

Venereal Disease, Public Health and Social Control: The Scottish Experience in a Comparative Perspective (*)

ROGER DAVIDSON (**)

SUMMARY

I.—Introduction. II.—Gender. III.—Generation. IV.—Class and Race. V.—Morality. VI.—The Quest for Compulsion. VII.—The Triumph of Voluntarism.

ABSTRACT

During the first half of the twentieth century, VD became in many countries a metaphor for the forces of physical and moral pollution that appeared to threaten social order and racial progress. By reference to some central aspects of the Scottish experience in a comparative perspective, this article seeks to identify the common denominator of anxieties and assumptions which fuelled public health initiatives towards VD and which defined the boundaries within which VD policy options were discussed.

In particular, it will explore various dimensions of social control associated with the treatment and regulation of VD; the degree to which VD controls and procedures have targeted and stigmatised «sexually active» women, their use to regulate the sexual behaviour of the young, and the way in which discourses shaping medical practice and policy towards VD have enshrined both class and racial stereotyping. The article also examines the powerful moral agenda which shaped the categories and content of treatment and the focus of epidemiology and public health debate. Finally, the institutional and cultural factors shaping the distinctively compulsionist stance of Scottish public health administration towards VD will be explored as a means of identifying some of the possible comparators needed for broader comparative analysis of VD policy in the twentieth century.

BIBLID [0211-9536(1997) 17; 341-368]

Fecha de aceptación: 16 de abril de 1997

(*) I am indebted to the Wellcome Trust, whose financial assistance made possible much of the research upon which this article is based.

(**) Doctor in History, Reader in Economic and Social History. Department of Economic and Social History. University of Edinburgh. William Robertson Building. 50 George Square. Edinburgh EH8 9JY. Roger.Davidson@ed.ac.uk.

I. INTRODUCTION

Society's response to venereal disease (VD) has been shown to be a central strand in that «whole web of discourses» that has constructed and regulated sexuality in modern society. During the late nineteenth and early twentieth centuries, VD became in many countries a metaphor for physical and moral decay, for the forces of pollution and contamination that appeared to threaten the institutions of social order and racial progress. Alarm over the issue of VD therefore offered an opportunity to express concern about the moral direction of society and changing standards of conduct. Given the supposedly «wilful» nature of its diffusion and its threat to «social hygiene», it also provided a powerful justification for the social construction and proscription of dangerous sexualities.

The significance of VD in shaping and reflecting perceptions of sexuality, and in defining the response of the State to patterns of sexual behaviour in the twentieth century has been the focus of extensive research (1). In earlier studies, concepts of social control initially used

-
- (1) See especially, DAVENPORT-HINES, R. *Sex, Death and Punishment: Attitudes to Sex and Sexuality in Britain since the Renaissance*, London, 1991, ch. 5-7; MORT, F. *Dangerous Sexualities: Medico-moral Politics in England since 1830*, London, 1987; BLAND, L. «Cleansing the Portals of Life»: The Venereal Disease Campaign in the early Twentieth Century. In: M. Langan and B. Schwarz (eds.) *Crises in the British State, 1880-1930*, London, 1985, ch. 9; BRANDT, A. *No Magic Bullet: A Social History of Venereal Disease in the United States since 1880*, Oxford, 1985; FEE, E. Sin vs. Science: Venereal Disease in Baltimore in the Twentieth Century. *Journal of the History of Medicine and Allied Sciences*, 1988, 43, 141-64; PIERSON, R. R. The Double Bind of the Double Standard: VD Control and the CWAC in World War II. *Canadian Historical Review*, 1981, 62, 31-58; CASSEL, J. *The Secret Plague: Venereal Disease in Canada 1838-1939*, Toronto, 1987; QUETEL, C. *History of Syphilis*, Cambridge, 1990; MURNANE, M.; DANIELS, K. Prostitutes as «Purveyors of Disease»: Venereal Disease Legislation in Tasmania 1868-1945, *Hecate*, 1979, 5, 5-21; TIBBITS, D.R. *The Medical, Social and Political Response to Venereal Diseases in Victoria 1860-1980*, Ph.D. dissertation, Monash University 1994; FLEMING, P.J. Fighting the «Red Plague»: Observations on the response to venereal disease in New Zealand 1910-45, *New Zealand Journal of History*, 1988, 22, 56-64; FLEMING, P.J. *Shadow over New Zealand: The response to Venereal Disease in New Zealand 1910-45*. Ph.D. dissertation, Massey University, 1989; VAUGHAN, M. Syphilis and Sexuality: the Limits of Colonial Medical Power. In: *Curing their Ills: Colonial Power and African Illness*, London, 1991, Ch.6.

to analyse the social politics surrounding the regulation of nineteenth century prostitution- pre-eminently the Contagious Diseases Acts- were redeployed to interpret the formal and informal strategies of the central and local state in the twentieth century to identify and penalise those who deviated from appropriate norms of sexual behaviour. Indeed, for some historians, VD legislation could best be understood not as health legislation, but as legislation concerned with social order and control in a sexually repressive society (2). Subsequently, an understandable pre-occupation of feminist discourse with the gender discrimination of VD controls has been supplemented by increased awareness of other dimensions of stigmatisation and control, including class, generation, and race, and by increasing evidence of the social complexity of the cultural and institutional factors shaping VD policy in different countries.

By reference to some central aspects of the Scottish experience within a comparative perspective, this paper seeks to illustrate these shifts in the historiography of VD and to identify the common denominator of anxieties and assumptions which fuelled public health initiatives and which defined the boundaries within which the debate over VD policy options was commonly conducted. In order to contain the comparative analysis within manageable proportions, the major focus will be on the Anglo-Saxon experience, particularly within the British Dominions, where there were broadly shared cultural and legal traditions. It does not seek to incorporate the growing body of literature on the evolution of twentieth-century VD policy in other European countries, where often, as in France and Spain, the practice of regulated prostitution led to distinctive patterns of public health administration.

II. GENDER

The overriding feature of the VD controls and procedures developed in twentieth century Scotland has been the degree to which they have, as in many other countries, targeted and stigmatised young, «sexually

(2) See, for example, MURNANE; DANIELS, note 1, p. 19.

active» women (3). Underpinning this discrimination has been a social epidemiology, widely articulated in public health reports and official policy memoranda, that has portrayed such women as the fundamental source and «reservoir» of infection, reflecting in turn a double standard of sexual morality. Certainly, the anatomical problems of diagnosing and treating VD in female patients, and the asymptomatic course of gonococcal infection in many women, contributed to the view of women as the pool of infection. But, as in Canada and New Zealand, the extent to which they were blamed for the spread of VD seems to have drawn on a deeper and more primitive notion of «woman as polluter» (4).

