activist, Henry James O’Farrell. An outraged public meeting of 2000 citizens on 20 March 1868 decided to build a large public hospital, and early subscriptions raised 34,393 pounds. The decision to build a hospital was seen as an expiation of Sydney’s ‘communal shame’ (Maddox, K., Schlink of Prince Alfred: A Biography of Sir Herbert Schlink, Sydney, 1978, p. 16).


\textsuperscript{104} Sir Thomas Anderson Stuart arrived in Australia in 1883, and immediately took up his post as Professor of Physiology and Anatomy at Sydney University. Even prior to becoming Chair of the RPA Hospital Board of Directors in 1901, he had been a member of the Board of Directors since his arrival in Australia in 1883. Anderson Stuart was President of the NSW Board of Health from 1892 to 1896, and was President of the Royal Society of NSW in 1893 and 1907. Anderson Stuart is also often described as the founding father of the Medical School at Sydney University. Morrison, P., in ‘The Obscurity of J. T. Wilson,’ Individuals and Institutions in the History of Medicine, Conference Proceedings, Sydney, 1999, argues that with the death of Anderson Stuart, there was a power vacuum at both the Sydney University Medical School and RPA Hospital, and this saw the demise of the ‘Edinburgh school’ in favour of ‘native-born’ appointments.
key role in providing for the hospital’s long-range financial stability. From 1873 to
1902, the position of Secretary was honorary, but in 1902, Mr William Epps became
the first salaried Secretary on a salary of 300 pounds per year. Mr Epps held the
position of Secretary for thirty years and was in effect the first Chief Non-medical
Executive Officer.\textsuperscript{105} Two of the key figures therefore in the administration of RPA
Hospital between 1901 and 1925 were Sir Thomas Anderson Stuart and Mr William
Epps, both of whom served for almost the entire period.\textsuperscript{106}

The first Medical Board of RPA Hospital was composed of honorary medical staff, a
total of nine physicians and surgeons. The Medical Board provided a formal link
between medical staff and the administration of RPA Hospital. The Medical Board
was headed by the salaried Medical Superintendent, who, along with the Secretary of
the Board of Directors, was a significant player in hospital politics. In 1915, Dr
Clayton was appointed as permanent Medical Superintendent, on an annual salary of
between 1100 pounds and 1500 pounds per annum.\textsuperscript{107} With a salaried Secretary and a
salaried Medical Superintendent ‘the active control of non-medical staff was now to
be shared.’\textsuperscript{108} The Medical Board represented the private and institutional interests of
honorary medical staff, and they played a significant role in determining the nature
and extent of venereal diseases services at RPA Hospital. Other staff at the hospital
included nurses and wardsmen, scientists and technicians, and their roles will be
discussed in chapter 2.

Neither Boards of Directors nor Medical Boards were static entities, and in the period
under discussion there were regular changes in personnel, as well as important
developments in the nature and roles of the Boards themselves.\textsuperscript{109} Horsburgh has
noted that in the period leading up to 1910, one particular question exercised Hospital

\textsuperscript{105} Doherty, M. K., \textit{The Life and Times of RPA Hospital, Sydney, Australia}, Sydney, 1996, p. 271.
\textsuperscript{106} The full Board of Directors of RPA Hospital in 1906 comprised: Sir Norman MacLaurin
(Cancellor of the University of Sydney), Sir James Fairfax, Moritz Gotthelf, Sir Albert Gould, Sir
James Graham, Sir Philip Sydney Jones, James Inglis, Dr F. Antill Pockley, The Hon. C. K. MacKellar,
P. H. Morton, Dr Cecil Purser, Senator J. T. Walker and William Cotter (Maddox, K., \textit{Schlink of
Prince Alfred}, p. 26).
\textsuperscript{107} Doherty, \textit{The Life and Times of RPA Hospital}, p. 294.
\textsuperscript{108} Ibid., p. 271.
\textsuperscript{109} The Hospital itself experienced enormous growth as well, in the number of hospital beds and
patients. In an address at the Annual General Meeting of the Governors and subscribers in 1916, Sir
Thomas Stuart, indicated that there were 414 beds open for use, and ‘the daily average number of
patients in the hospital had been kept down to 379.6.’ Anderson Stuart also indicated that the cost per
bed was approximately £112 per annum (Medical Journal of Australia, April 1916, p. 342).
Boards and politicians alike: the extent to which subsidised hospitals should be controlled or influenced by the governments that partially funded them.\textsuperscript{110} There were two main reasons why this question was debated: the first revolved around the possibility that a subsidised hospital might make a profit, and the second centred on the ‘depressing effect of subsidies on the level of private philanthropy.’\textsuperscript{111} These questions remained substantially unresolved throughout the period, but with the passing of the Public Hospitals Act in 1929, and the subsequent development of the Hospitals Commission, subsidies became a dead letter in relation to hospitals. Horsburgh also describes how subsidies were made to general hospitals: initially they were made on a \textit{per capita} basis for pauper patients who were admitted on the Colonial Secretary’s orders. By 1885, at RPA Hospital, claims for subsidies were submitted monthly, ‘but not until the respective patients had been discharged,’ and theoretically only one claim could be made in respect of each patient.\textsuperscript{112}

In the first three months of 1912, \textit{The Sun} in Sydney ran a series of correspondent’s letters about the effectiveness of general hospitals, and the level and appropriateness of government subsidies. These letters captured some of the important public sentiments related to hospital administration and management. During 1912, Dr H.H Schlink was the Medical Superintendent of RPA Hospital, and William Epps remained Secretary. Both of these figures reported regularly to the Chief Secretary’s Department on the media debates, and contributed through the letters columns of \textit{The Sun}. RPA Hospital was attacked by ‘Ex-nurse’ and ‘Wardsman’ for being mismanaged, financially incompetent, and unable to meet the needs of the sick-poor. On 14 February 1912 ‘Ex-nurse’ wrote:

\begin{quote}
The financial system on which the hospitals work has been shown to be absurd, the treatment of nursing staff nothing short of a scandal, and now it is made abundantly evident that the accommodation provided for the sick is altogether inadequate.\textsuperscript{113}
\end{quote}

\textsuperscript{110} Horsburgh, ‘Subsidy and Control’, p. 65.
\textsuperscript{111} Ibid., p. 65.
\textsuperscript{113} \textit{The Sun} Clippings and Correspondence between William Epps and the Chief Secretary’s Department,” Establishment of Venereal Diseases Clinics, NSW State Archives, Box no. 10/43028, folio 34/26.
On 17 February 1912 ‘Wardsman’ asked:

I would like to ask Dr Schlink: (1) Is the reason of this admittedly bad state of affairs the result of mismanagement, and if so, whose? (2) Would this state of things have come about if the hospital had been under Government control and (3) Does it not really seem that this Board of private individuals has undertaken too big a task?\textsuperscript{114}

On 23 February, Dr Schlink responded by suggesting that the government was to blame because subsidies were insufficient: ‘the government shows a disinclination to drain up the wells of charitable benevolence.’ Schlink added that if the government wanted to control hospitals, then it really only needed to expand the Coast Hospital to carry 2000 beds. On the question of the experience of the Board of Directors, Schlink responded ‘where can more qualified managers be found than the gentlemen who have given their services over the last twenty years?’\textsuperscript{115} By way of highlighting the cost-effectiveness of the RPA Hospital, Schlink also included material that compared bed use and costs per head at ten international hospitals.\textsuperscript{116} Ultimately, the Chief Secretary approved a special grant of £8000 in March 1912, an amount supplementary to the annual subsidy of £4750. By 1912, subsidies were not paid according to each patient, but in a pound-for-pound program matched to charitable contributions. This pound-for-pound matching process would become the model for Commonwealth/State funding for venereal treatments.

Because of the potential to be attacked by the media and the public, mechanisms were in place at RPA Hospital to ensure that government exercised influence in the operations of the hospital itself. As Horsburgh argues, the allocation of subsidies ran the risk of leaving governments exposed: a government could find itself ‘held accountable for actions over which it has no real control.’\textsuperscript{117} Horsburgh identifies three levels of influence which were exerted to militate against this possibility:

\textsuperscript{114} Ibid.
\textsuperscript{115} Ibid.
\textsuperscript{116} Ibid.
\textsuperscript{117} Horsburgh, ‘Subsidy and Control,’ p. 71.
systems of inspection, government representation on Boards of Directors and the establishment of separate bureaucratic structures to administer the whole field, such as the 1929 changes in NSW. The RPA Hospital had made allowance from its inception for the placement of three government representatives on the Board of Directors, inspections were regularly conducted and these increased over time. In relation to the management of venereal diseases at RPA Hospital, two other levels of government influence were discernible: the tying of subsidies to performance measures which included the number of persons treated, and able to be treated, in outpatient clinics, and the promise of funds for capital works. I will describe in chapter 2 the machinations that accompanied the reduction in operating hours and patient quotas at the Outpatient Clinique, and the negotiations that accompanied the proposal to construct a dedicated Venereal Block.

**Administration of venereal diseases services in NSW**

Significant shifts were also occurring in the management of venereal diseases in NSW in this period. These changes were happening at the level of practice and policy: service provision changed and notions informing the provision of services changed. Governments across the world in the late 19th and early 20th centuries believed that they had some role in the management of venereal diseases, often in a way which placed prostitutes as central vectors of transmission. Levine has examined the development of contagious diseases regulations across a number of British colonies between the 1850s and the 1880s, especially when the efficiency of the military or navy were at issue, and has examined the abolitionist movements which attended these regulations. However, unlike other Australian colonies (Tasmania, Victoria, Queensland), New Zealand and the United Kingdom, NSW did not introduce Contagious Diseases legislation in the last half of the nineteenth century, and did not legislatively address the detention of infected or apparently infected prostitutes until the PD Act of 1909. With the passing of this Act in 1909, the subsequent NSW Select

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Committee on the Prevalence of Venereal Diseases in 1915 and the VD Act in 1918, a clear line of government thinking and legislation was established. These three events also signify a shift in NSW in modes of rule related to the management of venereal diseases. Over the period, both Commonwealth and State governments expanded their role in the management of venereal diseases, services grew with an increasing emphasis on outpatient treatment, and there was a significant shift in the techniques and meanings of detention practices. This shift can be generally categorised as a shift from ‘lock’, with strong medico-penal connotations, to ‘dispensary’, with clear connotations of surveillance in a spatial and temporal zone.

Limited inpatient treatment services were provided for patients with venereal diseases in NSW in this period. This situation was reflected across Australia in both the quantity and quality of inpatient public facilities. Facilities however did not remain static between 1901 and 1925 and the number of hospitals providing venereal treatment services across NSW certainly increased. Lewis remarks: ‘clinics were understaffed, poorly equipped and overcrowded.’\textsuperscript{119} All inpatient venereal facilities in NSW were gender-specific. Male venereal patients could only be admitted at the Coast Hospital (a specific infectious diseases government hospital) or Liverpool State Hospital as general patients. At the Coast Hospital there was capacity for 35 venereal patients, and at Liverpool Hospital, there was capacity for 30 venereal male patients. Arthur described the facilities at the Coast Hospital as ‘primitive,’ and the facilities at Liverpool as ‘thorough.’\textsuperscript{120} St Vincent’s Hospital on occasion took inpatients that were naval men, and sometimes provided inpatient services for women, ‘as a favour.’\textsuperscript{121} Some male venereal patients were seen at both Rookwood and Newington Asylums. No other metropolitan or country hospital provided inpatient facilities for male venereal patients. RPA and Newington hospitals were the only institutions that provided inpatient facilities for women, or children with VD. RPA Hospital had two wards for female patients which I describe in chapter 2. Newington Hospital had one ward for 12 female patients with VD, which came into existence in 1916. In all of NSW however there were no inpatient wards specifically for men or male children.

\textsuperscript{120} Arthur, R., Existing Facilities for the Treatment of Venereal Diseases in NSW with Recommendations for their Improvement, p. 5.
\textsuperscript{121} Legislative Assembly of NSW, Minutes of Evidence Taken before the Select Committee on the Prevalence of Venereal Diseases, (NSW Select Committee) Progress Report, Sydney, 1915, p. 41.
with venereal diseases. In the mid-1920s, the Department of Public Health engaged in a significant recruitment drive to encourage a range of hospitals to provide venereal inpatient services, with mixed success. This paucity of venereal inpatient services arose because general hospitals ‘avoid trying to have them,’ a symptom of the medical ambivalence I discuss in chapter 3. By 1928 however, after ten years of operation of the VD Act, government hospitals were certainly better equipped to provide venereal inpatient services; 48 beds were available at the Coast Hospital, 49 beds at Liverpool State hospital and 12 beds at Newington State Hospital, as well as including pre-existing beds at RPA Hospital.

The establishment of an inpatient facility for women with venereal diseases at Newington Hospital (a government hospital in the western suburbs of Sydney) in 1916 provides compelling evidence of the central role played by the NSW Department of Public Health. Lengthy correspondence occurred between RPA Hospital, Newington Hospital and the Department of Public Health prior to, during and after the establishment of the facility over the period March 1915 through March 1916. The proposal first arose as a result of the desire of authorities and specialists at RPA Hospital to segregate ‘case-hardened’ prostitutes off ward D3 at RPA Hospital, and leave this ward for married women, young single women and girls. Authorities from RPA Hospital wrote to the Minister for Public Health recommending that a new ward should be established at the Newington General Hospital, thus removing the venereal load from RPA Hospital. The rationale behind this recommendation was that prostitutes were morally contaminating other women. The Minister, in writing to Newington Hospital, suggested that the proposed new ward would be for ‘women suffering from gonorrhoea, who have undergone primary treatment at the venereal clinics of the metropolitan hospitals, but who require more or less prolonged attention.’ In response, the Assistant Superintendent at Newington Hospital suggested that there were two small wards and a yard currently

122 NSW Select Committee, p. 41.
123 ‘Report prepared by the Under Secretary of Health on Comparative Costs of Venereal Treatment Services in NSW, 2 May 1928,’ NSW State Archives, Establishment of Venereal Diseases Clinics, Box no. 10/43028, folio 34/26.
124 ‘Associated Correspondence between Newington Hospital, RPA Hospital and the NSW Department of Public Health March 1915–March 1916,’ Establishment of Venereal Diseases Clinics, NSW State Archives, Box no. 10/43028, folio 34/26.
125 ‘Memorandum from Secretary of Public Health to the Assistant Superintendent, Newington Hospital, 4 May 1915,’ NSW State Archives, Box no. 10/43028, folio 34/26.
occupied by ‘imbecile patients’ that could be adapted for the purpose. In May, R.T Paton, the Director-General of Public Health visited the proposed wards at Newington Hospital. In August, the Secretary of RPA Hospital wrote again to the Minister pointing out that ‘at present we have to refuse admission to many acute cases for whom beds would be available if the chronic cases were removed.’

Categories of acute and chronic care were often conflated with treatment modalities for ‘decent’ and ‘indecent’ women. With the installation of a portable copper and sink, one small ward of 12 beds finally became available at Newington Hospital in September 1915. Throughout this correspondence, the Newington ward was consistently referred to as the ‘lock’ ward, and patients as ‘lock’ patients, with ‘lock’ consistently placed in inverted commas, signifying both the fact that the ward was designed for ‘case-hardened prostitutes’, who were being informally and curatively detained, and that ‘lock’ was a terminology in transition. At the end of November 1915, of 22 patients who had been admitted to Newington Hospital for ‘lock treatment’, one had gonorrhoea, one had gonorrhoea and syphilis, two had secondary syphilis and 18 had tertiary syphilis.

Negotiations initiated by Newington Hospital early in 1916, subsequent to this correspondence, demonstrate three important factors in the pattern of service growth that characterised the development of venereal treatment services at most hospitals in NSW during this period. Having established a 12-bed ward for ‘case-hardened’ prostitutes with chronic syphilis or gonorrhoea it was only a matter of months before the Newington Hospital administration itself started to lobby the Minister for Public Health for new facilities so that acute cases could be segregated from chronic cases, that is, so that prostitutes could be separated from women who were not deemed to be prostitutes. Secondly, the Assistant Superintendent argued that a new facility was required because ‘the ward in which these patients are located is too close to other wards and there is insufficient space for them to walk about without coming in contact

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127 ‘Memorandum from Resident Medical Officer to the Secretary of the Department of Public Health, 4 September 1915,’ Establishment of Venereal Diseases Clinics, NSW State Archives, Box no. 10/43028, folio 34/26.
128 ‘Lock Patient Return from Newington Hospital, 1 December 1915,’ Establishment of Venereal Diseases Clinics, NSW State Archives, Box no. 10/43028, folio 34/26.
with other patients. Thirdly, in response to a request from the Director-General of Public Health, on 8 February 1916 Newington Hospital provided a breakdown of where their venereal patients had been referred from. Of 29 patients, one had come from Matron Campbell’s Home in Glebe, one from the Church Home in Glebe, and one from RPA Hospital. The sole patient who had been referred from RPA Hospital, despite the earlier protestations of the Hospital authorities, had in fact been ‘discharged from that Hospital and three weeks later applied for admission here.’ The other 26 patients ‘did not come direct from any other institution.’ Nearly all of the women who utilised the inpatient ward at Newington hospital, then, had been self-referrals. Within six months of opening a venereal inpatient facility, Newington Hospital was segregating venereal patients according to moral and social categories, distancing venereal from non-venereal patients and responding to the unmet, direct needs of the population itself. I will discuss these phenomena in relation to venerealisation in the following chapter.

Outpatient facilities across metropolitan Sydney grew more quickly and responsively than inpatient services, particularly in the period after the passing of the VD Act 1918. In 1911, the first day outpatient facility opened at RPA Hospital for both men and women. Other outpatient facilities operated at Sydney Hospital, and from 1917, an evening clinic from Royal South Sydney Hospital, and from Royal Alexandra Children’s Hospital for female children. Arthur indicated that all of these outpatient facilities were very well attended. The only venereal diseases facility in country areas was situated in the Hunter Combined Health District at Newcastle, ‘where a few patients come one night a week for treatment.’ With the emergence of the Ministry of Public Health in 1913, and with the advocacy of the Hon. Fred Flowers, the Board of Health itself opened an outpatient clinic at its premises in Macquarie St, Sydney, in 1914, but ‘for some reason, possibly because its existence was little known, the attendance of patients was small, and it was closed after some months.’ This attempt at direct service provision was not tried again until the passing of the Public Hospital Act in 1929, when a departmental clinic for male patients was established in

129 ‘Memorandum from Assistant Superintendent Newington Hospital to Director-General of Public Health, 24 February 1916.’ Establishment of Venereal Diseases Clinics, NSW State Archives, Box no. 10/43028, folio 34/26.
130 ‘Memorandum from Assistant Superintendent E. R. Morris to Director-General of Public Health, 8 February 1916.’
Albert St, under the supervision of the Director of Venereal Diseases, Dr J. Cooper Booth. Specific treatment facilities were provided at Liverpool during World War 1 for military personnel, and these were clearly designed for male patients. In the ten years after the passing of the VD Act 1918, the Department of Public Health lobbied most metropolitan hospitals to undertake outpatient venereal services, at the very least. Some, like Royal North Shore Hospital, Rachel Forster Hospital and the Women’s Hospital did, whilst others, including St Vincent’s Hospital, did not.

One key factor in the growth and diversification of venereal treatment services across the entire period was economic. Whilst keen to develop and subsidise services, government was also eager to ensure that venereal and other health services were cost-effective. At a number of important junctures across the period, the Department of Public Health gathered information from subsidised hospitals on the staffing and accommodation costs associated with venereal treatments, per bed, and comparative to other hospitals. In 1914 for instance, RPA Hospital estimated that to run a venereal outpatient clinic from 2:00 p.m. to 8:00 p.m. six evenings a week would annually cost £2145, £1000 of which would be utilised on drugs. Personnel included in this figure are discussed in chapter 2. In 1914 it was also estimated that it would cost £845 to run one inpatient ward with fifteen beds, staffed by four nurses and three wardsmen, excluding medical costs. The total costs associated with the Venereal Department were estimated to be £2990. By 1925, William Epps forwarded to the Department of Public Health a Statement of Revenue and Expenditure for the Venereal Outpatient Department for the year ended 30 June 1925. For this period, outpatient expenditure was £4017, of which £1479 was committed to salaries, and £1237 to drugs. Interestingly, for this period £977 was raised in revenue, including £392 as contributions from grateful patients and £585 as payments for drugs. Between 1914 and 1925, the cost of running the outpatient department had nearly tripled. In this same document, Epps estimated that the cost of running one bed for a venereal inpatient was £200 per annum. The cost of running one inpatient ward of 15 beds had risen from £845 to £3,000 in 1925. The full government subsidy in 1925 for both inpatient and outpatient services was £2,000. Epps concluded, and was supported by the Senior Medical Officer of Health, E. Sydney Morris, that RPA Hospital was

132 ‘Report submitted to Under Secretary of Health by the Secretary of RPA Hospital, 19 August 1925,’ Establishment of Venereal Diseases Clinics, NSW State Archives, Box no. 10/43028, folio 34/26.
under-subsidised for venereal services.\textsuperscript{133} Morris estimated that a significant proportion of the financial deficit at the Hospital was caused by the overtime worked by RMOs, Attendants, Dispensers, Foreman Porters and Sisters.

By the end of 1928 the government subsidy for RPA Hospital remained at £2,000, but the total expenditure by the Hospital on venereal treatment services had risen to £10,131. Similarly, the total State-wide expenditure on venereal services at general hospitals stood at £12,432, whereas total government subsidy for these hospitals stood at £3200. Only one quarter of all costs associated with outpatient venereal treatment services at general hospitals in NSW were covered by government subsidy by May 1928. This was despite the introduction of compulsory treatment and notification in the NSW VD Act 1918. However, with the addition of 109 new beds at government institutions (Coast, Liverpool and Newington Hospitals) at a cost of £9253, and with non-subsidy costs associated with drugs (£1516), microbiological tests (£12,586) and payment to medical practitioners for notifications (£128), total government expenditure for 1927 exceeded £37,000. These total funds ensured that there were 74,963 outpatient attendances, 142 beds for venereal inpatients, 2095 new cases of gonorrhoea diagnosed and 1148 new cases of syphilis diagnosed. Throughout this period, costs associated with venereal inpatient and outpatient services were always an important consideration in service design and delivery and comparative costs between general and state hospitals were regularly investigated.\textsuperscript{134}

The paucity of services and funding was not lost on contemporary commentators. Frederick Flowers, Minister for Public Health between 1911 and 1913, held progressive views on the distribution of treatment services in the metropolis. As early as 1910, Flowers was advocating the establishment of night clinics at RPA Hospital in a first step towards tying new technologies into service delivery patterns.

For nearly a year I was in communication with the authorities of the Prince Alfred hospital to induce them to open what is now called night clinics. I met with a great deal of opposition, but eventually I succeeded… I think that this committee, if it has

\textsuperscript{133} Ibid.
\textsuperscript{134} 'Report prepared by the Under Secretary of Health on Comparative Costs of Venereal Treatment Services in NSW, 2 May 1928,' Establishment of Venereal Diseases Clinics, NSW State Archives, Box no. 10/43028, folio 34/26.
not already seen the clinic in operation, will find it to its advantage to pay it a visit to see what a great success it has proven to be…It will be necessary that the other hospitals should relieve them and take on a part of this work. I had a conference with the doctors on this subject. I laid particular stress on the necessity for admitting anyone for treatment, without any regard to his position in society, whether he was poor or rich, and without asking his name, or where he lived, or any other particulars.135

Flowers’ advocacy of free, confidential, accessible outpatient services met with considerable opposition from medical practitioners. While government argued for decentralised, confidential and accessible treatment facilities, medical practitioners argued for the containment and limitation of treatment facilities. Dr Gordon Wellesley Bray, for instance, argued that one large venereal institution would best serve the metropolis. Dr Bray, in his evidence to the Select Committee, also placed the Outpatient Clinique in the broader context of treatment at other hospitals in the metropolis. According to Dr Bray, ‘every other hospital’ had a limited but ‘separate’ outpatient service for venereal patients. This evidence is in direct contrast to the evidence of Dr Arthur in Existing Treatment Facilities, and to George Black in The Red Plague Crusade,136 who stated that RPA Hospital was the only hospital with a venereal outpatient service.137

Following the Select Committee in to the Prevalence of Venereal Diseases 1915, and the appointment of two successive Ministers of Public Health in the space of three years, the pace quickened in regard to lobbying for increased, improved and diversified venereal treatment services in NSW. Both George Black138 and J.D

135 NSW Select Committee, pp. 84–90.
137 Arthur, R., Existing Facilities, p. 11. Most residents of regional NSW unable to pay a practitioner privately, and seeking treatment for venereal diseases, would have traveled to Sydney, and there were a significant number of regional residents who were described in the medical records of the venereal wards at RPA Hospital. I describe some of these patients in chapter 3.
138 George Black (1854–1936), M. L. A., Chief Secretary and Minister for Public Health in NSW for a short time from April to November in 1916, was a prominent Labor Party politician, who was eventually expelled on the issue of conscription. Black was a recognised writer who edited a number of journals and newspapers, including The Australian Worker and the Bathurst National Advocate, as well as the first History of the NSW Labor Party. Black published The Red Plague Crusade: Ignorance a Racial Enemy, Cures and Preventives, Sexual Education advocated through the NSW Government Printer in 1916. This booklet’s aim was similar to Dr Arthur’s: to outline existing treatment facilities, and to propose developments to improve treatment facilities. There was however a significant
Fitzgerald took considerable interest in the development of metropolitan-wide venereal services. George Black personally advocated the establishment of night clinics at Royal North Shore Hospital and Newcastle Hospital, inpatient facilities at Sydney Hospital, and no changes to South Sydney Hospital, where ‘that district is served by the RPA Hospital.’ Black also advocated the construction of an ‘inexpensive ward of fibro-cement’ at Newington Hospital, and advised the Government Architect, George McRae, to develop plans for outpatient facilities at Royal North Shore Hospital. J. D. Fitzgerald, the Minister for Public Health from late 1916, suggested that night clinics should be opened at St Vincent’s (which politely refused), Balmain, South Sydney, North Sydney, St Georges and the Royal Alexandra and the Women’s Hospitals. In January 1917, the new Minister for Public Health met with a deputation from the Sydney Hospital Board to discuss the ‘question of Venereal Treatment.’ Whilst the Minister argued that Sydney Hospital was already well placed to provide both inpatient and outpatient venereal treatment services, members of the Board suggested that without extra space, in the form of new buildings, outreach dispensaries at Paddington or Redfern, or tents on the Domain, venereal treatment services could not be provided. The members of the Board were as one in arguing that ‘patients could not be treated in the general hospital.’ One Board member, Mr Stinson, suggested that ‘he had no desire to use the present critical situation unduly to press for additional space for the permanent scheme of extensions to the Hospital.’ Despite these protestations, many of the negotiations about the provision of venereal treatment services across the period were precisely about broader issues related to subscriptions, funding and the shortage of general, non-venereal hospital beds.

Writing of the period just prior to the VD Act 1918, Dr Richard Arthur argued that metropolitan hospitals were ‘altogether inadequately equipped for even dealing with

difference. Black placed considerable emphasis on the role to be played by preventive measures and preventive remedies. Black was writing, as well, before the first passing of the VD Act in 1918, and after the opening of the Outpatient Clinique on 11 January 1915, and spent significant time promoting the virtues of the recently opened Clinique.

139 ‘Letter from Director-General of Public Health to George Black, 21 March 1916,’ Establishment of Venereal Diseases Clinics, NSW State Archives, Box no. 10/43028, folio 34/26.
140 ‘Minutes of the Deputation from Sydney Hospital Board Meeting the Minister for Public Health, 4 January 1917,’ Establishment of Venereal Diseases Clinics, NSW State Archives, Box no. 10/43028, folio 34/26.
141 Ibid.
the patients that present themselves, and unless the facilities for treatment are largely augmented the new legislation will be to a considerable extent nugatory.’ Arthur proposed a range of augmentations and capital works across metropolitan Sydney. At RPA Hospital Arthur advocated a new dedicated Venereal Block, and the extension of operating hours at the Outpatient Venereal Clinique on the proviso that this would be a purely temporary measure until the building was constructed. This ‘inducement’ approach, where venereal treatment facilities would be provided if certain conditions were met, was the organising principle that existed between the Commonwealth, the States and local hospitals. Dr Arthur proposed that a new Venereal Block should also be constructed at Sydney Hospital, on grounds allotted from the Domain, and that ‘patients could at all times enter from the Domain, though they should not be debarred entrance by the main gate if they so desired.’ At Royal North Shore Hospital, situated near the centre of a large and rapidly increasing population, and at Royal South Sydney Hospital, ‘serving a mainly working class district of about 80,000 persons,’ Arthur argued again that Venereal Blocks needed to be constructed, and medical staff enlarged. In relation to inpatient services, Arthur suggested that all male patients should be concentrated in either the Coast or Liverpool hospitals. Arthur saw these proposals for the extension of treatment facilities as ensuring that ‘the most modern scientific methods for the detection and treatment of venereal diseases’ would be employed.  

Whilst venereal services in public settings were mostly for the indigent poor, the well-to-do had other options. Wealthy patients mostly attended private practices, but the fear of having a social equal knowing about a venereal infection drove some wealthy patients to public or charitable institutions. There is some evidence to suggest that some wealthy people attended RPA Hospital, even disguising themselves and ‘dressing down’ so as not to be recognised. There is other evidence to indicate that the rich attended private medical practitioners, paid what was appropriate, and were referred to specialists as and when it was deemed necessary. Many private medical practitioners were not up to date in current treatment regimes for syphilis and gonorrhoea, and it was likely that the treatment provided by some of these

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142 Arthur, R., Existing Facilities, pp. 8–9.
143 NSW Select Committee, p. 77.
144 Ibid., p. 42.
practitioners was outdated. L.P Johnston argued that some treatments for syphilis, like mercurial inunction, were only suitable for private patients, because they were expensive, and only the well-to-do had the skills to use them.\textsuperscript{145}

Public facilities for the treatment of venereal diseases in the indigent poor, on the other hand, were often understaffed, ill-equipped and very crowded. Dr L.P Johnston, who worked as an Honorary Surgeon at St Vincent’s Hospital and in private practice, compared venereal treatments in both. Johnston suggested that in his private practice he would see fourteen patients in four hours, and at a public clinic there was an expectation that five times as many patients would be seen in the same period. In public clinics, Johnston argued that it was impossible to adhere to ‘precise methods’ of treatment.\textsuperscript{146} Lewis argues that this was a different situation to public tuberculosis treatment centres, which many middle and upper class patients attended. He identifies as well that some medical practitioners desired that public facilities for venereal diseases treatment remained unattractive, crowded and understaffed so that they did not lose ‘paying patients to free public clinics.’\textsuperscript{147}

And yet, despite the poor standard, and paucity, of public venereal diseases treatment facilities, poor people regularly attended these clinics. This is in contrast to a complex array of references to the relationship between class and venereal diseases in the evidence presented to the NSW Select Committee of 1915, all of which painted the poor as being more likely to become infected, less likely to seek treatment and more in need of being monitored, than their higher class, more married counterparts.\textsuperscript{148} The views we have of working-class Australians in this period are usually through the eyes of middle-class observers, although Smart argues that the sexual mores of young working-class people ‘were different from those of the middle classes and less constrained by the ‘good/bad’ dichotomisation.’\textsuperscript{149}

\textsuperscript{145} Ibid., p. 42. \\
\textsuperscript{146} Ibid., p. 44. \\
\textsuperscript{147} Lewis, The People’s Health, p. 235. \\
\textsuperscript{148} NSW Select Committee, p. 32, p. 46. \\
\textsuperscript{149} Smart, J., ‘Sex, the State and the “Scarlet Scourge”: Gender, Citizenship and Venereal Diseases Regulation in Australia during the Great War,’ Women’s History Review, 1998: 7:1: p. 12.
In NSW, then, in the first quarter of the twentieth century, the management of venereal diseases was much debated. These debates did not lead to significant increases in or diversification of inpatient facilities, and only led to limited increases in outpatient facilities. What was observable was the increasing role that governments played in the administration and management of venereal diseases services for the indigent poor. In a number of situations, for example in the shift of inpatient facilities for prostitutes from RPA Hospital to Newington Hospital in 1916, the Department of Public Health played a crucial role. This consolidation of government involvement was roughly synchronous with changes that I have described in relation to health administration in NSW. For instance, with the establishment of the Ministry of Public Health in 1913 there was a concerted attempt to improve outpatient facilities for venereal diseases, with the Board of Health itself trialling an ambulatory clinic. By 1929, with the passing of the Public Hospitals Act, a departmentally run outpatient clinic for male venereal patients was established. In chapter 2 I will discuss two particular government initiatives, the Salvarsan Subsidy and the Commonwealth/State Pound-for-Pound Subsidy, both of which signalled the intention of governments to have an increased stake in venereal diseases management.

**NSW Prisoners Detention Act 1909**

The NSW PD Act 1909 was one of the final gasps of a long line of contagious diseases legislation which had been passed across the Australian colonies and the British Empire in the latter part of the nineteenth century. In Queensland in 1868, New Zealand in 1869, Victoria in 1878, and Tasmania in 1879, contagious diseases legislation was passed. Although contagious diseases legislation had been passed in

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150 Lewis, *Thorns on the Rose*, provides a detailed overview of this period on a colony-by-colony basis (pp. 104–121). Lewis examines the progress and eventual repeal of Contagious Diseases legislation across Australia. These did not succeed, but many, including a considerable number of medical practitioners, continued into the new century to lobby for contagious diseases legislation. Levine, in *Prostitution, Race and Politics*, compares the development of contagious diseases legislation in Queensland, Hong Kong, Straits Settlements and India.

151 Levine, *Prostitution, Race and Politics*, p. 101, points out that there were attempts to repeal the Queensland laws in 1884 and 1886. These abolitionist attempts failed, and Queensland retained the legislation through to its repeal in 1911. The new VD Act, however, retained the same registration and compulsory examination of prostitutes. The twentieth century Brisbane lock hospital was at Boggo Road Gaol Reserve.
Levine demonstrates that the colonial expression of this legislation took different forms, dependent on local circumstances related to ‘the management of sexuality, women, race and imperial policies.’ Levine characterises contagious diseases legislation as the primary means by which prostitution was controlled, and ‘almost the only way that VD came under legal scrutiny.’ Such legislation drew a clear link between ‘female sexual activity, and disease transmission.’ Generally, contagious diseases regulations allowed for the compulsory detention of convicted prostitutes in lock hospitals until cured, and were designed to assure military and naval health. Levine demonstrates, however, that in Queensland, soldiers and sailors were not a significant part of the colonial landscape, and so the legislation did not specifically apply to military and naval personnel. She suggests that in the tropical north of the colony, contagious diseases legislation represented a ‘racialised approach to the management of sexuality.’ In Tasmania, lock hospitals were established at the Cascade female factory building in Hobart, and the female house of correction in Launceston. Lock hospitals were ‘often a consequence of contagious diseases legislation,’ and were characteristic of port towns like Hobart. In Hobart, for instance, the Navy expressed concern at the number of sailors becoming infected whilst ashore, and indicated that they would only establish a summer base in Hobart if some attempt was made to regulate prostitutes. This link between the lock hospital, garrison towns, treaty ports and naval personnel is evident across the literature, and points to one of the key objections to contagious diseases legislation by the early feminist/Christian alliance in Britain: the perceived role of the state as a procurer or pimp for defence force personnel.

Levine has demonstrated that the movement towards introducing contagious diseases legislation was countered by an effective coalition, in the metropolis and in the colonies, to repeal this legislation. Although there was a significant attempt to

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152 McHugh, P., *Prostitution and Victorian Social Reform*, London, 1980, p. 35. McHugh sees the beginnings of agitation for contagious diseases legislation as occurring in the Crimean War. McHugh argues that it was during this period that a number of commentators, including Florence Nightingale, made strong correlations between the health of the armed forces, prostitutes and venereal infection.


154 Not all commentators were impressed by the effective campaigns of the abolitionists, and the repeal of contagious diseases legislation. Fournier remarked that the ‘medical supervision of prostitutes was attacked more vigorously than ever by a society originating in Anglican piety, organized against the regulation of all prostitution…their objections are already superannuated and refuted by satiety.’
introduce contagious diseases legislation in NSW in 1875, such regulations did not eventuate. Lewis argues that one of the key precursors to the introduction of the draft contagious diseases legislation in NSW by Mr Farnell MHA in 1875 was argument about the location of the Royal Navy Depot, and whether the depot should have been in Sydney, Hobart, Auckland or Melbourne. Farnell used the need for Sydney to continue to accommodate the Royal Navy as a major argument when he introduced the second reading of a draft contagious diseases Bill in 1875. He also referred to the spread of contagious diseases legislation across most ‘crown colonies’ and argued that it was therefore important to promulgate similar legislation in NSW. His opponents however were well aware that such legislation was already under intense scrutiny in the United Kingdom. Farnell’s primary argument was that such legislation would only be effective if it focused on the entire civilian population, and was not restricted to ‘specific areas to protect the health of the armed forces.’ This broadening of the legislative net was one of the main reasons that the legislation did not proceed beyond the second reading of the Bill. Whilst the medical profession was well disposed to the proposed legislation, both the Methodist and Presbyterian churches strongly opposed the propositions on ‘social, moral and religious grounds.’ Attempts to introduce contagious diseases legislation in NSW in 1875, then, foundered for a number of reasons.

The NSW PD Act 1909 was preceded by a flurry of correspondence and investigation from the NSW Board of Health related to the prevalence of venereal diseases amongst prostitutes and naval personnel. The Vice Admiral, based in Sydney had raised significant concerns about the effect of venereal diseases on ‘the efficiency of the
Fleet,’ and the Board of Health was keen to interrogate whether ‘CD Acts can signal
depurate the amount of disease in garrison towns and naval stations, although they are
unpopular yet something might be done.’\footnote{\textit{Letter from Board of Health to I.G. Police,} Containment and prevention of venereal diseases
1906–1916, NSW State Archives, container 5/5300.} The Board of Health surveyed a large
number of medical practitioners and public hospitals in an attempt to ascertain
whether prevalence warranted the enactment of contagious disease legislation. I detail
the extent and nature of this epidemiological inquiry in chapter 4. Other investigative
approaches were also attempted to ascertain whether such legislation was
epidemiologically and politically acceptable. In 1906, the Board of Health established
contacts with other states in Australia to determine whether legislation passed in those
states had been effective. In correspondence from the NSW Board of Health to the
Chief Health Officer in Hobart, Dr Millard asked: ‘what was directed to be done, how
much of it has been done, what remains to be done, and what can be added?’\footnote{\textit{Memorandum from Dr Millard to Department of Public Health Bureaucrat,} Containment and prevention of venereal diseases 1906–1916, Colonial Secretary’s Special Bundle, NSW State Archives, container 5/5300.} From
Hobart, Dr Elkington responded that the Act ‘effects little real regulation’ because
there were five major defects. Chief amongst these defects was the ‘necessity for
proving that the woman is or is reputed to be a common prostitute, or has solicited
prostitution within 14 days of the making of the complaint.’\footnote{\textit{The four other defects with the Tasmanian legislation noted by Dr Elkington were that some women
masked gonorrhoea with topical applications prior to examination, some diseased women were
impersonated by healthy women, ‘clandestine prostitutes were a more potent factor than the
professional article,’ and the lack of power ‘for dealing with diseased males whether of homosexual
proclivities or habitual associates of prostitutes’ (‘Letter from Dr Elkington to NSW Board of Health,’
Containment and prevention of venereal diseases 1906–1916, NSW State Archives, container 5/5300).} Despite these
reservations, the NSW Department of Public Health pressed ahead with plans to
implement contagious disease legislation.

In July 1908 a draft Bill was prepared. There were significant differences between the
definitions and inclusions in this draft, and the eventual Act of 1909. The July draft of
the legislation defined lock hospital as a ‘hospital or part of a hospital or of a gaol
declared to be a lock hospital’ whereas the Act defined a lock hospital ‘as hospital or
part of a hospital or of a public gaol, prison, or house of correction, or of a place of
detention declared to be a lock hospital.’ By 1909, any place where a person could be
or was detained was able to be a lock hospital. In the July draft ‘common prostitutes’...
could be examined by a medical practitioner ‘before sentence’; by 1909, prisoners who were suspected of being infected and had already been sentenced for some other crime, including vagrancy, drunk and disorderliness or theft, could be ordered by a magistrate to be removed for treatment to a designated lock hospital.\textsuperscript{161} The case books of women detained under the PD Act illustrate how after a period of detention, a red notation stating ‘PD Act’ would be made to signify that the prisoner was now considered to be a prisoner/patient in a lock hospital.\textsuperscript{162} If the initial clause related to detention ‘before sentence’ had stood, then the Act could not have been described as an Act to detain prisoners. The final significant difference between the July draft and the Act of 1909 was that the earlier draft contained five clauses related to the establishment of Hospital Registers of patients treated for venereal diseases, and the development of reporting lines to the Department of Public Health. By 1909, these pre-emptive notification clauses had been removed.\textsuperscript{163}

In 1908 a Bill for the Protection and Cure of Certain Contagious Diseases was introduced, but suspecting opposition, the name of the bill was changed to the PD Act, so as not to ‘frighten a number of well-meaning people.’\textsuperscript{164} This legislation was more targeted than the legislation that had been proposed in NSW in 1875. Most importantly, it provided for compulsory detention of prisoners, including prostitutes, until cured, if they were found to have venereal diseases when they were incarcerated for any reason.\textsuperscript{165} For instance, a prostitute who was arrested for soliciting could be examined, and if found to be infected, could be detained until cured. In NSW, in the first year of the PD Act, 43 men and 27 women were detained. I will examine further data related to the period immediately after the PD Act in chapter 4. Despite these low numbers, and writing in 1919, Dr Arthur argued that treatment facilities needed to be coordinated to deal with people detained under the PD Act. Arthur argued that Newington Hospital should focus on female detainees, and that one of the ‘women’

\begin{footnotesize}
\textsuperscript{161} PD Act 1909, clause 4 (1).
\textsuperscript{162} ‘Record of Female Prisoners Suffering from Contagious Diseases Detained under the Prisoners Detention Act of 1908,’ December 1908 – August 1909, NSW State Archives, container 5/226.
\textsuperscript{164} Cited by Lewis, Thorns on the Rose, p. 146.
\textsuperscript{165} NSW State Archives houses a volume which provides details of women detained under the PD Act. The volume includes details on the date received, date re-sentenced, date discharged and brief details of treatment (‘Record of Female Prisoners Suffering from Contagious Diseases Detained under the PD Act of 1908,’ December 1908 – August 1909 (Kingswood, 5/2226 part)).
\end{footnotesize}
hospitals in Sydney should be asked to set aside a special ward for pregnant women.’ In relation to men detained under the PD Act, Arthur suggested that ‘it would be better to set aside Long Bay Penitentiary as a receiving hospital for all prisoners with venereal disease.’

The NSW PD Act 1909 became effective and initially operated at almost precisely the same time as arsenical treatments (Salvarsan) became widely available. The Act also coincided with a downturn in the use of mercurial treatments. This combination of circumstances posed problems for medical and penal authorities, because under the provision of the Act infected prisoners were to be detained until cured. A. A. Palmer, the Government Medical Officer in 1915, argued that the mercury treatment for syphilis necessitated detention for three years, but because a prisoner could not be detained for that long, they were often only kept for six months, if they remained free of disease. Prisoners with gonorrhoea were detained for one month, if they remained free of disease. Palmer acknowledged that ‘it is impossible to lay down when a man is cured, either in the case of syphilis or gonorrhoea.’ Salvarsan shortened the period of time that prisoners needed to be detained until cured, but for Palmer, this was short-sighted because there were a high number of prisoners who appeared to be cured, but suffered ‘sharp attacks’ of syphilis a month later. Initially penal authorities were told that one injection of Salvarsan would effect a cure, but a process of trial and error suggested that ten injections was more appropriate. Because of the absence of nursing staff in prisons, some discussion took place as to whether prisoners should inject Salvarsan themselves. It was eventually decided that the warder should make the injection. The detention of prisoners until cured under this legislation was acknowledged at the time to be a forlorn hope, given the transitional nature of treatments and the mutable nature of ‘cures.’

The NSW PD Act 1909 included a number of important clauses premised on medico-penal responses to venereal diseases. Bashford has indicated that this legislation was

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166 Arthur, Existing Facilities, p. 9.
167 NSW Select Committee, p. 28.
168 Ibid.
169 Ibid.
170 Ibid.
designed to work in tandem with the Police Offences Act, ‘which rendered soliciting punishable by imprisonment.’ The PD Act allowed any prisoner to be inspected for venereal disease. In the same way that the legislation broadened the net of those citizens who could be detained if proof was provided ‘in private on oath’ of venereal infection, the legislation also widened the definition of the places in which citizens could be detained. With the passing of the 1909 legislation ‘lock hospital’ finally entered the legal lexicon in NSW. As we have seen, the Act conflated patient and prisoner, hospital and prison and detention and cure, loosely, determinedly and coercively. This conflation occurred at a time when the presumed diagnostic precision of the Wasserman procedure was not available. The Act also allowed a patient/prisoner to appeal, and not to be released whilst the appeal was being heard. Because the legislation allowed for the patient/prisoner to be ‘detained until cured’, often the period of curative detention was longer than the period of penal imprisonment for which the prisoner was initially convicted. In these instances, ‘detention’ was the term utilised, to differentiate from the ‘penal servitude’, the term used for the initial conviction. Through stealth, and in the shadow of the perilous controversies which had surrounded the introduction of contagious diseases legislation across the British Empire, the NSW PD Act 1909 had introduced a medico-penal template into NSW for the administration of venereal diseases.

Some argued that the PD Act would have no impact on the prevalence of venereal diseases in Sydney, whilst others argued that the effect of venereal diseases on sailors would be minimised as result of the legislation. Aspects of the legislation that allowed for a prisoner/patient to request an examination by a ‘medical man other than the prison surgeon’ caused disquiet. Some argued that the legislation had a significant effect on providing men with treatment, but generally, it ‘was a waste of time to administer it’, because it ‘let women go.’ By 1915, the most controversial aspect of the legislation was the incapacity to ‘detain’ prostitutes who had not been convicted of a criminal offence, but had only been fined for a summary offence.

172 NSW PD Act 1909.
173 NSW Select Committee, p. 12.
174 Ibid.
175 Ibid., p. 32.
Henry Storry Hawkins, Police Magistrate of NSW in 1915, detailed a salutary narrative that highlighted the perceived shortcomings of the legislation:

Only last month there was one woman who was in for a minor offence. She had been fined, and I think she had a week within which to pay the fine. She had to be discharged at the end of the period of detention, and the doctor told me that she was suffering from thirteen running sores around her privates. She was a prostitute, and yet she was allowed to go out and spread the disease.\(^{176}\)

Debates about the efficacy of the PD Act remained unresolved by the time of the VD Act 1918. The Act represented a significant, but awkwardly late, moment in the history of contagious diseases legislation across the British Empire. It introduced the concept of coercive segregation, framed around the idea of an ambiguous lock hospital, informed by a medico-penal response, and targeting prostitutes as primary vectors of infection. It is important to note that this occurred at a time when most other colonies across the Empire were eschewing the lock approach to contagious diseases control. It was not however the last gasp of such legislation: in 1915 New Zealand introduced a PD Act, which had similar provisions to NSW. This legislation was as ineffective as that in NSW.\(^{177}\) In NSW, the effectiveness of the contagious diseases approach was thoroughly interrogated by the NSW Select Committee on the Prevalence of Venereal Diseases.

**NSW Select Committee on the Prevalence of Venereal Diseases 1915**

This important Select Committee was one of a set of approaches to the management of venereal diseases that had been introduced by the Holman Labor government in NSW between 1910 and 1915. A number of prominent citizens approached the Labor

\(^{176}\) Ibid.

\(^{177}\) Between 1916 and 1922, 28 persons were detained under the New Zealand legislation, consisting of 19 men and 8 women. The New Zealand Committee of Inquiry in 1922 found the NZ PD Act 1915 'unsound, because the venereal diseases from which such persons suffer are in no way a greater danger to the public than the same diseases in the law-abiding subject of any class, and furthermore, the Committee have no reason to conclude from the evidence that convicted persons, as a whole, show a higher percentage of venereal cases than those who never enter a prison' (Venereal Diseases in New Zealand, p. 16).
government after the outbreak of World War 1 to conduct an inquiry into the prevalence of venereal diseases in NSW, and chief amongst these was Dr Richard Arthur. These citizens lobbied for such an inquiry on a number of fronts. Arthur was a prominent member of the Temperance Alliance, and argued that drunkenness and illicit sexual behaviour were linked. Arthur also suggested that the investigation should be configured as a Royal Commission, that it ‘should not be composed of medical experts’ and ‘that for many reasons it is desirable that women should have representation.’ Other lobbyists were concerned about reports of high rates of venereal diseases amongst soldiers, and were concerned about the impact of these diseases on civilian populations after soldiers returned home. By 1915, soldiers were already returning from Egypt, being demobilised at the Liverpool Camp, and women were regularly taking the train to Liverpool to see them. The Commonwealth government was becoming increasingly interested in the relationship between military personnel, prostitutes and venereal diseases. Queensland had in 1911 reviewed and recommitted to its contagious diseases legislation and Western Australia had only recently introduced the nation’s first venereal diseases legislation. It was originally intended that the investigation into venereal diseases in NSW would be the work of a subcommittee of the Tuberculosis Advisory Board, but the Holman government was eventually prevailed upon to convene a Select Committee. Lewis remarks that many prominent citizens in Australia were well aware of the progress of the United Kingdom Royal Commission on Venereal Diseases, and this also provided an impetus for the establishment of the NSW Select Committee. General dissatisfaction with the reach and impact of the PD Act 1909 also prompted some citizens to lobby the Holman government to instigate an inquiry.

178 Lewis, Thorns on the Rose, p. 164.
179 ‘Personal Letter from Dr Richard Arthur to the Premier, Mr Holman, 2 July 1914,’ Establishment of Venereal Diseases Clinics, NSW State Archives, Box no. 10/43028, folio 34/26.
181 Throughout 1916 the Medical Journal of Australia editorialised and reported regularly on the venereal diseases legislation being introduced in Western Australia. On 23 December, 1916, the Journal argued that ‘notification has no importance in the scheme of preventive medicine, unless the knowledge obtained is utilised for the purpose of tracing the source of infection and cutting them off.’ In Australia, this is one of the earliest references to contact tracing in the context of venereal diseases.
182 ‘Letter from the Under Secretary of Public Health to the NSW Chief Secretary,’ Establishment of Venereal Diseases Clinics, NSW State Archives, Box no. 10/43028, folio 34/26.
183 Lewis, Thorns on the Rose, p. 163.
Nine Members of the Legislative Assembly were appointed to the Select Committee,\textsuperscript{184} and at its first meeting on 13 July 1915, Dr Richard Arthur was appointed chair. The Committee convened seventeen times between July and December 1915, and took evidence from 38 witnesses.\textsuperscript{185} Although the Committee was given leave ‘to make visits of inspection, from time to time, for the purpose of holding enquiries and taking evidence,’ no such visits were made. All sittings of the Committee were held in the Committee Rooms at the Legislative Assembly, and on two occasions, sittings were cancelled because of the absence of a quorum. There was an eerie lack of commitment to the proceedings of the Select Committee, as if it were a foregone conclusion or a set-piece. Two members of the Legislative Council, The Hon. Fred Flowers and The Hon. Sir Charles MacKellar, were called to give evidence. There is some evidence to suggest that the Committee’s Progress Reports were censored, with the evidence of some witnesses not included in the official record, including Lieutenant Colonel McMurray MD, Dr Creed MLC, and Sir Herbert Maitland.\textsuperscript{186} All members of the Committee and all witnesses called to give evidence were men, as opposed to the United Kingdom Royal Commission and the New Zealand Select Committee, where in each case two of the Commissioners or committee members were women. It should also be noted that no final report, with recommendations, was ever produced. Nevertheless, the evidence presented to the Committee, and the discourses discernible in this evidence, highlight beliefs, concepts and organising ideas pertaining to the management of venereal diseases, and the modes of rule that attended those beliefs.

\textsuperscript{184} The Committee members were Dr Richard Arthur, Colonel Onslow, Mr Thomas, Mr Morrish, Mr Fitzpatrick, Mr McGirr, Mr Millard, The Hon. T. Brown and Mr Stuart-Robinson.

\textsuperscript{185} By comparison, the New Zealand Commission of Inquiry in 1922 included six Commissioners. The Commissioners comprised three medical practitioners, a Member of the Legislative Council and two women, one of whom represented the Hospital Boards of the Dominion. The Commission took evidence on 17 occasions and interviewed 74 witnesses. Thirteen women were interviewed, and representatives of a range of charitable and voluntary organizations were also interviewed. The Commission made special mention of the written evidence provided from Dr J. H. L. Cumpston, Director-General of Health in Australia and Dr Everitt Atkinson, Commissioner of Public Health in Western Australia (Venereal Diseases in New Zealand).

\textsuperscript{186} Black, \textit{The Red Plague Crusade}, p. 5. Black mentions that McMurray, Creed and Maitland were called, and gave evidence to, the Select Committee, but the evidence of these witnesses does not appear in the Final report.
Most of the 38 witnesses to the Select Committee were medical practitioners, with many being prominent specialists or bureaucrats in a range of fields. Most of the seventeen sessions of the Select Committee were framed around a pre-ordained set of questions, mapped out by the Committee members before the session began. Dr Arthur dominated proceedings: his questions were leading, and his follow-up questions were detailed. Lewis has characterized Arthur as being primarily interested in the relationship between alcohol consumption and infection with either syphilis or gonorrhoea. Dr Arthur’s Committee members mostly followed his lead, or echoed his questions. Some Committee members had particular themes that were followed at various points, when the opportunity arose. Often, at the end of an interview, Dr Arthur asked a number of final questions, to tidy up the process. Although there were 17 sessions and 38 witnesses to the Select Committee, there were a finite number of themes that were of most immediate interest to the Committee members. Much of the evidence to the Select Committee was centred on prostitution, marriage, compulsory treatment, notification, returned servicemen, and current services for the treatment of venereal diseases.

The Select Committee heard evidence which assessed previous approaches to the management of venereal diseases, echoed long-standing and unresolved themes related to the regulation of prostitution, and presaged all the important themes which would eventually be included in the VD Act 1918. The evidence heard by the NSW Select Committee placed it squarely as the parliamentary bridge between the PD Act 1909 and the VD Act 1918. The Commissioners looked back to the PD Act, and asked whether the current reach of that Act was sufficient, or whether it should be extended to cover those offences that only attracted a fine. They took evidence which suggested that those who could have their fines paid for them had to be released, even though they were infected with venereal diseases. The Committee members also looked forward to the VD Act, and canvassed most issues that were eventually addressed in that legislation. Notification, compulsory treatment, the outlawing of Chinese therapists and other ‘quacks’ and the public provision of venereal treatments were all subjects of interest to the Committee members. I will discuss each of the

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187 The Hon. Sir Charles MacKellar, Sir Thomas Anderson-Stuart, Herbert Henry Schlink, Professor D. A. Welsh, The Hon. Fred Flowers, Dr Cyril Corlette, Dr Gordon Wellesley Bray, Dr Ralph Worrall and R. T. Paton were prominent witnesses, whose evidence will play a role in this thesis.
188 Lewis, Thorns on the Rose, p. 165.
aspects of the VD Act in chapter 4. Whilst there was significant discussion on the regulation, inspection, examination and possible segregation of prostitutes, and the licensing of brothels, issues that had characterised earlier contagious diseases legislation, by the time of the VD Act 1918 these issues were no longer considered to be of legislative interest, or even a political possibility. Other issues interrogated at the Select Committee for which legislation was not passed included the issuing of ‘cleanliness’ certificates and undertaking blood tests for venereal diseases prior to marriage.

Some witnesses and Committee members at the NSW Select Committee were however acutely aware of the directions of the UK Royal Commission, even though at the time of the Select Committee, the Royal Commission had not tabled its recommendations. Bashford characterises the Royal Commission as being initiated by medical practitioners ‘after important diagnostic and therapeutic breakthroughs made preventive programs more viable.’ She argues that feminists played a significant role in the debate around venereal diseases, and that ‘the centrality of women’s issues in the evidence and recommendations of the Royal Commission on Venereal Diseases reveals the extent to which first wave feminism had influenced the definition of the issue.’

The Select Committee members in NSW in 1915 allowed no space for the input of women however. Lewis argues that initial reluctance to conduct a Royal Commission, because of the fear of ‘reawakening middle class feminists, working class men and concerned Christians’ eventually gave way in the face of powerful lobbying from the medical profession and the press. Lewis characterises the UK Royal Commission as ‘the most authoritative of the period’ and argues that most of the 35 recommendations of the Commission were related to diagnosis and treatment. It is worth noting that the NSW Select Committee made no recommendations despite its awareness of important diagnostic and treatment breakthroughs. The Royal Commission recommended that compulsory treatment should not be introduced, and that notification should only be introduced after the

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189 Bashford, in Caine, The Woman Question in England and Australia, p. 60, p. 84.
190 Two members of the United Kingdom Royal Commission into Venereal Diseases were women.
191 Lewis, The People’s Health, p. 231.
192 Lewis in *ibid*, indicates that certain patients would face compulsory treatment: namely, Poor Law patients and military and naval patients ‘were to be detained until cured’, p. 231.
establishment of a network of free, confidential public venereal diseases clinics.\textsuperscript{193} The NSW VD Act, which followed up many of the debating points of the Select Committee, took a very different route, introducing notification mechanisms and compulsory treatment before adequate treatment facilities were in place.

The UK Royal Commission on Venereal Diseases was followed by the Public Health (Venereal Diseases) Regulations 1916 and the UK Venereal Disease Act 1917. The Regulations declared that venereal diseases were endemic, and ‘that in view of the present War’ emergency regulations needed to be executed and enforced in every county or borough.\textsuperscript{194} It was specifically regulated that every council should ensure that any medical practitioner could access appropriate pathological reports, that any medical practitioner could obtain Salvarsan, that treatment facilities were available in hospitals, and that all information related to the treatment of a venereal patient remained confidential. The Regulations also stated that councils could provide instructional lectures and informative publications if they deemed it appropriate. The UK VD Act 1917 was a short statute which defined who alone, in certain areas, could treat venereal diseases, and prohibited all persons from advertising their capacity to treat venereal diseases.\textsuperscript{195} The Act made it illegal to advertise treatments for venereal diseases which included ‘pills, capsules, powders, lozenges, tinctures, potions, cordials, electuary, plaisters, unguents, salves, ointments, drops, lotions, oils, spirits, medicated herbs and waters and chemical and officinal preparations.’\textsuperscript{196} Following the recommendations of the Royal Commission, the UK VD Act 1917 did not introduce provisions related to notification and compulsory treatment. However the UK Public Health (Notification of Infectious Disease) Regulations 1918 prescribed the particular form in which notifications of ophthalmia neonatorum were to be made. In this period, in the UK, ophthalmia neonatorum was the only form or consequence of venereal infection that was made notifiable.\textsuperscript{197} The NSW VD Act took a very different route, opting for widespread and multi-faceted notification and compulsion when other countries were opting for voluntarism. This awkward timing, placing NSW out

\textsuperscript{193} Lewis in \textit{ibid}, indicates that free public clinics in the UK increased from 113 in 1917 to 193 in 1925, p. 232.
\textsuperscript{194} Harrison, L. W., \textit{The Diagnosis and Treatment of Venereal Diseases in General Practice}, London, 1918, pp. 463–466.
\textsuperscript{195} \textit{Ibid.}, p. 461.
\textsuperscript{196} UK Venereal Diseases Act 1917.
\textsuperscript{197} Harrison, \textit{The Diagnosis and Treatment of Venereal Diseases in General Practice}, p. 465.
of step with other countries in the Empire, had also been characteristic of the PD Act in 1909.

**Venereal Diseases Act 1918**

There were marked differences between the tone, intent and impact of the NSW PD Act 1909 and the NSW VD Act 1918: the momentous activities of the decade between 1909 and 1918 ensured these differences.\(^{198}\) In many ways the VD Act could not have occurred without both the PD Act 1909 and the Select Committee 1915. The 1918 legislation was called the ‘VD Act’ but the definition of ‘venereal disease’ (in the singular) which prefaced the legislation included ‘gonorrhoea, gleet, gonorrhoeal ophthalmia, syphilis, soft chancre, venereal warts or venereal granuloma.’\(^{199}\) The 1918 legislation oscillated between the older singular form, and the newer plural form: ‘disease’ versus ‘diseases’. This observation is not only nominal: I have noted already that communicable sexual infections were clustered, whilst non-sexual communicable infections were particularised. By 1918, therefore, there was some movement towards acknowledging that venereal diseases were a plural set of infections: this was not acknowledged in the PD Act. Although that legislation in its sub-title referred to persons ‘suffering from certain diseases’ and in its prefatory and main clauses referred throughout to ‘contagious diseases’, it did not specify any particular infections. The language of the PD Act placed it firmly in an older medico-penal model. Between 1909 and 1918 the very discourse of venereal diseases changed considerably.

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\(^{198}\) The same progression was followed in New Zealand. A PD Act had been introduced in 1915, and the Social Hygiene Act was passed in 1917. This legislation required an infected person to consult a medical practitioner, but no penalty was provided, and so there was ‘nothing to compel such persons to do these things.’ This legislation also outlawed treatment by anyone other than a registered medical practitioner, and ‘provided towards hospital maintenance a higher subsidy for venereal patients than is receivable for the maintenance of patients suffering from other infectious diseases’ (*Venereal Diseases in New Zealand*, p. 17).

\(^{199}\) Dr A. J. Gibson argued that the NSW VD Act 1918 was flawed because it did not define gonorrhoea: ‘is the diagnosis of gonorrhoea strictly limited to those infections caused by the gonococcus or whether the allied infections caused by other organisms were to be included’ (*Medical Journal of Australia*, June, 1919, p. 521). A. G. Butler argued that the VD Act was inappropriately involved in ‘bringing together for legislative purposes such totally dissimilar diseases as syphilis and gonorrhoea.’ Butler suggested that the only real connection between the two infections was the social circumstances of their spread, but that they were medically dissimilar. (*Medical Journal of Australia*, April, 1922, p. 477.)
There were other significant differences between the two sets of legislation. The PD Act had focused on prisoners, and particularly prostitutes: Lewis demonstrates that only 66 women (out of 366 women) over a period of ten years were actually curatively detained under the legislation.\textsuperscript{200} The VD Act focused on the whole citizenry: the reach of notification and compulsory treatment was far greater. The PD Act operated on a medico-penal model, where the prisoner became a patient. Under the Venereal Diseases legislation, the patient remained in an unlocked setting, with separate temporal and spatial borders of control, which I discuss in the next chapter. These borders of control comprised penalties, coerced attendance with appointed medical practitioners, non-consensual treatments and adherence to treatment timeframes and were premised on, and supported by, the diagnostic and therapeutic advances that had been made in the previous decade. I discuss the VD Act 1918 in significant detail in chapter 4, precisely because it was legislation which understood, counted and conceptualised populations, as opposed to individuals.

The NSW VD Act 1918 was an ‘Act to regulate the treatment of venereal diseases; (and) to prevent the spread of such diseases,’ and was assented to on 19 December, 1918.\textsuperscript{201} The Act itself was not gazetted until November 1919,\textsuperscript{202} at a time when some of the public treatment provisions of the legislation were better able to be met. Between the Select Committee of 1915, and the initial debates about the Act in the NSW Parliament in 1918, the University Society for Combating Venereal Diseases had been formed. The Society played a significant role in maintaining momentum after the Select Committee 1915, and as indicated by Arthur, presented a draft of the proposed legislation to the NSW government.\textsuperscript{203} I discuss the roles and functions of this Society in chapter 5.

The VD Act focused on nine major provisions, mostly related to the relationship between government, medical practitioners and patients. This relationship constituted the new ‘lock’: the spatial and temporal network of communication, surveillance, compulsion and notification. Examples of this new ‘lock’ space included the fact that only a licensed medical practitioner could treat patients with venereal infections, and

\textsuperscript{200} Lewis, \textit{Thorns on the Rose}, pp. 144–147.
\textsuperscript{201} NSW VD Act 1918.
\textsuperscript{202} VD Act 1918 Regulations, Government Gazette No. 255, 10 November 1919.
\textsuperscript{203} Arthur, \textit{Existing Treatment Facilities}, p. 9.
only a licensed medical practitioner, or a pharmacist operating under a medical practitioner’s instructions, could prescribe medications. Every person suffering from any venereal disease, or ‘suspecting that he is so suffering’, had to consult a medical practitioner within three days.\textsuperscript{204} Every person with a venereal disease, once having consulted a medical practitioner, had to stay with that medical practitioner until ‘cured’, unless moving to another medical practitioner under carefully prescribed circumstances. When a medical practitioner became aware that a person was suffering from a venereal disease, the medical practitioner had to ‘give notice thereof to the Commissioner in the prescribed form, in the prescribed period.’ Medical practitioners had to warn those infected with venereal diseases that they were infectious, that they should not contract marriage ‘until certified under this Act as cured,’ and had to provide patients with printed information regarding the disease. If a medical practitioner became aware that an infected person intended to marry, then it was lawful under the Act to inform the ‘other party to the proposed marriage’ of the other party’s infection. When a person became ‘free of infection’ the person was to be issued with a Certificate of Health by the medical practitioner. A medical practitioner appointed by the Governor was to be appointed the Commissioner of Venereal Diseases under the Act. The Act also provided for the Minister of Health to arrange with the managers of any Hospitals receiving subsidies from the State to make effective provision for the reception, examination and treatment free of charge for ‘prescribed’ persons suffering from venereal diseases.

The VD Act also allowed for severe penalties for landlords who failed to evict tenants who used their rooms for the purposes of prostitution. At first glance, this clause would appear to have had an impact only on individual prostitutes. As the legislation took effect however, this clause had a significant impact on the operation and availability of brothels across Sydney. Molesworth argued that ‘the effect of this law has certainly been to break up the brothels, and to drive the individual prostitute from pillar to post.’\textsuperscript{205} Such an outcome was controversial, because many commentators believed that prostitutes were forced onto the streets and into the parks, and were

\begin{footnotes}
\item[204] NSW VD Act 1918.
\item[205] ‘The Incidence of Venereal Disease and Method of Prevention,’ Medical Journal of Australia, September 1916, p. 245.
\end{footnotes}
therefore less able to be regulated.\textsuperscript{206} Molesworth argued that when clients of
prostitutes moved from brothels to streets, they 'proceeded to worship at a new shrine –
that of the amateur.'\textsuperscript{207} During the war, the 'amateur' prostitute had been
categorised as being a young, single working woman who engaged in premarital sex,
sometimes for payment. The 'amateur' was also referred to as a 'square girl.'\textsuperscript{208}
Generally, medical practitioners agreed that this clause of the VD Act was a failure
precisely because 'it was extremely unwise to chase the prostitute from place to
place.'\textsuperscript{209}

In November 1919 Regulations related to the VD Act were published in the
Government Gazette.\textsuperscript{210} These Regulations provided substance and form to many of
the key clauses of the 1918 legislation. Fourteen Regulations were published, and
eleven \textit{pro forma} letters, forms and statistical grids. Because notification of infected
individuals by medical practitioners was a key component of the legislation, the
Regulations detailed the length of time a person needed to remain under treatment
prior to being notified. For instance, a person diagnosed with syphilis needed to attend
'once in every two weeks during the continuance of primary or secondary syphilis,
and thereafter not less than once in every four weeks.'\textsuperscript{211} A person diagnosed with
gleet needed to attend once in every fourteen days. Template forms were provided for
the notification of infected individuals (form B), and these acted as a receipt for the
remuneration that medical practitioners received for each notification. A medical
practitioner in private practice received two shillings and sixpence for each
notification, and a medical officer at a hospital received one shilling.\textsuperscript{212} Medical
practitioners also received ten shillings for examining indigents and between five and
seven shillings for ongoing treatment of indigents.\textsuperscript{213} Notification and compulsory
treatment could well have been lucrative practices for medical practitioners. Other

\begin{itemize}
\item \textsuperscript{206} 'British Medical Association News: Scientific,' \textit{Medical Journal of Australia}, September, 1916, pp.
372–374.
\item \textsuperscript{207} 'The Incidence of Venereal Disease and Method of Prevention,' \textit{Medical Journal of Australia},
September 1916, p. 245.
\item \textsuperscript{208} 'British Medical Association News: Scientific,' \textit{Medical Journal of Australia}, September, 1916, p.
372.
\item \textsuperscript{209} \textit{Ibid.}, p. 373. Medical practitioners who supported these claims were Dr H. C. Adams, Dr D. Kelly,
Dr Sinclair Gillies and Dr A. A. Palmer.
\item \textsuperscript{210} VD Act 1918 \textit{Regulations}, Government Gazette No. 255, 10 November 1919.
\item \textsuperscript{211} VD Act 1918 \textit{Regulations}, regulation 4.
\item \textsuperscript{212} \textit{Ibid.}, regulation 7a and 7b.
\item \textsuperscript{213} \textit{Ibid.}, regulation 14.
\end{itemize}
templates included the Notice of Change of Medical Advisor (form A), Certificate of Cure or Freedom from Venereal Diseases (form G), the annual statistical return by each medical practitioner (form J), the Notice of Change of Medical Practitioner (form D) and even the prescribed Warning Notice to Patients (form E). The Regulations, gazetted almost a year after the legislation, attempted to give effect to some of the ambiguous clauses of the Act. The delay however did not inspire confidence in medical practitioners, who were to be both agents and financial beneficiaries of the legislation. In chapter 4, I will describe how many medical practitioners, despite the reassuring templates and incentives of the Regulations, remained ambivalent about notification and compulsory treatment.

