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Damage Control

The Untold Story of Venereal Disease in Hamilton

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Damage Control: The Untold Story of Venereal Disease in Hamilton

D. Ann Herring

On 15 January 1914 some of Canada's most distinguished physicians gathered at the Academy of Medicine in Toronto to discuss a very disturbing matter: the spectacular spread of venereal disease. Those who saw the most or feared the worst said it had reached epidemic proportions and they faced a plague; however, because of the general attitude toward VD, this plague, unlike others, was a well-guarded secret. (Cassel 1987:3)

Venereal disease, now known as sexually-transmitted disease, has a long history of association with humanity. Syphilis, in particular, has attracted enormous debate and controversy ever since the fifteenth century when it erupted in epidemic form in Naples, Italy. This controversy continues not only because there are unresolved questions about where and when syphilis emerged (Powell and Cook 2005), but also because shifting attitudes, perceptions and values toward sexuality affect medical practice, social behaviour, public health practices and the experiences of people afflicted with it (Brandt 1987).

This was certainly the case in early twentieth century Canada, the period within which this book is set. The shocking revelation in 1914 that the Canadian Expeditionary Force had the highest level of venereal disease of all the military

units serving in Europe was met with surprise, disgust and fear (Cassel 1987). At the time, venereal disease symbolized corrupt sexuality and was understood to be a sign of moral pollution, filth, and disordered sexual practice (Brandt 1987). How could such a disturbing situation have arisen in Canadian society? What did it signal about the state of morality, personal character, and the social order? Who was to blame for this hidden epidemic: irresponsible individuals or deplorable social conditions? What did the unexpectedly high prevalence of diseases transmitted through sexual behaviour mean for the future of the fledgling country? How could the damage wrought by venereal disease be prevented, controlled and cured?

Damage Control takes up these questions and tells the untold story of how venereal disease, particularly syphilis, was experienced and understood in Hamilton, Ontario from World War I (WWI) to the mid-twentieth century. Written by fourth-year Honours Anthropology students studying infectious disease at McMaster University, this book is the product of a collaborative writing process. The authors brainstormed the subject matter of the book, then conducted in-depth research in archives in Hamilton and beyond to compile a rich set of newspapers, public health reports, images, and statistics which they shared through a university website. They made stimulating suggestions for each others' chapters as the writing progressed from the germ of an idea to a fully-developed discussion. In short, everyone contributed to the entirety of the book in an exemplary demonstration of dedicated teamwork and commitment to the project.

The book begins with Adam Perkovic's discussion of the symptoms of syphilis, its complicated stages of development, effects on the body, and the various ways in which physicians treated sufferers from the fifteenth century to the present (Chapter 2). Mercury and arsenic-based treatments persisted until the discovery of penicillin in the 1940s, illustrating that for much of its history, receiving treatment for syphilis could be as dangerous as the disease itself. Syphilis persists as a global health problem, even though effective testing and treatments exist, simply because they are either not available or too expensive in many parts of the world.

How did syphilis come to the attention of the Canadian public during WWI (Chapter 3)? Lauren Bederski explains how the problem of venereal disease (VD) first surfaced when men underwent medical examinations when they enlisted with the Canadian Expeditionary Force (CEF). By the end of the war,

almost 16 percent of the men in the CEF had been diagnosed with a venereal disease, the result of a combination of military policies for recruiting soldiers with VD, encouraging soldiers on leave overseas to patronize brothels and changes in the treatment of infected soldiers. Courtney Corbeil (Chapter 4) argues that the dangers of battle, and the low life expectancy of soldiers, made venereal disease into a *medical* problem for the military, rather than the grave *moral* problem it had become among civilians back home. Medical lessons learned overseas were translated into public health initiatives in Canada in the aftermath of the war and drew heavily on prevention strategies and treatments developed for soldiers.

In fact, a nation-wide campaign aimed at funding clinics to provide free treatment became a cornerstone in the postwar public health strategy to treat the 15 to 20 percent of Canadian citizens believed to be infected with venereal disease (Chapter 5). Taryn Turik discusses how VD clinics, such as Hamilton General Hospital's basement clinic, reflected class and power relationships. The clinics failed, in large measure, because they became places where people with low incomes were publicly shamed for contracting venereal disease. Their more affluent neighbours could avoid the stigma of VD simply because they could afford to be treated, confidentially, by a private physician.

Marissa Ledger (Chapter 6) examines attitudes toward children who acquired syphilis from their infected mother *in utero* (congenital syphilis). Considered on the one hand to be innocent victims of their parents' immorality, these children were nevertheless feared as a reservoir of infection capable of passing on the affliction and 'feeblemindedness' to successive generations and increasing already worrisome rates of infant mortality. Perceived as threats to the social and economic health of a Canadian society consumed with rebuilding and replacing its wartime losses, these children became prominent targets for the child health and eugenics movements, even though other infections, such as diphtheria, took a larger toll of child mortality.

Indeed, venereal disease came to signify not only the disordered sexuality of individual bodies, but a disordered social body. In Chapter 7, Melissa Yan explores how medical, social, and political authorities – people in power – shaped ideas about 'social hygiene' and how this idea was put to work through public education projects aimed at preventing venereal disease. The powerful social hygiene movement, heavily influenced by Dr. Gordon Bates, argued that the 'sex instinct' in children could only be suppressed if they were taught to be moral

citizens through correct sex education at school, physical exercise, controlled heterosocial spaces, and other prescribed hygiene practices. These ideas filtered into virtually every aspect of life in Canada, and found local expression in the Hamilton Social Hygiene Council. Murray Clayton (Chapter 8) scrutinizes one facet of this educational project: films designed to teach the public about venereal disease and how to prevent it. Ostensibly produced to expose the perils of venereal disease, the content and messages of these films actually reveal more about early twentieth-century views on morality, sexuality, gender and race in Canada and the U.S. than they do about the diseases themselves.

Social hygiene ideas and prevailing attitudes about morality also found their way into Canadian law. As Julilla Paul notes (Chapter 9), popular anxieties about sexual behaviour, gender and mental health ('the feebleminded') had an impact on all levels of government, helping to shape specific pieces of legislation relating to venereal disease. 'Syphilitic' and 'feebleminded' had essentially become conflated into one and the same category of person, and neither was considered to be desirable in the Canadian 'race'. As a result, legislation to control Canadians' ability to marry and have children became a preoccupation, fueled by medical advice, advocates of the social hygiene and eugenics movements, and broader popular opinion.

Alex Rewegan (Chapter 10) examines how prostitutes came to be a locus of stigma and blame as Canadians responded to the perceived venereal disease crisis in the early twentieth century. The image of 'the prostitute' as an immoral, diseased, degrader of men, and enemy of the state was juxtaposed against the image of the ideal, moral, nurturer woman who was nested in the ideal, monogamous family and who would ensure the future health of the Canadian population. By blaming prostitutes for venereal disease, this already despised group became further marginalized while the men who bought their services stayed out of sight.

The churches became actively involved in the discussions around venereal disease, family life and sexuality (Chapter 11). Grace Carruthers delves into the motivations, activities and positions taken by Christian clergy in Hamilton as they sought to relate their religious messages to the moral and social dimensions of the problem. From the social purity movement (which emphasized that living a Christ-like life would prevent the pollution of venereal disease), to handing out pamphlets and hosting speaker series, the churches worked in concert with other

organizations aiming to prevent the 'immoral lives' they believed would lead to venereal disease.

In the final chapter, Dhananjay Tomar reflects on the treatments offered for venereal disease in Hamilton after the discovery that penicillin cures syphilis. Citing statistics for Hamilton for 1950, he notes that arsenic and mercury – both of which are toxic – were used to treat syphilis and gonorrhea seven years after penicillin became available in 1943. He wonders whether the old stigma attached to venereal disease, present in the early twentieth century, influenced some physicians' decisions about how best to treat their patients decades later.

HIV/AIDS tends to dominate discussions of sexually-transmitted diseases today. Still, there are echoes of the concerns expressed by Canadians when syphilis emerged in the early twentieth century: how can we explain why this is happening, what does it say about our society, and what can be done to control the damage?

Acknowledgements

We would not have been able to undertake this project, let alone complete it in three months, without the assistance of many generous people. We extend our thanks to Dr. Petra Rethmann, Chair of the Department of Anthropology, and to the McMaster Anthropology Society for providing the seed money to print the book. Without their financial support and belief in our book project, it never would have come to fruition. Many librarians and archivists generously helped the authors identify and retrieve sources essential for their research. We thank in particular Anne McKeage at the History of Medicine Library at McMaster University; Danielle Charron, Margaret Houghton and the staff at the Hamilton Public Library; the staff at the Educational Archives & Heritage Centre in Hamilton and at the Archives of Ontario; and Kandace Bogaert, PhD candidate in Anthropology, for their unflagging assistance throughout this project. James Clark, Communication Assistant in the Faculty of Social Sciences, took the photograph of the authors shown on the back cover. Media Production Services at McMaster made sure everything was printed properly. Parents, pets and friends provided enormous support throughout the project. This book would not have been possible without each and every one of you. Thank you!

2

The Changing Treatments for Syphilis

Adam Perkovic

A mixture of biniodide of mercury, potassium iodide and syrup of sarsaparilla, called the syphilitic cocktail, became particularly popular. (Rasmussen 1969:184)

'Syphilis' and 'venereal disease' may not be completely unfamiliar terms, but what do they really mean? One of the aims of this chapter is to answer these questions as well as to provide a general understanding of these diseases. My aim is to bring the jargon-filled scientific realm of the medical side of venereal diseases, and of syphilis in particular, into the realm of the familiar. I discuss the effects of these diseases on the body, summarize their history, examine current treatments and explore early medical practices in our very own Hamilton, Ontario in the early twentieth century.

The term 'venereal disease' refers to a group of illnesses that enter the body through either sexual transmission or blood transfusion. The word 'venereal' itself refers to activities involving sexual desire or sexual intercourse in general (Wills 1952:477). It is a word that was more commonly used in earlier time periods and often carried negative associations with promiscuity and premarital sex. Thus, the term 'venereal disease' originally came from the union of the word venereal, implying sexual acts, with the diseases that became associated with this type of behaviour. In the early twentieth century, the term

venereal disease mainly referred to syphilis, gonorrhea, and chanchroid, which were the most prevalent diseases of this kind. This term was abandoned and has been replaced with the term 'sexually transmitted disease' (STD), a medical category that now contains many more diseases (Campbell 1981:1629).

For as long as venereal diseases have existed, investigators have tried to gather and record as much information about them as they could, and to use the information in order to combat them in the most effective way possible (Rasmussen 1969:184). The three forms of venereal disease identified in the early twentieth century were known to produce superficial or visual symptoms on the exterior of the body, such as rashes, warts, lesions, mucous, bumps, and various other forms of presentations. In fact, the symptoms of syphilis, its mode of transmission and effects on the body have been understood for hundreds of years (Cooper 1895:1-2). Not only is syphilis one of the oldest known venereal diseases, it is also very interesting due to the fact that the disease can manifest itself in several ways throughout the body and is capable of changing into different, more complex forms over time.

What We Know About Syphilis

Syphilis has been well understood from as early as the fifteenth century, when a severe epidemic of the disease raged through Europe, beginning around the year 1495 CE. Although this epidemic may not necessarily mark the origin of syphilis, as this is extremely difficult to determine, the fifteenth century represents the first time this disease was recorded as a problem on a massive scale (Cooper 1895:1-2). Following this initial outbreak, potential remedies began to be put into practice, such as the infusion of holy wood, bloodletting, and the application of hen's dung on infected regions. Ultimately, the only treatment that showed any success in dealing with the outbreak of syphilis was the application of mercury, a poisonous heavy metal, to the affected regions of the body. Mercury was mainly praised for its ability to

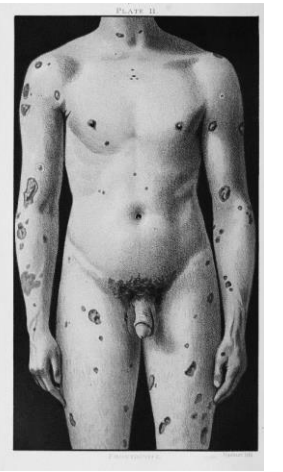


Figure 2.1: Lesions caused by syphilis (Cooper 1895:Plate 11).

show promise in healing open lesions of the disease (Rasmussen 1969:184). Mercury was already being used to treat other skin diseases at the time, and therefore it seemed a natural option to use on the superficial lesions and wounds caused by syphilis. Although mercurial treatments began as ointments that were rubbed into lesions, other methods of application were soon developed that included internal medication, plasters, and even inhalation of mercury vapours (Rasmussen 1969:184-5).

From 1493 to 1905, a 400-year long debate swirled around the use of mercury to treat syphilis. This discussion revolved around the observation that although it seemed effective in curing physical manifestations of the disease on human skin, mercury treatments often caused many negative side effects (Rasmussen 1969:184). Some of these side effects included vaso-motor disturbance (flushing of the face that could lead to vomiting), increases in bodily temperature, severe cerebral symptoms (which could result in death), jaundice, erythema and dermatitis (Harrison 1925). It was not until 1905 that another major discovery was made that revolutionized the understanding and treatment of syphilis.