In the view of interwar Scottish health officials, informed by the social and medical ideology of the Social Hygiene Movement, the «vicious» habits and unresponsiveness of young women to treatment regimes were both immoral and unclean. Their promiscuity, broadly defined as any non-marital intercourse and increasingly depicted within the rhetoric of public health as «amateur» prostitution, was viewed as a form of «sexual atavism» that undermined racial «fitness» and evolution. Their deviance from contemporary expectations of appropriate female sexual behaviour was perceived not only as a central factor in the continuing spread of venereal disease but also as a threat to the health and stability of family and community relationships (5), and VD Medical Officers

(3) Unless otherwise stated, the discussion of Scottish public health ideology and policy in this paper is based on sources cited in DAVIDSON, ROGER. «A Scourge to be firmly gripped»: The campaign for VD controls in Interwar Scotland. *Social History of Medicine*, 1993, 6, 213-235; Venereal Disease, Sexual Morality and Public Health in Interwar Scotland. *Journal of the History of Sexuality*, 1994, 5, 267-293; Fighting «The Deadly Scourge»: The Impact of World War II on Civilian VD Policy in Scotland. *Scottish Historical Review*, 1996a, 75, 72-97; Searching for «Mary Glasgow»: Contact Tracing for Sexually Transmitted Diseases in Twentieth Century Scotland, *Social History of Medicine*, 1996b, 9, 195-214.

(4) See PIERSON, note 1, p. 52; FLEMING (1989), note 1, pp. 171-172.

(5) In many countries, such perceptions were associated with wider concerns over the impact of war and shifts in patterns of income, employment and leisure upon the role and behaviour of women in society. See especially, FLEMING (1989) note 1, p. 121; CASSELL, note 1, p. 187; TIBBITS, note 1, p. 186. For the origins and broader implications of this «atavistic» view of female sexuality, see especially, RUSSETT, C. E. *The Victorian Construction of Womanhood*, Cambridge, Mass., 1989,

urged that health and police authorities be given powers to detain promiscuous sexual delinquents in hostels until they were both medically cured and employable. Likewise, while motivated in part by concern at the impact upon family health of male default from treatment, the abortive interwar campaign in Scotland for the compulsory notification and treatment of VD was fuelled by a desire to contain the «sexual recidivism» of women. As in Australia and New Zealand, female default due to medical or logistical reasons was often presented as wilfulness or viciousness peculiar to female sexual proclivities. In addition, as eugenic ideology gained currency, women who evaded treatment were increasingly stigmatised as «moral imbeciles» whose alleged mental deficiency posed a major threat of racial degeneration (6). The range of non-statutory follow-up procedures adopted by VD clinics to reduce levels of default and re-infection were also highly gender specific. Men were not normally subjected to domiciliary visits by social almoners nor the target of the same investigation and socio-medical surveillance, and insofar as VD clinics formed part of «the new hygiene of the Dispensary» focusing upon patterns of social contact and transmission, it was predominantly female sexual behaviour that was monitored.

In both World Wars, Defence Regulations in Scotland, as in England and Wales, identified the «consorts» of servicemen as the critical vectors of disease and singled out for statutory controls the «amateur prostitutes» or «good time girls» supposedly seeking and dispensing unsafe sex, who were deemed to constitute a major threat to the health and military efficiency of the nation (7). Although the notorious Defence Regulation 40D of 1918 which had sought to criminalise the transmission of VD to the armed forces was not renewed, Defence Regulation 33B of 1942 was explicitly designed to target a «dangerous minority of infected women» or «amateurs». In introducing notification for «contacts» named by two or more patients as the source of infection, and penal sanctions for

pp. 63-76; GILMAN, S. L. *Difference and Pathology: Stereotypes of Sexuality, Race and Madness*, Ithaca and London, 1985.

- (6) FLEMING (1989), note 1, pp. 9, 72, 175; BROOKES, B. Aspects of Women's Health, 1885-1945. In: L. Bryder (ed.) *Essays on the Social History of Medicine in New Zealand*, Wellington, 1991, p. 162; TIBBITS, note 1, p. 182.
- (7) See especially, DAVIDSON (1996a), note 3.

such contacts who refused to submit to medical examination and treatment, the Department of Health for Scotland was responding to the call from public health officials for measures to restrain the «harpies who prey[ed] on Service men» and the «black-out girls whose moral delinquency was threatening the war effort and the national moral fibre». Once again, sexually active, unmarried females were defined as the pool of venereal infection and it was clearly assumed that informants would be predominantly male servicemen who had impetuously dipped into it.

Predictably, during the period 1943-7, Defence Regulation 33B was operated overwhelmingly against women by military authorities in order to protect the health and efficiency of their male troops. In the prosecutions that were held, health officials and magistrates continued to endorse a double moral standard, with infected men being depicted as «victims» and their female consorts as sexual predators. Female defendants had their alleged «promiscuity» paraded before the courts and media without any opportunity to establish their innocence beyond submitting to medical examination, while male informants, who might often be highly promiscuous, were neither legally required to attend court proceedings nor to submit to a prescribed regime of treatment. Moreover, as in other countries such as Canada and the U.S.A., this double standard was visibly reinforced by the posters and other propaganda materials issued by public health authorities portraying a demonology of VD from which male figures were notably absent (8).

A comparison of the Scottish experience with that of wartime VD policy elsewhere reveals many similarities. Thus, in New Zealand, a comprehensive set of controls was introduced in 1941-2 empowering Medical Officers of Health, in collaboration with the police and American military authorities, to detain for examination and treatment suspected carriers of VD. In practice, the regulations were applied selectively and targeted female consorts. Other examples of discrimination were evident in the dismissal of servicewomen found to be infected, as being «a threat to the moral welfare of fellow recruits», and in propaganda campaigns that emphasised not only the medical repercussions of female

(8) See especially, PIERSON, note 1, p. 50; BRANDT, note 1, illustrations 14, 18-20.

venereal infection but the social ostracism and indelible «stain» incurred by female promiscuity (9).

In Canada, wartime VD procedures were similarly informed by a double standard of sexual morality that relied upon «the appeal to fear and loathing in the image of the «loose woman»» as a reservoir of infection and, as in the U.S.A., (10) a powerfully stigmatising concept of promiscuity as a behavioural lapse in men but an inherent and lasting trait in women. The same asymmetry in the medical treatment of women prevailed, with infected women frequently discharged from the services or detained in hospital for the duration of their treatment, subjected to highly intrusive screening programmes and denied equal access to antibiotics and preventive facilities (11).

Arguably, the most discriminatory VD controls were to be found in Australia. According to Sturma:

«In wartime Australia, the public's response to venereal disease was metaphorically, as well as literally, directed against the aspirations of women. Just as venereal disease threatened individual health, women's new autonomy was viewed as threatening the social body. That efforts to exert greater control over sexual conduct were directed mainly toward women was indicative not only of a double standard for male and female victims of the disease but also of the belief that women's changing role threatened the very fabric of domestic moral order. The need to regain moral order provided a rationale for reasserting traditional sex roles, and in this respect venereal disease as a public health issue served as an ideological tool and instrument for women's repression» (12).

