

*'Oh God that Our Own Lovely
City of Adelaide Be Not Placed in
the Same Category':
Venereal Diseases in Interwar
Adelaide 1920–1939*

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Introduction

WHILE IT MAY BE TEMPTING TO TRACE THE SOCIAL HISTORY OF VENEREAL diseases at times of the greatest peaks of activity, such as in war-time, in the absence of extraordinary circumstances health policy can be examined not exclusively as emergency legislation but also as an indicator of a more protracted concern for the physical and moral health of society. In fact, in Australia between 1920 and 1939, commonly known as the interwar period, anxiety was palpable. This Adelaide case study shows that during this time, with the absence of legislation providing for compulsory notification and treatment, the control strategies characterised a three-pronged attack—prophylaxis, propaganda and the control of problem girls, that is, the control of homeless girls suspected of having a venereal disease. On each of these issues there was conjecture about what was appropriate in the case of instruction on prophylaxis, what was possible given available resources, and what was acceptable as the focus for control strategies inevitably fell on a certain group of women and girls.

This article argues that, despite a continuing concern about the issues surrounding venereal diseases in other States, the lack of formal policy strategies were characterised by a concerted attempt to address the venereal diseases control problem without resorting to coercion. Education and friendly persuasion formed the basis of a campaign sometimes thwarted either by the economic circumstances of the time or by the moral code then governing Adelaide society. Health authorities at this time grouped the more common but less serious gonorrhoea with the infrequent but more serious syphilis into the one category 'venereal diseases'. For the purposes of this article, I have done the same.

The work of Sander L. Gilman on images of illness, health, sexuality and race has been influential for its identification of the translation of theological concepts of the corrupt body into medical categories. Gilman argues these categories have come to ‘permeate all of the other categories of science, including the dominant “science” of the nineteenth century, the biology of race’.¹ The outwardly visible signs of the disease, which identify its sufferers, during the nineteenth century became indicators of moral and, thus, social miscreants. Sexual diseases in this context represent evidence of degeneration. This shift from theology to morality led to a ‘public obligation to control sexuality as a source of pollution’ fuelled by a ‘sense of lurking danger within the body’.²

This theme is particularly strong in discourses surrounding the various campaigns for the control of venereal diseases in the late nineteenth and early twentieth centuries. In the matter of health care, ‘individual and corporate responsibility’, ‘individual initiative’, ‘exertion and diligence’, and ‘personal discipline’ were considered by early public health theorists more valuable to the nation, more constructive and permanent, than a too-rapid or superficial provision of external facilities for securing social well-being.³ Thus, the responsibility of maintaining good health was an important imperative for good citizenship. But as Peter Baldwin has written, the British in the nineteenth century turned out to be ‘great interveners of a certain stripe’ in the area of public health, despite their *laissez faire* reputation. Making the ill legally liable for endangering others or transmitting disease, and the forced removal to hospital of those suffering diseases in a contagious state and who were without adequate domestic circumstances, were measures thought to be vital for the maintenance of public health. While protective of individual liberties Britain submitted to sanitary regulation that encroached on personal rights.⁴

Thus, from its original preoccupation with sanitation, the issue of compulsion in public health in Britain and Australia quickly incorporated a debate over the liberty of the individual and their responsibility to the common weal. When the same principles were applied to the control of infectious diseases, a distinct discourse surrounding public health was initiated. When venereal diseases were introduced into the equation, medical responses to public health issues merged with moral responses often injected with pseudo-scientific prescriptions for national fitness. Usually such prescriptions were also infused with related issues—the age of consent, prostitution, abortion, alcoholism and mental deficiency. The consequences of such ‘social evils’, rather than offering categorical justification for decisive measures for their control, confronted social policy reformers with considerations as to what was possible, what was practical and what was ethical. This article examines these three requirements in South Australia during the interwar period.

Richard Davenport-Hines suggests that public attention to venereal diseases diminished in the 1920s due to a combination of factors that reduced the problem as far as the public was concerned. There was, according to Davenport-Hines, a declining preoccupation with racial purity, boredom with furious medical controversies, wider access to self-disinfection after intercourse, the opening of rehabilitation hostels for infected young women, the advent of new therapies like bismuth or salvarsan, an increase in the number of clinics, and an improvement in the scientific services available to treat new cases.⁵

However, Roger Davidson, in his series of articles on venereal diseases control in Scotland, has demonstrated the persistence of a preoccupation with the control of venereal diseases in the interwar period after the rejection of coercive policy in Britain. The Scottish Venereal Diseases Service (SVDS)—which included free, voluntary treatment in an extensive network of clinics, as well as mobile education units and a team of health workers who chased up those defaulting on their treatment—was, Davidson argues, interventionist.⁶ By this he means that although the SVDS was not coercive in the legal sense nor was it *laissez faire* either. In the pre-penicillin days, what to do about the spread of venereal diseases without resorting to what had been labelled draconian legislation was a conundrum for health officials and government.⁷ Although health authorities in Adelaide often referred to the British scheme as their model for venereal diseases control in the interwar period, there was, in actuality, little correlation between the two schemes in terms of infrastructure and facilities. Nevertheless, rather than relaxing on the issue of venereal diseases control as Davenport-Hines suggests happened in Britain, in South Australia, as in Scotland, the situation was as intense as it had been during World War I. Believing that you attract more flies with honey than with vinegar, to intervene without seeming to coerce the population into submission was the aim of health authorities at the time.