The concept of notification did not suddenly appear in NSW with the VD Act 1918, and the Commonwealth government played a significant role in convincing most states including NSW to provide for notification within their venereal diseases legislation. There had been significant discussion of options related to notification for many years. It was a hotly contested approach to venereal diseases management, and for a range of other diseases. Even prior to the formation of the Commonwealth Department of Health on 7 March 1921 the Commonwealth government was offering subsidies to State governments that introduced legislation requiring notification of venereal diseases. The Commonwealth Health Department adroitly tied legislation providing for notification to the ‘pound-for-pound’ funding scheme. This scheme was one of the first tied Commonwealth/State funding schemes in which funds contributed by the State were matched by the Commonwealth. This proposal was warmly welcomed by the editors of the Medical Journal of Australia in July 1916, who advised the States to accept the conditions of the Commonwealth Government and ‘to

214 Ibid., regulations 1 to 14 ‘The Warning Notice to Patients’ (form E) read: ‘You are suffering from a venereal disease. Venereal diseases are contagious. If you communicate the disease to any other person, or do or permit or suffer to be done any act likely to lead to the communication of the disease to others, you are liable under the abovementioned Act to imprisonment for twelve (12) months, or to a fine of 100 pounds, or to both fine and imprisonment. You are warned not to marry until medically certified under the Act as cured. Penalty on conviction five years imprisonment or a fine of 500 pounds, or both fine and imprisonment.’

215 By 1915 in NSW a number of infections were notifiable. Enteric fever, scarlatina and diphtheria were made notifiable in 1898, bubonic plague in 1900, acute anterior poliomyelitis in 1912, acute malaria in 1915 and epidemic cerebro-spinal fever and pulmonary tuberculosis in 1915. Smallpox and leprosy had been made notifiable prior to 1898. There were different forms and methods of notification depending on the infection. Smallpox was to be immediately notifiable by telegram, for instance, and leprosy was to be notified by a letter addressed to the Board of Health (Medical Journal of Australia, August 1916, p. 97). In 1915, there was considerable debate as to whether measles (morbilli) should be made a notifiable disease (Medical Journal of Australia, August 1916, p. 41).
provide Night Clinics in connexion with the hospitals.' The proposed subsidy was subject to the following conditions:

1. that notification of cases by medical practitioners be made compulsory;  
2. that all practicable measures be taken for tracing the source of infection;  
3. that the treatment shall be on recognised modern lines, and adequate precautions taken against the spread of infection;  
4. that arrangements be made as soon as possible for the performance of examination for microscopical examination for diagnosis and for blood examinations;  
5. that clinics be established, where practicable, for the special treatment of venereal disease, and that patients be admitted on first appearance, on the same basis as all other patients;  
6. that patients admitted to such clinics be entitled to free treatment;  
and  
7. that the hospital concerned will agree to undertake to arrange for a series of lectures or practical demonstrations each year to undergraduates and graduates on some subject or subjects connected with venereal diseases for attendance at which no fee will be charged.

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216 Medical Journal of Australia, July 1916, p. 43.  
217 The eventual form and parameters of the notification provisions in the legislation introduced in NSW in 1918 were by no means predetermined: in the UK and Europe notification took many shapes and forms, and had a chequered history. Baldwin identifies two forms: a weak version which only reported the fact of infection, ‘without naming names, as the basis of reliable statistics’; and ‘the strong, normative variant,’ which reported the identities of patients, with the real possibility of compulsory treatment, arrest or isolation (Baldwin, P., Contagion and the State in Europe 1830–1930, Cambridge University, 1999, p. 437). Opinion was divided as to the appropriate response for venereal diseases, some rejecting ‘notifiability as inappropriate for venereal diseases and those welcoming it as part of the prophylactic armamentarium needed to replace regulation.’ Of course, notification of a range of infections had been a common practice since the late nineteenth century in the UK. As Porter indicates, the Infectious Diseases (Notification) Act 1889 made not only life-threatening illnesses like smallpox, typhus, diphtheria and scarlet fever notifiable, but also diseases such as measles (Porter, D. (ed.) The History of Public Health and the Modern State, Atlanta, 1994, p. 135. Baldwin indicates that venereal diseases were not included in this legislation (Baldwin, Contagion and the State in Europe 1830–1930, p. 436). He argues that because syphilis was more prevalent than other diseases, and its duration prolonged, authorities were uncertain about what they ‘could or should do with the thousands of notifications they might be expected to receive’ (Baldwin, Contagion and the State in Europe 1830–1930, p. 436).  
218 This was of particular concern to the medical practitioners at RPA Hospital because of the influx of poor venereal patients.
The above conditions formed the basis of legislation introduced in most states. Clause 1 was the linchpin condition from the Commonwealth’s perspective: compulsory notification by medical practitioners of venereal infection was the premise on which other provisions were built. The Commonwealth did not set a condition related to compulsory treatment: rather, it set conditions related to adequate treatment facilities, free treatment, and treatment ‘on recognised modern lines.’ All States however went one step further and introduced provisions related to compulsory treatment, which in itself was tied to notification. Clause 5 was significant because it was premised on the idea that adequate treatment facilities would be available to ensure patients were admitted ‘on first appearance:’ in fact, adequate treatment facilities, both inpatient and outpatient, often proved illusory. The introduction of quotas ensured that most patients were not able to be seen on first, second or third appearance. Clause 7, which called for appropriate medical training on issues related to venereal diseases, was the only limited call the Commonwealth made on expectations related to education and prevention. Because the ‘pound-for-pound’ funding was not tied to the development of preventative education measures, none of the states included such measures in their legislation. Cumpston, Commonwealth Director-General of Health, more generally conceded that some medical practitioners, and specialists, were often behind the times when it came to the treatment of venereal infections: ‘the treatment of these diseases, especially of syphilis, has advanced so rapidly within the last few years that it is by no means uncommon to hear of practitioners who still treat cases by out-of-date methods which are no more than palliatives.’ In relation to clause 4, RPA Hospital was well placed to ensure microbiological diagnostic tests, including the Wasserman reaction, which had been extensively used since 1910. Despite the passing of legislation in each state of Australia between 1915 and 1920 the medical

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219 In this period as well we are seeing the coincident emergence of a number of professional specialties, including epidemiology, venereology and bacteriology. Early in this period, venereology hovered between gynaecology and dermatology, with syphilis having a dermatological focus, and gonorrhoea having a gynaecological focus. The medical treatment of syphilis was also called syphology, and syphilis specialists, syphologists.

220 Cumpston, Venereal Disease in Australia, p. 29.

221 RPA Hospital had a well-developed pathology unit under the guidance of J. B. Cleland.

222 The extensive use of the Wasserman reaction at RPA Hospital from as early as 1911 will be demonstrated in chapter 3.

223 Venereal diseases legislation providing for notification and compulsory treatment was passed in Victoria in 1916, Tasmania and Queensland in 1917, NSW in 1918 and South Australia in 1920. Western Australia had been the first state in Australia to pass venereal diseases legislation, in 1915.
profession and some health bureaucrats remained divided about the efficacy of notification.

There were significant oppositions to many of the goals and clauses of the NSW VD Act 1918 and subsequent Regulations, most of which related to the nexus between coercion and consent. Lewis argues that the NSW legislation was slower in coming than other Australian states because ‘in political circles a strong animus existed against compulsion in relation to communicable disease control.’

In the parliamentary debates which preceded the introduction of the Act, The Hon. J. B. Nash argued that the Act was an infringement of the relationship between medical practitioner and patient, and that the word ‘cured’ was used in the legislation – when ‘the medical profession did not cure, it only treated.’

The Hon. J. B. Peden argued that ‘while no-one is going to underrate the importance of education or religious or moral teaching, the one great chance of dealing with this disease is by compulsion: compulsory notification, compulsory treatment.’

Peden captured the tension at the heart of the legislation: consent or coercion, persuasion or penalty, education or incarceration. Peden conditionally supported coercive segregation: he argued further that, as in Western Australia, compulsory examination of those who the Commissioner ‘had reason to believe’ were infected with venereal disease should be included in the legislation.

The NSW legislation did not include this clause,
sometimes referred to as the ‘tittle-tattle’ clause, primarily because it held echoes of earlier fraught contagious diseases legislation.\(^{228}\)

Compulsion, however, remained the mainstay of the NSW legislation, but as much compulsion of practitioners and patients. Some medical men who were members of Parliament objected to being compelled to provide notifications to the Commissioner for Venereal Diseases, arguing that medical practitioners were being turned into ‘detectives and policemen.’\(^{229}\) Marguerite Dale, Honorary Secretary of the Hygiene Association, argued that ‘a woman co-administrator of the Act should, as a matter of common justice, be appointed.’\(^{230}\) Others objected to the provision of a ‘Certificate of Health’, when the word ‘cured’ in relation to venereal diseases ‘had no meaning.’\(^{231}\) The Hon. J.D FitzGerald suggested that the legislation was deficient because it did not tackle important issues related to prevention education, and in the debate surrounding this inclusion, it was counter-argued that education was ‘outside the function of Parliament.’\(^{232}\) Prior to the passing of the legislation, there had been discussions as to the appropriate mode of rule to embody in the legislation. The clauses related to marriage best reflect these discussions. The first step in the marriage clauses of the VD Act was for the medical practitioner to encourage and educate the infected person to inform their future spouse; if this proved unsuccessful, then the medical practitioner intervened, and legally disclosed infection. This staged approach would later be adopted in relation to contact tracing. The marriage clause was a delicate mixture of persuasive and punitive techniques. One correspondent to the Medical Journal of Australia suggested that this tension could be resolved ‘if legislation specifically arranged for co-operation with such bodies as health associations, town planning and infant welfare associations, rescue workers, associations of sanitary engineers, religious organisations and medical associations and should embody their

\(^{228}\) NSW Parliamentary Debates, session 1918, 9George V, vol. LXXXIV, p. 3509.

\(^{229}\) Ibid., p. 3507.

\(^{230}\) Sydney Morning Herald, 3 December 1918.

\(^{231}\) NSW Parliamentary Debates, session 1918, 9George V, vol. LXXXIV, p. 3503. The Hon. J. D. Nash argued that the wording of the legislation should: ‘Thought to be cured…there are words in the bill which have practically no meaning. “Cured” has no meaning. The medical profession does not cure; it only treats. We can tell you when in our opinion a man has got rid of the organisms which stand for this disease. That is all the most expert men in the country can tell you.’

expert knowledge." Possibilities for segregating venereal populations were limitless when all modes of rule were interconnected.

Medical practitioners were one of the key lobby groups who were ambivalent about aspects of the venereal diseases legislation in NSW. Over the decade from 1915 to 1925 the Medical Journal of Australia published a high volume of articles, reports, letters and editorials on issues related to venereal diseases and legislation. During 1916, a majority of articles in the Medical Journal of Australia concerned debate about the proposed clauses of state-based legislation, with an emphasis on the efficacy of notification, compulsory treatment, and compulsory examination, and articles and advertisements related to the efficacy of Salvarsan, and some of its substitutes. By 1919 the Medical Journal of Australia was publishing articles that highlighted that prevention education had not been included in the legislation. Other articles interrogated the medico-political ramifications of the various Acts which had been passed in Australia, and posed questions as to what actions or processes were needed to follow, or follow up, such legislation. By 1922, the Medical Journal of Australia was publishing articles which assessed the default system introduced in Western Australia, examined the cost-effectiveness of legislation, reported on the 1922 Commonwealth conference held in Canberra to specifically discuss the degree of the effectiveness of the measures adopted in all states except South Australia, and published a range of heated correspondence on

234 ‘Medical Matters in Parliament: Western Australia,’ Medical Journal of Australia, 1 January 1916, P. 20
235 ‘The Health Act of Western Australia,’ Medical Journal of Australia, 29 January 1916, p. 99–100;
‘A New Form of Touting,’ July 15, p. 41.
237 ‘The Pathology of Syphilis,’ Medical Journal of Australia, 1 July 1916, p. 8
238 ‘Problems in Connexion with the VD Act 1918,’ Medical Journal of Australia, 21 June 1919, p. 501
240 Ibid., pp. 518–521.
the issue of prophylaxis. Two enduring tensions throughout the period were the extent to which legislation should be persuasive or punitive and whether the space the ‘defaulter’ occupied was imagined as the clinic or the penitentiary. For example, JB Cleland, NSW’s leading microbiologist, teased out the politics of persuasion when he commented that:

Though it may be Utopian to expect that the community will adopt at once or as a whole the basic principles that have been here enumerated, it is the duty of our profession to weigh them carefully, to test them surely, and if they seem worthy to press them on every possible occasion. To us the public look for guidance; though at first they may pay little heed to advice, perhaps unwelcome, if we reiterate again and again the views we know to be sound, they will at last credit them, or at least by our importunity open their ears to what we have to say.

The Act represented a significant moment in the uneven development of liberal regimes of responsibilisation, precisely because it attempted to crystallise and endorse a coercive set of strategies whilst in prevention domains there was a move towards self-regulation. This was noted in the years following the passing of the legislation in NSW by a number of commentators, one of whom argued that a greater reliance on active cooperation, education and sociological measures would have improved the impact of the legislation:

Public health enactments should constitute statutory advisory commissions of experts from such bodies to assist in the working of the Act by actual active cooperation and by educational efforts. Venereal diseases legislation should constitute an honorary commission to watch the sociological side of the position. A special clause in the Act should make such a statutory appointment

244 ‘The Prevention of Venereal Disease,’’ Medical Journal of Australia, 18 February 1922, p. 186. Prophylaxis was extremely contentious in the early 1920s for a range of reasons which I discuss in chapter 5: one main reason, however, for the controversy was precisely because prevention education, including prophylaxis, had been avoided in all state-based legislation.

with defined powers and duties which should, broadly speaking, be designed to coordinate the social and ‘sanitary’ ideas of preventive efforts.\textsuperscript{246}

It is difficult to assess the impact and importance of the venereal diseases legislation in the longer context of venereal diseases management in NSW, as there are serious epistemological issues with the notion of impacts. There were numerous possible resolutions to the interactions of social forces, individuals and beliefs in the lead up to the VD Act: one piece of legislation was not necessarily caused by one, or any number, of particular factors. There were also uneven and combined patterns of belief and action depending on circumstances and interests which motivated all the key players – parliamentarians, lobbyists, medical practitioners and patients.

There were however considerable impacts on particular hospitals. The capacity of individual hospitals to receive, examine and treat ‘prescribed persons’ free of charge was of immense concern to the RPA Hospital Board of Directors. In an internal Memorandum, the Medical Superintendent argued that:

\begin{quote}
The VD Act, which came into operation on 1 December, has thrown an increased amount of work upon the Administrative staff. If the requirements of the Act stopped at notification, our task would be comparatively simple. It goes further, however, and demands that failure on the part of the patients to attend regularly for treatment shall be reported to the Commissioner. This necessitates the closest supervision over the attendance of each individual. Our hospital would be an ideal site for a large Venereal Clinic, capable of controlling 1000 patients. We are in the centre of a large industrial population, and the nearest hospital to the Western Suburbs. Any expenditure (for the new clinic) would be repaid many times over by the improved health of a large industrial population.\textsuperscript{247}
\end{quote}

There are some notable features of this Memorandum. By 1920, the language of hospital authorities had moved closer to the language of surveillance: notification,

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supervision and control of populations was now the norm. The VD Act 1918 was put forward as the reason for this shift, particularly the provisions in the Act which not only called for notification of infection, but also for notification of failure to comply with treatment. Hospital authorities were not referring to individual patients: they were referring to populations from the industrial suburbs, and to the improved health of these populations. Hospital authorities became more interested in improving the health of venereal patients when the prospect of funding for a large venereal clinic was mooted. There was in fact a subtle attempt by the editors of the RPA Hospital Gazette to argue that RPA Hospital was better positioned than other metropolitan hospitals to be ‘capable of controlling 1000 patients.’ Treatment was perceived as being a subset of the broader category of control. Given the hospital’s role over nearly twenty years in providing one of the few dedicated inpatient and outpatient venereal services in the state, these claims may well have had some justification. It is also possible to observe, however, public health politics at work: authorities jockeying for a slice of the limited health pound to control venereal patients. The hospital and its Boards existed in an uneasy equilibrium with the Department of Public Health, and the VD Act 1918 and its subsequent Regulations made the relationship between these bodies more complex.

**Counterposing the contemporary discourses**

Whilst the management of venereal diseases across NSW in the period c. 1901–1925 can be understood through the governmental pillars provided by legislation and parliamentary committees, and shifts in the mode of rule from medico-penal models to less transparent borders of spatial control, it is important to identify the philosophies of responsibility and obligations which informed these governmental responses. This is an appropriate place in which to conclude this chapter, because it provides the window through which subsequent chapters related to treatment, prevention and epidemiology are framed. The ambivalence at the heart of responses to venereal diseases in NSW grew from the differences in values, attitudes, beliefs and opinions which informed the activities and practices of key individuals and institutions. The same phenomenon was evident in the prevention domain: different values, attitudes, beliefs and opinions informed the position that key individuals took
on such fundamental issues as prophylactic packets and access to contraceptive information. These differences are embodied in the evidence of two witnesses to the NSW Select Committee of 1915: the Hon. Fred Flowers and Dr Ralph Worrall.

In July 1915, Dr Arthur asked Dr Worrall, the first head of the Outpatient Clinique at RPA Hospital:

What value do you attach to venereal clinics?

Dr Worrall responded:

I think they have advantages and disadvantages. From inquiries I have made in Sydney, it seems to me they engender a light view of venereal diseases among those who frequent the clinic, or have to resort to them for treatment. They are giving the idea among the youth that venereal diseases are easily cured, and also that they are not half bad. These patients have special privileges which other sick folk have not; special hours are set apart for them, with special doctors and special accommodation. A sense of shame used to characterise them when they attended clinics with other patients, but they are now all tarred with the same brush, and joke about the disease. There is not the sense of shame on their part that there used to be. I do not say that venereal clinics ought to be abolished, but I do say that they will not accomplish what Mr Flowers intended when they were established. I do not believe there is a doctor in Sydney who thinks they will exercise any appreciable influence on the incidence of the disease.\(^{248}\)

Dr Worrall’s evidence to the Select Committee was lengthy and comprehensive. He was in fact called twice to give evidence to the Committee, and on each occasion, he drew an immediate distinction between venereal and non-venereal patients: he positioned venereal patients as receiving special privileges, as irresponsible about their infection, and as people who frequented (as opposed to attended) the Clinique. Dr Worrall also believed that the stigmatisation of venereal patients (by having them

\(^{248}\) NSW Select Committee, p. 62.
present for a consultation in full public view) encouraged an appropriate sense of shame, and that the provision of special hours, doctors and accommodation only encouraged flippancy amongst patients. For these reasons, Dr Worrall stated that he did not believe that venereal clinics would have any ‘appreciable influence on the incidence of the disease.’

Dr Worrall’s judgements about the irresponsibility of venereal patients were not isolated: the evidence of the Select Committee was replete with similar observations, although with some notable exceptions. A prevailing discourse on venereal patients in this period positioned these patients as sick in a very different way to non-venereal patients: the venereal sickness was a moral sickness that attacked the community, and hence the need for isolation, for special accommodation, doctors and hours. Venereal patients were also often described as moving through the community in a group, or as a seething mass, tarred with the same brush, and as having limited judgment to be able to avoid infection, or responsibility to seek treatment for infection. Venereal patients therefore required special care and treatment, although paradoxically, this special treatment was perceived to give the venereal patient privileges which allowed them to avoid what was considered to be the appropriate stigma of shame.249 In many ways, the venereal patient was caught in the net of a complex ambivalence: perceived to be infectious and therefore needing separate facilities, but also perceived to be benefiting inappropriately and irresponsibly from these separate facilities.

At the NSW Select Committee on 21 September 1915 Frederick Flowers was asked by Dr Arthur:

Can you give the Committee a résumé of the conclusions you arrived at in regard to the means of dealing with this question ... of venereal diseases in the community?

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249 In a medical text of 1915 McDonagh, in arguing that venereal patients were special, suggested that they were more knowledgeable and inquisitive than other patients. McDonagh argued that: ‘Every venereal patient should be looked upon as a special sort of individual, and the physician in charge should always adopt a most optimistic tone. The knowledge that many patients have of medical science is often much greater than that with which they are accredited, so that, in any suspicious patient, I have always found it to be a good plan to let him follow my line of argument, and to tell him the reason why so and so many injections are given, and why the treatment is continued so and so long... When the position is laid before them, they naturally ask questions’ (McDonagh, J. E. R., The Biology and Treatment of Venereal Diseases, p. 484).
Flowers responded, in sharp contrast to Worrall:

It is an accepted fact that venereal disease is just as damaging to the community as tuberculosis or alcoholism. Yet no decisive step has ever been taken by the State to grapple with venereal diseases per se. When grave complications ensue and the patient comes along with a disease having a different name, but directly due to venereal trouble, he or she is received into the public hospital with open arms. Had such patients some inducement to come along for skilful treatment – whether rich or poor without any questions being asked – when they first know themselves to be infected much misery would be spared them in the later vagaries of the disease under a respectable name. To put things plainly, venereal disease, if not properly treated at the outset, becomes other things, often necessitating serious surgical operation...

The outstanding fact is that free skilful treatment, obtainable under the seal of confidence, without any inquisitive questioning, presents the only inducement under which sufferers will come along voluntarily for medical attention. I am only directing my remarks to cure, not to methods of prevention.

Dr Arthur here intervened, saying:

After all, that is prevention to some extent, is it not?  

Flowers’ remarks were carefully considered, and very much concerned with the public health aspects of venereal diseases management, the effects of venereal diseases on the community, and the particularly damaging economic effects involved in ongoing hospitalisation. Flowers addressed the issue of stigma and shame in a very different way to Dr Worrall. He viewed venereal diseases from a longer perspective, with their various sequelae: sequelae for which the presenting symptoms were often far removed from the original infection. These sequelae were, as well, often called

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250 NSW Select Committee, pp. 84–90.
different things, and in the renaming, lost the associated stigma.\textsuperscript{251} By medical practitioners de-venerealising the venereal, Flowers pointed out that they exposed their biases and beliefs. Whereas Worrall argued that shame would encourage a person towards appropriate treatment, Flowers argued that shame would drive a person underground, where treatment was unavailable.

Flowers saw other prerequisites for the delivery of appropriate services to venereal patients, all of which represented the opposite end of a public policy debate to those views expressed by Dr Ralph Worrall. He suggested that treatment should be free, skilful, confidential, voluntary and non-inquisitive. The Select Committee members found these proposals unpalatable, and were inquisitive themselves as to why these characteristics should be cornerstones of a preventative approach to the treatment of venereal infection. Skilful treatment was eventually interpreted in the VD Act of 1918 as meaning only that treatment administered by a registered medical practitioner. It would appear that non-inquisitive questioning\textsuperscript{252} remained an elusive objective, given the prurience of the medical practitioners appearing before the Select Committee, and the evidence presented in the medical records of the RPA Hospital.

Worrall and Flowers represented two opposed, prevailing and co-existing discourses on the nature of services for venereal patients. Worrall argued that venereal patients had ‘special privileges which other sick folk have not; special hours are set apart for them, with special doctors and special accommodation’, and this decreased the amount of shame which would have been useful in their treatment, and a useful deterrent. Flowers argued that ‘free skilful treatment, obtainable under the seal of confidence, without any inquisitive questioning, presents the only inducement under which sufferers will come along voluntarily for medical attention.’ Shame, according

\textsuperscript{251} Ibid., p. 84. In his evidence Flowers quoted the example of locomotor ataxy, often associated with primary syphilis, and when thus associated, responded to in a very different way to late stage locomotor ataxy, which was not perceived to be associated with syphilis.

\textsuperscript{252} This phrase, ‘non-inquisitive questioning’, could refer to early usage of what in modern times might be referred to as contact tracing. It could also refer to a clinical technique, often used by sexual health counselors today, of using neutral language and active listening in the performance of the taking of the sexual history. Fluker provided the following description of contact tracing in England in the pre-penicillin years: ‘There was Defence of the Realm 33B; if two or more people named an alleged contact as the source of an infection, the clinic had power to compel her (his) attendance for examination and if the infection was confirmed, to treat appropriately. In the event of any refusal there was power to imprison, twice exercised. With one informant persuasion only was allowed.’ (Fluker, J. L., ‘Personal Reminisces of a Venereologist before Penicillin,’ International Journal of STD and AIDS, 1990: 1: pp. 443–446.)
to Worrall, decreased risk, and apportioned blame. Neither shame nor blame were considered by Flowers as being appropriate strategies in reducing morbidity and mortality. These were only two of a continuum of views. One was the view of a medical practitioner, and the other the view of a Labor politician, an ex-Minister of Public Health. These differences played out not only in the treatment domain: in the field of prevention education, and in responses to epidemiology, these discursive differences also fuelled policy formulation, resistance and re-formulation.

**Conclusion**

Any twenty-five year period is certain to encompass a certain amount of change. The first decades of the twentieth century in NSW saw significant administrative changes in the field of public health, and perceptible shifts in the meanings attached to health. The passing of the Public Health Act in 1896 in NSW, the growing diversification of the Department of Public Health between 1904 and 1913, and the growth of Health Districts, Divisions and Branches were all indicators of changing logics of health. Hospitals, as well, were changing roles, functions and directions, and becomingly increasingly tied to government subsidies and control. In 1913 the formal supervision of general hospitals, private hospitals, state hospitals and specific hospitals came under the Director-General of Public Health, and in 1918 the Hospital Advisory Board was created, albeit a Board with little effective control over these institutions. It was not until the passing of the Public Hospitals Act in 1929 that a Hospitals Commission exercised effective control over general hospitals. Within the Department of Public Health, venereal diseases were formally recognised with the creation of the Division of Venereal Diseases in 1918, a Division which was to survive in various forms, apart from one short period in the 1970s, until the present day.253

In line with other hospitals, RPA Hospital was developing stronger financial and administrative ties with government, and the governing bodies of the hospital, the Board of Directors and the Medical Board, underwent significant change. Despite the

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253 This Division within NSW Health is currently called the AIDS/Infectious Diseases Branch.
fact that for almost the entire period Sir Thomas Anderson Stuart and Mr William Epps were two key individuals in the hospital’s administration, there were important developments in the nature and roles of the Boards themselves. Significant issues included the composition of Boards, government representation, government subsidies, balancing charitable and public health imperatives, the tying of subsidies to performance measures, and questions of control, influence and independence. RPA Hospital also struggled with its role in relation to the management of venereal diseases. One of only a few venereal service providers, and probably the major player throughout the period, the hospital also resisted this profile, arguing that venerealisation would be detrimental to its broader goals. I discuss this fear of venerealisation in more detail in chapter 2.

Up to, and after, the VD Act 1918, there was a paucity of venereal diseases service across NSW. This was particularly true for regional NSW, but also true for metropolitan Sydney. Despite legislative attempts to mandate compulsory treatment, the number of outpatient and inpatient treatment facilities increased only marginally during the period. This is also despite the fact that the NSW government, at three significant moments – the PD Act in 1909, the Select Committee in 1915 and the VD Act in 1918 – invested considerable energy and expertise into solving the administrative and management problem that venereal diseases presented. I have traced a line through these governmental interventions, and I have identified a perceptible shift in outlook and focus. This shift, occurring at the same time as the growth and diversification of the Department of Public Health, was from an older ‘contagious diseases’ paradigm to a slightly more sophisticated and finessed ‘venereal diseases’ paradigm. This shift was characterised by a move from a medico-penal interpretation, with a focus on the individual prisoner/patient, particularly the prostitute, to a coercive and segregative approach that focused on identification of the ‘notified person’ and the ‘defaulter.’ I have suggested that this movement from curative detention to unlimited spatial and temporal borders of control was echoed in other domains related to the management of venereal diseases, and was in fact analogous to the general thrust of the period from government to self-government.
Chapter 2
Administering Venereal Diseases at Royal Prince Alfred Hospital: the ‘venerealisation’ of a Hospital

During the first three decades of the twentieth century, the Royal Prince Alfred Hospital attempted to solve the complicated puzzle of managing a rapidly increasing caseload of patients with venereal diseases within the evolving nature and capacity of a general and charitable hospital, under shifting constraints established by government and public expectations. The Hospital was the site for the contest between different ways of organising ‘venereal’ spaces, with some experts advocating older style lock spaces, others suggesting a combination of flexible inpatient and outpatient settings, with a range of views in between. The residual rationales and techniques of lock hospitals complicated attempts to find cost-effective and progressive solutions because many medical practitioners remained committed to paradigms which sequestered and punished ‘venereal’ patients. I argue in this chapter that older spatial management practices at the Royal Prince Alfred Hospital were modelled on the ‘panopticon’, whilst newer practices were modelled on the ‘dispensary.’ I have utilised Foucault’s concept of the panopticon and Armstrong’s theorisation of the dispensary as templates for this analysis. 254 The concept of the panopticon was most clearly evident in ward spaces, and the concept of the dispensary was most evident in outpatient services. Whether ward or clinic, panopticon or dispensary, however, the key motive for service design, development and delivery was the hospital’s fear of being ‘venerealised.’ This fear was the common denominator in the delineation and classification of venereal spaces at RPA Hospital.

The discussion of the definition and marking out of venereal spaces at the hospital was filtered through complicated agendas related to gender, disease and service delivery. Hospital authorities experimented with a number of arrangements of hospital spaces in their attempts to juggle what they perceived to be the competing needs of

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specialist and generalist service delivery,\textsuperscript{255} ‘venereal’ and ‘non-venereal’ patients, inpatients and outpatients,\textsuperscript{256} male and female venereal patients and different ‘grades’ of female patients. I suggest that these were the five clear rationales which guided spatial arrangements at hospitals during this period. The dichotomy between venereal and non-venereal patients arose precisely because one set of patients was perceived to be morally ill, and the other perceived to be physically ill, leading to the potential for non-venereal patients to become morally ‘infected.’ ‘Venerealisation,’ or the process (and fear) of having general hospital service provision overwhelmed by specific venereal diseases services whilst other hospitals did not provide venereal services,\textsuperscript{257} was rooted in this moral equivocation. The separation of male and female venereal patients, with males occupying outpatient spaces and general inpatient spaces, and females occupying dedicated inpatient spaces and limited outpatient spaces, sprang from a number of sources, including medical and biological assumptions, the fear of

\textsuperscript{255} There was significant debate about the benefits of service provision in specialist venereal hospitals. One of the key debates that played out in the evidence presented to the NSW Select Committee on the Prevalence of Venereal Diseases in 1915 related to the tension between specialist and generalist service delivery of venereal treatments. Fournier, writing of metropolitan Paris in 1906, identified some of the tensions which accompanied the provision of venereal services from general hospitals, when he argued that the treatment of venereal diseases ‘should not be carried out by the creation of special departments at the general hospitals, but by the creation of new special hospitals entirely devoted to the treatment of venereal diseases’ (Fournier, A., The Prophylaxis and Treatment of Syphilis, London, 1906, p. 16). It was generally agreed that the venereal wards at RPA Hospital were inadequate to meet the needs of metropolitan Sydney, but when questioned about the possibility of extending ward space, Sir Thomas Anderson Stuart argued that ‘it would never do to make it into a venereal hospital. It is a general hospital and a teaching hospital, and we must have a certain proportion between the kinds of cases treated’ (p. 79). Legislative Assembly of NSW, Minutes of Evidence taken before the Select Committee on the Prevalence of Venereal Diseases, Progress Report, Sydney, 1915.

\textsuperscript{256} Nearly all references to outpatient venereal services in internal RPA Hospital documents referred to the ‘Venereal Clinique’ specifically, not the clinic. It is only possible to guess at the reason. It is possible that the term only reflects the French provenance of the word ‘clinic’. However, Tuberculosis treatment services were called sanatoria, psychiatric treatment services were called asylums, leprosy treatment services were called lazarets, and this term, ‘Clinique’, might have been an attempt to develop a specific terminology for outpatient venereal treatment services. Certainly, the use of this French construction would point to a popular apprehension, that venereal diseases were a French disease. Another French word (locque) had provided venereal diseases with the term that had been used for centuries to describe inpatient treatment services: ‘lock’ hospital. But by the early twentieth century not only had the term lost currency, but the concept as well, as opposed to sanatoria, lazarets and asylums, terms and concepts which were in their heyday.

\textsuperscript{257} The influx was so significant at RPA Hospital that authorities argued that other hospitals in Sydney were not fulfilling their responsibilities in relation to treating venereal patients. They argued that they risked being perceived as an exclusively venereal hospital: of becoming venerealised. The editor of the journal of RPA Hospital, the RPA Gazette, identified this fear, and its consequences, when he argued: ‘the reputation that Prince Alfred has been getting, as the only place at which a Night Clinic has been in existence for the treatment of venereal disease, tends to cause patients who are not suffering venereally to go to other hospitals, and this is, they think, unjust to Prince Alfred Hospital as well as to the patients of a class who are not suffering from venereal troubles, but who have long been excellently well treated at Prince Alfred Hospital’ (RPA Hospital Gazette, 30 December 1916, no. 56, vol. xiv).
sexualising medical spaces, and the perceived need to detain women for long periods of time. The ‘grading’ and segregation of women was based on moral taxonomies related to ‘decent’ married women, ‘case-hardened’ prostitutes and increasingly in this period, ‘amateur’ prostitutes.

Based on these rationales, the organisation of spaces at RPA Hospital proceeded in a piecemeal way between 1901 and 1925. The first ten years of the new century saw a clear focus on inpatient facilities for women, whilst the second decade saw an added focus on outpatient facilities for both genders. In 1911 the first day outpatient clinic opened in the general outpatient department, and in 1915, the first evening ambulatory venereal clinic began at RPA Hospital, operating from specific rooms away from the general outpatient department. This was an important event in the history of venereal diseases management at the Hospital because it proved to be a watershed in the administration’s view of their capacity to cater to venereal patients. By the third decade of the new century, the elements of compulsion and notification in the NSW VD Act 1918 necessitated a significant expansion of outpatient facilities and a realignment of staffing and cost structures at the hospital. The RPA Hospital was one of the few institutions in NSW which provided a combination of venereal inpatient and outpatient services at this time.

**Space**

In hospitals, effective architectural and metaphoric definition and use of space was, and remains, an imperative. Foucault examined the relationship between space and power. He recognised three forms of spatialisation in relation to medical matters. The first and second related to the location of a disease in a family and in a body. The third related to ‘all the gestures, by which, in a given society, a disease is

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258 It is important to remember as well that gender demarcations in the broader medical world had long been considered necessary.


260 Fournier, A., in *The Prophylaxis and Treatment of Syphilis*, London, 1906, p. 16, described a similar phenomenon in France. Fournier argued that the number of beds for the treatment of venereal diseases was ‘notoriously insufficient,’ and that the number of beds ‘should always be equal to or superior to the demand.’

261 Adams has argued that domestic architecture in the late nineteenth century was informed by a growing willingness ‘to rationalise the conduct of life in accordance with medical rules’ and this created a path for the emergence of asepsis, hygiene and bacteriology (Adams, A., *Architecture in the Family Way: Doctors, Houses and Women, 1870–1900*, Montreal, 1996, p. 34).
circumscribed, medically invested, isolated, divided up into closed, privileged regions, or distributed throughout cure centres, arranged in the most favourable way.’

It is the tertiary level of spatialisation which is most useful in understanding the venereal spaces at RPA Hospital. Questions related to the locale of the hospital, and to the location of the venereal spaces within the hospital, occupied the Board of Directors and the Medical Board. Questions about the compartmentalisation of internal space, the arrangement of wards, the positioning of beds, and the physical relationship between the venereal and the non-venereal wards were also regularly addressed. As I describe the venereal wards and clinics in more detail, I argue that people with venereal diseases were circumscribed, medically invested and isolated, with the intention being to arrange them in the most favourable way to avoid the stigma of the hospital being venerealised.

The panopticon, an important model related to the arrangement and meaning of space, was developed by Foucault from the original ideas of Jeremy Bentham. For Bentham, the panopticon was more than an architectural figure: it proposed a solution for doctors, penologists and educators to the problem of a small number of staff maintaining power and control over a large number of patients, pupils or prisoners. The panopticon was then a technology of power ‘capable of resolving the problems of surveillance.’ He argues that with population increases and economic changes in the late 18th and early 19th centuries, it became necessary to ‘practise an exhaustive and individuating analysis of the social body.’ Bentham’s panopticon met this need because it allowed for power to circulate through finer and finer channels, ‘taking hold of individuals, their bodies, their gestures, every one of their daily activities.’ On the one hand, hospitals were arranged to avoid contact, contagion, physical proximity and overcrowding; on the other, hospitals had to be appropriately ventilated and lit. Foucault characterised the problem as dividing space and leaving it open, ‘in order to

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263 Elden, S., ‘Plague, Panopticon, Police,’ *Surveillance and Society* 2003: 1:3: pp. 240–253. It is worth noting that Bentham’s initial schema for the panopticon had been ‘for the reform of prisoners certainly, but also for the treatment of patients, the instruction of schoolchildren, the confinement of the insane, the supervision of workers, beggars and so on’ (p. 242).
ensure a form of surveillance at once global and individualising, while carefully 
separating the individuals under observation.’ By arranging space so that a specialist, 
a matron, a doctor, or a nurse was able to watch a patient so that the patient or 
prisoner could not assume that they were being watched, or not watched, was the 
principle which motivated the panopticon. If a patient could never be sure whether he 
was being observed, then according to Foucault’s schema, the patient became his own 
guardian. These imperatives gave medical practitioners considerable importance: in 
fact, Foucault argued that medical practitioners became ‘spatial arrangers’ when 
social hygiene, or the health, cleanliness and location of populations became an 
economic imperative. Foucault has remarked that ‘doctors were indeed, in part, 
specialists of space.’

Armstrong extends the metaphor of the panopticon with his theorisation of the 
dispensary. Using the development of the dispensary in Edinburgh at the end of the 
nineteenth century as an historical model, Armstrong argues that the meanings and 
arrangements of power through space changed as health service delivery changed. 
Dispensaries had been providing care to poor people for centuries, but the 
tuberculosis dispensary which opened in Edinburgh in 1887 was different, he argues: 
as well as being an outpatient clinic, the dispensary ‘arranged for a staff of nurses to 
visit the homes of patients so as to discover their needs, to report on their 
circumstances, to act as a conduit for charitable agencies, to report on contacts and to 
teach the healthy way of life.’ This way of operating was different from the 
traditional hospital dispensary in four important areas. First, by radiating out, illness 
was sought and identified in the community, not just in the clinic. Second, by working 
in the community, the relationships between people became pathologised, particularly 
in the instance of tuberculosis, and venereal diseases. Third, the dispensary allowed 
for improved surveillance of the population, through its capacity for panoptic 
observation. Finally, the dispensary transformed the physical space between people 
‘into a social space traversed by power.’ Interestingly however, the panoptic 
capacity of the dispensary was perceived by Armstrong to be less effective in the

264 Foucault, M., in an interview with Michelle Perrot entitled ‘Eye of Power’ in Lotringer, S., Foucault 
266 Ibid., p. 10.
context of venereal diseases. As ‘specialists of space’ medical practitioners maintained control over patients and diseases in disparate settings – wards, clinics, private practices and community settings.

The dispensary and the panopticon are important frameworks for understanding the development of venereal spaces within RPA Hospital. I investigate ward space modeled on the panopticon and outpatient space modeled on the dispensary, the relationship between architectural space and the exercise of power, the people who occupied the spaces, both medical practitioners and patients, and the diseases, procedures and investigations which brought them together in the one space. Across the first three decades of the twentieth century there was a significant disinvestment in ward space modeled on the panopticon, and a considerable investment of resources, meaning and technologies in outpatient or dispensary spaces.

Lock hospitals

Venereal spaces at RPA Hospital grew out of a long tradition in the United Kingdom, Europe and the Australian colonies of treating venereal patients in isolation, and in detention. Lock hospitals were an approach to regulating individuals suspected of being infected with venereal diseases through examination, detention, and in some contexts compulsory treatment until cured. Alfred Fournier, writing in 1906, saw a great untapped potential in lock hospitals: they could have provided rich pathological and clinical material for medical training and constituted a ‘great school of syphilis.’ In reality however lock hospitals were often poorly run and understaffed.

268 Dr Alfred Fournier (1832–1914) was an internationally acclaimed dermatologist and venereologist, whose main body of work on syphilis was produced in the later part of the nineteenth century. By the first quarter of the twentieth century, Fournier was recognised as one of the leading experts in syphilology, and his medical texts were widely and promptly translated, including into English (Waugh, M. A., ‘Alfred Fournier, 1832-1914: His Influence on Venereology,’ British Journal of Venereal Diseases, 1974: 50: pp. 232-236). Fournier inherited the mantle of a master of syphilology from his teacher and mentor Phillipe Ricord, the prominent French syphilologist who differentiated syphilis and gonorrhoea, and who identified the three stages of syphilitic infection. Fournier himself was the first Professor of Cutaneous and Syphilitic Diseases at the Paris Faculty of Medicine in 1879, and the head of the venereology departments at both Hopitaux de Lourcine and Saint-Louis. In opposition to most theories of his time, Fournier demonstrated the syphilitic origin of both tabes dorsalis and general paralysis of the insane. In 1899, in France, Fournier published The Prophylaxis and Treatment of Syphilis, a seminal textbook that was to exert significant influence on the development of systems for responding to venereal diseases. In 1901, Fournier founded the ‘Societe francaise de prophylaxie sanitaire et morale,’ a melting pot of medical, social and political affiliations.
Levine provides a graphic picture of the variable operation of lock hospitals in colonial contexts. They ranged from bedding for a handful of detainees to institutions with multiple wards. Lock hospitals were often thrown together in a rush, physically uncomfortable and run without qualified nursing and medical staff because patients were perceived to be in need of discipline, not treatment or cure. Whilst Levine examines the implementation of contagious diseases legislation and lock hospitals in Queensland, others have examined the implementation of lock spaces in other states and colonies of Australia. Riley examines Australia’s role in sequestering islands to isolate people with venereal diseases in Papua New Guinea. Briscoe examines a
similar phenomenon off Western Australia with the establishment of Bernier and Dorrier Islands for male and female Aboriginal venereal patients. Lewis highlights similar practices of incarceration on islands off the coast of Queensland.

Although this period saw an overall decline in the establishment of lock hospitals the concept did not disappear: it proved an idea which was particularly amenable to mutation. Bashford argues that although the lock hospital as an entity diminished towards the end of the nineteenth century, well into the twentieth century ‘the lock hospital was sustained as a model, as well (in some locations) as an actual practice for the removal of the morally as well as the medically dangerous.’ Tibbits argues similarly that although the concept was waning, lock hospitals were in fact being established and operated by stealth. Despite the fact that the wards and clinics at RPA Hospital were not detention centres for compulsory treatment (although compulsory treatment was mandated by the VD Act of 1918) many contemporary commentators referred to the wards themselves as ‘lock wards.’

from 10% to 1% of the Trobriand population, led to the development of lock hospitals in Rabaul, and Kaveing.

Briscoe, G., in Disease, Health and Healing: Aspects of Indigenous Health in Western Australia and Queensland 1900–1940 (PhD thesis, ANU, 1996) charts the sorry development of lock hospitals on Dorre and Bernier Islands off the coast of North-Western Australia. Throughout the period a total of 635 indigenous people were admitted to what Briscoe refers to as the ‘Lock-up Hospitals’, 426 females on Dorre Island, and 209 males on Bernier Island. Jebb, M., in Blood, Sweat and Welfare: A History of White Bosses and Aboriginal Pastoral Workers (University of Western Australia, 2002) describes three phases of colonisation in the Kimberleys, and in the first phase situates the incarceration of Aboriginal people in lock hospitals.

Lewis provides a clear overview of the response to Aboriginal people suspected of having venereal diseases in a number of states of Australia and of the development of lock hospitals. He indicates that in Queensland, aboriginal people were incarcerated on Fantome Island, near Palm Island, off Townsville (Lewis, M., Thorns on the Rose, New Haven, 1998, pp. 374–385).


Tibbits, D. R., ‘VD Behind Bars,’ Proceedings of the Fourth Biennial Conference of the Australian Society of the History of Medicine, 1995, pp. 167–170. In 1878 the Melbourne hospital had a lock ward, with eight to ten beds, for prostitutes, where, Tibbits notes, inmates were given treatment as well as needlework, ‘sewing the shrouds for the dead…’ By 1916, with the passing of the new venereal diseases legislation, the language had changed to ‘voluntary patients’. Tibbits notes however that voluntary patients who submitted themselves for treatment were asked to sign an undertaking that they would not discontinue treatment without authority. If patients discontinued treatment, they could be fined 50 pounds, or jailed for six months. Similarly in 1922, Dr Robertson, the Victorian Chief Health Officer, wanted to establish a venereal sanatorium to rehabilitate voluntary girls. After the Coode Island hospital closed in 1923, attention was drawn to the case of young girl who was found to have venereal disease and no adequate means of support, and inappropriately sent to jail. As a result of the subsequent fracas, Fairhaven was established in 1926, on the site at Yarra Bend of the Fairfield infectious diseases hospital. Tibbits remarks, that even in 1926, sturdy high fences topped with barbed wire, and patients locked in their dormitories at night meant that ‘Fairhaven was in effect a twentieth century lock hospital.’

A number of medical practitioners who gave evidence to the NSW Select Committee referred to ‘lock’ wards, including H. H. Schlink, Barrington Fourness, E. H. Molesworth and P. Clubbe.
medico-penal assumptions behind the concept of ‘lock’ space had diminished, the concept of ‘lock’ as a segregative space had not. Lock concepts were a way of categorising, articulating and delineating venereal space: a segregated space for the management of contagion, and the containment of the fear of venerealisation. At RPA Hospital this transformation of the ‘lock’ concept was observable in both wards and outpatient clinics.

**Wards**

Despite attempts during the 1870s and 1880s to raise subscriptions to build RPA Hospital, with its central Administration Block and four three-storey pavilions, the construction of the hospital was piecemeal. The upper floor of the pavilions was to have had a large ward of 32 beds, and the middle floor was to have had a ward of 14 beds. The ground floor housed a large ward, surrounded by a deep colonnaded verandah. On the ground floor of each pavilion were small private wards, called the Ogilvie Wards, funded from a 1000 pound bequest. Two of the pavilions were constructed and occupied in the 1880s, and the final two, the Victoria and Albert pavilions, were built in 1904. In her memoir, Dorothy Armstrong remarks that it was not until 1926 that all 224 beds of these two new pavilions were ready to be occupied. Apart from these pavilion wards, RPA Hospital also had an isolation department, consisting of ‘6 single-roomed, detached, timber and galvanised iron

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277 Doherty, M. K., *The Life and Times of RPA Hospital*, Sydney, 1996. p. 75. These private wards were intended for ‘the reception of gentlemen who are able and willing to pay for their maintenance whilst in Hospital, preference being given to naval officers who may fall sick whilst in port.’ In utilising the evidence of Muriel Knox Doherty it is important to remember that her long and influential nursing career began in 1921 as a trainee nurse at RPA Hospital, and so she was not a witness to nursing practices in the early part of the century.

278 Armstrong, D., *The First Fifty Years*, p. 24. Armstrong provides the following opening dates for a range of buildings at the RPA Hospital: Pavilion C., 1886; Pavilion D., 1887; Administration Block, 1887; Isolation Cottages, 1886; the first part of the Nurses Home, 1892; the Victoria and Albert pavilions, 1904; Isolation Block, 1928; Gloucester House, 1936; King George V Memorial Hospital, 1941. Armstrong also notes the increase in the number of available beds: 146 in 1882, 224 in 1887, 318 in 1905, 392 in 1911, 510 in 1918, 530 in 1931, 1532 in 1964.

279 Ibid., p. 10.
cottages.”  

The initial design of the pavilion system at the RPA Hospital had not been intended to accommodate venereal patients. However, the Board of Directors had lobbied government to build specific ‘lock’ accommodation for venereal patients from as early as the 1870s. At some point between 1898 and 1906, a ward in the basement of the C pavilion became available for the inpatient treatment of 15 women with venereal infection. A second ward for 15 women and female children became available in 1906. Some referred to these two wards as one single ward, as did Dr Herbert Henry Schlink,282 in his evidence to the NSW Select Committee on the Prevalence of Venereal Diseases.283 The need for such dedicated wards was vigorously debated throughout the period, with some arguing that specialist inpatient services guaranteed quality care, and others arguing that such services institutionalised the ‘venereal stigma.’ Others suggested that it was ‘absolutely impossible’ to cure a prostitute unless she was treated as an inpatient.284 The establishment of these female wards coincided with the creation of a new department at RPA Hospital for the treatment of male and female venereal patients in 1906. The first honorary medical officer in charge of this department was Dr William J Munro, who held the post until 1909.

Men with venereal infections could also be hospitalised at RPA Hospital, but they were placed in the general medical wards in the men’s pavilion, a situation with

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280 Doherty, M. K., The Life and Times of RPA Hospital, p. 83.
281 This Commission also received evidence from a Professor Wilson, who commented that ‘lock cases were received at the hospital but there was still no special ward’ (Doherty, M. K., The Life and Times of RPA Hospital, p. 111).
282 Dr Herbert Henry Schlink was chair of the Medical Board at RPA Hospital between 1910 and 1912, and, in 1926, became Chair of the Board of Directors, and remained so until 1962.
283 NSW Select Committee, p. 67. In Adelaide during this same period inpatient treatment was provided for males in the lock ward and for females in the Magdalen ward (Hart, G., From Night Clinics to the Internet: A History of Sexually Transmitted Diseases in South Australia, 1916–1996, Adelaide, 1998, p. 3).
284 NSW Select Committee, p. 41.
which the Board of Directors was not entirely happy.\textsuperscript{285} Despite continued lobbying throughout the period and beyond, the first exclusively male venereal disease ward in any public hospital in Australia was not opened until 16 November 1943 at RPA Hospital.\textsuperscript{286}

The two basement venereal wards for female patients at RPA Hospital were referred to as ward X and ward Y by a number of coy contemporary commentators, although in the evidence of the NSW Select Committee on the Prevalence of Venereal Diseases, Dr Schlink records the venereal ward as being ward D.\textsuperscript{287} Schlink argued at the Select Committee that an inordinate amount of attention was paid to the development of the outpatient clinic at the expense of a full discussion of the need for venereal inpatient services. Wards and outpatient spaces were not always perceived to be complementary. Inpatient services were paramount, Schlink argued, because ‘from the medical or the sociological point of view it is well recognized that it is safer and quicker to have the patients in bed and to give full doses of Salvarsan.’\textsuperscript{288}

Microbiological rationales, then, kept prostitutes being treated in ward spaces. Schlink provided a brief administrative history of D, and indicated that in 1915 the ward was unofficially divided: the dermatologist looking after those suffering from syphilis, and the surgeon after the gonorrhoeal patients.\textsuperscript{289} At the same Committee, Dr Joseph Foreman referred to the wards as the ‘lock ward’, and suggested that they were primarily set aside for the long-term treatment and containment of prostitutes. Dr Foreman also suggested that outpatient clinics would not have the capacity to treat and contain prostitutes.\textsuperscript{290} Ward space, then, was perceived to have the greater potential for keeping a watchful eye on female prostitutes.

In a lengthy deposition to the NSW Select Committee in 1915, Dr Schlink detailed the problems he observed in the venereal wards, and outlined some possible solutions. He

\textsuperscript{285} Armstrong, D. M., \textit{The First Fifty Years: A History of Nursing at RPA Hospital, Sydney from 1882 to 1932}, Sydney, 1965, p. 113.

\textsuperscript{286} Doherty, M. K., \textit{The Life and Times of RPA Hospital}, Sydney, 1996, p. 313. This ward for male venereal patients had been known as Violet Cottage, but became known as the Royal Prince Alfred No. 1 Special Hospital.

\textsuperscript{287} Both M. K. Doherty and D. Armstrong in their separately referenced memoirs refer to these wards in this manner.

\textsuperscript{288} NSW Select Committee, p. 109.

\textsuperscript{289} Ibid., p. 108.

\textsuperscript{290} Ibid., p. 71.
believed that D3 was so inadequately staffed that patients themselves did most of the routine work of the ward.\(^{291}\) This led to the second problem on the ward: patients treated each other. This was undesirable because old hands taught new ones how to douche themselves, and prostitutes mixed with ‘decent’ women. Whilst Schlink saw dysfunctional recruitment and grooming, the women may have experienced these relationships somewhat differently. Schlink suggested that such relationships would occur whilst ever ‘nursing staff is so numerically weak’ and he recommended that a permanent sister be placed in charge of the ward.\(^{292}\) The third issue resulted from D3 having to accept referrals of chronic patients from the NSW Board of Health Hospital Admissions Depot, instead of concentrating on acute cases of syphilis and gonorrhoea. The fourth problem resulted from inadequate accommodation for the children of female patients. Schlink recommended the establishment of a male venereal ward (to be housed in the surgical ward, C3), the use of basement D3 for prostitutes only (along with the transfer of some prostitutes to Newington Hospital), the establishment of a new venereal ward for ‘decent’ women, girls and children, and the development of a suite of three or four pathological laboratories. The proposed new venereal ward for women was ‘to be specially constructed and composed of a number of small rooms which would allow a proper social grading to be made.’\(^{293}\) Categorised as such, female venereal patients could be rigorously observed, and divided so as to ensure limited contact across classes and types. Social ‘gradings’ were to be mirrored in the spatial arrangements of the venereal wards, so as to facilitate surveillance,\(^{294}\) and to ensure no cross-contamination.\(^{295}\)

\(^{291}\) Doherty has described the conditions in D3 as ‘high pressure’, and remarked as well that ‘these patients were treated like any other sick person and were allowed to leave when they pleased’ (Doherty, M. K., The Life and Times of RPA Hospital, p. 312). All ambulant female patients wore the same uniform: blouses and long blue serge skirts ‘tied around the waist with strong black tape’ (Doherty, The Life and Times of RPA Hospital, p. 82). Male patients and hospital porters all wore dark blue serge trousers, waistcoats trimmed with red braid and white hospital shirts. From the inception of the women and female children’s ward, there were a significant number of obstetrics cases on D3, and in the period ‘1908–1914, most infants born to the syphilitic girls inherited the disease.’\(^{292}\) NSW Select Committee, p. 108.

\(^{293}\) Ibid., p. 108.

\(^{294}\) Similar management problems were not encountered in the Magdalen ward at Royal Adelaide Hospital because it was ‘under-used by patients with venereal disease and was converted to a general female ward and renamed Patience Ward’ (Hart, G., From Night Clinics to the Internet: A History of Sexually Transmitted Diseases in South Australia, 1916–1996, p. 3).

\(^{295}\) There is some disparity in the evidence relating to the use of infection control procedures with venereal patients in NSW during this period. Armstrong remarks that there were occupational hazards for nurses and resident medical officers, and suggests that ‘nurses and doctors sometimes received a splash in the face while giving treatment’ (Armstrong, D., The First Fifty Years, p. 113). On one occasion, despite vigorous hourly irrigation with arsyrol, a young nurse was purported to have lost her
In his evidence to the Select Committee on the Prevalence of Venereal Diseases, Dr Schlink talked at length about the ‘types’ of women who were admitted to D3 as well as submitting a comprehensive analysis of the numbers. Dr Schlink categorised women in the following way:

We have a particular ward of 30 beds, which is given over entirely to female venereal disease, but we have great difficulty in the classification of cases. We get prostitutes and women who are not prostitutes, also children and married women. At times we get three or four cases of hardened prostitutes in the ward, and then there is objection on the part of the married women. They refuse to remain there, because the girls taunt them. I have heard of cases where these girls have followed the married women into the district where the married women live, and who have told people that these women were in the red lamp ward with themselves. One problem in the indoor department is that we cannot classify the women according to their grades. I would put them in three grades: the hardened prostitute, the girl who has just contracted venereal disease, probably for the first time, and the married woman. Married women, children and young girls should be kept separate from the prostitutes, in a separate ward. That could be done by the resident medical officers and the nurses. They are able to pick out in 24 hours a woman who has had a bad influence on the ward.

eyesight. Armstrong argues that on D3 dressings from sores were put in a special receptacle for burning, all soiled linen was washed on the ward in a special bath of disinfectant, before going to the general hospital laundry, and gloves and gowns were worn by all nurses and resident medical officers at all times. It is not clear to which period Armstrong is referring (Armstrong, D., The First Fifty Years, p. 113). Dr R. T. Paton, in his evidence to the NSW Select Committee, argued that no special instruction was given to nurses treating venereal patients at the Coast Hospital, and that in fact midwives were at considerable risk of infection. Paton did acknowledge that he was aware of doctors and dentists who had been occupationally infected (NSW Select Committee, p 14). Cleland also acknowledged that medical men ‘sometimes contracted syphilis in the course of examining a patient’ (NSW Select Committee, p. 23).

Ibid., pp. 108–112. Dr Schlink himself occupied much column space in the Sydney Morning Herald during 1915 when he was publicly accused of being a German sympathiser, and of being unfit to practice medicine in Australia.

Ibid., p. 67.
Dr Schlink recognized three types of women: the ‘case-hardened’ prostitute, the young woman newly infected (also referred to as ‘recently fallen females’) and the married woman. These classifications were premised on sexual conduct, and the relative degree of guilt or innocence attached to that conduct. Dr Schlink was keen to establish that the ways in which he classified women formed natural divisions, that the women themselves initiated and maintained. The narrative of the prostitute following the married woman back to her home so as to disclose her recent stay at the venereal ward conveniently set up a division and disharmony between women of ‘different grades’. In his written recommendations to the Select Committee Dr Schlink argued further that ‘case hardened prostitutes’ should be hived off to Newington Hospital, and that RPA Hospital should be set aside for ‘married women, children and girls not of the prostitute class.’ Schlink argued that the medical management of venereal infection in women was more complicated: I argue in chapter 3 that this was the case partly because of the complex sexual and reproductive meanings which attached to women’s lives. Finally, Schlink argued that the venereal ward at RPA Hospital, if it was freed of the need to treat ‘case hardened prostitutes’ could also treat puerperal septic cases and cases of septic abortion. Such an addition would have given D3 the character of a gynaecological ward ‘and would thus fail to become known amongst the public as a red lamp ward.’ Schlink indeed was a ‘specialist of space,’ conceptualizing hospital wards and corridors as sociological categories.

By 1914 inpatient accommodation for female venereal patients at RPA Hospital was critically insufficient to meet demand and the limitations of spatial arrangements were used as an argument to augment government funding. In a detailed deposition to the Under Secretary of Health in July 1914, the Secretary of RPA Hospital, William Epps, argued that there were a number of important reasons why inpatient accommodation needed to be expanded, strongly echoing the arguments of Dr Schlink, indicating that the hospital was developing a consistent approach to this issue. In relation to treating syphilis in both men and women, Epps directly quoted

298 ‘Letter from William Epps to Under Secretary of Health, 18 July 1914,’ NSW State Archives, Box no. 10/43028, folio 34/26.
299 NSW Select Committee, p. 108.
300 Ibid., p. 109.
301 ‘Letter from William Epps to Under Secretary of Health, 18 July 1914.’
Schlink and argued that it was ‘much safer and quicker to have the patients in bed and to give full doses of Salvarsan.’\textsuperscript{302} In order to achieve these treatment goals, Epps suggested that a male venereal and dermatological ward be opened for 15 patients. He also suggested, in line with Schlink, that the current female ward, D3, be reserved for prostitutes, and a new ward constructed for ‘married women, children and girls not of the prostitute class.’ This ward was to comprise several small rooms to allow ‘a proper social grading.’\textsuperscript{303} Indicating the importance of the Wasserman reaction, four small laboratories were to be attached to the ward. Epps calculated that four nurses and three wardsmen (one for night only) would be required to staff both the female and male wards, at a total annual cost of £845. If these suggestions were implemented, Epps argued that ‘the Hospital would be doing a great national work.’\textsuperscript{304}

By April 1915, on the eve of the NSW Select Committee on the Prevalence of Venereal Diseases, staffing shortages and the co-mingling of different ‘grades’ of women had made D3 virtually untenable in the eyes of the Hospital Board.\textsuperscript{305} The Chairman found this to be:

\begin{quote}
   a most undesirable state of affairs, as the patients become aware of each other’s complaints, and it is found almost impossible under these circumstances to elevate the tone of the ward.\textsuperscript{306}
\end{quote}

Another solution was proposed: it was suggested that a permanent Sister be put in charge of the ward, and ‘taught to paint and swab patients, as in other clinics of this type in Europe.’ In effect, the wards were perceived to be failing because they were spaces that were not living up to their panoptic potential: women could not be monitored, and educated towards appropriate self-monitoring, in the absence of a permanent Ward Sister.

\begin{footnotes}
\item[302] Ibid.
\item[303] Ibid.
\item[304] Ibid.
\item[305] ‘Letter and attachment from William Epps to the Under Secretary of Health, 13 April 1915.’
\item[306] ‘Letter and attachment from William Epps to the Under Secretary of Health, 13 April 1915.’
\end{footnotes}
Despite regular requests from RPA Hospital, the inpatient ward for women and female children receiving treatment for venereal infection continued to operate uninterrupted and unexpanded during the first decades of the twentieth century, and beyond, without considerable change or relocation. This was because the ward represented a contained and segregated site that did not flow over into the treatment of non-venereal patients, and therefore did not pose a venerealisation threat. The inpatient ward allowed for the segregation, observation and documentation of women according to the hospital’s grading system. Space on the ward was therefore arranged to secure and consolidate the imperatives of the hospital administration.

**Outpatient Clinics**

Because the day and evening outpatient clinics at RPA Hospital could not be contained and monitored, they presented significant management problems at all levels of the hospital administration, problems particularly associated with the fear of venerealisation. Outpatient facilities had been successfully utilised in a number of health and welfare domains, prior to their first use in NSW for the night treatment of venereal diseases in 1915: the idea of the outpatient dispensary was a particular mainstay of colonial hospitals.\(^{307}\) Lewis illustrates that the NSW government opened the first infant health clinics in 1914 and by 1918 there were 28 such clinics in operation.\(^{308}\) The development of outpatient clinics at RPA Hospital and other hospital sites in Sydney was a highly contested process, which threw a range of key stakeholders together to disentangle their vested interests: the British Medical Association, hospital authorities, medical practitioners and the media. Theoretically, my analysis of the spatial context of the Outpatient Clinique places it midway in a continuum between the panoptic approach which characterised approaches to the venereal wards, and a later dispensary approach which radiated into the community.\(^{309}\) Armstrong’s theorisation is too radial and community-centered to map easily onto the venereal outpatient clinics at RPA Hospital. It does, however, provide

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\(^{307}\) Levine, *Prostitution, Race and Politics*, p. 70.


an insight into what was to follow and positions the outpatient clinic as a theoretical staging post between the panopticon and the dispensary.

There is considerable evidence to suggest that both the day and evening Outpatient Cliniques at RPA Hospital were perceived as being spaces which threatened the good order of the hospital, and the general nature of its admissions. Many witnesses to the NSW Select Committee on the Prevalence of Venereal Diseases 1915 spoke of the exuberant crowds on Missenden Road, queuing to attend the Clinique. Some suggested that the crowds swelled on Missenden Road because no appropriate waiting room was attached to the clinic. Other commentators, including Richard Arthur and George Black, referred to the popularity of the RPA Hospital clinics. The outpatient spaces were primarily male, although not exclusively. Women did attend, and when men and women queued together, jostling and commingling in public, with men being characterised as almost cocky and exhibitionistic, this presented a very different management issue to hospital authorities. There was considerable discussion about the relative advantages of outpatient and inpatient treatment for men and women, and for different types of women. The venereal wards were exclusively female spaces, and thus the very commingling that had led to infection could be deterred. In outpatient spaces, however, particularly when patients entered and exited the clinic, such commingling could not be avoided, and the consequent melee was perceived to be sexually charged and inappropriate.

310 Witnesses to the NSW Select Committee who commented on the ‘jostling’ crowds included Dr Gordon Wodeley Bray (pp. 36–37), Dr Langloh Parker Johnston (pp. 41–42), Dr Cyril Ernest Corlette (pp. 45–46), Dr Edmund Harold Molesworth (pp. 48–49), Dr Ralph Worrall (p. 62), Sir Thomas Anderson Stuart (p. 80), Dr Nathan Alexander (p. 101) and the Hon. Fred Flowers (p. 85). Flowers remarked that he thought it was a ‘public meeting’ when he first visited the night clinic.

311 NSW Select Committee, p. 37.

312 That women attended the outpatient Clinic is strongly evidenced in the medical records of RPA Hospital, where they were regularly referred from the inpatient wards to the Clinique, for ongoing treatment. Many witnesses also attest to women attending the outpatient clinic, although they were discouraged because treatment was often coupled with control and containment (ibid., p. 67). Schlink argued that with women ‘you can cure acute cases in a short time if they will come into the hospital and go to bed much more quickly than in the outpatient department, because when women are going about their home duties the treatment is more or less spasmodic and irregular’ (ibid., p. 67).

313 Dr Joseph Foreman argued that although night clinics were now ‘in vogue’, for men and for women, inpatient services were almost universally appropriate for women, and only occasionally appropriate for men (ibid., p. 74).

314 The Hon. Fred Flowers argued that ‘girls’ were reluctant to attend the outpatient clinic, but that men were keen to attend. Flowers suggested that word-of-mouth was an important process by which men informed each other of the ‘wonderful work’ done by the clinic, but that this word-of-mouth was not so effective amongst women (ibid., p. 88).
Outpatient spaces were like gateways between clearly disciplined and regulated medical wards, and wide, unruly, ungoverned public spaces (see Figure 1). It was acknowledged that venereal outpatient services had ‘excessive numbers of patients,’ and that this made it impossible ‘to give sufficient attention to more than a certain number of patients, resulting in the last-comers being imperfectly examined and treated.’ It was also agreed that outpatient venereal spaces were ‘attended by a mixed class of patients.’ A large number of soldiers, for example, preferred the clinic at RPA Hospital to the treatment they received at the Liverpool Army camp. This very mixture was perceived to be the problem: men mixed with women, and ‘rogues, vagabonds and prostitutes mingled with honest persons.’ Likewise, touts did the bidding of ‘charlatans,’ who provided quick, inexpensive treatments with alternative practitioners in the vicinity. As with the female wards, in the hectic space outside the outpatient clinic one of the key connections which authorities attempted to avoid was that between prostitutes, and their pimps, and ‘honest’ women. The swelling numbers of people waiting to attend the Outpatient Clinique on Missenden Road meant that even people who were not attending the clinic had to run the gauntlet of venereal patients before reaching their destination at another part of the hospital. Writing of other contexts, Fournier described ‘the honest wife or a workman, who has come to hospital for pneumonia or typhoid fever, compelled to associate with prostitutes and prowlers, or what is still more dangerous, with one of the pimps who practise recruiting for the brothels and wine shops.’ Authorities feared that the vibrant admixture of patients outside venereal outpatient spaces may have induced ‘honest’ people to cross over to wild and wayward practices. There was a concomitant acknowledgement that ‘the more crowded the hospital practice, the less does it serve the interests of prophylaxis.’

315 Fournier, The Prophylaxis and Treatment of Syphilis, p. 132.
316 Ibid., p. 17.
317 NSW Select Committee, p. 34.
318 Fournier, The Prophylaxis and Treatment of Syphilis, p. 17.
319 The July 1916 edition of the Medical Journal of Australia carried a number of outraged articles on the number of touts who operated outside the outpatient clinics. The Journal referred to these people as ‘vipers’ who needed to be arrested and convicted of fraud. In one instance, the Journal argued that the tout was doing the bidding of an ex-Attendant at the clinic who had ‘learned the job from A to Z and had started a practice on his own’ (p. 42).
320 NSW Select Committee, p. 80.
322 Ibid., p. 133.
When venereal patients queued and jostled close to the entrances of a general hospital, the cocktail of class, infection and gender appeared to encroach on, and spatially infect, the hospital itself. In the context of gender commingling outside outpatient spaces, venerealisation could also be read as sexualisation. In the four years between the opening of the day clinic in 1911 and the opening of the night clinic in 1915, RPA Hospital found itself literally surrounded by venereal patients: ‘the Institution was positively flooded with patients, who overwhelmed not only the accommodation, but
the staff, and the vicinity of the hospital on the nights when the clinics were opened it was just as if people were going to the races or the show. Many patients believed that new treatments would provide a miraculous cure. Another commentator remarked that: ‘the hospital was quite overwhelmed by them. Every inch of space was utilised, and men were standing crowded together waiting their turn to be seen. So great was the rush that the vicinity of the hospital was like some parts of the city on race days and the police had to be called in to regulate the traffic and keep order.’

This scene could not have been more carefully designed to strike terror into the hearts of the disciplined and disciplining medical practitioners at RPA Hospital: disorderly crowds, being regulated by the police. Both hospital authorities and medical practitioners felt under siege, and experimented with a number of arrangements and augmentations in their attempts to place distance between the orderly ward and the chaotic street. At the annual meeting of the Governors and subscribers of the RPA Hospital in 1916, Sir Thomas Anderson Stuart was reported as describing the Outpatient Clinique in the following terms:

Unfortunately, the Night Clinic had been an overwhelming success in regard to numbers, but, fortunately, also an overwhelming success in regard to results. These patients overran the institution, and the doors had to be closed, in order to limit their number. Sir Thomas expressed the opinion that this state of affairs was a disgrace and a shame to Sydney, and a perpetual menace to its people.