Other Australian studies come to very similar conclusions. The 1942 National Security (Venereal Diseases and Contraceptives) Regulations

(9) FLEMING (1989), note 1, Ch. 4; BROOKES, note 6, pp. 162-163.

(10) For parallel ideologies and outcomes in the U.S.A., see especially, BRANDT, note 1, pp. 167-168.

(11) PIERSON, note 1, pp. 31-58.

(12) STURMA, M. Public Health and Sexual Morality: Venereal Disease in World War II Australia, *Signs*, 1988, 13, 740.

introduced wide-ranging powers for the notification, examination, detention and treatment of persons suspected to be suffering from venereal disease. In practice, as with the operation of Defence Regulation 33B in the United Kingdom, the National Security Regulations were applied by the military, police, and health authorities almost exclusively against specific groups of sexually active women, especially the alleged «amateurs» who consorted with American servicemen (13).

Since the establishment of the National Health Service in 1948, in association with health education, the major control strategy for sexually transmitted diseases in Scotland has been the development of a voluntary system of contact tracing rather than any form of compulsory notification and/or treatment. However, even within such a system, a continuing discrimination against women can be detected. During the 1950s and early 1960s, tracing was primarily restricted to female contacts identified by the armed forces or by the «principal municipal protective organisations» and to identifying the inmates of the more notorious brothels and prostitutes operating in the docks. Thereafter, although more systematic interrogation of infected patients was instituted in most Scottish cities, administrative guidelines from Central Government have continued to identify «promiscuous female contacts» as the major vectors of disease. The asymmetry with which public health officials have continued to perceive and to treat sexually transmitted disease is well illustrated by the taxonomy adopted by Edinburgh Public Health Department until the early 1960s in its so-called «sociological observations» on the source of infection, in which the diffusion of S.T.D.s continues to be interpreted as primarily a function of female sexual promiscuity with the significant retention of the highly stigmatic term «amateur» [prostitution] for non-marital female sexual encounters (14). The lack of a male analogue to

(13) See especially, SAUNDERS, K.; TAYLOR, H. *The Impact of Total War Upon Policing: The Queensland Experience*. In: M. Finnane (ed.) *Policing in Australia: Historical Perspectives*, Sydney, 1987, pp. 157-163; MURNANE; DANIELS, note 1, pp. 15-18; TIBBITS, note 1, pp. 7, 217-222. As in Scotland, a significant proportion of women contacts notified to health authorities were found to be free from infection.

(14) See especially, *E.[dinburgh] P.[ublic] H.[ealth] D.[epartment] Annual Report*, 1955, p. 158, where the sources of male infection are categorised as «Prostitutes; Amateur

the index of promiscuity of infected female contacts, published within the annual reports of Glasgow Health Department during the 1960s and early 1970s, has arguably similar implications (15).

III. GENERATION

Another major feature of the formal and informal controls operating within Scottish VD policy and administration, often reinforcing gender discrimination, was the desire to regulate the sexual urges of the young. During and after both World Wars, the public health debate surrounding VD was informed by acute concern at the apparent breakdown of familial and community controls upon the social and sexual behaviour of adolescents, and especially of the so-called «problem girls» (16). Shifts in the lifestyle of juveniles occasioned by changes in income and consumption patterns, and the onset of new forms of leisure and entertainment such as the dance-halls and cinemas, with their appeal to illicit desires, were perceived as a threat to the rational, sober, responsible sexuality expressed within marriage, necessary for social stability and racial health.

Contemporary debate over VD policy was used to articulate such anxieties. To Scottish health administrators such as Dr A. K. Chalmers, who viewed World War I as having fractured sexual norms, new control initiatives were imperative to counter «the lower moral code sapping the vigour of our youth», and a range of policy options including social hygiene education, the endorsement of the vigilante work of purity organisations, and the institutionalisation of sexual delinquents, were subsequently explored in interwar Scotland. In particular, «problem girls» were singled out for detention in a range of Church and Remand

types; Marital partner», while the sources of female venereal infection are analysed under «Prostitution; Promiscuous *Amateur* contact; Marital partner».

- (15) See, for example, *Medical Officer of Health for Glasgow Annual Report*, 1969, pp. 203-204.
- (16) This term was not always confined to adolescents. It was also frequently used to denote sexually active, single women so as to present them as retarded and in need of local authority control and restraint.

Homes and Magdalene Asylums with a view to moral re-education and industrial training.

Similar anxieties over youth culture and sexuality characterised VD debate and policy-making in other countries. In the U.S.A., the «new faddish dances from the toddle to the black bottom» and contemporary music with its «monkey talk, jungle squeals, grunts and squeaks and gasps suggestive of cave love» were cited as both a moral and medical threat (17). Likewise, in interwar New Zealand and Australia, VD came to stand as a metaphor for the ills of a younger generation «whose health, culture and behaviour seemingly betokened a civilisation which had lost both the power and the will to control its baser instincts». New theories of sexual delinquency and disease both reflected and reinforced a prevailing concern to regulate and reform adolescent behaviour, and propaganda material continued to instil fear of infection in the young as a deterrent from sexual transgression (18).

In Scotland, the likely impact of World War II upon adolescent sexual permissiveness, inflamed, according to public health officials, by the «»blackout», by boredom and by the lack of emotional control in conditions of stress», revived such concern, although, once again, control initiatives were highly gender specific. Night curfews and identity cards were proposed for minors as a means of restricting the movement of sexually promiscuous girls, especially in the vicinity of railway stations. There was an escalation in the use of remand homes by the police and public health authorities in order to detain juveniles involved in moral offences. In the First World War, a system of Women Patrols had been authorised under the auspices of the Scottish Union of Women Workers, to monitor the behaviour of girls in the vicinity of military camps and, where possible, to disrupt illicit liaisons. During the Second World War, reliance was placed instead in Glasgow and Edinburgh upon units of the Women's Auxiliary Police Corps dedicated to the surveillance of the conduct of young girls.

Similar strategies were adopted by other wartime administrations.

(17) BRANDT, note 1, pp. 126-128.

(18) FLEMING (1989), note 1, pp. 123-125; TIBBITS, note 1, p. 182. For French and Canadian anxieties, see, QUETEL, note 1, p. 193; CASSELL, note 1, p. 187.