Context

As a direct result of the World War I, the debate surrounding public health at the national level was drawn towards the development of medical and population policy as a means for national renewal. In 1935, South Australia enjoyed the ‘doubtful distinction’ of having the lowest birth rate of all the Australian States. In the previous year there had only been 14.5 births per 1000 of the population, which was half the rate of 1914. The number of births in 1934 was 8459 in a population of 584,000, making it the lowest number of births in the State since 1876 when the population was only 224,560. After the first 100 years

of the colony, although natural increase and the birth rate were alarmingly below the national average, so too was the death rate, as were figures for serious crime, drunkenness, illegitimacy, insanity and suicide.⁸ Thus, despite some positives, 'To-day's need', according to Public Health Notes in 1935, was 'more babies and better ones!'⁹ With the well-being of future generations given as the justification for controlling venereal diseases, and with compulsory notification and treatment for of them accepted as the solution by almost all Australian States, in South Australia other disease control strategies, some even more controversial than legislation, were debated, discussed and adopted.¹⁰

By 1922, Adelaide legislators and some health officials were questioning the delay in putting the *South Australian Venereal Diseases Act 1920* into operation. But for the South Australian government at the time, the decision to seek alternatives to compulsion appeared to be vindicated by the experience of those States where legislation did not appear to be hitting the mark. The *1922 Report of the Commonwealth and States of Australia Conference on Venereal Diseases* did not consider that venereal diseases legislation had been in force long enough to form an opinion, based upon reliable statistical data, that any reduction in the prevalence of venereal diseases had occurred. However, it was possible to draw some conclusions. Firstly, while conditions during the war had drawn attention to the prevalence of venereal diseases in Australia, there was no definite proof that there had been any appreciable increase in venereal diseases in the general community as a result of the discharge of returned soldiers. Secondly, judging from the infant mortality rates of infants under one month of age, the conference could cite no evidence to show that the passing of legislation had reduced the prevalence of congenital venereal infection. Thirdly, the venereal diseases acts in the other States were thought to be unequal in their effectiveness across the community, as more men than women were under treatment. Although the acts were equally successful in securing more effective treatment for both private and hospital patients, they were not equally successful as far as notification was concerned.¹¹

Despite its reluctance to state categorically that the legislation had achieved the purpose for which it was enacted, the conference did determine that it had, at least, been a contributing factor in the production of a more complete appreciation by practising medical officers of the 'national gravity' of venereal diseases, and had contributed to a valuable cooperation between the general profession and health authorities.¹² Furthermore, as a result of the passing of venereal diseases acts in other States, a greater proportion of infected persons had received more effective treatment than before. But this was also partly due to the opening of clinics offering greater opportunities for free and efficient treatment. In spite of the consequential success of the various vene-

real diseases acts, the *Report of the Royal Commission on Health 1926* regarded the prevention and control of venereal diseases generally as a complicated problem incorporating more than just medical or scientific concerns. Economic, political, social, moral and even religious considerations required that progress be slow and gradual. Hence, too much should not be expected from legislation that was difficult, and in some respects impossible, to enforce.¹³

Furthermore, doctors at the coalface like Glenn Howard Burnell, medical officer in charge of the Adelaide Hospital's night clinic which treated most venereal cases, remained outspoken on the limits of legislation throughout the interwar period, as he had during the war. Burnell asserted that some venereal cases would escape detection under any system, and that just as many would remain undetected under legislation as under the voluntary scheme. 'I believe', he argued, 'if you have efficient treatment at the clinic the patients will go for it without being compelled by legislation'.¹⁴ In his report to the board of management of the Adelaide Hospital in 1934, Burnell reported that the night clinic had had a number of patients who were not suffering from venereal disease. He suggested that this was because the public was realising, more and more, the necessity of early diagnosis and treatment. While he did believe that legislation had a role to play in 'special cases', he did not recommend relying on it as a general preventive.¹⁵ Rather, Burnell emphasised the necessity of educating the medical profession, arguing that it would be quite useless to attempt to introduce legislation to cover compulsory notification, and to prohibit chemists from giving treatment, until the profession was better able to cure the diseases.¹⁶ On whether the *South Australian Venereal Diseases Act 1920* should be proclaimed, Burnell believed that legislation was not going to affect the problem very much at all. As had been demonstrated with other problems, he argued, legislation did not have a great deal of effect.

Burnell's suspicion surrounding compulsion was echoed by Albert Southwood, chairman of the Central Board of Health. In a report to the chief secretary in February 1934, following his own inquiries among the medical profession in other States, Southwood formed the opinion that the legal compulsion to notify was imperfectly carried out. For various reasons, which he did not specify, some doctors refused to notify their cases. Tracing defaulters was also recognised as problematic. To control the compulsory notification and compulsory treatment of patients with a venereal disease, a large staff would be necessary. Even in Western Australia, Southwood noted, where venereal diseases work was conducted in a more thorough manner than elsewhere, it was doubtful whether the results could be considered satisfactory.¹⁷

Southwood suggested an interim strategy involving widespread and vigorous instruction of the public that would, he felt, produce better

results than compulsory notification. He argued that, 'To lead the people in the ways of health by teaching them seems to me a sounder plan than to try to drive them by compulsory measures'.¹⁸ Southwood believed that such a strategy followed 'the British system'. The general view of English experts, according to Southwood, was that compulsory notification would not achieve more than was being done under a voluntary system. A better plan would be to encourage early and adequate treatment through the provision of good and ample facilities and free clinics available at all hours.¹⁹ Proclamation of the *South Australian Venereal Diseases Act 1920* would, he claimed, be a backward step and one likely to lead to concealment. Instead, he suggested that a bill of 1930 providing for the proclamation of parts of the act be enacted, as the way would then still be open for proclaiming the sections of the principle act relating to compulsory notification and treatment at a later date.²⁰ Thus, without the support of Southwood, as chairman of the Central Board of Health, and Burnell, as medical officer in charge of the night clinics, suggestions that the *South Australian Venereal Diseases Act 1920* be proclaimed were dismissed.²¹

Practicalities

The interwar period would reveal that the rejection of compulsion was the correct course of action in Adelaide, at least for practical reasons. The Attorney-general and State premier explained that the delay in proclaiming the *South Australian Venereal Diseases Act 1920* was due to the expense of effective administration.²² In 1922–23, the Loan Estimates Committee allocated £5000 for the erection of accommodation at the Adelaide Hospital for people with venereal diseases. Sketch plans of the accommodation were drawn up by the architect-in-chief and returned with suggestions by the inspector-general of hospitals, Bedlington Morris, who estimated that the building would cost approximately £6000 with administration running to £4500.²³ Based on these figures, Chief Secretary Bice questioned the cost of bringing the act into force and recommended that proclamation be deferred until accommodation could be provided.²⁴ The Premier appeared to be dissatisfied with Morris' estimate, however, insisting that the only unavoidable expenses in connection with the operation of the act were the fees payable to medical practitioners for notifications (2/6d for each notification), the cost of hospital treatment for patients suffering from a venereal disease, and the expense of printing and distributing forms required under the regulations.²⁵