In 1905, German scientists Fritz Schaudinn and Erich Hoffmann discovered that syphilis was caused by *Treponema pallidum* (or *T. pallidum*), a spirochaete bacterium shaped like a corkscrew. This essentially meant that the source of syphilis was not only concretely determined, but also that doctors and scientists globally would be able to develop methods in order to screen patients for this disease. In 1907, shortly after the discovery of *T. pallidum*, the first blood test for syphilis was invented by scientists August von Wassermann, Albert Neisser, and Carl Bruck. This blood test became known as the Wassermann test, and it allowed for much more rapid diagnoses and subsequent treatments for people suffering from syphilis. Furthermore, another significant discovery was made 1909, when chemotherapy for syphilis was born with the introduction of arsphenamine (arsenic), or compound 606, in addition to mercurial treatment methods already in use (Rasmussen 1969:185). Although irritation, abscesses, or even gangrene were among the negative reactions patients experienced to arsenic treatment, the combined use of arsenic alongside mercury and bismuth became increasingly popular and eventually the norm in the 1920s (Thompson 1920:245-5). Medical textbooks from this time period recommend that other treatment be used in conjunction with these three main curative chemicals on specific areas of

the body, such as the skin, hair and nails, mucous membrane, the tongue, the larynx, nasal mucous membrane, alimentary canal, abdominal organs, arteries and veins, periosteum, bones, joints, cartilages, muscles, sexual organs, eyes, ears, nervous system, and even to treat mental health (often referred to as insanity) (Thompson 1920:xii-xvi).

The most commonly used treatment in the early twentieth century consisted of variations in the administration of mercury, whether through ingestion (with slightly differing dosages and types of mercury), or through other applications to the body by inunctions, plasters, fumigations, hypodermic injection, intravenous injection, or through suppositories (Thompson 1920:217-229). Arsenic was also available in different forms, and each type would have been prescribed according to the needs of the individual (Rasmussen 1969:184-185). Despite the frequent use of both mercury and arsenic solutions that appeared in the 1920s, physicians and medical practitioners were very much aware of the dangers these medicines posed for the body.

The last significant development in the understanding of syphilis and venereal diseases in general did not present itself until 1943. This date marks the confirmation that penicillin was an effective treatment for these diseases (Rasmussen 1969:187-188). Our current understanding and treatment of syphilis has only been refined since then, and the continued use of different forms of penicillin and penicillin-based medicines prevails as some of the most effective

Born on February 21st, 1866 in Bamberg, Bavaria, August von Wassermann is best known for the blood test that shares his name. The Wassermann test, which he created with his collaborators Albert Neisser and Carl Bruck, helped to revolutionize the ability to correctly identify syphilis within an individual. The test was carried out on a blood sample and subsequent reaction, and proved to be one of the most beneficial medical discoveries of the twentieth century. Wassermann was an extremely knowledgeable and experienced practitioner in his field of immunity research and his development of this test is but one of many important discoveries that Wassermann contributed during his scientific career (The British Medical Journal, 1966: 436-437).

Box 2.1: August von Wassermann biographical information and Wassermann test.

forms of treatment today. For more information on penicillin, see Chapter 12.

Syphilis in Hamilton in the early 20th Century

Now that we have established the types of treatment used in the early twentieth century, what can we conclude about their application in Hamilton, Ontario? Certainly medical textbooks that were frequently updated, and whose authors kept a close eye on the evolving circumstances that surrounded syphilis, were available to local physicians. One such textbook, published by L.W. Harrison in 1925, explicitly lists types of treatment, negative effects of treatment, and a discusses the prevalence of syphilis and standards of treatment in the city of Toronto, which is close to Hamilton. It is likely that individuals living in Hamilton during these same years would have been subject to the same types of treatment. Cases of syphilis were diagnosed in Hamilton as early as 1905 to 1906 (City of Hamilton 1906), and records indicate that two individuals died from tertiary syphilis while another died from congenital syphilis during that period. Thenceforth, recorded statistics increase, such that by 1924 there were at least 758 known cases of syphilis across the country, with that number increasing to 1441 cases in 1927 and to 2297 cases by 1930 (Canada, Dominion Bureau of Statistics 1970)

Our Contemporary Understanding of Syphilis

Today, the term ‘venereal disease’ has been discarded and replaced with the term, ‘sexually transmitted disease’ (STD), which now includes many more diseases of this nature than were known in the early twentieth century (Campbell 1981:1629). Syphilis is still understood to be caused by the spirochaete bacterium, *Treponema pallidum* (or *T. pallidum*) which is known to be acquired in adults through sexual transmission or blood transfusion, or in infants as a congenital disease passed from an infected mother. The acquired form of syphilis has two stages: early syphilis and late syphilis, and there are important distinctions between them (WHO 2003:39).

Early syphilis is characterized by primary, secondary and early latent stages. Primary syphilis manifests itself visually as an ulcer or chancre at the site of infection. Secondary syphilis is associated with a skin rash (or condylomatalata, which are wart-like lesions on the genitals or other site of

infection), mucuocutaneus lesions (wounds afflicted with mucous), and generalized lymphadenopathy (abnormal or swollen lymph nodes) (WHO 1995:22). Early latent stages of syphilis and late latent stages of syphilis often may not manifest themselves clinically at all. The early latent stage refers to patients who have had the infection for less than two years' time, and late latent syphilis refers to infections that have existed for over two years. Other forms of late syphilis typically include complications in other regions of the body, namely gummatous (a growth that can form in numerous regions of the body), neurological syphilis and cardiovascular syphilis (WHO 1995:22).

In order to treat syphilis effectively and consistently, the World Health Organization has developed a set of standard guidelines for identifying and treating variations of the disease (WHO 2003:39-40). The current approach to treating syphilis is somewhat similar to older methods, in the sense that they involve consistent rounds of medication. However, since the advent of penicillin-based treatments, medicinal practices involve maintaining a level of penicillin and antimicrobials within the body as opposed to the constant re-application of combinations of mercury and arsenic. Generally, a penicillin level of over 0.018 mg per of litre of blood within the body is considered efficient to kill the spirochaetes, and this level needs to be maintained within the patient for at least 7 to 10 days in forms of early syphilis, and longer in late forms. (WHO 2003:39-40). In dealing with forms of late syphilis, the World Health Organization recommends a different penicillin-based medication, namely benzathine benzylpenicillin, at a dose of 2.4 million units, administered for up to a three-week period of treatment (WHO 2003:43-44).

One of the issues that has always faced physicians treating patients with syphilis is that there are many forms of the disease and, as much as treatments have improved immensely over the harmful and aggressive mercurial and arsenical treatments used in the first half of the twentieth century, each individual's situation must be taken into account (WHO 1995:19-21).

Final Thoughts

Venereal disease, and syphilis in particular, is an example of a disease that has had a high level of awareness among the general populace, as well as a significant social impact. Over time, both the methods of treatment and public perceptions of

syphilis have changed drastically, and despite the effective treatment now available through the discovery of penicillin, syphilis is still a disease worthy of our attention as it has managed to survive for hundreds of years.

3

Fit to Fight: Venereal Disease during World War I

Lauren Bederski

Canadians had their share of infamous accomplishments. The most notorious of these was the record level of VD in the Canadian Expeditionary Force (CEF). It was the highest among the troops in the western European theatre. (Cassel 1987:122)

The First World War (WWI) brought about a great deal of social, political and cultural change, not only within Canada but on a global scale. World War 1 inevitably played a pivotal role in both the health care and public health movement, particularly in regards to venereal disease. Soldiers enlisting in the war effort were effectively immunized for several infectious diseases, such as smallpox (Center for Disease Control and Prevention 2002), however there were countless unanticipated cases of syphilis among soldiers within the Canadian Expeditionary Forces (CEF), which had the highest reported rates of venereal disease among all of the commonwealth forces fighting for the British Empire (MacDougall 1994).

This chapter examines the impact of venereal disease throughout the years of WW1 (1914-1918), and seeks to portray how social and cultural perspectives regarding syphilis, among other venereal diseases, changed due to the events of the war. I explore how larger trends in venereal disease are reflected at the local

level by scrutinizing primary military and medical records for Hamilton soldiers who enlisted as part of the CEF. This project involved research into the records of venereal cases among soldiers within the CEF at the national level, followed by a cross comparison of attestation papers and hospital records specific to soldiers from Hamilton. The records for Hamilton soldiers showed similar trends to those found for the entire CEF.

Fit to Enlist

When Britain first joined World War 1 and declared war on Germany in August of 1914, Canada, as a subservient colony of Britain, fulfilled its obligation to join the war as well. The war was expected to end by Christmas of 1914, and as thousands of Canadian men signed up, the definition of who was 'fit to fight' depicted the image of a young, athletic, healthy Canadian man (Ciment 2007).

Recruiting for the Canadian Expeditionary Force began in Hamilton on 7 August 1914 and eligible soldiers rushed to enlist with the 13th battalion, a previously existing militia in Hamilton that contained several hundred men (Greenhouse 1977). Many eager men were rejected for reasons of 'physical defect'. Often these defects were not serious, such as the need to wear glasses; however, at the onset of the war, venereal disease was included among these suggested defects (Greenhouse 1977). In other words, individuals volunteering to enlist in the CEF who exhibited symptoms of syphilis, or another type of venereal disease, were not considered 'fit' for the military and were turned down for overseas service.

When the war lasted much longer than originally anticipated, however, and as time progressed, the CEF became desperate for volunteers. Beginning in the late 1915s, and progressively so until the end of the war in 1918, more and more men who volunteered were considered fit for duty overseas, no matter the condition or severity of any 'defect' they may have possessed at the time of enlistment. As a result, more men who were already infected with a venereal disease were also permitted to enlist.

Soldiers were required to undergo a physical examination before enlistment. For men from both rural and urban settings, this was often the first time they had received a medical assessment because examinations by physicians in hospitals and clinics were not yet common (Cassel 1987). These medical

examinations revealed the prevalence of venereal disease in Hamilton, as well as across Canada. This discovery resulted in growing fear of a venereal disease pandemic, which inevitably generated a significant public health movement to deal with the situation.

There were 418,052 men registered in the CEF across the entirety of the war. By the end of the first year of the war in 1915, it was reported that 30,000 men were infected with venereal disease. By the end of the war, this number had grown to a final report of 66,083 cases, and 18,612 of them were known to be syphilis (Cassel 1987). During the First World War 5420 officers and men from Hamilton had enlisted and fought with the CEF, and it is suggested that some 15%, or approximately 813 of those men, were infected with a venereal disease (Greenhouse 1977).

"Do not wait until it is too late. If you want to be in this big adventure – Join Now. If you want to share it with Hamilton's best – Join Now. If you would be a man among men; if you would carry your head erect and meet unflinchingly the gaze of your fellows – Join Now." (The Hamilton Herald 1916)

Figure 3.1: Picture of the recruitment poster for the 120th City of Hamilton Battalion.

Although the prevalence of venereal disease in Hamilton was first noticed at the time of enlistment and initial medical examinations, the more detrimental impact and progression of the spread of infection among Hamilton soldiers occurred when the soldiers of the CEF arrived overseas to begin their training procedures in England (Cameron 1938).

According to Greenhouse (1977), Hamilton played a significant role in the events of World War I. The city of Hamilton was a site of aerial and weapons training, provided over $1.2 million in war bonds, and proved to have the highest recorded number of enlistments across Canada. Within the first few years of World War I, over 10,000 Hamilton men, approximately 10% of the population at the time, had enlisted to fight overseas for the British Empire.

Several battalions were established in Hamilton during WW1, including the 205th (Tiger) Battalion, also referred to by locals as the Sportsman's Battalion. This battalion consisted of notable Hamilton athletes, including Olympic medalist Robert Kerr, and George Malcom Ireland, a member of the 1915 Grey Cup Team.

More significantly, the 120th City of Hamilton Battalion was the first battalion in the British Empire to be named after its host city. Posters of the 120th Battalion (see Figure 3.1) were used increasingly as newspaper advertisements and public posters to entice Hamilton men to enlist (The Hamilton Herald 1916). The battalion offered the prospect to fight along Hamilton's finest and the chance for adventure.

Box 3.1: Hamilton in World War I

An Outbreak on the Front

Canadian men of the CEF were sent to Salisbury Plain in England for intense and detailed training prior to facing battle on the Western front. Within the first four months of the war, 1249 men from the CEF were diagnosed with a venereal disease; by the end of the war over 15.8% of the entire CEF had been infected. This was six times the rates of venereal cases among British soldiers at the time (Cook 2007).

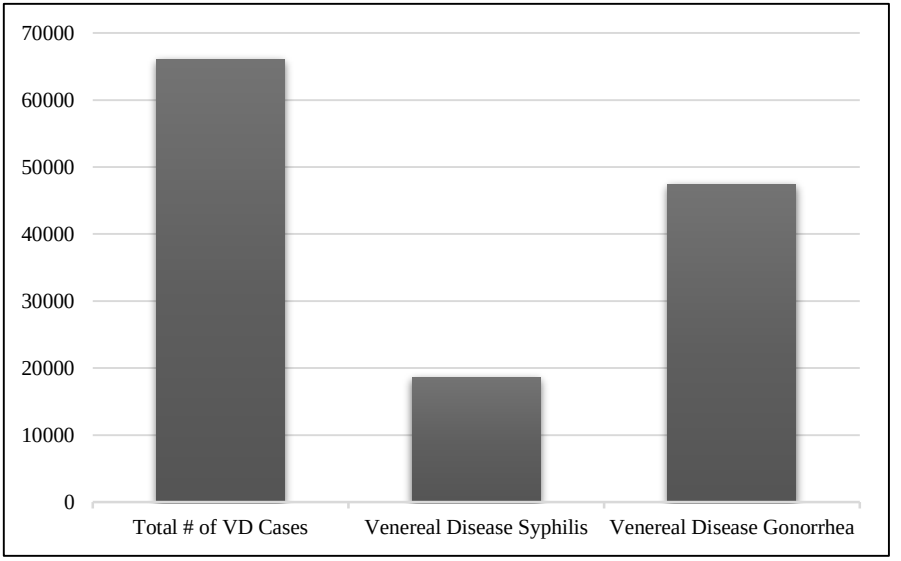


Figure 3.2: Total number of venereal disease cases among the Canadian Expeditionary Forces during the First World War, 1914-1918.