In New Zealand and Australia, curfews for adolescent girls were proposed and the use of women police and reformatories to control «vicious» girls greatly extended (19). In New South Wales, the policy of the Police and Social Welfare Department was to arrest girls seen with Americans «unless they could prove that they were working, and to haul them off for a venereal disease test». A report on the Girls' Industrial School in Parramatta in 1945 noted that a frequent reason for committal was the «presence or suspicion of venereal disease [...] irrespective of a girl's delinquency» (20). In the U.S.A., public health agencies such as the Baltimore Venereal Disease Council, established in 1942, were equally preoccupied with the surveillance and sanctioning of juvenile promiscuity, to the extent that such promiscuity often displaced the disease as the main focus of medical attention (21).

In post-war Scotland, the discussion of STD prevention and epidemiology has continued to be informed by inter-generational concerns and used to express normative judgements on contemporary youth culture and sexual mores. Public health reports have frequently identified VD as a symptom of adolescent alienation from a morally bankrupt, acquisitive society. Typical was the concern expressed by the Physician in Charge of Edinburgh's VD Services in 1959 at the emerging «cult of sexual sensuality» amongst juveniles in the absence of «parental or community restraint» and under the evident influence of «the worst type of American and negro films, booklets, music and dancing» (22).

IV. CLASS AND RACE

The debate over S.T.D. controls in twentieth century Scotland has primarily been conducted within middle class and professional circles.

(19) STURMA, note 12, p. 733; FLEMING (1989), note 1, pp. 94-97.

(20) MURNANE; DANIELS, note 1, p. 16.

(21) FEE, note 1, pp. 156-157; BRANDT, note 1, p. 168.

(22) *E.P.H.D. Annual Report* (1959), pp. 142-143. While it was reluctantly conceded [*Ibid.* (1956), p. 157] that there was little evidence «that the *teddy boy* cult [...] or Rock 'n Roll has any influence on the influence of venereal infection», its «addicts» were typified as «unco-operative in treatment» and lacking in «the self-discipline necessary for cure».

While working-class organisations have passed sporadic resolutions on the issue, it has rarely impinged upon working-class politics. It has not, for example, figured in the proceedings of the Scottish Trades Union Congress or in local municipal elections. Yet, arguably the «discourse» shaping medical practice and policy toward VD has reflected and reaffirmed patterns of class as well as sexual subordination. Closer examination of the ideology and operation of the VD service in Scotland reveals that treatment and propaganda have been used to articulate essentially middle-class values of moderation, self-restraint, abstinence, and hygiene as a means of remoralising the poorer classes who attended the clinics. As D. Evans has rightly speculated: «Even when treatment was effective, the experience of patients may have been stigmatizing and disempowering. Patients were likely to be working class and may have experienced the treatment and education they received as a form of social control» (23).

Implicit in the categorization of patients and «defaulters» was an assumed correlation between class and «wantonness». It was predominantly working-class sexual behaviour that was scrutinized and appraised (or, more accurately, stereotyped) by the public health authorities. Similarly, despite the absence of any reliable data on the social distribution of venereal disease, it was the «libertines» and «intransigents» within the working class who were identified as the major vectors. As Armstrong has demonstrated, the «deference» of patients to the medico-moral behavioural prescriptions of middle-class health clinicians and administrators, including the need for «rational» and «temperate» habits, was central to the new hygiene of the dispensary (24). It was entirely consistent that, when venereologists and local authorities came to advance proposals for compulsory notification and treatment for VD, as in the 1920s and 1940s, they were content to ignore those patients receiving private treatment and to regulate solely those attending public clinics. A major criticism of wartime regulations were that they applied only to

(23) EVANS, D. Tackling the «Hideous Scourge»: The Creation of the Venereal Disease Treatment Centres in Early Twentieth-Century Britain, *Social History of Medicine*, 1992, 5, 413-433 (p. 431).

(24) ARMSTRONG, D. *Political anatomy of the Body: Medical Knowledge in Britain in the Twentieth Century*, Cambridge, 1983, pp. 103-106.

the socio-economic groups attending the public VD clinics and it is arguable that, given the absence of any mandatory system of contact notification, post-war contact tracing procedures initiated by public health authorities have continued to concentrate upon lower-income patients.

The class specificity of Scottish VD controls and procedures was echoed in public health developments elsewhere. Although in many countries, «propaganda» material portrayed VD as a peril that cut across class lines, and often featured middle-class victims, in fact it was lower-class sexual practices that «bore the full brunt of stigmatisation» (25). The view that clandestine or «amateur» prostitutes were predominantly working class and that they demonstrated the «wayward sexual mores of the labouring classes» underpinned Australian VD procedures in the interwar period, and similar assumptions shaped social hygiene ideology in France and the U.S.A., often in association with middle-class racism and nativism (26). VD regulations were often selectively applied, along with vagrancy and other public order controls, to restrict the mobility and social life of homeless, unemployed females «whose lives were not anchored in a respectable family environment» (27). This class discrimination was at its most overt in the administration of wartime regulations. In Queensland, for example, in World War II, «working-class women and teenage girls who publicly flaunted conventional morality were subjected to scrutiny, vigilance and calculated retribution through state harassment, segregation and punishment». In collaboration with the vice squad, public health officials incarcerated working-class women suspected of infecting servicemen in the Lock Hospital, «situated spatially and symbolically» in the grounds of the main prison in Dutton Park, while middle-class «patients» were permitted to receive discreet treatment from their medical practitioners or from the Infectious Disease Unit of Brisbane General Hospital (28).

Often, class values and assumptions could override or cut across

(25) See, especially, STURMA, note 12, p. 738.

(26) TIBBITS, note 1, p. 181; QUETEL, note 1, pp. 181, 204; BRANDT, note 1, pp. 22, 157.

(27) MURNANE; DANIELS, note 1, pp. 5, 15.

(28) SAUNDERS; TAYLOR, note 13, pp. 159-163.

considerations of gender in shaping VD proposals. Thus, as in New Zealand and Canada, Scottish middle-class women's groups such as the Women's Citizens Association were in the van of the interwar campaign for the surveillance, detention, and moral regeneration of the hard core of working-class, «problem girls» who defied middle-class standards of sexual and vocational propriety. Their attempts to control «sex delinquency» inherited from prewar evangelical rescue work a quintessentially bourgeois view of working-class, female adolescent «promiscuity» as requiring custodial treatment to ensure a material and moral environment in which norms of sexual passivity might be instilled. Similarly, during the Second World War, while opposing the introduction of D.O.R.A. 33B, women's groups advocated a range of control measures for working-class «sexual delinquents» who were allegedly harassing servicemen in the Scottish ports and cities. Thus, the Scottish Branch of the National Vigilance Association pressed for a more rigorous use of the 1937 Children and Young Persons Act as a means of giving the police and social workers more scope for restraining the «lower class» of good-time girl. The Medical Women's Federation recommended more approved schools and detention homes for such delinquents. Likewise, the Scottish branches of the Association for Moral and Social Hygiene and the National Council for Equal Citizenship both advocated more women police to discipline «vicious» girls who were perceived as major vectors of VD, and to patrol «danger areas» such as stations, camps, and parks.