But the standard of facilities for diagnosis and treatment in the Adelaide Night Clinic, and its ability to cope with an increased num-

bers of patients, had been a cause of considerable concern for doctors like Burnell and Harold Rischbieth, medical officer in charge of the Female Night Clinic since the war. A staunch supporter of compulsion, Rischbieth argued in 1919 that it was impossible under existing conditions to employ the most modern methods; even to approach such standards of care would require the clinic to be operating night and day. A much larger staff, as well as additional apparatus, would be required. It was necessary, therefore, to employ ‘older methods’ and allow patients to be responsible for some of their treatment themselves.²⁶

Despite renovation, by 1925 the situation was still unsatisfactory. In his evidence at the Federal Commission on Public Health, Burnell alluded to the conditions under which venereal diseases were treated. He was convinced that the clinic was not getting the best results from existing methods of treatment and, in particular, that the money spent on treating females was being wasted. It was useless, in Burnell’s view, to treat only once a week a woman suffering from gonorrhoea. In his experience, because of the nature of women’s anatomy, most women were not able to treat themselves effectively in their own homes. As far as the clinic was concerned, Burnell testified, ‘for all the good we are doing on the female side, we might as well shut down’.²⁷ He also complained that he had to see up to 100 cases a night in one room. Although there was an irrigation room in which patients could ‘irrigate’ themselves, Burnell declared that he had no ‘special’ equipment.²⁸ As a result, the clinic was not used effectively by the public. ‘They do not want the secondary treatment,’ he declared, ‘and I am sure if they were given first class treatment, every one would go’.²⁹ When asked his opinion on what improvements should be made, Burnell suggested that more money be spent on facilities, that the clinic open every night of the week, and that more medical officers be appointed and none asked to treat more than twenty-five cases at one time.³⁰ Finally, Burnell accused the government of establishing the clinic ‘just to save its face’: by having provided somewhere to treat those with a venereal disease it could be seen to have done its job, thereby placating public concern.³¹

Prevalence

While practical and economic considerations were a significant pre-occupation, so too was the extent of the problem. Determining just how much venereal disease existed in Adelaide during the interwar period was an issue fraught with difficulty, mainly because, with no compulsory notification, there were no reliable figures to go by. Figures of attendance at the clinics were used as a guide but by no means accepted as an accurate indication of the extent of the problem.

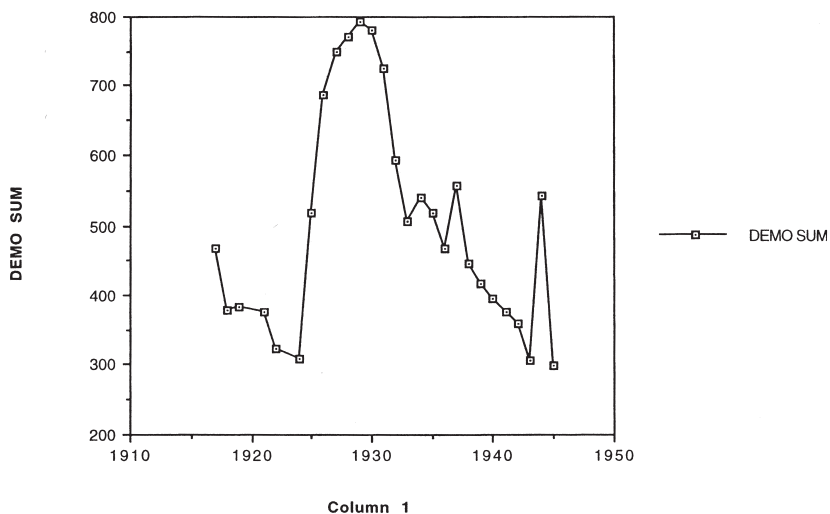


Figure 1: Data from 'Patient Numbers', male and female Night Clinic attenders.

(Source: *Annual Reports of the Board of Management, Adelaide Hospital.*)

Nevertheless, attendance figures in this graph suggest that the inter-war period was characterised by a peak of activity at the clinic. This dramatic increase may be accounted for by a greater vigilance and anxiety on the part of individuals, or perhaps that the high levels of unemployment at the time allowed a larger number of patients to attend the clinic, rather than indicating that an epidemic had occurred. Despite the inconclusiveness of these figures, there were some hysterical predictions as to the extent of the problem. In August 1924, a science congress under the auspices of the Australasian Association for the Advancement of Science brought Sir James Barrett, president of the Association for the Prevention of Venereal Disease, to Adelaide.³² Alarming statistics quoted by Barrett for Melbourne compelled the daily newspaper the *Register* to cry, 'Oh God that our own lovely city of Adelaide be not placed in the same category'.³³ In the view of some, it already was.

By 1933, at a meeting of the Public Health Committee of the Adelaide City Council, Lord Mayor Barrett (no relation) referred to a report from the medical officer of health in which equally alarming statistics were quoted. It appeared that although the number of cases treated at the venereal clinic at the Adelaide Hospital for the year ending 31 December 1932 was smaller than might be expected, Barrett, drawing on data supplied in the *Commonwealth Year Book*, calculated that in a city of 50,000 (the size of Adelaide), 2000 would become infected during a ten-year period with an infection ratio of six men to

one woman. As only 600 new male cases had been reported at the Adelaide Hospital clinic during 1932, this could only mean, in Barrett's estimation, that 1400 persons were either receiving private advice or not being treated at all.³⁴

Such reports were met with derision from the medical officer of health for Adelaide, Dr E. Angus Johnson, who seemed impatient with the emotional responses to the problem both from officials and the general public. As far as Johnson was aware, no reliable statistics existed on which to base an opinion. While he admitted that the prevalence of venereal diseases was probably worse than the notification figures of other States suggested, the extent of the problem was unknown. Johnson chastised the 'self-appointed authorities' who reported that 'practically everyone is suffering, either consciously or unconsciously, from acquired or inherited venereal disease while others laugh at the idea'.³⁵ Whatever the actual number of sufferers, the fact that venereal diseases existed at all in the State alarmed many health workers. If legislation was not forthcoming, other strategies needed to be found, strategies to which we now turn.