Military officials believed soldiers were contracting VD from local women and notorious prostitutes in the area. During leave from training and field combat, men were granted day passes to venture out for leisure activities to London, England or Edinburgh, Scotland, as well as to numerous towns and villages throughout France (Cameron 1938). CEF officials did not anticipate the overwhelming amount of leisure time spent with prostitutes and women of the area. Soldiers of the British colonies, including Canada and Australia, were paid more daily allowance than British soldiers, which also contributed to the attraction of local prostitutes to the men of the CEF. Furthermore, Britain did not regulate prostitution as the French did (Cassel 1987).

When men first arrived overseas in 1914 and 1915, moreover, the idea of finding solace in local brothels was not only accepted but encouraged as a way to maintain the health of the men. Married men in particular were encouraged to visit brothels as it was thought that it was important for their overall physical health to maintain a regular sex life as they might have had back home with their wives. Brothels in France were oriented to the rank of the officer, 'Blue light' districts were considered more prestigious and were reserved only for those of a much higher rank within the CEF, while 'Red light' districts allowed all men. It was assumed by the CEF that if a man contracted venereal disease through recreational time, the condition would be disclosed to the military medical officers upon the soldier's return from leave (Cassel 1987). However, this was not the case, and men who had contracted venereal diseases were less than willing to disclose this information for fear of judgement, loss of pay, and the medical notice of venereal disease sent to their wives back home.

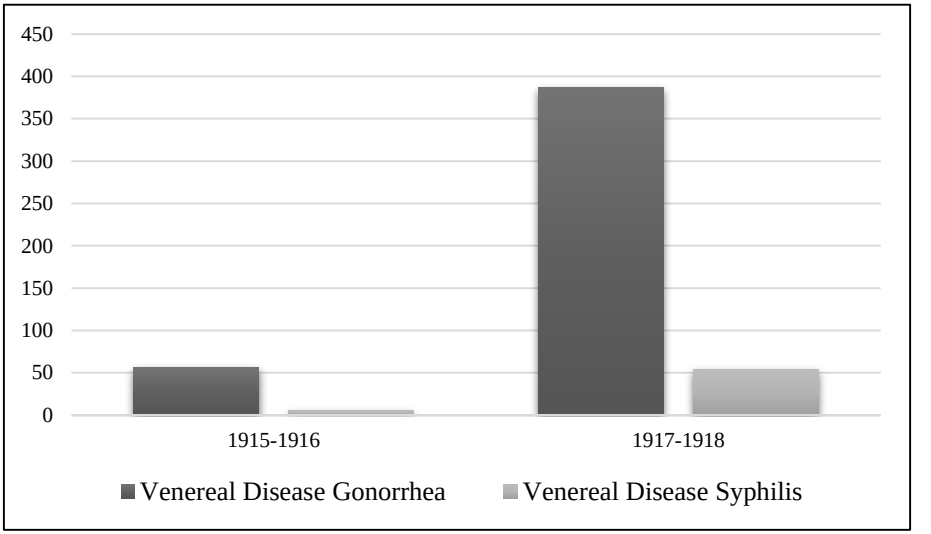


Figure 3.3: Number of cases of Venereal Disease among Hamilton soldiers in the Canadian Expeditionary Forces (Military Hospital, Hamilton ONT, MD2 Book No. 112, 1916).

At the beginning of the war, the military hospital in Shorncliffe, England had reserved 250 beds for venereal cases; by 1916 that number had risen to 1000 and still could not contain the number of venereal cases being admitted (Cassel 1987). It was at this point that the medical war effort was stepped up in an attempt to deter and cure venereal disease among the soldiers.

Controlling the Spread

As World War I continued far beyond 1914, new trends in the medical conditions of soldiers fighting in the CEF began to emerge. Until 1916, men known to be positive for syphilis or gonorrhea were discharged immediately and admitted into military hospitals for medical assistance (MacPhail 1925). The hospital stay for an admitted case of venereal disease often lasted between 20 and 30 days, and this meant the soldier received no pay for the duration of his hospitalization (Cameron 1938). By the end of 1915, it was discovered that VD has become an epidemic of sorts and an overwhelming number of cases became known to the military hospitals, at which point regulations within the CEF began to change for soldiers.

By 1916, weekly physical exams were performed on the men's genitals, as well as upon return from leave. Any soldier found to have venereal disease was forced to reveal the source of their disease, and that woman was then deported from the area, and often restrained or criminally charged (MacPhail 1925). This was the first time active measures were taken to prevent the spread of venereal disease among soldiers, and the CEF continued to increase regulations and educational awareness among the men. An activity once condoned as good for the physical health of the soldiers was now not only frowned upon, but disallowed altogether. Graphic lectures and medical pamphlets were used to discourage the men from venturing to brothels or taking up company with prostitutes on the street. At this time, punishment for testing positive for venereal disease meant loss of recreational leave and more pay was lost than during a hospital stay (Canadian Medical Week 1918). Finally, by 1917 and 1918 Canadian war efforts had established several hospitals overseas, including Etchinghill, Witley and Bramshott, England. These hospitals were strictly designated to treat venereal disease and each contained hundreds of beds (Ciment 2007).

Your Country Needs You

As the war carried on and the number of casualties rose, the British forces became desperate for men and the CEF attempted to recruit as many potential volunteers from Canada as possible. The desperate need for soldiers also contributed to a change in the ideal image of a 'fit' soldier for the CEF. As discussed previously, during the early years of the war not only were few volunteers accepted, but men were turned away for minor 'physical defects', including venereal disease. Attestation papers from the CEF from 1916 to 1918 include a "fit" approval even for those soldiers know to be positive for venereal disease (Greenhouse 1977). Furthermore, there were changes to the length of stay for men with venereal disease admitted to military hospitals. Between the years of 1914 and 1916 they stayed a length of 20 to 30 days or until they were deemed cured (Cameron 1938), if they were admitted at all, because prior to 1915 all cases of venereal disease were either evacuated or discharged from duty (MacPhail 1925). By 1917 and 1918, cases of venereal disease were admitted and discharged within a day, with soldiers staying in hospital for a week at the longest. Reasons for discharge changed from "cured-fit for duty" in the early years to "recovering" (Barriefield Park Barracks Hospital 1918-1919). Cases of syphilis were taken very seriously and at times were treated similarly to a war crime, as these individuals were deemed to have a 'self-inflicted' wound. They were judged to be avoiding active duty and, furthermore, to be using funds and medical support that could better go towards soldiers suffering more serious battle injuries and disabilities (MacPhail 1925).

Returning Home to Hamilton

World War I was a pivotal time for the public health movement aimed at controlling venereal disease. The war effort made it necessary to conduct medical examinations on enlisting soldiers to determine their fitness to fight, which unmasked the previously unknown prevalence of venereal. The number of cases of VD only increased during the war along with the inevitable travel of men to the theatre of war. In 1916, rates of venereal disease began to rise dramatically among soldiers from Hamilton and in the Canadian Expeditionary Forces in general, and were highest in 1917 and 1918. Many factors contributed to this rise,

including the decision to accept men with VD into the CEF, coupled with periods of leave during which solders were encouraged to patronize brothels.

The events of World War I contributed to the rise in venereal disease, but it was not until the war ended in 1918, and the men returned home, that public health initiatives emerged to control it in Hamilton. That said, as the number of cases of VD became exceedingly alarming, so did the realities of the war, in terms of overall casualties, injury, and more detrimental cases of disease. Approximately 10% of the CEF -- more than 50,000 soldiers -- died during the war (The Canadian Encyclopedia 2006), which places the concerns about VD in sobering context.

4

Treatment of Venereal Disease and Knowledge Translation in World War I

Courtney Adele Corbeil

...military physicians and government officials were caught between their obligation to protect the public health and their duty to sustain the war effort. (Humphries 2012:21)

This chapter focuses on the medical treatment offered to soldiers with venereal disease in Europe during World War I (WWI). As the prevalence of venereal disease grew among them, treatments had to be developed to ensure their swift and successful recovery to prevent the loss of able-bodied men from the war effort. I discuss the treatments soldiers received, and how these treatments changed over time, in addition to the success rates of these treatments.

I also explore the punishments for venereal disease meted out by military officials to enforce 'moral standards' among the soldiers. Essentially, I ask whether the need for soldiers to fight the war outweighed and, in effect, broke down conventional morality regarding venereal disease and sexuality (Farmer 2003:146; Salazar 2006). Finally, this chapter asks whether treatments developed for soldiers during the war were translated into medical practice on the home front after the war ended.

Treatment of Soldiers

During World War I there were 66,083 recorded cases of VD among Canadian soldiers. This does not include soldiers whose condition was undiagnosed and who, as a result, did not receive some kind of treatment. This under-reporting of cases stems from the fact that soldiers in the Canadian army sought treatment for venereal disease on a voluntary basis (MacPhail 1925:285-287).

Until the end of 1915, soldiers with venereal disease were sent home, not treated (MacPhail 1925:284). This practice could not be continued, however, as men were needed to sustain the war effort. As a result, in 1916 a specialty hospital dealing specifically with venereal disease opened and another was added in 1917 (MacPhail 1925:214). Ablution chambers were set up in barracks in which men could be 'disinfected' with potassium permanganate and calomel ointment (MacPhearson 1923:125). This practice changed in 1918 as the prevalence of soldiers with VD increased; thereafter, tablets and ointments could be requested by soldiers for personal use (MacPhearson 1923:126). It was hoped that more soldiers would take responsibility for their personal hygiene after possible contact with venereal diseases.

Figure 4.1: American soldiers entering an ablution chamber (Davison 1919).

Infected soldiers could also be disinfected by skilled attendants. This involved a process in which the soldier was first washed with soap and water, then with mercury perchloride (MacPhearson 1923:127). Mercury was a common treatment for VD due to its known toxicity. Although the negative side effects were well known, it was believed it was more important to ensure the patient was cured of VD than to worry about these effects (Hayden 1901). Once thoroughly cleaned, an injection of argyrols or protosil was

given in the urethra and a health care professional would thoroughly wash the genital area with calomel ointment to sooth any irritation (MacPhearson 1923:127). (For more information on medical treatments offered at this time, see Chapter 12). Both doctors and soldiers felt that disinfection by a skilled professional was extremely successful in stopping the progression of venereal disease.

A preventative Depot was instituted in Havre, France due to the large number of cases contracted there. After returning from leave, each man would be questioned regarding any possible exposure to venereal infection. If he replied in the affirmative, he would be advised to undergo preventative treatment and be disinfected by a professional. During six months of preventative treatment at Havre (Table 4.1), none of the 5,153 soldiers who underwent this disinfecting process contracted the infection (MacPhearson 1923:129). It is possible that symptoms did not developed until they had arrived at another station; however, on the surface, these statistics suggest the treatment was successful.

Date	Number of men passing through Canadian Base and Permanent Staff	Number of Treatments taken by Officers and Men	Number of Men who developed VD after being disinfected by a skilled attendant	Total Number of Men admitted to hospital with VD from Depot	Number of known Cases of VD of Men failing to report for treatment
Nov 1916	13, 959	155	0	119	9
Dec 1916	13, 113	476	0	101	5
Jan 1917	5, 113	542	0	83	8
Feb 1917	6, 304	853	0	83	6
March 1917	7, 204	1, 492	0	69	12
April 1917	11, 573	1, 635	0	72	9
	57, 266	5, 153	0	527	49

Table 4.1: Disinfection by a skilled professional records from Canadian Base Depot, Havre (MacPhearson 1923:129).

Full treatment involved a series of shots that contained mercury (MacPhail 1925:285). Soldiers would often be discharged from the hospital and put to work

before they were healed, especially men who did not exhibit severe symptoms and did not feel ill. Arrangements were made to ensure they continued their treatment while working (MacPhearson 1923:136). Many doctors felt they were caught between providing sufficient health care to soldiers and sustaining the war effort (Humphries 2012:21). This is an example of one of the compromises doctors had to make to ensure the war had enough men, while also ensuring that infected soldiers were properly treated.

It was extremely difficult to measure the effects these treatments had on the progress of disease. This is because it was not possible to conduct follow up blood tests on the majority of soldiers. Consequently, the results of treatment could only be determined by observing relapses (MacPhearson 1923:148). In one study of 371 soldiers who had regularly been treated for syphilis with mercury, 151 of them had been readmitted once, 115 twice and 49 three times during the first year after they had been discharged. This means that in one year alone 899 admissions for syphilis occurred among only 351 soldiers (MacPhearson 1923: 149). This study does suggests that relapses were common and that the available treatments were not particularly effective.

By the end of 1917, education was believed to be the best form of preventative treatment. Pamphlets and lectures were given to soldiers (MacPhail 1925:288). They also received a lecture from doctors and other health care personnel upon arrival at their camp, then every 6 weeks at the battlefront, and every week in convalescent depots (MacPhearson 1923:123).