Recent research has also revealed the impact of racial stereotyping and discrimination upon VD policy-making in many countries. Thus, Fleming emphasises the enduring assumption that Maori women were the reservoir of disease in New Zealand, polluting the white population and demoralising pakeha girls. Typical was the view of Elsie Bennet, General Secretary of the Y.W.C.A. that:

«The behaviour of many coloured girls is definitely a menace [...] They have [...] a different moral standard from our white girls, which causes a man to expect from the latter that which he receives from the former» (29).

(29) Cited in FLEMING (1989), note 1, p. 178.

As a result, the earliest and most coercive measures of screening and control tended to target Maori women (30).

Similarly, in Australia, aboriginal women were frequently identified as the source of both moral and racial «pollution» and forcibly segregated if suspected of being diseased. Information on the treatment of native populations in Canada is meagre, but in the U.S.A., racial prejudice has evidently been a potent factor in shaping VD procedures, especially in the South. Both Fee and Brandt chart how, after the First World War, syphilis, which had been perceived as «a disease of vice and prostitution», was «redefined as a black disease»; how white doctors and public health officials perceived blacks as «diseased, debilitated and promiscuous», a «syphilis-soaked race» who were the victims of their own «uncontrolled or uncontrollable sexual instincts and impulses; and how such perceptions led to a range of medico-moral strategies varying from racially targeted social hygiene programmes in Baltimore to the deliberate neglect of the notorious Tuskegee Syphilis experiment (31).

Nor, despite the absence of a significant new immigrant population, has the debate surrounding VD in Scotland been entirely free of racial prejudice. As in previous centuries, in public health reports, «foreign» infections have not infrequently attracted disproportionate blame for rises in the incidence of the disease,(32) and there have been powerful xenophobic, if not racial overtones in their postwar critique of the impact of overseas, and specifically «negro», influences upon the sexual mores of the younger generation (33).

(30) BROOKES, note 9, p. 163.

(31) MCGRATH, A. «Black Velvet»: Aboriginal women and their relations with white men in the Northern Territory: 1910-40. In: K. Daniels (ed.), *So Much Hard Work: Women and Prostitution in Australian History*, London, 1984, pp. 233-297; CASSELL, note 1, pp. 192-193; FEE, note 1, pp. 145-147; BRANDT, note 1, pp. 157-158; JONES, JAMES H. *Bad Blood: The Tuskegee Syphilis Experiment*, London, 1981.

(32) Thus, in 1953, the Medical Officer of Health for Edinburgh attributed the survival of syphilis within the city largely to the the importation of infection from countries «where Mars, Bacchus and Venus are still a formidable trio». *EPHD, Annual Report* (1952), p. 99.

(33) See especially, *EPHD, Annual Report* (1959), p. 142.

V. MORALITY

Underpinning the development of the VD services in twentieth century Scotland has been a powerful moral agenda which has shaped the categories and content of treatment, the focus of epidemiology and public health debate, and the broader socio-sexual engineering of the dispensaries and public health committees. Consistent with the medico-moral ideology of the Social Hygiene Movement, Scottish interwar administrators viewed venereal diseases not just as a physical pathology but as the «stigmata» of the transgression of moral norms. Disease «venereally acquired» remained synonymous within the minds of most practitioners with moral turpitude and sexual intemperance. Thus, for Dr William Robertson, Medical Officer of Health for Edinburgh in the 1920s, infection was the «noose» into which «licentious and immoral people» ran their heads.

Clinicians and public health officials subscribed to an aetiology that incorporated an explicit taxonomy of guilt and blame and clearly differentiated between patients according to the moral culpability of their condition, with traditional principles of «less-eligibility» shaping attitudes to medical treatment, welfare support and civil liberties. At one end of the spectrum were the «innocent patients» suffering from «innocent infections»- the children and married women «against whom», in the words of the Scottish Board of Health, there was «no suggestion that they had transgressed any moral or other law» and for whom a range of medical and welfare provisions were provided with the minimum of stigma. At the other end were the defaulters, particularly infected married men and «problem girls», who were doubly guilty. Not only had they contracted VD wilfully and venereally by means of «illicit» and «promiscuous sexual intercourse» but also remained major vectors of the disease by virtue of their failure to sustain treatment and to modify their sexual behaviour. It was for these deviants that Scottish health officials sought to introduce compulsory notification and treatment, the loss of civil liberties being viewed as a legitimate stigma for those «libertines» whose behaviour endangered the sexual health and social efficiency of the nation.

A moral agenda also informed social and governmental responses

to VD elsewhere. In interwar Europe, North America, and Australasia, debate and propaganda surrounding VD was similarly used to articulate anxieties over the moral direction of society and to reaffirm traditional sexual mores. A similar moral taxonomy and epidemiology prevailed, linking disease and promiscuity, and in many countries, such as France, the «medico-hygienic stance remained as repressive as ever as far as the moral implications of the anti-venereal struggle were concerned» (34). Despite the best efforts of public health leaders such as Thomas Parran in the U.S.A. to «transform the discourse of venereal disease», prevention, care and control strategies continued to be heavily constrained by moral priorities and caveats (35). Moreover, such concerns were assured of an international currency by the widespread networking of social hygiene and purity organisations (such as the Women's Christian Temperance Union), accompanied by a multilateral exchange of propaganda materials, including films, designed to present the medical aspects of VD within a strict moral framework (36).

Despite the impact of the Second World War, of new chemotherapies, and of greater public awareness and discussion of S.T.D.s, at an attitudinal level, strong elements of this moral agenda continued to inform the response of Scottish health administrators well into the second half of the twentieth century. VD policy continued to be determined as much by moral anxieties as by the medical dimensions of the problem, and by a moral epidemiology that perpetuated the concept of infection as a function, if not punishment, of sexual deviance. Nowhere were the moral boundaries to VD policy-making more clearly and continuously drawn than in the debate over prophylaxis. In interwar Scotland, the majority of public health officers had supported the Social Hygiene Movement's resistance to the issue of prophylactic packets and the

(34) QUETEL, note 1, p. 204; FLEMING (1986), note 1, pp. 61-64; TIBBITS, note 1, p. 128. Efforts by certain Spanish doctors in the 1930s to remove any moral agenda from the anti-venereal campaign, in line with Republican democratic values, were frustrated by the onset of the Civil War. See, CASTEJÓN BOLEA, R. *De la higiene de la prostitución a la lucha antivénerea: enfermedades venéreas y medicina social en España (1868-1936)*, Ph.D. dissertation, Universidad de Granada, 1996.

(35) See e.g., BRANDT, note 1, pp. 8, 128, 155; CASSELL, note 1, pp. 102; PIERSON, note 1, pp. 35-36.