Prophylaxis

As well as the economic difficulties, the efficiency of curative medicine for venereal diseases, before the advent of penicillin, remained questionable. The movement towards preventive strategies for the control of venereal diseases in the interwar period involved the general acceptance of measures that were as controversial, if not more so, as coercive legislation. When J. H. L. Cumpston, federal director of quarantine and a member of the new public health lobby, urged that the knowledge and experience gained in the control of venereal diseases under military conditions be extended for the benefit of the civil community, a new debate opened up. In February 1922, the *Report of the Commonwealth and States of Australia Conference on Venereal Diseases* advocated that immediate self-disinfection prophylactic depots for males and females be established in the community as widely as practicable.³⁶

The medical profession generally supported prophylaxis in principle, providing that it was proven to be effective and was accompanied by educational material. An article in the *Medical Journal of Australia* in 1923 commented that, even though the prophylactic packets issued to soldiers during the war had proved to be of dubious benefit, under military discipline ablution centres had served an invaluable purpose. However, there was some doubt within the medical profession as to the value of prophylaxis in the civil community. In the fight against venereal diseases in Britain, prophylaxis had not shown itself to be a

decisive primary weapon. The news that the two ablation centres provided by Manchester Town Council had been closed after two and a half years was an issue that demanded attention from proponents of prophylaxis in Australia. The article went on to suggest that the decision to close the centres indicated that, in the view of the Manchester health authorities, the system had been given a fair trial in a civil community and been found inefficient as a means of preventing infection on a large scale.³⁷ While some of the already sceptical health authorities in Adelaide found this news discouraging, others like Rischbieth forged ahead.

While Rischbieth believed compulsion was the key to venereal diseases control in Adelaide, he admitted that there were 'other matters' of considerable importance in the suppression of syphilis that 'would probably do more than any other single measure to diminish its incidence.'³⁸ Prophylaxis by the use of calomel ointment, he asserted, should be brought to the notice of everyone likely to run the risk of venereal infection. In an article in the *Medical Journal of Australia* in 1922, based on a reply to an inquiry instituted by the Office Internationale d'Hygiène Publique in Paris, Rischbieth revealed that his earlier declaration that he could cure every case of syphilis presented to the night clinic was looking shaky. He wrote:

I have grave fault to find with neo-arseno-benzol and with the other drugs... because their original therapeutic promise has not been fulfilled. They... no longer give such permanent good results. In the specimens that we obtain here larger doses and more of them are required to produce the desired disappearance of the response to the Wassermann test than formerly. And the proportion in which the alteration of the serum is not permanent, is increasing. It is conceivable that we are dealing with a more virulent strain of *Spirochaeta pallida* than formerly or a type of patient with lesser powers of resistance... The therapeutic value of specimens of the same drug varies from time to time and I can only conclude, as the result of my clinical observation, that it is becoming less and less.³⁹

From this time onwards, Rischbieth, and others were beginning to acknowledge that prophylaxis, or post-coital self-disinfection, might be as effective against syphilis as drugs. Such methods, however, would require the general public to think differently about venereal diseases. It was this part of the problem that Rischbieth attacked first. In an article to the press during 'Health Week', he declared that 'no good and much harm' would result from confusing the practical problem of medicine with others of a social, ethical and moral nature, however important. The problem was not one of ethics or of morals, but of natural science. Rischbieth pleaded:

Do not let us confuse the problem of its eradication with other problems. Do not let us speak of syphilis in sensational language, and call it ‘the red plague’, but by its proper name. Do not let us call it ‘the social evil’—if by that term we mean syphilis—for it is in that sense a misnomer.... [L]et us think clearly.

Rischbieth appealed to all those interested in the welfare of children for moral support in the world-wide movement ‘now getting under way for the eradication of syphilis’.⁴⁰

Though accepted practice in the military, prophylaxis as a method for the general population was not taken seriously until the national campaign hit Adelaide in 1924. Sir James Barrett put a bee in the bonnet of those concerned with eradicating venereal diseases from South Australia when he gave an illustrated lecture at the Adelaide Town Hall, under the auspices of the Public Health Association, on the methods necessary for combating venereal diseases. Barrett told the ‘crowded audience’ in attendance that ‘scientific investigation’ could demonstrate that anyone exposed to infection could, by the adoption of ‘certain medical sanitary methods’, escape infection. The claim that such methods resulted in increased immorality was answered by the fact that if venereal diseases had been sent to make people moral then it had failed. From his experience in managing large bodies of men, Barrett argued that fear was no deterrent.⁴¹ While few doubted the theory surrounding prophylaxis, the real problem was finding an acceptable way to get the message across to the public without causing offence.

For instruction on prophylaxis, the use of pamphlets was believed to be, at least by some, the most appropriate vehicle. Pamphlets issued during the early interwar years went no further than to describe the symptoms, outline complications and advise that treatment should be early and maintained.⁴² The Local Board of Health for Adelaide cooperated with distribution by offering to supply copies, without charge, for other local boards to distribute.⁴³ Rischbieth, however, while acknowledging that the pamphlets had ‘improved out of all knowledge’ since his time, complained that they made no mention of prevention. To remedy the situation, in 1934, he initiated a move to include information specifically dealing with prophylaxis in a pamphlet for the general public. If venereal diseases were to be obliterated, argued Rischbieth, prophylaxis must be promoted and, without some reference to it, the pamphlet would lose much of its use and value. As physicians seldom saw the ravages produced by untreated or inefficiently treated syphilis, Rischbieth asserted, there was a tendency ‘in the younger school’ to ‘let up’ on it. The ‘master key’ was prevention, and he suggested that the pamphlet go into detail as far as instruction was concerned.⁴⁴

Albert Southwood, at the Central Board of Health, favoured the pamphlet issued by the Adelaide Hospital authorities to patients attending the venereal diseases clinics. When the time came for new supplies to be printed, upon the advice of Rischbieth, Burnell and the inspector-general of hospitals, Southwood suggested some amendments that included instruction on prophylaxis, which all agreed was necessary for the eradication of venereal diseases.⁴⁵ However, a week later on his way to Fremantle by train, Southwood had a change of heart. He had noticed that in a pamphlet issued by the Department of Public Health, Western Australia, no details were given for prevention, but, instead, abstinence was recommended. Stating that he did not like those ‘nasty details of preventive treatment’, Southwood suggested that all references to methods of prevention be left out of the updated pamphlet as it was unlikely that many laymen would be able, or be interested enough, to carry them out properly anyway.⁴⁶ Thus, it would seem that prophylaxis was really only entertained by a scientific minority and did not represent an alternative to compulsion. The prophylaxis debate failed to excite significant interest or support, and in Adelaide, as elsewhere, treatment remained curative rather than preventative at least in terms of sexual health practice.