Paul Farmer draws attention to the barriers to health care that result from social inequality and the lack of human rights (Farmer 2003: 29-30). During WWI, however, it is clear that any soldier, regardless of military rank, could receive treatment at any time. While people of lower socio-economic standing often do not have access to adequate healthcare, it is clear that sustaining the war effort was so important that equal health care was available for all soldiers.

Punishments/Moral Beliefs

By the end of 1915, soldiers who contracted venereal disease were no longer sent home because of the need to sustain the war effort. Instead, soldiers were treated in specialty hospitals on the military bases and were admitted with a diagnosis of ‘self inflicted wound’ (MacPhail 1925:274). This diagnosis meant they were not

eligible for privileges given to other sick soldiers, such as wages, while they were being treated (MacPhearson 1923:123). Not only was this a way to punish the soldier and save the military money, withholding wages was also a way to inhibit soldiers from having enough money after treatment to continue the activities that led them to contract venereal disease in the first place. Sales of alcohol were also restricted to the hours of 1 to 3pm and 6 to 9pm. Restricting alcohol availability was believed to inhibit bad behavior; however, this proved to be an extremely difficult rule to implement and maintain (MacPhearson1923:122).

It was believed that the poverty and chastity associated with war lead to temptation among soldiers on leave in large cities (MacPhail 1925:284). Due to the uncertainty and dangers of war, in fact, acts that under other circumstances were considered to be immoral, such as visiting brothels, were understood and accepted, and even condoned in some instances (Daily Mail 2011). Beardsley describes prostitution during the war as "something between a necessary evil and a vital auxiliary service" (Beardsley 1976:190). This is because during the most violent phases of the First World War a junior officer had, on average, just six weeks to live (Daily Mail 2011). As a result, venereal disease among soldiers was not seen so much as a moral issue as a medical one.

Knowledge Translation

To what extent were treatment practices transferred from the battlefront to the home front? At the end of the First World War it was estimated that 15 to 20 per cent of Canadians were infected with syphilis or gonorrhea (Mawani 2006:150). Something had to be done to address such numbers and, as was the case during the war, specialized clinics were believed to be the best course of action.

In 1919, the Dominion Department of Health in Canada was established, which included a section specializing in venereal disease (Cassel 1987:168). The Dominion Department of Health in Canada was essential to this effort and gave grants to various provinces to create VD clinics (Cassel 1987:168). The first venereal disease clinic in Hamilton was built in 1920. Dr. Roberts, who made this decision, put Agnes Haygarth (RN) in charge of the new VD clinic. Nurse Haygarth was extremely experienced and was judged to be the best fit for the job due to her familiarity with VD from her work as a nurse overseas during the war (Ancestry.ca 1914). Therefore, not only were medical practices transferred from

the battle to the homefront, but the personnel who treated these diseases overseas were also transferred to continue their work back home.

As was the case during the war, one can also see that public health initiatives began to rely heavily on preventing venereal disease. Public health materials used on the battlefront, such as pamphlets, poster campaigns and lectures, began to be used more prominently as prevention mechanisms back home (Bates 1922:63). Therefore, although the war increased the prevalence of venereal disease at home, at the same time, it also led to a transformation of local healing practices.

Agnes Haygarth is known as a pioneer in public health nursing throughout Ontario, Canada. Haygarth was a nurse on the battlefront during WW1; however, her greatest achievements can be linked to her role as the Director of Public Health Nursing in the City of Hamilton from 1933-1956. She was the first director under this Public Health System and organized the department. Mrs. Haygarth was especially interested in maternal and child health and, as a result, many of her projects dealt with these groups. She was also a founder of the Women's Auxiliary to the Department of Health, a volunteer organization that lasted for 40 years and provided necessities for babies and assisted staff at large pre-natal clinics.

Box 4.1 Agnes Haygarth (Hamilton Spectator 1980).

In addition, Nurse Haygarth suggests that the war also changed public perceptions of venereal disease. She explains that VD was once discussed in 'hushed' tones and was considered to be different from other diseases because of the moral implications associated with its sexual mode of transmission. Following the war, however, she notes, "Today the venereal diseases go with the other diseases to make up the whole public health problem" (Haygarth 1920:228). This new concept placed VD under the umbrella of public health, eliminating much of the secrecy behind venereal disease and allowing clinics to be established where everyone could receive treatment, rather than rely on costly home visits (Haygarth 1920). Therefore, not only did the war have an effect on the way venereal disease was treated and prevented, but also on the social stigma attached to it.

This program did not last long. By end of the 1920s, as a result of the Great Depression, many VD efforts had been halted and were not picked up again until WWII, due to the loss of government funding (Canada's Public Health Association n.d.).

5

Private Diseases and Public Shame: The Role of Venereal Disease Clinics

Taryn Turik

While great numbers of people were treated in these public clinics, many Canadians – especially the wealthy – continued to seek treatment from private physicians (...) clinics were beset by a number of problems including overcrowding, inadequate facilities, and lack of expertise. (Mawani 2006:150)

In the early 1920s, the provinces of Canada began to help fund venereal disease clinics in populated cities (Archives of Ontario 1919). This chapter discusses the role of these clinics during the 1920s and 1930s in the treatment and prevention of venereal diseases.

Providing free medical treatment to those afflicted with syphilis and gonorrhea was one of the government's main strategies for eradicating venereal disease (Cassel 1987:177). However these clinics were plagued by several problems that reduced their efficacy. By examining the political and economic factors that affected venereal disease clinics it is possible to appreciate the larger social context in which the disease was understood and why the clinics failed to attract people needing treatment. This chapter discusses the federal government's involvement in establishing and maintaining clinics through grants and how this

system of funding affected the level of public health received in these clinics. It also considers how the treatment process discouraged people from returning for treatment. In addition, since the clinics provided free treatment, a person's economic class became a determining factor in who attended them. Finally, by focusing on the 'basement clinic' set up in 1920 in Hamilton's General Hospital it is clear that the majority of people attending local clinics had no other choice but to seek treatment there. Overall, this chapter argues that venereal disease clinics were seen as places of public shame and that only the people who could afford to visit private physicians avoided the embarrassment.

Diminishing Government Grants

After World War I, the extent of civilian Canadians infected with venereal disease was estimated to be approximately 15 to 20 percent (Mawani 2006:150). Medical treatment thus became a serious concern and nation-wide campaigns to control venereal disease were implemented with the help of the Dominion Department of Health (Box 5.1). Furthermore, a major strategy of these campaigns involved establishing free venereal disease clinics across the country. To this end the Dominion Department of Health began to provide grants for the prevention and control of venereal disease to the provinces (The Globe and Mail 1920a).

In 1919 the federal government allotted $200,000 for venereal disease control across the country (The Globe and Mail 1920a). This money was to be divided among the provinces based on the percentage of the total population of Canada they contained (Archives of Ontario 1919). However, to actually receive the money, each provincial legislature had to match the amount of money received and the provincial programs being funded had to meet certain requirements. These requirements included offering free treatment in hospitals, clinics and to those incarcerated in provincial institutions as well as maintaining diagnostic laboratories and a specialist in charge of a provincial venereal disease division (Cassel 1987:169). As the provision of free treatment was required to receive the grants, this money was primarily used by the provinces to set up and maintain free venereal disease clinics (Archives of Ontario 1919). Therefore, it can be seen that the existence of these clinics in Canada and their ability to function were both inextricably linked to these grants throughout the 1920s.

The Dominion Department of Health was established in Canada in 1919 mainly in response to the need for nation-wide medical strategies (Cassel 1987:168). These issues were discussed at biannual meetings of the Dominion Council of Health where the joint federal-provincial council made decisions about the extent of federal involvement in the future of these problems (Archives of Ontario 1919). Major concerns at the time consisted of medical inspection of immigrants, quarantine, food inspection, tuberculosis, infant mortality and venereal disease (Cassel 1987:168).

In fact, the need for a coordinated campaign to control venereal disease on a national level in addition to the failure of the medical system to deal with the 1918 influenza pandemic are a couple of the main factors that led to the creation of this federal department of health. According to Cassel (1987:168-169) it was believed that a federal department could help with the venereal disease problem in three ways: financially by giving grants, scientifically by implementing standards, and politically by standardizing legislation. Therefore, when the Dominion Department of Health was created, one of its ten divisions was devoted to the control of venereal disease.

Box 5.1: Dominion Department of Health

However, these federal grants decreased as time went on (Table 5.1). The annual venereal disease grant remained $200,000 for the first five years, but at the end of 1923 the focus shifted to reducing government expenditures and providing a balanced budget (Cassel 1987:194). Due to the strong case made by the Dominion Council of Health, the full grant was continued into 1924 (Archives of Ontario 1923). But this was a short-lived success as the grant was reduced to $150,000 the next year despite a lobby organized by Gordon Bates (Archives of Ontario 1924). The annual grant continued to go down from that point on. In 1925 it was decreased to $125,000 and in 1927 it was only $100,000 (Archives of Ontario 1925, 1927). Finally, the grant ceased completely in 1931 (Cassel 1992:153).

By examining the fiscal origin of the clinics and the decreasing annual funds, it is evident that many of the problems associated with venereal disease clinics in the 1920s and 1930s occurred because of limited resources. Maintaining

free clinics with ever-decreasing funds often led to problems such as "overcrowding, insufficient facilities and a lack of expertise" (Mawani 2006:150). With less money fewer clinics could be set up. It was harder to afford the drugs for treatment and the personnel who administered them. The problem was compounded by the fact that free clinics had no other funding sources.

Fiscal Year	Total Federal Grant	Ontario's Share
1919-20	$200,000	$28,736.84
1920-21	$200,000	$57,473.68
1921-22	$200,000	$57,473.68
1922-23	$200,000	$57,473.68
1923-24	$200,000	$60,171.83
1924-25	$150,000	$45,128.86
1925-26	$125,000	$38,443.12
1926-27	$125,000	$38,443.12
1927-28	$100,000	$32,425.93
1928-29	$100,000	$32.425.93
1929-30	$100,000	$32,425.93
1930-31	$100,000	$32,425.93
1931-32	$0	$0

Table 5.1: Amount of federal grant for venereal disease control and Ontario's share for each fiscal year from 1919 to 1931 (Cassel 1987:Appendix D).

Treatment: An Unusual and Unpleasant Procedure

In the 1920s and 1930s, the treatment for syphilis and gonorrhea was long and uncomfortable (see Chapter 2). The drugs used in treatment caused discomfort, irritation and nausea and the regular and necessary examination of the genitals would have been embarrassing for patients. In general, clinics were designed to be functional and not to put people at ease (Cassel 1987:186). The majority of clinics across the country had fairly open designs and many did not even have screens to separate patients (Cassel 1987:182). Therefore, patients had little to no privacy inside a venereal disease clinic and being treated in full view of others while seeing and hearing the reactions of other patients would have added greatly to the discomfort of the treatments (Cassel 1987:182).

Making matters worse, the recommended treatment for syphilis included sixty or more weekly clinic visits. More often than not, people would stop coming back after one or two visits once their symptoms faded instead of following through with the entire treatment regimen (Fee 1988:125). It was very difficult to get people to attend regularly for such a long and degrading treatment process. Women in particular found the experience of being treated for gonorrhea hard to face, which led to fewer women being treated than men (Cassel 1987:186). Since people disappeared before they were technically cured the clinics were not nearly as effective as they could have been.

Follow up protocols were introduced at the end of the 1920s in an effort to increase the number of patients who were cured (City of Hamilton 1930b). In Hamilton, public health nurses started to make visits to "Delinquents from Clinics" to remind people to return for treatment (City of Hamilton 1930b). The number of people successfully treated and released with permission did increase into the 1930s, though many were still using false names to hide their identity which made such follow-up visits impossible (Cassel 1987:186).

Social Inequalities and Public Shame

Considering how unpleasant venereal disease clinics could be one wonders about those unfortunate enough to attend these clinics and how they found themselves there. In general, only people who could not afford medical treatment were forced to expose their private disease to public shame (Fee 1988:124). In other words, only people of low social standing or those who were forced to go by law actually attended venereal disease clinics in the 1920s and 1930s.

As the disease was so inextricably linked with shame, most people chose to seek the more discreet treatment of family physicians (Cassel 1992:160). In Canada, diagnosis and drugs for treatment were supplied free of charge as long as the patient turned to a recognized source of medical care (Cassel 1987:177). As such, the medications were free whether one went to a hospital, a clinic or to a private physician. However, private physicians charged a fee for their services whereas care at a clinic was free (Cassel 1987:178). Considering the number of visits required to be cured, visiting a private physician was very costly regardless of the fact that the drugs were free. Therefore only those who were too poor to afford a private solution to their problem ended up at the public clinics.

This led to an increase in the stigma attached to venereal disease as it came to be seen as a lower class problem (Fee 1988:125). Elizabeth Fee (1988:126), who examined public clinics in Baltimore in the 1920s, postulates that due to the large number of poor African American residents seeking treatment, venereal disease came to be seen as a "Black disease." The differences in health care options for the wealthy and the poor led to an increase in stigma and even to racial framing of the disease. In this way, clinics became places where people of few means were publically shamed for their disease while those of the middle and upper classes were able to treat themselves privately.