Sir Thomas Anderson Stuart also described the scene when he took the Colonial Secretary, Mr George Black, to witness the melee:

He saw that the state of things was exactly as I had said, that the place was simply, as a Scotchman would say, ‘hotching’ with patients. They were very

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323 RPA Hospital Gazette, October 10, 1919, no. 67, vol. xvii.
324 Within Sydney, news had traveled fast about new treatments, which according to word-of-mouth only required one injection to effect a cure. Dr Richard Arthur suggested that ‘the general public should be disabused of the idea that one or two injections of Salvarsan would completely eradicate syphilis from the system’ (NSW Select Committee, p. 28).
325 RPA Hospital Gazette, December 16, 1921, no. 76, vol. xviii.
difficult to control, very disorderly, and we had simply to close the doors when we had enough in, and leave the others out.\textsuperscript{327}

Not all venereal patients walked off quietly having been turned out by hospital authorities. Six months after the opening of the night clinic, in June 1915, one disgruntled patient wrote to the Minister of Public Health, complaining of his/her treatment at RPA Hospital. Although the original letter does not survive in the Departmental files, both the letter from the Secretary of RPA Hospital, Mr William Epps, to the Minister, and the Minister’s response, are extant.\textsuperscript{328} The venereal patient, calling him/herself ‘A Sufferer’ wrote to the Minister, who forwarded the correspondence to Mr Epps, who prepared a reply and returned it to the Minister. It is possible to hear echoes of the venereal patient in the reply of Mr Epps:

‘A Sufferer’ suggests that instead of the Clinique being open on 2 nights a week, the hours be extended every night until 9pm. The Committee considered the terms of the letter but found it to be quite impossible to carry out any such scheme. The effect would be to upset the whole general work of the hospital.

The Minister declared himself satisfied with this response, therefore concurring with the need not to ‘upset’ the general work of the hospital.\textsuperscript{329}

RPA Hospital instituted a number of changes to outpatient facilities between 1911 and 1925 to respond to issues of overcrowding and unruliness. There were four significant restructures of the venereal outpatients department. To begin with, all venereal outpatients ‘were treated in the outpatient surgical department, but there were obvious objections to the mixing of these cases with other surgical cases.’ The next step was to ‘institute what was described as a special surgical department for male and female outpatients.’\textsuperscript{330} From being treated in a mainstream outpatient clinic, the venereal patient was separated out in 1911, and treated in a special clinic. As a result, both attendances and prescriptions of Salvarsan increased. An advantage from the

\textsuperscript{327} NSW Select Committee, p. 80.
\textsuperscript{328} ‘Letter from Mr William Epps to the Under Secretary of Health, 21 June 1915,’ Establishment of Venereal Diseases Clinics, NSW State Archives, Box no. 10/43028, folio 34/26.
\textsuperscript{329} Ibid.
\textsuperscript{330} NSW Select Committee, p. 109.
perspective of hospital authorities was that venereal patients did not contaminate non-venereal patients, and they could be disciplined in a marked space. The third step in the ongoing adjustment of venereal outpatient services was ‘to open up a night clinic for these cases, to enable those who are engaged in the daytime and cannot attend during the ordinary outpatient hours, to come to the hospital for treatment.’

This third step not only removed the venereal patient from non-venereal patients, and marked out their venereal territory, but ensured that their attendance at the Outpatient Clinique was under the cover of night, thereby reducing the visibility of a ‘festive’, unruly and commingling queue developing on Missenden Road. The fourth restructure of the outpatient clinic occurred in the mid-1920s, in response to the further explosion of attendances caused by the VD Act 1918.

There was a significant advantage for patients who worked during the day to be able to attend at night, and for some patients there may have been an advantage in attending outside the full glare of daylight. Some medical practitioners suggested that, in the Salvarsan era, night clinics were inappropriate because patients needed to be kept for ten hours’ observation, ‘and that the loss of a day’s work would in any case be unavoidable if 606 (Salvarsan) were administered.’ It needs to be remembered however that prevailing constructions of the ‘poorer classes’ who suspected they were infected with venereal diseases were ambivalent, if not contradictory. Those who attended in broad daylight, and hung about on Missenden Road, were branded shameless by many of the witnesses to the NSW Select Committee. Those who attended at night, to avoid public glare were branded shameful by many of these same witnesses. Despite these admonitions, the outpatient clinics were an outstanding success. One commentator suggested in 1915 that ‘the clinic runs day and night – all day every day, and three nights a week. We have seven clinics a week for women and six for men. After registration, women attend between 10 and 1, and the men at any time between 2 and half-past five.’

In July 1914 the Secretary of RPA Hospital, William Epps, submitted a detailed plan to the Under Secretary of Health for the complete restructure of the venereal

331 Ibid., p. 40.
332 ‘Minutes of the Chief Secretary’s Office on Night Clinics for Syphilis,’ Establishment of Venereal Diseases Clinics, NSW State Archives, Box no. 10/43028, folio 34/26.
333 NSW Select Committee, pp. 33–41.
outpatient department. This plan was submitted after the opening of the day clinic, but nearly a year prior to the opening of the night clinic. In this plan, Epps suggested that the ‘outdoor clinique’ should comprise departments for men and for women, with separate waiting rooms and different attendance times. The female department was to concentrate on douching, painting, swabbing and Salvarsan injections. A Resident Pathologist was to attend every evening to conduct ‘complement deviation work, smears, vaccines, Wassermans etc.’ Two theatre attendants were to be appointed to the male department to assist ‘in the massage of prostates, the giving of injections, the preparation and sterilisation of instruments and the preparation and administration of Salvarsan.’ Two nurses were to be appointed to the female department. With the addition of a Senior and Junior Resident Medical Officer, a drug dispenser and a registration clerk, the full staffing complement was to be nine persons. The total annual expenditure on salaries was to be £1145 with an additional £1000 budgeted for drugs.\footnote{Epps’ systematic outline of a model outpatient venereal clinique utilised space to ensure the separation of genders, at all stages of treatment, and by all clinical staff.}

Other hospitals confronted similar issues related to hospital space and gendered treatments.\footnote{Hart has described the approach to outpatient clinics at the Royal Adelaide Hospital in 1916. The Adelaide night clinic opened in 1916 ‘to all who cannot pay elsewhere,’ but men attended on Mondays and Fridays and women on Wednesdays.\footnote{Fournier described the responses of St Lazare Hospital in Paris in 1906. Chiefly as a result of queuing and overcrowding at St Lazare, Fournier suggested that roughly twelve venereal dispensaries, or outpatient services needed to be established at a number of general hospitals in Paris. He described these proposed services as polyclinics, and they were to be situated in key arrondissements ‘so as to save patients the loss of time caused by long journeys.’\footnote{Consultations were to take place at days and hours convenient to male and female patients, printed instructions}} Other hospitals confronted similar issues related to hospital space and gendered treatments.\footnote{Fournier, Treatment and Prophylaxis of Syphilis, p. 133.}}
were to be given to each patient, and patients were to be provided with their own case notes to bring to consultations. The polyclinic was to provide staff and space so that each patient could be seen in private, breaking away from the ‘odious system of consultation in batches.’ There were some key similarities and differences between outpatient services in Paris in 1906 and those in Sydney between 1911 and 1925. Both cities were attempting to reconcile limited resources with high demand, and both were confronting the management issue of providing venereal services in general hospital settings. Both cities as well were providing services that were crammed with patients, staggering their hours of opening to meet the needs of patients.

Whilst acknowledging that there was a place for venereal outpatient services, the very success of both the day and evening venereal outpatient clinics at RPA Hospital was of immense concern to hospital authorities. Hospital authorities responded by introducing fixed quotas for venereal patients. Dr Gordon Bray, the first Director of the outpatient clinic, wrote:

The hospital authorities are not admitting everyone. They said the accommodation was not big enough, and they would not admit any new patients until we reduced our numbers from 1300 to 500. After that they agreed to let us have 20 new patients a week; now we are not getting any new patients at all, because the authorities shut down on them. We had an attendance of 1,367, but since then the hospital authorities have imposed

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338 Ibid., p. 133. These printed instructions read: ‘1. Syphilis is a disease which is curable, but is only cured by a long course of treatment lasting for several years, even when there is no external sign of the disease. 2. It is extremely contagious, especially by the sores and erosions, however small they may be, which generally occur in the genital organs and in the mouth, but which may be produced on any part of the body. A patient with syphilis must, therefore, abstain from any sexual intercourse when he has the slightest lesion on the genital organs. He must also abstain from kissing when he has any sores on the lips or tongue; for a kiss, even on the healthy skin, may be contagious. 3. Contagion may also be transmitted through the medium of any object which has been in contact with the morbid secretions of the disease – glasses, spoons, forks, bottles, pipes, cigars, cigarettes, linen, towels, clothing etc. 4. Syphilis is hereditarily transmitted to children (who generally die) when it has not been sufficiently treated. A syphilitic subject should not marry till after at least three or four years’ methodical treatment, and then by permission of a doctor. 5. A child born of a syphilitic father or mother should never be confided to a wet-nurse, because it may transmit syphilis to that nurse. 6. When a syphilitic subject is infected with any other illness, he should always inform his doctor of his former syphilis, for his declaration may be useful for the direction of treatment and the cure of the complaint.’

339 Ibid., p. 135.

340 Ibid., pp. 129–130. Fournier asked: ‘Would it not be absurd to sequestrate a person free from any morbid symptom, in order to absorb a few pills or a few doses of iodide? What would be the use of hospitalising a patient affected with palmar or plantar syphilides?’
restrictions with regard to the time. Persons were allowed in at any time between 2 o’clock and six, but now the time is cut down to half past five. People have to come now by 9 o’clock, but formerly they could come between 9 and 1. They come before 9 to be registered.341

The fixed quota system provides some important insights into the operation of the Outpatient Clinique, the tension between medical practitioners and the medical authorities, and the tenacity of patients in navigating shifting opening hours. The authorities at RPA Hospital had imposed restrictions on opening hours, which meant that by the end of June 1915 patient attendances were no longer increasing.342 This pattern of diminishing service was repeated during the period 1915–1925. The outcome of this imposition of quotas was that patients responded in a disciplined way to meet the tightened conditions. As Bray described, patients needed to arrive according to a strict schedule: before 9:00 a.m. to register, although women would only actually be seen between 10:00 a.m. and 1:00 p.m., and men between 2:00 p.m. and 5:30 p.m. This amounted to an all-day wait to seek diagnosis and treatment. Despite the ambiguous, and at times hostile, response of hospital staff, and rigorous treatment regimes, venereal patients continued to attend according to the rules.

The notion of venereal outpatients being refused treatment astounded some commentators. Dr Arthur, when questioning Dr Bray at the NSW Select Committee in 1915, was incredulous:

You are really turning people away? We are now.

You are constantly getting applicants for treatment but the hospital authorities refuse to receive them? Yes. The trouble was that they could not crowd them into the place. We had to post notices up and let the applicants come in batches. The outpatients of the other departments were being interfered with.

341 NSW Select Committee, pp. 33–41.
342 See chapter 4, in which I discuss attendance patterns at the RPA clinic, based on the evidence of the Weekly Returns.
That points to the necessity of having similar clinics opened at once in other parts of the metropolis, does it not? Yes.

Do you feel strongly on the necessity for that? I do. But I think one large clinic would be more satisfactory than numerous small ones, on account of the expense of running them...the trouble at the hospital is not the number who attend, but the fact that we have no place where the patients can sit, no where to put them...I did the morning and afternoon work alone, and at night I had extra assistants. On Monday nights I have two assistants, and on Tuesday night I have one.\textsuperscript{343}

When Dr Bray referred to the outpatient services of other, non-venereal, departments ‘being interfered with’ we glimpse the marginality of the Outpatient Clinique in the overall operation of RPA Hospital. The Clinique was perceived by hospital authorities as stigmatising: the brand of venerealism could ‘infect’ all departments of the hospital. Medical practitioners and authorities alike were concerned that RPA Hospital would develop a reputation as the venereal hospital.\textsuperscript{344} When questioned about the possibility of extending ward space at RPA Hospital, Sir Thomas Anderson Stuart argued that ‘it would never do to make it into a venereal hospital. It is a general hospital and a teaching hospital, and we must have a certain proportion between the kinds of cases treated’.\textsuperscript{345} The \textit{RPA Gazette} argued that medical staff would be affected by this venerealisation: ‘Royal Prince Alfred is not a venereal hospital; it is a hospital for general medical and surgical work, but if the time of the staff is to be taken up by attention to the numerous influx of venereal patients, it means they cannot attend to other branches of medicine, and that their training and that of the students

\textsuperscript{343} Ibid., pp. 33–41.
\textsuperscript{344} Despite this fear of venerealisation, Dr Bray was not convinced that the establishment of separate, smaller clinics, at other hospitals, would assist in meeting the demand. Most other commentators, including Frederick Flowers, Richard Arthur and George Black, all argued for the establishment of a broad range of metropolitan and rural clinics. It may have been the case that Dr Bray was interested in concentrating services at RPA Hospital as a way of establishing the need for a purpose-built clinic, a place to put venereal patients, separate from other departments. This argument for a special building became more rancorous over the next ten years.
\textsuperscript{345} Ibid., p. 79.
suffers. 346 Shrouded behind Dr Bray’s evidence to the NSW Select Committee are
glimpses of the patient: the frightened man or woman, presented with an array of
competing treatment options, attempting to make informed choices and locate
affordable and painless treatment. Patients however were hindered at most junctures
by an under-prepared public health system, which was too prepared to avoid
treatment, allowing patients to fall through the gaps. Case studies of individual
patients who presented at the venereal wards or clinics at RPA Hospital will be
examined in more detail in chapter 3.

Medical practitioners and the Outpatient Clinique

Venereal outpatient spaces caused intense disquiet amongst medical staff and hospital
authorities and considerable evidence survives of the protracted negotiations
undertaken when the night clinic was about to be established. These negotiations shed
light on why there was a deep-seated fear of venerealisation. It was during Frederick
Flowers’ tenure of the Ministry of Public Health between 1911 and 1915 that the first
serious negotiations regarding a night clinic at RPA Hospital commenced, and issues
related to the fear of venerealisation soon surfaced. In June 1914, as well, negotiations
commenced with Sydney Hospital to establish a night clinic, and similar refrains
regarding venerealisation were raised.347 The Sydney Morning Herald reported on the
negotiations with both these hospitals.348 In July 1914 Thomas Anderson Stuart,
Chairman of the Board at RPA Hospital, and Frederick Flowers, Minister of Public
Health met to discuss the establishment of a night clinic.349 This meeting provided
new impetus, and the Board of the RPA Hospital suggested that it could open one, but
only by closing down a number of afternoon clinics. This proposal was not well
received by the Minister, and in response, on 30 July the Department established a
night clinic at the Hospital Admissions Depot (HAD) in Macquarie Street, Sydney.
This clinic was opened on Mondays for men and Thursdays for women, was intended

346 RPA Hospital Gazette, 30 December 1916, no. 56, vol. xiv.
347 The Honorary Medical staff at Sydney hospital objected to night clinics on three grounds. First,
night clinics would make it difficult to educate medical students in venereal diseases. Second, artificial
light would make it difficult to distinguish syphilitic rashes. Third, no one would attend a night clinic,
if it branded him or her a victim (‘Minutes of the Chief Secretary’s Office on Night Clinics for
Syphilis,’ Establishment of Venereal Diseases Clinics, NSW State Archives, Box no. 10/43028, folio
34/26).
349 ‘Letter from William Epps to the Under Secretary of Health, 27 July 1914.’
to ‘serve all the waterside workers including the City of Sydney’ and was often referred to as the Venereal Dispensary. This clinic was not a success, despite a round of promotional letters being sent to relevant services, including the Navigation Department and the Sailors Home. One reason for the lack of success was that medical staff, including Dr E. H. Molesworth, boycotted the clinic because they were not permitted to make enquiries about a patient’s capacity to pay. Whilst this HAD night clinic was proving to be unsuccessful, negotiations continued with the Board of RPA Hospital. In August 1914 the Board offered to open night clinics and maintain day clinics if all reasonable expenses were met. The Minister deferred his decision regarding finances until November 1914, and during that time the Medical Board raised serious concerns regarding confidentiality and the classification of the indigent poor.

The RPA Gazette commented that ‘medical men feel that if, when they entered the RPA Hospital, they had believed that they were entering a venereal hospital, they would not have so much right to complain of the present condition of things.’ The Medical Board of the hospital rigorously monitored the early days of the Clinique, and one of their other key considerations was the tension between paying patients, the indigent poor, and those who had the capacity to pay, but did not. The Medical Board Minutes during the period from 1914 to 1919 discussed the Venereal Clinique frequently.

At its meeting on 29 May 1914, for example, before the Clinique opened, the Medical Board argued:

\[\text{It was finally proposed by Dr Gordon Bray, seconded by Dr Molesworth, that no objection be raised to the establishment of a Venereal Clinique between the hours of 4pm and 6pm. This motion was defeated by the casting vote of the Chairman and the following motion was carried – ‘That the Secretary be directed to write and invite each of the hospitals having outpatient departments within the metropolitan area to meet in conference with the Sydney and Royal...}\]

\[\text{350 Ibid.} \]
\[\text{351 ‘Letter from British Medical Association to Dr E. H. Molesworth, 13 January 1915,’ Establishment of Venereal Diseases Clinics, NSW State Archives, Box no. 10/43028, folio 34/26.} \]
\[\text{352 RPA Hospital Gazette, 30 December 1916, no. 56, vol. xiv.} \]
\[\text{353 Royal Prince Alfred Hospital, Medical Board meeting of 29 May 1914, Medical Board Minutes, 13 May 1902–12 October 1927.}\]
Prince Alfred staff and hold a discussion on the advisability of establishing night venereal outpatient clinics.

The Medical Board was concerned that RPA Hospital would become known as a ‘venereal hospital;’ it therefore suggested that other hospitals develop venereal treatment services. Dr Bray was a fierce advocate of the Clinique, and also its first Head. Dr Molesworth was well known in medical circles. At the suggestion of Professor Welsh on 17 June 1914 the Medical Board decided to delegate the issue to a subcommittee, arguing that ‘the question of venereal diseases was so far-reaching it would be advisable to appoint a subcommittee to respond on the whole question.’ This subcommittee was appointed despite the fact that the conjoint meeting of the metropolitan hospitals, called for at the May meeting, had decided it was favourable to the establishment of Venereal Cliniques, particularly ‘for the necessitous poor who cannot attend during the day.’ The subcommittee was to comprise Professor Welsh, Dr Molesworth, Dr Schlink and Dr McKelvy. In some ways the deliberations of the subcommittee were hamstrung, because the Medical Board agreed to send the following resolution to the Board of Directors of RPA Hospital: ‘that while the Honorary Staff is prepared to conduct Evening Cliniques for the treatment of venereal diseases, the matter requires so much consideration, that a subcommittee of the Medical Board has been appointed.’

On 10 July 1914, the Medical Board agreed to staff the Outpatient Clinique, and candidates for the available positions at the Clinique were read into the Minutes. By December 1914, candidates were jockeying for positions in the Clinique, and on the two existing venereal wards for women and children. At a time when the treatment of venereal patients was a new specialisation, there were professional demarcations which needed to be decided. At the Board’s meeting on 3 December 1914, appointments were made in the fields of syphology, ophthalmology and gynaecology. Having agreed to participate in the conduct of the Clinique, nearly a year after first raising the issue, the Medical Board now argued over the spoils of office.

Despite being prepared to conduct the Cliniques, and vying for positions, medical staff continued to resist the full implementation of the plan, particularly interrogating

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354 Ibid.
definitions of ‘anonymity’ and the ‘necessitous poor.’ In January 1915, just ten days before the opening of the Clinique, the Medical Board met and discussed the Minister’s request that venereal patients be permitted to receive free treatment. In relation ‘to that class who were unable to pay’ it was agreed that the Minister ‘had asked too much of the profession.’ The Minister had in fact asked that ‘no enquiries as to name or financial status to be made in regard to the admission of patients to the Outpatient Clinique’, and that ‘he would not be prepared to provide any funds for the conduction of the Clinique unless his requests were complied with.’ The Medical Board was concerned: two cornerstones of their practice, the impact of notification and the capacity to request payment from patients, were under threat. There were good reasons in terms of public policy for the Minister to have made these requests, but the Medical Board voted to send a resolution to the Board of Directors objecting to these conditions. At the 3 December 1914 meeting of the Medical Board it was agreed that: ‘in view of the statement by the Minister of Health in the public press that patients attending the Clinique need not register their name, the staff would refuse to cooperate in its conduction were this called upon. He was also against any further expansion of Evening work at the Hospital and definitely requested the Directors to maintain the principle that the hospital was only for the necessitous poor except in the cases of accident and emergency.’

At its meeting on 29 January 1915, two weeks after the opening of the Outpatient Clinique, the Medical Board received a response from the Board of Directors of RPA Hospital. The Medical Board accepted the offer to conduct the Evening Cliniques, but also attached a letter from the Minister ‘which insisted on no enquiry being made re name and circumstances of those applying for admission.’ In this letter, Flowers argued strongly that ‘the chief essential in the case of venereal diseases is secrecy for the patient.’ Flowers also suggested that ‘in fact the individual might more or less be termed a negligible quantity except in so far as his cure removes a source of infection.’ Perhaps unadvisedly, the Minister also threatened to disclose the situation to the media, venturing ‘to think that public opinion if the facts are disclosed will be

355 Ibid.
very strongly in favour of the views held by him.”357 After the British Medical Association passed a resolution demanding that ‘adequate safeguards are taken to confine the benefits of the Clinic to persons who are unable to pay for private treatment,’ Flowers did in fact draft a letter for distribution to the press.358 In this letter Flowers described the BMA resolution as ‘warlike and arbitrary’ and ‘the BMA gentlemen’ as ‘fighting a shadow.’359 In this tense climate, the Board of Directors asked the Medical Board if they ‘were not agreeable’ to establishing a Clinique along the Minister’s lines. The Medical Board wrote back to the Board of Directors advising them that the Clinique had opened, had been attended ‘by marked success,’ and that in opposition to the Minister’s demands, they were registering names and enquiring as to financial status.

In an attempt to resolve this impasse, which had been widely canvassed in the media, the Minister for Public Health met with a deputation from the British Medical Association on 15 February 1915.360 This deputation included thirteen medical practitioners, and a range of issues related to confidentiality and payment were canvassed.361 Seventeen pages of minutes were taken of this meeting, and the tone was alternatively angry and conciliatory. Dr Thomas argued that paying patients ‘were their bread and butter’ and the proposed night clinic could deprive them of their bread and butter. Flowers responded by suggesting that private medical practitioners

357 Ibid.
358 ‘Minutes of BMA Meeting 21 January 1915,’ Establishment of Venereal Diseases Clinics, NSW State Archives, Box no. 10/43028, folio 34/26. The full motion read: ‘That no member of the Branch shall (except in case of emergency) either in an honorary or paid capacity treat any patient at any Public Venereal Clinic, unless adequate safeguards are taken to confine the benefits of the clinic to persons unable to pay for private treatment.’
359 ‘Letter from Frederick Flowers to Sydney Morning Herald, 11 February 1915,’ Establishment of Venereal Diseases Clinics, NSW State Archives, Box no. 10/43028, folio 34/26.
360 Letters and articles appeared in the Sydney Morning Herald and Daily Telegraph on 11 and 12 February from the Minister of Public Health and the British Medical Association. After Frederick Flowers’ letter appeared in the Sydney Morning Herald he received correspondence from members of the public who were impressed with the stance he had taken. Albert Watson from Ashfield commended the Minister for ‘teaching the medical fraternity that the State, not the BMA Executive, is the supreme power where the health of the community is concerned’ (‘Letter from Albert Watson to Frederick Flowers, 14 February 1915’ NSW State Archives, Box no. 10/43028, folio 34/26). E. M. Curry from Enmore told the Minister that ‘thousands of men in Australia work from year to year paying the last doctor’s bill or getting ready for the next and as the doctor sets his own fee he estimates how much he can squeeze out of the patient or his friends at the present or in the future’ (‘Letter from E. M. Curry to Frederick Flowers, 14 February 1915’ NSW State Archives, Box no. 10/43028, folio 34/26).
361 ‘Minutes of the Conference between the British Medical Association and the Minister of Public Health,’ Establishment of Venereal Diseases Clinics, NSW State Archives, Box no. 10/43028, folio 34/26.
saw very few cases of venereal diseases, to which most agreed. Dr Thomas also suggested that medical practitioners were ‘proud of being able to do things for our unfortunate brothers and sisters in the way of helping them in an honorary capacity at the public hospitals,’ but he argued that they needed to maintain the right to question patients about their capacity to pay. Dr Crago was more specific when he argued that:

We object that the millionaire should go and get treated without cost. Why should the country be put to that expense? Every dose of Salvarsan costs 10/6 and a man might be worth thousands of pounds and well able to pay for the medicine and treatment. This is the whole point.  

The other major concern of the deputation related to the confidentiality of patients. Dr Read suggested that the suppression of names at the Venereal Clinique defeated its own ends because:

A man comes along with venereal troubles: you cannot address him: he comes to you: you treat him and see him a few times at the clinic: and then he thinks he is cured: take syphilis: he needs to be under supervision a considerable time: he goes away and you never see him again, and you have no means of tracing him, and he spreads the disease broadcast. When you only remove the smoke and leave the fire underneath to burn, it is no good.

Flowers listened patiently, but ultimately refused to give any ground on either issue. In fact, as the deputation neared its end, Flowers pressed his advantage by arguing that there was ‘quite a new era coming:’

I do not know how much longer the public are going to stand the assumption on the part of the medical fraternity that they are the champion philanthropists of the State. I want you to understand that you doctors will have to accommodate yourselves to alterations and changed conditions like everybody else, and that venereal diseases is not a matter between doctor and patient only. It is a matter for the State to deal with.

These extended negotiations had serious consequences for patients. On 30 December 1916, almost eighteen months after the Clinique first opened, the RPA Hospital

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362 Ibid.
363 Ibid.
364 Ibid.
Gazette carried a two-page lead article on the Outpatient Clinique. The Gazette argued that the hospital had been abandoned by the Department of Health to treat 1000 patients, and that it was not coping with the increased attendances. The Board therefore argued that the hospital could not keep treating the 500 patients it promised, and could now only treat 200 patients. The Gazette also quoted a Truth newspaper article, the implications of which will be discussed in detail later in this chapter. Later articles in the Gazette indicated that medical authorities at RPA Hospital believed that they were carrying the burden for all venereal patients in the metropolitan area, and that this was unreasonable.

Outpatient spaces represented the intersection between the disciplined world of the medical ward, where panoptic surveillance was achievable, and ungoverned public spaces. As such, outpatient spaces represented a gateway from one set of spaces to another. The liminal space they occupied suggested sexual transgression, and as such all aspects of outpatient services received wide media coverage. The struggle over the opening of the Clinique was about who would control venereal spaces, who would enter them and how, and mechanisms for monitoring once inside. On one level, the struggle over the opening of the Clinique was administrative: it centred on internal relationships and processes. On another level the opening of the Outpatient Clinique focussed attention on significant questions about venerealisation: could the provision of high-profile, and popular, venereal services actually infect other, non-venereal hospital spaces? Finally, the struggle over outpatient spaces was about sexuality and space: about how public spaces where men and women co-mingled and interacted were seen to be encroaching on the ordered atmosphere of the hospital. The outpatient venereal services at RPA Hospital were sites for the contestation of ideas around public and private health, treatment ambivalence, the operation and coexistence of

365 RPA Hospital Gazette, 30 December 1916, no. 56, vol. xiv.
366 Ibid. The article began: ‘The Board...felt that the character of the Hospital as a general hospital was being undermined in the public estimation, while its effectiveness as such was being interfered with, and finally it was decided that the number of cases under treatment at one time should be limited to 200. If these are acute cases, and under constant treatment, as they should be, they will occupy all the attention of the available staff and all the available accommodation, and this is as much as the hospital should be called upon to do. This decision has been communicated to the Minister for Health, and is now being given effect to.’
367 Evidence from weekly returns presented in chapter 4 indicates that at least one other hospital, Sydney Hospital on the Domain, was seeing significant numbers of ambulatory venereal patients.
368 NSW Select Committee, p. 106.
venereal and non-venereal services and spaces (the concept of venerealisation) and the functioning of the outpatient gateway between wards and the wider world.

The proposed Venereal Block

In 1921, firm proposals for a Venereal Block re-surfaced. This timing is significant because the proposals were being discussed after the gazetting of the VD Act 1918, and therefore in a period when treatment and prevention terrains, and modes of rule, had changed. The Venereal Block was proposed at a time when compulsory treatment and notification had become law. As I have indicated earlier, throughout the period there was a perceptible shift in the management of venereal diseases from medico-penal notions of detention until cured to concepts of responsibilisation that were modelled on the dispensary. My discussion of the proposed Venereal Block, whilst acknowledging its antecedents in the panopticon, will also identify its attempts to monitor venereal patients within borders of control and modes of rule that were more loosely defined, spatially and temporally.

In 1921, the NSW Government Architect Mr G McRae drew up plans for the Venereal Block at Camperdown. These plans, which included architectural

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369 Lobbying for a purpose-built facility at RPA Hospital had been occurring since at least July 1914 (‘Letter from William Epps to Under Secretary of Health, 18 July 1914,’ NSW State Archives, Box no. 10/43028, folio 34/26). In many of the negotiations which occurred over the establishment of a night clinic at RPA Hospital, hospital authorities often predicated their support on a concomitant commitment to the construction of a Venereal Block. Early plans were prepared by the Public Works Department in 1914. These plans proposed an Isolation Block which included a Tuberculosis Building and a Venereal Building. The Tuberculosis Building was to ‘provide a separate outpatient department for Tuberculosis cases’ and the Venereal Building was to ‘provide accommodation for indoor female venereal cases.’ William Epps suggested that ‘until these two Blocks are erected, with accommodation for indoor venereal cases, this class of case cannot be effectively and safely treated at the hospital.’ Mr Epps also intimated that Frederick Flowers had guaranteed the erection of a Venereal Block in a Memorandum with the Chairman of the Hospital Board on 12 March 1913 (‘Letter from William Epps to Under Secretary of Health, 18 July 1914’). Throughout this period the only purpose-built facility was constructed at the Rachel Forster Hospital in Surry Hills in the early 1930s.

370 RPA Hospital Gazette, October 10, 1919, no. 67, vol xvii. ‘The government now has to face the problem that under the VD Act just passed, patients are compelled to undergo treatment, and chemists will not be allowed to treat them as in the past. To make the Act at all effective therefore provision must be made for patients to receive treatment at the public hospitals or elsewhere.’ The practical implications of the legislation were evident: attempts to increase surveillance through notification and to provide medical practitioners with a monopoly on treatment of venereal diseases necessitated more funds for public hospitals.

371 Ibid.
elevations, cross-sections and floor plans, provide an insight into the thinking behind the design of the new Block, and demonstrate the significance of hospital design and architecture in the management of venereal diseases. The proposed Venereal Block was propelled by a panoptic vision: the venereal patient needed to be observed whilst arriving, waiting, being treated and leaving and the patient needed to be recorded and documented. By bringing structured ward space, conditions and disciplines to the outpatient setting, in a separate building, architects and bureaucrats attempted to avoid the potentials for sexualisation and venerealisation inherent in the outpatient setting: they were attempting to avoid the very issues which had plagued outpatient clinics.

The Block was also conceived of as being a significant space for the compulsory treatment of patients identified by the VD Act 1918, and as such replaced the older locked ward, or lock unit within a penitentiary, or any of the other permutations of ‘lock’ space posited by the PD Act 1909. The Block was to be capable of providing accommodation for around 32 inpatients suffering from venereal diseases and probably 800 outpatients.\(^\text{372}\)

Hospital authorities presented five arguments to government, and published them in the *Hospital Gazette*, as to why a Venereal Block needed to be built at RPA Hospital.\(^\text{373}\) Firstly, and ironically, it was argued that general hospitals were better than lock hospitals for the treatment of venereal infections, primarily because the former ‘advertised them as being sufferers’ who would feel ‘tabooed’ in attending a lock hospital. Within the general hospital, however, venereal patients were kept apart: on the one hand, to prevent infection, and on the other, to ensure surveillance and discipline.\(^\text{374}\) Whether in a separate or lock hospital, or separated accommodation

\(^{372}\) *RPA Hospital Gazette*, December 16, 1921, no. 76, vol. xviii.

\(^{373}\) These comments were broadcast in the *RPA Gazette*, the hospital’s magazine which was essentially the brainchild and work of the Secretary and Chair of the Board of Directors, Mr William Epps and Professor Anderson Stuart. Mr Epps had worked as a journalist prior to taking on the role of Secretary, and still kept up part-time work as a stenographer on Hansard in the NSW Legislative Assembly (Doherty, *The Life and Times of RPA Hospital*, p. 272). The *RPA Hospital Gazette* was the first such journal of hospital activities in Australia, and was distributed broadly across the country (ibid., p. 272).

\(^{374}\) *RPA Hospital Gazette*, December 16, 1921, no. 76 vol. xviii. ‘It is generally acknowledged that treatment of venereal diseases should be carried out in a general hospital. All experience shows that neither men nor women will attend special Lock hospitals, as this advertises them as being sufferers, who must be tabooed. When the venereal ward for females was transferred to this hospital (from Sydney Hospital) it was predicted that women would not come to the hospital, but the ward has always been full. There is no discrimination between them and other patients except that they are kept apart, to prevent infection.’
within a general hospital, both the hospital authorities and the medical staff desired segregation.375

Secondly, the proposed new building was to replace both the existing venereal wards and the Outpatient Clinique, by housing them in one building, which was twice removed from the other functions and procedures of the hospital. The medical staff ‘very strongly desired’ this. By ensuring that venereal patients were ‘entirely removed from the vicinity,’ particularly in the context of the venereal diseases legislation which allowed for compulsory treatment, the Venereal Block began to look a little like an old-fashioned lock hospital.376 There was however one important difference: the proposed Block was not intended to be a detention centre, whilst still achieving reproductive and sexual control.377 Thirdly, as I have noted, there was a real fear that the crowds of undisciplined venereal patients that had swamped outpatient spaces would grow further unless a larger, more distant unit was established.

A fourth argument was also mounted as to why RPA Hospital was best suited to building the Venereal Block: the passing of the ‘New Venereal Act in 1918, where treatment of infected cases is rendered compulsory, but in the absence of adequate accommodation this is at present impossible.’378 The hospital saw itself playing a role in embodying the legislation, but recognised that medical practitioners had to be convinced of the utility of this idea.379 Finally, the Hospital argued that it was much

375 Ibid. ‘The proposed block is to contain ward accommodation for 32 patients, to permit of these being removed from the centre of the hospital (where they may and do come into contact with other patients), which change is very strongly desired by the medical staff.’

376 Ibid.

377 Ibid. Finding the staff to treat the number of venereal patients was also difficult: ‘But the main reason for the new department is that owing to the cramped accommodation now available, only a section of those patients who would come to the hospital for treatment, if they could be admitted, can be treated. Probably two patients at least to every one treated are turned away because it is physically impossible to accommodate them, and because the medical staff and their assistants have no space in which to carry out the work of treatment.’

378 Ibid. The Act was supposed to take force on 1 January 1920, but the Gazette argued that the government was not ready, and ‘the Government of the day recognised that it had really no machinery in operation, and no accommodation for the hosts of men and women who would at once come, by reason of their infection, under its provisions.’

379 Medical Superintendents Reports 1910–1923, RPA Hospital. The need for improved treatment facilities to respond to measures relating to compulsory treatment was suggested by the Medical Superintendent of RPA Hospital: ‘The VD Act came into operation on 1 December. Acting upon instruction from the Board, I have restricted the number of patients to as near 450 as possible. It has been necessary for me, therefore, to send all new cases reporting in accordance with the Act to the Hospital Admission Depot for treatment. The task of notifying cases of venereal disease has been very onerous, but the staff is coping with the work satisfactorily. Not being satisfied with the efficiency of
better placed than the Prince of Wales Hospital in Randwick to treat venereal
patients. Randwick was described as being ‘most inconveniently situated for the
majority of the persons affected…it is at what may be termed a dead-end, so far as
traffic arrangements are concerned, and can only be approached in one way.’ RPA
Hospital, on the other hand, was described as being close to a large number of inner
suburbs, accessible by four different tram services, and accessible to nearly two thirds
of the metropolitan population.

The entire thinking behind the proposed design of the Venereal Block was isolation
and observation (see Figure 2): separation of venereals from non-venereals, of men
from women, of outpatients from inpatients and of ‘gonnorheals’ from ‘syphilitics.’

The Block was designed to facilitate careful observation and documentation of the
entire attending population. Health and illness were perceived as occupying both
spatial and temporal zones, both in the sense that regulation of both health and illness
were dependent on the arrangement and proximity of space, and the sequence of care.

Mr McRae remarked:

The proposed site for the Isolation Block is at the northern corner of the
hospital grounds, having a frontage to a lane of Missenden Road. The building
will be of brickwork with stone dressings, and will be two stories in height.
The main entrance will be in the centre, and the right and left wings will be set
apart for different venereal diseases. The whole of the ground floor will be

the work done in our Clinique, I approached the Honorary Medical Officer in Charge, asking for
suggestions.’

RPA Hospital Gazette, December 16, 1921, no. 76, vol. xviii. ‘The RPA is by far the most
accessible hospital to the great mass of the industrial population of the metropolis.’

Ibid. The Government Architect, G. McRae, also argued in relation to access, although his
arguments related to confidentiality as an issue: ‘The hospital has placed at disposal for the proposed
building an area in its grounds which is specially suited for this purpose. The land abuts on to a
thoroughfare which permits of patients reaching the building without passing through the hospital
grounds, and it would probably be acceptable to most of the patients, as it does not face a main street
from which entrance would be noticeable.’

See also Kisacky, J. S., ‘Restructuring Isolation: Hospital Architecture, Medicine and Prevention,’
Bulletin of the History of Medicine, 2005: 79: pp. 1–49. Kisacky examines changing practices of
isolation at the New York Hospital between 1771 and 1930, and concludes that changing strategies
reveal a transformation of the underlying understanding of the role that hospital architecture played in
disease incidence.

RPA Hospital Gazette, December 16, 1921, no. 76, vol. xviii. The Gazette described proximity in
the following way. ‘Really, therefore the RPA Hospital is easily accessible to probably from one half to
three quarters of the population of the metropolitan area, either by train or by 4 separate tram services –
Newtown, Leichhardt, Forest Lodge and Glebe.’
used for the treatment of patients of both sexes – separate days for each sex – whereas the upper floor will be wholly used for the accommodation and treatment of female patients.

Figure 2 – Floor plan of proposed Venereal Block (source: RPA Gazette, December 16, 1921, no. 76, vol. xv111)

The Floor Plan for the proposed Venereal Block reflected a structured, gendered and panoptic approach to the treatment of venereal diseases. Foucault has suggested that the panopticon represented ‘a technology of power capable of resolving the problems of surveillance.’ Such power was able to be realised because the panopticon embodied a model for the few having power and control over the many, through a process of
'compulsive, subjugating, unbearable surveillance.' In the context of the pervasive fear of venerealisation which had impelled venereal policy at RPA Hospital, the proposed Venereal Block represented the real possibility of improving and perfecting surveillance. The lower floor was entirely dedicated to outpatients. From the moment the patient walked through the lobby, and in doing so, past the doctor’s offices and consulting rooms, the building opened into a large waiting room, with rows of patient seating. Directly behind the waiting room was the lift, which would ferry female inpatients to the upper floor. There was no dedicated space for male inpatients, unless, as was mooted, another floor was added to the proposed building. The gendered receptive capacity of the proposed Block stood in clear relief to the sexualised throngs which were imagined to jostle outside the outpatient spaces.

On either side of the entrance vestibule and waiting room were the treatment rooms, on the right, syphilis patients, and on the left for ‘other patients’ who would have mostly included patients with gonorrhoea. The interesting aspect of this segregation of diseases was that it left no room for the patient who, upon a first visit, was not diagnosed with any particular disease. This phenomenon is discussed in chapter 4, namely that there is no evidence in the either the weekly returns or the medical records, or the Report of the Select Committee, of those patients who presented suspecting they had a venereal infection, but upon examination were diagnosed as being free of infection. This phenomenon has direct bearings on prevailing attitudes towards prevention.

The section of the lower floor which was devoted to ‘syphilitics’ was divided into a consulting room, two treatment rooms, a patient’s room and a clerical room. The verandah opened onto the concealed lane off Missenden Road. By comparison, the section of the lower floor which was devoted to ‘gonorrhoeals’ was divided into a consulting room, six cubicles, two treatment rooms, a patient’s room and a dispensary. This reflected the rather hasty treatment which was provided to patients with gonorrhoea, including irrigation and swabbing. Gonorrhoea patients would have been seen in the small cubicles, quickly, and after visiting the dispensary, sent on their way before returning for the next treatment. Dr Bray gave evidence on just this issue.

when he appeared before the NSW Select Committee 1915. The following interchange occurred between Dr Richard Arthur, and Dr Bray:

The treatment you chiefly carry out in connection with gonorrhoea is the irrigation treatment?
Yes.
That is you irrigate the urethra with some antiseptic solution?
Yes.
How long does that procedure take in each case?
It takes about ten minutes for each man.
Then one man would only be able to put through about five or six patients at the most in an hour?
Yes, if the patient is having a full irrigation. They do not all have the same irrigation. There is superficial, anterior and posterior irrigation.
But you could put it down at six or seven patients at the most in an hour?
Yes. 

Syphilis patients, on the other hand, were required to be treated for longer periods, in many cases up to two years, and on each visit were required to receive slow intra muscular injections of Salvarsan, or treatment with topical mercurial solutions. I detail these treatments in chapter 3. The design of the lower floor reflected the medical desire to move patients through the outpatients department quickly. It also reflected the desire to keep an eye on the patients as they passed from consulting room to cubicle to dispensary, and then back through the waiting room before departure. At all stages of the consultation, and from all vantage points, whether the hasty gonorrhoea intervention or the more prolonged syphilis consultation, patients were seen and monitored.

The same need for surveillance underpinned the design of the upper floor, and the circulation of female patients between the floors. Access to the upper floor, after initial diagnosis and treatment on the lower floor would have been back through the waiting room and the rows of patient seating to the lift. The movement through this

385 NSW Select Committee, p. 37.
crowded area, and the ascent to the hospitalised venereal area, would have been a
dismal procession. Once on the upper floor of the proposed Venereal Block, one can
imagine the world closing in. The upper floor was fully self-contained, and women,
who would have been admitted for periods of up to three months, would probably not
have left the floor unless accompanied by staff. Lavatories, kitchen, dining room and
an operating room meant that female venereal patients would have been segregated
from other non-venereal patients for all necessary processes. There was provision for
32 beds on the ward, arranged along the balcony wall, and arranged so that staff could
move easily through the wards. At the prices quoted by William Epps in the 1920s of
roughly £200 per bed per annum, this ward would have cost £6,400 per annum. In his
evidence to the Select Committee, Herbert Henry Schlink described his perception of
categories of women in the female venereal ward, and even without Schlink’s clear
contempt for ‘case-hardened prostitutes’ with venereal infection, the arrangement of
the upper floor would have made for complex and trying human relationships.

This description of the proposed NSW Venereal Block was not vastly different to the
description of London lock hospital in London in 1870:

The patients (female) are lodged in a new wing; the wards are lofty and kept
scrupulously clean. Each inmate has a separate bed, provided with three
blankets, and a hair mattress…The patients are not allowed to go into other
wards, but there is an open court in which they can take exercise, and they
have a sort of hospital dress in place of their own clothes, which are left under
the care of the matron… in a little room at the end of the ward water is laid on,
and copper basins are hung by a chain to the wall; these basins are kept for the
women to wash their faces. This arrangement is specially made to prevent any
contagion.\textsuperscript{386}

This description free-ranged between ‘patients’ and ‘inmates’,\textsuperscript{387} suggesting the
conflation of treatment and punishment, and the older medico-penal ‘lock-up’ notion.
In the 40 years since Acton’s description, however, there had been considerable


\textsuperscript{387} ‘Inmates’ may also of course simply denote institutions like boarding houses, not necessarily
prisons.
movement and change in the management of venereal diseases in both the UK and NSW. I have previously described the transition from contagious diseases legislation, which positioned prostitutes as primary transmitters of infection and lock hospitals as primary treatment and detention centres. I have also described how in NSW the PD Act 1909 continued, by stealth, this line of contagious diseases responses, and how Lewis identifies roughly 60 women who were curatively detained under this legislation between 1909 and 1918. By the VD Act 1918, curative detention had been replaced by notification and compulsory treatment, and it was proposed that the Venereal Block, a segregated and segregative treatment facility, would play a role in this level of control. The Venereal Block was not built precisely because the panoptic principles inherent in its design were gradually shifting to the diffusion of power through the dispensary. This was especially so after the VD Act 1918 identified medical practitioners as the primary agents for the surveillance of people with venereal diseases.

**Staffing**

I have argued that the design of ward and outpatient spaces, and the design of the proposed Venereal Block were intended to minimize the number of staff needed to maintain effective control and surveillance of patients. Key staff involved with venereal patients were medical practitioners, nurses, wardsmen and porters.

Within orthodox management of venereal diseases, medical practitioners played a mixed and evolving role. One of the key limitations related to venereal treatment in hospitals was the inadequate training provided to medical practitioners (and nurses) in venereology. D.A Welsh, Professor of Pathology at Sydney University in 1915, suggested that training in conducting and interpreting a Wasserman reaction for medical undergraduates was ‘too complicated’ and required ‘several months’ steady application to do that alone.’\(^{388}\) In a text widely read by Sydney physicians, Fournier argued that all venereal services within general hospitals should be open to all medical students and that a medical degree should include three months’ special study of venereal diseases. Such provisions do not apply in teaching hospitals today. For

\(^{388}\) NSW Select Committee, p. 26.
medical practitioners there was a template for work in venereal services. Fournier argued that ‘outpatients should be attended by assistant physicians or surgeons; inpatients by the honorary physicians or surgeons’. He also argued that medical officers in charge of outpatient departments should hold office for at least five years, so ‘as to serve a thorough apprenticeship to the specialty, in the interests of the patients.’ Because of the inadequacies of training and the difficulty of attracting medical practitioners to venereology, Fournier argued that ‘the outpatient practice of special hospitals is not always what it should be.’ Consultations were often left to house-surgeons, ‘and by these to the dressers, at other times examinations were hurried, and often only the urgent cases were attended to properly.’ Many witnesses to the NSW Select Committee 1915 also referred to the harried responses of medical practitioners in NSW. The very structure and administration of medical services for venereal patients tended towards ambivalence.389

Medical practitioners were not the only players: nurses and wardsmen were also involved in delivering services on wards and in outpatient clinics. Miles argues that in the United Kingdom, both male and female nurses worked with venereal patients well before changes introduced by Florence Nightingale.390 In the United States in 1910 a manual for nurses working with venereal patients was written by L.L Dock.391 By 1919 in the United Kingdom nurses were able to render early venereal treatment on an ‘emergency’ basis, and because male nurses were difficult to obtain, ‘as a rule, female nurses attended both male and female patients.’392 By the mid-1920s in the United Kingdom, in another textbook dedicated to venereal nursing, nurses were instructed on assisting surgeons with intravenous injections, performing irrigation for prophylaxis and undertaking a range of treatments for gonorrhoea in women.393 The earliest attempt to educate nurses on venereal diseases was by the Central Midwives

391 This textbook was entitled Hygiene and Morality: A Manual for Nurses and Others, Giving an Outline of the Medical, Social and Legal Aspects of the Venereal Diseases, New York, 1910 (cited by Miles, K., ‘The Historical Role and Education of Nurses for the Care and Management of Sexually Transmitted Infections in United Kingdom: 1 Role’).
392 Ibid., p. 4.
393 Turner, W. W., A Handbook in Venereal Diseases for Nurses and Others Engaged in the Outline Treatment of these Diseases, London, 1928 (cited in Miles, K., ‘The Historical Role and Education of Nurses’).
Board in London in 1916. They issued a series of leaflets giving nurses information about gonorrhoea and syphilis. By the early 1920s, a number of hospitals in the United Kingdom were providing venereal diseases instruction to nurses, which included information on ‘the dangers involved in nursing such cases.’ In both role and function, and education and training, venereal nursing in this period in the United Kingdom was beginning to develop into a nursing speciality.

There is evidence to suggest that there were no dedicated training programs in NSW for female or male nurses working with venereal patients. Although Dr R.T Paton in his evidence to the Select Committee of 1915 suggested that it would be advisable for nurses, and especially midwives, to receive instruction, he acknowledged that this did not happen. On occasions, nurses were permitted to attend the few lectures on venereal diseases that were provided for medical undergraduates. Between 1901 and 1925 in NSW female nurses worked with female patients on the venereal wards: there were no venereal wards for men. Wardsmen worked with male patients in the Outpatient Clinique and presumably female nurses worked with female patients at the Clinique. Bashford provides some context to this division of labour by demonstrating that in NSW in the late 1860s and early 1870s male nurses were fairly swiftly replaced by female nurses. She argues that although this process was uneven, with some major and country hospitals employing predominantly male nurses up to the turn of the century, the reasons for the eventual change were threefold: hospital nursing was reconstructed as philanthropic; the newly feminised nursing role was tied culturally to a discourse on purity and respectability; and the nursing role came to embody middle-class values.

Generally, nurses were poorly paid. There were significant differences between salaries paid to nurses at general hospitals and government hospitals. In 1912 nurses worked 9 and ½ hour days and received a day off each week, and a month’s holiday on full pay every year. At RPA Hospital first-year probationers received £10 per annum; second-year probationers, £15; third-year probationers, £20; and fourth-year

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394 Miles, K., ‘The Historical Role and Education of Nurses,’ p. 2.
395 Ibid., p. 2.
396 NSW Select Committee, p. 14.
probationers received £30. Charge nurses received £60 per annum and sisters received £70 with an annual increase until £100 was reached. The Medical Superintendent at RPA Hospital, Dr H.H. Schlink suggested that pay scales were different at the government-run Coast Hospital. At this hospital, probationary nurses were paid £70, and Sisters £90. Dr Schlink believed that this was unfair to Sisters because they ‘should receive a more substantial increase than girls who work without any knowledge of a nurse’s duty.’ Schlink also suggested that probationers at the Coast Hospital derived benefits from free medical lectures, and mischievously suggested that ‘one might as well pay medical students and give them lodgings for the work they do for a hospital while pursuing their studies.’

The uneven feminisation of nursing work was not only hospital specific: it was also disease specific. By the time of the establishment of the Outpatient Clinique in 1915 male nurses and wardsmen were the key health providers for male patients with venereal diseases, and these wards and clinics may have been the only aspect of nursing that remained dominated by males. Bashford has argued that the image of the respectable, middle-class Christian nurse rendered possible ‘intimate contact between middle class women and working class men.’ The philanthropic image of the female nurse tending the sick-poor male was a powerful and emblematic image. In fact, lady-nurses came to be contrapuntally imaged as the possible antidote to another emblematic image: the diseased, infectious prostitute. These images do not necessarily work in the context of nursing venereal patients, however: male venereal patients throughout the period, and at most hospitals, were treated by men. Bashford indicates that at the Sydney Infirmary in the 1880s, and after the massive changes brought about by the feminisation of nursing, there was only one male nurse left, and his role was to work with the venereal patients. Although there were proponents of the employment of female nurses in venereal wards, including Dr Herbert Schlink, female nursing of men with venereal illness is not evident in NSW during the period 1901–1925.

398 “The Sun” Clippings and Correspondence between William Epps and the Chief Secretary’s Department,” Establishment of Venereal Diseases Clinics, NSW State Archives, Box no. 10/43028, folio 34/26.
399 Letter from H.H. Schlink to William Epps, 13 May 1913, Ibid.
400 Ibid.
401 Bashford, A., ‘Female Bodies at Work,’ p. 69.
In the evidence of Dr Gordon Bray to the NSW Select Committee a number of complex issues were raised which related to staffing the outpatient clinic. Dr Bray responded to the queries of Dr Arthur:

Have you any wardsmen to assist you? I have a staff of two wardsmen. One works all day. Before 30 June that man was on a certain shift. He might be working one week on an afternoon or morning shift, and would only attend at night, and, unless the shift was altered, he could make provision and attend during the day. A man could come in the morning and be irrigated, or he could walk in at any time between 10 and 6. Now there are more restrictions; but even now we do the work in the morning.

Wardsmen worked long hours, and were involved in a range of tasks. Not only were they involved in preparing Salvarsan for injection, they played a significant role in the administration of gonorrhoea treatments. Again, Dr Bray responded to the queries of Dr Arthur:

One wardsman could not carry on that work for more than four or six hours continuously, could he? We have one man who does it all day. He works in the morning, in the afternoon, and again at night. He is only allowed to work 48 hours a week.402

In a period when international and domestic attention was directed toward working conditions and labour, Dr Bray was acutely aware that a wardsmen could not work more than 48 hours a week, although a great deal of work was collapsed into that period. Bray’s evidence also indicates that the primary staff involved in treating venereal patients at the Outpatient Clinique were medical practitioners and wardsmen. I have argued that medical practitioners generally endeavoured to reduce the amount of venereal work they did, and it would appear that nursing care was similarly sparse. In fact, as the above evidence demonstrates, wardsmen were the key contact between the hospital and venereal patients. I have previously cited evidence related to the venereal ward at RPA Hospital suggesting that female patients cared for each other.

402 NSW Select Committee, pp. 33-41.
Extended care was not provided by medical or nursing personnel, particularly for the treatment of gonorrhoea in males. As Bashford indicates: ‘in many smaller institutions where there were no students to assist the resident and visiting medical men, the wardsmen were the primary medical assistants, a role which did not necessarily exclude them from more menial duties and responsibilities which involved physical contact with the bodies of male patients.’

Wardsmen and medical practitioners worked long hours, and from Dr Bray’s evidence, in a perfunctory manner. Patients were pushed through the Clinique quickly, often within ten minutes, with ten minutes being the outer limit for a ‘full irrigation.’ There is a sense in Dr Bray’s evidence of venereal patients being herded through like cattle in a dip, being disinfected as they went, and not really having an opportunity to interact with, or consult, the medical practitioner or the wardsmen.

In an extended Memorandum to the NSW Select Committee in 1915 Dr Herbert Schlink provided an overview of the staff that would have been needed to provide adequate treatment to venereal patients at the Outpatient Clinique. Schlink divided the staff into three categories: salaried, honorary and administrative staff. Salaried staff included a Senior Resident and Junior Resident Medical Officer, a Senior Resident Pathologist, two theatre attendants and two nurses. The first theatre attendant worked in the male department, massaging prostates, giving injections and preparing and sterilizing instruments; the second prepared and administered Salvarsan. Honorary staff included a Syphilologist, a Gynaecologist and a Urogenital Surgeon. These honorary staff were assisted by nurses, students and wardsmen. Administrative staff

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403 Bashford, A., ‘Female Bodies at Work’, p. 67.
404 A similar perfunctory process for the treatment of female venereal patients is noted by Acton when describing a treatment process in the London lock hospital in London, in 1870: ‘The inspections are conducted in the following manner. The women are introduced one at a time from the wards by one nurse into a special room, containing a properly-raised bed…the patient ascends the steps placed by the side of the bed, lays down, places her feet in the slippers arranged for the purpose, and the house surgeon separates the labia to see if there are any sores. If no suspicion of these exists, and if the female is suffering from discharge, the speculum is at once employed. In this institution several sizes are used, and they are silvered and covered with India-rubber. The head nurse after each examination washes the speculum in a solution of permanganate of potash, then wipes it carefully, oils it ready for the next examination, so that the surgeon loses no time, and the examinations are conducted with great rapidity. In the course of one hour and three quarters I assisted in the thorough examination of 58 women with the speculum’ (Acton, W., Prostitution, Considered in its Moral, Social and Sanitary Aspects, London, 1870).
included a Dispenser and a Registration Clerk. It is not possible to discern how far these recommendations varied from the reality. It is clear however that actual staff were inadequate to meet the needs of a growing population.

Whilst the nursing of male venereal patients escaped the feminisation process described by Bashford, the majority of venereal patients treated in clinics remained men. In relation to the gender of patients at the Outpatient Venereal Clinique, Dr Bray provided the following insights in his responses to Dr Arthur:

- Are the clinics in the evening for both male and female patients? Yes.
- Can you give us some figures in connection with the attendance of both males and females – what is the total number treated? From 11 January to 30 June, 1320 separate cases.
- What proportion of these were males, and what proportion females? 1009 males and 311 females. Those figures include a lot of children.
- Can you tell us the number of those suffering from syphilis, and those from gonorrhoea?.. To 750 cases of gonorrhoea there would be about 250 of syphilis.

Dr Arthur’s questions were mostly designed to establish the epidemicity of venereal infection and to ensure that epidemiological issues related to gender and the difference between gonorrhoea and syphilis were canvassed. Dr Bray provided the evidence which was sought. In the first six months of the Clinique, from January to June 1915, over 1320 separate cases were treated. Roughly three quarters of these treated patients were male, and approximately one quarter of the cases treated were syphilis. Although there was no attempt here to establish the rates of either gonorrhoea or syphilis differentially in men and women, the weekly returns data which are analysed in chapter 4 does establish differential rates. The basic data provided by Dr Bray conformed to the patterns which are discerned later, and support

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405 NSW Select Committee, p. 109.
406 NSW Select Committee, pp. 33–41.
the contention of this thesis that venereal infections did not constitute a ‘plague’, and did not disproportionately affect women.\textsuperscript{407}

Conclusion

RPA Hospital was a place where venereal diseases were treated. It was also a place where venereal diseases were avoided, because of a range of reductive and avoidance strategies on the part of hospital administrators, public health bureaucrats and medical practitioners. I have examined how it was run, and by whom, with particular reference to the positioning of venereal services within the general hospital. I have examined what the wards looked like, who worked in them, the architecture of a proposed venereal block for the treatment of patients, and the meanings and distribution of venereal and non-venereal space within the hospital. I have noted as well the complex internal and external tensions which characterised the practices and procedures of the hospital as it sought to deal with the complexities of working in a mixed philanthropic and public health domain and to determine its identity within an evolving framework of charity, benevolence and government funding. Through this descriptive process, I have analysed how the fear of personal, institutional and social venerealisation motivated many of the practices and techniques of the hospital.

Although traces of the notion of lock hospitals remained in the allocation and arrangement of venereal spaces, there was a gradual shift from medico-penal models based on the panopticon, to more diffuse models based on the dispensary. Venereal spaces were gendered, so as to avoid the sexualisation of space, and segregated, so as to avoid the venerealisation of general hospital space, and to limit the venerealisation of designated wards and clinics. In the context of outpatient spaces, there was a fear

\textsuperscript{407} Dorothy Armstrong, in a personal memoir, provides graphic illustration and memory of actually working on the venereal ward in her history of nursing at RPA Hospital. Armstrong recalls that the treatment of venereal diseases entailed ‘depressing and distressing work on the part of nurses’. Nurses were not left for long on the wards, and they were always ‘pleased to return to other wards’. Armstrong recalls as well that ‘the rather dark wards, the wearing of gowns and gloves all day, and the relative absence of visitors had a further depressing effect’. Barrier nursing was practiced in the venereal wards. Armstrong provides some history on the treatment of venereal patients in other Sydney Hospitals, but concludes that by 1914, RPA Hospital had become, and remained for some time, ‘the only hospital which undertook the treatment of men, women and children on an extensive scale and cases came from all over the state’. After painting a sad picture of the syphilitic infant, Armstrong concludes by recalling that the ‘ward acquired, for us, quite a sinister air’ (Armstrong, \textit{The First Fifty Years}, pp. 112–114).
that venerealisation and sexualisation were co-existing phenomena. Existing and proposed venereal spaces – wards and clinics – at RPA Hospital were designed, situated and ordered so as to facilitate minimal contact between venereal and non-venereal patients. In all venereal spaces there was an attempt to minimise contact between venereal patients and staff, and in the same way that there was a fear that space would become sexualised or venerealised, there was a concomitant fear that staff, and particularly female staff, would become contaminated.

The enclosure of space was also designed to ensure that current treatments were best able to be administered, and so that patients could be observed in wards or clinics as individual patients with venereal infections, and as the population of venereals. For instance, the series of cubicles for irrigating males with gonorrhoea were a specific utilisation of space to facilitate efficiency. The ward for women and female children, D3, was situated in one of the main pavilions, but in the basement (and a number of attempts were made to have this ward relocated) outside any of the four main pavilions of RPA Hospital. The proposed Venereal Block provides a graphic example of the way in which architecture and hospital design was being tailored to diseases. Isolated, segregated, and internally arranged so as to facilitate the segregation of men and women, and ‘syphilitics’ and ‘gonorrhoeals’, the proposed Venereal Block would have been an appropriate facility for implementing the VD Act 1918, precisely because it allowed for the compulsory treatment and surveillance of venereal patients without the need for detention.408

Through all of these changes, the population of Sydney kept presenting at RPA Hospital for treatment - despite reductions in operating hours and decreasing quotas on the number of patients who could be treated. Even in the light of policies to reduce the intake of new patients, policies excluding long-term and chronic patients, and policies excluding patients who were not improving, both inpatient and outpatient numbers increased. When posters were mounted advising patients that attendants would not take bribes to receive preferential treatment, it is possible to gauge the

408 In 15 years’ experience in sexual health services in NSW, I am not aware of any purpose-built STI accommodation. I am aware however of purpose-built Methadone Treatment centers, and the level of surveillance inherent in these buildings is extraordinary.
persistence and determination of venereal patients. Despite the Medical Board of the hospital demanding the treatment of only the ‘necessitous poor’ and full disclosure of personal details, and despite the opening of the Sydney Hospital Venereal Clinique, patients kept attending the hospital in Camperdown for exhausting, long-term punishing treatments. Despite this demonstrated commitment, engagement and self-regulation, however, the government gazetted legislation in 1921 which introduced regulations to coerce the population of NSW to undertake treatment.

Chapter 3

Medical Ambivalence: Venereal Treatments c. 1901–1925

The first decades of the new century saw considerable changes in the treatment of both syphilis and gonorrhoea, in particular the development of the Wasserman reaction as a diagnostic tool and Salvarsan as a treatment for syphilis. Individual hospitals and governments were keen to harness these new technologies to improve treatment responses. Lewis remarks that ‘Australian doctors…had been encouraged by the growth in knowledge of, and capacity to treat, syphilis in the decade before World War 1. They had been pressing governments to act to reduce its prevalence by encouraging early treatment.’ Many medical practitioners saw the potential of greater diagnostic precision and improved treatment regimes, whilst others felt that improved treatment would decrease the deterrent effect of a venereal infection. Health bureaucrats saw the improved technologies as a tool in maintaining a watchful eye over the body politic: surveillance, notification and compulsory treatment were predicated on the ability to precisely diagnose and confidently treat. Levine has characterised this as a period which saw ‘a flurry of biomedical breakthroughs,’ and ‘a new wave of public and political anxiety over syphilis.’

In this dynamic environment, the medical treatment of people with venereal infection was complex and inconsistent. On the one hand, venereal patients were diagnosed and

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409 NSW Select Committee, p. 37.
410 Syphilis and gonorrhoea were acknowledged to be the primary venereal diseases, which incurred the most significant sequelae. They were however not the only genital infections which were sometimes considered to be venereal diseases. McDonagh, J. E. R., in The Biology and Treatment of Venereal Diseases (London, 1915) suggested that herpes genitalis, molluscum contagiosum, genital warts and chancroid were other possible venereal conditions (pp. 450–458).
treated in new ways: on the other, they were marginalised, sequestered, relegated and often refused treatment.\footnote{Dr L. P. Johnston, when describing the capacity of both RPA Hospital and Sydney Hospital to provide venereal inpatient services for men remarked that ‘in fact they avoid trying to have them.’ (Legislative Assembly of NSW, Minutes of Evidence taken before the Select Committee on the Prevalence of Venereal Diseases, Progress Report, Sydney, 1915, p. 42.)} I will argue in this chapter that venereal patients were treated with a deep and abiding ambivalence by experts, authorities and clinicians. I have used ambivalence in this context to denote on the one hand uncertainty or ambiguity, and on the other to suggest the coexistence in the one person, organisation or governing body of conflicting attitudes. Whilst technological change produced excitement and optimism, it also produced acute uncertainty about the duration of infectivity of venereal diseases, amongst other things.\footnote{Davidson, R., ‘Venereal Diseases, Sexual Morality and Public Health in Inter War Scotland,’ Journal of the History of Sexuality, vol. 5, no. 2, October 1994, p. 290.} Similarly, responses to venereal infections have always produced coexisting attitudes: the historiography shows the co-incidence of compassion and condemnation, coercion and consent, fear and acceptance, with a clear historical trajectory toward avoidance.\footnote{It has been argued by Tibbits that ambivalence towards the treatment of venereal diseases had a long history and was characteristic of the Australian colonies in the nineteenth century. Tibbits suggests that the colonies excluded people suffering from venereal diseases from inpatient treatment, a view confirmed by Hyslop in relation to Ballarat Hospital (Hyslop, A., Sovereign Remedies: A History of Ballarat Base Hospital, 1850s–1980s, Sydney, 1989). Tibbits remarks: ‘The running of these hospitals was dependent on public donations and VD patients were judged to be as unfit for charity. Friendly societies did not pay benefits for VD treatment because they regarded VD as a self inflicted injury. Until the establishment of special government funded clinics in the twentieth century, many sufferers were untreated and unwarned of their infectivity to others’ (Tibbits, D. R., ‘VD Behind Bars,’ Proceedings of the Fourth Biennial Conference of the Australian Society of the History of Medicine, 1995, p. 157). Smith also argues that venereal diseases in England had a history of being systematically excluded from treatment facilities. Smith demonstrates that most voluntary hospitals would not admit venereal diseases cases, ‘for fear of losing subscribers,’ and that hospitals in garrison towns, including Winchester and Colchester, refused to provide venereal wards. Dispensaries would not supply medicines, and ‘workhouse infirmaries would not admit venereally diseased paupers’ (Smith, F. B., The People’s Health 1830–1910, Canberra, 1979, p. 294). Writing of the period 1914–1918, Lewis remarks that ‘many practitioners had no desire to treat such stigmatised diseases and were happy to allow the clinics to do the work’ (Lewis, M., The People’s Health: Public Health in Australia, 1788–1950, p. 233). Hall argues that ‘both men and women with venereal disease were discriminated against. Many medical institutions refused to admit patients with venereal diseases. Voluntary hospitals usually explicitly excluded VD patients.’ (Hall, L., ‘Syphilis as a Medical Problem and Moral Metaphor, 1880–1916,’ Courtauld Institute Symposium, May, 1998). This treatment ambivalence had its own tortured history going back to the 16th century in Europe. Allen demonstrates that panicly towns barred their gates against syphilitics and hospitals refused to admit syphilitic patients, including the famous Paris hospital Hotel-Dieu, which prided itself on its generosity. Lewis argues that that this treatment ambivalence was because syphilitics were ‘reviled because people believed they had brought their torments upon themselves’ (Allen, P. L., The Wages of Sin: Sex and Disease, Past and Present, London, 2000). These phenomena did not cease with the twentieth century. Fournier, writing in 1906, argued that in France ‘cases of venereal disease of both sexes are either refused admission into hospitals, or, if admitted, are relegated to badly-ventilated and unsanitary quarters. Such offences to humanity and good sense are intolerable’ (Fournier, A., The Treatment and Prophylaxis of Syphilis, London, 1906, p. 18). These phenomena also extended to the prevention of venereal diseases, as indicated by Professor D. A. Welsh, a founding member of the University of Sydney Society for}
ambivalence towards treating venereal patients sprang from a number of sources: deep-seated stigma, fear of the other, and fear of contamination (or fear of venerealisation) and significantly, from the tensions that existed between medical practitioners and public health professionals. These tensions have been observed to some extent in the practices and procedures of RPA Hospital, but were evident as well in the relationships between hospitals, the NSW government and the Commonwealth government.

In the previous chapter, I analysed venereal spaces at RPA Hospital, highlighting the development and diversification of inpatient and outpatient services in the first, second and third decades of the twentieth century. In this chapter I will use the same periodisation to investigate treatment responses to venereal diseases in NSW. The period prior to 1910 I shall refer to as the pre-Salvarsan era, and I will briefly describe some of these treatment. The period from 1910 to the passing of the VD Act 1918 was characterised by significant developments in the field of bacteriology, improving both diagnostic and treatment responses. I will discuss the use, impact and meanings of both the Wasserman reaction and Salvarsan as orthodox treatment in NSW, and compare them with a range of alternative responses in the same period. Part of this examination will involve the analysis of medical records from RPA Hospital and what they divulge about venereal patients themselves. The third decade of the century was characterised by the implementation of the two main provisions of the NSW VD Act 1918: notification and compulsory treatment. Amongst other things, this legislation unswervingly endorsed orthodox treatment responses, criminalised alternative approaches to venereal treatment, and set out a painstaking process for the implementation of notification and compulsory treatment processes. I will investigate the impacts and consequences of these twin pillars of venereal diseases management,

Combating Venereal Diseases. Welsh wrote: ‘It is still a prevalent and a horrible idea that it is pandering to vice to check the ravages of these plagues. It is an idea that has dominated generation after generation of well-intentioned men and women, who feared that vice would be encouraged if venereal diseases were prevented’ (Welsh, D. A., ‘The Enemy in our Midst: Venereal Disease,’ Proceedings of the University of Sydney Society for Combating Venereal Diseases, Sydney, 1916).

Medical ambivalence based on stigma is not only an historical condition. Kinghorn demonstrates that in modern times general hospitals have refused to countenance the inclusion of venereal services within their facilities, and stigmatisation of venereal patients ‘has long been institutionalised within hospitals and their staff.’ Kinghorn, G. R., ‘Passion, Stigma and STI,’ Sexually Transmitted Infections, 2001: 77: pp. 370–375.
from the perspective of both the Commonwealth and NSW government, and the hospitals they supported.