Propaganda

Rischbieth’s suggestion in 1922 that propaganda advertising the venereal clinics be displayed in Adelaide’s ‘sanitary conveniences’ had alarmed both medical officers of health, T. Borthwick and E. Angus Johnson (who was also chairman of the Public Health Committee). In their view, such a suggestion could not be entertained as an isolated act, on the grounds that it would bring discredit to public utilities which had established a reputation for scrupulous cleanliness and freedom from the risk of conveying disease.⁴⁷ But by 1924 the Local Board of Health of Adelaide had produced its own poster for display in public conveniences. The poster was modelled on one put out by the Australian Association for Fighting Venereal Diseases for use in Victoria, where a system based on compulsory notification and treatment was operating. But all references to legal obligation were replaced with words of encouragement to seek advice and early treatment either at the Adelaide Hospital or the Children’s Hospital in North Adelaide.⁴⁸

Burnell’s recommendation in 1925 of an educational campaign on the lines of that run by Barrett—including Commonwealth-sponsored lectures, special films and the appointment of an expert in the field to visit the States—was revisited in 1933.⁴⁹ The Public Health Committee of the Local Board of Health for Adelaide suggested that a medical

man be authorised to give lectures on behalf of the board to young people in offices and gymnasia on the dangers and prevalence of venereal diseases, and on the necessity of seeking medical advice immediately the symptoms become apparent.⁵⁰ Other proposals included the employment of female doctors to lecture to women, instruction for schoolboys from the age of fifteen years, the establishment of ablu-tion centres, and the inclusion of notices in public conveniences of advice on where interested persons might apply for information.⁵¹

But these proposals did not invite support from other leading health officials. Medical officer of health Johnson believed that no medical man would lecture to people on the prevention of venereal diseases. Any attempt, Johnson warned, to explain sexual hygiene to the community would draw the accusation that young people were being encouraged to act immorally. Furthermore, it did not seem appropriate during the depression to appoint doctors to salaried positions for the purpose of advising people who had contracted a venereal disease. In any case, Johnson believed that although in Adelaide there had been no attempt to teach people the few simple precautions necessary to avoid infection, that every warning and assistance to obtain medical advice in the cure of the diseases had already been given.⁵² Something more innovative was required. Thus, campaigners for a better public understanding of venereal diseases and its many dangers resorted to using the cinema, a place of popular entertainment, to get the message across.

The Health Association of Australasia enthusiastically praised the use of films as a means of health propaganda in alerting citizens to the dangers of promiscuity. The idea was also supported by the cinema industry. A representative of Adelaide newspaper the *Advertiser* approached the managers of the city's leading picture theatres and asked if they would be prepared to cooperate in a health campaign by screening health films. The *Advertiser* reported that all were unanimous in their sympathy with a scheme that had as its object the physical welfare of the community. However, it was agreed that great discretion would have to be exercised in showing films dealing with venereal diseases. Mr F. E. Chivers, manager of West's Olympia, while prepared to show films of an educational nature was cautious about showing them to mixed audiences for fear of causing offence. Mr W. Foster, manager of the Wondergraph Theatre, greeted the proposal with enthusiastic support but advised that the films should, if possible, be in story form. Medical facts couched in technical language would be of no use, but stories of 'human interest which drove home the essential points would be popular'. He pointed out that the American film *The End of the Road*, which had already enjoyed a successful run three years previously in Australia, had treated the problem inoffensively and there had been no complaints of it being out of place on a picture program.

Mr Claude E. Webb, manager of the York Theatre, declared that he would not show anything that was unsuitable for women and children. For this reason, as far as Webb was concerned, films dealing with venereal diseases should only be shown at special screenings so the public would know beforehand what they were going to see.⁵³

So as not to spring potentially offensive material on loyal patrons, the press promoted dramatic and documentary films that were thought to be in the public interest. *Damaged Lives*, an American production sponsored by various social hygiene associations around the world, offered something different to devotees of motion pictures. The *Advertiser* described the film as ‘a dramatic portrayal of a human drama, conveying at the same time a definite lesson to adults and adolescents of the danger lurking for the thoughtless in the so-called “social-diseases”’. Presented in Australia under the auspices of the Racial Hygiene Association of NSW, *Damaged Lives* was followed by a ‘frank and illustrated lecture’ which ‘dealt tactfully and delicately, with sex reproduction and physiological facts having to do with the... effects and cure of certain diseases’.⁵⁴ The film was so successful that it was held over for a second week. The campaign had forced the movie-going public to acknowledge that the evil existed and, the *Register* assured, was preparatory to an attempt to overcome it.⁵⁵ The campaign, as far as the press was concerned, had almost demolished the social convention that forbade the mention of the words ‘syphilis’ and ‘gonorrhoea’. But there was another social convention that could not be demolished—that of blaming women and girls for the spread of venereal diseases.

Problem girls

When asked at the Federal Commission on Public Health in 1925 what proportion of the cases of venereal diseases at the night clinic could be attributed to an infection from professional prostitutes, Burnell answered that he was certain no more than one patient in four under his care had been infected in such a way. The commission accepted the supposition that professional prostitutes had become educated on the prevention of venereal diseases, and were more careful than some in the wider community because their livelihood depended upon it.⁵⁶ Subsequently, from the late 1920s until the outbreak of World War II the focus of blame fell upon homeless, infected young women.