A Case Study of Hamilton's Basement Clinic

Now that the larger context of clinics has been examined, this chapter turns to consider the clinic established in 1920 in the basement of Hamilton's General Hospital/City Hospital (Figure 5.1) (City of Hamilton 1930a).

Figure 5.1: Hamilton General Hospital/City Hospital 1910 (Vintage Postcards of Hamilton 2014).

Before discussing the ways in which Hamilton's clinic failed, it is first necessary to know how many people were actually being treated there. By examining Figures 5.2 and 5.3, it is possible to see the number of cases recorded by the clinic each year from 1921 to 1935. The number of syphilis cases ranged from a low of 168 in 1922 to a high of 647 in 1935, while the number of gonorrhea cases ranged from a low of 127 in 1927 to a high of 329 in 1931. Overall, there is a general increase in cases of both diseases treated at clinics over the years, with a slight decrease around the years 1926-1927.

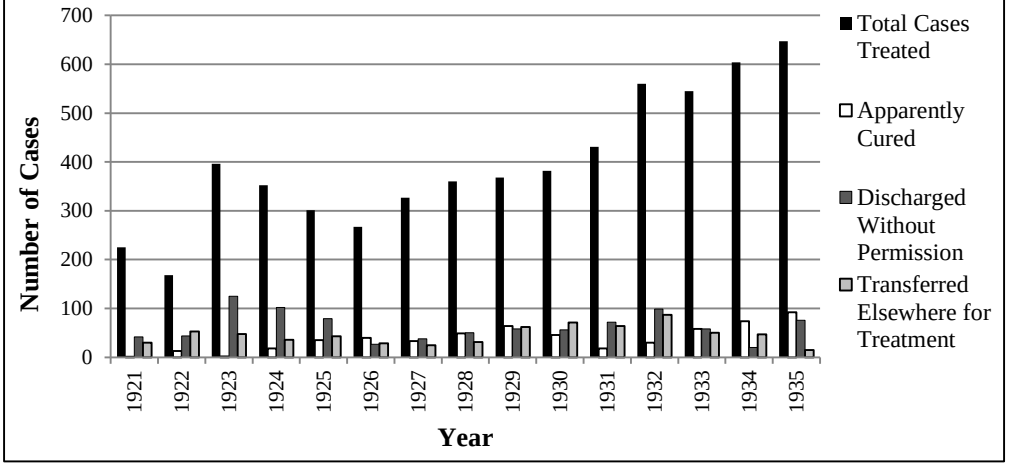


Figure 5.2: Number of cases of syphilis treated and discharged at the Hamilton venereal disease clinic (City of Hamilton 1921-1935)

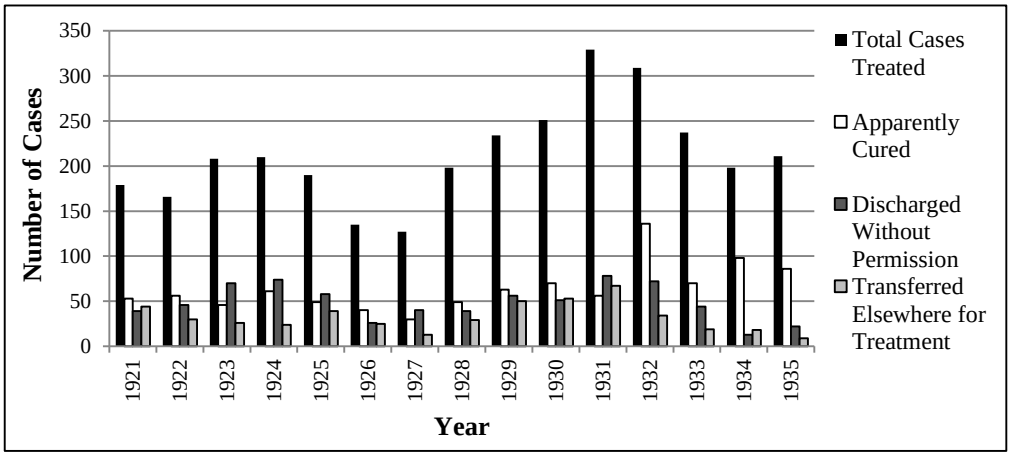


Figure 5.3: Number of cases of gonorrhea treated and discharged at the Hamilton venereal disease clinic (City of Hamilton 1921-1935).

These figures also demonstrate some of the failings of the clinic. Figure 5.2 shows that the number of patients who were successfully treated for syphilis

and released was almost always lower than the number who left without permission (though it does become the opposite by the middle of the 1930s). For example, in 1923, 125 people were discharged without permission while only 2 were apparently cured. To be considered 'apparently cured' it was necessary to undergo full treatment and then return at four-month intervals for a year for follow-up tests (Cassel 1987:186). Since returning for treatment for such a long time was exceptionally unappealing to most people, being 'discharged without permission' by not fulfilling the entire treatment would have seemed much easier.

Figures 5.2 and 5.3 also indicate that the total number of cases of syphilis and gonorrhea was always much greater than the number of people apparently cured. For example, in 1935, the year with the most syphilis cases cured (92), there were still 555 people who came to the clinic and were not. In 1932, the year with the most gonorrhea cases cured (136), there were still 173 people who were not. Overall, these two graphs demonstrate how ineffective the clinic was at curing venereal disease.

Another reason why the Hamilton clinic failed to effectively treat venereal disease was irregular attendance by patients. The reports of several social service nurses state that people often gave false names or were transients. This made it impossible to track them down when they stopped showing up for treatment (City of Hamilton 1924). In her 1921 report, Agnes Haygarth suggests that these people were often unemployed. Therefore, not only do the reports confirm the problem of irregular attendance, but they also indicate that many patients had low incomes. Having a job could also make it difficult for a patient to attend a venereal disease clinic. Doctors and other clinic staff were paid little or nothing for their work, but their cooperation was necessary for the clinics to function. As a result, clinics were often open at times that suited the employees' personal schedules (Cassel 1987:181). Since no doctors wished to work in the evenings, there were no evening hours for the Hamilton clinic. This meant that men who could not justify missing work to go to a clinic missed the necessary treatment altogether (City of Hamilton 1936).

The annual health reports also provide some general impressions of the people the clinic was drawing in. In one report, Catherine Flock describes a couple of typical cases: young girls discovered by the Big Sisters and a 21-year old man who was arrested and forced into treatment (City of Hamilton 1924). The general picture is one of young people with few means forced to go to the clinic

by others. Table 5.2 provides the different ways in which people ended up at a venereal disease clinic. The number of people who reported voluntarily for treatment never exceeded a third of the total number of patients being treated (City of Hamilton 1925-1935). The rest were referred by private physicians because they could not afford the treatment, forced there by the law, taken there from elsewhere in the Hamilton General Hospital after a positive test, etc. (City of Hamilton 1925-1935). Evidently this was not a place that you would typically choose to go unless there were no other options.

Referred by:	1925	1926	1927	1928	1929	1930	1931	1932	1933	1934	1935
Private Physicians	73	55	44	61	65	99	113	90	49	57	84
Other Localities	17	8	6	28	26	10	30	18	18	23	14
Health Department / Law	27	18	29	37	43	24	36	49	36	42	16
Other People	18	49	11	30	18	20	8	16	9	7	17
General Hospital	66	60	64	71	81	104	121	130	122	108	112
Self-Reported	56	36	60	63	75	137	178	170	143	96	88

Table 5.2: Number of venereal disease cases referred to the Hamilton clinic from different sources (City of Hamilton 1925-1935)

Overall, it would seem that Hamilton's venereal disease clinic reflects perfectly the overarching pattern observed elsewhere of ineffective treatment provided to low income residents.

Clinic Failure: Past and Present?

Venereal disease clinics were established in Hamilton and elsewhere in Canada because of spiking venereal disease rates in the aftermath of World War I. Though clinics were necessary to provide treatment to the public, venereal diseases were so stigmatized that these clinics were considered shameful places.

Only those people who could not afford any other form of treatment ended up at the free clinics. Most only attended briefly, regardless of whether they were fully cured or not. Clinics became places where people with low incomes were publicly shamed for contracting a venereal disease while more affluent people were able to hide their situation and deal with their disease privately. The statistics for treatment of venereal disease in Hamilton in the 1920s and 1930s demonstrate that public health care was largely ineffective.

The idea was to make treatment available to all and eradicate venereal diseases. As the Hamilton case shows, the clinics failed to make a perceptible dent in the prevalence of venereal disease. As there was no discernible progress, there arose a lack of political will to sustain the funding for the grants because the Dominion Department of Health believed that it had already fulfilled its duty (Cassel 1987:197). The clinics were set up to serve the interests of the Canadian populace by providing free treatment to rid society of an unwelcome disease. But in the end they failed to meet their mandate because of a lack of funding. Without the money to create better conditions, venereal disease clinics of the 1920s and 1930s simply could not accomplish what they were intended to do. Although it should be noted that the clinics did treat a number of people who would otherwise have gone untreated, ultimately these clinics were not as successful as the government had likely hoped.

The relationship between shame and sexually transmitted diseases has been maintained from the 1920s to the present day and the stigma attached to the various diseases is still a powerful barrier to obtaining medical care (Fortenberry et al. 2002:378). Though the conditions of clinics and the treatment process have both been vastly improved, many people still refrain from seeking medical treatment. In the end, no matter how many physical improvements are made to ease the discomfort of such a situation, all campaigns to reduce sexually transmitted diseases will fail until a radical alteration is made to society's perceptions. This was the case in the 1920s when their clinics failed to significantly decrease the prevalence of venereal disease and it is still true now as sexually transmitted diseases are on the rise. Until the stigma attached to these diseases is removed, sexually transmitted diseases will remain a significant medical problem in our society.

6

Venereal Diseases in the Innocent: Congenital Syphilis and the Child Health Movement

Marissa Ledger

He developed general paralysis at fifty, only one of his sons reached manhood, his only daughter was a chronic invalid and his wife wondered at the puniness of his grandchildren. (Spohn 1921:355)

This chapter focuses on inherited venereal disease, primarily syphilis, acquired by babies *in uteru* from their infected mother. I also consider how individuals with *congenital syphilis* were perceived and treated differently than adults with venereal disease acquired later in life. In order to understand the perceptions of congenital syphilis, I use death records from Hamilton as well as articles from *The Canadian Medical Association* and *Public Health Journal* to establish the connection between increased infant mortality from syphilis and the development of the Child Health Movement in the early twentieth century. I explore the social value placed on healthy children, how these values influenced behaviour and debates about how child health should be maintained, and why child health came to be viewed to be more important than health at any other age (Moscovici 1988). The early twentieth century was characterized by significant efforts to improve child health and decrease infant mortality rates. I show how the Child Health

Movement played a role in shaping the response to congenital syphilis because of its focus on promoting repopulation and rebuilding a healthy nation after World War I.

Understanding Congenital Syphilis

The transmission of syphilis from mother to child is known to take place through the placenta; transmission can occur any time during pregnancy. The severity of congenital syphilis depends on the length of time the mother was infected before pregnancy; interestingly, late stage syphilis that has entered a latent phase results in less severe birth defects than primary syphilis (Arnold and Ford-Jones 2000:463). Children suffering from congenital syphilis have many symptoms, which are summarized in Table 6.1.

System	Symptoms
Skeletal	• Mulberry molars (many cusps) • Square cranium • Saber shins (bowing of tibia) • Flared scapulas (shoulder bones) • Protruding mandible
Ear	• Hearing loss
Ocular (Eyes)	• Interstitial keratitis (corneal scarring and inflammation) • Vision loss
Nose	• Persistent rhinorrhea (runny-nose)
Skin	• Inflammation and rash • Blistering
Neurological	• Intellectual disability
Hutchinson's Triad	• Interstitial keratitis • Hutchinson's incisors (notched biting surfaces) • Hearing loss

Table 6.1: Common symptoms of congenital syphilis (Arnold and Ford-Jones 2000; Ikeda and Jenson 1990; Wales 1963).

The English physician Sir Jonathan Hutchinson studied congenital syphilis in the late nineteenth and early twentieth century, and his research shaped what many North American doctors understood about the disease. Hutchinson is well known for Hutchinson's triad, a group of symptoms used to diagnose congenital syphilis (Table 6.1). In the early twentieth century it was understood that if syphilis were transmitted to the fetus in the first three months of pregnancy, it would most likely result in miscarriage. If it were transmitted between the third and seventh month, this would result in a premature birth or a stillbirth. If syphilis were not transmitted until the seventh month of pregnancy, the baby would likely be born alive but later die from the disease or, in rare cases, live with severe disabilities into late childhood or even early adulthood (Brown 1923:246). Syphilis does not usually result in sterility of infected children, so it can be passed on to multiple generations.

Children who live past their first birthday commonly show changes in their bones and teeth (i.e., Hutchinson's incisors). They also commonly suffer from loss of vision, loss of hearing, and mental deficiencies (Morgan 1921). Gordon Bates (1921), head of the Canadian National Council for Combating Venereal Diseases, reported that congenital syphilis resulted in up to 35 percent of cases of congenital deafness and approximately 30 percent of cases of blindness in children. Physical disabilities resulting from bone and joint deformities are also found in about 70 percent of cases.