(36) CASSELL, note 1, pp. 221-222.

establishment of public ablution centres on the grounds that, irrespective of their medical efficacy, they might legitimize «irregular» and promiscuous sex and thus actively promote immorality by removing the natural penalties associated with promiscuity. During the Second World War, some attempt was made by venereologists and the Scottish Medical Advisory Committee to obtain a wider availability and use of self-disinfection packets and condoms, but the consensus of Scottish professional and public opinion, including that of the churches, the women's movement, and welfare agencies, continued to view such measures as an offence against «the social and moral code» and an incentive to sexual license and «moral lawlessness». The same set of anxieties produced considerable ambivalence amongst clinicians and public health officers in the late 1940s towards new forms of chemotherapy on the grounds that, by reducing the perceived dangers and discomforts of VD, fear of infection no longer acted as a deterrent to sexual indiscretion.

Wartime VD policies elsewhere were similarly driven by moral panics and prescriptions. Although supervised prophylactic treatment centres were established for male civilians and servicemen in Australia and Canada, a double standard of sexual morality ensured that no such facilities were available for women (37). Portrayed in the media and public debate as symptomatic of a general breakdown in sexual morality and as a powerful symbol of moral corruption, VD became pivotal to a range of wartime social and behavioural controls activated by police and public health authorities (38). In New Zealand, «the literature of the period continued to exploit the fear of infection as a means of enforcing moral attitudes and presented venereal disease as the natural and inevitable consequence of immoral behaviour». As in the interwar period, moral inhibitions continued to deny state-funded prophylactic information and provisions to civilians. Instead, venereal disease prevention focused on publicising the dangers of «easy» women, and on police action against brothels and night clubs (39). Furthermore, as in Scotland, the likely impact on sexual mores of the increased use of penicillin in the treatment of syphilis and gonorrhoea served to reactivate the moral

(37) PIERSON, note 1, p. 44; TIBBITS, note 1, pp. 226, 231.

(38) See especially, STURMA, note 12, p. 728.

(39) FLEMING (1989), note 1, pp. 143-144; FLEMING (1986), note 1, p. 64.

agenda of VD administrators in many countries. Concern that antibiotics might «subsidize venery» and «inaugurate a world of accepted, universalised, safeguarded promiscuity» was strongly reminiscent of the moral dilemmas that had surrounded previous debates over the proposed introduction of abluion centres and other preventive measures (40).

Such ideological constraints also operated within the social politics surrounding the discussion of S.T.D.s in post-war Scotland. There is a notable similarity between the language and assumptions of the social hygiene and purity literature of the interwar period and those articulated in the Public Health Department reports of the 1950s and 1960s. Taxonomies of guilt and moral culpability still prevailed, especially in official analyses of the sources of infection. One finds the same medico-moral concern at the «sensual license» produced by the loosening of traditional moral standards, by the weakening of religious influences, and by the influence of dubious leisure pursuits- preeminently «the darkness of the cinema or the easy relationships of public dance-halls» (41). Moreover, more recent archives reveal that the medical response of the Scottish Health Department and Scottish Council for Health Education to S.T.D.s continued until the 1970s to be circumscribed by a perception of the problem as intrinsically one of a moral decline in sexual behaviour. As in the U.S.A., new forms of STDs, such as genital herpes, revived the long-standing association of disease with immorality and with the call «for a more restricted sexuality» (42).

Just how far and why the relationship between the moral and medical dimensions of VD policy making varied between different countries is difficult to identify and explain. While Fee and Brandt emphasise that the debate between the moral and scientific contingents of the social hygiene campaign reflected «a continuum of opinion», their accounts of public health developments in the U.S.A. highlight a polarity between moral and biomedical approaches that was central to defining the discourse surrounding venereal disease controls (43). In many respects,

(40) See specially, BRANDT, note 1, pp.172-173; FEE, note 1, p. 162.

(41) See e.g., *E.P.H.D. Annual Reports* (1959) pp. 142-144; (1962), pp. 157-158; (1969), p. 71.

(42) BRANDT, note 1, pp. 179-180.

(43) BRANDT, note 1, pp. 46-47, 50-51, 113, 121; FEE, note 1, pp. 141, 161.

Davenport-Hines' treatment of «the dominant and conflicting mentalities» which have fashioned policies towards venereal disease in twentieth century England, focusing upon the ongoing conflict within the social hygiene movement over prophylaxis, conveys a similar story (44). In contrast, in Scotland and New Zealand, the evidence would suggest that, although the response of public health authorities to venereal disease was often ambivalent, overt conflict between medical and moral viewpoints was strikingly absent. Instead, they were closely intertwined, with moral issues prescribing the boundaries within which debate took place and within which both social and medical strategies were formulated. Such variances may, however, be more apparent than real. As Fleming suggests, the more polarised interpretations of venereal disease policy, juxtaposing the scientific progressivism of public health officials against the moral absolutism of conservative pressure groups, may in part be a construct of «present-day historians to whom the reluctance of a previous generation to avail itself of all medical weapons appears inexplicable and irrational» (45).

VI. *THE QUEST FOR COMPULSION*

One of the most distinctive features of the public health response to S.T.D.s in twentieth century Scotland has been the succession of campaigns for controls involving compulsion, which has contrasted markedly with the more voluntarist stance of health administrators south of the border. It is valuable to outline the reasons for this divergence as it may provide traction on the range of variables needed for a broader comparative analysis of S.T.D. strategies elsewhere in the world. During the 1920s, Scottish local health authorities, backed by a wide range of professional groups within Scottish society, launched a sustained campaign for more stringent local authority powers to combat the spread of venereal disease. In the course of the decade, three separate bills were advanced —the most notable being the Edinburgh Corporation (Venereal Disease) Bill of 1928— seeking to notify, detain and to penalise infected persons (as

(44) DAVENPORT-HINES, note 1, chs. 6-7.

(45) FLEMING (1989), note 1, pp. 213-214.

well as the parents of infected children) who refused to seek or to sustain treatment. Despite the defeat of this campaign, many clinicians and local health authorities continued to lobby for additional VD controls throughout the 1930s, gaining the endorsement of the Committee on the Scottish Health Services in 1936. During the Second World War, Scottish local authorities and social hygiene agencies renewed their efforts to secure more rigorous controls. They viewed Regulation 33B as insufficiently robust to deal with the dramatic rise in the incidence of VD, and in 1944, persuaded the Scottish Office to fight the issue in the War Cabinet. In the event, the voluntarist ideology of the English Ministry of Health prevailed, but a further campaign for compulsion was launched in Scotland in the late 1940s. Although it had effectively run its course by 1950, as late as 1968, the M. P. for Glasgow, Shettleston, sought to reintroduce wartime controls in order to combat the rising incidence of gonorrhoea.