Although this periodisation will frame my analysis of venereal treatments in NSW, it is important to note that treatment responses evolved unevenly. For example, despite the rapid introduction of Salvarsan as a treatment for syphilis after 1910, older treatments, both orthodox and alternative, continued throughout the period. In a medical text from 1915 for example, five years after the introduction of Salvarsan, McDonagh identified antimony, mercury, potassium iodide and nucleinate of soda, as well as Salvarsan as treatments for syphilis. Similarly, treatment regimes and dosages related to Salvarsan itself changed substantially during the period. It is probable that the public perception of Salvarsan as a ‘magic bullet’ accounted in part for the high demand placed by patients on inpatient and outpatient venereal services after 1910. A consistent ingredient across the period however was ambivalence. A significant source for this ambivalence resulted from what Fournier writing in 1906 described as the general consensus that venereal diseases were either ‘merited’ or ‘unmerited.’ Merited disease resulted from either isolated illicit contagion, or ‘a series of contagions resulting from a life of debauch.’ Unmerited disease derived from licit contagion, infections which were mostly ‘honest, moral or purely accidental.’ Illicit, merited infections far outnumbered unmerited infections and treatment responses were tied to merited and unmerited transmissions. I will conclude this exploration of the uncertainty and ambiguity that surrounded treatment with a detailed examination of a number of patient’s case histories, arguing the compliant and conscientious nature of venereal patients in NSW, despite ambiguous evidence after 1918 related to treatment defaulters.

Treatments prior to 1910

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418 This formulation echoes the ‘guilty’ and ‘innocent’ appellations ascribed to early cases of HIV/AIDS in the 1980s: gay men were perceived to be ‘guilty’ and those who acquired infection through blood transfusions were perceived to be ‘innocent.’
420 Lewis, M., Thorns on the Rose, New Haven, 1998. Evidence from Lewis related to treatment defaulters, and the tension between compliant and defaulting venereal patients, will be examined in chapter 4.
Throughout the nineteenth century a range of treatments were available for both syphilis and gonorrhoea. Mercury was the great mainstay, although it waxed and waned in popularity amongst both orthodox and alternative practitioners. Fournier described the process of mercurial inunction, the treatment which was most prevalent in Europe and the United Kingdom until the last quarter of the nineteenth century.\(^{421}\) Technically, this process involved sequestration, overheating, depuration, inanition and salivation: in lay terms, this meant that the venereal patient was enclosed in an over-heated chamber for twenty to thirty days, bled, purged, bathed and medicated with ‘concoctions such as watercress, chicory, chervil and pimpernel,’ and then the patient was coated in mercury, covered in wool and placed in a warm bed with thick bedclothes so as to induce perspiration. Fournier reported that this resulted in the patient, the bed linen and the walls of the room turning black ‘with a sort of mercurial scum,’ and being referred to as ‘black chambers.’ Such treatments may well have been the predecessors of three of the significant markers of treatments for venereal diseases: they were, and were perceived to need to be, painful, prolonged and punitive. Sequestration, for instance, served dual purposes: it provided a space for treatment, and it removed venereal patients from other contacts. These may well have been the precursors to the prolonged, inpatient treatment of women throughout the early part of the twentieth century. Fournier suggested that by the beginning of the twentieth century, inunction had been replaced by a ‘series of rubbings with mercurial ointment combined with good diet and hygiene, and a total absence of the sequestration…of former days.’\(^{422}\) In the years immediately prior to the introduction of Salvarsan, this abridged treatment with mercury was perceived as the only specific treatment for syphilis, but because it was ‘extremely poisonous in the curative dose,’ it had to be administered in small doses over a long period.\(^{423}\) Dosage of mercury was determined either by the effect on symptoms, or the effects of mercurial poisoning. Mercury was offered as injections, frictions, pills and liquors, and even as a foot salve in cacao-butter (see Figure 1). When offered as pills, mercury was often combined with a range of substances, and marketed accordingly. For example the popular Blue Pill contained mercury, confection of roses and powdered liquorice. Supporters of

\(^{421}\) Fournier, *The Treatment and Prophylaxis of Syphilis*, p. 4.
\(^{422}\) Ibid., p. 76.
Broussais’s inflammatory theory of disease offered baths, enemas and laxatives.\textsuperscript{424} Hall argues that mercurial treatments ‘savoured of the punitive’ causing, as much as the disease itself, physical stigmata.\textsuperscript{425}

Mercury was not the only anti-syphilitic treatment prior to 1910. A range of heavy metals, including gold, platinum, silver and antimony were also used as treatments for syphilis. Some experts advocated the use of homoeopathy whilst others practised cauterisation or excision of chancres. During the 1840s, syphilisation – or ‘repeated injections of the syphilitic virus so that the subject would be no longer susceptible to developing syphilis’ – was advocated by some, but opposed by many others. Other common anti-syphilitic remedies included guaiac,\textsuperscript{426} sarsaparilla, cinchona, walnut, opium and sulphuric acid. Gonorrhoea treatments included mercury, nitrate of silver, nitrate of potash prepared as solutions or lotions. Lewis suggests that the range of pre-Salvarsan syphilis and gonorrhoea treatments was not marked by therapeutic success, and this led to a certain ‘therapeutic nihilism.’ An experiment in Norway between 1890 and 1910 found that mortality rates for untreated venereal patients, both male and female, were 50 per cent higher than those of treated patients who received a range of mercurial preparations.\textsuperscript{427} Acknowledging that animals are immune to syphilis, Fournier described a number of experiments, including his own, to develop a serum or vaccine which could be useful in humans. In these experiments, patients were injected with serum from dogs, horses, sheep and ox, and in some instances, in the hope of developing an antitoxin, with the ‘blood serum from syphilis subjects in the tertiary or even the secondary stage.’\textsuperscript{428}

\textsuperscript{424} Lewis, \textit{Thorns on the Rose}, p. 45.
\textsuperscript{425} Hall, ‘The Great Scourge’: Syphilis as a medical problem and moral metaphor, 1880–1916.’
\textsuperscript{426} Guaiac is a substance harvested from the hard, greenish brown wood of the lignum vitae tree and other trees of the genus guaiacum.
\textsuperscript{427} Lewis, \textit{Thorns on the Rose}, pp. 44–45.
\textsuperscript{428} Fournier, \textit{The Treatment and Prophylaxis of Syphilis}, pp. 212–214.
A wide variety of treatments were utilised in NSW during the nineteenth century. Mercury baths were used to treat primary syphilis, and following experiments in Germany in the 1860s, mercury was injected and applied externally at the same time. It was suggested in 1881 that an effective treatment for gonorrhoea was the injection through the urethra by catheter of a gallon of cold water, followed by an injection of zinc sulphate solution. In Australia, eucalyptus oil was also used as a treatment for syphilis. Lewis suggests that Australian medical practitioners were quick to adopt practices which had been tried in Europe or the United Kingdom, but they were also prepared, particularly towards the close of the nineteenth century, to conduct their
own experiments with syphilis treatments. Lewis details a number of curious experiments conducted in Melbourne and Sydney, ranging from herbal combinations, anti-syphilitic serums to continued experimentation with mercurial dosages, combinations and administration methods. In NSW animals were not only used to test experimental treatments for syphilis: they were also used to research the natural history and progression of the disease. By 1916, such research was being more extensively undertaken, although ‘apes and monkeys rarely proceed to the tertiary stages, and the late manifestations, involving the central nervous system, have not as yet been reproduced in these animals.’

In the years immediately prior to the development of the Wasserman reaction and Salvarsan, mercurial treatments remained popular in both orthodox and alternative regimes, but a number of developments pointed towards imminent bacteriological breakthroughs. The successful inoculation of a chimpanzee by Metchnikoff and Roux in 1903 demonstrated that syphilis was a pathogen that was carried in the blood of an infected person, and that it was the secondary stage of syphilis that was contagious. Neisser demonstrated that generalised infection with syphilis took place a number of hours after inoculation, suggesting that cauterisation or excision of primary lesions was fruitless. These discoveries led to attempts to identify preventive lotions and ointments which could be applied prophylactically to prevent infection. Calomel ointment was the most popular of these ointments, and although very popular, did not achieve a high level of success. In 1906, Fournier argued that all treatments for syphilis were unable to affirm a cure, and that this should be communicated to patients. The lack of success of preventives and treatments for both syphilis and gonorrhoea in the period before 1910 influenced the range of governmental responses which were considered to be efficacious. It is not surprising then that the latter part of the nineteenth century was characterised both by treatment nihilism, and by the

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431 Mercury remained popular after the rapid uptake of Salvarsan. Into the second decade of the twentieth century, orthodox medical textbooks wrote approvingly of the efficacy of mercurial treatments, arguing that ‘syphilitic disease was treated effectively long before the discovery of the syphilitic spirochete.’ Internal and external administration of mercury was found to be a rapid and effective response to syphilis (Browning, C. and MacKenzie, I., *Recent Method in the Diagnosis and Treatment of Syphilis*, Constable and Company, London, 1911, p. 153).
introduction and repeal of a series of ineffective contagious diseases legislation. In the context of a range of general breakthroughs in medical and sanitary science in the later part of the nineteenth century, syphilis stood as ‘a ghastly reminder’ of scientific inadequacy.\(^{434}\) New diagnostic and treatment regimes after 1910 influenced the development of a diverse range of governmental responses, in ways that would have been unthinkable a generation earlier.

**Orthodox and alternative treatment responses 1910–1918**

Across this period syphilis was perceived to play an extraordinary role in general medicine, particularly after the discovery of the micro-organism causing syphilis in 1905.\(^{435}\) Hall demonstrates that by the end of the nineteenth century syphilis was perceived as ‘an imitator’ which could mimic the effects of many other diseases, and as such it provided a ‘potent metaphor’ for a range of physical and moral concerns.\(^{436}\) It is difficult now to imagine how pervasive and instrumental syphilis was perceived to be, as a disease. Osler’s dictum was often applied by medical practitioners to the treatment of syphilis: ‘a thorough knowledge of syphilis as the key to good medicine was certainly true.’\(^{437}\) Syphilis was implicated in a range of diseases and conditions, and was generally considered to be an infection that caused or exacerbated these conditions.\(^{438}\) Significant morbidity and co-morbidity was associated with syphilis, but importantly, only limited mortality.\(^{439}\) Treatment for syphilis was closely associated with parasitology, pathology, dermatology, neurology, serology,

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\(^{434}\) Hall, ‘‘The Great Scourge’: Syphilis as a medical problem and moral metaphor, 1880–1916.’

\(^{435}\) Morton and Rashid demonstrate that venereal syphilis and a worldwide scatter of diseases resembling it are caused by microscopically identical organisms each precipitating identical antibodies. The organisms have caused clinical conditions that resemble each other but with clinical variables among themselves as well as between each other. ‘Thus, some authorities talk of one disease, treponematosis, and others talk of trepanomatoses.’ Current examples of other trepanomatoses include yaws, and historical examples include spirocolon in Greece, pian of Nerac in France, button scurvy in Ireland, sibbens in Scotland and radesgye in Norway (Morton, R. S. and Rashid, S., ‘The Syphilis Enigma: The Riddle Resolved,’ Sexually Transmitted Infections, 2001: 77: pp. 322–324).

\(^{436}\) Hall, ‘‘The Great Scourge’: Syphilis as a Medical Problem and Moral Metaphor, 1880–1916.’


\(^{438}\) D. A. Walsh, Professor of Pathology at Sydney University in 1915, when presenting evidence to the Legislative Assembly of NSW (Minutes of Evidence taken before the Select Committee on the Prevalence of Venereal Diseases, (NSW Select Committee) Progress Report, 1915, pp. 20–21) detailed an exhaustive list of conditions and ailments that were held to be caused by syphilis, pp. 24–25.

\(^{439}\) For instance, in 1913 in NSW only 62 deaths were specifically ascribed to syphilis in the Statistical Register for that year.
The perception that it was linked to a broad range of conditions and diseases certainly heightened the profile, importance and meanings attached to this particular venereal disease. Some argued that syphilis was ‘one of the three great racial poisons at work in the community,’ indicating that one of the significant meanings attached to syphilis was eugenic. Governments were acutely aware of the multiple sequelae of syphilis, and their legislative interventions were to an extent based on their understanding of the impact of these sequelae on populations. The perceived ubiquity of syphilis framed many of the important debates of the period, including debates about the efficacy of new diagnostic and treatment regimes.

The emerging field of bacteriology and improved understandings of natural history and progression also played a significant role in how government perceived itself responding to syphilis and gonorrhoea between 1910 and 1918, and beyond. The contiguous development of both the Wasserman reaction and Salvarsan provides real clues as to why treatment for venereal diseases became more concentrated and contentious in the decade from 1910 to 1920 and why most states in Australia adopted venereal diseases legislation towards the end of the decade. Governments confronted the fundamental puzzle of how to get this new technology and the appropriate patients together. Levine has remarked that measures to ‘tackle VD coincided with the self-

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440 The American Journal of Syphilis, for example, had 15 departmental editors in the years leading up to 1920, publishing articles in all the listed fields. American Journal of Syphilis, St Louis, vol. 4, Jan.–October 1920. Similarly, the evidence presented to the NSW Select Committee encompassed urology, gynaecology, ear, nose and throat specialists, eye specialists and experts in the field of congenital syphilis.

441 Venereologists were often equally diverse, not only working with syphilis or gonorrhoea patients. Fluker remarks that at one time he ‘did a mixed job, involving infectious diseases, acute medicine, tuberculosis, a little orthopaedics and, of course, venereology.’ (Fluker, J. L., ‘Personal Reminiscences of a Venereologist before Penicillin.’)

442 Anderson, F., The Root of the Matter: Social and Economic Aspects of the Sex Problem, Workers Education Association, Sydney, 1918, p. 4. Anderson went on to remark: ‘Why prate about a White Australia, and erect fine buildings for posterity? We are a diseased and dying people!’

443 A Commission in New Zealand in 1922 commented that ‘it is an important factor in the production of blindness, deafness, throat affections, heart disease and degeneration of the arteries, stomach and bowel disease, kidney disease and affections of the bones…the economic loss resulting from this disease is enormous as regards young, old and middle-aged, and it respects not sex, social rank or years’ (Committee of the New Zealand Board of Health, Venereal Diseases in New Zealand: Report of the Special Committee of the Board of Health appointed by the Hon. Minister of Health, Wellington, 1922, p. 10).

444 Green has noted that historically, interest in syphilis has waned as case numbers have fallen, ‘and this holds true today.’ Green, T., Talbot, M. D. and Morton, R. S., ‘The Control of Syphilis, a Contemporary Problem: A Historical Perspective,’ Sexually Transmitted Infections, 2001: 77: pp. 214–217.
conscious rise and remodeling of the medical profession, and were heralded as modernising and propitious measures designed to bring safety and comfort to the population." By 1912, medical practitioners were regularly using the Wasserman reaction as a diagnostic tool for syphilis. As a generic term, the Wasserman reaction referred to several blood tests that enabled physicians to diagnose syphilis and assess the progress of treatment. These blood tests were fallible and did not necessarily signify ‘active syphilis.’ I investigate the terminology used by pathology services between 1910–1918 in NSW later in this chapter: these services used terms like ‘positive,’ ‘completely positive,’ ‘nearly completely positive,’ and ‘negative’ to describe sensitivity and specificity. These new technologies opened the possibility of quarantining those who could be definitively diagnosed and the provision of ‘a clearance’ (i.e. the issuing of cleanliness certificates to those about to be married) to those who could be definitively cured, although there was considerable debate about the potential of these technologies to achieve these goals. The NSW VD Act 1918 authorised a medical practitioner to provide such a clearance. These socio-

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446 The early and widespread use of the Wasserman reaction in NSW is evidenced in the unpublished medical records. The Medical Records, in bound volumes according to disease, are located in the secondary repository of the Medical Records Section of the RPA Hospital, Sydney. Records related to May F., Florence G., Edith H. are located in Syphilis 1, Year 1910–14, Serial Nos. 1–50. Lewis remarks that ‘despite its considerable limitations, the Wasserman test meant that even without clinical symptoms, syphilis could be identified, and the efficacy of therapy could be estimated with unprecedented reliability. The laboratory had become an essential element in the control of syphilis’ (Lewis, Thorns on the Rose, p. 124).

447 The Wasserman reaction was not the only test for syphilis. The Luetin test was somewhat like the tuberculin test, was best given in the quiescent stages of the disease, and was dependent on the possibility of developing a pure culture (NSW Select Committee, p. 26).

448 The specificity of any medical test refers to the percentage of people who test positive for a certain condition who do actually have it. Sensitivity refers to the percentage of people who test negative to a certain condition who don’t actually have it. In the context of these definitions, a test that produces a high number of biological false positives, for instance, would be said to have low specificity. It is important to note that no test will be 100 percent specific or sensitive. McCalman refers to the inaccuracy of the Wasserman reaction when discussing the testing of pregnant women for syphilis in Melbourne (McCalman, J., Sex and Suffering: Women’s Health and a Women’s Hospital, Melbourne, 1998, p. 137).


450 McDonagh, J. E. R., Biology and Treatment of Venereal Diseases, pp. 487–492. McDonagh argued that a negative Wasserman did not necessarily mean that a patient was free of infection, and that it was therefore impossible to set a time limit on treatment efficacy to determine marriage. McDonagh recorded that other syphologists had set a time limit on a cure, including Fournier, who suggested that four or five years after a ‘cure’ was sufficient time.
political sequelae of the new technologies were only tangentially cognisant of the non-definitive nature of the Wasserman reaction and Salvarsan. Technological developments did however promise the very real possibility for improved early diagnosis and therefore improved early treatments.  

The Wasserman test was a complement-fixation test developed in 1906. A complement-fixation test was a diagnostic of syphilis using blood serum or cerebrospinal fluid. It was a modification of the complement-fixation reaction developed by Jules Jean Baptiste Vincent Bordet (1870–1961) and Octave Gengou (1875–1957) which had been developed in 1901. Complement-fixation tests are still in use today, and depend upon 'the fact that in the course of certain diseases, including syphilis, a substance with the properties of an antibody appears in the serum of affected patients.' The ‘antigen’ used was an alcoholic muscle extract, usually from a bull's heart. The active substance was a lipid called cardiolipin. This antigen reacted with certain antibodies, so-called reagines that commonly occur in the blood of syphilis patients. Because syphilis antibodies are not specific for syphilis, they may occasionally occur in other diseases, like malaria and leprosy. They may also occur in diseases allied to syphilis, including yaws, bejel and pinta. When such diseases trigger a positive Wasserman reaction it is referred to as a biological false positive. Importantly, such biological false positives also occur in acute infections involving fever, including bacterial or viral pneumonia, and during pregnancy, although ‘whether or not pregnancy is of itself a cause of such reactions is uncertain.’ Many of the poor young women attending the outpatient clinic at RPA Hospital were pregnant, and in 1919 venereal patients may also have been affected by the influenza epidemic. Although the particularities of biological false positives were not well understood in this period, the evidence of the medical records suggests that there was some understanding of the limited specificity and sensitivity of the Wasserman

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451 The *Medical Journal of Australia* editorialised in 1916 that ‘modern scientific methods have made diagnosis more accurate, and have placed into our hands an index of the progress of cure. As time proceeds no doubt these methods will become still more accurate’ (*Medical Journal of Australia*, October, 1916, p. 368).

452 Browning and MacKenzie described the process for undertaking the Wasserman reaction in 1912. ‘A mixture is made of organ extract (antigen), the suspected syphilitic serum, and complement (normal guinea pig’s serum), the mixture being then placed in the incubator at 37 degrees C.; in the second stage sensitized corpuscles in order to ascertain whether or not the complement has disappeared’ (Browning, C. and MacKenzie, I., *Recent Method in the Diagnosis and Treatment of Syphilis*, Constable and Company, London, 1911, p. ix).

reaction. When Wasserman test results were described as ‘completely positive’ or ‘nearly completely positive’ or ‘negative’ for instance there was an emerging sense that both pathologists and medical practitioners understood the limited specificity and sensitivity of the test. Browning and Mackenzie in a syphilis text of 1912 devoted a chapter to discussing the latest research on the specificity of the Wasserman reaction, determining that ‘the results of the examination of many thousand sera by workers in all parts of the world have now established the specificity and clinical value of the reaction.’ This assessment was made less than three years after the initial development of the Wasserman reaction.

The early lack of specificity of the Wasserman reaction is confirmed by the evidence of J. B. Cleland, Principal Government Microbiologist, in his evidence to the NSW Select Committee on the Prevalence of Venereal Diseases in 1915. Cleland stated that in 1911, only two years after the Wasserman reaction was discovered, there were 540 Wasserman reactions undertaken in NSW. In 1912 there were 1348 reactions; in 1913, 413 reactions; and in 1914, 642 reactions. Cleland detailed the statistics related to positive and negative reactions for 1913. Wasserman reactions were carried out to detect a range of syphilitic conditions, including primary, secondary and tertiary syphilis, suspected syphilis, cerebral syphilis, tabes dorsalis and congenital syphilis. Results were given under each of these conditions in four categories: positive, incomplete positive, incomplete negative and negative. For example, in the condition of secondary syphilis, there were 41 positive recordings, 10 incomplete positives, seven incomplete negatives, and 29 negative results. Overall, across all syphilitic conditions, more than 60 per cent of specimens submitted to the microbiological laboratories produced negative results, and 25 per cent produced ‘positive’ or ‘incomplete positive’ results. 10 per cent of all specimens produced incomplete

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454 Browning and MacKenzie, Recent Method in the Diagnosis and Treatment of Syphilis, pp. 99–129. Browning and Mackenzie reported that because the Wasserman reaction also identified leprous antigen, a further test was required to differentiate. The second test most often used was the tuberculin test, because it reacted to leprosy, but not to syphilis (p. 100).

455 The Wasserman reaction was largely superseded by the VDRL (Venereal Diseases Research Laboratory) test which became available in 1946, and the RPR (Rapid Plasma Reagin) test. Both of these tests are commonly used in Australia today. In the late 1970s, the Wasserman reaction was still being used at Sydney Hospital, according to the current medical practitioners. One other syphilis test, the TPI (Treponema pallidum Immobilisation) test, which relied on the syphilis antigens being extracted from the testicles of laboratory rabbits, was commonly used at pathology laboratories at Westmead Hospital in the 1970s. Cages of rabbits were kept in pathology units for this purpose.

456 NSW Select Committee, pp. 20–21.
negatives, and just fewer than 10 per cent produced incomplete positives. This high percentage of negative results suggests that most people presenting for syphilis tests belonged to that group of patients attending clinics, not noted in the data, who were screened for tests, but never needed to be treated, or after 1918, notified. Such ambiguity begs certain questions. Would an ‘incomplete positive’ have counted as a diagnosis in the context of the NSW VD Act 1918, and therefore be notifiable? Would a ‘nearly completely positive’ be notifiable? Would compulsory treatment with Salvarsan begin on a person with suspected syphilis who registered an incomplete positive? Salvarsan was not a magic bullet and the Wasserman reaction was not an infallible marker: high expectations from medical practitioners and public health professionals coupled with incomplete and ambiguous results point to some of the reasons for ambivalence in treating venereal patients.

Some Wasserman reactions were undertaken at the Sydney offices of the Chief Microbiologist but most were undertaken ‘in proper rooms at a Hospital or in a medical man’s consulting rooms.’ Medical practitioners took about 5 cc of blood with a large barrel syringe and transported the specimen to the Microbiological laboratory. Cleland indicated that most specimens arrived from institutions, including State hospitals, smaller suburban and country hospitals, prisons, military and naval authorities and the Quarantine Department of the Commonwealth. Testing was therefore mostly conducted under the auspices of government. On occasions private practitioners submitted specimens from patients who could not afford ‘to have the examination made outside.’ Country hospitals dispatched specimens to the laboratory and they were also reminded how to do this in advertisements placed in the Medical Journal of Australia. Chemists in country areas where there were no medical practitioners were considered unsuitable to draw specimens because they may have ‘put a few bubbles of air into the blood,’ causing death. Cleland suggested as well that fewer gonorrheal than syphilis slides were forwarded to the laboratory, primarily because the clinical diagnosis could be made more definitively. When slides were forwarded, analysis was complicated because women’s samples ‘swarmed with other bacteria’ and because the gonococcus was a ‘shy grower’ and very difficult to culture. The services of the Microbiological laboratory were becoming increasingly important.

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457 Ibid.
across a range of infections. As Cleland suggested ‘bacteriology is now one of the most specialised subjects of medical science, and, as a rule, the general practitioner has not the time or the facilities to carry out even the simplest bacteriological examinations.’

One very real problem with the early use of the Wasserman reaction involved the transitional uses of both mercurial and arsenical (Salvarsan) treatments which changed only slowly after 1910. Many patients had been treated with various mercurial formulae, and there was a possibility that this treatment may have induced a negative Wasserman reaction. Intramuscular injections of mercury were perceived to be more effective than ‘mercury by the mouth,’ and injections were associated with continental treatment and oral administration with treatment in the United Kingdom. By 1915, orthodoxy in NSW recommended intravenous Salvarsan, but even in 1910 ‘mercury by mouth’ was most common. Immediately after 1910 most patients who presented at venereal clinics were thus not treatment-naïve, particularly given the length of most mercurial treatments. It was therefore difficult to know whether a negative Wasserman indicated absence of syphilis because of a mercurial or an arsenical cure, or a combination of both. Cleland suggested that ‘if the mercurial treatment had been effective in destroying the parasite’ then a negative Wasserman could have ensued. Cleland was dubious, however, about the possibility of mercury effecting a cure, suggesting that ‘an efficient cure by mercury may completely cure the disease, as far as we can say, as of course, was the case before the use of Salvarsan.’ As medical practitioners became more confident in the use of Salvarsan they began consciously to use mercurial and arsenical treatments simultaneously. Medical practitioners argued that the spirochete was ‘very knowing’ and became tolerant, which had the potential to lead to drug resistance. The response to this possibility was to ‘use mercury to get at the spirochetes before they recover from the effects of the Salvarsan, and then Salvarsan before they get over the effects of the mercury.’

Salvarsan, or ‘606,’ was an organic preparation of unsaturated trivalent arsenic, known as an arseno-benzol. Prior to Erlich and Hata’s first published accounts of the

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458 Ibid., pp. 20–22.
‘absolute curative effects of Salvarsan,’ the administration of arsenic in protozoal infections had been a long recognised method of treatment. Earlier arsenical compounds had been too toxic for the human body, and the breakthrough provided by Erlich and Hata was that in arsENO-benzol they discovered a drug ‘which approaches the ideal in chemotherapy, a drug which possesses a maximum toxicity for the invading parasite, and a minimum toxicity for the organs of the body.’ Salvarsan was in fact the third of four generations of this arsENO-benzol, having been preceded by ‘Ideal’ and ‘Hyperideal,’ both of which were considered to be ‘less soluble, more potent and more toxic’ and superseded by Neosalvarsan. Erlich and Hata’s initial experiments with Salvarsan had been in rabbits, where syphilis was induced in the cornea and the scrotum of the animals before being treated with Salvarsan. Small amounts of Salvarsan were found to completely eliminate any presence of the spirochete in rabbits. Early administration of Salvarsan in humans vacillated between subcutaneous, intra-muscular and intravenous injections, with medical opinion eventually agreeing that intravenous injections were the most efficacious. Because Salvarsan was known to be unstable, one of the issues with the administration of the drug was the problem of getting the powder into the solution, while at the same time maintaining asepsis and avoiding oxidation. Oxidation was likely to change the toxicity of the drug, creating serious side effects. Browning and MacKenzie reported however that the administration of Salvarsan was followed ‘as a rule by a sense of well-being on the part of the patient.’ In the immediate years after its discovery, Salvarsan was perceived to be a magic bullet: ‘the medical world rejoiced at the news that the first specific therapy for a germ-caused disease had been discovered…Paul Erlich had discovered the magic bullet – Salvarsan, a preparation of

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460 Browning and MacKenzie, I., Recent Method in the Diagnosis and Treatment of Syphilis, p. 155.
461 Asenic had been used to treat malaria ‘with much benefit’ and trypanosomiasis (ibid., p. 154).
462 Ibid., p. 155.
463 McDonagh, Biology and Treatment of Venereal Diseases, p. 294.
465 Browning and MacKenzie provided a detailed account of the method for intravenous injection, including advice on where the cylindrical funnels, rubber tubing and venepuncture needles could be purchased (ibid., p. 155). It is important to note that in 1900, hypodermic syringes were valuable medical instruments, handmade from glass, and expensive. They cost up to US $50 each. In 1920, only 100,000 syringes were manufactured worldwide; the greatest increase in syringe manufacture came with the use of penicillin after World War 2. (Drucker, Ernest, Alcabes, P., Marx, P., ‘The Injection Century: Massive Unsterile Injections and the Emergence of Human Pathogens,’ Lancet, vol. 358, no. 9297.)
466 Browning and MacKenzie, Recent Method in the Diagnosis and Treatment of Syphilis, pp. 174.
organic arsenic that was reported to cure syphilis in a week. By a single injection! Salvarsan ‘seemed like magic to those who first used it and saw the spirochetes, which mercury had only slowed down, vanish completely.’

Medical texts which detailed the properties of Salvarsan were available as early as 1912, and throughout the second decade of the twentieth century carried significant research and information on Salvarsan, its properties, and substitutes. Writing in 1912, McDonagh ‘endeavoured to take the broadest view, and to state fairly the pros and cons of Salvarsan.’ In The Biology and Treatment of Venereal Diseases, he examined the intricacies of Salvarsan for the treatment of primary, secondary and tertiary syphilis, as well as for allied diseases, including epilepsy, basal meningitis, cerebro-spinal meningitis, myelitis, ophthalmoplegia, cerebral thrombosis, yaws, malaria, sleeping sickness, leprosy, psoriasis, variola and scurvy. In a technique which is still common today with HIV/AIDS medications, McDonagh’s text was crammed with testimonials from thankful patients and excited medical practitioners. One patient, after receiving one injection of Salvarsan, provided the following testimonial: ‘I can hardly express my delight in being able to inform you that I am beginning to feel my old self again…The rash has gone and the glands are going; … those in the neck are reduced to the size of small peas…The awful depression and shooting pains are relieved, and once more I am beginning to feel there is some pleasure in being alive.’ Similarly, a satisfied medical practitioner wrote that: ‘I am very glad that you have so successfully carried out the treatment and I must congratulate you on its probable successful issue, as I think there could hardly be a worse case than this to test the treatment upon.’ Despite these testimonials, Salvarsan had a range of side effects or possible adverse reactions, including: ‘nausea and vomiting, pulse disturbance, heavy perspiration, and respiratory embarrassment; several hours later, gastrointestinal symptoms and chills and fever developed, and later again, skin eruptions (which sometimes went on to become universal exfoliative dermatitis.)’

Although McDonagh warned that Salvarsan like ‘all newly discovered remedies… has had to pass through the two stages of extravagant laudation and extravagant abuse,’

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469 McDonagh, Salvarsan in Syphilis and Allied Diseases, p. 147, p. 102, p. 115.
470 Lewis, Thorns on the Rose, p. 125.
471 McDonagh, Salvarsan in Syphilis and Allied Diseases, p. v.
the first decade of Salvarsan, and its substitutes, was greeted with a high degree of excitement.

The initial excitement concerning Salvarsan soon faded. Experience over the decade from 1910 to 1920 demonstrated that it produced many, often serious, side effects, and occasionally proved fatal. Salvarsan was in fact contra-indicated for people with diabetes, kidney disease and some tertiary presentations of syphilis, including tabes dorsales and general paralysis of the insane. Treatment of marasmic infants and old people was also contraindicated. McDonagh reported that 'the number of cases of blindness following Salvarsan…is legion…and youth dare not have Salvarsan for fear it is going to kill him or make him blind.' He also reported that ‘half to two hours after injection’ the patient often experienced acute pain in the gums, electric shocks down the arms and legs, acne vulgaris, giddiness and exfoliative dermatitis. After a decade of Salvarsan, Erlich produced compound ‘914,’ or Neosalvarsan, which continued to have serious side effects, but was still in use in most venereal diseases clinics immediately prior to the widespread use of penicillin in 1943 (see Figure 2). There is direct evidence that patients were tempted to seek treatment because Salvarsan had been promoted as a ‘magic bullet’ and high attendances at venereal clinics would indicate that patients were aware, and accepting, of the treatment.

Excitement related to the early manifestation of Salvarsan was evident in the medical records of the venereal wards of RPA Hospital between 1910 and 1918. The delight with which Salvarsan was received was evident in the treatment of Flora A., for example, a recently arrived immigrant from England, and a patient at the Royal Prince Alfred Outpatient Clinic in 1912, whose medical record survives. Flora was described as having had all syphilitic lesions removed as a result of treatment by Salvarsan. Again in 1912, Enid B. was the first person to have a definite ‘cured’ placed on her medical record as a result of Salvarsan. Lara C. was only relieved of

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473 McDonagh, Salvarsan in Syphilis and Allied Diseases, pp. 27–35.
474 Ibid., p. 483.
475 Ibid., pp. 301–302.
476 NSW Select Committee, p. 28.
477 Royal Prince Alfred Hospital medical records, Syphilis 1, Year 1910–14, Serial No. 12.
478 Royal Prince Alfred Hospital medical records, Syphilis 1, Year 1910–14, Serial No. 11.
symptoms after two doses in 1913, but her case was interesting because of the symbols, in the form of ‘$’ signs, which were used to describe various stages of syphilis. Meg D. was admitted to the venereal ward and diagnosed with both syphilis and gonorrhoea in 1912. She was discharged after two months, a period of time which included six Wasserman tests and five treatments of Salvarsan. The medical practitioner’s goal was to treat Meg with the new magic bullet, Salvarsan, and after each treatment, undertake a Wasserman test to ascertain whether she was free of the infection. The process of validating the effects of Salvarsan with a Wasserman reaction was described in the medical literature of the period. Lara, Enid, Flora and Meg were all treated between 1912 and 1913 and all four of these women were counted as Salvarsan success stories, with the Wasserman reaction providing the bacteriological endorsement of success. Despite these success stories, there was a degree of uncertainty about the efficacy of Salvarsan. This uncertainty was reflected in changing dosages over the period, and the use of the results of Wasserman reactions in determining Salvarsan dosages. Medical texts also reflected this uncertainty. McDonagh, writing in 1915, suggested that ‘chemotherapy is a very distinct advance upon our old empirical method of prescribing drugs, but it must be remembered that the science is in its earliest infancy, and that even the foundation upon which Salvarsan was built, has turned out to be unsound.’

Figure 2 – An advertisement for Salvarsan substitutes (source: MJA, 1916)

479 Royal Prince Alfred Hospital medical records, Syphilis 1, Year 1910–14. Serial No. 30. ‘$’ is still a medical shorthand way of writing syphilis. In this period however, the ‘$’ was duplicated thus – ‘$$‘ – or triplicated – ‘$$$‘ – to denote primary, secondary and tertiary syphilis.
480 Royal Prince Alfred Hospital medical records, Syphilis 1, Year 1910–14, Serial No. 13.
481 McDonagh, Salvarsan in Syphilis and Allied Diseases, pp. 56–58. Writing as early as 1912, McDonagh stated that ‘the earlier reports are very conflicting as to the influence of Salvarsan on the Wasserman reaction, but it may be at once stated that a positive reaction can be converted in every case into a negative one provided a sufficient number of injections are given.’
482 Ibid., p. 347.
483 This was one of many advertisements for syphilis treatments that appeared in the Medical Journal of Australia during World War 1. It is important to note that Salvarsan was a German preparation, and the other preparations listed in the advertisement were prepared in countries loyal to the Empire, and distributed through the ‘British Empire, Colonies and Dominions.’
Sometimes the Wasserman reaction was over-used, in venereal and non-venereal clinical settings. Over a period of two months Meg was tested six times for syphilis, recording a range of results from negative to completely positive. A similar diagnostic and treatment path awaited Gertie from East Hills. Gertie, a young single waitress was treated with intravenous Salvarsan on four occasions and had three Wasserman reactions during August and September 1912. Gertrude’s blood tests indicated that she had moved from ‘nearly completely positive’ to ‘trace of positivity,’ a result attributed by the medical practitioner to treatment with Salvarsan.

Asa, a 17-year-old chair caner, was diagnosed with primary syphilis, was treated with intravenous Salvarsan four times, had three Wasserman reactions conducted, and

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484 For instance, more than 90 percent of all patients admitted to the asylums at Gladesville and Callan Park between 1913 and 1915 were tested for syphilis, and of these 14.4 percent returned a positive Wasserman reaction (NSW Select Committee, p. 17).


shifted over a month from being ‘nearly completely positive’ to ‘negative.’ Asa, Gertie and Meg were all young women for whom the new diagnostic technology was assiduously used. Imprecise diagnoses and therapeutic decisions were communicated to patients with certainty.

Success with Salvarsan was perceived to be so significant in NSW that by 1915 the Minister for Public Health, George Black, was advocating the development of a Salvarsan Subsidy Scheme for public hospitals. This scheme began in NSW in 1915, the same year as the evening Outpatient Clinique opened at RPA Hospital. The scheme involved the government purchasing annually, through the drug branch of the Stores Supply Department, 2000 pounds’ worth of substitutes for Salvarsan, or 8000 doses, ‘to be supplied free to all hospitals subsidised by government, on condition that these drugs should be administered free of charge to those who could not afford to pay, and that the health department should be furnished yearly with statements regarding the sex, age and condition of those thus treated – the patients to be indicated merely by numerals or by initials.’ Basic demographic data was collected under this scheme but it was not until the NSW VD Act 1918 that people living with venereal diseases were notified by name. The scheme put the war-scarce and expensive Salvarsan substitutes into general hospitals where they could be used for the poor and indigent.

Patients with syphilis or gonorrhoea who attended venereal services at RPA Hospital required an extraordinary amount of commitment, and stamina. With the introduction of Salvarsan, treatment for syphilis lasted eighteen months, at least, and was curiously intermittent: patients presented for three months, then ‘holidayed’ for three months, before re-presenting. Treatment regimes were different at Sydney

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487 Royal Prince Alfred Hospital medical records, Syphilis 1, Year 1910–14, Serial No. 16.
489 Fluker confirms the tenacity required to undertake treatment for venereal diseases in the pre-penicillin era when he remarked: ‘Penicillin was not available and treatment was with heavy metals, arsenic and bismuth, supplemented by potassium iodide in heroic dosage and mercury pills. Treatment lasted for two years and produced its own morbidity which necessitated inpatient beds’ (Fluker, ‘Personal Reminiscences of a Venereologist before Penicillin,’ pp. 443–446).
490 NSW Select Committee, p. 36. The following exchange took place between Dr Richard Arthur and Dr Gordon Wellesley Bray: ‘And after the Salvarsan, what treatment did they receive?’ ‘They got intra-muscular injections of mercury preparation once a week.’ ‘You continue that for how long?’ ‘We give them ten injections running; that covers three months. Then we give them a rest for two or three months, and then another ten injections. We continue these intermittent periods for one-and-a-half
Hospital, and generally specific institutions developed local treatment regimes.\textsuperscript{491} Prior to the war, patients who could afford it paid 3s. 6d. for a dose of Salvarsan.\textsuperscript{492} For cases of acute gonorrhoea in men, gravity-fed urethral irrigations with strong antiseptic solutions were prescribed, on a daily basis, over a period of twenty weeks.\textsuperscript{493} D. A. Welsh, Professor of Anatomy at Sydney University in 1915 suggested that urethral irrigations were essential to ‘pursue the gonococcus to its lair’ and to ‘swell out the wrinkles of the urethra and force the gonococcus to come out.’\textsuperscript{494} Urethral irrigations were often accompanied by internal medicines including urotropin as a urinary disinfectant, acid soda phosphate to assist the action of the urotropin and tincture of hyoscynamus as a sedative.\textsuperscript{495} Treatments for gonorrhoea were not without risks, and on occasions, infection from a dirty catheter, used in the treatment of stricture, could occur.\textsuperscript{496} Treatment of gonorrhoea in women at the RPA Hospital involved swabbing the vagina with fresh yeast, ‘which we get every morning from the brewery…inserting a suppository of powdered yeast.’\textsuperscript{497} Some medical practitioners believed that gonorrhoea was intractable. Writing in 1916, the Medical Journal of Australia opined that ‘it has long been recognized that the treatment of gonorrhoea is far from satisfactory, and that, notwithstanding the introduction of a large number of vaunted remedies, no man can promise a cure in any given patient.’\textsuperscript{498} In light of this perceived intractability a number of experiments proceeded to identify a vaccine for to two years.” “It is assumed that, at the end of that time, if the treatment has been faithfully carried out, the majority of cases are cured?” “Yes.” “How long has the treatment by means of intramuscular injection of mercury been in use at the Prince Alfred Hospital?” “Only since the clinic started, that is since 11 January.””

\textsuperscript{491} The standard treatment for syphilis at Sydney Hospital in the same period was based on the stages of syphilitic infection. Dr L. P. Johnston reported that patients ‘in the primary stages got four to six injections of Salvarsan, four in the primary, six in the secondary, and two in the tertiary. Then we follow on for at least one year with intramuscular injections of mercury. We do not administer by the mouth at all’ (ibid., p. 42).

\textsuperscript{492} Ibid., p. 35.


\textsuperscript{494} NSW Select Committee, p. 27.

\textsuperscript{495} Ibid., p. 38.


\textsuperscript{497} NSW Select Committee, p. 42.

\textsuperscript{498} ‘Mercury Succinimide in Gonorrhoea,’ Medical Journal of Australia, August 1916, p. 255. This article quoted research undertaken by Dr L. W. Harrison which suggested that intravenous mercury succinimide was effective, primarily because it treated gonorrhoea as a blood infection, not an infection which had responded well to topical applications like germicides, balsams and resins.
gonorrhoea and three approaches showed early promise: subcutaneous, intravenous and sensitised vaccines.⁴⁹⁹

In 1915, one medical practitioner at the Outpatient Clinique, Dr Gordon Bray, pointed out that in the seven months the Clinique had been running, not one venereal patient had dropped out and that venereal patients were some of the best patients that the hospital admitted.⁵⁰⁰ Dr Bray also made it clear that because of the war Salvarsan was scarce,⁵⁰¹ and although Salvarsan was considered to be more expeditious than mercury, alternative treatments were utilised, including intramuscular injections of mercury once a week.⁵⁰² This would have been a punishing treatment regime, particularly after a short period of intravenous Salvarsan, with the range of possible

⁴⁹⁹ MacDonagh, Biology and Treatment of Venereal Diseases, pp. 435–460. MacDonagh reported that sensitised vaccines using human serum taken from the vein of a gonorrhoeal patient demonstrated that the ‘symptoms of the disease disappeared more quickly, reactions were practically nil, and no toxic phenomena occurred’ (p. 446). To date, no vaccine has been developed for gonorrhoea.

⁵⁰⁰ NSW Select Committee, pp. 36-41.

⁵⁰¹ See advertisement in Figure 2. In the purchase of Salvarsan, Black referred to substitutes for the drug, and some options included: ‘Kharsivan, a British preparation almost identical with Salvarsan and quite as effective, and Luargol, a new French drug, known in the military service as 1.0.2, likely to be as successful as anything yet in use (Black, The Red Plague Crusade, p. 18). Both of these alternatives, particularly in the period 1914–1918, had the advantage of not being discovered or prepared by the German pharmaceutical industry. Black remarked that at the beginning of the war, venereal ‘sufferers’ were thrown into a desperate pit ‘by that cornering of Salvarsan, in a few unscrupulous hands, which followed the outbreak of the war’ (Black, The Red Plague Crusade, p. 18). Clearly, the thought that members of the German Defence Forces were able to access Salvarsan, and members of the Allied forces were not, would have spurred a range of activities, including possible espionage, to manufacture an accessible alternative to Salvarsan. Apart from Kharsivan and Luargol, a third preparation was Galyl. Galyl was said to be ‘more successful than Salvarsan, in conjunction with mercury and iodides, in overcoming the papular syphilides.’ One unfortunate side effect of Galyl noted by Black was its aphrodisiac effect, and that certainly would have had a tempering effect on any prescribing medical practitioner in NSW at this time. Cheaper treatment alternatives, made by the Allies, were always being examined, and Black, in 1916, was able to remark that ‘already we are quite independent in this direction of the Germans, and in consequence, “606” has dropped to its normal ante-war price of five shillings, from the five pound and six pound per dose charged during the first months of the war.’ At the conclusion of this discussion, Black remarked: ‘It is comforting to know, however, that we are no longer dependent on Germany for the preparations needed in venereal treatment.’

⁵⁰² The scarcity of Salvarsan meant that tremendous effort was put into finding a substitute that could be used particularly on soldiers. Luargol was a French preparation which was comprised of arsenic, antimony and silver, and was known as ‘102.’ It was developed and ‘adapted to the special conditions of war.’ that is, it rendered the ‘patient non-infectious within the shortest space of time possible, and cured the lesion which incapacitates him with the minimum of risk.’ Soldiers were therefore able to be returned to duty expeditiously. Although there were side effects, ‘102’ was considered to be a powerful ‘military therapeutic.’ The report on French experiments with Luargol was contained in the August edition of the Medical Journal of Australia. The experiment itself had only recently been presented in Paris, in March 1916. In fact, Dr E. H. Molesworth was sent six tubes of Luargol between March and August, and was able to report in the same edition of the Journal his own conclusions. Molesworth concluded that he did not ‘see any reason why we should go back after the war to the German drug’ (Medical Journal of Australia, August, 1916, pp. 129–131). In the second decade of the twentieth century, treatment breakthroughs traveled quickly from Europe to Australia.
adverse reactions and side effects.\textsuperscript{503} And yet evidence shows that patients submitted conscientiously to long treatment regimes. Although ‘terrified,’\textsuperscript{504} venereal patients at the Outpatient Clinique persisted, and Dr Bray painted a picture of people in the industrial suburbs around Camperdown surmounting considerable hurdles in their attempts to locate accessible and affordable treatment. Writing of venereal patients in London, McDonagh supported Bray’s evidence when he argued that venereal patients were special, because they were optimistic, knowledgeable and inquisitive.\textsuperscript{505} The medical records which I examine later in this chapter present a range of compliant and inquisitive individuals.

The changing nature of the diagnostic and treatment landscape and the impact that these new technologies were having on medical practitioners were on show at an important meeting of the NSW Branch of the British Medical Association held in Sydney on 20 October 1916. Three lengthy papers were presented at this meeting, and each presentation was printed in the \textit{Medical Journal of Australia}, along with a synopsis of the debate which followed the presentations.\textsuperscript{506} These debates placed considerable emphasis on the Wasserman reaction and Salvarsan \textit{vis-à-vis} the role of prostitutes, both professional and amateur. Dr E. H. Molesworth suggested that all Sydney hospitals should establish venereal outpatient clinics, that intensive, intravenous treatment with arseno-benzol was appropriate, particularly if combined with mercurial treatments, and that all venereal treatment should be compulsory.\textsuperscript{507} Dr J. B. Cleland argued that social and biological issues related to prevention were more important than issues related to treatment, because prevention was better than cure. Amongst a range of suggestions, Cleland argued that people should marry younger, and that men should be discouraged from remaining single by increasing taxes and

\begin{footnotes}
\item[503] Fluker reports on the side effects of treatment with arsenic: ‘Toxic reactions from arsenic were frequent and very occasionally fatal. Intravenous administration required both skill and care. It was advisable for patients to rest for some minutes beforehand. Too rapid injecting produced vomiting and fainting especially after a heavy meal and the merest drop in the tissues around a vein produced a “bad arm” with much swelling and pain.’ (Fluker, ‘Personal Reminisces of a Venereologist before Penicillin,’ pp. 443–446).
\item[504] NSW Select Committee, p. 33.
\item[505] McDonagh, \textit{The Biology and Treatment of Venereal Diseases}, p. 484.
\end{footnotes}
favouring married men for employment and promotion. Dr Richard Arthur argued that medical practitioners needed to be aware of the advantages of early treatment that many medical practitioners continued with ‘happy-go-lucky varieties of treatment’ and that notification and compulsion were cornerstones of effective treatment. During the question and answer session which followed the presentations Dr Worrall suggested that venereal clinics would have no appreciable impact on the spread of infections, Dr Pockley suggested that it was virtually impossible to determine when a cure for syphilis had been effected, even with the Wasserman reaction and Dr Adams argued that calomel ointment and simple antiseptic solutions were efficacious for gonorrhoea infections. The NSW Branch of the British Medical Association typified the range of ambivalent attitudes in the medical profession regarding new treatment options.

Prior to the passing of the VD Act in 1918 chemists and alternative therapists played a significant role in treating venereal patients in NSW. Often these practitioners were accessible and affordable, and operated at a time when hospitals were actively discouraging venereal patients from attending. The presence of these practitioners was often opposed by medical practitioners and their Associations and by 1918 alternative therapists had been effectively outlawed from providing treatments to people with a suspected venereal infection. A registered pharmaceutical chemist, on the other hand, remained able to provide treatment for venereal disease, but only on the prescription of a medical practitioner.

The demarcation between quackery and orthodoxy was and is blurred: practices and therapies moved from one domain to the other over time. In the late nineteenth century, practices like hydropathy, massage and electrotherapy had been vilified by orthodox practitioners, but by the early twentieth century these practices had been

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510 Evidence presented to the NSW Select Committee in 1915 was inconsistent on this point. Many witnesses, including Dr G. W. Bray (p. 34) argued that the practices of alternative therapists were burgeoning, whilst others (Dr R. T. Paton, p. 14) argued that such businesses used to thrive, but ‘I do not know of any men who are carrying it on now to a great extent.’
511 Some contemporary commentators questioned why it was necessary to single out venereal diseases, and argued that treatments for tuberculosis and cancer should be restricted to qualified medical practitioners (ibid., p. 14).
subsumed into orthodoxy. Many of these very practices were in fact performed by nurses in orthodox contexts. Martyr argues that the turn-of-the-century decline in some infectious diseases and the concomitant rise in chronic diseases led to an increase in patients seeking alternative treatments. The reverse phenomenon was occurring with ‘strong drugs’: they were removed from lay hands and delivered in monopoly to allopathic practitioners.\textsuperscript{512} At times there was direct competition between orthodoxy and quackery for the business of venereal patients, and this resulted in the lambasting of each other’s techniques. Alternative practitioners pilloried the use of mercury, claiming that it was poison, and promoted their practices instead, including sandalwood. Medical practitioners in turn derided alternative approaches, with Dr Argyle of the British Medical Association stating: ‘One of the principal difficulties in the way of dealing with the question satisfactorily…is that people think that they should have the right to allow anyone they choose to treat them.’\textsuperscript{513}

In the second decade of the twentieth century in NSW chemists were fighting to improve their reputation and credibility. Wright suggests that a chemist had ‘the taint of abortion practice, while he panders to the vice of the drug fiend, and the sex maniacs, and while he makes part of his living as a mere huckster.’\textsuperscript{514} Martyr characterises the crisis of confidence confronting chemists with the question: ‘Were they health professionals in their own right, or mere distributors of drugs?’\textsuperscript{515} Chemists did not position themselves as alternative practitioners: in fact, in a complex relationship, they differentiated themselves from herbalists and distributors of patent medicines.\textsuperscript{516} Prior to 1918, the chemist’s shop was often the first port of call for a person who suspected they might have a venereal infection, and a popular remedy was sandalwood, applied topically. A correspondent to the \textit{Bulletin} noted that sandalwood was ‘noticeable among the pimply-faced fraternity in dirty bars and restaurants.’\textsuperscript{517}

\textsuperscript{513} \textit{Ibid.}, p. 199.
\textsuperscript{515} Martyr, \textit{Paradise of Quacks}, p. 219.
\textsuperscript{516} \textit{Ibid.}, pp. 219–220.
\textsuperscript{517} The availability of sandalwood was increasing as a result of the development of cropping and plantation techniques on the New Hebrides. Most histories of Vanuatu will refer to the burgeoning
Donovan has noted that ‘the medical profession has traditionally been hostile to products associated with STD avoidance, particularly when they are not doctor initiated.’

Regulations which were passed subsequent to the VD Act in November 1919 severely constrained the capacity of pharmaceutical chemists to provide any treatment for venereal diseases, except on the prescription of a qualified medical practitioner. These included most mercurial and arsenical compounds, whether in pills, capsules, tablets or emulsions. Sandalwood oil, copaiba, Methylene Blue and all medicated bougies, which had been the mainstay of much alternative therapy, were similarly prescribed. These constraints were mild compared to the heavy-handed response to alternative therapists. The 1919 Regulations included a pro forma Special Warrant to be issued by a Stipendiary or Police Magistrate for the seizing ‘of any article capable of being used unlawfully for the alleviation of venereal diseases.’ Houses, offices, shops or rooms could be entered with the use of ‘force to break down and open doors’ and any article, medicine, instrument or appliance could be seized. It is important to note however that despite these recriminatory and monopolistic approaches, between 1921 and 1935 there were only 18 convictions for sale of prohibited drugs by chemists, and only two for treatment by unqualified practitioners. These Regulations were accompanied by further Regulations related to compulsory treatment and notification.

**Compulsory treatment and notification 1918–1925**

A network of provisions, requirements, penalties, and fines related to treatment were built into the NSW VD Act 1918 and patients found themselves occupying a sandalwood trade of the New Hebrides in the early part of the twentieth century, and of the trade which existed between Australia and the New Hebrides (Haines, The Grains and Threepenn’orths, p. 172).

Donovan argues as well that after the passing of venereal diseases legislation in Australian states, ‘while pharmacists could dispense products such as antiseptics that were specifically requested by their customers, it was illegal to promote them or to provide any verbal or written advice on how to use them’ (Donovan, B., ‘The Repertoire of Human Efforts to Avoid Sexually Transmissible Diseases: Past and Present Part 1: Strategies Used Before or Instead of Sex,’ Sexually Transmitted Infections, 2000: 76: pp. 7–12).

Regulation 3 listed a range of treatments which required a medical prescription (VD Act 1918 Regulations, Government Gazette No. 255, 10 November 1919).

VD Act 1918 Regulations, Government Gazette No. 255, 10 November 1919, form K.

Lewis, Thorns on the Rose, p. 217.
markedly different treatment terrain after this legislation was gazetted. The most significant change in the treatment landscape was governmental: medical practitioners were required to notify patients with venereal diseases, and patients were compelled to undertake treatment. I suggest that compulsion had the curious effect of inducing non-compliance in previously compliant patients. Whilst the legislation did affect alternative treatments, it did not have an impact on the type and nature of orthodox treatments: the Wasserman reaction continued to be the primary diagnostic tool for syphilis, with some arguing that it was over-used. The potential of the interactions between the diagnostic tool and the treatment regime, however, was not lost on medical practitioners and government. Whilst it was largely as a consequence of the capacity to readily diagnose, treat curatively, and link both processes to compulsion and regulation that venereal diseases legislation eventuated at this time, the NSW VD Act 1918 was also built on its legislative predecessors – the NSW PD Act 1909 and the NSW Select Committee 1915.

The legislation was detailed and circumscribing. Within three days of suspecting a venereal infection, a patient had to consult a medical practitioner, or a hospital. If a patient did not seek treatment in the prescribed time, they were ‘liable to a penalty not exceeding one hundred pounds, or imprisonment for a period not exceeding three months.’ Patients were then compelled to attend for treatment ‘at least once in every such period as is prescribed.’ Penalties attached to those who did not attend for treatment as required. Patients were required to inform their medical practitioner of changes in address, within seven days, ‘or face a penalty not exceeding five pounds.’ If patients changed medical practitioner, or if a medical practitioner ‘dies or for any reason is unable or unwilling to treat him further,’ a patient had to immediately place himself under the treatment of another medical practitioner. Patients were compelled to continue treatment until cured, even if ‘they ceased to be liable to convey infection.’ Medical practitioners were required to notify government of all

522 McDonagh, *The Biology and Treatment of Venereal Disease*, p. 497. McDonagh argued that medical ‘men prefer to learn all about the Spirochete and the Wasserman reaction, mainly because laboratory knowledge is easier to acquire than is clinical knowledge, but it is also very largely due to the fact that there are not enough men, whose knowledge of venereal diseases is sufficient to warrant them in undertaking tuition in this subject.’

523 VD Act 1918, section, 4. (1) and (2).

524 VD Act 1918, section, 7 (1).

525 VD Act 1918, section, 8.
persons being treated for venereal diseases, and to further notify when a patient failed to appear for treatment within a period of ten days. If a medical practitioner suspected that a patient with venereal infection intended to marry, then the medical practitioner could inform all relevant parties of the patient’s infection. Similarly, if a patient with venereal infection did marry then s/he would have committed an indictable offence and could be imprisoned with or without hard labour for a period of five years, or given a fine ‘not exceeding five hundred pounds.’ Similar fines existed for those people who knowingly infected any other person with a venereal disease. Patients with venereal infection were also proscribed from working in any food-handling capacity. When a medical practitioner was satisfied that a patient was no longer able to convey infection, then a patient could be presented with a ‘certificate of cure’ in the prescribed form.

From the moment a patient suspected a venereal infection, through to the issuing of a ‘certificate of cure,’ government was interested in monitoring behaviour. All stages of the treatment process were to be meticulously observed, noted and reported to government. Any treatment lapses, or defaults, were also to be observed and reported. As a result of the opportunity provided by the treatment intervention, patients were also to be monitored in a range of settings, whether personal relationships, accommodation or employment. Any lapses in conduct in these personal domains, including sexual intercourse occasioning infection were reportable, and indictable. The modes of rule inherent in these provisions highlight the significant changes that had occurred since the NSW PD Act 1909. Government was shifting its attention from the prostitute in the brothel or the lock hospital, to a much broader population in a wide range of situations and settings. The medical practitioner was positioned as the fulcrum in this network of requirements and penalties related to treatment. Notification was the mechanism by which compulsory treatment was enforced, not only at the first interaction with a medical practitioner, but also if treatment defaults occurred, if marriage was contracted, or if a patient knowingly infected another. Although a notification from a medical practitioner did not disclose the name and address of a patient, scrupulous attention was paid to the treatment journey of venereal patients after 1918.
Regulations supplementary to the VD Act were gazetted in November 1919. These Regulations detailed what was meant by compulsory treatment, and notification. In relation to compulsory treatment, forms were attached that allowed a medical practitioner to advise the Department of Public Health if they had diagnosed a patient with venereal disease, to advise another medical practitioner if a patient was moving to his practice, to advise the Department if a patient had moved from his practice, to advise the Department if a patient had defaulted on treatment against prescribed standards and to notify a patient and the Department that an individual was free or cured of venereal disease. The Regulations included templates to cater for most contingencies foreseen in the legislation. In relation to pharmaceutical chemists the Regulations detailed the drugs that could not be sold or supplied unless prescribed by a duly qualified medical practitioner. These included ‘any synthetic organic arsenical compound or synthetic organic silver compound.’ These Regulations precluded the sale or supply of Salvarsan or Neosalvarsan except with a prescription. Other drugs which were proscribed included any patent or proprietary medicine, any mercurial emulsion, sandalwood oil or any gonococcus vaccines or serums. The Regulations ‘fleshed out’ the 1918 legislation, and provided the Department of Public Health with the apparatus to enforce the Act.

Some sections of the VD Act and the subsequent Regulations however were poorly defined and created unresolved and problematic issues for the NSW Department of Public Health well into the 1930s. Section 27 (b) of the Act specified that where the Minister arranged for a medical practitioner to examine and treat a patient that the medical practitioner would be remunerated. This often applied to people living in rural areas, where there was limited access to venereal treatment services. Regulation 14 specified that in such circumstances a medical practitioner would be paid ‘ten shillings for an examination’ and ‘for treatment, the first attendance on each patient, the sum of seven shillings, and for each subsequent attendance the sum of five shillings.’ Although this appeared clear, correspondence between medical practitioners and the Commissioner of Venereal Diseases demonstrated that many issues remained unresolved. In 1929 Dr Rutherford from rural NSW requested free

526 VD Act 1918 Regulations, Government Gazette No. 255, 10 November 1919.
527 Ibid.
Salvarsan and appropriate remuneration for examining and treating two male patients. After a lengthy correspondence the Commissioner for Venereal Diseases requested that the Commissioner for Police delegate a constable to make confidential inquiries as to whether the male patients were indigent. Detailed financial responses were eventually made to the Commissioner for Venereal Diseases who subsequently approved the expenses of Dr Rutherford. Similarly, in 1935 a Dr Birch from northern NSW claimed remuneration for examination and treatment of a married couple. After the usual police investigations, and thirteen weeks, the Commissioner approved the expenses. Dr Birch wrote to the Commissioner suggesting that ‘the legislation for the treatment and prevention of venereal diseases is an absolute farce.’ To ensure that such delays were not encountered again the Commissioner requested that his Department design and circulate pro formas for such exigencies: one form to be completed by an applicant claiming medical treatment as an indigent person, and another to be completed by a medical practitioner in respect of an applicant claiming medical treatment as an indigent person. These developments suggest that not only were certain aspects of the VD Act 1918 slow to be given life, but also that in the 17 years between the original Act and the Birch correspondence, concepts of indigence had changed.