A major complaint by women’s organisations against compulsory notification and treatment contained in the *South Australian Venereal Diseases Act 1920* was that it would discriminate against those most unable to protect themselves, namely women. However, even voluntary schemes could be interventionist if not compulsory. Women of

the lower and more vulnerable classes were accused of spreading venereal diseases. From the late 1920s, the institutionalisation in reformatory accommodation of women and girls suffering from a venereal disease was a recommendation supported by women's organisations as well as women of higher authority. The president of the National Council of Women, Elizabeth Bowman, in a letter to the chief secretary urged 'concentrated attention' on the matter of homeless girls suffering from venereal diseases. Associations affiliated with the council, Bowman stated, felt that the city was in need of some accommodation in connection with the Adelaide Hospital, where patients in the infectious stages of venereal diseases might receive the necessary indoor treatment. Public opinion, Bowman asserted, was 'developing strongly in this direction'.⁵⁷ Since no charitable institution would admit known sufferers the government needed to step in. This idea was later supported by the Democratic Women's Association of South Australia.⁵⁸

The principal of the Women Police, a special force established during World War I, added her weight to the proposal. Women Police assumed the role of welfare workers and undertook the care, protection and moral reclamation of women and young persons.⁵⁹ Between 1933 and 1941 several girls who came under their notice featured in reports to the commissioner of police. The Women Police arranged accommodation, sometimes in hospital or rescue homes, for women and girls suffering with a venereal disease who had nowhere to go. They assisted with rations and fares for clinic treatment, and escorting outpatients back and forth to the clinic at the Adelaide Hospital.

Throughout the period, a strong belief grew among the Women Police that it would be of 'great service to the community' if the clinic patients, especially younger girls, could be kept under supervision by an authorised body. This was because some of the patients, by reason of poverty or lack of privacy, found it impossible to carry out the necessary home treatment—irrigation of the infected area.⁶⁰ In 1937, the principal of the Women Police recommended that the supervision of women and girls with a venereal disease should be stepped up a pace. If a remedial ward could be established at Barton Vale Reformatory for the reception of girls with a venereal disease over the age of eighteen years in receipt of government relief, an important step in the fight against the diseases would be taken. Entrance to the ward was to be voluntary, with the girls being required to sign a form promising to remain at the institution until the medical officer discharged them.⁶¹

However, the need to accommodate homeless infected girls does not appear to be supported by the experience of the night clinic. Dr H. M. Fisher, medical officer of the Female Section at the Night Clinic, argued that there were no homeless women with a venereal disease attending as out-patients. At any one time Fisher detected no more than one such

case, and overall he was personally aware of only three cases. He proposed, instead, to confer with the almoner of the Adelaide Hospital so that she would be ready to assist in finding homes for such girls, should it be necessary in the future.⁶²

When more in-patient accommodation for women was provided, the innovation was modest. In August 1939 Fisher complained that a patient admitted from the clinic automatically passed out of the hands of the medical officer into those of one of the honorary gynaecological staff, causing a break in the continuity of observation. Fisher felt that in-patient accommodation under the control of the medical officer was essential.⁶³ Medical superintendent Rollison responded by making available two beds in Da Costa Ward for the treatment of cases of acute gonorrhoea and acute syphilis. Chronic cases, however, would continue to be treated as out-patients.⁶⁴ This move effectively averted debate on the establishment of a hostel and reformatory wards in Adelaide, at least for the time being.

Women's organisations, which saw their role as a protector of the rights of women, demanded a measure of intervention that could restrict and control women with a venereal disease. The campaign by some women's organisations to establish a system where certain categories of women could be institutionalised indicated that supporters of a voluntary scheme, as were most women, were not averse to a level of intervention that could imitate coercive measures in particular circumstances. The acceptance of any level of compulsion in any circumstances could potentially spell danger for the voluntary scheme. But women's organisations, when the well-rehearsed debates surrounding compulsory notification and treatment re-emerged during World War II, stood their ground and remained an important mediator in the government's attempts to solve the venereal diseases control problem.

Conclusion

Thus, the prevention of venereal diseases by available methods in interwar Adelaide was a persistent and contentious issue. Despite relative success in controlling the problem, and the belief that its prevalence was lower than in other States, concern surrounding venereal diseases remained important to many of those responsible for the community's health. Indeed, fear of racial decline and the devastating effect that congenital syphilis could have on the next generation was as strong at the outbreak of World War II as it had been in the years immediately following the first war. In the interwar years all health authorities could do was to lobby for better facilities in the treatment of venereal diseases and hope that the education campaign was hitting its mark.

For social and economic reasons, the problems associated with the prevention of venereal diseases made the development from the purely curative to the preventative contentious in Adelaide. The level of prevalence, the apparently successful intervention of the Women Police in female cases, the lack of facilities to cope with large numbers of patients legally obliged to attend the clinic, and suspicion surrounding the value of compulsion provided ample justification for persisting with the voluntary scheme in the interwar period. In addition, although the criticisms of Rischbieth and Burnell reveal the situation to be far from ideal, and unlikely to be remedied in the short-term, the night clinics had been judged a success. Their operation had led to more efficient treatment and public awareness of venereal diseases and their etiology, thereby reducing the incidence of the diseases. While Burnell complained about facilities and Rischbieth pushed a more scientific approach in control strategies, Southwood and others sought to take control of venereal diseases to the public. Conscious of the risks of offending interwar sensibilities in Adelaide, Southwood's work was made all the more difficult by the radical solutions put forward by military folk, especially those associated with the national campaign for the control and eradication of venereal diseases. Interstate interlopers like Sir James Barrett stirred up health officials with their too worldly and open approach.