Canadian Child Health Movement in the 20th Century

The 1920s saw increased attention paid to childhood health in Canada, likely due to high infant mortality rates in the early 1900s. In early twentieth-century Hamilton, infant mortality (deaths per 1000 live births) peaked in 1912 and steadily declined thereafter (City of Hamilton 1930b). The goal of the Child Health Movement in Hamilton and Canada was to decrease these high infant mortality rates. The Public Health Committee on Infant Mortality in London, Ontario named the twentieth century "The Century of the Child" (London Public Health Committee 1921:403). Childhood health was important because it was believed that the "health, wealth, and happiness of the nation depends on the children who must carry on the national affairs of their generation" (Spohn 1921:352). The Child Health Movement in Canada overlapped with the end of

World War I. Therefore, the emphasis placed on childhood health may have been a response in part to the loss of young men during World War I and the belief that the population needed to be reconstructed. In the eyes of a nation that had lost a large number of its strong men to the war, healthy children became valued as the individuals who would rebuild the country.

In an attempt to improve childhood health, in 1919 the Provincial Health Officer planned for each city in Ontario to have a central Health Centre from which other clinics would extend over the city. All of these clinics would focus on providing care for expectant mothers, babies, and children until school age (Royer 1921: 291). This concern for child welfare is evident in Hamilton where in 1920 there were four Child Health Clinics. Compared to other public health clinics in the city, child welfare and pre-natal clinics were relatively more accessible. They were open for more hours per week and located in more sections of the city than any other type of clinic (City of Hamilton 1920). By 1930, there were some twenty Child Health Clinics in Hamilton and multiple clinics were open daily except Sunday (City of Hamilton 1930b). Dr. James Roberts, Hamilton's medical health officer, was committed to decreasing infant mortality rates through these clinics (see Box 6.1). Many other efforts were made to improve childhood health, including bringing nurses into schools, decreasing childhood malnourishment, and increasing the number of children receiving vaccinations.

Figure 6.1: Well Baby Clinic in Hamilton. (Courtesy of the Archives of Ontario, Public health nursing photographs)

While many direct efforts were made to improve childhood health, paying attention to reproductive and maternal health was also seen as a method to decrease infant mortality and promote the birth of healthy children in Canada (Brown 1923). Women were encouraged to attend pre-natal clinics during pregnancy and Well Baby Clinics once the baby was born. Well Baby Clinics existed in most Ontario cities, including Hamilton, to ensure the continual health of the infant. They were dedicated to completing check-ups for

infants, offering advice and training to mothers on how to best care for their children, providing treatment for diseases, and giving immunizations. Many pre-natal and Well Baby clinics were opened around the city of Hamilton in the 1920s (City of Hamilton 1920). Reproductive health and maternal education campaigns were not solely focused on improving the health of mothers during pregnancy but rather also aimed to promote the birth of healthy infants and maintain their health through childhood. Therefore, reproductive health campaigns can be viewed as one of the preventative efforts of the Child Health Movement.

The Canadian Child Health Movement of the 1920s roughly corresponds with the period when congenital syphilis was considered a threat to the population of Hamilton. As a facet of the Child Health Movement, reproductive health was viewed to be particularly important for combating congenital syphilis. Since syphilis is an inheritable disease, it was necessary to ensure maternal and paternal health in order to prevent congenital syphilis. Pre-natal treatment was arguably the most important initiative for protecting the health of children of syphilitic mothers because treatment in early pregnancy could greatly increase her chances

Dr. James Roberts was Hamilton's medical health officer from 1905-1940. He was responsible for implementing many public health programs aimed at decreasing infant mortality rates in the city. From 1910 onwards he was very focused on childhood health in Hamilton and was dedicated to decreasing infant mortality rates (Gagan 1981:169). He believed that public morality was in part responsible for infant mortality and that young men and women needed to be educated about the duties of maternity and paternity. He started his campaign against infant mortality with the "clean milk" for babies campaign (Gagan 1981:187).

In 1915 Dr. Roberts left Hamilton to serve overseas as a volunteer in the war and many public health programs aimed at benefiting children suffered from his absence. As more and more health officials were lost to the war, women began to have a larger presence in public health and they became responsible for continuing Dr. Roberts' efforts to protect the health of children in the city.

Box 6.1: Dr. James Roberts

for delivering a healthy child that would survive through infancy (Spohn, 1921: 354).

Hamilton's Children

How common was congenital syphilis in Hamilton? Figure 6.2 shows the incidence of congenital syphilis, premature and stillbirths in Hamilton from 1905 to 1930. The data indicate that deaths from congenital syphilis increased from only 1 case in 1905 to a peak of 5 in 1916; the levels remained steady thereafter, slowly decreasing around 1930. A similar trend is seen in the number of stillbirths and premature births over the same time period (except for a peak in 1918 in association with the Spanish Influenza pandemic) and both decrease slightly thereafter. When these trends are compared to overall numbers of deaths in children under the age of one, it is evident that they rise and fall in conjunction with each other. Overall deaths increase from 1905 to peak in 1920 of almost three times greater than 1905; the numbers then decline slightly but still remain

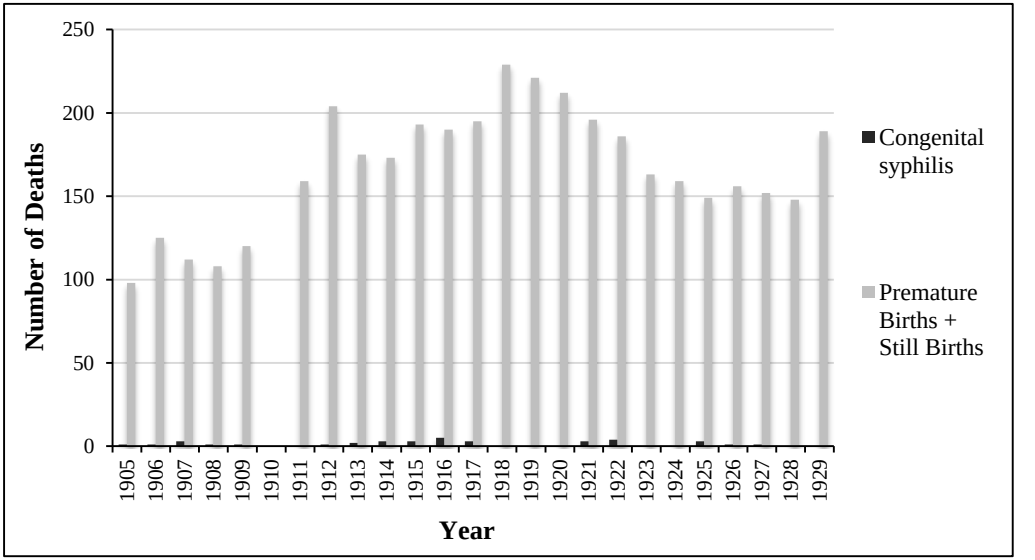


Figure 6.2: Infantile deaths in Hamilton from congenital syphilis, premature and stillbirths (City of Hamilton 1905-1929).

much higher than in 1905.

It is important to include the number of stillbirths and premature births in this discussion because syphilis is a common cause of miscarriages and stillbirths in pregnant women. Morgan (1921), for example, studied reports from the Hospital for Sick Children in Toronto from which he estimated that at least 30 percent of miscarriages and stillbirths resulted from syphilis in the mother. He also reported that approximately 18 percent of premature births were due to syphilis. In another study, Gordon Bates reported that nearly 20 percent of syphilitic pregnancies resulted in miscarriage or stillbirth (Bates 1921:386). Therefore, if there were changes in the number of cases of congenital syphilis over time, there would likely also be similar changes in the number of stillbirths and premature births.

On the other hand, cases may have been underreported because it may have been difficult to make an accurate diagnosis of congenital syphilis if the physician was unaware of the mother's infection and if no obvious deformities were present in the neonate. There is evidence, moreover, that medical professionals did not always consistently record cases of congenital syphilis. Due to the stigma associated with venereal disease, it was common for syphilis to be left off records in order to preserve an individual's reputation. As E. A. Morgan states, "there is a very evident and very pardonable hesitancy on the part of all physicians to enter syphilis as the cause of death on a certificate which is apt to be, as one English physician puts it, 'Hawked about among relatives for the delectation of prudes'" (Morgan 1921:501). For this reason, cases of congenital syphilis that resulted in premature births or stillbirths were likely often recorded simply as that and not identified as cases of congenital syphilis due to the stigma attached to that diagnosis.

The concern with childhood health in the early twentieth century seems to coincide with peaks in the number of deaths from congenital syphilis, stillbirths and premature births between 1905 and 1930. There appear to be two small peaks in the number of infant deaths from congenital syphilis in Hamilton, one from 1914 to1918 and another from 1921 to 1923. The number of stillbirths was the highest from 1918-1922; the number of premature births was relatively steady from 1911-1926, at which point they dropped drastically (Figure 6.2). Before 1915, the number of infant deaths ascribed to congenital syphilis or stillbirth and premature birth were much lower. The high number of deaths from congenital

syphilis in Hamilton between 1914 and 1923 may be a result of an increase in cases of venereal disease contracted by soldiers during World War I (see Chapter 3), who then infected their wives and children. The increase in cases of congenital syphilis between 1914 and 1923 may also be a product of wider public discussion of venereal disease, leading to more cases being recorded.

The Child Health movement in the 1920s was not stimulated by increased rates of congenital syphilis, but rather the urgency with which congenital syphilis was treated likely resulted from increased attention to childhood health. The high rates of infant mortality associated with congenital syphilis, nevertheless, were emphasized in almost all discussions of the condition.

Rebuilding a Nation Through Children

Children infected with venereal disease from their parents were viewed as innocent victims of disease. They were not judged to be immoral or feeble-minded for contracting the disease, in the way that their parents were. The way in which innocence and guilt were tied to venereal disease sheds light on how the disease was perceived at the time. Cases of acquired syphilis among men and women were seen as signals of a lack of morality and appropriate sexual hygiene and thus were associated with guilt. Innocent infection, according to De Forest (1894:254) arose in two ways: syphilis acquired from ordinary marital relations and congenital syphilis acquired from an infected mother. This perception of innocence in children, combined with the high value placed on children in Canadian society at this time, affected the seriousness with which cases of congenital syphilis were discussed.

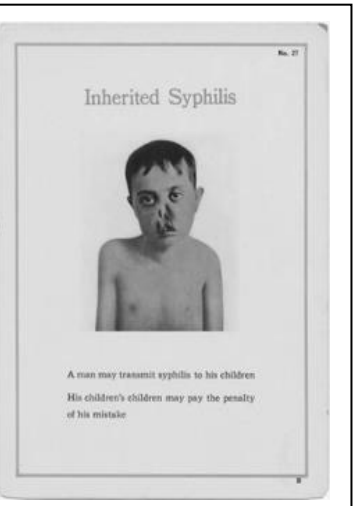


Figure 6.3: Poster warning about the destructive effects of congenital syphilis on families, 1922 (Courtesy of University of Minnesota Social Welfare and History Archives).

Congenital syphilis was treated as a serious problem primarily because of the social and economic costs believed to be associated with it. In the annual report from the Division of

Preventable Diseases from Ontario in 1923, all deaths due to congenital syphilis were detailed, followed by a statement that this annual reporting was exceptionally important because the disease had a direct effect on the birth rate for the province of Ontario (Archives of Ontario 1923:13). Congenital syphilis was seen as a threat to the future of the nation because it was directly linked to a decrease in birth rates. The threat of congenital syphilis to the Canadian population was also partially fueled by the loss of about 66,000 Canadian soldiers during World War I. The need for reconstruction after the war meant rates of infant mortality needed to be decreased in order to allow for population growth. Infant and prenatal deaths from congenital syphilis were viewed as a "social and economic loss of the nation" (Morgan, 1921: 500). Children were necessary to bring economic success and development, and to do this they needed to be healthy.

The perceived threat to future generations posed by congenital, as well as the understanding that these children were innocent inheritors of the disease, created a sense of urgency about the problem. Congenital syphilis was seen to be a very serious disease even in light of high child mortality from other infectious diseases, such as influenza, diphtheria, and tuberculosis because, unlike these acute infections, it had long-term effects and had the potential to create generations of sufferers. Syphilis affected not only the immediate children of infected individuals, but also the third and in some cases fourth generations. This worry led to initiatives aimed at preventing and treating it. Owing to the belief that inherited venereal disease could be successfully prevented with proper public health measures, significant efforts were made to combat venereal diseases in children and pregnant women.

Strategic Prevention

Preventing syphilis before pregnancy was understood to be the fundamental first step in reducing rates of congenital syphilis. This involved treating syphilis in men and women who were entering into marriage or who were already married, mainly through encouraging them to complete the full treatment regimen before a family was started. Also, in 1928, a Bill was sent to the Senate that would prevent legal marriage of any individuals who had venereal disease, however it was never passed (The Senate of Canada, 1928). The proposed Bill is interesting because it

connects the idea of individual guilt to acquired syphilis. The proposed Bill seems to have been a form of moral punishment to prevent people with syphilis from entering marriage. It also shows the extent to which the value of children permeated society; promoting a healthy population of children extended to preventing the birth of unhealthy children.

A more controversial method was the proposal that contraceptives be used in order to prevent pregnancy in syphilitic mothers altogether. In *The Public Health Journal*, for example, Dr. Knopf advocates that syphilitic mothers be taught how to prevent conception during infectious stages (Knopf 1917:119). At the time, many people believed birth control would reduce the population and allow women to escape their duties of motherhood. However, doctors argued for the need for birth control because it would decrease rates of abortion and prevent pregnancy during periods of infection. Keeping in mind that at this time it was believed that the institution of marriage was meant to be the first step to starting a family and men and women had a duty to create healthy families, it is understandable that even in light of preventing congenital diseases, giving men and women the means to escape this responsibility was not universally accepted.