The treatment journeys of venereal patients after the introduction of the VD Act in 1918 highlight the lack of government preparedness to operationalise the legislation and can be charted in the medical records of RPA Hospital. Emily S. was admitted to the venereal ward in 1922 for a period of one month. Her medical practitioner recorded a ‘very rapid response to anti-syphilitic treatment’ and she was discharged to attend the outpatient clinic, regularly. Jean R. spent one week in the venereal ward, before discharging herself to seek ‘private treatment.’ Elsie B. spent three weeks in the venereal ward, and although her chancre had not been treated, she ‘desired to go home’ and was permitted to leave and attend the outpatient clinic. May W., who

529 ‘Correspondence between Dr Rutherford and NSW Department of Health’, Supply of Drugs for Venereal Diseases at Rachel Foster Hospital, container 10/43029, folio 30/1370, NSW State Archives.
530 ‘Correspondence between Dr Birch and NSW Department of Health,’ Supply of Drugs for Venereal Diseases at Rachel Foster Hospital.
531 ‘Pro formas for the Treatment of an Indigent Person,’ Supply of Drugs for Venereal Diseases at Rachel Foster Hospital.
532 Royal Prince Alfred Hospital medical record, Syphilis 1, Serial No 101 – 150, 1920–1928.
533 Royal Prince Alfred Hospital medical record, Syphilis 1, Serial No 101 – 150, 1920–1928.
534 Royal Prince Alfred Hospital medical record, Syphilis 1, Serial No 101 – 150, 1920–1928.
was seven months pregnant, and living with primary syphilis and gonorrhoea, spent a week in the venereal ward in October 1924 and arguing that she had ‘urgent business’ discharged herself, against the advice of her medical practitioner, Dr Molesworth. May W. was asked to complete a certificate which read:

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I hereby certify that I
(insert patients name)
am removing from the RPA Hospital,
at my own request, against the advice of
(insert doctors name)
Signed
Medical attendant:
Signed
Patient:
Signed
Witness:
Date
```

In the 1920s nearly one in ten patients left RPA Hospital venereal ward against the advice of their medical practitioner and were asked by attending medical practitioners to complete this certificate. Given the provisions of the VD Act 1918, many of these patients needed to provide evidence to the medical practitioner that they were leaving against advice. This certificate was developed to afford some protection to medical practitioners, who had to provide treatment, and who also had to notify. Whilst the mechanism for enforcing compulsion in the Act was under question the certificate could at least verify that the medical practitioner had opposed the

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535 Medical practitioners understood that not all children born to a woman living with syphilis would necessarily be syphilitic. Drs Kenny and Gamble detailed a case of a married woman who contracted syphilis through wet-nursing, remained unaware of her infection for many years, and was eventually admitted to an asylum with general paralysis of the insane. During the time that the patient was infected, and did not know of her infection (referred to as an occult infection), she had five children, only three of whom were positive to the Wasserman reaction. The authors note that these children ‘will probably marry, and being themselves the subject of syphilis, their children are liable to be below standard, possibly epileptics, or sufferers from other neuropathies’ (Medical Journal of Australia, March 1916, p. 222).

536 It should be noted that this type of Certificate is still widely used when patients discharges themselves from hospital against medical advice. This type of Certificate is not unique to venereal diseases.
premature discontinuation of treatment. The VD Act provided for the notification of patients who discontinued treatment and did not return within 10 days. May W was in fact readmitted three days after signing the certificate, but left again shortly after. She returned three months later, delivered her child ‘under light chloroform anesthesia,’ and left the hospital against advice, again, after two weeks. There is no evidence on the medical record that May W was notified for these breaches of the legislation. It is very important to note however that this one individual could well have been notified three times for discontinuing treatment, a point I examine in chapter 4.

There were significant differences in the treatment journeys of venereal patients before and after the VD Act 1918. Female inpatients spent far shorter periods on the venereal wards, averaging two months between 1910 and 1918, and two weeks in the 1920s. More patients were discharged from the wards to become ambulatory patients of the outpatient clinic, and more rapidly. Most patients were still poor young women, who worked in domestic service, and presented with issues related to venereology and gynaecology. Most curiously, however, there appears to have been a shift in patient conscientiousness and compliance before and after 1918, that is, before and after the legislation which made notification and treatment compulsory. Between 1910 and 1918 there is compelling evidence that venereal patients voluntarily arrived, began and continued painful treatments for long periods. By the 1920s, the medical records demonstrate that one in ten venereal patients were not continuing treatment, and were in fact leaving against the advice of their medical practitioner. These patients were labeled ‘defaulters.’ I will ask in 4 whether the new legislation, with its emphasis on notification and default reporting, changed patient attitudes and whether the element of treatment compulsion in the legislation actually changed the behaviour of venereal patients.

**Venereal patients and their medical records**

Venereal patients in NSW were significantly affected by the ambivalent treatment environment, and changing legislation. I aim now to contextualize these changes by

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mapping in detail the treatment journeys of a number of individuals whose medical records were kept by RPA Hospital. My analysis of the effects of changing treatment paradigms on those with venereal diseases is restricted to individuals as patients: evidence is only available for individuals when they came into contact with medical practitioners in public hospitals. A note of caution needs to be sounded in interpreting the evidence of the RPA Hospital medical records. As Porter has suggested, historians need to avoid the dangers ‘of anachronistic back-projection,’ a tendency which could be easily adopted in the history of patients and sickness. This tendency can lead to a judgmental interpretation of the evidence, where contemporary medical practices, methods and interventions can be perceived as insufficient, harmful or ineffective in the light of modern standards. Similarly, Gilman argues that there are complexities in attaching modern understandings of treatments and technologies to contemporary responses that were firmly rooted in their time when he asks: ‘the historian of medicine is not expected to be able to cure a stomach ache: should the historian of a particular historical method be required to solve the problems raised by its use? Historians of medicine are not physicians…historians of medicine are cultural historians.’

Before investigating actual medical records it is important to understand what constituted a medical record at RPA Hospital in this period. There was a detailed

\[540\] The patient was a relatively new object of study in medical history, according to Porter, writing in 1985 (Porter, R., Patients and Practitioners: Lay Perceptions of Medicine in Pre-industrial Society, Cambridge, 1985, p. 1). Porter argues that the very word ‘patient’ can be confusing because in early modern times the word denoted any person who was sick or suffering, and not necessarily a person ‘under a doctor.’ The ‘powerful connotations of passivity’ which currently apply to the word ‘patient’ may not have existed in the past. Notwithstanding these definitional quandaries, Porter acknowledges that the sick person, or patient, was often not examined in medical histories, and that the aim of his collection of essays is to ‘show that the sick constitute important objects of historical study.’ To this end, Porter details a relatively large historiography concerned with the impact of epidemics, the body, the relationship of sickness to religion, the language of sickness and popularised medical knowledge (ibid., p. 3). Porter argues that social historians generally ‘have given the sick a wide berth,’ and that if people were to become the subjects, and not just the objects of social history, then historians of sickness needed to create a history ‘from below’ (ibid., p. 7). Historians, as well, needed to create a history that avoided the dangers ‘of anachronistic back-projection,’ a tendency which could be easily adopted in the history of patients and sickness. In the fifteen years since Porter’s overview of the historiography of the patient, considerable work has been undertaken in just this field.

\[541\] Benjamin argues that well into the twentieth century, ‘where good and systematically compiled medical records did exist, it was usually due to the insistence of an individual doctor, or a group of doctors, or the entire medical staff of an institution, who wished to make use of them for a specific personal or collective interest of their own’ (Benjamin, B., Medical Records, London, 1980, p. 2).

\[542\] Porter, Patients and Practitioners, p. 20.

process for instigating, maintaining, cataloguing and storing medical records at the hospital in the first decades of the twentieth century, and this process changed somewhat during the period. Mitchell describes the case note system prevalent at Sydney Hospital in 1920:

Surviving material dates from the introduction of a modified Bertillion system of disease classification, adapted from that in use at RPA Hospital in 1920, and formally adopted by Sydney Hospital from 1922. Each set of case notes was assigned two index code numbers, enabling unit location as either part of a disease series, or numerically according to when the patient registered. When fifty sets of papers in a disease classification had accumulated in filing cabinets, they were bound and then shelved.\textsuperscript{544}

Mitchell’s description of the Bertillion system was based on the American Medical Association’s \textit{Standard Nomenclature of Diseases and Operations},\textsuperscript{545} which listed fifty diseases for classification and binding. In 1942 this was reduced to 25 disease classifications.\textsuperscript{546} The Bertillion system was not only a way of ordering and classifying patients’ notes, but also a way of understanding and knowing diseases and infections. Research in the Secondary Medical Records Depository at RPA Hospital indicates that in relation to syphilis and gonorrhoea, the Bertillion system had been in operation since at least 1910. Batches of syphilis and gonorrhoea medical records were located at RPA Hospital.\textsuperscript{547} The Bertillion system of maintaining medical records at RPA Hospital was predicated on the totalising nature of the disease, and clusters of abstracted patients being categorised, recorded, historicised, treated and known according to their disease. Each set of fifty medical records was bound together in a volume, given a serial number, and filed. Each medical record included nursing notes and charts, notes from medical practitioners, treatment regimes and pathology request and result forms. Given that syphilis and gonorrhoea patients were

\begin{flushleft}
\textsuperscript{545} Ibid., p. 136.  
\textsuperscript{546} Ibid., p. 116.  
\textsuperscript{547} Investigations with the Chief Archivist at RPA Hospital indicated that many medical records from the period 1910–1920 were still being held in a secondary depository. With permission, I sorted through the thousands of batched medical records, and recovered nearly a full set of records relating to gonorrhoea and syphilis for the period.  
\end{flushleft}
treated separately in specific outpatient departments, and when hospitalised, were assigned beds in specific venereal wards, the classification of medical records by disease simply reinforced this segregative approach.\textsuperscript{548}

Each medical record began with a printed front covering page with a set of categories to be completed. It should be noted that the front pages of the medical records were diligently and thoroughly completed, most probably by the clinical clerk, who also signed off when the file was completed.\textsuperscript{549} The records have been interrogated according to themes, and case histories will be presented to demonstrate these themes. After the front page, the medical gaze became more intense. Medical practitioners’ notes varied from peremptory to exhaustive. The handwritten notes of medical practitioners were guided by the pro-formas embedded in the record, and a range of detailed categories outlined by the hospital had to be completed. These categories included complaint and duration, family history, personal history (including sexual history), present illness and the outcome of a physical examination. The medical record pro forma was structured as follows:

\begin{center}
\begin{tabular}{|l|}
\hline
\textbf{GENERAL HISTORY} \\
\hline
1.\textit{Anamnesis} \\
\hspace{1cm} Complaint and Duration \\
\hspace{1cm} Complaint must as far as possible be written in patient’s own words. \\
\hspace{1cm} The Family History \\
\hspace{1cm} Date, Age and cause of death, Gout, Rheumatism, Syphilis, TB, alcoholism, neoplasms and nervous affections, and malformations \\
\hline
\end{tabular}
\end{center}

\textsuperscript{548} The following sets of medical records related to venereal diseases were located in the secondary repository, and form the basis for this interrogation of the medical records:

\begin{center}
\begin{tabular}{|l|ll|}
\hline
Disease & Year & Serial Nos \\
\hline
Syphilis 1 & 1910–14 & 1–50 \\
Syphilis 111 & 1912–13 & 201–250 \\
Syphilis 111 & 1913–14 & 251–300 \\
Syphilis 111 & 1914–15 & 301–350 \\
Syphilis 111 & 1915 & 351–400 \\
Syphilis 111 & 1915–16 & 401–450 \\
Syphilis 111 & 1916 & 451–500 \\
Syphilis 111 & 1916–17 & 501–550 \\
Syphilis 1 & 1920–28 & 101–50 \\
Syphilis 1 & 1927–31 & 951–1000 \\
Gonorrhoea & 1918 & 1151–1200 \\
Gonorrhoea & 1919–20 & 1301–1350 \\
\hline
\end{tabular}
\end{center}

\textsuperscript{549} The following information was gathered on the front page of the medical record: Name, Address, Register No., Ward, Age, Social Condition, Religion, Occupation, Country, Date Admitted, Date Discharged, Disease/Result, Operation/Result, Clinical clerk, Nurse in Charge, Resident Medical Officer, Remarks.
2. The Personal history
   a) Environment and Habits
   Hygienic conditions of home, residence in other lands, occupation, hours and exposure, diet, alcohol, tea, coffee, tobacco, drugs, exercise, sleep, clothing.
   b) Sexual History
   Menstruation, intermenstrual discharges, pregnancies, pareunia.
   c) Previous Illnesses, Accidents
   Their date, duration and severity, measles, scarlet, diphtheria, syphilis, gonorrhoea, malaria, typhoid, TB, gout, rheumatism, diabetes, convulsions, epilepsy, other nervous affections, neoplasms, cardio-vascular diseases, plumbism etc.

3. The Present Illness
   a) Cause, date and manner of onset
   b) Order of subsequent systems up to present time
   c) Symptoms now present
   d) Previous similar attacks and their treatment.

4. Physical Examination
   Temperature, pulse, frequency, rhythm, tension, blood pressure, respiration, dyspnoea, cough, voice, general state of consciousness and intelligence, temperament, facial expression, attitude, gait, general deportment, dress or decubitus, general state of development and nutrition, height, weight, girth, configuration of thorax, size and shape of head, special characters of hands, cutaneous surface, degree of moisture, complexion, pallor, plethora, jaundice, cyanosis, pigmentation, oedema, emphysema of skin, eruptions, hair, trophic changes, glandular enlargements.

5. General condition

Apart from the fact that the medical practitioner’s gaze was singularly directed by the hospital to particular observations, there are a number of general observations to be made about the structure of the medical record. The complaint and duration had to be ‘as far as possible written in patients own words.’ The medical practitioner was encouraged to hear the patient, and to record what he heard faithfully. Writing at the time, however, Henry McKisack, cautioned that when patients made ‘statements involving a diagnosis’ it ‘should be recorded with some indication that it is unverified information – quotation marks serve the purpose.’ Clearly, the patient was heard and recorded, but recorded in such a way as to identify suspected attempts at self-diagnosis. In practice, the medical practitioner heard only a small, designated and oft-repeated set of symptoms that conformed to his view of the disease, or the suspected diagnosis.

Occasionally the medical practitioner would record a phrase in inverted commas which was meant to suggest the voice of the patient, and this is the most accessible the patient becomes in the medical records. It is worth noting as well that when asked to complete the section on ‘sexual history’ the key instructions related to reproductive, and women’s health, and included no examination of risk factors for infection, or issues related to men’s health. Both syphilis and gonorrhoea were mentioned a number of times, but not under ‘sexual history,’ as if these diseases were general infections unrelated to sexual activity. Finally, the physical examination was exhaustive and included craniometric observations, observations based on older taxonomies, and social characteristics. Medical practitioners rarely completed this section, but the intention was to direct the gaze towards the look of the patient, both physically and socially.

Many medical practitioners were acutely aware that the medical record served a significant medico-legal function. L. W. Harrison, an ex-Army doctor who became a leader in venereal diseases treatments in the United Kingdom writing in 1918 argued that clinical notes were the best defence against ‘trumped up charges of negligence’ and that many medical men found themselves implicated as witnesses in civil or criminal trials involving questions of venereal diseases. Most commonly, these legal matters were related to marriage and employment, and if the question revolved around the accuracy of a syphilis diagnosis, Harrison argued that pathological proof was indispensable, whilst symptomallogical and therapeutic evidence were not. Harrison also argued that legal situations related to the treatment of venereal diseases were becoming increasingly common for a number of reasons. These included ‘the dissemination amongst the public of so much curious and imperfect knowledge,’ the knowledge amongst the public that venereal diseases ‘may be contracted otherwise than in sexual intercourse,’ the much discussed fear that a medical practitioner could in fact pass on the infection non-sexually and the general imprecise nature of diagnosis and treatment meaning that patients who were cleared to marry because they were cured may have remained infectious to their partners. Medical practitioners were at risk of being challenged for breach of confidence, and for libel and slander, and Harrison argued that these actions particularly applied when ‘the words alleged to have been uttered impute venereal disease.’ Working from their medical records, medical practitioners were also often required to provide diverse certificates to
venereal patients. Harrison argued that the need for accuracy on a medical certificate needed to be tempered by an understanding of stigma, that ‘venereal disease does occur without personal wrong doing,’ and that a medical practitioner could state that as far as he was aware ‘the disease is not due to the misconduct of the patient.’

Other historians, but apparently very few, have investigated medical records as a way of developing histories of specific groups of patients or illnesses. McCalman claims in her recent history of the Women’s Hospital, Melbourne ‘that for the first time in the English-speaking world, a historian has been permitted to work directly from patient records. Thousands of detailed case notes, from the 1850s to the 1930s, have remarkably survived intact.’ I am fortunate therefore in having a precedent in this examination of the venereal records from RPA Hospital. McCalman’s aim was to use case histories ‘as a window into the private lives and reproductive health of poor women over the past century and a half.’ Looking through a ‘window’ into confidential medical records runs the risk of becoming voyeuristic. McCalman recognises this potential when she suggests that ‘some readers may find what follows too graphic for comfort. The use of case histories is not gratuitous, however, but carefully considered. This is a history of medical and surgical practice, of nursing techniques and of medical culture; that is, of a hospital at work, and we need to see clearly what that work was and what its consequences were.’ McCalman does in fact methodically chart changes in medical and surgical practice, and her text

551 Harrison, The Diagnosis and Treatment of Venereal Diseases in General Practice, pp. 428–433, p. 455, p. 441.
554 Ibid., p. viii.
555 Ibid., p. ix.
marginalia, which explain contemporary medical practices, place the medical records in a broader social and cultural context.\textsuperscript{556} I am however only peripherally concerned with technique: my aim is to utilise the medical records to evidence the medical gaze, to explore the dynamic existing between the medical practitioner and patient, to listen to those traces of the venereal patients’ voices that remain, and most importantly to provide specific examples of the ambivalence which existed towards treating venereal patients.\textsuperscript{557}

\textbf{John S. – effecting a cure?}

John S. was a patient of both the venereal wards and the Outpatient Clinique at RPA Hospital who first presented in 1916, at a time when mercury and arsenic were jointly used as treatment responses and when the PD Act 1909 was the only operational venereal diseases legislation in NSW. His journey from admission to discharge provides an intimate account of the relationship between the patient and the teaching hospital. There was not one single medical record for John: each time he entered the hospital or attended the Outpatient Clinique a new medical record was started. There were ten medical records related to John.\textsuperscript{558} The front page of each medical record, containing all personal and demographic information, was completed on each occasion, as though John was new to the hospital each time he presented. John first presented at 2.15 p.m. on 3 November 1916, at which time he was diagnosed with tertiary syphilis and syphilitic meningitis. The following details were recorded on John’s first visit:

\textsuperscript{556} Some of the ways in which historians can use patient records have been discussed by Warner. Warner stresses that medical records can be most effective as sources when used in conjunction with other evidence – including texts, images or artefacts. In relation to medical texts, Warner argues that the comparison of the medical record and text can lead to an acknowledgement of the disparity between normative statements and actual practices. By comparing patient’s notes with pathology journals, historians are able to observe some of the processes involved in clinical decision-making. Warner recognizes that most patient records come from institutional sources, including hospitals, asylums and outpatient clinics. For historians, as well, charting the formal transformation of the medical record over a period of time can also provide valuable insights into epistemological sensibilities (Warner, J. H., ‘The Use of Patient Records by Historians,’ \textit{Health and History}, 1999: 1: pp. 101–111).

\textsuperscript{557} The medical record was informed by the actual case history undertaken by the medical practitioner, which generally occurred at the first consultation of medical practitioner and patient. In 1926, Dr James A. Corscaden provided a theory and practice of medical history-taking which demonstrated prevailing ideas related to the ‘case history’ (Corscaden, J. A., \textit{History Taking and Recording}, New York, 1926, p. 9).

\textsuperscript{558} Royal Prince Alfred Hospital medical record, \textit{Syphilis 111}, Year 1916–17, Serial Nos 501–550.
Serial No.: 509  
Name: John  
Address: Mrs John, Glebe  
Ward:  
Age: 23 years  
Social Condition: Single  
Religion: Presbyterian  
Occupation: Paper Seller  
Country: New Zealand  
Admitted: 3 November 1916 Hour: 2:15pm  
Discharged: 29 December 1916 Hour: 3:00pm  
Disease: (1) Syphilis ($) TTT (2) Syphilitic meningitis  
Result: (1) and (2) relieved  
Operation: 9 Lumbar Punctures with anaesthetic  
1 Lumbar Puncture without anaesthetic  
Resident Medical Officer: C McDonald

Subsequent pages in John’s initial medical record fleshed out his presenting symptoms, and other aspects of his medical history. John’s initial complaint upon presentation was recorded as ‘headache and vomiting and loss of memory for two weeks.’ The medical practitioner recorded this in the section where he was requested to write in the patient’s own words the nature of the complaint and its duration. To indicate that he was approximating to John’s articulation of symptoms, the medical practitioner placed inverted commas around the phrase. The medical practitioner recorded that John had a father who died at 62 of Bright’s disease (this disease was often associated with syphilis) and a mother who was alive and well. John also had three brothers and three sisters who were alive and well. One sister had died five months previously in Sydney Hospital of meningitis and two other siblings had died of unknown causes. Other recorded information tells us that John was born in New Zealand, smoked one packet of cigarettes per day, ‘had syphilis two years ago’ and had ‘slightly stammering speech.’ Under General Comments the following was recorded:

559 Royal Prince Alfred Hospital medical record, Syphilis 111, information extracted from cover sheet of Serial No. 509.  
560 Bright’s disease is a broad descriptive term once used for kidney disease with proteinuria. The name Bright’s disease is derived from a description of the diseases published in 1827 by Richard Bright, an English physician.
Patient looks ill – he is mentally slow and very irritable. His body, lips and tongue are tremulous. He breathes through his mouth. Patient was quite well 2 weeks ago, when he suddenly got a severe frontal headache which ‘sent him silly,’ followed by vomiting. Since then he has had about 12 attacks and his mental condition has changed. He has become irritable and excitable and lost memory. No pain in back or limbs.

Again, the medical practitioner enclosed in inverted commas phrases that he wished to attribute to the patient. Somehow, unusually, John got hold of his medical record. Perhaps during a consultation when the medical practitioner was absent from the room, John left his mark. He wrote in his medical record:

\[\text{John}\]
\[\text{I wont go homes}\]
\[\text{Im 22 years old}\]

Not only then do we hear John filtered through the medical notes, but we see the script of John as he corrected the record which stated that he was 23 years old, and stated his desire to stay away from home, or to go home. John’s statement places him in the domain of the subaltern.\footnote{561}

Because there were no specific venereal wards for men at RPA Hospital John was resident in the general ward from 3 November 1916 to 29 December 1916: nearly two months, including Christmas. During his hospitalisation John had 10 lumbar punctures, a diagnostic procedure to test for the presence of neuro-syphilis, and thirteen pathology tests, including results which indicated that he was Wasserman negative and tuberculosis negative.\footnote{562} A negative Wasserman would indicate the

\footnote{561}{I have found notions of the subaltern, and readings in subaltern studies, useful in locating the voice of the venereal patient. See Spivak, G., \textit{In Other Worlds: Essays in Cultural Politics}, New York, 1987; and Alam, J., ‘Peasantry, Politics and Historiography: Critique of New Trend in Relation to Marxism,’ \textit{Social Scientist}, v. 1983:11: p. 43.\footnote{562}{Bayly, H. W., \textit{Venereal Disease: Its Prevention, Symptoms and Treatment}, London, 1919, pp. 27–29, discusses lumbar punctures and provides illustrations (p. 165). It is important to note that the lumbar puncture remains a significant diagnostic tool today, although it is probable that multiple lumbar punctures would be performed on the one patient in a short period of time.}}
absence of the syphilitic spirochete, so there must be some question as to whether John had syphilis.

Upon John’s discharge, his medical record noted that he was ‘relieved’ of both tertiary syphilis and syphilitic meningitis. The medical practitioner hadn’t ‘cured’ John, and we don’t know whether John believed that he could be cured or whether he believed he was cured. Ultimately the medical practitioner knew that he could only relieve symptoms. This was the silence between the medical practitioner and the patient: the unspoken expectations and attitudes towards diagnosis, relief of symptoms and treatment of cure. Having been relieved of his symptoms, John returned for ongoing diagnostic procedures, and during the next three months attended the Outpatient Clinique on ten further occasions for lumbar punctures.\(^{563}\)

This regime of lumbar punctures was punishing, so punishing in fact that the medical practitioner finally advised suspension of the procedure. On 8 May 1917, John was treated for ‘specific meningitis,’ having previously been diagnosed with ‘syphilitic meningitis,’ despite having a negative reaction to the Wasserman reaction. In his surviving batch of medical records, John was not treated with intravenous Salvarsan. This may well have been because he was Wasserman negative.

**Amelia W. – venerealising the patient**

For some patients, many non-venereal conditions were treated as expressions of the venereal: patients, like hospitals, could be venerealised. Similarly, many issues related

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\(^{563}\) Royal Prince Alfred Hospital medical records, *Syphilis 111*, Serial No. 510 – 3/1/17 First admittance for weekly lumbar puncture; Serial No. 513 7/1/17 Admitted for lumbar puncture; Serial No. 515, 24/1/17 Admitted for lumbar puncture; Serial No. 517, 31/1/17 Admitted for lumbar puncture; Serial No. 520, 8/2/17 Admitted for lumbar puncture; Serial No. 521, 14/2/17 Admitted for lumbar puncture, for syphilitic meningitis; Serial No. 524, 26/2/17 Admitted for lumbar puncture, for specific meningitis; Serial No. 531, 8/3/17 Admitted for lumbar puncture; Serial No. 534, 15/3/17 ‘Patient was admitted for lumbar puncture but none was done as Dr Mills advise suspension for a period, Discharged’; Serial No. 543, 8/5/17 ‘Patient previously treated for specific meningitis, now complaining of headache and Dr Mills wished him to be readmitted into hospital to have lumbar puncture performed under general anaesthetic.’
to fertility or reproduction in women were interpreted as expressions of venereal infection. Added to this conflation of categories was the tendency to elide relief of symptoms, and treatment. This elision implied a capacity to treat in order to relieve symptoms, and a concomitant capacity to treat to effect a bacteriological cure. The medical record of Amelia W. evidences these phenomena: venerealisation of the non-venereal, including fertility, and elision of treatment and symptomatic relief. The record also presents fragments of the patient’s life outside the hospital, with reflections on Amelia’s parlous economic and social circumstances.

Amelia W was a 59-year-old woman, at her first consultation resident in Surry Hills. With her occupation listed as domestic duties,\textsuperscript{564} she was admitted on 4 May 1916 with abdominal pain. The admitting medical practitioner gave two diagnoses: both syphilis and a wandering spleen. After having her abdomen tapped, or an abdominal paracentesis, Amelia was discharged the next day.\textsuperscript{565} Tapping, like the puncturing undertaken on John S, was a common procedure: this one allowed for an abdominal puncture for the aspiration of fluid. The procedure was mostly undertaken to remove excess fluid in the peritoneal cavity of a patient with cirrhosis of the liver, although it was also a procedure used to drain an ovarian cyst. During the procedure, the amount and character of the fluid obtained was recorded. The medical record also listed all previous occasions when Amelia was admitted for a ‘tapping’: 5 November 1914, 20 November 1914, 19 April 1915, 27 July 1915, 20 November 1915 and 15 March 1916. Upon her discharge Amelia’s results were recorded as ‘relieved.’ The relief would appear to have been short-lived because Amelia was admitted again on 15 March 1916 and on the following dates throughout that year: 18 July 1916, 14 August 1916, 19 September 1916 and 20 December 1916. Over a period of two years, Amelia was admitted on 11 occasions, mostly only for one night, to the venereal ward to be tapped.

Throughout the medical records of patients with syphilis, tapping was a common procedure. Bowra has indicated that since the early 18\textsuperscript{th} century tapping had been the preferred method of treatment for ovarian cysts, and during this surgical procedure, a

\textsuperscript{564}Royal Prince Alfred Hospital medical records, \textit{Syphilis 111}, Serial No. 453.
\textsuperscript{565}Tapping is the surgical puncture of a cavity for the aspiration of fluid, and abdominal tapping involves the insertion of a trocar through a small incision and into the abdominal cavity to remove ascitic fluids. Tapping, as a procedure, was designed both as a treatment and a symptomatic relief.
needle was inserted into the cyst and the fluid drained.\textsuperscript{566} By the nineteenth century, ovariotomy had replaced tapping as the preferred method of treatment for ovarian cysts, although tapping still occurred. With many who presented at the Outpatient Clinique for tapping the procedure appeared unrelated to the diagnosis of syphilis. The medical records show a tendency to conflate diagnostic procedures, treatments and symptomatic relief. Patients were often not aware of the purpose of particular approaches. This was certainly the case with Amelia, for whom ascites would appear to have been the primary diagnosis.\textsuperscript{567} However, because an earlier Wasserman reaction had indicated the presence of the syphilitic spirochete, Amelia was treated for a non-venereal condition in the venereal ward. This tendency towards venerealisation was noted at the time of the Outpatient Venereal Clinique. Writing in 1919 Hugh Wansy Bayley noted:

\begin{quote}
The treatment of gonorrhoea and syphilis unfortunately must always be largely based on personal idiosyncrasy and is not, therefore, suitable to any dogmatic routine or stereotyped schedule, and some experienced practitioners consider that at the present there is a tendency to over-treat these diseases, with the result that occasionally men suffer more from the effects of treatment than they would have suffered from the diseases themselves ... a positive Wasserman reaction unsupported by any other evidence also appears to be too often accepted as conclusive evidence of active syphilitic infection.\textsuperscript{568}
\end{quote}

After a particular visit in September 1916, the medical practitioner recorded about Amelia:

\begin{quote}
Patient was rather disturbed this morning… patient went out this afternoon. Her condition is getting steadily worse each time of admission.
\end{quote}

\textsuperscript{566} Bowra, J., ‘Ovariotomy as a History of Thought,’ paper presented to the Social Change in the 21\textsuperscript{st} Century Conference, Queensland University of Technology, 22 November 2002, p. 4.

\textsuperscript{567} The condition of ascites has various possible underlying causes. Today, ovarian cancer would often be the most common cause. The pressure caused by the build-up of ascites is most uncomfortable, and causes extreme breathlessness. The pain associated with the tapping procedure, in Amelia’s case, would have had to have been balanced by the pain associated with the condition itself. Tapping was the only surgical control of ascites utilised by medical practitioners at the time of the Venereal Clinique. At the risk of medical back projection, it should be noted however that this procedure is now considered only a temporary measure that poses problems of rapid fluid shift, loss of protein, and the potential for introducing infectious agents into the peritoneum.

\textsuperscript{568} Bayley, Venereal Disease: Its Prevention, Symptoms and Treatment, pp. xiii.
Amelia’s steady decline may have been to some extent a result of the diagnostic imprecision which was applied to her conditions. Over the two years that Amelia attended the venereal ward, and after 11 tappings, a number of diagnoses were recorded in the case histories, and these varied widely in the space of three months. We are able to witness this imprecision because each time Amelia attended a new medical record was begun. Certainly, with a reasonable continuity of medical staff, medical practitioners would have known Amelia, but this did not produce diagnostic uniformity. Amelia was diagnosed with the following conditions on the following dates: 4 May 1916 – syphilis, wandering spleen; 15 March 1916 – syphilitic liver, moveable spleen; 18 July 1916 – syphilis, wandering spleen, and ascites; 14 August 1916 – syphilitic sclerosis of the liver; 27 December 1916 – syphilis, ovarian cyst, and wandering spleen. The notes made by medical practitioners in Amelia’s medical records during 1916 indicate the slow deterioration of her health. On 5 May 1916, the medical record indicated:

Feels quite well. Abdomen still very distended, but fairly resonant. Eyes react:
Legs not so swollen.

Then again, on the 14 August 1916, the medical record indicated:

Patient readmitted for tapping: feet have swollen considerably this time and patient looks very white and drawn. Has some cough. Spleen is enlarging, and liver seems to have a prolongation down right side: was given a note to go to Newington

Newington was a state hospital for the indigent poor, and had been mooted by Dr Herbert Schlink as a reasonable place to establish a venereal ward for ‘case-hardened prostitutes.’ During March and April 1916 negotiations did in fact take place about the necessity of establishing a ward at Newington for ‘case-hardened’ prostitutes who were considered to be inappropriately placed with non-prostitutes at RPA Hospital. This ward eventually opened in August 1916, and Amelia would have been one of the
In a subsequent medical record (19 September 1916), Amelia ‘would not stay in Newington,’ although we do not learn why. Amelia’s deteriorating health was linked to her accommodation crisis. During 1916, the medical records chart the shifts in Amelia’s accommodation. The following residences were listed:

15 May 1916 Living alone at Lakemba
4 May 1916 Living in Surry Hills
18 July 1916 Living at Campsie
14 August 1916 ‘was given a note to go to Newington’
19 September 1916 ‘would not stay in Newington’

Not only was there a regular change in Amelia’s accommodation, but her accommodation was often quite distant from RPA Hospital, necessitating a long journey to be tapped. The final medical record for Amelia, from September 1916, stated:

Patient was admitted today to be tapped ... Looks very pale and white. Would not stay in Newington. Spleen is further enlarged: will not take medicine regularly.

Amelia eschewed offers of institutional accommodation and refused to comply with medication. Despite not taking medicine regularly Amelia appeared to be a conscientious patient over the two years she attended the venereal ward regularly and willingly for painful procedures. Amelia’s attendance at the venereal ward may have caused her considerable emotional distress, particularly given that the procedures and interventions performed on her were not specifically related to syphilis. Amelia was venerealised: her ascites, her possible cirrhosis, her possible ovarian cyst, were automatically linked to syphilis, when this may not have been the case. Amelia was on the roundabout of medical interventions: repeated procedures, living alone, accommodation crises, considerable pain, and having to attend the venereal ward. Amelia was caught in a world of medical uncertainty: being treated in the venereal

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569 I describe these negotiations in detail in chapter 2.
ward for non-venereal illnesses, and being caught in the shadow land between diagnosis and treatment.

**Reuben X., Victor Y. – treating poor young men**

Only a small number of the surviving medical records detail the venereal history of men and boys. Those that do relate similar stories to those of the poor young women who were treated on the wards: stories of tenacity and terror. Reuben X. had great difficulty in being heard by his medical practitioner and did not survive his admission to RPA Hospital. Victor Y. had a brief but harried stay in the venereal wards, and the medical records do not provide any real clues as to the eventual outcome. Both of these poor young men stand out, however, because of the fragments of their voices and experiences that echo in the medical records.

Reuben, a 23-year-old stoker on HMS Encounter was admitted to a general ward on 31 October 1916, and died five days later.\(^\text{570}\) Upon admission, Reuben was diagnosed with syphilitic meningitis and lobar pneumonia. Reuben’s troubles had started well before being admitted to the RPA Hospital:

> Patient admitted last night in semi conscious condition and unable to speak. Is stoker on HMS Encounter – treated on board for syphilis contracted 18/12 ago – by (several injections) of mercury. After one of which 14/12 ago he became paralysed on left side (supposed to be due thrombosis). Was treated on ship for six weeks and then in St. Vincent’s hospital for about six weeks – after which he appeared cured and went home to Sydney. Yesterday morning he became speechless.

Reuben’s treatment had been prolonged and problematic, undergoing a set of therapies both in the naval arena, and at a hospital not known for its treatment of venereal diseases. These treatments spanned a total of eighteen months, during which time Reuben appeared to have become progressively worse. Reuben clearly had

\(^{570}\) Royal Prince Alfred Hospital medical records, *Syphilis 111*, Serial No. 488.
trouble making himself heard during earlier treatment, and this did not cease after commencing treatment at Royal Prince Alfred. Reuben’s medical practitioner noted:

Patient looks healthy – lies restlessly and tosses about jerky legs and grinding teeth. Arms appear flaccid but he moves both voluntarily from time to time and will hold them up when told to do so. Legs in same condition. No actual paralysis detected. Can move tongue and face on demand. Understands what is said to him at least to some extent. Makes attempts to answer questions sometimes. Cannot understand written speech and will not attempt to write.

Reuben was not in a position to voice his illness, although he made valiant attempts ‘to answer some questions some times.’ Two days after admission, Reuben was given a lumbar puncture, and his position was described as ‘good.’ Despite this assessment Reuben died two days later at 2:30 a.m.

Not long before Reuben’s death a very modern adolescent drama was being acted out on the ward. On 17 July 1916 a 14-year-old stable boy from Bathurst, Victor Y., was admitted and diagnosed with ‘syphilis three.’ Victor was eventually discharged on 31 August 1916, after more than six weeks’ hospitalisation, and his condition was described as ‘relieved.’ Victor was not silent like Reuben. The following notes were made by the medical practitioner during the course of Victor’s hospitalisation. 18 July: ‘Patient has large ulcer on right hand side of face involving angle of jaw and neck beneath. Started as a swelling – painless – 6 months ago. Opened in Bathurst hospital. Opening is still present, ulcer being above and in front of it…slight yellowish discharge. Family history – father died of stroke, mother of chest trouble. No brother or sisters’; 20 July: ‘Boy has been missing from home since 7 January. Police notified. Says father ill treats him.’ 21 July: ‘Wasserman positive.’ 23 July: ‘Mother and father turned up today – eminently respectable and not dead’; 25 July: ‘Ulcer much smaller, tongue cleaner.’ 5 August: ‘Vast general improvement. Ulcer much smaller. Mouth and tongue very clean now.’

571 Royal Prince Alfred Hospital medical records, Syphilis 111, Serial No. 471.
Victor had been treated in Bathurst, and like Reuben, showed no signs of improvement. It is not possible to ascertain why Victor left Bathurst, but it may well have been to seek treatment for an ulcer that clearly was not healing. Victor felt compelled to describe himself as single; as not part of a family. Victor may have denied his family because he did not want to be returned or because he did not want them to be aware of his presence in the venereal ward. There is clear evidence from other sources that treatment facilities in regional areas were minimal, and many young people had to make the trip to the city.572 During this period as well the construction of ‘adolescence’ as a staging post between childhood and adulthood was occurring. Scott argues that the focus of public health in relation to venereal diseases in the first two decades of the century shifted from prostitutes to young people, and that this shift had significant consequences, particularly in the development of preventative programs.573 Certainly, a range of organisations were discussing adolescence, and not only in the context of ‘amateur’ prostitutes: the Workers Education Association in 1919 held the first conference in NSW in adolescent health.574 Victor’s anonymity only remained intact for a couple of days. Within two days of admission, the medical practitioner had unearthed a range of information related to Victor. Victor had been missing from home for nearly six months, the police had been notified, and the medical practitioner had questioned Victor as to why he had left home, with Victor responding that his father mistreated him.

By 21 July Victor’s Wasserman reaction was returned from pathology and Victor was confirmed as Wasserman positive. Only one Wasserman reaction was performed. The medical practitioner was in a quandary: a teenage, runaway boy with syphilis had brought himself to the venereal ward, and while the boy claimed mistreatment at home, the boy was still a minor. Within a week of admission, Victor’s parents arrived, ‘eminently respectable and not dead.’ Notes on Victor’s medical record end abruptly on 5 August, despite his discharge not taking place until 28 August. It remains impossible to describe Victor’s fate. Victor may not have made written notes on his

574 The Workers’ Educational Association held two relevant conferences related to young people in two years. Two reports were produced on these conferences: Workers’ Educational Association, Report on the Conference on the Teaching of Sex Hygiene, Newtown, 1918 and Workers’ Educational Association, Report on the Conference on Adolescent Health, Sydney, 1919.
medical record, as did John, but his stubborn presence speaks through the medical records. Victor desperately attempted to seek treatment, to remain confidential, and avoid mistreatment. Victor’s will alone got him from Bathurst to RPA Hospital, and to treatment.

Reuben X, John S and Victor Y were atypical patients of the venereal services at RPA Hospital: the overwhelming majority of surviving medical records relate to poor, young women. This is at clear variance with the evidence presented in the next chapter, which demonstrates that the majority of ambulatory day patients attending the Outpatient Clinique were men. This discrepancy is reflected in the perceived extra complexity of diagnosing and treating venereal infection in women, a complexity that necessitated prolonged stays in hospital. This discrepancy also reflected the perceived need to sequester women with venereal disease, to ensure that they had no sexual contacts. Tibbits addresses just this question when she asks: ‘Why were civilian women and not civilian men with VD isolated?’ Tibbits suggests two main reasons, one stressing that girls and women were perceived to threaten and contaminate the manhood and health of the race, and the other, more humanitarian rationale being that ‘young women who had gone astray needed to be properly treated, rehabilitated and returned to health.’ Despite these broader rationales, Tibbits argues that there were specific medical reasons for long hospital treatment for women, including for gonorrhoea the idea that ‘6 weeks to 2 months of vigorous treatment by the direct application of strong germicides to the whole length and breadth of the urethral and cervical canals was considered necessary to render non-infective a female with gonorrhoea.’ With syphilis, long isolated hospital treatment meant that women who were pregnant got appropriate care and treatment, and congenital syphilis could be detected. Prolonged, segregated treatment for women meant that they could be watched, that their sexual lives could be acutely monitored and that they had no opportunity for sexual contacts.

Mary F., Freda G., Ellen H., Lois I. – ‘relieved,’ ‘cured’ or ‘recovered’?

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575 Royal Prince Alfred Hospital medical records, Syphilis 111, Serial number 77.
577 Tibbits, ‘VD Behind Bars,’ p. 162.
‘Relieved,’ ‘cured,’ ‘recovered’ and ‘no sign of any syphilitic lesion,’ were the final prognoses on these four female patients who were treated at the venereal wards at RPA Hospital. All undertook Wasserman reactions, and all were treated with Salvarsan. The Wasserman reaction was used as both an initial diagnostic tool and as a confirmatory test to determine the efficacy of the intervention with Salvarsan.

In 1912, Browning and Mackenzie suggested that ‘due caution must be used in speaking of a permanent cure. Several years must elapse before the real value of Salvarsan can be estimated. At present we can only provisionally judge of probable cure, on the one hand by the disappearance of the signs and symptoms of the disease, and on the other hand by the permanent establishment of a negative Wasserman reaction.’ ‘Completely positive,’ ‘nearly completely positive,’ ‘negative,’ and ‘incomplete positive’ were some of the results of the Wasserman reaction achieved by these women. There were clearly inherent limitations in the interpretation of the reaction and practitioners were only able to use the diagnostic tools that were available.

On 17 August 1912 Mary F., a 22-year-old single shop assistant from Arncliffe was admitted to the venereal ward and diagnosed with both syphilis and gonorrhoea. Mary was discharged on 25 September 1912, re-admitted, and finally discharged on 5 October, after six Wasserman tests and five treatments of Salvarsan. The following results were recorded for Mary’s Wasserman reactions:

<table>
<thead>
<tr>
<th>Date</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>20/8</td>
<td>Complete positive</td>
</tr>
<tr>
<td>27/8</td>
<td>Complete positive ++++</td>
</tr>
<tr>
<td>12/9</td>
<td>Nearly complete positive +++</td>
</tr>
<tr>
<td>26/9</td>
<td>Negative</td>
</tr>
</tbody>
</table>

McDonagh, in *The Biology and Treatment of Venereal Diseases*, described a consultation with a patient, for whom the ability to effect a cure with Salvarsan was paramount. McDonagh wrote: ‘A strong, healthy looking man with early generalised syphilis once consulted me. His first question was, Have I syphilis? His second question was, Can I be cured? He afterwards informed me that, if I had not answered his second question in the affirmative, he would have done away with himself’ (p. 484).

Experiments that attempted to determine the efficacy of Salvarsan were also conducted amongst patients in asylums at Gladesville and Callan Park in NSW. Eric Sinclair, the Inspector-General of the Insane, reported on an experiment where patients were injected with Salvarsan, and then the serum of the patient was drawn and used as a remedial agent, being re-injected back into the spinal cavity. Sinclair reported that this treatment produced a slight improvement in paralysis, and a significant improvement in mental condition (*NSW Select Committee*, p. 18).


Each of these results were recorded on a separate pathology request form, the top half of which was the request from the attending medical practitioner and the bottom half of which recorded the results from the pathologist. Recorded against the result of ‘complete positive’ for 20 August 1912, the pathologist wrote: ‘please put in sex and whether married.’ The medical practitioner had left blank the section of the request form that designated these responses. The pathologist required some sociological markers in his assessment of the blood, indicating as Lupton has suggested that ‘a diagnosis based on a medical test is not a purely objective, technical event, but relies upon the social context of both doctor and patient.’ Mary’s results were largely ambiguous over the 7 weeks that they were taken. Mary’s blood tests ranged from negative to completely positive and the pathologist had developed a system of plus signs to categorise the degree of positivity. McDonagh reported that at this stage the Wasserman reaction was an imprecise tool, and in these early days of the administration of Salvarsan, it was being used extensively as a measurement of the efficacy of treatment. McDonagh recorded that ‘antisyphilitic treatment has the power of converting a positive Wasserman into a negative,’ but this could change literally overnight, so that a patient could be given no guarantees, ‘however long his blood had been negative.’ Upon Mary’s discharge the medical practitioner reported that Mary had been ‘relieved’ of syphilis and was ‘recovered’ from gonorrhoea.

Freda G. was a 22-year-old married woman, resident in Leichhardt, who was admitted to the venereal ward on 28 October 1912. Freda was diagnosed with syphilis 1 and 2, presumably referring to both primary and secondary syphilis, and during her first visit to the ward was treated with intravenous Salvarsan on two occasions. Freda remained in the ward until 6 November 1912. The following notes were recorded on Freda’s admission: ‘Patient is an immigrant arrived 4 months ago from England. Is married however: has had a macular rash on body for a fortnight, sore on vulva for one month.

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582 These sociological markers were not required for notification purposes, because syphilis was not to become a notifiable disease in NSW until 1918.
584 McDonagh, J. E. R., Salvarsan in Syphilis and Allied Diseases, pp. 56–57.
585 Ibid., p. 57.
Has been living with her husband who is also an English man. Hair is not falling out but has had a very sore throat.’ Freda was asked to return to the ward on 11 November for further treatment, which she did, and on this occasion it was recorded: ‘Patient readmitted for injection of 606. See previous history. Now has no sign of any syphilitic lesion. Given .4 gramme 606 intravenously.’ The medical practitioner underlined ‘no sign’ of ‘any syphilitic lesion’ himself in an apparent acknowledgement of the pronounced efficacy of Salvarsan as a treatment of syphilis. It should be noted that Freda’s symptoms were indicative of both primary and secondary syphilis, and that the sore on the vulva, or the lesion, would be indicative of primary syphilis. If this initial sore was a chancre, then its eventual disappearance without the use of Salvarsan would have been guaranteed.

On 9 May 1912 a 33-year-old married woman from Redfern, Ellen H., presented at the venereal ward with a chancre on the lip. Ellen was described by her medical practitioner as being ‘a well developed healthy looking woman with no sign of pain.’ Ellen was in hospital for just over a month, being discharged on 8 June 1912. During this time she was treated four times with intravenous Salvarsan. Upon discharge the medical practitioner, for the first time in the medical records (1910–1920) wrote the word ‘cured’ beside the category ‘results.’ Ellen was certainly cured of her chancre, but the attending medical practitioner would have been aware that the initial chancre disappeared by itself, without Salvarsan. Ellen was hospitalised for a month, treated with painful intramuscular injections, and ‘cured.’

Lois I., a 25-year-old single mother from Strathfield, was admitted on 15 March 1913 and diagnosed with primary syphilis. Lois’s medical record utilised the detailed pro forma outlined above, and the following notes were made against certain categories:

*Complaint and duration:* ‘Painful swelling under jaw on left side for month and sore between lower lip and gum.’

586 Fluker indicates that some of the effects of syphilis were the same as some of the side effects of being treated with Salvarsan, particularly optic atrophy (Fluker, J., ‘Personal Reminiscences of a Venereologist before Penicillin,’ pp. 443–446).
587 Royal Prince Alfred Hospital medical records, Syphilis 111, Serial number 12.
588 Royal Prince Alfred Hospital medical records, Syphilis 111, Serial number 30.
**Environment and Habits:** ‘Is a servant girl – lives a quiet life.’

**Sexual History:** ‘Has had one child – periods regular.’

**Previous Illnesses:** ‘About one month ago patient noticed an ulcer between the lower lip and alveolar margin which gradually extended in size and was very painful. She attributed it to a misfitting lower set of false set of teeth. About one week later she noticed a lump between her jaw on the left side which grew to about the size of hen’s eggs, and became red and painful. Three days ago she noticed a lump on the right side of her neck below the jaw which grew to about half the size of a hen’s egg and was painful to touch. No rash. No sore throat.’

The information recorded against each category was minimal, but we can observe that by 1913, and with the new structured record as opposed to the informal ‘Bedside Notes,’ the medical practitioner was including relevant medical history and environmental notes. There was also a very detailed description of the ‘previous illness,’ which referred regularly to her interpretation of events and historical recollection. This interpretation of Lois’ medical record is not inserted so as to suggest a progressive improvement in history-taking or case-notes, or a more conscious attempt by the medical practitioner to hear the voice of the patient, but simply as an example of medical records that did work. In other words, medical records which reflected the quiet, persistent and subdued voice of the patient and the attentive attitude and demeanour of the medical practitioner. Over a period of one month, Lois was treated with intravenous 606 twice, and was discharged with a firm ‘relieved’ of symptoms against her name.

**Conclusion**

Chronic and acute, epidemic and endemic, treatable but not curable: these were some of the dichotomies that engendered ambivalence in the management of venereal diseases. This ambivalence lay at the heart of how the category of the ‘venereal’ was constructed in NSW in the first three decades of the twentieth century: an ambivalence that generated positive and negative outcomes. Ambivalence towards people with either gonorrhoea or syphilis was rooted in deep-seated stigma and a fear of venerealisation. This fear of venerealisation operated at an individual and an institutional level: hospitals were arranged, wards were administered, spaces were
organised, contacts were minimised and individuals were treated or not treated so as to avoid the possibility of moral, social and physical infection. Specific types of sexual activity produced this fear, particularly when it was performed outside prevailing classed norms. In the cultural, moral and scientific apparatus that was encoded so as to prescribe and inscribe sexual activity it is possible to detect the dividing line between venereal diseases and other communicable diseases: treatment of venereal diseases was punitive in part because of the moral sickness perceived to be at the heart of venereal infection.

Ambivalence did not only produce fear, however: it also generated positive change. The Commonwealth government’s attempt to develop a uniform national response to venereal diseases was a significant moment in the early history of Commonwealth/State relations. Notification was a serious attempt not only to monitor the epidemiology of venereal diseases but also to ensure that patients were able to access treatment. Compulsion was a double-edged sword. On the one hand, evidence has been presented to suggest that such a measure was unnecessary, given the move towards self-regulation by patients. On the other hand, and paradoxically, it did constitute an honest attempt by government to ensure that public hospitals provided venereal services to poor people in NSW. The attempt by the NSW government to put affordable Salvarsan in the dispensaries of venereal clinics was laudable. Similarly, the attempt to ensure that people living at a distance from venereal treatment centres received equitable access was also praiseworthy. Legislative changes however were not uniformly positive: the marginalisation of chemists and alternative therapists after the NSW VD Act 1918 meant that many venereal patients may have lost a source of accessible and affordable treatment. On the other hand, it is important to consider that legal endorsement of more ineffective treatments could have had detrimental effects in terms of disease transmission.

The impact of new diagnostic and treatment technologies was also ambiguous. A great deal of excitement accompanied both the Wasserman reaction and Salvarsan in their early stages: this shifted to caution and, in some instances, disappointment, by the end of the second decade of the twentieth century. I have argued that these technologies had a significant impact on patients: new treatment regimes were developed, new treatment facilities were established, ambulatory clinics were
founded, different ways of thinking about social impacts were envisaged and notification and other legislative responses were seen to be necessary. Legislative responses developed after almost a decade of using both the Wasserman reaction and Salvarsan: government watched as medical practice realized the legal and social potential of the new technologies. By the time the NSW VD Act was passed in 1918 many of the inadequacies of both technologies had also been brought to light. This lag meant that the VD Act 1918, and its subsequent Regulations, was almost a dead letter before it was enacted: the move to self-regulation ensured that the Act was in a sense misplaced in time. In one important area, however, the legislation had a significant impact: the construction of the category of ‘defaulter,’ a category that has continued to inform the historiography, and a category I discuss in the next chapter.

I have also argued that practices and apparatus like the medical record and the case history were mutable: these ways of recording, documenting and knowing venereal patients were changing during the period. Patients themselves were swabbed, punctured, tapped, injected and irrigated as part of punishing diagnostic or treatment regimes, and left hospitals sometimes after months of internment only relieved of symptoms, until the next time. The medical records and evidence from the NSW Select Committee 1915 testify that in their conduct, venereal patients were often compliant, conscientious and responsible, while at the same time resisting both treatment ambivalence and the territorialisation of their bodies. Patients sometimes had the subaltern consciousness that they were being manipulated by the medical profession, and thus performed strategies to persuade, cajole or convince medical practitioners to achieve their ends. These survival strategies became more pronounced after the passing of legislation enforcing compulsory treatment.

From contemporary public refrains on the meaning and place of venereal diseases through to the policies and practices of individual hospitals, and the relationships between Commonwealth and State governments, there was a high degree of uncertainty about the treatment of venereal diseases. This uncertainty flowed through to the strained medical marketplace: medical practitioners, specialists, chemists and a range of alternative therapists jockeyed, competed and lobbied to provide venereal treatments, or avoid having to treat venereal patients. In the technological field as well, changing procedures and treatments produced a great deal of uncertainty. This
uncertainty had most impact on patients themselves. Patients were ‘nearly’ diagnosed with syphilis, were treated with Salvarsan even though they had not been diagnosed with syphilis, underwent prolonged, painful and punitive treatment regimes, left hospitals with no clear indication as to whether they had been cured, and yet, found ways to regulate their own sexual health.

Chapter 4
Epidemiology: the watchful eye and the venereal count

In this chapter I shift my focus from the individual patient under treatment to the broader population under surveillance; from the clinical examination of the body to the count of the venereal in the body politic; from the ‘medical gaze’ to the ‘watchful eye’ and from the Royal Prince Alfred Hospital medical records to the RPA and Sydney Hospital weekly returns to government. Through to the NSW PD Act in 1909 venereal counting was largely predicated on a contagious disease nexus that linked prostitution and naval personnel: it focused on sites where these populations intersected with government, including naval vessels, ports, hospitals and prisons. In this period venereal statistics were generally commissioned and marshalled by government agents. By the second decade of the twentieth century venereal diseases were being counted by individual hospitals and there was an attempt to mandate that all hospitals across the State keep a register of venereal patients and provide such statistics to the NSW Board of Health.589

Much of the push for this increased monitoring came from real and imagined assertions from contemporary commentators of a ‘red plague’ of venereal diseases.590

590 Contemporary uncertainty about the actual extent of venereal infection is reflected in the historiography. Levine has argued that ‘venereal diseases were largely in decline in the aggregate from the mid-nineteenth century,’ and paradoxically at the same time ‘that they captured public and medical attention’ (Levine, P., Prostitution, Race and Politics, New York, 2003, p. 2). Smart has remarked of NSW that ‘we do not know with any degree of accuracy the prevalence of venereal diseases in the population before the 1920s, and even then the statistical calculations were based on incomplete data’ (Smart, J., ‘Sex, the State and the “Scarlet Scourge”: Gender, Citizenship and Venereal Diseases Regulation in Australia during the Great War,’ Women’s History Review, 1998:7: p. 17). Thame argues that it was ‘impossible to measure accurately the mortality due to venereal diseases,’ and that notification figures were ‘not at any time considered to be an accurate guide to the incidence of venereal diseases in the community.’ Thame does however quote contemporary evidence to suggest
This fear of a red plague led to attempts to publish and disseminate statistical information related to venereal diseases, and statistical ‘facts’ were used to announce and denounce venereal epidemic. New legislation, particularly the NSW PD Act 1909 and the NSW VD Act 1918 introduced new categories and Regulations which needed to be monitored, and processes had to be developed to measure the impacts of such legislation. The 1920s saw the creation of two important new venereal categories that quickly became surrogate markers of venereal prevalence and informed the development of many twentieth century venereal stereotypes: the ‘notified person’ and the ‘treatment defaulter.’ By the 1920s the NSW government was overtly and directly interested and involved in the ‘venereal count’ and legislation both precipitated changes to and necessitated changes in this process.

The most significant change in enumerative mechanisms across this period involved the dispersal of responsibility for the venereal count from government officials, then hospital bureaucrats to a host of medical practitioners in private and public settings. Counting people with venereal diseases was more than an exercise in collecting statistics. It involved selecting who would be counted on what criteria, and by whom,

that ‘syphilis was also blamed for 20–25% of mental illness, 35% of hereditary imbecility, and a considerable amount of vascular disease and nephritis.’ Somewhat more precise assessments of prevalence have been made in the historiography for the period after the introduction of notification procedures in venereal diseases legislation in 1918. In the context of poor enforcement of notification in NSW, Thame argues that the number notified per 100,000 ranged between 266 in 1921 and 207 in 1930 (Thame, C., Development of Health Services in Australia, PhD thesis, ANU, p. 117). Lewis argues that ‘notifications were an uncertain guide to incidence” because of under-reporting by doctors. Doctors failed to notify because ‘it was seen as futile; it was irksome; or it was kept quiet to protect the patient.’ This notification data from Lewis and Thame applied to the period after 1920, after the introduction of the NSW Venereal Diseases legislation in 1918. It therefore does not accurately reflect the prevalence and incidence of venereal diseases prior to 1920. Lewis does however point out that incidence in Sydney ‘was considerably greater than notifications indicated’ (Lewis, M., Thorns on the Rose, New Haven, 1998, p. 216). For the period after 1921, ‘it would seem that around 10 percent of lower-class people had syphilis and that probably more had gonorrhoea’ (Lewis, M., The People’s Health: Public Health in Australia, 1788–1950, Westport, 2003, p. 230). For Brisbane, on the other hand, the Medical Journal of Australia posited significantly lower rates in December 1916, claiming that ‘it is more advantageous to turn to Queensland for information as to the value of preventive measures based on nameless notification than to grope in the dark.’ One method for measuring epidemicity during this period was to examine the number and nature of notifications provided to State Health departments after the enactment of venereal diseases legislation. Given that the earliest legislation to include notification was in Queensland (in 1911), commentators often looked to this state for prevalence data. The Journal found that in 1914, 1090 notifications were made; in 1915, 1414; and in 1916, 1946. This represented an incidence of 2.8 per 1000. Syphilis incidence, in particular, was 0.05 per 1000. The Journal noted that in European cities, syphilis was said to range between 12 percent and 15 percent (Medical Journal of Australia, December 1916, p. 545).

Some other states in Australia, including Victoria and Western Australia, approached the epidemiological task of counting and categorising venereal population more fully and earlier than NSW because of pressure from lobby groups, or the earlier introduction of venereal diseases legislation.
thus creating and constituting a venereal population. Counting also involved the documentation, classification, organisation, aggregation and dissemination of data. Each of these activities was determined by the social and political contexts in which decisions about counting were made. From 1901 to 1925 in NSW venereal surveillance became increasingly dispersed through a range of sites and practices, allowing for the exercise of power through new techniques. Hacking argues that statistics ‘may think of itself as providing only information, but it is itself part of the technology of power.’

My main aim in this chapter is to interrogate how the NSW government counted venereal populations, and to trace the development of enumerative mechanisms between 1901 and 1925. I will approach this genealogy at three separate moments across the period so as to demonstrate a shift towards a diffusion of populations being counted, and an expansion of practitioners undertaking the count. This shift was broadly analogous with the shift in treatment modes from ‘panopticon’ to ‘dispensary,’ and in prevention from punitive to responsibilist approaches. I will first examine how venereal populations were counted prior to and as a result of the NSW PD Act 1909. This will involve an analysis of counts that preceded the legislation, and of surviving data arising from the PD Act. I will then analyse the weekly returns to government (outpatient statistics) that were collected and collated from Royal Prince Alfred and Sydney Hospitals between 1917 and 1920 to demonstrate how the NSW government began to stake a claim in the counting of venereal populations. Both these hospitals collected regular weekly venereal data on gender, new diagnoses and treatment, and such data was provided to the Department of Public Health. These data were aggregated and disseminated, but only to a limited extent. In this chapter I will perform some statistical analyses of these data utilising the resultant evidence to shed light on the relationship between gender, gonorrhoea, syphilis, epidemicity and venereal treatments at both Sydney and RPA Hospitals. Finally, I will analyse notification and default statistics collected after the passing of the NSW VD Act 1918 to demonstrate that through the 1920s the NSW government created and located new venereal categories, dispersed responsibility for collecting venereal data and relied on

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medical expertise for interpreting these data. I will also interrogate whether the evidence of default supports a notion of venereal populations as reluctant to undertake, and resistant to, treatment.

The changing nature of the venereal count through this period was predicated on developments in the fields of epidemiology and statistics. Ways of counting, populations counted and rationales for counting changed across the period, so that by the 1920s epidemiology was being used as a tool to sustain a ‘watchful eye’ on venereal populations and to assist in the very definition of venereal populations, through the creation of new and persistent venereal categories. This watchful eye was cast over those who were infected with venereal diseases, and those who were presumed to be infected; it was cast over young single women who were perceived to be ‘running at large’; it was cast over mothers who ran the risk of infecting future generations; it was cast over the poorer classes;\(^ {593}\) it was cast over defence forces personnel who were to an extent a captive audience, available for experimentation; and it was cast over children. Epidemiology was a tool for governments to achieve biopolitical ends: it was utilised as a rationale in the development of coercive policies and legislation, gendered treatment regimes and raced and classed prevention strategies.

**Statistics and Epidemiology**

Statistics is, and was, not a value-free or culturally neutral discipline. Hacking has argued that the printing of numbers was ‘a surface effect’ behind which lay new technologies for classifying and enumerating, and new bureaucracies with the authority and continuity to deploy the technology.\(^ {594}\) In NSW the Department of Public Health, as a result of the growth and diversification that I described in chapter 1, was positioned and authorised to classify and count a range of populations, including venereal ones. Statistics played a crucial part in developing health and other bureaucracies in this period because the accumulation of data and the actions flowing

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from it validated a bureaucratic rationale.\textsuperscript{595} Hacking has argued that the ‘bureaucracy of statistics imposes not just by creating administrative rulings but by determining classifications within which people must think of themselves and of the actions that are open to them.’\textsuperscript{596} The counting of venereal populations was more than an artefact of enumeration: statistics played a role in ‘making up people.’ Far from being value-free, statistics played a significant role in constituting people as subjects and populations as observable.

Statistics was a technology of power that had grown steadily throughout the nineteenth century. Prior to the nineteenth century governmental enumeration had been primarily related to taxation, military matters and life insurance, but by the late nineteenth century there was ‘an avalanche of printed numbers. The nation-states classified, counted and tabulated their subjects anew.’ Hacking suggests that in the mid-nineteenth century ‘society became statistical’ and that between 1820 and 1840 there was an exponential increase in the number of numbers being published. Nobody argued for this movement towards statistics: ‘they merely found themselves practising it…there was a sheer fetishism for numbers.’\textsuperscript{597} Developments in statistics in the nineteenth century were accompanied and supplemented by technological developments in medical research. The compound microscope allowed for the identification of infectious pathogens, and therefore shifted the focus of late nineteenth century epidemiology to exploring the role of pathogens in disease patterns.\textsuperscript{598} Likewise, the counting of venereal populations in the early twentieth century was assisted by the development of the Wasserman reaction for diagnosing syphilis.

One early leading exponent and practitioner of health statistics was Major Greenwood, who was appointed to the first chair in Epidemiology and Vital Statistics in Great Britain at the London School of Hygiene and Tropical Medicine in 1927.\textsuperscript{599}

\textsuperscript{595} Bashford argues that statistics in public health ‘were put to use as ways of gathering and formulating information about individuals and aggregating it,’ and that the discipline of statistics not only informed the emergence of epidemiology, but also of sociology and demography. Bashford, A., Imperial Hygiene, New York, 2004, p. 9.
\textsuperscript{596} Hacking, The Taming of Chance, p. 194, p. 3.
\textsuperscript{597} Ibid., p. 3, p. 1, p. 186, p. 192.
Greenwood drew an analogy with the physician and the epidemiologist to underline his commitment to vital statistics: ‘a statistical method is essential in the work of the epidemiologist, as essential as skill in manual diagnosis, in the use of clinical instruments, the stethoscope, the clinical thermometer, the sphygmomanometer is to the clinician.’\textsuperscript{600} The interrelationship between the individual patient and the population of patients was a regular theme in medical literature of this period, and the concomitant mirroring of one to the other, telescoped or microscoped, was an \textit{idée fixe}. Greenwood acknowledged that the study of vital statistics as a cornerstone of epidemiology was contentious: ‘a respectable minority of epidemiologists…believe that the statistical method is of very small value.’\textsuperscript{601} Greenwood argued that:

the physician’s unit of study is a single human being, the epidemiologist’s unit is not a single human being but an aggregate of human beings and since it is impossible to hold in the mind distinctly a mass of separate particulars he forms a general picture, an average of what is happening, and works upon that.\textsuperscript{602}

Greenwood also observed that the epidemiology of venereal diseases occupied a special place because of the relationship between sickness and sin. He asked: ‘[If] venereal disease was produced by a sinful action, the victim was a sinner. He or she was also a sick person. Was the victim to be punished for the sin, cured of the sickness, or treated in both ways?’ Greenwood was unequivocal in his perception of the role that the epidemiologist played in significant questions related to sin and sickness. He stated that ‘it was not the business of an epidemiologist to discuss the ethical and psychological reasons for these facts, but it is his business to consider their bearing upon the evolution of venereal diseases as a crowd phenomenon.’ Greenwood analysed administrative ‘attempts by the State’ to control venereal diseases and concluded that in most countries ‘the treatment of the venereally sick has been

\textsuperscript{601} Ibid., p. 17. Greenwood argued that such deficiencies that existed in relation to Vital Statistics were due to methodology, and that doubters would be able to be persuaded by a new methodology. G. E. Ardill, Honorary Secretary of the Public Morals Association, in a letter to the editor of the \textit{Sydney Morning Herald} on 6 August 1918, argued that: ‘Statistics, even accurate statistics, may be very useful and instructive, or very harmful and misleading, according as they are all round in character, and looked at in relation to all the facts of the case or otherwise. If not properly adjudged they cause action of a spasmodic and sometimes unwise character.’ Ardill argued that this was the case in relation to the statistics used to inform the development of the NSW VD Act 1918.
\textsuperscript{602} Greenwood, \textit{Epidemics and Crowd-Diseases}, p. 15.
completely freed from an associated moral condemnation on the part of administrators.’ This optimistic assessment was not reflected in the interactions of medical practitioners and venereal patients at RPA Hospital. Greenwood did concede however that, even in 1935, ‘the social taboo, the association of venereal disease with sin, renders the statistical appraisement of the prevalence either now or in the past wildly conjectural.’ Epidemiology could play a role in constituting venereal populations themselves, and I argue in this chapter that perceptions of epidemicity were underscored by moral considerations.

Epidemiology was an expression of general statistics in a health domain, and forms of quantification in epidemiology were indelibly related to forms of classification. Lupton suggests that the choice of what phenomena require measurement and surveillance epidemiologically is a product of socio-cultural processes, related to

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603 Ibid., p. 340. Greenwood asked two statistical questions in relation to venereal diseases. Firstly, what was the mortality from syphilis between 1910 and 1930 in England and Wales, and secondly, ‘how many men (or women) will acquire syphilis (or gonorrhoea) before they die?’ Greenwood conceded, after marshalling considerable data from the Registrar-General’s Statistical Review, and after describing sophisticated statistical procedures for projecting acquisition and death rates, that: ‘Beyond the platitudinous statement that the attack-rate from gonorrhoea is much larger than that from syphilis no cautious statistician would go.’

604 The emergence of epidemiology as a specific field of data collection and research in France and England in the mid-nineteenth century was closely associated with developments in the calculus of probabilities, statistical techniques, and methods of gathering data on sub-populations. Hacking suggests that for half a century after the great cholera epidemic of 1832 ‘Europeans were obsessed by fears of epidemic disease, but as the fears declined, so the very notion of an epidemic passed from deterministic scourge to probabilistic contagion’ (Hacking, The Taming of Chance, p. 189). In fact, Petersen and Lupton have argued that the growth of the hygiene or public health movement provided a raison d’être for epidemiological research (Petersen and Lupton, The New Public Health: Health and Self in the Age of Risk, p. 28). Worboys suggests that this was happening in the UK from as early as 1850. Worboys argues that ‘for most public health doctors, the most important question about the nature of disease was not about the intimate nature of pathological or physiological processes in individual bodies, but how diseases were spread into and within populations. Thus, the dominant approach for understanding disease in public health medicine was epidemiological (Worboys, M., Spreading Germs: Disease Theories and Medical Practice in Britain, 1865–1900, Cambridge, 2000, p. 39). This reference to ‘public health doctors’ would have included the Medical Officers of Health, but would not have included medical practitioners in general practice. Worboys argues that public health policy in the second half of the nineteenth century in Great Britain was riven ‘with divisions between so-called contagionists and anti-contagionists’ (Worboys, Spreading Germs, p. 40). Contagionists argued that control of epidemic diseases should be based on quarantine and cordons sanitaires, whilst anti-contagionists were opposed to the use of isolation.

605 Any standard text on the history of epidemiology will lead the reader through the various milestones in the development of epidemiology during the nineteenth century (Fox, Hall and Elveback, Epidemiology: Man and Disease, London, 1970 and Winslow, C. E., The Conquest of Epidemic Disease, Wisconsin, 1980). At the root of epidemiology is the ‘population,’ or the group of people who have been infected, are at risk of being infected, or could be prevented from being infected. It could also be noted that, particularly in the mercantilist West, notions of ‘risk’ have a history which mirrors the history of the idea of ‘populations’. Lupton charts the development of concepts of risk, and places the roots firmly in insurance proposals associated with mercantilist expeditions (Lupton, D., Risk, London, 1999).
governmental pressure, the feasibility of measuring, and ethical and political considerations amongst other things. Primarily however counting depended upon current knowledge about the links between human behaviours or embodied characteristics, and illness and disease.\textsuperscript{606} Between 1901 and 1925, embodied characteristics of certain sub-populations shifted. Epidemiology invariably set out to create categories into which people could be classified. This act of categorisation shaped the data collected in certain ways, and the production of the final category. For example, categorisations of prostitutes shifted across the period from representations of the ‘case-hardened’ or career prostitute to the ‘amateur’ prostitute, and these categories were reflected in epidemiological, medical and legislative interventions. Similarly, the legislative constitution of the ‘notified person’ and the ‘defaulter’ after 1918 shaped the data collected and the production of the final category.

Epidemiological and statistical experts supported each other in establishing their disciplines as knowledge industries.\textsuperscript{607} The adoption by epidemiological researchers of ‘scientific’ and quantitative methods of data analysis further legitimated public health, endorsing its claim to be a profession. In the management of venereal diseases, the key experts who worked with government to define, count and regulate venereal populations were medical practitioners. They were however not the only source of expertise, and shifting modes of rule across the period were linked to a contest between medical, sociological and educational expertise in the management of venereal diseases. By the 1920s medical practitioners in NSW were well placed to act as agents for government in the collection and interpretation of venereal data. Medical


\textsuperscript{607} The creation of the expert field of epidemiology through tertiary institutions can be traced back to the 1850s in England. In describing the genesis of the Diploma of Public Health at various Universities and Colleges, and in conjunction with professional organisations, Fee and Acheson discuss the part that the teaching of epidemiology, meteorology and bacteriology played in this training. They demonstrate that between 1850, when the Epidemiological Society of London was formed, and 1895, when bacteriology was first examined, epidemiology was taught at a number of institutions. At one of its first meetings in 1850, the Epidemiological Society defined epidemiology thus: ‘Rigid examination into the causes and conditions which influence the origin, propagation, mitigation and prevention of epidemic diseases in order to throw light into the whole question of epidemics.’ In the teaching of epidemiology during the period 1850–1900 in Great Britain at least epidemiology still had a firm role in the clinical management of individual patients. However, in the very formation of the Epidemiological Society, its links with the College of Surgeons and the College of Physicians, and in the establishment of a curriculum for the teaching of epidemiology, it is possible to see the beginnings of the specialisation and the professionalisation of this group of medical practitioners. Although epidemiology began to develop a process for teaching and educating expertise, ‘epidemiology was not to be recognised as a science in its own right until after the First World War’ (Fee and Acheson (eds.), A History of Education in Public Health, pp. 67–68).
experts assisted government to define new vocabularies (syphology), to problematise new issues (the ‘defaulter’) and to translate political concerns related to control into a specific vocabulary of health or discipline (compulsory treatment and notification). In this period many medical and epidemiological ‘facts’ were presented as truths to the lay public. The Wasserman reaction provided a clear diagnosis of syphilis, Salvarsan ‘cured’ syphilis, prostitutes almost exclusively spread venereal diseases, and both syphilis and gonorrhoea were in epidemic proportions: these were obstinate venereal verities of the period, which statistical endeavours reinforced. Both epidemiology, and its constituent statistics became ‘scientific’ disciplines, where countable facts became authorised truths.

The NSW Prisoners Detention Act 1909

In the first decade of the century in the seaport of Sydney two of the earliest measured venereal categories were prostitutes and naval personnel, both of whom had a long history in the epidemiology of venereal diseases. The NSW PD Act 1909 provided a legislative basis for counting (and containing) these sub-populations. I have described in chapter 2 how this Act was a de facto piece of contagious diseases legislation that was fundamentally, although not exclusively, about prostitutes. Because NSW had not previously enacted contagious diseases legislation, the PD Act 1909 was the first legislation in NSW that linked venereal diseases and prostitution and through which government attempted to measure and contain their conduct. In the case of the PD Act, so-called ‘case-hardened’ prostitutes were arrested, documented, photographed and counted. By the time of the NSW Select Committee in 1915 other categories of prostitutes, both ‘amateur’ and ‘clandestine’ had emerged, and many commentators believed that the PD Act was ill-conceived and no longer able to count or contain these categories of prostitutes. I will examine the antecedents and sequelae of the PD Act to demonstrate that the NSW government itself, and not disparate medical practitioners, impelled and conducted early twentieth century venereal counting, and that early counts were myopically focussed on the category of ‘case-hardened’ prostitutes. Both of these phenomena had changed by the 1920s.
I have described in chapter 1 how early drafts of the PD Act were circulated by the Department of Public Health in July 1908, and were significantly different to the ultimate Act of 1909. The most significant difference was that the July draft contained five important clauses that attempted to codify the venereal count and clarify reporting lines between hospitals and the Department of Public Health. Although these clauses were omitted because they appeared to propose a process of notification for hospitals, the draft clauses illustrate how government had intended to collect venereal data. The Draft proposed that ‘at every hospital partly or wholly supported by public funds’ the Medical Superintendent or Matron would maintain a Register of persons treated for venereal diseases. All medical staff of the hospital that treated persons with venereal diseases were to write to the Medical Superintendent in the prescribed form, and the Superintendent would enter the prescribed details into the Register. Any person authorised by the Board of Health was able to ‘inspect such Register and take extracts from it.’ It was also proposed that the Board of Health could request that the Register be forwarded to the Board upon request for inspection. The final clause proposed, ironically, that all matters contained in the Register were to remain secret and not be communicated to any other person. The inclusion of the above clauses in the PD Act could well have ensured that a more consistent approach to determining and monitoring venereal prevalence and populations was instigated before the VD Act 1918. Because neither hospitals nor private medical practitioners were compelled to collect and report venereal data in 1909, the NSW Select Committee on the Prevalence of Venereal Diseases 1915 struggled to obtain generalised, authoritative data about venereal prevalence. It took World War 1 to harden the government’s resolve, and make medical practitioners and hospitals instruments and agents of the venereal count.

These statistical clauses were included in the Draft Bill because an attempt in 1906 by the Board of Health to determine venereal prevalence in NSW had been a spectacular failure. On 22 March 1906 the NSW Board of Health embarked on a tightly controlled and narrowly defined epidemiological inquiry to determine prevalence. The

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609 Ibid.
610 Ibid.
611 Ibid.
results of this survey remained hidden in the Colonial Secretary’s Office. This investigation was a precursor to proposed contagious diseases legislation, and instigated by the Vice-Admiral, who was concerned for the ‘efficiency of the Fleet’. A Circular headed ‘Venereal Disease in Sydney’ was distributed to 41 private medical practitioners, and to eight government-funded institutions, including hospitals and gaols. The Circular requested data in three categories: how many cases of nominated venereal diseases were treated in 1905, and with what results; whether these figures represented an increase or decrease on the previous year; and if respondents ‘were unable to furnish exact figures could they express an opinion’ on current prevalence as compared with former years. Three diseases were nominated (syphilis, gonorrhoea and soft chancre) and three stages of syphilis were also categorised (primary, secondary and hereditary). This confusion of the categories of ‘hereditary’ and ‘tertiary’ syphilis was noted by some respondents. Respondents were asked to provide data for each of these diseases, for males and females, and to specify whether the diseases had been cured, relieved, not relieved or resulted in death. A template was provided for this purpose. Only 13 of the 41 medical practitioners responded to the Circular, and a number responded by writing, ‘this work would entail 12–24 hours of continuous work which I regret I am unable to spare.’ The low response rates from medical practitioners, and their reluctance to provide data, were both indications of the unwillingness at this juncture to become agents of the Department of Public Health. The Board of Health itself judged the exercise a failure when it wrote that:

The replies which have been furnished in response to the enquiries made are, as will be seen at once, quite useless for the purposes the Board had in view,

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613 At least nine of the medical practitioners who presented evidence to the NSW Select Committee on the Prevalence of VD 1915 were contacted as part of this exercise. Only two of these medical practitioners, Dr Ralph Worrall and Dr Cyril Corlette, replied. Dr Richard Arthur did not reply, ‘Enquiry into the Prevalence of Venereal Diseases in Sydney,’ Containment and prevention of venereal diseases 1906–1916, container 5/5300, NSW State Archives, Kingswood.

614 The government funded institutions were Darlinghurst Gaol, Hospital Admissions Depot, Coast Hospital, RPA Hospital, Sydney Hospital, the Government Institutions in Parramatta, Biloela Gaol and Rookwood and Newington Asylums (Containment and prevention of venereal diseases 1906–1916, container 5/5300, NSW State Archives, Kingswood).


which were to learn something as to the extent of incidence of venereal
disease on the population, and if possible something of it in comparison with
that in earlier years.  

The Board of Health understood that the prevalence study it had undertaken was
experimental, but it was not impressed with the methodology employed:

The replies also show, in my opinion, that nothing of importance can be
learned by the method of enquiry adopted, which, nevertheless, appears to me
to be the only available method.  

This evidence suggests that the Board of Health was keen to count venereal
populations, but lacked the methodological long-sightedness to conduct such counts,
at this time. I describe later in this chapter a remarkable epidemiological experiment
in Victoria in 1911 that was able to develop an effective way of counting venereal
diseases in that state.

Responses to the Board of Health Circular were patchy, anecdotal and quietly
shelved. When statistics were returned, the numbers of cases were mostly very low,
with only handfuls of venereal patients being recorded. On both of these levels the
Board of Health was disappointed with the returns. Four medical practitioners
responded that they ‘had not kept the records necessary to fill in the statement.’
Most expressed an opinion that there had been no marked increase in the prevalence
of venereal diseases between the turn of the century and 1905. Many suggested that
whilst they saw very few patients in their private practice, they were more likely to
see higher numbers in public clinics or surgical departments.

Some questioned the nature of the investigation itself. Dr Cyril Corlette argued that he
had observed an increase in venereal cases, but that this was concomitant with ‘a
considerable increase in the total volume of practice.’ Corlette suggested that many

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617 ‘Letter to I. G. Police from Board of Health.’
618 ‘Letter to I. G. Police from Board of Health.’
medical practitioners ‘may not think to exclude this statistical fallacy.’ 620 Dr Jarvie Hood of Macquarie St was one of the few medical practitioners who provided precise statistics in the nominated grid. In 1905 Dr Hood had seen 75 men with venereal diseases and four women. Of these, 61 of the men had been ‘cured’ and all of the women had been ‘cured.’ 14 of the men had been relieved of symptoms. 621 A handful of respondents worked in private practice and maintained honorary positions at public hospitals. Dr Carruthers had a private practice in Balmain and treated the female prisoners at Biloela Gaol. In relation to the prison sentences that prostitutes received prior to the PD Act 1909 Carruthers argued that:

The sentences however were in numerous cases too short to allow for cure – in one or two cases the attention of the police was directed to them with the result of their re-arrest and wherever the attention of the magistrate was called longer sentences have been given. 622

Responses to the Board of Health Circular from government-funded institutions did not yield a consistent or productive dividend of venereal data. The Hospital Admissions Depot, a centralised intake office administered by the Department of Public Health, and from where diagnosed patients were distributed to public hospitals, submitted two sets of contradictory data for the period March 1905–March 1906. 623 Both sets indicated, however, that roughly twenty times more men were diagnosed than women, and roughly six times more gonorrhoea was diagnosed than syphilis. The response from the Medical Superintendent at RPA Hospital tabulated 229 cases of venereal disease for men and 43 for women. All of these cases were entered in the ‘Cured’ column of the grid, but the word ‘Cured’ had been scored. No entries were listed in the ‘Relieved’ or ‘Unrelieved’ column. 624 The return from the Coast Hospital was tabulated on a reformatted grid, and the category of ‘tertiary syphilis’ was

620 ‘Letter from Cr Cyril Corlette to the NSW Board of Health,’ Containment and prevention of venereal diseases 1906–1916, NSW State Archives, container 5/5300.
621 ‘Letter from Dr Jarvie Hood to the NSW Board of Health,’ Containment and prevention of venereal diseases 1906–1916, NSW State Archives, container 5/5300.
622 ‘Letter from Dr Carruthers to the NSW Board of Health,’ Containment and prevention of venereal diseases 1906–1916, NSW State Archives, container 5/5300.
623 ‘Submission from Hospital Admissions Depot to Board of Health,’ Containment and prevention of venereal diseases 1906–1916, NSW State Archives, container 5/5300.
624 ‘Submission from RPA Hospital to Board of Health,’ Containment and prevention of venereal diseases 1906–1916, NSW State Archives, container 5/5300.
inserted into the template. The Government Medical Officer for the Parramatta Institutions inserted the same row. As the Board of Health itself noted, there were methodological problems with the Circular’s design, one of which may have been the confusion of ‘hereditary’ and ‘tertiary’ syphilis. The Secretary of Sydney Hospital noted that there had been a decrease of 55 cases in the number of venereal patients treated from 1904 to 1905. The Government Medical Officer for the Parramatta Institutions noted that there had been a ‘decided decrease’ in venereal diseases at Parramatta Gaol, the Girls Industrial School and the Newington and Rookwood Asylums. At the Girls Industrial School there had been ‘no cases of syphilis for some years’ and a 25% reduction in the cases of gonorrhoea, despite public renditions of the ‘red plague’. Each of these institutions, quite separate from the government’s count, were creating their own categories through which to understand venereal diseases.

By July 1906 the Board of Health’s endeavour to count and categorise venereal diseases in Sydney was being reviewed. In a memorandum of review the Board of Health noted that a number of issues remained unproven by the prevalence exercise. These included ‘the comparative prevalence of prostitution during recent and former years, the relative numbers of secret and acknowledged prostitutes and what legal powers of control exist over prostitutes.’ Although the Board of Health had framed a Circular that attempted to gauge general prevalence, their real questions remained unanswered. In its attempts to determine the need to press forward with contagious disease legislation the Board was most interested in the relationship between prostitutes, venereal diseases and naval personnel. It did not however collect data specifically related to these categories, although many respondents referred to the role of ‘common prostitutes’ in the spread of venereal diseases. The count of prostitutes was not undertaken because their role in the transmission of venereal diseases was held to be axiomatic.

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625 ‘Submission from Coast Hospital to Board of Health,’ Containment and prevention of venereal diseases 1906–1916, NSW State Archives, container 5/5300.
626 ‘Submission from Government Medical Officer of Parramatta Institutions to Board of Health,’ Containment and prevention of venereal diseases 1906–1916, NSW State Archives, container 5/5300.
627 ‘Submission from Sydney Hospital to Board of Health,’ Containment and prevention of venereal diseases 1906–1916, NSW State Archives, container 5/5300.
In this early part of the century prostitutes were perceived by many of the experts involved to be ‘running at large,’ and were often described as ‘case-hardened’, ‘common’ and dangerous. As the sites and practices of prostitution shifted during and after the First World War, and into the second decade of the century, the categories of ‘amateur’ and/or ‘clandestine’ prostitutes entered discourse. These women were perceived to be a risk to the population because it was more difficult to police and regulate them precisely because they could include any young woman, engaging in sexual activity, anywhere. Paradoxically, the older paradigm of the ‘case-hardened’ prostitute was extemporaneously valorised: some contemporary commentators argued that at least this professional woman knew how to take care of herself. Fournier pointed to the development of the amateur category as early as 1906 in France when he described the risk posed by young women who ‘organised around

629 On the first formal day of sittings of the NSW Select Committee on the Prevalence of Venereal Diseases 1915, Robert Thomas Paton, Director-General of Public Health in NSW, gave evidence. Dr Paton was asked by Commissioner McGirr: ‘I understood you to say that you do not believe in the registration of street women; instead of their running at large, as they do today, would it not be better to have even merely ocular examination of them once a week - would not that reduce the chances of disease?’ This question of the registration and inspection of prostitutes was topical because although the PD Act of 1909 had allowed Magistrates to detain convicted prostitutes ‘until cured,’ it had not allowed them to detain those who were held for fines. Medical practitioners, in general, found this state of affairs unsupportable, and the line and tone of the Commissioner’s questioning suggests that they would have liked to have seen the PD Act amended as a result of the Committee’s Report, which it was. Commissioner McGirr’s question itself indicated his beliefs about the unruly prostitute – ‘running at large’, like an animal. Thomas Paton’s response to Commissioner McGirr was not supportive of inspection and regulation: ‘What I said was that registration and inspection would, in my opinion, lower the number of cases; but I do not think it would abolish the disease...people would have a false sense of security. A man might go to a brothel without as much fear as he goes at present. He might go jauntily, and thinking that as the government Medical Officer had examined a particular woman, he would go safe; and that false sense of security might lead to intercourse and infection. It does not matter how thorough the examination is. A most competent man might examine a woman and not find anything to justify him in saying that she had venereal disease; and yet, a couple of nights afterwards, she might transmit syphilis to a man.’ Legislative Assembly of NSW, Minutes of Evidence taken before the Select Committee on the Prevalence of Venereal Diseases, Progress Report, Sydney, 1915, (NSW Select Committee) p. 15.

630 The amateur prostitute became the focus of regulatory attention in NSW during and after World War 1, according to Smart (Smart, J., ‘Sex, the State and the “Scarlet Scourge”,’ p. 12). Smart argues that prostitutes were ‘public women’, occupying public spaces, with their boundaries limited and patrolled by male regulators. Prostitutes were defined in different categories, with concern about the ‘common’ or ‘hardened’ prostitute diminishing as concern for the ‘amateur’ prostitute increased. Smart argues that constructions of the amateur appeared in NSW about 1914, coinciding with the war, and with the nation’s desire to constrain women’s bodies so as not to be a danger to the fighting forces. As notions of the amateur prostitute gained currency, the older paradigm of the clandestine prostitute became less of a concern (Smart, J., ‘Sex, the State and the “Scarlet Scourge”,’ p. 12). The clandestine was configured as a professional, although often only to top up wages, whereas the amateur was often defined as a working girl ‘who went with soldiers for a good time rather than for money’ (Smart, J., ‘Sex, the State and the “Scarlet Scourge”,’ p. 23). Smart suggests that constructions of clandestine operated before the war, and constructions of amateur operated from about 1916. The amateur prostitute represented a potent symbol of the state’s willingness to extend its regulatory reach and methods to encompass young people, and their milieu, where once the brothel had been the focus of attention.
colleges and schools,’ frequented ‘women’s bars’ and moved between wine bars and boarding houses.\textsuperscript{631} In NSW, Molesworth classed the ‘amateur’ prostitute in three categories. Firstly, and generally, Molesworth categorised young women who had been ‘emancipated’ because of the war, who had entered the ‘industrial arena’ and who had ‘more constant and less supervised association with men of all sorts.’ Secondly, young working women who did not earn sufficient wages, and accepted payment for sex as ‘a second string.’\textsuperscript{632} Thirdly, Molesworth recognised women who earned sufficient wages, but required extra funds for luxuries, including ‘motor drives, smart dresses and furs.’\textsuperscript{633}

Although ‘amateur’ prostitutes were increasingly coming to the attention of authorities and experts, the PD Act 1909 was focused firmly on ‘case-hardened’ prostitutes. From that time forward male and female prisoners detained under the Act were counted. Some details survive on the numbers and nature of women detained under the PD Act between 1909 and 1914.\textsuperscript{634} Case books included details on the date received at the detention centre, date re-sentenced, date discharged and treatments administered. In volume 1, 162 women were listed and described in the case book. Nearly all of the female inmates listed and described in this volume were poor, and young, and the majority were described as having both syphilis and gonorrhoea. Two pathology request forms related to a particular inmate are included in the back of a case book, and they exemplify the close legislative connection between incarceration and treatment, between cure and liberty. In NSW, in the first year of the PD Act, 43 men and 27 women were detained under the provisions of the legislation. Women were kept for up to one year beyond their original sentence, and were treated at the lock hospital at the NSW State Reformatory for Women.\textsuperscript{635} Lewis demonstrates that between 1908 and 1918, of 366 women with venereal diseases found to be infected

\textsuperscript{632} Others saw the issue of wages for young single women as a much broader social issue. Dr L. E. Ellis, in an address to the NSW Branch of the British Medical Association in June 1919, argued that the amelioration of poverty could have an impact on the prevalence of venereal diseases. Ellis agreed that working girls may become ‘amateur’ prostitutes as a ‘second string,’ but he also suggested that a ‘living wage’ was important for all workers, ‘especially women workers.’ (Medical Journal of Australia, June, 1919, p. 502).
\textsuperscript{634} Record of Female prisoners suffering from contagious diseases detained under the PD Act of 1908, December 1908 – August 1909 (Kingswood, 5/2226 part). 1 vol. (part).
\textsuperscript{635} Tibbits, D. R., 'VD Behind Bars,' Proceedings of the Fourth Biennial Conference of the Australian Society of the History of Medicine, 1995, p. 158.
upon admission, 61 were required to remain beyond their original sentence to complete treatment at the lock hospital.\textsuperscript{636} Nearly one third of all women curatively detained under this legislation between 1909 and 1918 were detained in its first year of operation. In the decade between 1910 and the end of the war, then, only 34 women were detained under the provisions of the legislation. The impact of this legislation was discussed at the NSW Select Committee 1915 and it was generally agreed that the legislation had been limited because it allowed those women who had been only fined not to be incarcerated, and therefore not to be treated.

After prostitutes, naval personnel were the category about whom data related to the PD Act 1909 was most often collected in the first decade of the new century. There was considerable discussion at the NSW Select Committee 1915 about the efficacy of the PD Act, the six-year gap providing witnesses with some retrospectivity and data to observe the impact of the legislation. Most data sets associated with the PD Act tabled at the Select Committee related to prostitutes and naval personnel, and were occasionally embellished.\textsuperscript{637} Dr R. T. Paton provided evidence on the impact of the Act on naval venereal infections. At the time of the Select Committee Dr Paton was the NSW Director-General of Public Health and had been in this post for approximately two and a half years. He had also been the Inspector-General of Hospitals and Charities, the Government Medical Officer of Sydney, and the Resident Surgeon at Trial Bay Gaol. Dr Paton’s agenda was clear: he was keen to link his perception of decreases in venereal diseases, with the policies embedded in the legislation: namely, containment and compulsory treatment for prostitutes. He argued that legislation could have an impact on prevalence as a result of intervening in the conduct of individuals. This same phenomenon was observable after the VD Act of 1918: epidemiological data related to notification and default were collected, collated and published to demonstrate the efficacy of the new legislative responses.

Dr Paton referred to a Report signed by V. G. Thorpe, Fleet-Surgeon, dated 3 November 1911:

\textsuperscript{636} Lewis, \textit{Thorns on the Rose}, p. 147.
\textsuperscript{637} Paton was rigorously examined and challenged by Dr Arthur, who was able to compel Dr Paton to admit that decreases in venereal diseases between 1906 and 1909 could not be ascribed to legislation that was only passed in 1909 (NSW Select Committee, p. 12).
Submitted following report on venereal diseases during the quarter ended 30 September 1911. I am pleased to note that there has been a marked decrease in the prevalence of these diseases during the quarter, as compared with the previous 2 quarters, the numbers being:

<table>
<thead>
<tr>
<th></th>
<th>Gonorrhoea</th>
<th>Chancroid</th>
<th>Syphilis</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st quarter</td>
<td>63</td>
<td>6</td>
<td>7</td>
<td>76</td>
</tr>
<tr>
<td>2nd quarter</td>
<td>51</td>
<td>14</td>
<td>12</td>
<td>77</td>
</tr>
<tr>
<td>3rd quarter</td>
<td>43</td>
<td>3</td>
<td>0</td>
<td>46</td>
</tr>
</tbody>
</table>

The fluctuation appears to a great extent to depend upon the length of time the ships spend in Sydney, the numbers being: 1st quarter, 476 days; 2nd quarter 395 days; and 3rd quarter, 335 days. Sydney is responsible for 68 per cent of the total number of cases of venereal diseases ... the change for the better is attributed to the working of the PD Act. 638

These data were premised on the contention that sailors visiting Sydney paid prostitutes for sex, and as a result were exposed to venereal diseases. The very collection of data related to naval personnel placed the PD Act in the older tradition of contagious diseases legislation, in particular the UK legislation which was centred on garrison towns and ports, and the impact of prostitution on naval and military productivity. With the PD Act mandating the detention of convicted prostitutes until cured, the Fleet-Surgeon concluded that over a period of time sailors were less likely to be exposed to infection. Because of this reduced exposure, the Fleet-Surgeon was able to tabulate decreases in prevalence, and implicitly acknowledged that the naval workforce was being maintained as efficient and productive. The data provided by the Fleet-Surgeon had its own internal logic: epidemiology was utilised to demonstrate that there was a causal relationship between legislation, detention, changed conduct and decreased prevalence, all of which cumulatively resulted in improved productivity in the interests of the state.

638 Ibid., p. 11.
During 1911 in Victoria, important epidemiological experiments were being conducted. These demonstrated that whilst in NSW counting of venereal populations was still premised around the older contagious diseases nexus of prostitutes and naval personnel, in Victoria sophisticated methodologies were being implemented to measure and count a number of venereal phenomena. Following the Australasian Medical Congress in Melbourne in 1911, an Advisory Committee was formed to determine the ‘prevalence of syphilis in all its various forms.’ James W. Barrett was a member of this Committee, which was chaired by Dr Burnett Ham, himself Chairman of the Victorian Board of Health. The Committee suggested, and the government agreed and funded, a twelve-month study between 1 June 1910 and 31 May 1911 necessitated the passing of legislation to make syphilis notifiable. With syphilis notifiable for this period, circulars were sent to all medical practitioners within the metropolitan district inviting them to forward with each notification a sample of the patient’s blood for test by the Wasserman reaction, conducted by Dr Hiller at the University Bacteriological Laboratory. Notwithstanding earlier reservations regarding the accuracy of the Wasserman reaction, and earlier evidence from the RPA Hospital medical records suggesting the same ambivalence, this structured, sponsored epidemiological investigation was unique this early in the period.

The response from medical practitioners was overwhelming. As Barrett indicated, over 5700 cases were reported, and 14% of these later gave a positive Wasserman reaction. In his report on this study, Barrett commented:

> The collective investigation so conducted is the most extensive and important accurate research into the prevalence of syphilis that has yet been conducted in any part of the world, and the Government of Victoria has been highly eulogised in current medical literature.

International recognition was not the only consequence of this investigation. Barrett reported that as a result of the findings, the Wasserman test was made available for the whole State, free Salvarsan was distributed to hospitals and a 24-bed venereal ward was set aside for the treatment of males at the Prince Alfred Hospital in

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Melbourne. The results of the investigation were also ‘handed by the Government to the daily press for publication.’ Most significantly, it was proposed that the provisions of the NSW PD Act 1909 should be duplicated in Victoria. Unfortunately, Barrett paraphrased the meaning of the NSW PD Act as making it ‘a legal offence for any person other than a legally qualified practitioner to treat a case of disease, and [it] further makes it a legal offence for any person cognisant of the fact that he or she is suffering from a disease to communicate such disease to anyone else.’ This was precisely what the PD Act did not do: it would be another ten years before NSW would have legislation that enacted the above provisions. Barrett also observed that the process of epidemiological investigation could precede and inform legislative change.