As far as South Australia was concerned, the outbreak of World War II marked the end of an era in venereal diseases control. A national approach to the problem, inspired by the health of soldiers during the war, saw the end of the State's voluntary scheme. In 1947, the South Australian Venereal Diseases Act was proclaimed. While providing for a measure of coercion, venereal diseases were not made notifiable until 1966. The impetus for this change appears to have been the increase in the numbers of young people under sixteen years of age presenting with gonorrhoea. If class and gender had been useful categories of analysis for understanding patterns of detection and surveillance in the past, age was to emerge as a new determinant. This shift in focus from the recalcitrant to the young was made possible not by a new understanding of the role of law in public health, but by the ability of resources and medical progress to cope with compulsion. While the other Australian States debated similar issues throughout the interwar period, without the legislative backup of a formal health policy, health authorities and others were forced to countenance non-coercive strategies for disease control. The anxiety that ensued, in Adelaide at least, made the campaign for the control and eradication of venereal diseases one long war.

1. Sander L. Gilman, *Sexuality: An Illustrated History—Representing the Sexual in Medicine and Culture from the Middle Ages to the Age of AIDS*, John Wiley & Sons, New York, 1989, p. 231.

2. *ibid.*, p. 238.

3. E. E. Reynolds, *Ourselves and the Community*, CUP, Cambridge, 1932, p. 51.

4. Peter Baldwin, *Contagion and the State in Europe, 1830–1930*, CUP, Cambridge, 1999, p. 527.

5. Salvarsan, also known as 606, is a drug that is derived from arsenic. Bismuth is included in the heavy metals class used in medicine. Both were used for the treatment of syphilis. Richard Davenport-Hines, *Sex, Death and Punishment: Attitudes to Sex and Sexuality in Britain since the Renaissance*, Collins, London, 1990, p. 247; S. M. Tomkins, 'Palmitate or Permanganate: The venereal prophylaxis debate in Britain, 1916–1926', *Medical History*, vol. 37, 1993, p. 397.

6. Roger Davidson, "'A Scourge to Be Firmly Gripped': The campaign for VD controls in interwar Scotland", *Social History of Medicine*, vol. 6, no. 2, 1993, pp. 213–35; 'Measuring the Social Evil: The incidence of venereal disease in interwar Scotland', *Medical History*, vol. 37, 1993, pp. 167–86; 'Venereal Disease, Sexual Morality, and Public Health in Interwar Scotland', *Journal of the History of Sexuality*, vol. 5, no. 21, October 1994, pp. 267–94. For a discussion of the interwar period in Victoria as a part of an extensive survey of venereal diseases control see Diane Roslyn Tibbits, *The Medical, Social and Political Response to Venereal Diseases in Victoria 1860–1980*, PhD Thesis, Department of Microbiology, Monash University, Melbourne, 1994.

7. Any legislative proposal that included compulsory clauses, that is compulsory notification and treatment (such as it was) of individuals thought to be suffering from a venereal disease was immediately linked with the notorious Contagious Diseases Acts of late nineteenth-century Britain that provided for the detection, forced examination and treatment of prostitutes. These acts were repealed in Britain in the late 1880s.

8. A. Grenfell Price, 'South Australia and Its Capital', *Medical Journal of Australia*, 17 April 1937, pp. 596, 599.

9. 'The Falling Birth-Rate', *Public Health Notes: Bulletin by the Department of Public Health of South Australia*, Adelaide, no. 15, July 1935, p. 2.

10. For a discussion of the *South Australian Venereal Diseases Act 1920* see Susan Lemar, "'Outweighing the Public Weal": The venereal diseases debate in South Australia 1915–1920', *Health and History*, vol. 5, no. 1, pp. 90–114.

11. *Report of the Commonwealth and States of Australia Conference on Venereal Diseases*, Melbourne, 3 February 1922, p. 9.

12. *ibid.*

13. 'Report of the Royal Commission on Health 1926', *Commonwealth of Australia Parliamentary Papers*, general vol. iv, 1926–27–28, p. 28.

14. Dr Glen Howard Burnell, *Royal Commission on Health, Minutes of Evidence*, Melbourne, 1925 (15865,15904).

15. *ibid.* (15909–10).

16. *ibid.* (15865–7).

17. Dr A. Southwood, chairman of the Central Board of Health, Report to the Honourable the Chief Secretary, 'In Respect of the Necessity of Proclaiming the Venereal Diseases Act which Was Passed in 1920', 15 February 1934, SRSA GRG8/1/1934/8.

18. *ibid.*

19. Dr A. Southwood, 'How to Control Venereal Disease', *Public Health Notes*, Adelaide, no. 30, April 1939, pp. 22–3.

20. Southwood, 'In Respect of the Necessity of Proclaiming the Venereal Diseases Act'.

21. During the interwar period some statutory attempts were made to reduce the risk of infection to the innocent. The employment of diseased persons in the handling of food and drugs was prohibited in Section 30A of the *Food and Drugs Act 1908*. Sub-section (4) provided that a 'loathsome disease' means a disease proclaimed by the governor on the advice of the Central Board of Health to be so defined. In 1934 such a proclamation was issued. *The Criminal Law Consolidation Act 1935* provided for the detention, at the expiration of their sentence, of a person guilty of any offence of a sexual nature who was found to be suffering from venereal disease, or a mental condition rendering them incapable of exercis-

ing proper control over their sexual instincts. Legislation to control the spread of the diseases in the general community was still some way off.

22. ‘Venereal Diseases Act’, *South Australian Parliamentary Debates (SAPD)*, 18 October 1922, p. 993; ‘Venereal Diseases Act’, *SAPD*, 7 August 1923, p. 120.

23. Memo, 13 November 1933. SRSA GRG24/6/1933/1135.

24. Minute from chief secretary Bice, 9 September 1921. SRSA GRG24/6/1921/143.

25. Minute to chief secretary from premier and attorney general, 28 July 1922. SRSA GRG24/6/1921/143.

26. Annual Report, Board of Management, Adelaide Hospital 1919, p. 10.

27. Dr Glen Howard Burnell, Royal Commission on Health, Minutes of Evidence, Melbourne, 1925 (15864).

28. *ibid.*(15872–3).

29. *ibid.* (15905).

30. *ibid.* (15906).

31. *ibid.* (15905).

32. The aim of the association was to give stimulus and ‘more systematic direction to scientific enquiry’, obtain a greater degree of national attention to the objects of science, and remove the disadvantages that impede its progress. ‘Science Congress Opened in Adelaide’, *The Advertiser*, 26 August 1924, p. 11, col. A–D.