Think About the Children

Due to the collective value of good health and understandings about what types of diseases were acceptable in Canadian society in the early twentieth century, children who inherited syphilis were viewed as victims of their parents' immorality. They were a reminder of the debilitating effects of venereal disease that was becoming prevalent among Canadians. These collective values were formed in a time when Hamilton and other Canadian communities were trying to rebuild after World War I; health officials recognized the importance of immediately decreasing rates of congenital syphilis. This resulted in programs to prevent pregnancy and treat the infected children of syphilitic couples. Death from congenital syphilis in Hamilton was highest from 1913 to 1923; at this time there were also high numbers of deaths due to stillbirths and premature births. The Child Health Movement emerged in Canada against this backdrop. Men and women were told they had a responsibility to the nation to raise healthy children who would be the future of Canada. Poor childhood health was viewed as a threat to the security of the community.

7

Governing and Educating a "Common Mind for the Common Good of Society": The Social Hygiene Movement

Melissa Yan

People will gladly give millions to treat the victims of disease but they won't spend thousands to prevent illness… (Bates, cited in The Globe and Mail 1975:5)

During the early twentieth century, the social hygiene movement emerged from beliefs surrounding the social determinants of health and from the idea that social problems result either directly or indirectly from the 'sex instinct' (Brown 1922:31). The sex instinct was seen as an inevitable condition where "the urgent impulse for self-expression finds itself in conflict with the restrictive conditions of organized society" (Dale 1922a:1). More specifically, when venereal diseases became more prevalent during the interwar period, it was argued that they did not solely stem from the biological body but also from the social body and, consequently, could only be prevented and treated by considering the full range of medical, legal, educational, and recreational realms of this phenomenon (Brown 1922:31). By attending to the social body, it would be possible to create 'moral subjects' who, in Canada at that time, were imagined to be, stereotypically, white, middle-class, able-bodied, monogamous and heterosexual (Mawani 2006:145).

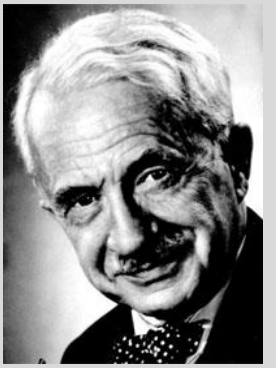
This chapter explores the way venereal disease control and prevention, in the form of the social hygiene movement, perpetuated the discourse on venereal disease in Hamilton from 1919 to 1935. This period provides a useful setting for examining venereal disease, its growing prevalence and the increasing concern about its prevalence, as well as the growing number of public health initiatives introduced after the First World War and the 1918 Spanish influenza pandemic. I explore how public health campaigns reflect the way sexually transmitted diseases, society itself, and certain individuals were regarded during this period. This chapter considers the ways in which health education was expressed, including acknowledging the social factors believed to prevent social hygiene, identifying the heterosocial spaces thought to promote immoral behaviour, and attempting to prevent venereal disease. The transmission of social hygiene knowledge to the public was meant to influence individual minds for the greater good of society. The purpose of this discussion is not to explore whether these initiatives were effective, but instead to reveal the beliefs and attitudes surrounding venereal disease during this period. In particular, I highlight how individuals holding power – government officials, health professionals, and health organizations – shaped the dissemination and content of knowledge provided to the public.

Combatting the Social

According to J.A. Dale (1922a:1), Director of the Social Service Department at the University of Toronto, social hygiene refers to "a healthy state of all the individuals of life in society" and depends on a balance between the individual and the environment. Social ills, such as syphilis and gonorrhea, arise when this balance is not achieved. In its broadest sense, the social hygiene movement not only targeted the health of the individual but the health and welfare of the whole community.

This view of venereal disease justified elaborate public health initiatives during the interwar period (1919-1935) and allowed prominent crusaders, such as Gordon Bates (see Box 7.1), to emerge as leaders of the movement. Many of them delivered speeches to the Hamilton Social Hygiene Council in the early 1920s and stressed the need to organize initiatives to combat venereal disease (Mawani 2006:147). As part of his Introduction to the Study of Social Hygiene in

Canada, for example, Bates informed the Council, "These diseases are significant in that their end results are not only disability and death, but far reaching social results which affect social organization and human happiness in a way characteristic of no other diseases" (Mawani 2006:147). These addresses shaped the discourse and strategies for prevention and education in cities across Canada, including Hamilton.



The Globe and Mail's (1975:5) obituary for Dr. Gordon A. Bates noted that he was born in Burlington, Ontario to an eye, ear, and throat specialist. During his childhood, he attended schools in Hamilton and Woodstock and eventually graduated from medical school at the University of Toronto at the age of twenty-one. In 1921, he married Dorothy Sawdy and they had three children. Bates lived to be 89 years old.

The founder and director of the Health League of Canada, Bates was the first Canadian physician to use the words syphilis and gonorrhea in public speeches (Rutty and Sullivan 2010a:2.15). As a strong advocate of public health initiatives, he was determined to control venereal diseases, which affected many Canadians owing to the lack of open discussion (The Globe and Mail 1975:5). In bringing public attention to these issues, he influenced numerous men, women, and children through newspaper articles, public lectures, motion pictures, and any other medium possible (The Globe and Mail 1975:5; Rutty and Sullivan 2010a:2.16). One of his many contributions included speaking to prominent councils, such as the Canadian National Council for Combating Venereal Disease (CNCCVD) and the Hamilton Social Hygiene Council, about how to combat venereal disease.

Box 7.1: Dr. Gordon A. Bates (Rutty and Sullivan 2010a:2.15).

According to Bates (1917:189), "…the truth in regard to venereal diseases will eventually rouse the public to a realization of the fact that low wages, the lonely boarding house, poor education, and late marriage in men and women, are causal factors which eventually they hold it in their power to remedy". Having

identified behaviours believed to be deleterious to the health of the community, it was understood that these behaviours had to be prevented. However, it is clear that ideas about immorality underlay this view of social ills. As a result, venereal disease prevention initiatives emphasized the need for 'normal' marital sexual activity, epitomized by 'moral subjects', and aimed to control 'abnormal' extra-marital sexual relations believed to lead to venereal diseases (Rutty and Sullivan 2010b:3.8). Thus, immorality became framed as the catalyst for venereal diseases and, thus, immoral behaviour had to be eradicated to combat them.

Late age at marriage was believed to be one of the causes of venereal disease, a pattern thought to be linked to poor economic and social conditions (Bates 1922:66). By educating the public about the benefits of early marriage, social hygiene advocates believed venereal diseases could be prevented, along with any undesirable traits in the moral subject (Dale 1922a:8). Demographic studies by Wu (1998:3-4) confirm that there was an overall decline in marriage rates in Canada from 1921 to 1995, however the average age at first marriage was lowest in the 1920s, and only began to rise in 1931. By 1941, both sexes experienced an increase in age-at-first-marriage, which may have contributed to the path towards social hygiene.

The social hygiene movement claimed that a lack of acceptable opportunities for healthy recreation for adults and children encouraged venereal diseases (Bates 1922:66). Proponents argued that schools and churches should be used to provide supervised activities and to promote outdoor recreation and sport. Unsupervised gatherings of young people in dancehalls should be discouraged. Housing conditions were identified as another possible source of infection. Inadequate housing that forced several families to crowd into a house intended for one family was believed to produce immorality as it allowed individuals to be in close proximity and thus created greater opportunities for immoral, unwanted sexual behaviour to occur (Bates 1922:67). Unsupervised boarding houses were also believed to encourage sexual behaviour (Bates 1922:67). Lastly, the family was considered to be the most important social unit for diminishing the venereal disease problem. If a family member disengaged from normal family associations and left home, social hygiene advocates argued that it was a public responsibility to ensure that person's well-being (Bates 1922:67). This was a particular concern for young people who left home and moved into boarding houses.

Although the social hygiene movement targeted specific circumstances for amelioration, it is important to note that it recognized some of the underlying factors that may have *led* to the circumstances believed to promote venereal disease. These included the disruptive force of poverty, enforced celibacy unsupported by high ideals of vows of chastity, boredom, the use of alcohol contributing to loss of self-control, and even the exposure of being an illegitimate child to an unmarried mother (Dale 1922a:8). Ostensibly, there are a variety of possibilities that were contended to have an impact on shaping the immoral character that would be reflected via unhygienic behaviour and various means for preventing and controlling this issue. However, these factors consistently returned to notions of moral lapse, with venereal disease symbolizing a lack of responsibility in the individual's character.

Control of Heterosocial Spaces

The understanding of how to govern the spread of venereal disease was translated into the way surveillance was maintained in *heterosocial* settings, defined as the "shifting and changing sites where young women and men come into contact and where transactions with potentially sexual dimensions arise or which others define in sexualized terms" (Hunt 2002:1). The social hygiene movement can be interpreted through Michel Foucault's ideas about the connection between knowledge and power. For Foucault, power is practiced and legitimated by subduing and disciplining individuals (Knepper 2007:75). To control venereal disease, certain places were therefore thought to require more surveillance.

Boarding houses, for instance, were generally viewed as common places for infection to occur, especially through prostitution (Bates 1918:186). In the early twentieth century, Hamilton was a small, highly industrialized city with relatively high rates of boarding house utilization (Harris 1992:337). One suggestion to control prostitution involved a system for registering and inspecting all boarding houses (Patterson 1917:176). Bates (1918:190) also argued that young men and women living in these houses should be able to meet under conditions that reflected initiatives developed for military camps during World War I, such as *The Hostess House*. This house was located at Camp Gordon in Atlanta, Georgia, a military base outside the city that allowed both black and white women of the Young Women Christian Association (YWCA) to meet in a

"homelike presence" with a "safe and wholesome atmosphere" (Judson 2003:102,105). This model boarding-house for girls in the midst of the army had a common room in which young girls could receive young male friends. The aim of these buildings was to prevent immoral sexual acts from occurring (Bates 1918:190; Patterson 1917:176). More specifically, such places offered options to counter unwanted working-class popular culture, which included gambling, drinking, sexualized dancing, and pre-marital sex (Judson 2003:106). It is also interesting how the influence of this American model in a Canadian setting demonstrates the transnational dissemination of discourse at the time.

In Frances E. Brown's (1922:42) speech to the Hamilton Social Hygiene Council on 23 February, he argued that even though particular spaces lead to infection, the general lack of housing accommodation was also a factor in the social hygiene problem. This was a particularly serious matter for young men and women with inadequate incomes, living in a large city away from home, where they were forced to live in crowded conditions, unsupervised by their families or communities. In turn, he suggested that the lack of jobs also seemed to encourage young women to live on a self-supporting basis in club or hotel environments.

Dancehalls were also viewed as settings in which venereal infections could spread. Social hygiene advocates argued that dancehalls provided the opportunity for young men to lure young girls; at the same time, young girls who regularly attended these events were also considered to be immoral and infected (Bates 1918:186). According to Dr. Margaret Patterson (1917:176), dancehall settings could be ameliorated by replacing "dim, unnatural lighting and foul air" with recreational environments consisting of "pure air and healthy surroundings". She also argued that, too frequently, certain classes of young individuals believed it was necessary to "be bad in order to have a good time" and that breaching the moral code was a pathway to enjoyment (Patterson 1917:176). An ordinance regulating public dance halls in the United States in 1919 was aimed at eradicating the "undesirable features" of public dances and to erect barriers around young individuals who chose to attend these places for amusement (Treasury Department of the United States Public Health Service 1919:21). The American government sought to eliminate prostitution as a whole and targeted these spaces because of the belief that prostitutes used them to meet clients and "secure victims" (Treasury Department of the United States Public Health Service 1919:21). Thus, this ordinance was enacted to remove the temptation to engage in

immoral sexual behaviours and, at the same time, to encourage the creation of moral subjects. This is similar to Canada's approach to strategically target and reduce the vices thought to provoke unhygienic behaviours.

Even if some spaces were understood to be more dangerous than others, it was still acknowledged that infection could occur virtually anywhere. This included spaces such as hotels, parks, meetings, and even the automobile (Bates 1918:186). In fact, it was believed that anywhere that young men and women could connect and interact created opportunities for contracting and spreading venereal disease. Thus, further initiatives were deemed necessary to more effectively control syphilis and gonorrhea. The most effective avenue to pursue, it was argued, was by providing education on venereal disease in schools and to the general public.

Education for the Masses

Although prostitutes, young single women, working-class men, and even foreigners were disproportionately targets of the strategies of public health (Mawani 2006:146), education was seen to benefit infected individuals and the general public alike. The responsibility for providing these teachings lay in the hands of various provincial governments and organizations, including the Canadian National Council for Combating Venereal Diseases (CNCCVD). At the forefront of the public education campaign, Bates (1918:187,189) suggested a scheme that included lectures, pamphlets, or film – any type of mechanism that would address venereal disease as well as sex hygiene – to influence overall societal attitudes.

According to the CNCCVD, public health literature on social hygiene had three main purposes: to provide Canadians with sufficient knowledge about the symptomology and consequences of venereal diseases; to encourage persons infected with venereal disease to seek testing and treatment; and to provide general, *correct* knowledge to men and women about social and sexual hygiene (Bates 1922:62-63; Mawani 2006:153; emphasis mine). It was the responsibility of the Social Service Department of a Venereal Disease Clinic to ensure the infected patients realized the importance of seeking and continuing treatment to prevent spreading their infection to others. This could be accomplished through pamphlets, instructional cards, or posters (Bates 1922:63).