Medical experts drew a number of important general conclusions from this investigation. Barrett concluded that ‘whether the hypothesis held by some practitioners – that syphilis is the principal cause of nearly all disease and death, prior to senility – is correct, or not, had not been proved. Adequate evidence, however, had been furnished to indicate the magnitude of the problem.’ Barrett further concluded that:

The management of these diseases has always been complicated by the admixture of practical medicine with morality. Medical men dislike vice perhaps rather more than most people because they see so much of its nauseous side.

Both Barrett and at a later stage Greenwood noted serious limitations in the epidemiological approach to venereal diseases precisely because of the taboo and stigma attached to such diseases: magnitude and morals walked side by side. It was this limitation that in many ways accounted for the development of quite specific yet multiple ‘venereal populations.’

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640 I have noted in chapter 1 that not until the 1940s in NSW was a venereal ward for men established.
642 Ibid., p. 454.
643 Ibid., p. 462.
Barrett reported two other epidemiological investigations conducted in Melbourne between 1911 and 1913. One involved the study of two sets of 100 post mortem examinations to ascertain whether syphilis had been the direct or indirect cause of death, and the other follow-up study, at the Children’s Hospital, involved study of disputed post mortem appearances. Barrett described the rationale for these investigations in the following terms:

On the one hand, the pathologists, the oculists, and the specialists in diseases of children asserted that syphilis was responsible for a vast amount of damage to mankind… on the other hand, some of the surgeons and many physicians…said that the grosser manifestations of syphilis were diminishing in frequency and the supposition that indirect troubles were so caused was not based on fact.\footnote{Ibid., p. 458.}

This important statement of the epidemiological debate centred on venereal diseases led to the sorts of investigations discussed above. That many medical practitioners assumed that syphilis was the primary cause of most deaths is an important idea to note, and despite the inconclusive nature of the tests, it is also important to note that Victoria was embarking in this period on some significant epidemiological counts of the population, counts which would not transpire in NSW until the 1920s.

\textbf{Royal Prince Alfred Hospital Weekly Returns}

Whilst the categories of ‘case-hardened’ prostitutes and naval personnel dominated venereal statistics in the early part of the twentieth century in NSW, in the period immediately prior to and during the gazetting of the VD Act and Regulations (1917–1920), statistical categories were primarily concentrated on poor men and women, particularly returned soldiers and ‘amateur’ prostitutes. These categories were being assiduously counted and monitored by individual hospitals. RPA Hospital collected and reported significant amounts of data related to venereal attendances prior to the VD Act 1918.\footnote{Raw venereal attendance data for RPA Hospital for the period 1917–1921 was located in batches in the NSW State Archives. Similar data was located for Sydney Hospital for the period 1919–1921. Ibid., p. 458.} One reason for this data collection was to prove that institutions and
populations were being venerealised, a concept I examine in chapter 2. In the case of RPA Hospital, such data was forwarded to the Department of Public Health, for further dissemination.  

Officials at Royal Prince Alfred and Sydney Hospitals aggregated the data from the weekly returns before forwarding them to the Department of Public Health. Numbers of total attendances, and numbers of new cases were provided to the Department on a weekly basis. Annual aggregations were also performed.  

Although these returns were collected locally and disseminated narrowly, they were an important bridge between the limited approach of the PD Act 1909 and the ‘notified persons’ and ‘default’ statistics of the 1920s. These weekly returns (a sample is at Figure 1) were forerunners to the notification data provided to the Department of Public Health after the VD Act 1918.

Figure 1 – Sample RPA Weekly Return to NSW Department of Public Health
(source: Weekly returns from RPA Hospital, March 1917)

have described the provenance and structure of this data in the introduction to this thesis, and provide a sample of a weekly return in Figure 1.

The Department of Public Health distributed weekly returns to the Sydney Morning Herald, Daily Telegraph, Sun, Evening News and the Newcastle Morning Herald.

Annually, the weekly returns were pulled together to create a picture of total attendances and total new diagnoses per year. There is evidence to suggest that the data were used to support the development of health services, not only by RPA Hospital in arguing for a purpose-built Venereal Clinique, but also by the Ministry of Public Health, in arguing within government for increased allocation of public funds for the treatment of venereal diseases.
Although there is no evidence to suggest that weekly returns data were utilised during this period to directly analyse patterns of infection in men and women, or comparative patterns of gonorrhoea and syphilis infection, that task is achievable as part of this thesis. The weekly returns for both Royal Prince Alfred and Sydney Hospitals listed the following information: total number of male attendances per week; total number of female attendances per week; total number of new gonorrhoea diagnoses, in both men and women; and total number of new syphilis diagnoses, in both men and women.\(^{648}\) I have analysed a number of variables, including gender rates, new diagnosis rates, seasonal fluctuations, comparative rates between syphilis and gonorrhoea, by gender, and by hospital, at both Royal Prince Alfred and Sydney Hospitals. I use this data from 1917 to 1921 to investigate a block of uninterrupted occasions-of-service, and to apply statistical interrogations to elucidate comparisons and to highlight patterns. There are accompanying notes and memoranda from the Hospital’s or the Minister’s Office which complement the data, and further enhance the picture of how epidemiology was being utilised as an organising idea by government to ‘make up’ venereal populations.

The accepted wisdom as presented by medical practitioners to the NSW Select Committee 1915 and other commentators was that women were the primary transmitters of venereal disease, that gonorrhoea was primarily a disease of women, that both syphilis and gonorrhoea were present in epidemic proportions, that patients needed to be compelled to attend outpatient clinics and that syphilis was endemic in certain women, particularly prostitutes. The weekly returns data for this period suggests otherwise. It supports the notion that the Outpatient Clinique was a well-attended and popular service. This data substantiates my argument that venereal patients willingly attended the Clinique, and that this willingness signified their own internalised desire for health, without the coercion implied in the VD Act 1918. Most importantly, the data do not support the contemporary notion that venereal diseases were in epidemic proportions, particularly at the moment of military demobilisation after World War 1.

\(^{648}\) Because the data contained in the weekly returns was comprehensive and internally consistent all data has been entered into an Excel spreadsheet.
For the period 1917–1921 it is possible to conclude from the data that significantly more men attended the Clinique than women (see Figure 2). In 1917 there were 10,829 male attendances, and 3688 female attendances. In 1918, there were 7605 male attendances and 5630 female attendances. In 1919, there were 7780 male attendances, and 3497 women. In 1920, there were 6153 male attendances and 2534 female. 649 These figures are expressed as a percentage in Figure 3.

Figure 2: Total Attendances at RPA Outpatient Clinic by gender and year

Source: Weekly returns NSW Archives f. 5/5300

649 Data extrapolated from Royal Prince Alfred Weekly returns.
It should be noted that attendances did not equate to actual numbers of patients: any one patient could attend on multiple occasions.\textsuperscript{650} Hart argues that at Royal Adelaide Hospital in 1916 patients averaged 10–20 visits for each venereal illness.\textsuperscript{651} Hart further argues that to the end of the 1920s women averaged 12 attendances per illness and men averaged 10 attendances. In 1929, Hart suggests that 65 percent of all clinic cases at the night clinic at Royal Adelaide Hospital were male, and 35 percent were female. These high numbers of occasions-of-service were related to inadequate therapies and treatment nihilism, amongst other things.\textsuperscript{652}

Using Hart’s ballpark figure that each patient attended on average on 15 occasions for venereal treatments, I have analysed the weekly returns to calculate how many actual patients received treatment for syphilis and gonorrhoea at RPA Hospital between 1917 and 1920:

\textsuperscript{650} In modern parlance these would be referred to as occasions-of-service.


\textsuperscript{652} Hart details statistics for the Adelaide night clinic for the period from 1917, the year after the opening of the night clinic, through to the present day. In 1919 for instance 357 cases of gonorrhoea and 176 cases of syphilis in men were treated on 4483 occasions. In the same year, 35 cases of gonorrhoea and 37 cases of syphilis in women were treated on 553 occasions. Cases of syphilis and gonorrhoea in men rose steadily in Adelaide during the 1920s, peaking in 1929 with 643 cases of gonorrhoea and 307 cases of syphilis being treated on 15,112 occasions (Hart, G., \textit{ibid.}, p. 83).
Table 1: Total patients per annum using venereal treatment services at RPA Hospital 1917–1920 *(source: data extrapolated from RPA Hospital Weekly Returns)*

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Attendances – New gonorrhoea diagnoses</th>
<th>New syphilis diagnoses</th>
<th>Total diagnoses</th>
<th>Total patients per annum (using an average of 15 visits per patient)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1917</td>
<td>1917 Men – 10,829</td>
<td>405</td>
<td>355</td>
<td>760</td>
</tr>
<tr>
<td></td>
<td>Women – 3688</td>
<td>95</td>
<td>113</td>
<td>208</td>
</tr>
<tr>
<td>1918</td>
<td>1918 Men – 7605</td>
<td>185</td>
<td>126</td>
<td>311</td>
</tr>
<tr>
<td></td>
<td>Women – 5030</td>
<td>69</td>
<td>81</td>
<td>150</td>
</tr>
<tr>
<td>1919</td>
<td>1919 Men – 7789</td>
<td>207</td>
<td>193</td>
<td>400</td>
</tr>
<tr>
<td></td>
<td>Women – 3497</td>
<td>69</td>
<td>68</td>
<td>137</td>
</tr>
<tr>
<td>1920</td>
<td>1920 Men – 6153</td>
<td>188</td>
<td>136</td>
<td>324</td>
</tr>
<tr>
<td></td>
<td>Women – 2534</td>
<td>57</td>
<td>58</td>
<td>115</td>
</tr>
</tbody>
</table>

For example, in 1917 at RPA Hospital there were 721 male patients, and 246 female patients treated for both syphilis and gonorrhoea. This would have equated to 60 male patients a month, and 21 female patients a month. These numbers are not staggering, and suggest that the perception of epidemicity may in fact have been created by the prolonged and multiple treatment regimes. Further, at RPA Hospital in 1919 there were 193 cases of syphilis in men treated on 7789 occasions, and 68 cases of syphilis in women treated on 3497 occasions.

The total numbers of venereal diagnoses and patients at RPA Hospital for this four-year period are modest.653 Between 1917 and 1920, 2157 men and 982 women attended RPA Hospital for venereal diagnosis or treatment. For the same period there were 1695 cases of syphilis and gonorrhoea treated in men, and 610 cases of syphilis and gonorrhoea treated in women. There is clearly a disparity between the total

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653 Similar modest figures were reported from New Zealand when a Commission of Inquiry in 1922 sought attendance and diagnosis data from the country’s four venereal disease clinics in Auckland, Wellington, Christchurch and Dunedin. In the two and a half years ending 30 June 1922, 3038 males and 596 females attended these clinics. This represented total occasions-of-service of 10,995 males and 8797 females. On these figures, each Clinic was seeing an average of only 27 men a month, and merely five women (Committee of the New Zealand Board of Health, *Venereal Diseases in New Zealand: Report of the Special Committee of the Board of Health appointed by the Hon. Minister of Health*, Wellington, 1922, p. 28).
number of patients and the total diagnoses, and in screening clinics there always will be. There were clearly a number of patients who presented at venereal clinics who were not diagnosed with a venereal infection, and therefore sent on their way. The data are largely silent on this category of patients, although Hart acknowledges that patients with no illness, including those attending for screening or medical check-ups, represented an increasing number of attendances at venereal clinics throughout the century.  

At RPA Hospital the number of male attendances was at its height in 1917, the year before the VD Act was introduced, plateaued between 1918 and 1919, and decreased markedly in 1920 (see Figure 2). The marked reduction between 1917 and 1918 was the result of the quota policy introduced by the Board of Directors, limiting the number of patients seen weekly at the Outpatient Clinique from 400 to 250. I have discussed this policy in chapter 2. On an annual basis, this meant that approximately 3000 attendances at the Outpatient Clinique in 1917 could not confirm a suspected diagnosis or continue treatment in 1918. It is safe to assume that these men did not attend other clinics: the reason quotas had been introduced at RPA Hospital was precisely because no other metropolitan hospital would establish an outpatient clinic.

The number of women attending the Clinique for either diagnosis or treatment was generally about one-third the numbers of men. As I have noted, by 1917 at RPA Hospital there were two inpatient wards for women, and the medical records indicate that there was considerable interchange between the wards and the clinic. Nevertheless, the weekly returns data relates to outpatients only. A notable observation is that between 1917 and 1918 there was a significant decrease in the number of men attending, but a significant increase in the number of women attending, from 3688 in 1917 to 5030 in 1918. A number of factors may have accounted for this increase: it is possible that the quotas introduced by the Board of Directors induced medical practitioners to prioritise women, and throughout 1918 there had been considerable media coverage of demobbed soldiers and their potential to be infected by both amateur and ‘case-hardened’ prostitutes. There may also have been a connection between the press attention being given to the introduction of the

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654 Hart, From Night Clinics to the Internet, p. 36.
VD Act in 1918, with its focus on notification and compulsory treatment, and the
dramatic decline in the numbers of men attending the Clinique. As I indicate later,
both the Influenza epidemic and the General Strike had an impact on attendances. 655
Neither of these events would have accounted however for the increase in the
numbers of women attending.

I have aggregated data that supports the hypothesis that syphilis and importantly
gonorrhoea were as prevalent if not more prevalent in men than in women. 81 per cent
of all new diagnoses of gonorrhoea at RPA Hospital in 1917 were in men, and even
though this fell to 72 per cent in 1918, generally three quarters of all diagnoses of
gonorrhoea during this period were in men (see Figures 4 and 5). New diagnoses of
gonorrhoea in women peaked in 1918, the same year that the number of women
attending the Outpatient Cliniques peaked. Although new diagnoses of gonorrhoea
were strongly associated with total attendances, total diagnoses of gonorrhoea at RPA
Hospital do not support the notion that gonorrhoea was primarily an infection of
women. Medical practitioners and politicians inflated the prevalence of gonorrhoea in
women precisely because of its impact on the reproductive capacity of women, and
because of the association of female reproduction with the perception of a falling
birth-rate. Between 1917 and 1920, similar patterns of infection were discernable for
syphilis. It is important to note however that in each year new diagnoses of syphilis in

655 The General Strike of 1917 placed particular stresses on the operation of the Outpatient Cliniques at
both Royal Prince Alfred and Sydney Hospital. In September 1917, the Under Secretary inquired as to
the ‘marked falling off in attendances at the Clinique.’ The Secretary responded promptly: ‘In reply I
beg to state that the falling off in attendance is due almost entirely to the strike conditions which have
prevailed. These have presented a number of members of the staff from being present at night, as it
would be impossible for them to reach their homes, and in any case the same reasons militated against
large attendances. We are hoping that now that the conditions for both the staff and the public are likely
to be normal the attendances will rise again and be as great as before the strike. Trusting this
explanation will be what you desire.’ This reply was forwarded to the Minister by the Under Secretary
with the following message: ‘Submitted for the information of the Acting Minister. The numbers have
fallen considerably in the last few weeks and while the reason could safely be divined it was thought
well to address the Hospital Committee on the subject. The above letter will doubtless be regarded by
the Minister as satisfactory. The matter will be kept prominently in view.’ Although the role the
General Strike played ‘could safely be divined,’ the Department of Public Health decided it was ‘well
to address’ the issue with the hospital. Even when the reason for the decrease in attendances was
patently clear, attempts were made to keep the hospital ‘on their guard’, and to let the hospital know
that they were still the subject of a ‘watchful eye.’ There was a hint that the Secretary of the hospital
discerned this paternalism when he closed his correspondence with ‘trusting this explanation will be
what you desire.’ And the Under Secretary for Public Health acknowledged to the Minister that ‘the
matter will be kept prominently in view,’ suggesting both the significance of the Weekly returns as a
tool for monitoring the ‘epidemic,’ and the layered and contra-indicatory nature of the ‘watchful eye’
over the venereal patient.
women were higher than new diagnoses of gonorrhoea. Similarly, in each year, new diagnoses of syphilis in men were lower than new diagnoses of gonorrhoea. These statistics ran counter to contemporary refrains.

Figure 4: Patients diagnosed with gonorrhoea at RPA Outpatient Clinic by year and gender, as a percentage

Source: Weekly returns NSW Archives f. 5/5300
Other themes emerge when comparing the weekly returns of RPA Hospital and Sydney Hospitals. The Outpatient Clinique at RPA Hospital started returning data fully a year earlier than Sydney Hospital, and during the period 1917–1921, Sydney Hospital’s data were less complete and at times duplicated. It is clear from the data that Sydney Hospital throughout the surveillance period had much lower attendances, (see figure 6) but significantly higher new diagnosis rates, particularly of gonorrhoea in men.

Figure 6: Total attendances by year and gender at Sydney Hospital
In the corresponding period the outpatient clinic at Sydney Hospital saw far fewer venereal patients than RPA Hospital. Accepting that each patient attended on average 15 times in 1917, then at Sydney Hospital there were 309 male patients, and 32 female patients. This would have equated to 26 male patients a month, and nearly three female patients a month. At RPA Hospital the corresponding figures for 1917 were 60 male patients a month and 21 female patients a month. Sydney Hospital saw roughly half the number of men and very small numbers of women. Women hardly attended Sydney Hospital and did so in reducing numbers. Sydney Hospital did not have inpatient facilities for either men or women, and I have noted that at RPA Hospital there was considerable traffic between ward and clinic. RPA Hospital had conducted the inpatient venereal ward for women since the early part of the century, and had built considerable expertise in the treatment of venereal infection in women. These data also indicate that there was a significant reduction in total numbers attending Sydney Hospital between 1918 and 1919, from 4639 in 1918 to 3475 in 1919.

These figures were mirrored in total attendances at RPA Hospital for the period 1917 and 1918. At RPA Hospital the reduction in total attendances was related to the introduction of quotas. There is no evidence to suggest that similar quota reductions were introduced at Sydney Hospital. It is curious that in the year World War 1 ended, and where there was considerable media attention on demobilised soldiers, one of only two venereal outpatient clinics in Sydney should see reductions in attendances.
As I have noted, these fluctuating figures may have reflected popular concern with the well-publicised introduction of the NSW VD Act 1918. Numbers of new diagnoses of syphilis and gonorrhoea at Sydney Hospital over 1918 and 1919 were low (see figure 7). Over the entire period, only 6% of all new diagnoses of either gonorrhoea or syphilis were recorded for women, and these were recorded in 1918. This would indicate that less than 50 women were diagnosed with either syphilis or gonorrhoea at Sydney Hospital. Numbers of new diagnoses of syphilis and gonorrhoea were also low in men, although other data analysed indicates that, as with RPA Hospital, diagnoses of gonorrhoea were higher than diagnoses of syphilis.

The various notes, marginalia and signatures on the weekly returns indicate that the Under Secretary of Public Health took the occasions-of-service from RPA Hospital very seriously. He noted his consideration of each return and interrogated any variation to patient numbers. I have included a sample from the weekly returns from April 1917 in figure 8, which demonstrates the level of interrogation, computation and sign-off which accompanied most weekly returns, particularly when there were significant variations in total attendances. The returns were collected not only for the purpose of surveillance but also for the purpose of publication. The Under Secretary of Health approved the publication of returns each week, in a prescribed list of metropolitan and provincial newspapers. The purpose of this publication was to act as a deterrent to the reading public, and to demonstrate that the government was acting to curb the ‘red plague.’ This is why the Under Secretary was perturbed when numbers dropped: it may have been perceived as the plague waning, the fear diminishing. It should be noted that after about two years of returns, a hasty decision

656 Although the press on a number of cited occasions were cooperative with particular hospitals, they proved to be less cooperative with the Department of Public Health. Often when the Department was requesting updated statistical information from the hospitals, the request would begin with: ‘with a view to facilitating the publicity arrangements of the department.’ The weekly returns contained many references to the distribution of the data to particular newspapers so that they could be published. Presumably, this was perceived as a preventative measure, much like the Grim Reaper advertisements, where horror and fear were perceived to operate as salutary deterrents. Having received the weekly returns, the Under Secretary would make a note for copies of the statistics to be sent to the Sydney Morning Herald, Daily Telegraph, Sun, Evening News and the Newcastle Morning Herald. At least from January 1917 these statistics were forwarded to the metropolitan and provincial press, but in December 1917, the Minister was presented with a briefing note which read: ‘Paragraphs furnished in relation to the attendances at venereal clinics are rarely published. Submitted that, save in the case of a marked increase or decrease in attendances, preparation of these paragraphs be discontinued.’ The publication of details regarding attendances at Venereal Cliniques was extraordinary: it is impossible to imagine any other medical condition, except in times of ‘epidemic,’ which would be so published.
was made not to publish the data in the newspapers. The reason stated in the marginalia was that despite delivering the returns to the newspapers, they were not being printed.

**Figure 8 – Sample Weekly Return, with marginalia (source: Extract from sample Weekly Return, May, 1917)**

The Influenza epidemic in the early months of 1919 had a significant impact on the operation of the Outpatient Clinique and prompted a flurry of correspondence between the hospital and the Department in addition to the normal marginalia of the weekly returns. One of the key reasons for this concern was because two populations, and two epidemics, coincided, and conflicted. On the 8 February 1919, the Minister was provided with a terse briefing.  

**Re: Venereal Clinics and the Influenza Epidemic**

Submitted for the Minister’s information The position at the present moment is;

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657 RPA Weekly returns January 1919.
658 RPA Weekly returns, January 1919.
(1) RPA Hospital
Acute cases only are being treated.

(2) Sydney Hospital
Closed

The clinics were to remain closed until mid-March, and the Sun, on Valentine’s Day 1919, ran the following article related to the closure:

The following notice, dated January 28, 1919, posted at the outpatient department of the RPA Hospital:

The outpatient department will be closed from today (Tuesday). The only patients to attend will be patients such as fractures, which need urgent and constant attention in the massage department, the morning dressings which need continued attention, and acute cases attending the venereal clinic... By this it will be seen that treatment of acute venereal disease is continued, and as a matter of fact not one case has been turned away on account of the influenza epidemic. The honorary and resident medical officers have been attending to patients in the Clinic at the usual hours, and continued treatment prescribed by them is also given at the usual hours day and night on each day of the week. Patients numbering 155 have already attended this week. The venereal clinic has been carried on at the same standard for the last 18 months. It is true that at the time the Board of Directors, owing to the numbers being so overwhelming as to prejudice proper treatment, made the limit of cases to be under treatment at one time 200; the attitude of the Board being that this number the hospital could efficiently cope with, and that this number was a fair quota for the hospital, with similar provision at the other public hospitals.659

Hospital authorities were at some pains to demonstrate that despite one epidemic being so virulent, the other epidemic was still being attended to. They were also at

659 RPA Weekly returns, January 1919.
pains to reassure the public, and the Department, that patients were not being turned away: that the quota of 200 was a justifiable policy, and that those who could not be treated at RPA Hospital were sent elsewhere. During this period no other medical conditions had quotas introduced.

Although neither the data nor the marginalia from the weekly returns support the contention of a venereal epidemic, particularly in the sense of the concurrent epidemic, influenza, there were many in both the public health and medical spheres who were keen to promote epidemicity, and many who were not. The press was not prepared to publish long lists of attendances at the Outpatient Cliniques prepared by the Department of Public Health but on many occasions was prepared to publish material that supported the hospital’s arguments for increased facilities to treat venereal patients. With hospitals recording, health bureaucrats monitoring, and the press publishing, or intervening in other ways, the conduct of venereal populations was carefully monitored. Individuals were subject to these connected practices of power. Dr Barrett, from Melbourne, pointed to the economic reasons for this watchful eye over the body politic when he recorded:

> The monetary cost of the eradication of venereal disease would not be very great. There is no form of public expenditure that might so truly be described as national and reproductive. It would result in the diminution of mortality, the diminution of insanity, the diminution of the expenditure on hospitals and asylums, the increased human efficiency, and the healthier enjoyment of life.\(^{660}\)

**The NSW Venereal Diseases Act 1918**

The VD Act provided significant direction on two important components of the venereal count: who was to be counted, and who would conduct the count. Through a network of regulations and penalties this legislation laid the framework for the creation of two important statistical categories: notified persons and defaulting persons. Whilst the PD Act had devised a framework for the Department of Public Health...
Health to count infected prostitutes and naval personnel, the VD Act positioned medical practitioners as crucial agents of the count of all citizens diagnosed with venereal disease, both compliant patients and defaulters.

This legislation was the most significant moment in the constitution of venereal populations in NSW in the first part of the twentieth century. The Act, and its epidemiological and enumerative sequelae, including notification and default statistics, was an important attempt by the NSW government to think broadly about measuring and interpreting venereal diseases and to use statistics to consolidate modes of rule. I have discussed in detail the provisions of this legislation, and its advocates, opponents and impacts in chapter 1. I have also discussed the importance of this legislation in relation to treatments in chapter 2, and will follow in chapter 5 by describing how this legislation was silent in relation to prevention education. Here however I will examine the legislation as an enumerative and biopolitical tool, conflating as it did medical expertise, the national interest and the sexual and reproductive conduct of populations, where individuals were statistically constituted in two new categories: the ‘notified person’ and the ‘defaulter.’ As I have previously noted, the legislation positioned medical practitioners as the conduit through which government power was dispersed. The legislation dispensed with the need to ‘take possession of a patient and to find a place to take charge of him and detain him against his will.’ Instead, medical practitioners could exercise power more subtly. Dr Read from the British Medical Association suggested that:

As long as you have the name and address you can follow a case. A man or woman could be communicated with and the importance conveyed to them of continuing treatment. In that way it would be brought home to them forcibly that for their own good and the good of the community they should go on with treatment.

In most states of Australia, when venereal diseases legislation was introduced, it was accompanied by commentary that positioned that legislation in a broader governmental and imperial framework. For instance, in relation to the introduction of the Western Australian legislation, the MJA editorialised that ‘the Act is a very interesting and important piece of experimental legislation, and, as such will be watched closely by hygienists, not only in the Western state, but also in every corner of the British Empire.’ Medical Journal of Australia, January 1916, p. 99.


‘Minutes of the Conference between the British Medical Association and the Minister of Public Health,’ Establishment of Venereal Diseases Clinics, NSW State Archives, container 10/43028.
Both on a case by case basis, and aggregated annually, I will examine post-legislative notification and ‘default’ statistics. These statistics represent the NSW government’s first full-scale foray into data collection and interpretation related to venereal populations, and elucidate the role that medical practitioners played in collecting and interpreting this data.

One reading of the NSW venereal diseases legislation is that developments in the domains of treatment and prevention, and the perception and promotion of the idea of epidemic, could be used as tools by government to increase the power of medical and scientific experts and the surveillance of venereal populations. Such a reading is accurate but limited: relationships between medical practitioners, individuals, governments and populations were more nuanced. I argue that the Act positioned medical practitioners as the experts through whom the counting of venereal populations would be filtered. I argue as well that the Act was introduced at a time when on the one hand there was a significant push towards self-regulation in relation to treating and preventing venereal diseases, and on the other, government was carving a role for itself and medical experts in keeping a ‘watchful eye’ on and counting venereal populations. This tension between regulation and self-regulation was played out in the creation and measurement of ‘notified person’ and ‘defaulter’ categories.\footnote{\textsuperscript{664} Smart captures this regulation/self-regulation paradox nicely when she positions venereal diseases in the context of citizenship and nationhood. Smart argues that the war pushed the states and the nation towards increased discipline: ‘the main outcome was a heightened emphasis on state power and subordination of the individual, on bureaucracy and surveillance – a symbolic deployment of discipline at home that paralleled their actual deployment on the battlefield’ (Smart, J., ‘Sex, the State and the “Scarlet Scourge,”’ p. 16). Others have noted this relationship between war and the subordination of the individual. Bashford suggests that the NSW VD Act 1918 was passed in part because of ‘the exigencies and the culture of extraordinary measures produced by the War’ (Bashford, \textit{Imperial Hygiene}, p. 169). More specifically, in relation to venereal diseases, Smart argues that moves towards compulsory notification gained pace as a result of war (‘Sex, the State and the “Scarlet Scourge,”’ p. 16). Writing of Victoria, Smart suggests however that the deployment of state power had limited effectiveness: ‘more effective policies and procedures for the whole population also involved encouragement of self-regulation through education and public information campaigns that operated on a number of levels’ (\textit{ibid}, p. 24). I will, in the next chapter, delineate some of these education and public information campaigns before, during and after the war. Smart saw two sets of strategies – formal controls and self-regulation – at play in the lead up to, and in the wake of, the VD Act 1918. Bashford argues that formal controls held the day in the 1918 Act: it ‘was a heavy handed piece of legislation’ (Bashford, A., \textit{Imperial Hygiene}, p. 169). I argue that the legislation was an important moment in counting and monitoring venereal populations in NSW precisely because it skilfully positioned medical practitioners as the enumerative interface between a watchful government and the diseased body politic.}
Whereas the NSW PD Act 1909 had been initially drafted to include quasi-notification procedures, the VD Act 1918 specifically included a template for registering venereal patients, and for tracking treatment compliance. The full responsibility for notifying and annually aggregating venereal diseases rested with medical practitioners. This was a far more diffuse approach than that posited in the PD Act. Medical practitioners needed to notify the Commissioner for Venereal Diseases if ‘any person consulting him is suffering from any venereal disease’ in the prescribed form without disclosing the name and address of the patient.\(^665\) The Commissioner for Venereal Diseases was a new role introduced by the legislation. Medical practitioners could be fined £20 for contravening this requirement up to a maximum of five times, but not exceeding £100. Penalties were attached to a range of prescribed activities of patients as well. Patients had to consult a medical practitioner within three days of ‘becoming aware of his condition’ (or be liable for a fine of £100 or three months’ imprisonment); continue to see a medical practitioner ‘once in every such period as is prescribed’ (or pay a fine of £20); advise of changes of address (fine £5); and advise of change of medical practitioner (fine £5). Regulations (1919) subsequent to the VD Act also provided a prescribed template for the Annual Return of cases of all venereal diseases seen by medical practitioners, and whether they were cured.\(^666\)

Nine of the key clauses of the NSW VD Act related to constraining an individual’s sexual and reproductive activity in the interests of the state, by placing borders of control around sexual activity, marriage, employment and treatment options. Those with a venereal infection could not ‘do or permit or suffer to be done any act likely to lead to the communication of the disease to others.’\(^667\) A penalty of £100 or 12 months in gaol applied for a breach of this clause. Similarly, a person could not marry ‘until medically certified cured.’\(^668\) In relation to treatment the Act said that ‘every person suffering from any venereal disease, or suspecting that he is so suffering’ had to consult a medical practitioner within three days, and once having consulted a medical practitioner, had to stay with that medical practitioner until ‘cured,’ unless

\(^{665}\) VD Act 1918 Regulations, Government Gazette No. 255, 10 November 1919, section 7.

\(^{666}\) VD Act 1918 Regulations, Government Gazette No. 255, 10 November 1919, form J.

\(^{667}\) VD Act 1918 Regulations, Government Gazette No. 255, 10 November 1919, form E.

\(^{668}\) Ibid.
moving to another medical practitioner under carefully prescribed circumstances. The legislation placed a series of spatial and temporal barriers around the venereal patient, and medical practitioners were the gatekeepers. Similarly, government needed to know about the treatment behaviours of venereal patients, and when a medical practitioner became aware that a person was suffering from a venereal disease, the medical practitioner had to ‘give notice thereof to the Commissioner in the prescribed form, in the prescribed period.’

Seven different offences arose from the VD Act 1918 and these included knowingly infecting others, failure to seek therapy and failure to continue therapy. Between 1923 and 1939, the following prosecutions were recorded: 18 for sale of prohibited drugs by chemists; two for treatment by unqualified practitioners; 12 for failure to seek therapy; 10 for failure to continue therapy; six for advertising cures for venereal diseases; nine for publishing a statement on a cure for sexual dysfunction or abortion; and one for knowingly infecting another, which was dismissed. I have not located evidence to suggest that any medical practitioners were fined for not notifying venereal diseases in the prescribed form, even though medical practitioners in NSW sometimes under-reported or mis-reported venereal diseases.

Even with thorough notification apparatus the 1920s saw decreasing numbers of people being notified to the NSW Department of Public Health. Such a decline was reflected in most states of Australia. Although New Zealand’s Social Hygiene Act 1917 had not enacted either compulsory treatment or notification, a significant epidemiological enquiry in 1922 found low rates of syphilis and gonorrhoea in that country. The first NSW Commissioner of Venereal Diseases, filling the post as the Director-General of Public Health, Dr R. T. Paton reported in 1921 that notification was made problematic because of insufficient clinic accommodation, false names and addresses and the reluctance of country hospitals to treat venereal patients. In 1921,

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669 NSW VD Act 1918.
671 In 1922, a Committee of Inquiry sought prevalence data from 750 medical practitioners, and received 635 replies. From returned data, and taking into account the population of New Zealand being 1,296,986, the Committee calculated that 1 person in every 812 was being treated for gonorrhoea and 1 person in every 914 was being treated for syphilis. The Commissioners saw this as ‘on the low side.’ They also asked medical practitioners to comment on whether they thought venereal diseases had increased in the previous five years: ‘199 answered yes, and 203 answered no’ (Venereal Diseases in New Zealand, p. 18).
9405 cases of venereal disease were notified, comprising roughly 71 percent gonorrhoea cases and 22 percent syphilis cases. By 1930, 5225 cases of venereal disease were notified, comprising 68 percent gonorrhoea cases and 27 percent syphilis cases. It is impossible to determine the accuracy of the Director-General’s data. Some have argued that medical practitioners under-reported, but this needs to be seen in the context of medical practitioners being paid by the NSW Department of Public Health for each and every notification. Did the decline across the 1920s reflect decreasing prevalence, increased non-reporting or mis-reporting by medical practitioners or some other phenomenon? Did the control system lose currency as the years passed, or were medical practitioners who had misgivings about the capacity of the Act reassured by its actual operation? If under-reporting did occur, it may have been because medical practitioners were not prosecuted for non-compliance.

There is some ambiguity as to what was counted as a venereal disease notification in statistics published by the NSW Director-General of Public Health in Annual Reports during the 1920s. Technically, only Regulation 7, which related to section 9 of the VD Act, was the formal notification Regulation. This Regulation stated that a medical practitioner needed to notify the Commissioner of Venereal Diseases within seven days if they treated a person suffering from venereal disease, on Form B of the Register’s schedule. The Regulations of November 1919 however also included four other situations where a medical practitioner had to notify the Commissioner. These were when a patient changed medical practitioner (Regulation 6); when a patient failed, or defaulted, with treatment (Regulation 8); when a medical practitioner issued a Certificate of Health (Regulation 10); and when notifying the Department of the annual return of the number of venereal cases (Regulation 12). Notification was also complicated by ambiguity about what constituted a diagnosis of syphilis. I suggested in chapter 3 that individual patients were often multiply tested for syphilis, and on different occasions achieved different results, ranging from ‘positive’ to ‘incomplete positive’ to ‘incomplete’ and to ‘negative.’ Would an ‘incomplete positive’ have counted as a positive diagnosis, particularly when it was the second test for a specific individual who had earlier achieved a ‘positive’ and would therefore

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674 Lewis, Thorns on the Rose, p. 217.
675 VD Act 1918 Regulations, Government Gazette No. 255, 10 November 1919.
have been notifiable? Did notification data aggregated by the Department of Public Health detail all instances of every notification, and not just a section 7 notification? If so, then what has been read as a marker of a specific infection in one person may well have been a marker of any number of events in any number of individuals. It is likely, for instance, that any particular patient during the course of prolonged treatment could be notified for any combination of the above events. It is also likely that any particular patient could be notified more than once for any particular event (for instance, changing medical practitioners three or four times over a period of two years). Because notification was multi-situational and potentially multi-counted the same individual, the possibility existed of notification data being inflated, even across the 1920s, where numbers of people notified in NSW were actually decreasing.

Total numbers of patients defaulting from the NSW VD Act also decreased during the 1920s. In the first year of operation, 2472 people defaulted, representing 26.3% of total notifications. Of these, 906 people resumed treatment, died or left NSW. Lewis has estimated that in 1921, 61.7 percent of venereal patients remained in default. It is likely that in its first year of operation all parties to the process of implementing systems to count venereal default would have experienced teething problems. Notwithstanding this proviso, the estimated default rate was extraordinarily high. By 1930, 774 people defaulted, representing 14.8 percent of total notifications. Of these, 448 patients resumed treatment, died or left NSW, indicating that 48.3 percent of patients remained in default. Although the decade saw a significant decrease in the number of people defaulting from treatment, the default rate remained high. This is especially curious in the context of the widespread compliance that characterised patient behaviour in the period before 1918.

After ten years of operation, 48.3 percent of patients who had started treatment for either syphilis or gonorrhoea in NSW did not complete their course of treatment, and therefore were not issued with a certificate in the prescribed form that ‘such person is cured of or is free from venereal disease,’ as codified in the legislation. An important concomitant statistic is that 51.7 percent of patients, who had initially

676 Lewis, Thorns on the Rose, p. 215.
677 Ibid., p. 215.
678 NSW VD Act 1918, clause 14 (1).
defaulted, for whatever reason, went on to resume treatment. I will examine reasons for the high default rate shortly, but it is important to understand how and when patients were persuaded, traced or forced back into treatment. The process of forcing patients to resume treatment for venereal diseases after an initial default was not, however, ‘contact tracing.’ I will refer to this phenomenon as default tracing, although this is not a term employed at this time. There were a range of points at which a patient could be technically designated as being in default, and this depended on the approach of the medical practitioner. A patient could be considered to be in default if he/she did not consult a medical practitioner within three days of ‘becoming aware of his condition,’ did not continue to see a medical practitioner ‘once in every such period as is prescribed,’ did not advise of changes of address and did not advise of a change of medical practitioner. Given the potential multiple default points, and the ambiguity of some of these clauses in the VD Act, a patient could be considered to be in default at any time from pre-diagnosis to eventual certification.

It is considerably more complex to understand how default tracing was conducted. Medical practitioners would have reported a default, but who would have traced, contacted and compelled the patient to resume treatment? The Regulations that were gazetted subsequent to the VD Act 1918 provide some answers to the question of how default tracing was conducted.679 The Regulations stipulated how frequently a patient had to attend for treatment, according to the infection, before s/he was considered to be in default. A person with syphilis needed to attend once every two weeks until stable, and then once every four weeks; a person with gonorrhoea had to attend once every seven days in the acute period, and thereafter once every 14 days; a person with soft chancre had to attend once every seven days; with gonorrhoeal ophthalmia, every day during the acute stage, and then once every seven days; with venereal granuloma, once every seven days; and with gleet, once every fourteen days.680 Although these prescribed periods were more definite than the Act, they still left a reasonable degree of interpretation with the medical practitioner. Regulation 8 specified that if within ten days of a prescribed period having passed a patient had not reported to the medical practitioner, then ‘such medical practitioner shall forthwith send a notice to the

679 VD Act 1918 Regulations, Government Gazette No. 255, 10 November 1919.
680 Ibid., Regulation 4.
Commissioner on Form C in the Schedule hereto.’ Any time a medical practitioner notified the Department of any issue pursuant to the Regulations, s/he was provided with two shillings and sixpence if in private practice, and one shilling if an officer of a hospital. Having received a notification of default, the Commissioner of Venereal Diseases notified the Commissioner of Police, and police constables were employed to compel the patient to resume treatment. Police constables were employed in other sections of the Regulations: a pro forma Special Warrant (form K) was included for raiding and seizing ‘articles, medicines, instruments or appliances’ from the premises of alternative therapists. Correspondence between a Dr Rutherford from rural NSW and the Commissioner of Venereal Diseases in 1929 suggested as well that police constables were employed to make discreet enquiries about the financial status of patients who sought free treatment as indigents. Default tracing was clearly in the financial interests of the private medical practitioner, but police undertook most of the unpleasant fieldwork.

There are a number of important factors that need to be considered when assessing the meaning of the high venereal default rate in NSW in the 1920s. Subsequent to the 1918 Act, the Department of Public Health was mandated to develop procedures to monitor treatment default. The system for notifying, treating, tracking and compelling treatment defaulters was complex and cumbersome. With the eventual gazetting of the NSW VD Act in December 1920, notification and treatment of venereal diseases became compulsory in NSW. I have observed earlier that part of the reason for the delay in the introduction of the Act arose because of insufficient treatment facilities to give meaning to the legislation. There were other issues in relation to treatment that affected the implementation of the legislation. Treatments themselves were changing, and in the early 1920s, Neosalvarsan, a refinement of Salvarsan, became the most commonly used treatment for syphilis. Treatments for gonorrhoea continued to rely on irrigation with antiseptic solutions. For both infections, debate continued as to appropriate dosage, administration, and regularity of treatment. In this rapidly changing context, government had to quickly develop an apparatus for notification of infected individuals, and compulsory treatment, and systems and techniques for

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681 Ibid. Regulation 8.
682 Ibid., Form K.
683 ‘Correspondence between Dr Rutherford and NSW Department of Health’, Supply of Drugs for Venereal Diseases at Rachel Foster Hospital, NSW State Archives, container 10/43029, folio 30/170.
dealing with and responding to treatment defaulters. Both notification and compulsory treatment worked at the level of the infected populations: in the 1920s lock hospitals were not necessary to spatially segregate people with venereal diseases.

Although the Regulations to accompany the Act were gazetted at the end of 1919, some important matters of fine detail remained unresolved. This not only led to initial confusion amongst medical practitioners and patients, but also probably affected the integrity of early default data, which for 1921 was particularly high. Medical practitioners asked whether ‘the diagnosis of gonorrhoea was to be strictly limited to those infections caused by the gonococcus or whether the allied infections caused by other organisms were to be included.’ Even with the Regulations, this remained unclear. Medical practitioners were also unclear as to whether they needed to keep a register of notified patients, under lock and key, and how administrative arrangements could be organised so that clerical staff did not become aware of the identity of the notified patient, and so breach the ‘third party’ clause. One rural medical practitioner sought financial support from the Department of Public Health to visit venereal clinics in Sydney and familiarise himself with modern practices, but was refused this support. Similarly, medical practitioners were concerned that the keeping of a register to track daily, weekly or monthly treatment regimes would be an onerous and complex responsibility. There was also a lack of clarity about whether the prescribed form for notification would be a ‘book with a butt and slip,’ about who would be responsible for monitoring overdue patients, either the medical practitioner or the Commissioner for Venereal Diseases, and the administration of the system of fines. Finally, there was significant doubt about the value and meaning of a clause in the Act and subsequent Regulations that suggested that medical practitioners would, or could, give a ‘Certificate of Cure of freedom from Infectivity.’ Many argued that this was optimistic, scientifically dubious, misleading and possibly negligent. With the development and implementation of the accompanying Regulations much of the detail of the legislation would eventually be fine-tuned.

There were however two fundamental aspects of the legislation which created immense confusion: medical practitioners were asked to notify venereal diseases that remained diagnostically imprecise (what were they notifying?) and they were also asked to provide Certificates of Freedom from Infectivity to patients when treatments were known to be therapeutically unclear (what constituted a ‘cure’?). Medical practitioners also asked whether prescribed periods for treatment within the Act applied equally to all venereal diseases (they did not, but the meaning of acute and chronic phases of diseases remained imprecise). Rapidly changing medical notions underpinned, and undermined, notification and default data.

Such observations are particularly apposite in the context of medical ambivalence and ‘practitioner default’ during the 1920s. I have suggested in chapter 2 that the system of quotas and diminishing service delivery that characterised venereal treatments at RPA Hospital immediately prior to the VD Act 1918 amounted to a profound medical ambivalence. Attitudes, practices and systems remained the same in the 1920s, and early default data were significantly affected by diminishing treatments and policies predicated on a fear of venerealisation. By January 1921 RPA Hospital, Sydney Hospital and the Hospital Admissions Depot were quite incapable of dealing with venereal patients, and ‘some were delayed and others refused admission.’ By 1924, after five years of operation of the new Act, venereal treatment facilities across NSW had reached breaking point. In July 1924, in what would appear to be a concerted campaign, the Medical Superintendents of both Sydney and RPA Hospitals wrote to Dr Dick, the Director-General of Public Health and de facto Commissioner of Venereal Diseases, advising that because of massive ‘congestion’ and the ‘poor facilities available’, it was ‘impossible to efficiently treat the numbers attending for the treatment of venereal diseases.’ The Medical Superintendent of RPA Hospital, Dr W. McCredie, suggested to the Director that ‘if you can find some place for them

689 ‘Memorandum from Under Secretary to Director-General of Public Health, 7/1/1921,’ Establishment of Venereal Diseases Clinics, NSW State Archives, container 10/43028.
690 ‘Letter from Dr Porter to Dr Dick, 16 July 1924,’ Establishment of Venereal Diseases Clinics, NSW State Archives, container 10/43028.
to have treatment we could get rid of them altogether.’ Dr McCredie argued that all cases of syphilis where treatment was at a ‘standstill’ and which were ‘quite safe from the public health point of view’ should be discharged, and be required to report back in three to six months. Only ‘fresh’ cases of syphilis were to be seen at RPA Hospital, and the maximum quota for venereal patients was fixed at 450 patients. Discharged patients were advised to attend the government-administered Hospital Admissions Depot, and were provided with the following letter: ‘as we are unable to treat this patient in our Venereal Clinic, will you please arrange for his treatment at some other institution.’ Such arrangements amounted to ‘practitioner default,’ but it is possible that they were counted as patient default. The pattern of diminishing service delivery and restrictive quotas that characterised the previous decade continued into the 1920s, and it is reasonable to question how this medical ambivalence affected default. It is possible that defaulting patients were unable to navigate the shifting treatment landscape, leading in effect to an ‘imposed default.’

If the very notion of the default and the constitution of the defaulter were dubious then the data collected about this group of individuals was often too readily taken as a surrogate marker of venereal prevalence. Both contemporary and current commentators have analysed ‘default’ data and observed not only that there were significant numbers of people who discontinued venereal treatment, but also that these ‘default’ data were in fact a marker for the general prevalence of venereal diseases. Western Australia passed its venereal disease legislation in 1915, and by 1921, when the NSW Act was just being implemented Western Australia had had six years of ‘default’ statistics. Everitt Atkinson, Commissioner of Public Health in Western Australia, provided an overview of ‘default’ statistics to the Australasian Medical Journal in January 1922, in which he argued that ‘the statistics constitute the material upon which we have to work and the less accurately they represent the true position,

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691 ‘Letter from Dr McCreedie to Dr Dick, 16 July 1924,’ Establishment of Venereal Diseases Clinics, NSW State Archives, container 10/43028.
692 ‘Memorandum from Under Secretary to Secretary of Public Health, 25 July 1924,’ Establishment of Venereal Diseases Clinics, NSW State Archives, container 10/43028.
693 ‘Letter from RMO at RPA Hospital to the GMO at Hospital Admissions Depot,’ Establishment of Venereal Diseases Clinics, NSW State Archives, container 10/43028.
the greater is our experimental error and the less correct are our conclusions.’

Everitt Atkinson’s epidemiological survey covered a five-year period, and he concluded that there were 5713 notifications, with six times as many men being notified as women, and five times as many cases of gonorrhoea being notified in men as syphilis, and only two times as many cases of gonorrhoea being notified in women as opposed to syphilis. Of these notifications, 2200 were reported as having suspended treatment, and 925 of these ‘have been caused to resume’ treatment. Everitt Atkinson suggested that those who did not resume treatment had either ‘left the state, are deceased or have been lost sight of, owing to the practice of some giving a wrong name or address.’ The use of the phrase ‘lost sight of’ suggests the malfunctioning ‘watchful eye’: venereal patients found ways to avoid the diffuse reach of the legislation. Everitt Atkinson suggested ‘it would be too fanciful to suggest that the figures submitted represent the total number of cases of venereal disease, but they must afford a reasonably reliable index of relative prevalence.’

Within a short period of time, ‘default’ data were read as prevalence data, whilst it was also acknowledged that ‘we cannot know how much has not come to our knowledge by notification.’

A similar attempt to interpret ‘default’ data, assess the impact of legislative responses which codified compulsion, and evaluate the relative merits of coercive and consensual approaches to the governance of venereal diseases was made in February 1922, when the Prime Minister of Australia convened a conference in Melbourne to assess the efficacy of state-based venereal diseases legislation. The conference concluded that more people were being more effectively treated, that more men were brought under the operation of all Acts than women, and that ‘legislation has not been long enough in force’ to ascertain whether prevalence had decreased. The conference

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697 Ibid., p. 65.
698 Ibid., p. 65. Everitt Atkinson also provided financial data which detailed the costs involved in administering the legislation. The total cost was 30,144 pounds, of which the Commonwealth provided 10,894 pounds. Nearly two thirds of the total costs were related to free treatment provided at government and subsidised hospitals.
699 Ibid., p. 66.
700 Medical Journal of Australia, 18 February 1922, pp. 196–199. The conference was attended by all state-based Directors of Public Health, commissioners of Venereal Diseases, representatives of the British Medical Association and representatives from various Commonwealth departments, including Health, Quarantine and the Serum Laboratories.
also laid out protocols for the vexed questions related to ‘Standards of Cure’ and ‘Standards of Treatment.’ These were designed to address significant definitional issues as to what constituted a ‘default,’ and who constituted a ‘defaulter.’ The conference also addressed issues related to prevention, prophylaxis and education that had been consistently avoided in all state-based legislation. Teaching of sex hygiene was perceived to be essential ‘for the ultimate control of venereal disease’, as was the linking of individual sexual and reproductive health with national concerns:

‘the Conference urges all parents and educational, philanthropic and religious organisations of the pressing necessity for a sustained campaign in cooperation with the medical profession in order to inculcate higher ideals of personal hygiene and national health on the community.’

This biopolitical ambition was to be achieved by seeking ‘the cooperation of the patient by gaining his or her confidence.’ At the same time however venereal patients were to be constrained in their interstate migration, with any person undergoing treatment being provided with a card ‘stating the nature of the disease, the amount and nature of treatment administered and the last pathological report.’

After nearly a decade of collecting notification and default data in NSW, health bureaucrats were using it to make some general observations about prevalence, and conclusions were reached about the populations who were perceived to be either most ‘at risk,’ or ‘a risk’ to the rest of the population. Adolescents figured strongly in these observations. At the NSW Racial Hygiene Association Congress in 1929, J. Cooper Booth, Director of the Division of Venereal Diseases, presented correlated age/notification statistics that indicated that nearly 45 percent of all notifications were in people between the ages of 16 and 25, and a further 30 percent of notifications were between the ages of 25 and 35. Nearly three quarters of all notifications in NSW were in people under the age of 35. Cooper Booth interpreted these statistics as

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701 Ibid., p. 198.
702 Ibid., p. 197.
703 Ibid., p. 197.
proving that ‘the child must have sufficient sex knowledge to protect itself by the time the 16th year is reached.’ There had been a shift before, and during, the 1920s, in the preventative domain, from a social purity to a sex hygiene approach. This shift included changes in both the populations who were of primary interest to government and the places and sites that were deemed to be significant in terms of transmission. Epidemiology, informed by notification data, was both informing and being informed by this perceptible shift toward the technology of self-regulation. Nevertheless, technologies of coercion continued to play a role during the 1920s.

Did the VD Act 1918 actually change patient behaviour? People were compelled to seek, and continue treatment, and if they did not, they were construed as being ‘defaulters.’ I contend that an important reason for the development of the stereotype of the non-compliant, irresponsible venereal patient was the deployment of policies and practices attached to ‘default’ in the 1920s. Lewis has assembled impressive quantitative data on the extent of default during the 1920s in NSW, and in other states. These statistics would appear to support the notion of the non-compliant venereal patient. The qualitative evidence I have assembled for the period prior to 1918 indicates that venereal patients were compliant, responsible and conscientious. Is it possible that the element of compulsion in venereal diseases legislation actually changed the behaviour of venereal patients? Some patients resisted techniques of domination. Clearly, however, there were a number of factors that determined whether a patient would default. For the interwar period in Scotland, Davidson has placed default in a broad cultural and social context, and claims that the non-compliant ‘behavioural stereotype deployed within Scottish public health was lacking in empirical support.’ Davidson argues that little research has been undertaken into the reasons for default, but that it was clearly a complex phenomenon. Fear of ‘social ruin,’ undertaking lengthy treatment without informing family or work colleagues, the cost of travel, judgmental clinic staff and invasive treatment are cited by Davidson as the primary reasons for default. In NSW, as well, default can be read at a number of

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705 Lewis, Thorns on the Rose, pp. 212–217. Lewis indicates that ‘for defaulters as a percentage of total notifications, there was a tendency for the percentage to decline between 1921 and 1933.’ Lewis also provides data for the periods 1938–1959 (p. 262), and for the entire period 1921–1971 (p. 296).
levels, and the complexities of default definitions, reporting and categories certainly raise some uncertainty about the ‘non-compliant’ and ‘irresponsible’ venereal patient.

Conclusion

In this chapter I have shifted the focus from the individual to the population, from the ‘medical gaze’ to the ‘watchful eye,’ and from the body to the body politic. Whilst the individual venereal body was treated with mercury or arsenic or antiseptics, the venereal body politic was treated with a set of tools and procedures that ensured the necessary segmentation, segregation and surveillance of the population. Techniques that were used to treat the body politic included legislation, regulation, statistics, observation, notification and documentation. I have detailed the early principles and practices of epidemiology as they related to venereal populations. In the same way that responses to treating individual bodies were ambivalent, ranging through commitment, engagement, reluctance and avoidance, responses to treating the social body were also ambivalent: sub-populations were subject to modes of rule which were assigned according to relative assessments of risk and danger. The development of two new important venereal categories in NSW in the 1920s, the ‘notified person’ and the ‘defaulter,’ allowed for the deployment of enumerative mechanisms that uncompromisingly tied prevalence to treatment compliance and non-compliance.

I have also argued in this chapter that epidemiology was more than a set of statistical devices utilised to measure numbers attending venereal disease clinics and rates of syphilis and gonorrhoea infection. In analysing systems in NSW from both before and after 1918, including both the PD Act 1909 and the VD Act 1918, I have suggested that epidemiology played a significant role in constituting venereal populations themselves. Legislation provided a framework for the counting of venereal populations, and in the absence of such frameworks, counting mechanisms were often localised and limited. Although the weekly returns of Sydney and RPA Hospitals were comprehensive, internally consistent and specifically noted and acted upon by the NSW Department of Public Health, at the time they were not broadly disseminated or interpreted, despite attempts to have them published.
The NSW VD Act 1918, with its emphasis on notification, compulsory treatment and default reporting created two new categories that were to become fundamental to venereal epidemiology over the twentieth century: the notified person and the ‘defaulter.’ The notified person was no longer perceived to be limited to the categories of ‘case-hardened’ prostitute or naval personnel: any citizen, but most frequently poor, young women, could be counted in venereal data provided by medical practitioners to government. Similarly, during the 1920s ‘defaulters’ quickly became a category that governments were keen to measure, because it confirmed many pre-existing stereotypes related to irresponsibility and recklessness. Both of these categories were able to be created by the dispersal of monitoring and surveillance mechanisms to medical practitioners: without notifying agents, governments would not have been able to achieve the reach they required to potentially count the entire infected citizenry. In a very short period of time, both of these categories became important markers for venereal prevalence. Governments sought to demonstrate that the number of people being notified for venereal infection, or the number of people who defaulted from treatment, equated to actual prevalence of venereal diseases in the community. I have argued that such an equation is fraught because the very definitions used to create the categories of ‘notified person’ and ‘defaulter’ were complex, cumbersome and inconsistent. The counting of these new categories was occasioned by the VD Act 1918, facilitated by the enlistment of medical practitioners as agents, and ultimately made possible by the ongoing attendance of a population that sought treatment for venereal infection.

Chapter 5

A Diffusion of Practices: Prevention of Venereal Diseases

In the first quarter of the twentieth century a range of individuals, organisations and governments were asking controversial questions about how venereal diseases could best be prevented. Fear of the multitude of social, sexual, economic, eugenic and physical ills that were perceived to accompany venereal diseases drove the framing of such questions. They asked who prevention strategies should target, and why; what
the messages of prevention should be; how young people could be educated towards sexual restraint; whether impeding sexual infection through pre-, intra- and post-coital prophylaxis would stimulate sexual activity, and what role medical practitioners, teachers, parents and clergy should respectively play in prevention. In preceding chapters I have examined the sorts of questions that were being addressed in relation to treating venereal patients, and counting venereal populations. The issue of preventing venereal diseases was never far from the surface when issues of treatment and epidemiology were being discussed: it was however a far thornier one to resolve. Over the period, both treatment compliance and notification to facilitate epidemiological counting could be legislated, and had been in relation to venereal and other communicable diseases. However, legislating to enforce citizens to practise sexual restraint, avoid sexual infections, change sexual conduct and empower governments to educate in all these domains had not been attempted (apart from VD Regulations in Scotland, and governments therefore found themselves in need of alternative strategies. This was in fact one of the tasks of hygiene, in NSW, and beyond. As Col. L. W. Harrison, a medical practitioner with extensive experience

707 Pre-coital prophylaxis, or anticipatory prophylaxis, included the supply of drugs and appliances for use by an individual before exposure to infection. Many abhorred this approach because it appeared to sanction pre- and non-marital sex. Intra-coital prophylaxis included condoms, which were costly, and difficult to obtain. Post-coital prophylaxis included early treatment applied after exposure to infection, and often involved calomel lotion, and disinfectants syringed into the urethra. All three of these prophylactic approaches attracted critics, and during this period none were generally implemented in civilian communities in NSW. See Medical Journal of Australia (1919), 'The Prophylaxis of Venereal Disease' 1: pp. 240–241; Medical Journal of Australia (1922), 'Letter to the Editor: The Prophylaxis of Venereal Diseases' 1: p. 169; Medical Journal of Australia (1922), 'Letter to the Editor: The Prophylaxis of Venereal Diseases' 1: p. 368; Medical Journal of Australia (1922), 'The Prophylaxis of Venereal Diseases' 1: pp. 93–94; Medical Journal of Australia (1922), 'Prophylaxis in Venereal Diseases' 1: pp. 108–111.

708 Other significant questions included how preventative strategies should be reviewed, and assessed; how soldiers could be persuaded to use condoms when visiting prostitutes; and whether there were lessons to be learnt from preventative strategies adopted with other communicable diseases, like tuberculosis, smallpox and diphtheria?

709 Davidson demonstrates that VD Regulations of 1916 promulgated by the Local Government Board for Scotland empowered Scottish Health authorities to liaise with the police, with medical and educational authorities, in the provision of instructional lectures and the diffusion of information on questions relating to VD.’ The Regulations laid particular stress on the need to highlight their ‘far-reaching and disastrous effects on the social efficiency of the family’ (Davidson, R., Dangerous Liaisons: A Social History of Venereal Diseases in Twentieth Century Scotland, Amsterdam, 2000, p. 135).

710 See Thin, R. N., ‘My Choice: The Life and Times of Colonel LW Harrison. The First Harrison Lecture,’ Sexually Transmitted Infections, 2000: 76: Supplement 1: pp. 34–35. Colonel Harrison’s early career was in the Royal Army Medical Corps, and by the end of the War he was running a venereology service for the British Army in north-west Europe based on a hospital with 3000 beds. It was on this extensive clinical experience that Harrison wrote a number of books on the prevention and treatment of venereal diseases. In 1919 he was appointed adviser in venereology to the Ministry of
in the management of venereal diseases with the Royal Army Medical Corps suggested in 1919: ‘the prevention of venereal diseases is a task which should concern every citizen of the Empire.’

From a hygienist perspective governments saw themselves as having a role in building the determination of individuals to be healthy and resist risk factors that promoted illness. Whereas earlier paradigms of sanitation had used legislation as a tool to ensure appropriate environments for good health, hygiene sought to civilise and enlighten individuals, often through subtle pedagogic techniques, and propaganda. The key directive of hygiene was self-care and self-competence: in other words, ‘responsibilisation,’ or self-government. In the prevention of venereal diseases, as the century progressed, modes of rule shifted towards responsibilisation. This was a shift in the way and the sites in which power was practised: the focus of public health moved from infected bodies to healthy bodies, and from pathologised spaces like brothels and ports and parks, to schools and homes and workplaces. As Scott suggests, ‘we do not witness a retreat of power, but a dispersal of powers into an array of new sites.’ Self-government in itself then was an instrument of government power, a sentiment powerfully caught not just by Foucault, but by the Alfred Lord Tennyson refrain quoted in the report Venereal Diseases in New Zealand:

The absence of proper training and instruction of the young is undoubtedly responsible for a great deal of the evil which has been shown to exist:-

*Self reverence, self-knowledge, self-control,-
These three alone lead life to sovereign power.*

Health and set up a model clinic at St Thomas’s hospital in London. He was a founder member of the Medical Society for the Study of Venereal Diseases (MSSVD), and by 1924 was acting as a liaison between the Ministry of Health and the National Council for Combating Venereal Diseases (NCCVD).

Harrison, L. W., *The Diagnosis and Treatment of Venereal Diseases in General Practice*, London, 1918, p. 418. There were also preventative discourses related to other infectious diseases, including tuberculosis, and these can provide a point of comparison with the discourse on venereal diseases prevention. In fact, prevention education processes utilised in tuberculosis were cited as an appropriate model for venereal diseases prevention education in Anonymous, *Should Syphilis be Notifiable?*, 1911.


Scott, ‘The Management of Venereal Diseases in New South Wales.’

Quoted by the Committee of the New Zealand Board of Health, *Venereal Diseases in New Zealand: Report of the Special Committee of the Board of Health Appointed by the Hon. Minister of Health*, Wellington, 1922: from Alfred Lord Tennyson’s (1809–1892) poem ‘O’Enone’. The full stanza reads: ‘Self reverence, self-knowledge, self-control/ These three alone lead life to sovereign power./ Yet not
In this chapter I argue that there were uneven changes in the modes of rule related to the prevention of venereal diseases in the period 1901–1925 that can be understood in the relationship of sovereign self to sovereign state, that is, biopolitically.\textsuperscript{716}

‘Prevention’ is a complicated domain. Notions informing it have changed considerably: paradigms which now inform prevention, like health promotion,\textsuperscript{717} population health,\textsuperscript{718} community development,\textsuperscript{719} harm minimisation\textsuperscript{720} and risk reduction\textsuperscript{721} were not a major part of earlier preventative discourse. I identify three prevailing preventative logics which were evident, albeit unevenly: preventative medicine, public health prevention and prevention education. I focus on prevention education, also sometimes referred to as health education, which had a number of expressions loosely grouped around ideas related to social purity and sex hygiene.

There were clear changes in who conducted prevention education, when such activities took place, how they were conducted, and to some extent, in the preventative curriculum. The trend was towards the dispersal of preventative techniques throughout the community. There were less clear changes however in what was being prevented – the preventative goals. Across the period goals remained focused on containing desire, restraining sex and sexuality, valorising marriage, and

\textit{for power (power for herself)/ Would come uncall’d for but to live by law:/ Acting the law we live by without fear;/ And, because right is right, to follow right/ Were wisdom in the scorn of consequence.’}\textsuperscript{716}

Foucault, M., \textit{The Birth of the Clinic: An Archaeology of Medical Perception}, London, 1973. This notion is also captured well in the Report of the New Zealand Inquiry into venereal diseases in 1922, when the commissioners remarked: ‘It must be obvious to every thinking person that looseness of conduct between the sexes such as is shown to exist in New Zealand is destructive to the highest ideals of family life associated with the finest types of British manhood and womanhood, and if not checked must lead to the decadence of the nation’ (\textit{Venereal Diseases in New Zealand}, p. 25).\textsuperscript{717}

For a thorough overview of the principles of practice of health promotion see Nove, T., and Heslep, J., \textit{Health Promotion Core Skills Program}, Western Sydney Area Health Service, 1994. For more particular information on sexual health promotion, see NSW Health, \textit{Sexual Health Promotion Guidelines}, North Sydney, 2002. For more information on one aspect of health promotion, capacity building, see \textit{A Framework for Capacity Building to improve Health}, North Sydney, 2001.\textsuperscript{718}

Population health is a newer paradigm for understanding public health. See NSW Health, \textit{Healthy People 2005: New Directions in Public Health in New South Wales}. This key policy document is founded on the principle that ‘public health generally targets the whole population or groups within the population, rather than individuals.’ Population health principles are integral to, for instance, \textit{Surviving our Success: NSW HIV/AIDS Health Promotion Plan}, NSW Health, North Sydney, 2001.\textsuperscript{719}

Community development is one component of health promotion, and is a key feature of both the Ottawa Charter for Health Promotion and Jakarta Declaration for Health. In relation to HIV/AIDS see Trussler, T., and Marchand, R., \textit{Field Guide: Community HIV Health Promotion}, Vancouver, 1997.\textsuperscript{720}

Harm minimisation as a concept has informed HIV/AIDS and Needle Syringe Exchange Program (NSEP) policy in NSW for most of the 1990s. Harm minimisation is popularly presented as being opposed to either a ‘zero tolerance’ or ‘abstinence’ program, although there is an uneasy balance between the concepts.\textsuperscript{721}

Harm minimisation policy is another common way of describing risk reduction, although there are clearly important distinctions between risk and harm.
therefore, it was perceived, avoiding sexual risk and infection. In the context of prevention education ‘avoiding’ is the appropriate word. The alternative logic of harm minimisation was only explored briefly by the Australian Imperial Force (AIF) during 1917–1918, but given how crucial the idea of ‘minimisation’ became later in the century, this early experiment is important. Preventative approaches in civilian and military spheres differed considerably, but impacted on each other, with both spheres being deeply affected by World War I. Preventative approaches in the Australian Imperial Force were avowedly and briefly experimental, and premised on pragmatic harm minimisation strategies that had little chance of being translated into the civilian domain, despite some dogged attempts. I argue finally that the legislative agenda that framed this period in NSW (the Prisoners Detention Act 1909, the Select Committee on the Prevention of Venereal Diseases 1915 and the Venereal Diseases Act 1918) did have preventative goals, but did not venture into the domain of prevention education. The VD Act in particular did, however, have preventative effects: its awkwardly coercive approach encouraged acceleration in preventative activity.722

Prevention domains

Venereal diseases preventative practices which operated in NSW between 1901 and 1925 did so in three linked and contested domains: preventative medicine (including diagnosis, treatment and vaccination), public health prevention (including notification, isolation and disinfection) and prevention education (including social purity campaigns and sex hygiene). Fournier presented just this schema in 1906, when he described the ‘only three ways of attacking syphilis’ as being treatment by hospitalisation, administrative measures and legislation and the provision of ‘better instruction.’723 Dr E. H. Molesworth, writing in the Medical Journal of Australia in 1916, described a similar schema again when he argued that limiting venereal diseases was dependent on legislation, education and treatment.724

722 Smart argues that the war provided an impetus for the development ‘of more effective policies and procedures for the whole population’ which focused on ‘encouragement of self-regulation through education and public information campaigns that operated on a number of levels’ (Smart, J., ‘Sex, the State and the “Scarlet Scourge”: Gender, Citizenship and Venereal Diseases Regulation in Australia during the Great War,’ Women’s History Review, 1998: 7: p. 24.
However, much of the historiography of the prevention of infectious diseases in this period focuses almost exclusively on the domains of preventative medicine and public health prevention with a particular emphasis on notification, microbiology and vaccination, often omitting prevention education. The history of prevention education, as conceptualised in the term ‘health education’ is often characterised as really taking off after World War 2, although it is important to note that health education logics and practices were seeded in the first decades of the twentieth century, and particularly in prevention education related to venereal diseases. Porter examines the development of the bureaucracy of public health in Britain and the shift from a sanitationist to a hygienist approach in the 1890s, concurrent with the growth and development of microbiology. She argues that the ‘new knowledge of the specific aetiology of diseases, meant that ‘prevention, had emerged from, but also emancipated itself from earlier sanitarianism.’ Porter’s elision here of ‘prevention’ and ‘preventative medicine’ is characteristic of the historiography, but the history certainly reflects that even in the 1890s a preventative agenda based on education was evident. In other words, preventative medicine was only one component of the broad preventative agenda. Worboys, in his analysis of preventative medicine, begins by introducing the three pillars of notification, isolation and disinfection. Similarly, Baldwin when discussing the prevention of syphilis deals almost exclusively with public health practices of prevention including notification, isolation and disinfection.

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725 See Hampshire, J., ‘The Politics of School Sex Education Policy in England and Wales from the 1940s to the 1960s,’ Social History of Medicine, 2005: 18: pp. 87–105. Hampshire concludes that serious consideration of school sex education by central government was first prompted by concern about venereal disease during the Second World War. Lord argues that sex education, at least in the USA, was being taken seriously during and after the First World War. In 1918, the United States Public Health Service (PHS) launched a sex education campaign intended to educate Americans on the risks associated with venereal disease. Women were perceived to be central to this effort and the Public Health Service called upon women to provide sex education in schools, homes, churches, and community settings (Lord, A. M., ‘Naturally Clean and Wholesome’: Women, Sex Education, and the United States Public Health Service, 1918–1928,’ Social History of Medicine, 2004: 17: pp. 423–441).


disinfection. Davidson, however, examines prevention education in the interwar Scottish context at length, and concludes that the strategies of venereal diseases prevention (pamphlets, posters, films, lecture scripts) ‘subscribed to an aetiology and epidemiology of VD that recognised an explicit taxonomy of guilt and blame.’

Prevention of venereal diseases was, and is, broader than its relationship to medicine and public health: its relationship to pedagogy and education was becoming increasingly important as the century progressed.

There is also a considerable historiography related to social purity, and its relationship to venereal diseases prevention. Bartley argues in the English context that in their attempts to curb prostitution and ‘make men chaste,’ social purists ‘endorsed a more or less consistent policy of repression, even though their stated intentions were protective.’ Morgan argues that Ellice Hopkins, and some of her contemporaries were surprisingly radical in their constructions of gender and sexuality. They provided a sustained critique of male sexual immorality, particularly in relation to venereal diseases, and can be construed as revolutionary feminists, according to

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731 Aspects of this complicated preventative agenda are identified in other literature related to the history of infectious diseases. Hooker and Bashford examine the reception to proposals to implement mass vaccination programs for diphtheria. They argue that opposition arose because ‘the very different logic of prevention it implied’ (Bashford, A. and Hooker, C., ‘Diphtheria and Australian Public Health: Bacteriology and its Complex Applications, c. 1890–1930,’ *Medical History*, 2002: 46: p. 61). Vaccination represented a ‘clear break’ with earlier sanitary techniques of public health that focused on ‘tracing carriers, prescribing habits of life and isolation, notification and cleansing by local physicians’ (Bashford and Hooker, ‘Diphtheria and Australian Public Health,’ p. 61). Hooker and Bashford argue that ‘there was considerable hesitation over abandoning a public health framework,’ even though other effective vaccines existed. Preventative medicine, as a distinct category, was undergoing significant change. Microbiology was altering the parameters under which preventative medicine had operated. Hooker also acknowledges that prevention was a complicated domain. In arguing that pasteurisation and immunisation presaged a new form of public health ‘which both incorporated, and superseded, the strategies that preceded their introduction’ (Hooker, C., ‘Sanitary Failure and Risk: Pasteurisation, Immunisation and the Logics of Prevention’ in Bashford and Hooker, *Contagion: Epidemics, History and Culture from Smallpox to Anthrax*, London, 2001, p. 129) she concludes that ‘they were primarily constructed through a logic of harm minimisation and population protection, different to other infectious disease control policies.’ Hooker identifies two compelling aspects of these technologies: they were two of the earliest preventative policies based explicitly on harm minimisation; and they were practised at a population level. I will argue that in relation to venereal diseases prevention in the AIF during World War I there was a well-articulated logic of harm minimisation.


feminist historian Sheila Jeffreys. Social purists were canny in being able to locate a space within religious discourse to ‘legitimate their demands for transformed relations between the sexes.’ As Morgan indicates, the relationship between the feminism and faith of purists like Hopkins was complex, accounting for the paradox of Hopkins’ contribution ‘to the emergence of one powerful women’s culture – social purity – and the attempted elimination of another female subculture – prostitution.’

Scott suggests that one strand of social purity was also fiercely anti-medical, contending that some purity campaigners saw pieces of sanitationist legislation, including the Contagious Diseases Acts, as ‘state sanctioned violation of the bodies of women and children.’ Scott argues that by the late 19th and early 20th centuries, purity discourse was ‘being used to reinforce imperialism, eugenics and a misogyny which was particularly directed towards working class and independent women.’ This change indicated the potential that lay at the heart of social purity: ‘to be co-opted and used as a repressive force.’

Social purity changed as it moved into the twentieth century, and as it assimilated medical discourse related to hygiene it was more easily locatable in the domain of public health.

Both social purity and sex hygiene logics informed the venereal diseases prevention education agenda in NSW. Social purity campaigns were rooted in the promotion of purity among men and boys, a chivalrous respect for womanhood, a comprehensive disavowal of the double standard and advocacy of both sexual restraint and marriage. Sex hygiene was not a different movement to social purity: in fact, it sprang from similar sources, and maintained many of the goals of earlier social purity movements. Sex hygiene, as the century progressed, developed a clear focus on sex education, and identified medical practitioners and teachers as key agents in the push toward sexual restraint and avoidance of sexual infection. Social purity grew as a movement in opposition to governmental regulation of prostitution, and therefore

739 Bashford has characterised the longer-term hygienic agenda as straddling the period from the later nineteenth century through to World War 2, and which ‘came to be a personal and political mission and imperative’ (Bashford, Imperial Hygiene, p. 4).
prostitutes, clients of prostitutes and brothels were key sites for preventative activity. Sex hygiene grew as a movement in a broader hygienic band that included social hygiene and racial hygiene.\footnote{Bashford, ibid., p. 5. Some other hygiene programs are listed by Bashford as domestic hygiene, tropical hygiene, maternal hygiene and international hygiene.} Davidson argues in relation to Scotland at this time that medical practitioners and purity groups were often in conflict over the ‘control and content of hygiene instruction.’ Scottish purity groups were concerned to ensure that information on venereal diseases should be lifted ‘to a higher sphere by purifying the thoughts of the rising generation.’\footnote{Davidson, Dangerous Liaisons, p. 143.} In NSW, although some argued that ‘advances made during the present century have tended rather to the improvement of diagnosis and treatment, than to the prevention of the spread of infection,’ there were significant shifts in prevention education techniques across the period.\footnote{MacDonagh, J. E. R., Biology and Treatment of Venereal Diseases, London, 1915, p. 493.} Importantly, the goal of prevention education remained constant: to educate young people about sex, without introducing them to desire.\footnote{Carter has commented that sex educators in this period were ‘caught between the desire to shape sexual activity and the fear of stimulating it …sex education occupied an uncomfortably ambivalent epistemological field.’ Carter, J., ‘Birds, Bees and Venereal Disease: Towards an Intellectual History of Sex education,’ Journal of the History of Sexuality, 2001: 10:2: p. 218.}

I will take a roughly chronological approach in my analysis of preventative agendas and techniques across this period. The major part of this chapter is focused on the techniques, tactics and tasks of a number of organisations, as they expressed themselves in their stated goals, objectives and strategies, and through their reports, Conference proceedings, activities and relationships. I will begin by examining an older style lobby group, the Australasian White Cross League, which began in NSW in 1896, and continued well into the twentieth century. I will then analyse the proceedings of the Workers’ Educational Association (WEA) Conference on Sex Hygiene in 1916, and discuss the preventative logics embedded in their proceedings. Soon after this Conference the University of Sydney Society for Combating Venereal Disease (USSCVD) was established. I will examine their goals and objectives. My analysis of the experimental harm reduction strategies adopted by the AIF will broaden the focus from prevention education, because the AIF used a raft of strategies in its attempt to ensure a fit and healthy fighting force. My examination of preventative approaches in the 1920s in NSW will focus on the impact of these
experimental approaches adopted by the AIF, and how they played out in the civilian domain, with particular reference to the litmus test issues of pre-, intra- and post-coital prophylaxis. In 1929, the newly established Racial Hygiene Association of NSW held its first Congress, and I will conclude this chapter with an analysis of the proceedings of this Conference, and an analysis of its preventative logics.

Community-based organisations and lobby groups

A plethora of social, political, moral and scientific organisations arose in NSW and other states of Australia immediately prior to, during and after World War 1, to deal with issues related to the prevention of venereal diseases. There were Associations, Leagues, Unions, Alliances, Committees and Societies: and they published, lectured, advocated, lobbied, distributed and educated in line with their avowed approach to the prevention of venereal diseases. Prevention education took the form of public lectures, advertising, leaflets, newspaper and magazine articles, booklets and pamphlets, educational and feature films, tours by guest speakers and plays. It

744 Davidson notes the same phenomenon in post-war Scotland, where the comprehensive program of propaganda observed by the Scottish Board of Health included ‘meetings, lectures, and exhibitions of films, both for laymen and for the medical profession; conferences with local health authorities, education authorities, and other public bodies; lectures at large public works and to social organisations; exhibition of suitable posters; advertisements and articles in newspapers, trade union journals and women’s periodicals, and distribution of appropriate literature, including leaflets for foreign seamen printed in most continental languages’ (Davidson, Dangerous Liaisons’, p. 138).

745 George Black, NSW Minister of Public Health 1916-1917, who wrote and distributed The Red Plague Crusade in 1916, was specifically interested in advocating what he described as ‘radical preventive measures.’ Black drew a distinction between different categories of prevention when he suggested: ‘Preventive measures are even more needed than curative or preventive remedies.’ For Black, preventive measures included instructions in the organs of the body, widespread information on venereal maladies, parental instruction, advocacy of chastity, encouragement of physical exercise and the distribution of literature on sexual hygiene. Black’s preventative prescription was a consortium of social purity and sex hygiene agendas: and given the historical juncture, this is not surprising. Black ranged between use of the terms sexual sanitation and sex hygiene. He also began to position adolescents as the new venereal diseases prevention focus. Black remarked: ‘The period of puberty is, of course, the most dangerous in the lives of men and women.’ Puberty, and adolescence, were beginning to be significant issues for other organisations at this time. Arching over Black’s consortia of preventative approaches was a significant eugenic imperative. Towards the end of his pamphlet, Black stated: ‘Pure Blood is more valuable to the State than pure gold’ (Black, G., The Red Plague Crusade, Government Printer, Sydney 1916, pp. 23-25).

746 A list of social hygiene VD films made in the United States between 1914 and 1918 is provided by Colwell, S.A, in ‘Gender, the Dissemination of Knowledge, and the American Campaign against Venereal Disease during World War 1.’ The End of the Road was the only one that was actually made as a feature film, with well known actors. It was ultimately withdrawn after limited release. Boon suggests that between 1911 and 1930, 115 health films were made in the UK, and in the 1930s more than 230 health films were made. He also demonstrates that a US sexual hygiene film, the End of the Road, attracted nearly 2500 attendees when it was shown in Blackburn, UK. The film was designed for
occurred in schools, workplaces, barracks, colleges, universities, clinics, town halls, libraries, and hospitals. Lobby groups played a significant role in developing these materials, distributing them, and advocating support from government. At first glance this community-based activity looks like the modern practice of community development or health promotion: the engagement of the community in promoting its own health. To an extent this is the case: some community groups and voluntary organisations were moving towards the advocacy of responsible and informed individual decision-making on issues related to health. However, these were not consumer groups: they had their roots in middle-class charitable and philanthropic initiatives that developed in the nineteenth century, they relied heavily on the engagement and patronage of prominent individuals, and they did not actively or openly engage those most affected (that is, people living with venereal diseases) in their activities.

Often organisations drew themselves up in response to particular issues, for example, the University of Sydney Society for Combating Venereal Diseases, which focused its attention on lobbying for the introduction of venereal diseases legislation in NSW between 1916 and 1918. Botsman argues that opposition to the PD Act of 1909, which was led by Dr Richard Arthur, catalysed a number of social and lobby groups into action: they pushed for alternatives to detention and isolation, including sex instruction and moral prophylaxis. Botsman proposes that these groups were an ‘important element in the formation of sex-education, family counselling and other networks.’ Bashford argues that in the United Kingdom the even earlier anti-Contagious Diseases legislation movements ‘haunted twentieth century public health in all kinds of ways.’ Sometimes these groups took strong moral approaches (the young women who lived near training camps, and warned of the dangers of promiscuity, venereal disease and pregnancy outside marriage. (Boon, T., Film and Contestation of Public Health in Interwar Britain, PhD thesis, Wellcome Institute, 1999).

Les Avaries, or Damaged Goods by Brieux, a play which explored a number of issues related to syphilis, particularly medical confidentiality and trust in marriage, toured the world in the second decade of the twentieth century, and was staged to large audiences in Sydney in 1915. A review of this play was included in the October 1916 edition of the Medical Journal of Australia (p. 365–366). After providing a detailed description of the plot, the reviewer concluded: ‘the play is by a Frenchman, a very artistic Frenchman. But it has been said that, while the Englishman’s national game is football, the national game of the French is love. Are we not running some risk of creating a similar tendency in Australia by fanning this appetite and by giving undue and even exaggerated prominence to the sexual and venereal questions?’

Association to Combat the Social Evil), clear eugenic approaches (the Racial Hygiene Association) or strong pedagogic approaches (Workers’ Educational Association) to the prevention of venereal diseases. Within particular documents, embedded in specific pamphlets and presentations, and locatable in organisational objectives, an admixture of these modes of rule is discernible.\(^{750}\) This was not always the case, with some groups being fiercely anti-prophylaxis, or profoundly anti-education, both of which it was argued could lead to promiscuity.\(^{751}\) Some argued at this time too that these organisations and lobby groups could, and should, be harnessed by government in the fight against venereal diseases. A. G. Butler argued in a letter to the Medical Journal of Australia:

> All organisations, official or voluntary, such as religious organisations, health associations, town planning and infant welfare organisations etc whose concern is social and civic order and elevation…are great potential reservoirs of knowledge, information and active cooperation which should be utilised; therefore legislation should specifically arrange for cooperation with such bodies and should embody their expert knowledge.\(^{752}\)

I have already noted that neither the NSW VD Act, nor any other State-based legislation, attempted to codify prevention education as an effective mode of prevention. Nor did such legislation specifically arrange for cooperation with the voluntary sector, or community-based organisations. This did not stop the NSW government funding such organisations however, as occurred in 1929 when the Minister for Public Health funded the Racial Hygiene Association.\(^{753}\)

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\(^{750}\) In his personal reminiscences of being a venereologist, Fluker reported his first encounter with prevention education in relation to venereal diseases sometime between 1910 and 1920. He wrote: ‘My first contact with venereology was in the men’s WC of Portsmouth and Southsea Southern Railway Station. Exactly at eye level in one of the urinals, was a metal board which gave precise instructions of what to do after a risk had been taken. A sixpenny piece should be covered (no more) with potassium permanganate crystals the latter should then be dissolved in a pint of warm water, the resulting solution being used to wash the genitals thoroughly.’ (Fluker, J. L., ‘Personal Reminiscences of a Venereologist before Penicillin,’ International Journal of STD and AIDS, 1990:1, pp. 443–446).

\(^{751}\) In the last five years, in NSW, Post Exposure Prophylaxis (PEP) and, over a longer period of time, sex education, have been positioned by conservative commentators as both progenitors and markers of promiscuity. Research by Moore, S., Rosenthal, D., and Mitchell, A., in Youth, AIDS and Sexually Transmitted Diseases, London, 1996, would appear to indicate that the reverse is true: sex education reduced the age at which young people had their sexual debut.


Kingdom as well the absence of prevention education measures in venereal diseases legislation did not stop the government providing funds to the voluntary sector. In 1919 the National Council for Combating Venereal Diseases (NCCVD) received £20,000 from the Ministry of Health to undertake publicity and propaganda, and in 1923 the same organisation received £66,000 to conduct propaganda from the Ministry of Health, and £500 from London County Council. Although venereal diseases legislation in NSW did not include voluntary funding mechanisms or clauses related to prevention education, such legislation did have impacts on prevention education techniques. Sometimes, as well, as in Scotland, regulations gave direction on prevention education strategies.

Davidson’s account of venereal diseases prevention education in interwar Scotland effectively demonstrates the extent to which differing and at times competing ideologies determined the preventative approach. Some local health authorities refused to display the more explicit posters of the NCCVD, fearing that they might offend ‘public opinion and purity activists.’ Lectures and slide-shows were often gender specific, and ‘talks to male and female adolescent groups were always conducted separately.’ Medical practitioners always provided lectures on medical aspects of venereal diseases, and usually a venereologist or infectious diseases officer delivered these presentations. The Scottish Board of Health preferred instructional films to feature films, fearing that feature films could be of pornographic interest to some audiences. Purity associations argued that feature films which discussed venereal diseases, in dark and intimate cinemas, were a risk to public morality. Local authorities responded by regulating ‘performances in terms of age, gender and social composition of the audience, according to the perceived suitability of each film.’ Despite these regulations, cinemas and lectures attracted large audiences and Davidson cites evidence to suggest that ‘an estimated 26000 people attended VD propaganda films in Scotland in the four months ending 30 January 1932.’

Australasian White Cross League

754 Davidson, Dangerous Liaisons’, p. 138.
755 Ibid., p. 138.
756 Ibid., p. 142.
757 Ibid., p. 139.
The White Cross League commenced in England after the Contagious Diseases Acts of the 1860s. It was primarily concerned with inculcating ‘purity’ – abstinence until marriage – in men and boys, advocating respect for girls and women, and eschewing the double standard. Bartley argues that the White Cross League was demonstrably political, targeting ‘men in high public office who undermined morality.’

The organisation had strong links with Protestant churches, and through the ministrations of Ellice Hopkins in England, reached both the USA and Australia during the 1890s. The Australian and New Zealand chapter of the White Cross League commenced in 1896, and Dr Richard Arthur was involved in its establishment in NSW. The correspondence of Ellice Hopkins and Richard Arthur illustrates some of the key marketing and promotional issues that were addressed in the early years. Hopkins advised Arthur that in the USA ‘head workers’ were unpaid, and they only earned what they made from their League presentations, leading to professional jealousies. Hopkins also referred to ‘the lady who has followed my example’ in addressing men being ‘innocent of the unspeakable charges that are brought against her,’ and following this exhortation, questioned the value and probity of ‘a woman pleading with men for women.’ Hopkins here alluded to the raison d’etre of the League: the persuasion of men by women (and men) to pledge to uphold the sanctity of women. Arthur and Hopkins negotiated the sale and distribution of her book, The Power of Womanhood, and discussed its utility as a text in Australian schools. They discussed as well the value of Australasian Leaguers wearing and selling small white cross pins for the lapel. Certain frictions entered their correspondence when Hopkins felt obliged to lecture Arthur on sales and distribution work in Australia, which she felt had been less than successful:

I am a little troubled about the circulation of my book in Australia, especially as to the utter failure of my appeal to the women of Australia through the newspapers, leaving out all mention of the edition of my book which I sent out

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759 The correspondence between Richard Arthur and Ellice Hopkins from the late 1890s detailed Hopkins’ concerns with the administration of the White Cross League in both USA and Australia.
760 Correspondence of Dr Richard Arthur and Ellice Hopkins, Dr Richard Arthur papers, ca. 1883–1932, MLMSS 473, Dixon Library, Sydney.
761 Ellice Hopkins to Dr Richard Arthur, 7 January 1900, Dr Richard Arthur papers, ca. 1883–1932, MLMSS 473, Dixon Library, Sydney.
762 Ibid.

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at my own risk as a token of my grateful affection. I have been disappointed
too at receiving so very few acknowledgements…It seems to me the best way
it could be managed, would be to sell them at meetings…your report of Mr
Bligh’s triumphant progress in New Zealand is simply delightful.\textsuperscript{763}

This brief extract from Hopkins’ letter of April 1902 points to some of the White
Cross campaign strategies: international speaking engagements and tours, book sales,
meetings, newspaper advertising and sponsorship. Such strategies were about the
dispersal of information, the use of ‘head workers’ and marketing approaches
strangely reminiscent of later ‘pyramid’ marketing strategies. The correspondence
between Arthur and Hopkins in general demonstrates that by 1902 the White Cross
League was established and growing in Australia, that Arthur was heavily involved,
and that the goals of the League were making a mark in the social landscape because
of the diffusion strategies that were being deployed. This was some time after the
apex of social purity activity in the United Kingdom.

The NSW chapter of the White Cross League was patronised by both the Governor
General of NSW and the Archbishop of Sydney, and was therefore well supported
through both government and church. The League’s objects were to promote:

\begin{quote}
\begin{enumerate}
\item purity among men and boys;
\item a chivalrous respect for womanhood;
\item the preservation of the young from contamination;
\item and a higher tone of public opinion.\textsuperscript{764}
\end{enumerate}
\end{quote}

Those men who took up the White Cross were obliged to: treat all girls and women
with respect, and endeavour to protect them from wrong and degradation; to
endeavour to put down all indecent language and coarse jests; to maintain the law of
purity as equally binding on men and women; to endeavour to spread these opinions
amongst companions, and to try to help younger brothers; and to use every possible
means to fulfil the command, ‘Keep thyself pure.’ These objects and obligations point

\textsuperscript{763} Ellice Hopkins to Dr Richard Arthur, 11 April 1902, Dr Richard Arthur papers, ca. 1883–1932, MLMSS 473, Dixon Library, Sydney.
\textsuperscript{764} Botsman, P., ‘Two Documents,’ p. 95.
to some of the key agendas of the White Cross League: to reject indecency, coarseness, contamination and degradation, and to embrace chivalry, purity, respect and companionship. These objects also pointed to the techniques of the White Cross: the dispersal of ideology through neighbourhoods, communities and families. The spectre of venereal diseases and prostitution hung over these objects and obligations.

The League in NSW was most active in the first decades of the twentieth century, and during the War. During this period it sponsored numerous pamphlets and booklets that were often published versions of addresses by prominent purity campaigners, including Dr Arthur himself. Titles included Conquering an Old Enemy, A talk with girls about themselves and Keep Yourself Fit. This last document was the published version of Arthur’s address to Army camps in Queensland and New South Wales. As with most purity literature, syphilis and gonorrhoea occupied key positions. The young soldiers whom Dr Arthur addressed were asked to:

> remember then that the flighty girl you may meet, and who is prepared to let you take liberties with her, is some other man’s sister and should be accorded your protection against yourself as well as against others.

I am not only concerned here with Arthur’s classic presentation of the purity objectives, but also with the mode of information dissemination that was the stock-in-trade of the White Cross League and other social organisations. Public addresses to mass meetings, publication of the address, sale of the publication and distribution through detailed networks was a significant modality for extending the reach of public health. An anonymous pamphlet of the League also spoke directly and reflexively to women about how they could undertake purity work. The author of Women’s Place in Purity Work suggested:

> Some women have regarded this work, if not with indifference, yet with a lack of interest. Others have realised the necessity for it...Every woman may

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765 Undated copies of The Training of Children for Purity, Conquering an Old Enemy (American Social Hygiene Association, New York), A Talk with Girls about Themselves (Australasian White Cross League, Sydney) and Keep Yourself Fit (William Brooks and Co., Sydney) were located in the private boxes of Dr Richard Arthur, MLMSS 473, Sydney.

prepare herself by reading up the subject, and she will be ready, not necessarily to speak in public on the matter, but to do so privately, and to pass on the books to others. Parents should have the books lent to them. Schoolmasters and mistresses should be interested in the work by means of the loan of books. In this way you can help to form public opinion on the matter of a needed change on the method of educating the young on moral questions.\textsuperscript{767}

Sophisticated, detailed and purposeful marketing strategies attempted to reach deep into the community. Men and women could participate equally, but the pledging onus was on men. The onus, as well, of the League’s work within schools during the first three decades of the twentieth century was primarily on boys and men. Lewis identifies the work of R. H. W. Bligh, a Leaguer and international purity speaker, as noteworthy: in 1916 alone he visited 100 state schools in Tasmania, and then visited Western Australia, Adelaide and Victoria, clearly with the support of the government. Bligh also accompanied Richard Arthur to Brisbane to speak to servicemen, and lobbied indefatigably to have White Cross League information included on a permanent basis in the curriculum of various states’ Education Departments. The League was never successful in having their particular model of morals and purity included in curricula, but as Lewis indicates, they ‘at least put the question of sex education on the public agenda.’\textsuperscript{768}

The League was not the only organisation doing purity work in NSW. Other groups took up the challenge of purity with slightly different messages, and these groups were still distributing information after World War 1. The Australasian League of Honour for Women and Girls commenced in 1915, and it aimed to reduce sexual promiscuity allegedly arising from wartime activities. The Interdenominational Council for Civic and Moral Advancement was established to monitor ‘venereal disease and its incidence on the moral life of the community and on the soldiers in our Expeditionary forces.’ The YMCA, the YWCA and the Woman’s Christian Temperance Union also carried out temperance work, which the author of Women’s Place in Purity Work suggested could include ‘temperance, anti-gambling, Sunday

\textsuperscript{767} An undated copy of Women’s Place in Purity Work was located in the private papers of Richard Arthur, MLMSS 473, Sydney.
\textsuperscript{768} Lewis, Thorns on the Rose, p. 175, p. 176.
observance or even Scientific Temperance instruction.'