A range of reasons may be advanced to try and explain this distinctively compulsionist stance of Scottish public health administration towards S.T.D.s. The incidence of the diseases does not appear to be a significant factor, in that, insofar as data was available, there was, up to the 1950s, no marked divergence in trend between Scotland and England and Wales. A more probable explanation may lie in the strong tradition of «civic authoritarianism» and interventionism in Scotland. The twentieth century campaign for VD controls of the Scottish local health authorities perpetuated a long-standing involvement of civic leaders, coordinated by the Convention of Scottish Royal Burghs, in the regulation and containment of «pestilential infections», dating back to the eighteenth century. The Scottish cities had been in the van of nineteenth century moves to impose compulsory notification for infectious diseases, even where, as in the cases of T.B. and ophthalmia neonatorum, social stigma was involved. Similarly, Scottish health officials had proved notably aggressive in developing the powers conveyed by the 1897 Public Health (Scotland) Act to examine, to isolate, and to prosecute infected persons endangering public health, and subsequently became increasingly frustrated at the apparent deference of the Scottish Board of Health to the «libertarian fears and feelings of the Cathedral cities south of the border». The distinctive preoccupation of Scottish compulsionists, from the 1920s through to the 1950s, with the regulation of «defaulters» also drew on

a vigorous tradition of moral accountability within the welfare provisions of the local state, and community disciplining of sexual behaviour by the Presbyterian kirk session (46). The free provision of treatment to «habitues» was regarded as a subsidy to vice. It offended against the principles of less eligibility that health expenditure on those venereally infected through wilful promiscuity should be permitted to enjoy «a free and unfettered regime» in the use of state-subsidised facilities, and especially in the eyes of the propertied, rate-paying, local elites who came to dominate the social politics of Scottish cities during the late nineteenth and twentieth centuries.

The distinctive ideology of the Scottish Social Hygiene Movement (led by the more influential Medical Officers of Health and VD Medical Officers, and commonly administered from within public health departments) both reflected and reinforced the municipal quest for compulsion. The Scottish Committee of the British Social Hygiene Council shared the commitment of the English branch to a moral as well as a medical strategy towards public health and its association of national health and efficiency with sexual discipline. As in England, the B.S.H.C. played a vital part in raising Scottish public consciousness of the incidence and effects of venereal infection and in networking the voluntary and governmental agencies dealing with the disease. However, whereas its work South of the border focused on educational issues and moral propaganda, with a lasting commitment to a voluntarist strategy towards VD, the Scottish Committee adopted a compulsionist stance and gave priority to co-ordinating a campaign for controls until the 1940s. Indeed, a prime consideration in the establishment of a separate Scottish Council for Health Education in 1942 was a concern to ensure that the Scottish commitment to compulsion continued to be recognised in government circles.

It is difficult to identify just why the movement in Scotland was so much more interventionist, although there is suggestive evidence that some of its more influential members, as in other countries such as New Zealand, were heavily influenced by eugenics and its more coercive

(46) See especially, BOYD, K. M. *Scottish Church Attitudes to Sex, Marriage, and the Family 1850-1914*, Edinburgh, 1980, pp. 4-12.

prescriptions for the «degenerate» (47). It may also be that the pattern of municipal health politics within Scotland provided a stronger platform for the views of a generation of social hygienists whose outlook towards VD had been shaped by service in the medical corps in wartime and who were concerned, by means of new controls, to establish the professional status of their expertise as venereologists (48). Possibly, Scottish compulsionists within the Social Hygiene movement, and especially the more prominent Medical Officers of Health, were able to exploit the more authoritarian culture of decision-making in Scotland and the greater willingness for medical expertise to shape civic agenda.

The response of women's organisations to VD controls also varied geographically. While Scottish legislation, such as the Edinburgh Corporation Bill, encountered fierce opposition from a range of feminist pressure groups, local branches of the Women's Citizens Association, Cooperative Women's Guild, and the National Council of Women were prepared to give their conditional support. As with similar organisations in Canada and New Zealand, they shared the view of the public health departments that greater powers were necessary to reduce the wilful or negligent spread of VD and to protect the welfare of women and children (49). In addition, they saw the opportunity in local legislation to regulate male sexual behaviour as part of the contemporary struggle for women's rights. They did not view additional sanctions as undermining the principle of «equal citizenship» but as reinforcing it by denying the right of infected men to «pollute the springs of life» through marital intercourse. Female proponents of controls dismissed the metropolitan-based agitation of other feminist groups such as the Women's Freedom League and the Association for Moral and Social Hygiene as unrepresentative of informed opinion in Scotland and as reflecting only the dogmatic and outdated «abolitionist» views of upper-middle class

(47) FLEMING (1986), note 1, pp. 58, 60.

(48) For a similar association of VD measures with professional advancement and the role of public health campaigns in advancing the development of new medical specialties, see also CASSELL, note 1, p. 174; MEDINA DOMÉNECH, R.; RODRÍGUEZ OCAÑA, E. Profesionalización médica y campañas sanitarias en la España del siglo XX, *Dynamis*, 1994, 14, pp. 77-94.

(49) FLEMING (1989), note 1, pp. 78-79; CASSELL, note 1, p. 142.

suffragists from London and Plymouth. Although Scottish women's groups had participated in the campaign against the Contagious Diseases Acts, the absence of such legislation in Scotland in the nineteenth century may explain the relative lack of anti-regulationist sentiment north of the border after the First World War.

Finally, the compulsionist thrust of Scottish VD policy has to be seen within the context of the continuing struggle by public health administrators and practitioners to maintain a Scottish identity in health affairs. During the 1920s, opposition in Whitehall and Westminster to Scottish proposals became rapidly subsumed within the broader constitutional debate over Scottish legislative autonomy, fuelled by the cultural renaissance and resurgence of Scottish nationalism. Indeed, when it became known that the Cabinet was proposing a three line whip against the Edinburgh Venereal Diseases Bill of 1928 (unprecedented for private legislation) the Secretary of State for Scotland was forced to draft an open letter to *The Times* denying that he had supinely deferred to the whim of the English Minister of Health. After 1942, the issue of VD controls became once again an acid test of the autonomy of Scottish health administration, and the persistence of the campaign had not a little to do with the constitutional agenda of the Secretary of State, Tom Johnston. Significantly, as late as 1953, the issue figured in evidence to the Royal Commission on Scottish Affairs as an illustration of the frustration of «Scottish aims and aspirations» under a constitutional structure that denied adequate legislative devolution to Scottish affairs.

Interestingly, this association between the quest for national identity and the campaign for comprehensive controls against VD is paralleled elsewhere. Australia's pioneering role in the introduction of compulsory notification and treatment for VD was identified by contemporaries with its constitutional youth and vigour in contrast to the antiquated inhibitions of the mother country (50). Similarly, in New Zealand, stringent VD controls were frequently canvassed as «a unique opportunity to avoid the ills of the 'old' world and to forge a clean, healthy, and vigorous society». As one leading campaigner remarked:

(50) TIBBITS, note 1, p. 161.