33. ‘The Red Plague’, *The Advertiser*, 28 August 1924, p. 15, col. D; ‘Venereal Disease’, *The Register*, 29 August 1924, p. 8, col. C&D.

34. Minutes of the meeting of Public Health Committee, 24 April 1933. ACA TCD (15) TCSF (S4) File No: 194A—Venereal Diseases. *Handwritten note suggests that this may be an error.

35. Memo from medical officer of health (MOH), Dr E. A. Johnson, to Town Clerk, Adelaide, 2 May 1933. ACA TCD (15) TCSF (S4) File No: 194A—Venereal Diseases.

36. *Report of the Commonwealth and States of Australia Conference on Venereal Diseases*, Melbourne, 3 February 1922.

37. ‘The Prophylaxis of Venereal Disease’, *Medical Journal of Australia*, 27 October 1923, pp. 443–4.

38. Letter from Harold Rischbieth to Hon. T. Pascoe, Minister for Agriculture, 18 August 1920. SRSA GRG24/6/1915/1338. Reproduced in ‘Venereal Diseases Bill’, *SAPD*, 7 September 1920, p. 575.

39. Harold Rischbieth, ‘The Therapeutic Value of the Arseno-Benzol Drugs’, *Medical Journal of Australia*, 21 October 1922, pp. 472–4.

40. ‘Venereal Diseases: The problem of syphilis by a medical practitioner’, *The Register*, 12 October 1922, p. 7, col. G. The practitioner was most likely Rischbieth. See for almost identical comments ‘The Public Health: A grave menace’, *The Advertiser*, 8 September 1922, p. 12, col. G in which he is mentioned by name.

41. ‘The Red Plague’, *The Register*, 29 August 1924, p. 11, col. G.

42. *Venereal Diseases*, pamphlet issued by the Local Board of Health for the City of Adelaide, October 1933, *passim*. ML 616.951 A228.

43. Circular to Local Boards of Health in South Australia from secretary, Local Board of Health for the City of Adelaide, 13 November 1933. ACA TCD (15) TCSF (S4) File No: 194A—Venereal Diseases.

44. Letter from Harold Rischbieth to A. Southwood, chairman, Central Board of Health, 28 March 1934. SRSA GRG8/1/1934/8.

45. Report the chief secretary from A. R. Southwood, chairman, Central Board of Health, 3 April 1934. SRSA GRG8/1/1934/8.

46. Letter from the secretary, Central Board of Health, to chief secretary, 18 April 1934. SRSA GRG8/1/1934/8.

47. Letter from E. Angus Johnson, chairman, Public Health Committee & T. Borthwick, MOH, to secretary, Local Board of Health, 19 September 1922. ACA TCD (15) TCSF (S3) Docket No: 2876/1924 – Venereal Diseases.

48. Memo from E. Angus Johnson, MOH, to secretary, Local Board of Health Adelaide, 1 September 1924. ACA TCD (15) TCSF (S3) Docket No. 2876/1924—Venereal Diseases; Letter from secretary, Adelaide Hospital Board, to secretary, Local Board of Health, Adelaide, 13 September 1924. ACA TCD (15) TCSF (S3) Docket No. 2876/1924—Venereal Diseases;

Letter from secretary, Local Board of Health, Adelaide, to Sir James Barrett, president, Australian Association for Fighting Venereal Diseases, 14 January 1925. CA TCD (15) TCSF (S3) Docket NO. 2876/1924 —Venereal Diseases.

49. Dr Glen Howard Burnell, Royal Commission on Health, Minutes of Evidence, Melbourne, 1925 (15907, 15909, 15737, 15939); in 1927 a Division of Tuberculosis and Venereal Disease was established in the Commonwealth Department of Health, with a medical officer as director. This division ceased to exist in April 1932.

50. Minutes of the meeting of the Public Health Committee 24 April 1933. ACA TCD (15) TCSF (S4) File No: 194A—Venereal Diseases.

51. Minutes of the meeting of the Sub-Committee re Venereal Diseases appointed by the Public Health Committee, 7 June 1933. ACA TCD (15) TCSF (S4) File No: 194A—Venereal Diseases.

52. Memo from the MOH, Dr E. A. Johnson, to the town clerk, Adelaide, 2 May 1933. ACA TCD (15) TCSF (S4) File No: 194A—Venereal Diseases.

53. 'Health Propaganda', *The Advertiser*, 26 August 1924, p. 9, col. A; see also *The Advertiser*, 26 August 1924, p. 8, col. F.

54. "Damaged Lives" Showing in Adelaide Soon', *The Advertiser*, 30 May 1934, p.10, col F.

55. 'Venereal Disease', *The Register*, 29 August 1924, p. 8, col. C&D.

56. Dr Glen Howard Burnell (medical officer in charge of Venereal Diseases Clinic at Adelaide Hospital), Federal Commission on Public Health, 1925 [15923–4].

57. Letter to chief secretary, H. Tassie, from Elizabeth Bowman, president, National Council of Women of South Australia, 12 July 1929. SRSA GRG24/6/1921/143.

58. Letter from Mrs D. R. Hicks, secretary, Democratic Women's Association of South Australia, to chief secretary, Sir George Ritchie, 5 November 1938. SRSA GRG24/6/1938/1218.

59. Letter from Minister for Police, Millington, to general secretary, Women's Service Guilds of WA Inc., 3 January 1929. SRSA GRG5/2/1928.

60. *ibid.*

61. Dr H. M. Fisher to the chief secretary, GRG24/6/674/40.

62. Letter from the chief secretary to the secretary of the National Council of Women of South Australia, 17 March 1939. SRSA GRG24/6/1913/1218.

63. Extract from Report of Dr H. M. Fisher, medical officer, Female Section Night Clinic, 26 June 1939. SRSA GRG78/1/1939/580.

64. Minute from secretary of the Adelaide Hospital Board, 1 August 1939. SRSA GRG78/1/1939/580; minute to the secretary of the Adelaide Hospital Board from medical superintendent Rollison, 12 August 1939. SRSA GRG78/1/1939/580.