In Victoria, the Association to Combat the Social Evil (ACSE) was established by Mrs James Booth in September 1918 as an avowedly purity driven organisation, whose pamphlets asked: ‘is venereal disease a purely medical problem, such as Small Pox, Typhoid and other like plagues? It does not seem so?’ This organisation sponsored the publication of the pamphlets that succeeded the WEA Conference on the teaching of sex hygiene in 1916, but only those pamphlets that supported a purity agenda. In the advertising that accompanied the chosen pamphlets they wrote: ‘The above Association is distributing this brochure as part of its Education Campaign. The address was given at a Conference on ‘Sex Hygiene.’ …the full report of the Conference may be had, bound in cloth, post free 2/2.’ As a relatively new organisation, in a rather crowded field, the ACSE was keen to be associated with the appropriate purity messages. Smart demonstrates that the ACSE, under Mrs James Booth, argued in 1918 for the tightening up of the Victorian venereal diseases legislation that had been passed in 1916. In the two years since the passing of the legislation, Smart suggests that social feminists were ranged against regulationists in debate over the ethics of the Act of 1916. Vida Goldstein of the Women’s Political Association argued that the Act victimised the poor and prostitutes: Mrs James Booth argued for greater stringency in the Act.

Three particular Protestant women’s groups – the Woman’s Christian Temperance Union (WCTU), the Young Women’s Christian Association (YWCA) and the Mothers’ Union campaigned for children to be taught about sex, reproduction and venereal diseases from an early age. Warne argues that these groups positioned mothers as primary sex-educators, but that over the period from 1890 to 1930 their modus operandi changed from one that reflected social purity moralism, to one that took account of a newly sexualised public domain, and a newly eroticised language of sex. Initially concerned with ‘the old problem of immorality’, these groups became increasingly concerned with acting as scientific sex-educators, both in the home and in the public sphere. Whereas once mothers were responsible for the education of their daughters, one commentator remarked that the old idea of mothers trying to

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770 Smart, J., ‘Sex, the State and the “Scarlet Scourge”,’ p. 20.

monitor and protect their daughters was now seen to be either farcical or tragic because ‘the great and increasing freedom claimed by all young people nowadays has shifted the duty of protecting them from their parents’ shoulders to their own.’ Warne remarks that ‘sex by the 1930s was not the same monster that churchwomen’s groups had set out to conquer in the late nineteenth century’: indeed, the discourse of sex and venereal diseases had changed considerably from 1890 to 1930. By 1930 issues related to sex-drive, sexual pleasure and contraception were being publicly discussed, opening up the whole gamut of dialogue related to sexual expression.  

During this period in NSW there was a high level of prevention education on venereal diseases being undertaken by community-based and voluntary organisations. Medical practitioners like Richard Arthur were involved in such groups, but so were hundreds of other individuals, particularly women affiliated with social, political and religious organisations. By the time of the Workers’ Educational Association (WEA) Conference on the Teaching of Sex Hygiene in 1916 in Sydney, the Australasian White Cross League sent two representatives, whereas the NSW Department of Education, the WEA itself, Sydney University and the Unions sent scores of representatives. During the War the Australasian White Cross League lost ground to a number of other organisations that were working to prevent venereal diseases, but the League and its affiliates were to be resurgent in the 1920s.

*University of Sydney Society for Combating Venereal Diseases (USSCVD)*

The USSCVD was established at Sydney University in 1916, and existed only until 1919: that is, it wound up after World War 1, and after the passing of the NSW VD Act in 1918. The Society was modelled on the British National Council for Combating Venereal Diseases, which had been formed in London in 1914. It was formed ‘by a number of students in fifth Year Medicine’ and was enhanced by the addition of leading members of staff and the convening of a ‘large representative

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gathering’ to launch the society. Whilst the USSCVD provided clear information about sexuality in the interests of controlling VD, it also prescribed standards of behaviour in sexual relations which focused on monogamy. Lewis argues that in this respect the USSCVD was fully within the tradition of social purity moralism. There were also aspects of the proceedings of the USSCVD that demonstrated the shift towards self-government. Although Roe remarks that Dr Richard Arthur was involved in establishing the Society, he is not listed as an office bearer or committee member in the inaugural year of the Society. Committee members of the USSCVD included a host of individuals who were also present at the WEA Conference on the Teaching of Sex Hygiene in 1916, and who also gave evidence to the NSW Select Committee in 1915. Some of these individuals included: Meredith Atkinson, Dr E. H. Molesworth, Peter Board, Under Secretary of Education, and Professor D. A. Welsh from the University of Sydney. In Sydney, in the middle stages of the War, there was a coterie of individuals who formed a core group advocating an expanded preventative response to venereal diseases.

The USSCVD had four objectives:

- to study the problems of venereal diseases, prostitution, and kindred evils;
- to organise and stimulate University action in regard to such matters;
- to take the necessary steps to educate public opinion to secure suitable legislation; and
- to deal in any other effective way with the problem.

These were not noticeably different to other purity organisations, but their remit was strategically contained. The Society aimed to stimulate activity within the University, and to utilise its links to influence government. One of their key strategies to influence government was through building and forming public opinion on the need

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774 Lewis, Thorns on the Rose, p. 178.
775 On the other hand, Sir Thomas Anderson Stuart was inaugural President of the Society, and he and Arthur had had a very public falling-out in 1907 in relation to the Immigration League of Australasia (Roe, Nine Australian Progressives, p. 163). So damaging was the split that Anderson Stuart established a rival organisation called the British Immigration League of Australia.
776 Proceedings of the USSCVD, p. 2.
for legislation. Because of this strategy the Society was to act in both the University and the public sphere, with an emphasis on building the momentum for change. In running a program of lectures, conferences and other meetings, it aimed to be inclusive, making provision ‘for inviting the cooperation of all individuals and societies capable of doing useful work in the same direction.’ In this way the USSCVD saw itself as occupying a leadership role in the crowded voluntary sector. Atkinson suggested that ‘in the publication of authoritative literature, the promotion of lectures and personal talks, the drafting and furthering of legislation, there are immense opportunities for excellent service.’ The society, in other words, was prepared to expend resources and utilise a range of established preventative strategies to tackle venereal diseases.

Specific members of the USSCVD lectured widely on venereal diseases, and often had their lectures published and distributed. Professor D. A. Welsh, who had occupied the foundation chair of pathology at Sydney University since 1902, and who was a founding member of the USSCVD, directly addressed soldiers in February 1916 and undergraduates in April 1916, with versions of his address ‘The Health of the Forces and the Forces of Health.’ This address was deemed to be so relevant to the public that it was reprinted in the Sydney Morning Herald, and by the YMCA for free redistribution to the naval and military forces of the Commonwealth. Welsh’s speech was an extended metaphor: he spoke to the soldiers of ‘our terrible foe,’ venereal diseases, of this enemy being well entrenched, having had the opportunity ‘to dig himself in for generations,’ of successful campaigns, and of clearing the ground for action. He spoke, as well, of ‘combating’ venereal diseases, and at Sydney University in 1916 the militant language of combatants was intended to fire patriotic enthusiasm on a number of fronts.

Professor J. T. Wilson, the foundation Challis Chair of Anatomy at Sydney University, was on the Executive Committee of the USSCVD, and in his speech to undergraduates titled ‘Our General Attitudes Towards the Problem,’ he carefully

777 Ibid., pp. 4–5.
778 Ibid., p. 19.
espoused a preventative program which separated ‘scientism’ from ‘moralism.’ Wilson argued that the real obstacle to the ‘rational and scientific’ treatment of venereal diseases was the ‘habitual association of these diseases with moral delinquency,’ and that ‘the only ethically significant consequences of moral or immoral behaviour are themselves moral, and not physical.’ This obfuscation of the physical and the moral was, according to Wilson, ‘prescientific,’ and venereal diseases should have been regarded in the same ways as any ‘transmissible pathological condition,’ including typhus, malaria or yellow fever. In the same speech, however, Wilson changed tack and register and spoke of prostitutes as ‘the priestesses and victims of unrestrained animal passion,’ who existed in ‘pure unvarnished slavery.’ Here Wilson suggested that prostitutes were slaves to their male clients, and that men needed to exercise sexual restraint to avoid sexual infection. This admonition ideologically and linguistically echoed the remonstrations of the Australasian White Cross League. Wilson also suggested that he would always fight to suppress prostitution, and not take it as a social and economic given, as some in the community had. Wilson’s speech graphically illustrated the discursive ambivalence which lay at the heart of the USSCVD: on the one hand, venereal diseases were objectively framed in a broader communicable diseases context, and on the other Wilson was unable to cast prostitutes as anything but slaves and victims.

Workers’ Educational Association (WEA) Conference on teaching sex hygiene 1916

The Workers’ Educational Association (WEA) Conference, held over three days at the Union Hall at Sydney University in November 1916, focused on the teaching of sex hygiene, but during its course free-ranged over a number of issues related to puberty, adolescence and the inculcation of sexual restraint. The WEA was founded in 1903 in the United Kingdom under the title of the Association to Promote the Higher Education of Working Men following a scheme proposed by Albert Mansbridge (1876–1952). In 1905 it became known as the Workers’ Educational Association, and

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779 The Wilson Museum of Anatomy at Sydney University is named after Professor J. T. Wilson. His greatest contribution to the collection was the appointment of Prosectors, originally 4th or 5th year medical students, to provide high quality specimens for the Museum and to act as Demonstrators. The earliest photograph of Prosectors in the department is dated 1903. Approximately 700 specimens were derived in this manner.

780 Proceedings of the USSCVD, pp. 6–11.
in 1913 the WEA was established in Sydney. At inception, the WEA in Sydney aimed to:

Be an organisation open to every friend of democracy, providing a common meeting ground to all, who, though differing on other questions of vital importance are united in the desire to raise the intellectual standards of Australian democracy.  

From the beginning the WEA in Sydney focused on forging links with unions and universities to develop educational courses for working men. Within three years of having been founded in Sydney, the WEA was providing a forum for one of the significant questions of the democracy: how to teach young Australians about sex hygiene, without introducing them to sexual desire.

Delegates to the Conference felt that they were engaged in momentous discussions that had the potential to change public discourse on sex education. Roe cites the evidence of an anonymous Conference participant and organiser who remarked: ‘there seemed to be something in the atmosphere of the gathering which broke down the barriers which usually exist between the sexes.’

This feeling that something new and radical was being attempted was evident in the Introduction to the Report of the Conference, published in 1918 in Newtown. Meredith Atkinson argued in this introduction that ‘at times it amounted almost to a feeling of awe in the minds of delegates that they were called to discuss a matter so vital to the welfare of coming generations.’

Contemporary commentators have also configured the Conference as a watershed. Roe remarks that ‘perhaps never had Australia heard such open talk

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782 Roe, Nine Australian Progressives, p. 169.

783 Meredith Atkinson was a noted trade unionist during this period and in the 1920s became a leading advocate for indigenous rights. Atkinson’s collection Trade Unionism in Australia emerged from a conference convened by the Workers’ Educational Association of New South Wales (WEA) in association with the Economic Research Society of Sydney and the Labour Council of New South Wales which was held at the University of Sydney between 5 and 7 July 1915 (M Atkinson (ed.), Trade Unionism in Australia, Proceedings of a Conference held in June 1915, Sydney, 1915).

about sex in public." Lewis suggests that ‘the Conference represented a decided advance towards public instruction of children.’ Despite these intimations of unrehearsed and collective enthusiasm, large meetings and gatherings like the WEA Conference were often carefully scripted, with a select participant list which included many of the ‘moral gatekeepers’ of the community. Describing large public meetings held in Scotland in the 1920s, Davidson argues that such careful orchestration was designed to ‘manufacture civic consensus on the issue and to represent both the medical and moral strands of social hygiene discourse.’

In relation to prevention education and venereal diseases, the WEA Conference was significant for a number of reasons. It was a significant site for the calibration of ideas related to social purity and sex hygiene, and in its articulation of the twin concepts of puberty and adolescence, the Conference represented a significant shift away from the medical policing of the prostitute, and towards a functional pedagogy in schoolrooms, homes and workplaces. The Conference also heard from a range of different health, education and welfare professionals, and in this sense represented the beginnings of the diffusion of expertise related to the prevention of venereal diseases. Papers were presented at the Conference by clergy, ‘physiologists, psychologists, mental pathologists, social workers, teachers, legislators and the school medical service,’ according to C. Savill Willis, the Principal Medical Officer with the NSW Department of Education. No longer was the prevention of venereal diseases the sole preserve of medical practitioners and police: there were a growing number of professionals who perceived themselves as having a stake in prevention education.

The Conference included a number of presentations over three days that were open to delegates only, and three keynote public lectures by Professor D. A. Welsh, Mrs

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785 Roe, Nine Australian Progressives, p. 168.
786 Lewis, Thorns on the Rose, p. 179.
787 Davidson, Dangerous Liaisons, p. 138.
788 Carter argues that in the United States, by the early 1920s, many people were ‘horrified’ at the way in which venereology assumed that ‘all details of pathology and morbidity were pedagogically legitimate and useful because empirically verifiable’ (Carter, J. B., ‘Birds, Bees, and Venereal Disease: Toward an Intellectual History of Sex Education,’ Journal of the History of Sexuality, 2001: 10:2: p. 249).
790 Davidson has noted the same phenomenon in post-War Scotland, where at a local level, medical practitioners were joined by ‘educationalists, social workers, church leaders and social hygiene and purity activists’ in information dissemination (Davidson, R., Dangerous Liaisons, p. 136).
James Booth and J. Smyth, which were attended by large audiences.\textsuperscript{791} The Report of the Conference not only included the full text of significant presentations, but also annotated versions of question and answer sessions that succeeded presentations, a glossary of terms used, and a full delegate list. Lewis reports that the first edition of the report sold 2000 copies quickly, and a second edition was quickly arranged: the WEA saw it as its ‘greatest success in book publishing to date.’\textsuperscript{792} Nearly 180 delegates attended the Conference, representing over 40 social, religious, feminist, university and union organisations. Over half of all delegates were listed as representing the Workers’ Educational Association (WEA), and a further 23 participants, who were all male, represented the NSW Education Department. Twelve disparate unions were represented, which sent 18 delegates. Most of the remaining delegates represented a cross-section of organisations from purity organisations like the Australasian White Cross League (two delegates), political groups like the Feminist Club (two delegates)\textsuperscript{793} and the Council for Civil and Moral Advancement (1 delegate) and a set of seven women’s groups ranging from the Mothers Union (1 delegate) to the YWCA (3 delegates). Nearly half of all delegates were women, and nearly half of all women attending were single women. It might initially appear incongruous for the Conference to include such broad union representation, but it should be remembered that sex hygiene advocates also promoted education in the workplace. The Conference delegate list was representative of the broad spectrum of interest which sex hygiene aroused, and the proceedings of the Conference, particularly the question and answer sessions, highlighted the move towards ‘self-reverence, self-knowledge, self-control.’\textsuperscript{794}

From the beginning of the Conference, Meredith Atkinson drew distinctions between public health prevention and preventative medicine, and prevention education:

\begin{quote}
While measures of medical treatment and prevention of venereal diseases, and legislative enactment dealing with prostitution and its concomitants, are matters of pressing public concern, it was felt universally that another great
\end{quote}

\textsuperscript{792} Lewis, \textit{Thorns on the Rose}, p. 179.
\textsuperscript{793} The Feminist club included women who would eventually found the Racial Hygiene Association in NSW.
\textsuperscript{794} Committee of the New Zealand Board of Health, \textit{Venereal Diseases in New Zealand: Report of the Special Committee of the Board of Health} appointed by the Hon. Minister of Health, Wellington, 1922.
task lay before the nation: preparing the minds of the young.\textsuperscript{795}

An emerging preventative pedagogy was positioned as being at least equal to treatment and notification as a response to venereal diseases, and the WEA Conference was represented by the participants as being a significant step in the process of prioritising preventative education. Atkinson articulated the central problem of the Conference as being how to teach sex hygiene, whilst at the same time imparting ‘without danger to the taught a knowledge of that inner life which can only be kept pure by safeguarding its sacred privacy.’ Atkinson, in other words, was keen to teach about sexual safety, without profiling desire. Atkinson’s mixture of purity and hygiene, of the teacher and the taught, and of the sensitive balancing act between knowledge and danger, captured perfectly the spirit of the WEA Conference. Atkinson identified three major themes that arose out of the Conference, even though no definite resolutions were recorded. First, that scientism and moralism had to coexist in the interests of ‘right conduct;’ second, that adolescents needed to be assisted to resist temptation; third, that there was vigorous controversy over questions of method and personnel in the teaching of sex hygiene. In relation to the teaching of sex hygiene, Atkinson articulated the issues:

How much should be taught, when it should be taught, how it should be taught, and who should teach it, were the great Questions of the Conference.

The consensus of the Conference swung towards classroom teaching in schools, as opposed to individual teaching, and the Conference was evenly split between those who favoured the medical practitioner, and those who favoured the teacher. On this issue Dr Willis, a keynote speaker at the Conference, categorically argued that the teacher was not the best person for this role.\textsuperscript{796} Willis detailed a proposed sex hygiene syllabus, argued against the teaching of sex hygiene in primary schools, outlined a full syllabus for teacher education in sex hygiene and detailed the pamphlet method of information dissemination from teacher to pupil to parent.\textsuperscript{797} Mechanisms were proposed and devised which allowed for the dispersal of information, through key

\textsuperscript{796} Ibid., p. 124.
\textsuperscript{797} C. S. Willis, in Atkinson, \textit{ibid.}, pp. 124–134.
players and stakeholders, including parents, teachers and pupils, whilst at the same time maintaining resonances of a cascading hierarchical authority. There was significant tension, as well, as to whether the clergyman should undertake sex education, with a general view emerging, according to Atkinson, that it was inconsistent ‘with the high aims of his calling.’

Atkinson also paraphrased the views of the Conference as accepting that the medical practitioner ‘was apt to be over-scientific’ in dealing with these issues.

The address of C. Savill Willis was one of the more contentious presentations at the Conference, prompting 16 different questions at its conclusion. One of Willis’s main contentions was that masturbation was less dangerous than ‘the exaggeration of the evil effects,’ which tended to frighten people. Masturbation was a litmus test issue, with traditionalists and progressives marshalling a range of prominent theorists to support their claims. In the minds of delegates, masturbation, pre-marital sex and venereal diseases were inextricably linked: not only could one activity lead to another, but the potential to be infected with venereal diseases arose from the same ‘base motive’ which impelled masturbation. Willis cited the support of ‘such eminent sexologists as Havelock Ellis, Bloch, Rohleder and Moll,’ whilst traditionalists cited ‘the opinion of the best authorities, such as Hall, Morror, Bigelow, Trewley and Lyttleton.’ Traditionalists objected to masturbation on moral grounds: ‘though the extreme results of insanity, paralysis or epilepsy may be rare, there is no doubt that many children continue the habit long enough for it to become very injurious, not only physically, but mentally and morally, and that it often leads in later life to grave moral evils,’ remarked Miss Glendenning in the question and answer session following the presentation. Mr Wilson, a delegate of the Australasian White Cross League, also questioned the veracity of Dr Willis’s claims on masturbation.

The address of J. Smyth, Principal of the Teachers’ Training College in Melbourne, entitled ‘Sex-education for Boys,’ is interesting because he specifically did not use the language of hygiene, and argued strongly for sex education to be undertaken by teachers. Smyth stuck to his preferred appellation of sex education. He spoke the

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798 Atkinson, ibid., pp. viii–x.
799 Atkinson, ibid., p. 127.
800 Ibid., pp. 124–134.
language of sex education, detailed an age-related pedagogy, saw sex education as a
fundamental part of moral education, and couched his pedagogy in a strong purity
framework. Smyth argued that a boy should be told about the organs in his body,
about birth and reproduction, and about the ‘connection between semen and the
virility of the body,’ whilst at the same time a boy must ‘reverence women and
understand that it is in his thoughts and acts in regard to this subject that he can best
prove his manhood, attain self control, consideration of the opposite sex, help to
remove evil from society, and be obedient to the will of God.’ Such sentiments
demonstrate how at this point in the century ideas related to social purity and sex
hygiene elided. Smyth also argued equally that ‘the doctor is usually the last person
who should impart sex ideas.’ He elaborated:

Too often (the doctors) training has made him a materialist, and on the basis of
materialism this subject cannot be taught. Teaching is an art, and must be
studied and practised. The teacher has studied this art, and so is the only
person competent to impart a difficult subject of instruction.

When pressed, Smyth argued that materialism could also be interpreted as hedonism.
In this statement Smyth was suggesting that the medical practitioner’s self-interest
disqualified him from being an appropriate teacher. In relation to sex education,
Smyth positioned the teacher, the pedagogue, as the only proper purveyor of sex
instruction, and argued that the medical practitioner was completely unsuitable. As an
educationalist, Smyth saw the key word in the phrase ‘sex education’ as being
‘education,’ and therefore the key discourse of its implementation being pedagogy.
Willis, on the other hand, saw the key word as being hygiene, which placed sex
instruction in a medical discourse, with medical practitioners the best available
instructors.

Most presenters at the WEA Conference, including Willis and Smyth, focused almost
exclusively on the provision of sex hygiene or sex education to young people, or
adolescents. Puberty and adolescence were of such significance to Conference
delegates that the glossary to the published Report included definitions of these two

802 Ibid., p.173.
constructions. Adolescence was defined ‘as the period of growth from childhood to manhood, from puberty to maturity, generally from 14 in males and 12 in females up to 21 years of age.’\footnote{Ibid., p. 199. The age brackets placed around childhood and youth are culturally and historically defined. In 2003, for the purposes of sexual health promotion and broader health agendas, young people are defined as people under the age of 26.} Puberty was defined ‘as the period at which male or female becomes functionally capable of generating offspring… generally from 12 to 14.’\footnote{Ibid., p. 200.} Puberty was defined biologically and adolescence sociologically. Adolescents were becoming a major focus of venereal diseases prevention education, and Smyth detailed a number of reasons for this attention. Smyth positioned adolescents as being unsupervised, impressionable and reckless: attending picture theatres by themselves, without any proper recreational centres, with ‘too much freedom, and often too much money.’\footnote{Ibid., p. 168.} Mr F. Young, from the Operative Stonemason’s Society, and a self-identified member of the working classes, also saw working-class adolescents as being particularly susceptible to poor sexual decision making, because of ‘the economic pressure of low wages, the bad housing conditions and the fact that many of their parents have had to begin work to earn their living before they received any adequate training themselves.’\footnote{Ibid., p. 182.} Young’s mention of class was the only reference at the WEA Conference to sex hygiene and sex education having different causes and consequences for the poorer classes and the well-to-do. Certainly, the evidence presented to the NSW Select Committee of 1915 concentrated almost entirely on the development of appropriate strategies for well-to-do boys, from the greater public schools.\footnote{In fact, two sets of evidence were collected for the NSW Select committee on the Prevalence of Venereal diseases, and two reports produced. The second report presented the evidence of a number of educators, school principals, and school medical officers on the efficacy of providing sex education to boys and young men.} Constructions of adolescence as problematic emerged during and immediately after the War, although differently so, depending on class. A construction of the female adolescent as a vector of venereal diseases, particularly the ‘amateur’ prostitute, also emerged during and after the War.\footnote{Davidson argues that at three points in the twentieth century, the two World Wars and the 1960s, adolescents were ‘depicted as a metaphor for the threat posed to rational, responsible sexuality posed by shifts in the income and consumption patterns of youth and their addiction to new forms of disinhibited entertainment’ (Davidson, R., Dangerous Liaisons, p. 2).} It was at this juncture in NSW that adolescents, particularly young women, first became a metaphor for uninhibited sexuality. The WEA backed up its 1916 Conference with a Conference in
Mrs James Booth, in her presentation titled ‘The Case for the Sex-education of the Adolescent Girl,’ argued that whereas ‘the adolescent girl was formerly sheltered from harm, today she runs the gauntlet.’ Booth stressed that the ‘adolescent today is without the restraint of dogmatic religion,’ and ‘at the time of adolescence the mind is unstable, and the awakening of the sex impulse, if untrained and unguarded, may tend to vice.’ Echoing Smyth’s sentiments regarding the excess of freedom for adolescents, Booth stressed however that sex was everywhere:

She finds it in the newspaper, in the tramcar, in the street, in the restaurant and at the picture show. She picks her own books at the circulating library.

Given the pervasive nature of information on sex, it was argued that information on the prevention of venereal diseases had also to be widespread. Earlier governmental responses had focused on the brothel and the street as the sites for possible contamination: under a broader hygienist model, the risk of infection, particularly for adolescents, lurked in most public and private places, including homes and schools and cinemas. Sex hygiene took the battle right up to the venue: adolescents would need to be monitored and educated in a variety of settings, if social and racial hygiene goals were to be achieved. Booth recorded what she considered to be the three fundamental criteria that could be applied as a test of the success or failure of sex education for adolescents. These were:

Has the Attitude of Mind been elevated towards love and reproduction? Has it increased personal reserve, and not broken it down? Has it inculcated a strong sense of racial and social responsibility.

Booth’s ‘personal reserve’ and ‘responsibility’ is in fact the Tennysonian ‘self-reverence, self-knowledge, self-control.’ Booth argued then that the responsibilisation...
of adolescents would not only achieve individual sexual health, but would also have
significant impacts on the racial and social health of the nation.

Whilst Mrs James Booth spoke of young girls, Mr J. Smyth spoke of young boys.
Boys were presented with a veritable cornucopia of preventative sentiments and
mixed messages, to the extent that sexual decision-making would have been
extremely complicated: venereal diseases prevention messages were bundled up with
messages related to masturbation and spermatorrhoea and prophylaxis. Smyth in
‘Sex-education for Boys’ quoted from an actual presentation he used with adolescent
boys aged 13 to 15:

Are you aware of the meaning of the change of voice which you are now
experiencing? It means the change from boyhood to manhood. It means you
are receiving a new, a strange and a great power. You all long to be strong, to
be good footballers, runners, wrestlers etc. you also long to grow up strong
men. You also long to smite evil, and to do noble deeds. This new power
entrusted to you will help you to realise all these longings, if you take care of
it. I shall tell you of it.813

In 1916, this call for boys to locate the crusading warrior within was particularly
timely: it was also a call to war. Messages presented to 15-year-old boys prior to
enlistment changed markedly after enlistment. Prior to war boys were told that ‘the
blood needs the semen in order to build up muscle, bone and brain,’814 that self-abuse
indicated ‘unclean thoughts and evil imaginations’ and that the use of preventives
[prophylactics] would lead to ‘the destruction of true love, of home, of a strong life
and of future happiness.’815 After enlistment boys were told that ‘good health is not
injured by avoiding sexual intercourse,’816 that French letters and blue label outfits are
‘frequently necessary,’ and masturbation was not mentioned at all in a standard
address to soldiers in Europe reported by Butler.817 During the War, prevention took
on a different logic, and boys were provided with different messages: as I discuss

813 Atkinson, Report on Sex Hygiene, p. 77.
814 Ibid, p. 77.
815 Ibid, p. 79.
816 Butler, A. G., The Official History of the Australian Army Medical Services in the War of 1914–
817 Ibid., p. 160.
below, harm reduction logics replaced moral imperatives. Australian soldiers in
Europe were told: ‘At this critical period, the Empire can ill afford to lose a man from
a disease that is preventable.’

At the same time as the WEA was hosting its Conferences in Sydney, similar
developments were taking place in Britain and the United States. Lewis remarks that in
the United States in 1900 in the social purity movement aimed to repress the sex-
impulse, and by 1920, ‘the United States Public Health Service was sponsoring 50
regional Conferences on sex-education in high schools and colleges throughout the
country.’ Lewis suggests that the education offered was intended to ‘preserve the late
Victorian moral and social order.’ The United States certainly moved quickly
towards diverting preventative apparatus towards a diversified and widespread
pedagogy, whilst at the same time, Lewis argues, preserving the purity commitment to
sex continence and fidelity. Carter has argued that in the United States, in the 1920s,
sex education was both improvised and limited, covering the physiology of puberty,
conception and the dangers of venereal infection, or integrated, including ‘personal
and social adjustment, and character and mental health as well as physical health.’
In Britain this tension between purity and sex education agendas was being acted out
at an organisational level. The National Council for Combating Venereal Disease
(NCCVD) was initially to have included the word ‘preventing’ instead of
‘combating,’ but this was changed because prevention could have been seen as
implied support for the distribution of disinfection packets to the civilian
community. Five years after the NCCVD came into existence the National Society
for the Prevention of Venereal Diseases (NSPVD) was established in 1919, and
advocated the installation in public toilets of automatic machines to vend disinfection
packets. Both disinfection and prophylactic packets became litmus test issues, in
the UK and in Australia.

818 Ibid., p. 161.
820 Carter, ‘Birds, Bees and Venereal Disease,’ p. 226. Carter also demonstrates that by 1920, 40% of
high schools responding to a federal survey claimed to be offering some sort of sex education. By
1927, 45% of American high schools were offering sex education, and 29% of these had developed
integrated programs.
821 Ibid., p. 183. A notice informing Australian medical practitioners of the formation of the National
Council for Combating Venereal Diseases in the UK was included in the Medical Journal of Australia
in September 1916 (p. 286).
822 Ibid., p. 183.
The WEA Conference on the Teaching of Sex Hygiene marked a significant moment in the development of discourses related to the prevention education of venereal diseases, much as the Congress of the Racial Hygiene Association in Sydney did a decade later. Various presenters, and delegates in question and answer sessions, made clear their views on a range of touchstone issues, including masturbation, the role of medical practitioners and teachers in providing sex instruction and a relevant curriculum for teaching sex education. Such issues were fundamentally and discursively associated with venereal diseases. Adherents to purity agendas, medical advocates of sex hygiene for young people, and pedagogues who expounded a curriculum for teaching adolescents sex education were all present. Serious debate arose in question and answer sessions about the relative values of particular approaches. The focus of most inquiry, however, was the adolescent, and the construction of the adolescent as being the most important target for venereal prevention education. In this sense, the evidence of the WEA Conference supports my contention that young people, and the sites of their activity, were the emerging focus of public health campaigns against venereal diseases. An emerging pedagogy of sex education supported this new direction.

Australian Imperial Force (AIF)

Throughout the twentieth century war has always been perceived as having a significant impact on the prevalence of venereal diseases. Historians have also noted that war has had an impact on the regulation of sexual behaviour both by civilian and military authorities, and that at times civilian and military authorities were at odds with each other on venereal diseases policy. There were certainly tensions between civilian and military responses in Australia during and after World War 1. Whilst approaches in the civilian community focused on developing a pedagogy of sex

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823 Carter has argued that in the United States, by 1919, a general consensus had emerged 'that too much emphasis on disease was poor preparation for healthy adult sexuality,' and so by 1925, teaching about venereal diseases was no longer at the centre of sex education. Interestingly, Carter also argues that it was around this time that both 'the facts of life' and 'the birds and the bees' entered the lexicon of sex education (ibid., p. 233).
hygiene that was compatible with admonitions towards self-control, within the AIF quite different strategies were being deployed. Dr Richard Arthur told officers of the AIF that condoms and prophylactic packages\textsuperscript{826} would never be used in the Australian Army: they would only be used by Japanese and German armies, because they encouraged fornication. Arthur made his speech in 1915. Yet, by 1918, 142,609 prophylactic packages had been distributed to Australian soldiers by the AIF,\textsuperscript{827} and soldiers could additionally purchase condoms as part of their prophylactic packet.\textsuperscript{828} What brought about this change in the AIF? Who advocated these changes, and who opposed them? How did policies related to punishment for concealment of infection, docking of pay for becoming infected, short arm parades,\textsuperscript{829} prophylactic treatment and health education relate to each other, and was there a logic which united them?

Responses by the AIF to the prevention of venereal diseases in the early years of the War were entirely punitive, in line with a broadly punitive approach adopted by both the British and American Armies. Beardsley suggests that because of microbiological developments including the Wasserman reaction and Salvarsan, many expected that venereal diseases would not be a problem in the armed forces.\textsuperscript{830} When the efficacy of these technologies did not live up to their promise, the AIF was keen to trial new strategies. In the early years of the War, the first line of action taken by the Australian Command and the Commonwealth Government was to embody in Australian Finance and Allowance Regulations a special military order dated 1\textsuperscript{st} February 1915 which laid down that ‘no pay will be issued while abroad for any period of absence from duty on account of venereal disease.’ It should be noted that concealment of venereal diseases was already a ‘crime’ (under King’s Regulations 462 and Section 2 of the Army Act). A. G. Butler, the official Australian military medical historian of World War 1, commented that this ‘punishment was a fierce one indeed and was made the

\textsuperscript{826} A typical prophylactic packet, sometimes referred to as a Blue Label ‘outfit’, was designed for post-coital disinfection of the genital areas, and included topical antiseptics (usually calomel ointment), protargol or argyrol for injection into the urethra, a syringe and an instruction sheet. A prophylactic package did not include condoms as a standard item.

\textsuperscript{827} Levine suggests that ‘the condom was mentioned far less in prophylactic debates’ than either prophylactic kits or blue light Depots. Some of the reasons for this reticence included their expense, eugenic anxieties around race suicide, pronatalist campaigns which stigmatized the condom and a decided reluctance to discuss contraception (Levine, P., Prostitution, Race and Politics, p. 149).

\textsuperscript{828} Butler, The Official History of the Australian Army Medical Services, p. 158.

\textsuperscript{829} ‘Short arm parade’ was soldier’s slang for a communal, medical inspection of the penis for the presence of venereal diseases.

more severe by the provision that the pay allotted by the soldier to his family, was also forfeit, and must be made up after his recovery before he could touch his own. The forfeiture was entered in his pay book. This process involved, in the soldier’s mind, the possibility of his “fall” becoming known to his people in Australia and was a greater source of anxiety to him than loss of pay.\textsuperscript{831} Such responses were in line with medico-penal modes of rule that characterised civilian responses in the late 19\textsuperscript{th} and early 20\textsuperscript{th} centuries. It should be noted that this policy changed on 1 January 1918 when it was accepted that the process left ‘intense embitterment.’ At this stage it was agreed therefore that stoppage of pay should only be two shillings and sixpence a day, with loss of field allowance for officers.\textsuperscript{832}

Attitudes towards the prevention of venereal diseases by the AIF changed substantially over the course of the War. In the early days of the campaign in Egypt, a medico-penal approach was adopted. At Mena in the Egyptian desert in 1914 venereal patients were quarantined in tents, wore a white band on their right arm and were surrounded by sentries and flying pickets. Patients were not allowed to leave the hospital lines, receive food or articles from outside or to receive visitors. Most of these patients were youths, ‘some still in their teens’ and infected for the first time. Any education related to sex hygiene, venereal infection or the risks of illicit intercourse was ‘not effectively undertaken.’ Butler conceded that these patients were treated as ‘criminals’ and with an unmitigated ‘fierce discipline.’\textsuperscript{833}

Within the AIF, the immediate goal in relation to the prevention and management of venereal diseases was military efficiency. Butler reflected this priority when he remarked:

\begin{quote}
The anti-social character of the venereal diseases, and the obloquy attaching to them, became accentuated, on the ground that they were subversive to victory and inimical to national interests, rather than ‘immoral.’
\end{quote}

Once freed of the call to morality, so common in civilian settings, the AIF was able to

\textsuperscript{831} Butler, The Official History of the Australian Army Medical Services, pp.153–159.
\textsuperscript{832} Ibid., p. 164
\textsuperscript{833} Ibid., p. 173.
experiment with a number of preventative strategies, a capacity that Butler phrased in the following way:

In civil communities the line of attack on venereal disease depended in great measure on the national attitude as to the ethics of the matter. But the AIF in Great Britain at least, was free to work out its own salvation unimpeded by considerations other than military efficiency.  

For the AIF, one key factor in maintaining military efficiency was taking measures to deal with the perceived primary risk prostitutes, both “hardened” and “amateur”, presented to soldiers’ health. Some aspects of prostitution were beyond the control of the AIF, despite the Dominion governments regularly haranguing Westminster to address both street- and brothel-placed prostitution in both Britain and France. Maisons tolérées operated in France, and both France and Britain appeared committed to a policy of *reglementation*, despite American disapproval. Arguing that the risk of infection was highest when soldiers were on leave from France in England, AIF preventative strategies around prostitution therefore focused on England. Butler’s rather idiosyncratic reading of the role played by women, and what motivated them, centred on women’s understanding of the national interest. He argued that ‘many women, not inherently abandoned, surrendered themselves partly in the belief that the loosening of sexual relations promoted the winning of the War, or was, in a way, a patriotic act.’ In Britain, ‘khaki fever’ was reported to be taking hold of the country, and as Levine demonstrates, this was said to be occurring ‘with or without material gain.’ Running parallel to ‘khaki fever’, Levine also demonstrates that women were taking on significant and targeted roles in civilian policing, fulfilling roles for women that had been advocated some time. The Australian government and the AIF attempted to convince women that ‘khaki fever’ ‘was inimical to national

834 Ibid., pp. 152–155.
837 Butler, *The Official History of the Australian Army Medical Services*, p. 155
interests.’ Butler argued that a feature of the ‘VD problem in any war was the rise to prominence of the “amateur” prostitute.’

Whilst still believing that prostitutes were central vectors of transmission, by 1916 the AIF had embarked on a ‘very remarkable experiment developed in the interests of the Australian Army and the Australian nation in the prevention or abortion of venereal disease in the AIF in Europe during 1916–19.’ This experiment was led by the subsequently much-decorated General Neville Howse (1863–1930), at this time Director of Medical Services with the AIF. Butler reported that General Howses’ aims were ‘promoting military efficiency and saving the national purse,’ that he ‘hated intensely VD’ and ‘was a rigid teetotaller.’ In the United Kingdom, General Howse ‘had a free hand, and within the scope of the civil law, could make what experiments he wished.’ The unimpeded capacity to experiment was a key element in the AIF’s response. The preventative strategies adopted by the AIF in this part of the War were informed by a logic of harm minimisation, a logic which Hooker has described as essentially out of place for this period. The military tended to take many of the daring steps in venereal diseases prevention because they were driven by the imperative to maintain the health of the fighting forces, and because they were remote from domestic constrictions.

Butler, The Official History of the Australian Army Medical Services, pp. 152–155.

Ibid., pp. 152–153.

General Neville Howse was Australia’s first Victoria Cross winner, and after World War 1 was elected as a Federal MHR for the seat of Calare between 1922 and 1929. From January 1925 to April 1927, Howse was Minister of Defence and Health, and Minister for Repatriation. In February 1928, he again became Minister for Health and Repatriation, and also for Territories. As Minister for Health, Howse strove to improve the treatment of cancer and venereal diseases. He purchased £100,000 of radium for medical purposes, establishing one of the first radium banks in the world. He assisted in the creation of the Australian College of Surgeons and the Institute of Anatomy.

Ibid., pp.152–153.

A similar innovative and experimental approach was evident in the development of treatment services for soldiers, both in England and at home in Langwarrin and Liverpool. This had not always been the case during World War 1 in the AIF: in fact, the watershed year of 1916 saw the deployment of the Australian Dermatological Hospital (ADH) overseas.


The AIF was certainly prodded to take daring preventative steps. From 1916 Ettie Rout, ‘a one-woman campaign against British indecision about prophylaxis and prevention,’ campaigned tirelessly to extend the use of prophylactic packages and early treatments in the AIF. Levine, Prostitution, Race and Politics, pp. 152–153.

Donovan suggests the following as bold steps in STD prevention undertaken by the military: graphic education programs with an emphasis on sexual abstinence and temperance, regulating local sex industries, providing post-coital chemical prophylaxis stations, providing prophylactic kits, or condoms, compulsory medical examinations and punishment for infected soldiers, quarantining...
By 1918, the AIF had implemented a series of blue light VD clinics (called blue light clinics), 848 other early treatment facilities, and was distributing prophylactic packages and providing condoms for purchase. 849 This contrasted markedly with the earlier punitive approach. Major J. W. B. Bean described these two approaches as the punitive method and the constructive method. 850 The punitive method regarded the infected soldier as a criminal, and the hospital as a penitentiary. Under the constructive method ‘everything was done to subject the men to home-like influences where they had the freedom in the afternoon and evening to visit friends.’ 851 Fundamentally however the two methods were premised on assessments of human motivation, and what tactics were most likely to be effective. Bean suggests that under the punitive method:

The patient was often made to feel like a criminal and the deterrent motive appealed to was fear – fear of losing his pay – of being found out by his people – of losing the respect of other men – of the routine of a VD hospital and its grisly sights and circumstances.

The constructive method presumed that:

Every man has a *vis medicatrix naturae* working for health of soul as well as for health of body. 852

This ‘healing power of nature’ referred not only to a belief in God’s universe, but also to the self-knowledge a person brought to their own health and well-being. Under the constructive method soldiers were held to be responsible for their own health. The transition from panopticon to dispensary, and from government to self-government infected military men, promoting visits to camps by wives and encouraging alternative recreational outlets (Donovan, B., ‘The Repertoire of Human Efforts to Avoid Sexually Transmissible Diseases: Past and Present Part 2: Strategies Used Before or Instead of Sex,’ *Sexually Transmitted Infections*, 2000: 76: pp. 88–93.)

848 ‘Blue light depots’ were sanitary stations where soldiers could report for post-coital prophylaxis.
849 Some contemporary commentators referred to condoms as ‘Malthusian Devices,’ highlighting the procreative and population decline aspects of condoms (MacDonagh, J. E. R., *Biology and Treatment of Venereal Diseases*, p. 495).
852 Ibid.
that occurred across the period 1901 to 1925, occurred in microcosm in the AIF between 1914 and 1918. In the AIF, in this period, the ‘watchful eye’ was turned on the self.

General Howse developed two broad lines of action to prevent venereal infection: ‘to minimise either the number of exposures to contagion, or the risks involved in such exposure.’ This configuration brought together both a broad harm minimisation approach (‘minimise the number of exposures to contagion’) and a specific risk reduction logic (‘minimise the risk involved in such exposure’). Practically, such an approach was intended to limit contact with prostitutes, and where contact did occur, to diminish the potential for infection through prophylaxis. The proposed strategy to reduce the number of exposures was to make infection a crime, and to expose the infection by publicity – ‘a kind of prophylactic blackmail.’ Other strategies were to promote morale, and to sublimate ‘the prodigious motive power.’ The proposed strategy to reduce risk involved in such exposure was to mount ‘a vast campaign of medical prophylaxis and preventative treatment – of males in the army and of females in the civilian community.’853 Harm minimisation and risk reduction were the articulated springboards for these strategies.

Whilst harm minimisation was the framework, the actual AIF prevention policy was fourfold: an educational campaign; the adoption of prophylaxis; the maintenance of a system of ‘abortive’ treatment of early cases; and the provision of a special hospital for developed cases. The policy was front-loaded to the educational and prophylactic end of the spectrum, and strategies included short arm parades, blue light depots, the purchase of condoms, information cards given to soldiers going on leave, and a list of places to go if soldiers had ‘run risk.’ Similar strategies were adopted in the German Army. Hirschfeld referred to preventative measures undertaken in the German army as being, amongst other things:

*Personal precautionary measures, (including) personal cleanliness to prevent inflammation of the prepuce and penis, lubrication of the member before*

As the end of World War 1 approached, then, most military commands were distributing prophylactic packets to soldiers. Distribution of prophylactic packages in the British Army commenced in 1918 and in the Australian Army in 1916. Levine argues that decisions to distribute prophylactic packages were occurring at a time when British and colonial forces were undergoing experiences different to each other in relation to venereal diseases. In the early part of the War admissions for venereal diseases amongst British soldiers were relatively low. By contrast, Dominion soldiers ‘showed a consistently high rate of admissions for VD,’ particularly Australian soldiers who showed ‘dramatic increases’ in late 1914 and early 1915 during their time in Egypt. Levine suggests that although proponents of the distribution of prophylactic packets in the AIF ‘would later boast of Australia’s farsightedness, the policy was driven mostly by need.’ Although needs based, the distribution of prophylactic packages in the AIF between 1916 and 1919 was a purposeful practice with positive consequences.

The components of prophylactic packets differed according to prevailing domestic attitudes towards prophylaxis, and the American Expeditionary Force in Europe conducted a tug-of-war over prophylaxis during World War 1. Glantz and Mariner argue that ‘unlike the New Zealand Expeditionary forces, which gave condoms to their soldiers, the United States prior to 1915 decided to give American soldiers after-the-fact, and largely ineffective, chemical prophylaxis,’ and no condoms. Levine argues that prophylactic packages had been distributed by the US Army in 1908 and the US Navy in 1909, but were abandoned after pressure from moral purity groups in

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855 Ibid., p. 146. Levine demonstrates that the situation in Egypt had been very unsettled since at least April 1915, when the Wazza riots had occurred, riots apparently related to tension and conflict between Australian soldiers and prostitutes and brothel owners in the Wazza district of Cairo (pp. 155–156). The NSW Select Committee on the Prevalence of Venereal Diseases in the second half of 1915 heard a range of evidence about the prevalence of venereal diseases in soldiers returning from Egypt, and the Wazza riots would have been fresh in the minds of the Commissioners and witnesses.
856 Ibid., p. 148.
Prophylactic packages distributed by the US army prior to 1915 included calomel ointment for syphilis and potassium permanganate solution or tablets for gonorrhoea, and cotton swabs for their application. By August 1918 the Chief of Staff of the US Army, in Bulletin no. 54 from General Pershing, regulated that soldiers must ‘submit to prompt prophylaxis.’ The Bulletin calculated that post-coital prophylaxis ‘depends upon the promptness with which it is employed’:

Within the first hour the failures are only one tenth of 1 per cent, second hour one half of 1 percent, and after three hours from 1 ½ to 7 per cent, the average rate of failure for the AEF being 2 per cent…indicating that in many organisations the prompt submission of prophylaxis is not enforced.

The American Expeditionary Force also acknowledged that despite their best endeavours, soldiers would still not undertake post-coital prophylaxis. A range of other, supplementary measures were therefore advocated in Bulletin no. 54 from General Pershing, including denial of leave, ‘sufficiently severe’ court martials, designating houses of prostitution as ‘off-limits’ and ‘by cooperation with the French police…the apprehension of clandestine prostitutes.’ Importantly, commanding officers were also to urge sexual continence, and to enforce sexual abstinence through ‘instruction, work, drill, athletics and amusements.’ The AEF also placed a cordon militare of five miles around every American military encampment, and used female police officers to patrol these borders. The AEF suggested to the British Command that they might be interested in adopting such policies, in only one of a set of preventative measures that the AEF proposed to the British. Because the American Expeditionary Force maintained strong links with civilian government it adopted less progressive and at times punitive measures even towards the end of the War when other Commands were adopting a range of pre-, intra- and post-coital options. Whereas the AIF took the opportunity of being a long way from home to implement experimental policies, the AEF kept a close eye on domestic politics. General

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858 Levine, Prostitution, Race and Politics, p. 147.
859 I have discussed in Chapter 3 some of the debates about the efficacy of solutions or tablets for the treatment of gonorrhoea.
860 United States Army, United States Army in the World War 1917–1919: Bulletins from GHQ and AEF, US Army Military History Institute, 1919, Bulletin no. 54, p. 82.
861 Ibid., p. 82.
862 Ibid., p. 83.
Pershing in Bulletin no. 54 remarked: ‘In this war of nations-in-arms the soldier is merely a citizen on war service’.  

Both pre- and post-coital treatments were included in Australian prophylactic outfits, with the optional inclusion of a purchased condom, often referred to as a ‘French letter.’ Levine suggests that condoms were not prominent in prophylaxis debates during this period, because of moralist, pronatalist and eugenic anxieties. Yet the decision by the AIF to only include condoms in prophylactic packages if they were purchased was a compromise position: condoms were not freely available, but they could be accessed. Butler remarked that in the 19 months prior to December 1919, not only were 142,609 prophylactic outfits distributed, but 168,563 soldiers attended for prophylactic treatment at Blue Light Depots in England.

Education on venereal diseases provided to Australian soldiers was highly schematised, and Butler provided a précis of the nature and content of the information given. The earlier punitive model included a series of lectures by a Chaplain in the Command Depots, which were ‘probably worse than useless’ for ‘it is not the church parade and the sermon that counts…it is most of all the home influence and the instinct of cleanliness ingrained there.’ By 1917, all AIF units were provided with venereal diseases education once a month, usually by medical officers and orderlies who undertook ‘this thankless task with initiative and insight.’ In each of these lectures condoms were described and instructions provided on their use. Other aspects of the education covered denunciation of the idea that sexual continence was ever harmful, promotion of the idea that alcohol affected self-control, a description of gonorrhoea, syphilis and chancroid, an appeal to the importance of keeping fit from the perspective of military efficiency, and finally, a description of the methods of prophylaxis and early treatment. Education also stressed that prophylaxis had to be carried out ‘exactly’ as prescribed, and with appropriate time limits. Levine cites commentators who suggest that soldiers responded in a range of ways to these serious admonitions: some laughed it off, some felt it their duty to get VD, and others

863 Ibid., p. 84.
864 Butler, The Official History of the Australian Army Medical Services, pp. 158–60.
865 Levine, Prostitution, Race and Politics, p. 149.
866 Ibid., The Official History of the Australian Army Medical Services, p. 161.
867 Ibid., p. 160.
868 Ibid., pp. 155–161.
welcomed the opportunity of being removed from the front whilst still others faked gonorrhoeal discharges so as to be sent home. The American Expeditionary Force slotted educational talks into ‘motion films and lantern slides’ as a strategy for reaching soldiers who may not have attended lectures, and advocated the use of ‘four minute speakers’ who spoke on many subjects, acknowledging that some ‘can be better taught through lectures than by classroom methods.’

After the War the practices of the AIF were considered for implementation in civilian life by Commonwealth and State governments, but were quietly shelved. The proceedings of the British Demobilisation (Infectious Diseases) Committee on 27 February 1919 made it very clear that the ‘very remarkable experiment’ in prevention in the AIF would not be carried over into civilian communities. Throughout the War regular meetings and committees had been held between the British War Office and representatives of the dominions and dominion representatives had made it abundantly clear that they were unhappy with British responses to the relationship between prostitutes and dominion soldiers in Britain. Colonel Raffin, Australia’s representative on this Committee, presented his view of the effectiveness of prevention campaigns mounted by the AIF, measures which had to be implemented in the absence of tighter controls from the British government. Like all good experiments, measuring the effectiveness of the preventative interventions was essential. Raffin presented data that suggested that during the 19 months ending December 1918:

- 235,277 soldiers went on leave from AIF depots
- 171,277 cards of instruction were accepted
- 142,609 prophylactic outfits were accepted

869 Levine, Prostitution, Race and Politics, p. 150.
871 Lewis remarks, ‘the upsurge of interest in sex education during World War 1 had been tied up with fears concerning the high prevalence of VD among servicemen, and when the threat of VD seemed to wane in the interwar period so did concern with sex education’ (Lewis, Thorns on the Rose, p. 187).
872 Butler, The Official History of the Australian Army Medical Services, p. 166.
873 Levine argues that ‘strong pressure’ from dominion governments induced the British government in March 1918 to introduce Regulation 40D, which made it an offence ‘for any woman with communicable VD to solicit or copulate with a member of the British armed forces.’ A similar regulation was passed in Canada in 1917, but no such regulation was passed in Australia in the period. Like earlier contagious diseases legislation, Regulation 40D catalysed tremendous protest, particularly amongst social purity and feminist groups (Levine, Prostitution, Race and Politics, p. 162).
– 168,563 attended for prophylactic treatment
– 12,128 attended for abortive treatment
– 8,173 were reported as cured after showing signs of disease. 

No figures were provided on the number of condoms sold, or distributed, nor was it possible to make projections on the number of infections avoided, although Colonel Raffin mused that:

It was hardly possible to judge the effect of any single one of these combined measures … without these measures VD would be enormously greater, but how far the numbers were kept down by prophylactic measures, by early preventive treatment, or by abortive treatment, it was impossible to say. Although the results of prophylaxis did not show a very marked diminution in the number of hospital cases, the methods were of value because the number of men attending the Blue Light Depots had greatly increased, and the number exposed to risk was probably much greater.

Colonel Raffin, General Howse, and A. G. Butler articulated harm minimisation logics as part of their understanding of prevention in the AIF. Policies were developed to minimise either the number of exposures to venereal diseases or the risks involved in such exposures. This multi-strategic preventative logic necessitated experimental approaches and was made possible by the unfettered command of the AIF. The articulation of a harm minimisation logic at the individual and institutional level within the AIF, short-lived as it was between 1916 and 1919, was an important development in the prevention of venereal diseases.

**Extending the AIF experiment after the War**

In 1918, at an Interallied Sanitary Conference in London, one of General Howse’s representatives outlined in detail the innovative Australian response to venereal prevention. This presentation was strongly predicated on an articulation of harm

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875 Ibid., p. 166.
876 Ibid., pp. 157–159.
minimisation logic, and couched in the social imperatives of the time, including eugenics and population decline. The Australian representative to the Sanitary Conference suggested that:

The urgency of the necessity for strong action to prevent disease became so evident, that it was decided some risk must be faced, utilising at the same time every means, moral, social and educative, to prevent harm resulting from increased knowledge which might be gained.

The knowledge that might have been gained threatened the very future of the country:

There was a risk also of initiating a certain number into the knowledge of methods which later might be used to prevent conception – undoubtedly a serious matter in a country like Australia, whose vital need is population.\(^{877}\)

The AIF kept an eye to demobilisation, and even though they had a free hand, there were longer-term national and social imperatives that had to be considered. Whilst it may have been possible to implement policies that had the potential to impact on procreation and conception when soldiers were far distant from wives and families, it was another matter entirely to suggest that such policies could or should be maintained when soldiers returned to their homes. The acknowledged risk of course was that soldiers would have learned prophylactic techniques whilst on active duty, and even if policies did not change, the men themselves would return instructed and capable of replicating their disinfection and prophylactic techniques. It was not coincidental that in the United States demobilisation was accompanied by an avalanche of feature films and lectures which attempted to guide the armed forces back into what was presumed to be pre-war sexual ethics and conduct.\(^{878}\) This is part of the reason why debates about the implementation of civilian prophylactics were rancorous: returned soldiers may have had the techniques of prophylaxis, but without access to the means of prophylaxis the ‘French letter’ became a dead letter.

\(^{877}\) Ibid.

There was an uneasy relationship between civilian and military prevention education and treatment strategies. Many treatment practices that had been trialled and developed in the army were often later adopted in public venereal clinics. Tibbits argues that treatment routines established at the Langwarrin Military Reserve (Victoria) Venereal Diseases Isolation Compound became a model for the establishment of civilian Venereal Diseases Clinics. Descriptions of the perfunctory processing of gonorrhoea and syphilis patients have been given in chapter 3 of this thesis, as are descriptions of the efficient processing of men and women through venereal clinics: both of these features had high degrees of military regimentation represented in them. Tibbits also argues that new syphilis treatments were extensively trialled on soldiers throughout the War, before being assessed as being ready for civilian use. For instance, regular application of antiseptics such as potassium permanganate or organo-silver compounds to gonorrhoea affected genito-urinary areas were first trialled in Victoria at Langwarrin. If the treatment of the venereal soldier was an experiment, so he was also used as an experiment for preventative strategies. These however were not as immediately or as readily transferred to the civilian population and after the War were rejected as liable to promote promiscuity and impede population growth. Levine has suggested that the notion that prevention ‘potentially acted as encouragement, with its strong emphasis on personal responsibility and individual behaviour, never ceased to be a common sentiment.’

When prophylactic disinfection was carried over into civilian communities, even for brief periods of time before being shut down, the techniques of disinfection were different to those practised in the army. Donovan suggests that post-coital genital washing, urinating and the application of topical antiseptics were ‘all strategies that were more common before better quality condoms became available, though they

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879 Tibbits, D. R., ‘VD Behind Bars,’ Proceedings of the fourth biennial Conference of the Australian Society of the History of Medicine, 1995. In the late 1990s, another prophylaxis, this time for AIDS, code named PEP (post-exposure prophylaxis) confronted a similar process: gay men taking up PEP were advised to follow instructions ‘exactly,’ and within appropriate time limits. Again, in the 1990s, one expressed fear of PEP was its ability to hinder safe sex messages. For further information on PEP refer to the PEP Study newsletters produced by the Australian National Centre in HIV Epidemiology and Clinical Research, University of New South Wales.

880 Levine, Prostitution, Race and Politics, p. 172.
were of dubious value because of poor compliance. Disinfection could be carried out by the male patient himself, or by a skilled attendant, although there was debate about which was the most efficacious, and whether self-disinfection was morally and medically appropriate. Harrison cited evidence from an experiment within the US Army in France in 1916, where of 2246 consecutive men in a certain station who were treated within an hour and a quarter of exposure to venereal infection, only two subsequently developed venereal disease. Disinfection in this experiment involved:

1. Thorough washing with soap and water. 2. Washing with perchloride of mercury lotion. 3. Injection into the urethra of 2.5% protargol or 10% argyrol, retained for 3 minutes. 4. Inunction of the parts with 33% calomel ointment. 5. Wrapping of the penis in toilet paper, which was kept on for three hours.

This procedure was common across the armed forces. In civilian communities, when self-disinfecting, the following method was most often suggested:

As soon as possible after exposure to infection: 1. Urinate. 2. Wash the whole genitals, pubis and lower abdomen with soft soap and warm water, Dry. 3. Swab the same parts well with 1/2000 Hydarg. Perchloride, paying particular attention to the mouth of the prepuce, corona, and frenum, all of which are particularly apt to be abraded. 4. Squeeze some semi-fluid calomel and thymol cream into the urethra, and finish by inuncting the parts well with a stiffer calomel and thymol cream.

The main difference between the two methods was the injection into the urethra: in civilian self-disinfection, the syringe was not provided. Despite frequent calls for the distribution of prophylactic packets, and condoms to the civilian community throughout and after the War, including at the NSW Select Committee on the

882 Harrison, The Diagnosis and Treatment of Venereal Diseases in General Practice, p. 420.
883 Ibid., p. 422.
Prevalence of Venereal Diseases in 1915, neither of these contentious strategies saw the light of day in NSW between 1901 and 1925.

Although logics of harm minimisation were not immediately carried over into civilian life after World War 1, debate about the efficacy of such practices and approaches during the War, and in post-War Australia, was intense.\textsuperscript{884} Lewis suggests that in the period 1918–1921 there were debates between those who advocated the establishment of ‘urban prophylaxis depots’ and the distribution of post-coital antiseptic packets, on the one hand, and those who saw such measures as immoral, and encouraging illicit sex.\textsuperscript{885} This fine balancing act was captured by the Commissioners appointed to inquire into the prevalence of venereal diseases in New Zealand in 1922. After describing and assessing the evidence related to prophylaxis, the Commissioners concluded:

\begin{quote}
The Committee must not be supposed to advocate prophylaxis as in any way a substitute for continence and the cultivation of that high moral tone that repels any suggestion of promiscuous sexual relationships, but they feel that they could not properly ignore reference to a method of prevention of these diseases which has proved very efficient in the services, to which there appears no reasonable ethical objection, and which brings their prophylaxis in line with that of other infectious disease.\textsuperscript{886}
\end{quote}

Between the lines of this pronouncement it is possible to hear the myriad of organisations and individuals representing purity and hygienic approaches, and the astounding footwork necessary to represent a divided constituency.

Smart argues that ‘suggestions that prophylaxis be made generally available evoked moral outrage and were not seriously considered.’\textsuperscript{887} In February 1922 the Prime Minister convened a Conference in Melbourne to discuss the impact of new state-

\textsuperscript{885} Lewis, Thorns on the Rose, p. 189.
\textsuperscript{886} Venereal Diseases in New Zealand, p. 33.
\textsuperscript{887} Smart, ‘Sex, the State and the “Scarlet Scourge”,’ p. 21.
based venereal diseases legislation, and amongst other things this Conference recommended ‘that prophylactic Depots, both for males and females, should be established as widely in the community as possible.’\textsuperscript{888} Using the experience of the preventative experiment undertaken by the AIF during the War, various commentators, politicians and bureaucrats developed pro and con arguments in relation to self-prophylaxis. For instance, Sir James Barrett and Dr Piero Fiaschi argued that the distribution of prophylactic outfits had been an unqualified success, while J. S. Purdy and Richard Arthur, who had once suggested that the AIF would never distribute condoms, argued that it had been an unqualified failure.\textsuperscript{889}

In January 1922, Dr Piero Fiaschi presented on the subject of ‘The Prophylaxis of Venereal Diseases’ to the NSW Branch of the British Medical Association.\textsuperscript{890} Fiaschi outlined a system of prophylaxis which could operate in NSW, and which focused on the development of a series of depots for venereal prophylaxis, specifically targeting men who had ‘run the risk.’\textsuperscript{891} In the early 1920s, the successful wartime experience of harm minimisation was interrogated and investigated, endorsed and denied, signalling the importance of this matter in the overall logic of prevention education. Butler had remarked that preventative measures in the AIF had been unimpeded by moralism: as the War closed, and the new decade was about to begin, governments were still not ready to broaden the hygienic approach to include self-prophylaxis. There was a shift towards self-government across this period, but strong moralistic forces ensured that self-prophylaxis was not part of this shift. At the conclusion of his speech on venereal prophylaxis Depots to the NSW Branch of the British Medical Association, Dr Fiaschi remarked:

\textsuperscript{888} Quoted in October 1922 in Venereal Diseases in New Zealand, p. 14.
\textsuperscript{889} Lewis, Thorns on the Rose, p. 189.
\textsuperscript{891} Fiaschi’s prophylactic Depots were to operate from 6 a.m. to noon and from 6 p.m. to 11 p.m. A clerk would be employed to take records and issue receipts. Males attending would pay a small fee. Two trained men would be employed to carry out treatments. Men who attended who were frankly ‘suffering from venereal diseases’ were to be referred to a clinic. The Depots ‘should be established in the vicinity of police stations, so that the public could quickly locate them, and also if the small staff were annoyed by disorderly individuals.’ Fiaschi argued that if a man had not been provided with a condom, a prophylactic tube or a hand syringe, then ‘he will repair to the Depot the same night as the engagement with Venus or the following morning.’ (Medical Journal of Australia, January, 1922, p. 92).
This is a young country and we do not want to wait for a lead from the old world in these matters. We should strike out fearlessly for ourselves and for the members of our community. We have given the old way a good long run and the results are too well known to all of you. 

Levine suggests that nations like Australia and New Zealand often positioned themselves as generators of new ideas, and Britain as the older and decaying civilisation, the new nations therefore ‘inheriting the mantle of modernity from the parent nation.’ Although the AIF had struck out fearlessly, introducing prophylactic packets fully two years before the British Army, civilian prophylaxis Depots did not see the light of day in NSW in the 1920s, or beyond. During and after World War 2 a limited number of sexual health clinics in NSW distributed condoms as part of genito-urinary consultations, but this was the closest NSW ever got to the prophylactic Depot.

The 1920s

The early 1920s in the USA saw the rapid expansion of sex education classes in high schools and colleges, and the consolidation of clinic-based prevention education and contact tracing processes. In Britain, the early 1920s saw significant debates about the advisability of distributing prophylactic packages, and an escalation in the activities of the British Social Hygiene Council. In NSW, how did the 1920s differ, if at all, from the previous decade, where the evidence has suggested that there was an uneven shift towards a pedagogic agenda, with its implication of responsibilisation, or self-regulation?

Lewis has argued that ‘while very little progress was made in Australia

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893 Levine, Prostitution, Race and Politics, p. 152.
894 Lewis, Thorns on the Rose, p. 187. See also Tomkins, S. M., ‘Palmitate or Permanganate,’ pp. 382–398. Tomkins argues that although these debates were rancorous, they were not of any real substance. She characterizes the debates as being about minor issues of chemical types and timing when she remarks ‘in their minds the differences between palmitate and permanganate and between disinfection at 10:45pm and 11:45pm were sufficient to tolerate the continued high incidence of a devastating and preventable disease.’
895 Rodwell, G., in ‘Lessons from the First World War: Drs Harvey Sutton and J. S. Purdy: Sydney’s Health Week: 1921–1950,’ provides a good description of the preventative and propaganda imperatives which impelled the first Health Weeks in the 1920s (Individuals and Institutions in the History of Medicine, Conference Proceedings, Sydney, 1999.)
with the issue of sex education in schools in the interwar years, interest in promoting knowledge of sexuality, especially as it related to prevention of VD, did not die out. The problem was that moralism reigned supreme.\footnote{896} Moralism did in fact remain the mainstay of preventative approaches in the 1920s. Moreover, techniques used to disseminate these logics continued to operate on the basis of diffusion and dispersal of information and knowledge through sophisticated marketing strategies and networks. Three aspects of preventative technique that did change however were that there was an increased volume of such activity, there was intense contestation about the politics of prevention and new technologies, including film and radio, exponentially increased the scope and reach of prevention activity.

The 1920s was a period of see-sawing advocacy of different preventative logics, not just in NSW, but also in the United Kingdom. A Commonwealth Conference of all Australian Health ministers and Commonwealth Health Department representatives was called in 1922. It was convened specifically to assess the impact of venereal diseases legislation in each state of NSW, and it somewhat controversially recommended that prophylactic stations should be established in all the major cities of Australia. This sparked new debates on this thorny issue. Much of the debate was self-consciously reactive and political: the instigation of one new Association would lead to the countermanding development of an ideologically opposed League. The distribution of a particular pamphlet advocating the development of urban prophylactic stations would lead to the publication and dissemination of opposing material. In the early 1920s, the touchstone issue was prophylaxis, precisely because it had been demonstrably successful during the War.\footnote{897} Organisations were formed to promote prophylaxis, and to oppose it. Prophylaxis represented the pivot on which distinctions between conservatives and progressives hinged: conservatives would not countenance contraception or pre-marital sex, and progressives argued for the capacity of individuals to minimise their risk through pre-, intra- and post-coital interventions. Towers demonstrates that this period in the United Kingdom saw two competing pressure groups, the National Council for Combating Venereal Disease and the Society for the Prevention of Venereal Disease, defending opposing approaches.

\footnote{896}{Lewis, Thorns on the Rose, p. 187.}
\footnote{897}{Butler, The Official History of the Australian Army Medical Services, pp. 157–159. Australia’s representative to the post-war Inter-Allied sanitary conference argued that the preventative approach adopted by the AIF had been successful in preventing infections.}
ideologies: the NCCVD advocated moral education and the SPVD advocated medical prophylaxis. Towers remarks that many of the interests represented by these groups, and their political perspectives and affiliations, were influenced by ‘factors only very tangentially connected to health education.’

In NSW, one of the key organisations that railed against prophylaxis was the Father and Son Welfare Movement. This Movement was established in 1926, and continued to promote only older paradigms related to chivalry and gallantry. It also had close ties to the Australasian White Cross League, which continued to distribute old and new literature throughout the 1920s. The Movement’s Advisory Council included the heads of the Anglican, Presbyterian, Methodist, Congregational, Church of Christ and Baptist Churches, and it had similar pledging agendas as the Australasian White Cross League. The Movement re-published Will Irwin’s *Conquering an Old Enemy*, and circulated it widely. This document returned to old themes related to prostitution, and the need for young men to eschew these ‘human beings – sometimes purely wicked, sometimes only unfortunate, sometimes intelligently evil, sometimes merely under-brained.’ Prophylaxis or condoms were not suggested as preventative responses: instead men were encouraged to ‘replace the low dance hall, the red-light resort, with innocent and healthful recreation.’

One of the key organisations that promoted prophylaxis during the 1920s was the Australian Association for Fighting Venereal Disease (AAFVD). Begun in Melbourne in 1921, it was the brainchild of Sir James Barrett, and his sister Dr Edith Barrett, and its purpose was to promote prophylaxis as a response to venereal diseases. The AAFVD was interested in educating 17-year-olds in sexual physiology (lecturers supplied); providing information on prevalence, prevention and treatment; and legislating without regulating. Smart argues that the AAFVD’s preventative agenda was differentiated according to gender: with prophylaxis and self-regulation being designed for boys and enlightened idealism being targeted at girls. In fact, the

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899 Irwin, W., *Conquering an Old Enemy*, The American Social Hygiene Association, distributed by the Father and Son Welfare Movement of Australasia, p. 12 (located in the papers of Dr Richard Arthur).
AAFVD espoused concrete and action-oriented strategies to prevent venereal diseases: it advocated the establishment of prophylactic depots in the metropolitan area, ‘advertised by means of public notices in urinals,’ and enhanced by the distribution of information through pamphlets and noticeboards within them. The Association also argued that ‘as condoms are an efficient preventative of VD, all restrictions on their importation and sale should be removed.’ Medical practitioners who lectured for the Association had to agree that the aim of the lecture was education of the public on prevention; that treatment was to be referred to only generally; and that the lecture was not to be used for any trade purpose. The AAFVD made good use of the new technology of films, and held screenings of UK and US films. The Presidency of the AAFVD in NSW was offered to J. S. Purdy, MOH for Sydney in 1922 by Dr Richard Arthur, amongst others. Purdy, in his preface to W. J. Thomas’ *Venereal Disease: a social problem*, suggested that the name AAFVD was chosen precisely so as to avoid the rancour which accompanied the establishment of similar societies in Britain, where much debate occurred about the use of the word ‘combating’ as opposed to ‘preventing,’ with ‘preventing’ taking on overtones of support for prophylaxis.

Recognising that there might be the same split as to the advisability of advocating prophylaxis in Australia as had occurred in England, the AAFVD in NSW adopted the following objectives:

To raise the standard of health and conduct:

a) by educating the public as to the physiological laws of sex;

b) by disseminating accurate information as to the prevalence and effects of venereal disease; and

c) by arranging courses of lectures and issuing suitable literature.

The use of ‘conduct’ in this outline of goals is important: health was expressly linked to behaviour, and the Association operated on the assumption that behaviour could be

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905 Thomas, *Venereal Disease: Shall They Be Warned*, p. 8.
changed, that conduct could be modified, and that conduct was linked to broader national imperatives. The NSW branch of the AAFVD did not insist on medical practitioners undertaking education, nor did they impose a cut-off age for the provision of education on sexual physiology. Given the composition of the Committee of the AAFVD in NSW it was not surprising that some radical measures were advocated. Dr Ralph Worrall, who had advocated the distribution of condoms at the NSW Select Committee of 1915, was a member, as was Dr Fiaschi, who had advocated urban prophylaxis Depots. Purdy pointed out that the goal was to establish a branch of the AAFVD in each state, and to establish a Federal Council at the Second Congress of the Public Health Association in 1922. Purdy concluded his preface to Venereal Disease: a social problem by recommending the book to the reader:

Mr Thomas...as a layman...has put forward a fair unbiased statement of the problem. Whilst some may not agree entirely with his views, such in my opinion expresses a trend of thought in this subject at the present time.\textsuperscript{906}

This ‘trend of thought’ was toward responsibilisation of the citizen by improving access to the means of prevention – pre-, intra- and post-coital prophylaxis. Not all agreed with this shift. A series of articles in the Medical Journal of Australia found the suggestions ‘astounding’ and argued that the focus on ‘sex talks, sex books, sex films, sex plays...’ was skewing the public towards profligacy.\textsuperscript{907}

There was a proliferation of sex education literature in NSW in the 1920s and 1930s which encompassed both traditional and progressive responses to the prevention education of venereal diseases. Without detailing a full summary of this literature, it is difficult to argue for a shift in the direction or logic of the prevention messages embedded in the text, and in their dissemination. Most of this literature reflects the uneven shift from government to self-government.\textsuperscript{908} Characteristic was the reply of

\textsuperscript{906} Ibid., pp. 10–11.
\textsuperscript{908} The following publications were examined as a representative sample of the literature of venereal diseases prevention: W. S. F. Bottomley, An Old Plague and a New Remedy, 1910; Anonymous, Should Syphilis be Made Notifiable?, 1911; Everett Atkinson and William Dakin, Sex Hygiene and Sex education, 1918; Mrs James Booth, The Prophylaxis of Venereal Disease, 1919; Mrs Frances Anderson, The Root of the Matter: Social and Economic Aspects of the Sex Problem, WEA, Sydney, 1918; W. J. Thomas, Venereal Diseases: Should they be Warned?, 1922; Hugh Wansy Bayley,
Mrs James Booth, of the Association to Combat the Social Evil (ACSE) to Sir James Barrett, which was printed as The Prophylaxis of Venereal Disease. Mrs Booth argued strongly against ‘the introduction of primary prophylaxis into civil community.’ In 1922, W. J. Thomas in Venereal Disease: a social problem, argued strongly in favour of primary prophylaxis, and devoted three out of eleven chapters to the prevention of venereal diseases, considering medical prevention, public health prevention and prevention education. The title of the book was telling: venereal diseases were not being positioned as a medical or a moral problem, rather, as a problem that could be addressed through a sociological discourse. At the same time, more traditional approaches were being advocated, particularly with the formation of the Father and Son Welfare Movement, and their distribution of a new range of ‘purity’ literature.

Atkinson and Dakin’s Sex Hygiene and Sex-Education, published in Western Australia in 1918, was a significant transitional publication, which covered reproduction and the development of ‘human sex functions,’ sexual abnormalities and perversions, sexual diseases, sex education and eugenics. The author’s hyphenated construction of sex-education was somewhat new in Australian literature, and was adopted by a significant number of commentators. The book was an eclectic mix of moralist and scientist positions. R. V. Storer, in his comprehensive Sex and disease: a scientific contribution to Sex-education and the control of Venereal Disease, published in Sydney in 1929, also promulgated a mixed ethic: sexual continence and chivalry and rigorous, pervasive schools-based sex education and pre- and post-coital prophylaxis were all promoted. J. S. Purdy also wrote the preface to Storer’s book, which was intended for doctors, students, social workers, parents, chemists and patients. By 1934, Storer published Adolescence and marriage: a survey of sex in modern life, and in a book that ranged over sexual ethics, sexual psychology, venereal diseases and sexual hygiene, and which acknowledged the work of Havelock Ellis, Storer carefully explained modern methods of contraception and coitus. Storer’s

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Footnotes:


910 Storer, R. V., Sex and Disease: A Scientific Contribution to Sex Education and the Control of Venereal Diseases, Sydney, 1929.
second book can be located in a sociological tradition, as opposed to a medical or moral tradition. Lewis has noted that ‘if the cause of sex-education in schools advanced little in the inter war period, the publication of books on sex hygiene and related concerns did become more frequent.’ This was particularly true of the 1930s.\textsuperscript{911}

**Racial Hygiene Association (RHA) Congress September 1929**

Towards the end of the 1920s, a group of nurses and feminists led by Lilly Goodison established the Racial Hygiene Association (RHA) of NSW (in the 1960s to become the Family Planning Association of NSW).\textsuperscript{912} The RHA started with three objectives:

- the teaching of sex-education;
- the eradication of venereal disease; and
- giving community instruction along eugenic lines.\textsuperscript{913}

Unlike the USSCVD and other earlier Associations, the RHA did not have a stated aim of working towards the eradication of prostitution. It did however have a stated aim of promoting eugenics, and therefore making explicit the connection between venereal diseases and race. In a significant shift from earlier organizations, the Association also provided information on contraception, but it did not open its birth control clinic until 1933. This combination of aims and activities would have been unthinkable even a decade earlier: enough had changed to permit the joint advocacy of sex education, contraception, eugenics and the eradication of venereal diseases. In its advocacy of these agendas, the RHA dispersed information throughout the community, and acknowledged that women could make decisions regarding their own sexuality and fertility. The RHA hosted weekly radio broadcasts during 1928–34, and covered subjects including sexuality, syphilis and birth control. In the late 1920s and early 1930s the Sydney, Newcastle and Canberra branches of RHA lobbied

\textsuperscript{911} Lewis, *Thorns on the Rose*, p. 194, p. 198.

\textsuperscript{912} Siedlecky and Wyndham have written thoroughly about the formation and early days of the RHA (Siedlecky, S., and Wyndham, D., *Populate and Perish: Australian Women Fight for Birth Control*, Sydney, 1990) as have Lewis (Lewis, *Thorns on the Rose*, pp. 192–193) and Scott (Scott, ‘The Management of Venereal Diseases,’ p. 77).

\textsuperscript{913} Racial Hygiene Association papers, MLMSS 450, Mitchell Library, Sydney.
government to fund and provide a wide-ranging program of sex education. It is important to note that their lobbying was directed at the Minister for Education in NSW, Mr D. Drummond. This lobbying acknowledged the RHA’s grasp of the emerging pedagogy of prevention education. Roe demonstrates that Dr Richard Arthur, Minister for Public Health, provided some limited funding to the RHA in 1929. Arthur’s financial support of an organisation advocating contraception demonstrates the significant shift which had occurred in the first 25 years of the twentieth century.

As the 1920s drew to a close, the new Racial Hygiene Association convened a well-attended and well-publicised Congress in Sydney. This Congress canvassed a range of views in relation to sex hygiene, but there were two clear foci: ‘youth,’ ‘adolescence’ and pedagogy, on the one hand, and race and eugenics, on the other. As Bashford indicates, both sex education and eugenics were integrally connected to public health, and the Racial Hygiene Congress can be read as a moment where a range of individuals and organisations came together to make this connection explicit, and active. There were also a number of fiery debates about the nature, meaning and impact of prophylaxis. Dr Richard Arthur, the Minister for Public Health, opened the Congress on 15 September and two of the keynote speakers were Sir James Barrett, a long-term and forceful advocate of prophylaxis, and J. Cooper Booth, the newly appointed Commissioner for Venereal Diseases with the NSW Department of Public Health. Although there were presentations related to sterilisation and mental illness, mental deficiency, marriage and divorce and racial profiles of Fijians, Maoris and Australian Aborigines, the bulk of the Congress was related to the discourse of racial hygiene and sex education.

914 Roe, Nine Australian Progressives, p. 97.
915 Bashford, Imperial Hygiene, p. 165.
916 Booth was the third Commissioner appointed under the provisions of the VD Act 1918, but it had taken 11 years to establish the Division of Venereal Diseases within the Department of Public Health. Booth had been preceded in this position by Dr R. T. Paton and Dr R. Dick. At about the same time the Publicity Branch of the Department of Public Health was established, which later transformed into the Health Education Branch in 1964. The role of the Publicity Branch was ‘to provide continuous health propaganda by means of press or radio, posters, exhibitions and leaflets for mass issue.’
917 Australian Racial Hygiene Congress Report, Sydney, 1929, p. 13. In one particular debate, Dr Sydney Morris, in one of the few references to Aboriginal people and venereal diseases in the primary evidence, remarked: ‘I think we might also bring it nearer home and include the Australian aboriginal, who was wiped out a generation ago by his white brother. Though the aboriginal killed indiscriminately in the first stages of his struggle, there is not one single instance recorded of an aboriginal having violated a white woman. We are inclined to think that the native races are much more
The transcripts of the Racial Hygiene Congress indicate that young people were the primary group considered to be in need of sex education, even more so than in the WEA Conference on the Teaching of Sex Hygiene of 1916. At the Congress, speeches were delivered which covered misunderstandings in adolescence, youth’s difficulties, including reticence on sex matters, sex education in schools, and the epidemiology of venereal disease in young people. Cooper Booth presented data based on notifications of venereal diseases since the introduction of the VD Act 1918. This was one of the first occasions where data from the decade-old legislation were publicly presented, and where data related to the impact of venereal diseases on young people were openly discussed. Cooper Booth’s figures indicated that 16.11 percent of all notifications were for the age group 16 to 20, and that 27.32 percent of all notifications were for the age group 21 to 25. Nearly half of all notifications were for young people under the age of 25. For Booth, these figures demonstrated that children needed to have sufficient ‘sex knowledge’ to protect themselves by the time they turned 16. Unlike the WEA Conference of 1916, Booth was able to demonstrate epidemiologically that adolescents were at increased risk of becoming infected with venereal diseases.

Many at the Congress agreed with Cooper Booth about the need for sex education for young people, but some disagreed. In one particularly fiery exchange, Marion Piddington gave an ‘impassioned speech’ in response to Sir James Barrett. Barrett had suggested that ‘if venereal diseases were left in the hands of the medical professions, they would be wiped off the globe with celerity…education alone will never stamp out venereal diseases.’ Piddington responded:

You doctors have been at it long enough, but you have not stamped it out yet.

Can you guarantee prophylaxis is the cure? I, as a teacher, feel it is a

primitive than our own! Can we say the same thing with regard to our own race and the aboriginal women? No.’


Booth’s full figures are as follows: birth to five (1.35%); six to ten (0.97%); 11 to 15 (1.20%); 16 to 20 (16.11%); 21 to 25 (27.32%); 26 to 30 (20.35%); 31 to 35 (10.67%).

These figures were somewhat different to those quoted by Fournier in 1906. Fournier analysed the age at which syphilis was first contracted amongst 11,000 of his male and female patients. These statistics showed that syphilis was contracted most frequently between the twentieth and twenty-sixth year in men, and in women between the eighteenth and twenty-first year.
tremendous responsibility. Won’t you help us teach sex-education? Why haven’t you done something?

Barrett replied:

Because every time the medical profession steps out to do it, it is met by opposition in the form of this demand for sex-education.921

In this interchange prophylaxis was pitted against sex education, and pedagogical perspectives against medical perspectives. Such public dichotomies were emblematic of this decade: both prophylaxis and sex education were logics of self-government, and the it had moved sufficiently to ensure that the debate was turned on internal logics of self-government, not modes of rule related to punishment and criminalisation.

Sir James Barrett, in his address to the Congress ‘A Survey of the Present Position of the VD Problem,’ symbolised the movement towards self-government that had taken place across the first quarter of the twentieth century. He maintained that individual citizens could ‘think it out for themselves.’ Barrett argued that a combination of prophylaxis and propaganda was needed to address the three key issues related to venereal diseases: early marriage and the elimination of promiscuity; prevention of infection; and treatment of people after they had been infected. The Congress generally agreed with this schedule for action. Importantly, however, Barrett proceeded to articulate the methods he thought would best achieve these goals. Barrett argued:

No organisation can do these things. It rests with the individual citizen to think it out… My judgement is that when people understand the facts, they will think it out for themselves and decide what course of action they will take. Everything depends on the breadth with which this matter is tackled.922

922 Ibid., p. 34.
This responsibilist sentiment is analagous to the *vis medicatrix naturae* of Major J. W. B. Bean, the dominant motive behind the constructive method of prevention in the AIF. At the end of the 1920s, after a decade of debate about sanitation, moralism, scientism, sex education, prophylaxis, and sex hygiene, Barrett articulated a position that pointed to the slow change in the logics of prevention.

**Conclusion**

Modes of rule, logics and techniques related to the prevention of venereal diseases changed slowly in NSW across the first quarter of the twentieth century. I have identified two modes of rule (government and self-government) and a range of techniques including persuasion, education, mobilisation, community development, instruction and responsibilisation. Across the period governments placed more emphasis on supporting communities and individuals to provide prevention education on venereal diseases. Lewis has characterised the period as witnessing “a small but discernable shift away from compulsion and towards persuasion in the administration of the control system.”

In the context of prevention education, this shift is also evident. The shift was not fundamentally about the content or curricula of such prevention education: most organisations advocated that goals remained focused on containing desire, restraining sex and sexuality, valorising marriage, and thereby, it was perceived, avoiding sexual risk and infection. The shift was decidedly about the techniques employed to achieve these goals, and the volume of activity that was concentrated on them. Fundamentally, preventative strategies were directed at individual citizens, for their exercise of self-government in relation to the prevention of venereal infection.

There was a dispersal of techniques and strategies to build the determination of individuals to be healthy and resist risk factors that promoted venereal illness. This was a biopolitics of sexual health.

**Conclusion**

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In the first quarter of the 20th century, governments, through their burgeoning public health structures, utilised technologies of control and technologies of self-control to understand, regulate, monitor and influence the venereal health of individuals and populations in NSW. Technologies of control included compulsion, isolation and detention – typified in the medico-penal institutions of the lock hospital, other lock wards and contagious diseases legislation. Technologies of self-control included persuasion, responsibilisation and education – typified in the development of prevention education materials, strategies and rationales. These technologies were intended to be acted on, or played out, by government, on individual citizens, or groups of citizens, who in this period were being increasingly conceptualised as populations. The technologies co-existed during the period, but ultimately there was a perceptible shift away from coercion and towards responsibilisation in the management of venereal diseases.

In the domains of treatment, epidemiology and prevention, power was increasingly channeled through increasingly diverse sites and practices. Brothels and parlours as spaces where ‘case-hardened’ prostitutes were monitored were giving way to a range of settings where ‘clandestine’ or ‘amateur’ prostitutes engaged in sexual activity and were monitored. Young people, in this period becoming categorized as adolescents, were increasingly being perceived as the most significant ‘at risk’ or ‘risk’ population, depending upon class, gender and race. The power to monitor, educate and notify these young people at risk of or living with venereal diseases began to shift from police and clergy to medical practitioners, teachers and social workers through a diffuse set of legislation, regulations and cultural processes. These shifts were an important element in the biopolitical activities and ambitions of the NSW government.

Such shifts were reflected in the policies, practices and procedures of Royal Prince Alfred Hospital in Camperdown. From its inception in the 1880s, the hospital had provided venereal diseases inpatient services for women, and as time progressed, the hospital found itself unable to escape this expectation. Recognised by the population of inner Sydney as one of the only hospitals which treated venereal diseases, it appeared to be locked in a pattern of increasing venereal diseases service delivery. The hospital struggled to shake this branding, and battled to find a balance between
generalist and specialist services and inpatient and outpatient venereal services. Whilst venereal services at the hospital grew and diversified, and government funding increased slightly, costs increased exponentially and patient attendances exploded. This situation was not sustainable, and the hospital fought the venerealisation of its services by developing ambivalent policies: by both turning against the patients themselves, and by extending services. Patients were denied treatment, relocated and turned away, but by the end of the period RPA Hospital was still seeing more venereal patients than any other hospital in Sydney, for shorter periods of time and most often in outpatient settings. The journey of Sydney citizens from diagnosis to discharge for syphilis and gonorrhoea underwent rapid change during this period, and these developments engendered profound treatment ambivalence. This ambivalence permeated all aspects of the relationship between patients, medical practitioners, nurses and hospitals.

As well as introducing the concept of venerealisation, and demonstrating how it operated at the level of patient, institution, government and discourse, I have worked closely with the records of one hospital in Sydney to illustrate how venerealisation worked locally, its rationales and consequences, painting a detailed picture of management practices and technologies. I have formulated other concepts related to the management of venereal diseases in this period. I have argued that the ‘red plague’ was part myth and part reality, particularly the contemporary assertion of prostitutes as a locus for transmission. I have suggested that most preventative activity was focused on public health prevention and preventative medicine, but prevention education practices increased and diversified during the period as rationales centred more on responsibilisation. One significant preventative experiment took place in the AIF, and revolved around the introduction of contentious prophylactic and risk reduction strategies. The subsequent debates about the transfer of such practices to civilian communities in NSW were an important step in the construction of new and enduring venereal categories. My formulation of the ‘defaulter’, and my suggestion that such a construction was founded on ambiguous notification processes and therefore uncertain epidemiology, is a fresh perspective on the category of default. Despite legislative shifts towards compulsory treatment and notification, I have argued that there is a strong and emerging sense in this period that people who
suspected they had syphilis, gonorrhoea or chancroid were keen to take responsibility for their health, and for the venereal health of their fellow citizens.

Commonwealth and state governments worked in unison to strengthen the roles that hospitals, clinics, bureaucrats and politicians played in the sexual and reproductive activities and motives of individuals. Where the sexual and reproductive lives of individuals intersected with national policies like eugenics and pronatalism, or with emerging sites of power like public health and epidemiology – through these technologies of power – is where we are able to witness the ultimate elision of government and self-government. Governments readily deployed public health systems and rationales in the interests of nation-building, and began to recognize that the appropriate promotion of self-government was in fact a tool for the exercise of government power. This is why we observe a shift from coercion to responsibilisation in the control system across the period.

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3. Theses


### Appendix 1

**Venereal Diseases Timeline – NSW**

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1864</td>
<td>First Contagious Diseases Act passed in Britain</td>
</tr>
<tr>
<td>1868</td>
<td>Queensland Suppression of Contagious Diseases Act passed</td>
</tr>
<tr>
<td>1879</td>
<td>Albert Ludwig Sigesmund Neisser discovered the gonococcus</td>
</tr>
<tr>
<td>1879</td>
<td>Tasmanian Contagious Diseases Act passed</td>
</tr>
<tr>
<td>1890s</td>
<td>Beginning of Australasian White Cross League in NSW</td>
</tr>
<tr>
<td>1896</td>
<td>NSW Public Health Act</td>
</tr>
<tr>
<td>1901</td>
<td>Commonwealth of Australia formed</td>
</tr>
<tr>
<td>1902</td>
<td>Formation of the German Society for the Prevention of Venereal Diseases</td>
</tr>
<tr>
<td>1903</td>
<td>Royal Commission into the Decline of the Birthrate in Australia</td>
</tr>
<tr>
<td>1906</td>
<td>Venereal Department opens at Royal Prince Alfred Hospital</td>
</tr>
<tr>
<td>1906</td>
<td>Women’s venereal ward opens at Royal Prince Alfred Hospital</td>
</tr>
<tr>
<td>1908</td>
<td>Notification and compulsory treatment introduced in Denmark</td>
</tr>
<tr>
<td>1908</td>
<td>NSW Prisoners Detention Act, introducing curative detention for those infected with syphilis and gonorrhoea</td>
</tr>
<tr>
<td>1909</td>
<td>Wasserman procedure for diagnosing syphilis became available</td>
</tr>
<tr>
<td>1910</td>
<td>Paul Erlhich and his assistants were able to finally market a preparation called “606” or “Salvarsan” as a treatment for syphilis</td>
</tr>
<tr>
<td>1911</td>
<td>Salvarsan or ‘606’ becomes available in NSW</td>
</tr>
<tr>
<td>1911</td>
<td>Opening of Royal Prince Alfred Hospital venereal outpatient day clinic</td>
</tr>
<tr>
<td>1914</td>
<td>World War 1 begins</td>
</tr>
<tr>
<td>1915</td>
<td>Establishment of Langwarrin and Liverpool bases for the confinement of venereally infected soldiers in Victoria and NSW</td>
</tr>
<tr>
<td>1915</td>
<td>Formation of the Association for Combating the Social Evil in Victoria (ACSE)</td>
</tr>
<tr>
<td>1915</td>
<td>Opening of the Royal Prince Alfred Hospital Out-patient Venereal Evening Clinique</td>
</tr>
<tr>
<td>1915</td>
<td>First female police officer appointed in NSW</td>
</tr>
<tr>
<td>1915</td>
<td>NSW Select Committee on the Prevalence of Venereal Diseases</td>
</tr>
<tr>
<td>1916</td>
<td>WEA Conference on the Teaching of Sex Hygiene in Sydney, NSW</td>
</tr>
<tr>
<td>1916</td>
<td>Establishment of University of Sydney Society for Combating Venereal Diseases (USSCVD)</td>
</tr>
<tr>
<td>1916</td>
<td>Victorian Venereal Diseases Act</td>
</tr>
<tr>
<td>1917</td>
<td>Harm Reduction logics introduced into the AIF in response to venereal diseases prevention</td>
</tr>
<tr>
<td>Year</td>
<td>Event</td>
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<tr>
<td>1917</td>
<td>Bernier lock hospital closes in Western Australia</td>
</tr>
<tr>
<td>1918</td>
<td>World War 1 ends</td>
</tr>
<tr>
<td>1918</td>
<td>NSW Venereal Diseases Act, introducing notification and compulsory treatment</td>
</tr>
<tr>
<td>1918</td>
<td>Publication of Atkinson and Dakin’s <em>Sex Hygiene and Sex-education in Western Australia</em></td>
</tr>
<tr>
<td>1919</td>
<td>Formation of the IUVD (International Union against Venereal Diseases)</td>
</tr>
<tr>
<td>1919</td>
<td>Cumpston publishes <em>Venereal Disease in Australia</em></td>
</tr>
<tr>
<td>1919</td>
<td>Richard Arthur publishes <em>Existing Facilities for the Treatment of Venereal Diseases in New South Wales, with Recommendations for their Extension and Improvement in 1919</em></td>
</tr>
<tr>
<td>1921</td>
<td>Introduction of Neosalvarsan in NSW</td>
</tr>
<tr>
<td>1922</td>
<td>Formation of the Australian Association for Fighting Venereal Diseases (AAFVD)</td>
</tr>
<tr>
<td>1926</td>
<td>Establishment of Improvement Society (later FPA)</td>
</tr>
<tr>
<td>1926</td>
<td>Establishment of Father and Son Welfare Movement</td>
</tr>
<tr>
<td>1928</td>
<td>Improvement Society changes name to Racial Hygiene Association of NSW, later to become the Family Planning Association (FPA)</td>
</tr>
<tr>
<td>1929</td>
<td>Inaugural Congress of the Racial Hygiene Association of NSW</td>
</tr>
<tr>
<td>1929</td>
<td>Publication of Storer’s <em>Sex and disease: a scientific contribution to Sex Education and the control of Venereal Disease</em></td>
</tr>
<tr>
<td>1929</td>
<td>Alexander Fleming discovers penicillin</td>
</tr>
<tr>
<td>1932</td>
<td>First purpose built VD clinic at Rachel Forster Hospital in Sydney, NSW</td>
</tr>
<tr>
<td>1938</td>
<td>Introduction of M and B 693 as treatments for gonorrhoea in Sydney, NSW</td>
</tr>
<tr>
<td>1936</td>
<td>Latex first used in condom manufacture, as opposed to rubber</td>
</tr>
<tr>
<td>1939</td>
<td>World War 2 begins</td>
</tr>
<tr>
<td>1940</td>
<td>Therapeutic use of penicillin begins, internationally</td>
</tr>
<tr>
<td>1942</td>
<td>National Security (Venereal Diseases and Contraceptives) Regulations introduced in Australia.</td>
</tr>
<tr>
<td>1943</td>
<td>Male venereal ward opens at Royal Prince Alfred Hospital</td>
</tr>
<tr>
<td>1945</td>
<td>World War 2 ends</td>
</tr>
<tr>
<td>1946</td>
<td>Repeal of the National Security Regulations in Australia</td>
</tr>
<tr>
<td>1947</td>
<td>South Australian Venereal Diseases Act</td>
</tr>
<tr>
<td>1948</td>
<td>Procaine penicillin first used</td>
</tr>
<tr>
<td>1949</td>
<td>The IUVD becomes the IUVDT (International Union against Venereal Diseases and Trepanometoses).</td>
</tr>
<tr>
<td>1950</td>
<td>Non-Gonococcal Urethritis established as a disease entity</td>
</tr>
<tr>
<td>1951</td>
<td>A. H. Harkness publishes <em>Non-gonococcal Urethritis (NGU)</em></td>
</tr>
<tr>
<td>1955</td>
<td>Identification of chlamydia trachomatis</td>
</tr>
<tr>
<td>mid 1950s</td>
<td>Treatments improve for candida albicans</td>
</tr>
<tr>
<td>1960</td>
<td>NSW Racial Hygiene Association changes name to become</td>
</tr>
<tr>
<td>Year</td>
<td>Event</td>
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<tr>
<td>---------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>mid-1960s</td>
<td>Herpes simplex virus begins to gain ground in Australia; also Trichomanis treatments improve.</td>
</tr>
<tr>
<td>1966</td>
<td>First contact tracer appointed at Sydney Hospital VD Clinic</td>
</tr>
<tr>
<td>1967</td>
<td>First social workers appointed at Sydney Hospital VD Clinic</td>
</tr>
<tr>
<td>1970</td>
<td>First recorded instance of sexually transmitted Hepatitis B virus.</td>
</tr>
<tr>
<td>1973</td>
<td>Formation of Australian Federation of Family Planning Associations</td>
</tr>
<tr>
<td>1974</td>
<td>Australian Royal Commission on Human Relationships begins; finished 1977</td>
</tr>
<tr>
<td>1975</td>
<td>Medibank introduced in Australia</td>
</tr>
<tr>
<td>1978</td>
<td>First Australian Sexual Health Conference</td>
</tr>
<tr>
<td>1979</td>
<td>Parramatta Sexual Health Clinic opens</td>
</tr>
<tr>
<td>1982</td>
<td>HIV/AIDS purported to begin in Australia</td>
</tr>
<tr>
<td>1984</td>
<td>AIDS Council of NSW (ACON) begins in Sydney NSW and expands to have offices in Wollongong, Newcastle, Lismore and Parramatta</td>
</tr>
<tr>
<td>1984</td>
<td>Terence Higgins Trust (THT) opens in London, UK</td>
</tr>
<tr>
<td>1987</td>
<td>Bigge Park Sexual Health Clinic established in Liverpool, NSW</td>
</tr>
<tr>
<td>1989</td>
<td>First Australian National HIV/AIDS Strategic Plan, to be succeeded by four more Strategic Plans, covering the period until 2005-08</td>
</tr>
<tr>
<td>Early 1990s</td>
<td>AIDS funding sees the rapid development and diversification of Sexual Health Clinics across NSW</td>
</tr>
<tr>
<td>1991</td>
<td>Nepean Sexual Health Clinic established in Penrith, NSW</td>
</tr>
<tr>
<td>1995</td>
<td>Combination therapies for the treatment of AIDS begins</td>
</tr>
<tr>
<td>1996</td>
<td>NSW Health establishes 17 Area Health Services, with oversight of sexual health clinics</td>
</tr>
<tr>
<td>1998</td>
<td>Milton Lewis publishes <em>Thorns on the Rose</em></td>
</tr>
<tr>
<td>1999</td>
<td>Promotion of Post Exposure Prophylaxis (PEP) begins in NSW</td>
</tr>
<tr>
<td>2000</td>
<td>Family Planning Association becomes FP Health</td>
</tr>
<tr>
<td>2002</td>
<td>Luxford Rd Sexual Health Clinic in Mt Druitt opens</td>
</tr>
<tr>
<td>2002</td>
<td>Sexual health modernisation initiatives begin in UK</td>
</tr>
</tbody>
</table>