«[...] we have already shown that we refuse to be trammelled by the traditions and conditions of the Old World, and we do not fear exploiting fresh fields. Why not then make some effort to eradicate a disease that has been at the root of so much racial decadence in the Old World». (51)

VII. *THE TRIUMPH OF VOLUNTARISM*

Some exploration of the reasons for the failure of the campaign for compulsion in Scotland may also throw up some useful comparators. Underlying the various strands of opposition to compulsion was a broader societal resistance to State intervention. VD controls such as compulsory notification and treatment posed fundamental issues of personal liberty and the inquisitorial rights of government. Resistance to compulsory regulations incorporated a growing critique of the role and power of the expert in democratic society, and concern that professional groups would collude with the State in the erection of authoritarian controls. As the Scottish Board of Health observed, there was an overriding fear in some quarters that «any legislation, however moderate and however wisely safeguarded, might prove a harsh and even tyrannous weapon in the hands of unwise officials, even though their unwisdom were based upon mistaken zeal». Opposition to controls also in part re-enacted the libertarian campaigns of the 1890s and 1900s against compulsory notification of infectious diseases and compulsory vaccination, with similar perceptions of a «professional despotism» based upon the social claims of an uncertain medical technology (52). The association of some of the leading medical advocates of VD controls with the more coercive schemes of social engineering advocated by Social Hygienists and Eugenists may have

(51) FLEMING (1986), note 1, p. 60. For the need to introduce controls against «old world degeneracy» see also BRANDT, note 1, p. 97.

(52) Interestingly, FLEMING (1989) [note 1, p. 205] attributes the relative restraint of New Zealand's VD controls in their invasion of individual rights, as compared with those in the U.S.A., to its inheritance of British libertarian notions of justice. In contrast, for CASSELL, (note 1, p. 250) a key factor in explaining the vigour of Canadian controls was the marked absence of any general debate over the respective role of the State and individual rights in sexual matters.

served to fuel public unease still further. Certainly, the increasing association of such controls in Europe with totalitarian regimes served to reinforce a fundamentally liberal approach to the issue in Britain, even during the Second World War and the period of postwar reconstruction. As Davenport-Hines has noted: «Medical people were conscious of the correlation between a nation's form of government and its legislation on social hygiene: the fact that Fascist Italy and Nazi Germany [...] had reintroduced state regulation discredited medical dirigisme in British judgement [...]» (53).

Compulsory measures in the Dominions and Scandinavia were regularly cited in the debate over VD controls in Britain but convincing evidence of their superiority to voluntary procedures was lacking. Scottish health officials in the 1920s could, for example, find little hard Australian evidence to fuel their interwar campaign. Reports on the VD provisions of Western Australia revealed continuing high default rates and widespread evasion of its controls «due to the constraints of public opinion and a lack of adequate facilities for medical diagnosis and treatment». Similarly, in the 1930s, comparative analysis of success rates in Scandinavia and Britain indicated little variance in their ability to contain venereal disease, an influential official enquiry concluding that the success of controls in Denmark and Sweden was less due to compulsion per se than to «the national characteristics and social outlook of the people», especially their greater health consciousness and social discipline, and the «more influential position of the medical profession» (54).

Moreover, the consensus for VD controls in Scotland was often more apparent than real. As Lucy Bland has observed, the evolution of VD policy in twentieth century Britain «clearly demonstrates the absence of a cohesive or unified state strategy», the State's view being «fragmented in its expression at different levels of the State apparatus» and evolving as part of a symbiotic relationship with a range of pressure groups and

(53) DAVENPORT-HINES, note 1, p. 270.

(54) Scottish Record Office, HH 65/115/8, Papers relating to Australian VD provisions, 1922; *Report on Anti-Veneral Measures in certain Scandinavian Countries and Holland*, London, HMSO, 1938, pp. 115-120.

ideologies (55). In particular, the progress and defeat of the Scottish campaign reveals the vital interplay between locally defined community groups and the broader concerns of central government (whether Whitehall or the National Executives of organisations such as the British Medical Association, British Social Hygiene Council, and National Council of Women) in the negotiation of policy options for containing S.T.D.s. To some extent, these tensions reflected a stronger tradition of moral authoritarianism within Scottish local government increasingly at odds with an English government intent on marginalising the State from sexual politics. At another level, they represented a dialogue between local middle-class political and professional interests and the State, in which the priorities of local and regional medical officials and pressure groups were overridden by the concerns of central government over the constitutional, medico-legal, and psephological implications of coercive health controls. Even at the local level however, as elsewhere, (56) there were significant strands of divergence within Scottish professional opinion over VD controls, and the interplay within and between groups such as public health officials, private practitioners, venereologists, social workers and civil servants in the «local state» was crucial in constraining the quest for compulsion.

The Scottish experience therefore suggests that, even within a voluntarist system of provision, the «discourse» shaping medical practice and policy toward S.T.D.s has both reflected and reaffirmed patterns of social and sexual subordination. At the same time, it also confirms that social control theory, in its more reductionist and simplistic form, signally fails to capture the complex institutional and professional relationships involved. Indeed, in its concern with issues of motivation, such an approach may divert attention from the not inconsiderable achievements of public health policy in reducing the ravages of VD in twentieth century society (57). Equally, such an approach tends to underplay the

(55) BLAND, note 1, pp. 193-194.

(56) See, for example, FLEMING (1989), note 1, p. 43; CASSELL, note 1, p. 253.

(57) While acknowledging the controlling aspects of VD administration, some medical historians have also stressed the innovative role of VD regulations in the twentieth century provision of state-funded personal health services. See, for example, CASSELL, note 1, pp. 248-249; EVANS, note 23.

markedly limited success of VD controls and propaganda in regulating the sexual behaviour of the mass of the population, for the story of VD administration in twentieth century Scotland is, as elsewhere, as much a story of sexual «wilfulness» as it is of control. Above all, as in many other countries, the social dimensions of discrimination and control involved in S.T.D. policy in Scotland are seen to be far from clear-cut and deeply imbedded in cultural and sociological factors that remain perhaps the most fruitful but arguably the most intractable field for comparative analysis (58).

(58) In particular, Jean Marie Kehoe and Megan Vaughan have both powerfully demonstrated the value of comparative epistemology in comparing medical «discourses» surrounding VD and their use in the execution of political agenda and the cultural construction of sexuality. See, KEHOE, J. M. *Medical Sexuality and Imperialism: British Medical Discourses Surrounding Venereal Disease in New Zealand and Japan*, Ph.D Thesis, Victoria University, New Zealand, 1992; VAUGHAN, note 1.