Additionally, public education was not only necessary for preventing disease, but also to shape the morals, character, and sexual nature of members of society (Mawani 2006:154). By providing knowledge and encouraging self-control, education was perceived as the mechanism needed to build character and ultimately shape good individuals by producing "a common mind for the common good of society" (Dale 1922a:7-9). This process of education toward self-governance is, in Foucault's (1988) terminology, an aspect of 'technologies of the self'. 'Technologies of the self' "permit individuals … to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality" (Foucault 1988:18). Thus, by placing responsibility on individuals to reproduce and embody state-instituted moral understandings, the authorities in Hamilton and elsewhere were able to regulate individuals and communities without using coercion. In the context of the social hygiene movement, Dale (1922a:9) believed this goal could only be achieved through a three-tiered ideal that would teach people: to recognize what matters; to pursue refinement and purification of feelings; and to engage in healthy activity. Once the individual was fully educated in these ways, he/she would be transformed into an ideal, moral character in a socially hygienic community.

Keeping the Future Generation in Mind

Many authorities, such as Dr. George DeWitt (1917:213), promoted the instruction of sex hygiene in schools to achieve social hygiene on a broader scale. This position was based on the idea that children are condemned to immorality because they have been raised in ignorance about sex; as a result, children need to be educated to live "a decent moral life" (Bates 1922:65). In his 1918 address to the Hamilton Social Hygiene Council, Bates (1918:190) asserted that children should have some preliminary knowledge about sex and it was the parents' responsibility to teach them.

Nonetheless, his position was controversial: should children be taught sex hygiene in school, and if so, how should this be done? While there was general agreement that it was important to teach the biology of sex, this was followed by the assertion that it was also necessary for children to understand the "purposes of nature" and to "be taught a definite respect for the sex function" as part of broader teachings about citizenship that would stimulate a sense of chivalry and idealism

about what constituted moral character (Bates 1922:65). There was general consensus that the parent was the most acceptable individual to teach children about the importance of venereal disease prevention by supervising and caring more about their children's education, emphasizing normal healthy recreation and outdoor activities, and supervising heterosocial interactions (Bates 1918:190; Bates 1922:65).

Although the important role of the parents and home was acknowledged, educators felt that families could not always be relied upon to teach social hygiene. For many, particularly Professor Peter Sandford (1922:19), the burden of teaching sex and morality had shifted to the school because the "demonizing sex instinct" was understood to begin to develop at birth. In his speech to the Hamilton Social Hygiene Council, Professor Sandford (1922:19) asserted that if this knowledge were neglected, there would be "incalculable harm". This meant early sex education was necessary to encourage the right habits and proper attitudes. In addition, he argued that while sex development is normal, this should be delayed for as long as possible by teaching children the value of physical exercise in an environment with fresh air, daily baths, independent sleeping, and wearing modest hygienic clothing that did not provoke the sex instinct. However, this can only be accomplished if parents and teachers display the correct attitudes of dignified honesty, and lack of "shame, mystery, frivolity, or vulgar familiarity" (Sandford 1922:20). Most importantly, the child's confidence in their abilities to openly speak to their parents must be ensured so that he or she can be trained to know how to respond to immoral individuals encountered later in life. Sandford claimed that not only does this shape the child's character, but such teachings nurture the ideals of purity and reverence for parents and parenthood. The primary goal of sex education, therefore, is to indoctrinate correct attitudes and proper ideals, and "with these things secure, everything else follows naturally" (Sandford 1922:21).

The Public Health Discourse: Regulating and Teaching Society

Public health initiatives to control venereal disease were introduced and enforced by health professionals and medical practitioners – authoritative individuals who had the power to recommend which initiatives should be employed and which should be discarded. These initiatives were not simply medical interventions; they

were viewed as powerful mechanisms to shape the morals, character, and sexual nature of citizens. The venereal disease problem was framed as a 'social' problem rooted in a biological sex instinct that could only be controlled by teaching appropriate behaviour and instilling a particular moral code in citizens. These initiatives were based on forms of authoritative medical knowledge that were then deployed to control heterosocial spaces, to produce moral citizens, and arguably reinforce the power of public health contributors. The Hamilton Social Hygiene Council developed public health literature that discussed the problem of venereal disease for the general public and for the school curriculum. Achieving the goal of social hygiene always turned to monitoring and deterring behaviour deemed immoral. The movement had an impact on law formation, gender issues, treatments for venereal disease, and the attitudes of the church. Thus, social attitudes, beliefs, and behaviour during the interwar period were at one and the same time forces influencing, and resulting from, these powerful campaigns.

8

More than Just a Movie: The Subtle Voice of Cinema

Murray Clayton

We feel very strongly that motion picture films are a most important medium for health education. Well-written and produced films...actually instill more information into observers than does any other teaching aid. (Dolce 1941, cited in Parascandola 1996:173)

In the winter of 1895, the first public screening of a moving film was presented to an audience in the basement of the Grand Café in Paris by the brothers Auguste and Louis Lumière. This spectacle became the benchmark for the advent of a new era in social communication, recreation and dissemination of knowledge.

Anthropology in particular has successfully utilized film and cameras in attempting to capture greater detail and accuracy than notes and memory may provide. Ethnography is made to come alive as we are immersed in an observable culture. Conversely, in the same way the hand of an impressionist artist may be seen on a canvas, the hand of the filmmaker reveals clues to the cultural environment in which they were influenced. A contemporary audience is able to find meaning and interpretations that uncover the values held by society at the time. With this in mind, the following chapter explores public service announcements and cinematic campaigns that reflect social and cultural attitudes towards venereal diseases. Through symbolic and interpretive theory (Geertz

1973), these films reveal how citizens of Canada and the United States "see, feel, and think about the world" (Ortner 1983:129). Institutional views of morality, gender and race are reflected in productions sponsored and commissioned by authoritative voices, including the Canadian National Council for Combating Venereal Disease (CNCCVD) and the Canadian Social Hygiene Council (CSHC). In film, creators not only rely heavily on symbolism to convey messages that public audiences receive, but they are also able to present these messages more subtly by placing them in a context aided by story and characters, and giving them time to develop. Visual culture and visual behaviour are intrinsic to analyses of film because they mirror the values of contemporary societies, the people who consume this culture. Cinematic representations of North America during the first half of the twentieth century provide detailed and focused information on the behavioral, moral and social characteristics of this culture.

Moral Deliberation, from *Damaged Goods* to *Sex Madness!*

With the popularity of new-century vaudeville and silent film, a new theatre opened in Hamilton boasting, "every performance will be strictly censored before being presented, and only a clean entertainment of an instructive and educative order will be permitted" (The Hamilton Spectator 1912b). In its role of maintaining moral standards of entertainment, the Lyric Theatre would be joined a decade later by the Tivoli Theatre, and both would find themselves challenged by the productions of the social hygiene movement. One film in particular proved to be especially provocative: the 1914 U.S. production of *Damaged Goods,* directed by Tom Ricketts and Richard Bennett.

Few other films reflect the change in cultural perspectives towards sexuality as clearly as *Damaged Goods*, and the change could be seen in each new version released. The first 1914 production is an American silent film based on the French theatrical production *Les Avariés* (Brieux 1901), which is about a young couple who contract syphilis. While critics had panned the play as, "dull and almost unendurable", the film adaptation was a hit, presented before overflow audiences in theatres (Tye 1998). The film was created as a fight against sex prurience by Edward Bernays, who realized the key to *Damaged Goods* was to transform the controversy into a cause. Bernays recruited backers who were

already public role models, including notables such as Rockefeller, Vanderbilt and even Franklin Roosevelt.

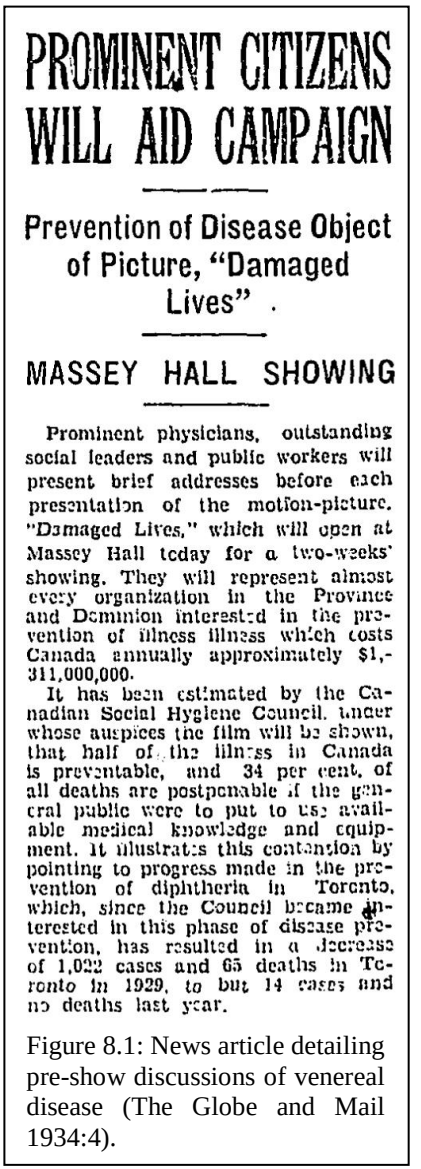
Believed to have begun the public hygiene 'film craze' of the 1910s (Schaefer 1999), the success of this film in reaching the public spurred further adaptations, produced in 1919 in the United Kingdom and 1933 in Canada under the title *Damaged Lives.* The latter version was conceived in Canada by J. J. Allen, a distributor and exhibitor, and the CSHC to replace the U.S. film *The End of the Road* (1919), and was directed by prominent Toronto physician Dr. Gordon Bates (see Chapter 7 for further information on Bates' contribution to the Canadian Social Hygiene Council).

Opening in Hamilton in 1924, the Tivoli Theatre on James Street was a venue for vaudeville and silent films and later for live stage shows. When *Damaged Lives* was released in 1933, moral sensibilities demanded, and thus advertised, separate screenings for men and women (The Globe 1933). In 2004, a portion of the front of the building, including the marquee, collapsed and the lobby of the Tivoli Theatre was completely demolished. As of 2014 the auditorium and other parts of the theatre remain active as a tourist attraction in *Haunted Hamilton* ghost walk tours.

Box 8.1: Façade of the Tivoli Theatre in 1941 (Haunted Hamilton 2014).

Initial reactions to the 1914 American film and the 1919 British version included criticism from their respective censor boards (Low 1971) for the blatant depiction of venereal disease and sexual intercourse throughout the productions. Morality-based censorship was already strong in Hamilton, as movies with

romantic depictions became the subject of great debate within the Board of Censorship (The Hamilton Spectator 1918). Ultimately, despite protests of church federations and individuals, the Board ruled that if "torrid scenes in motion pictures represent life truly, they will be stamped O.K.", which even included extended or passionate kisses. Despite heightened moral objections, *Damaged Goods* had been described by theatre critics as a masterpiece (Bamford 1999:20), and the success of the film set a precedent for the increasing production of similarly themed movies.



PROMINENT CITIZENS WILL AID CAMPAIGN

Prevention of Disease Object of Picture, "Damaged Lives"

MASSEY HALL SHOWING

Prominent physicians, outstanding social leaders and public workers will present brief addresses before each presentation of the motion-picture, "Damaged Lives," which will open at Massey Hall today for a two-weeks' showing. They will represent almost every organization in the Province and Dominion interested in the prevention of illness illness which costs Canada annually approximately $1,-311,000,000.

It has been estimated by the Canadian Social Hygiene Council, under whose auspices the film will be shown, that half of the illness in Canada is preventable, and 34 per cent. of all deaths are postponable if the general public were to put to use available medical knowledge and equipment. It illustrates this contention by pointing to progress made in the prevention of diphtheria in Toronto, which, since the Council became interested in this phase of disease prevention, has resulted in a decrease of 1,022 cases and 65 deaths in Toronto in 1929, to but 14 cases and no deaths last year.

Figure 8.1: News article detailing pre-show discussions of venereal disease (The Globe and Mail 1934:4).

When the Canadian production of *Damaged Lives* was released in 1933, it was banned from several states in the U.S., reflecting moral standards of decency that superseded the need to disseminate information about sexual practice. The film contained one of the earliest filmed nude scenes in North American history, in which a group of women undress to go skinny dipping (Schaefer 1999). Critics were concerned that these films were merely reliant on scenes of a sexual nature to draw in crowds and sell tickets (later referred to as 'sexploitation'). However, the testimony of the New York State Commissioner of Health claimed that *Damaged Lives* was, "an excellent moving picture...in no way offensive to good taste or to the principles of pedagogy" (Eberwein 1999), and the film was made available to the public three years after its ban. In an attempt to legitimize and propagate films with sexually explicit yet educational content in Ontario, audiences participated in pre-show lectures from prominent doctors and public figures, such as Dr. Gordon Bates (Figure 8.1).

The criticisms and concerns of sexploitation cinema were not wholly unfounded however, and *Damaged Goods* reemerged later in 1937, advertised as a film focused on premarital sex and lasciviousness, rather than on warning against venereal disease. Dramatic epithets such as 'shocking!', 'sinful!' and 'scandalous!' jumped from the official poster advertisement. This version was later re-issued with a new title: *Forbidden Desires*. The bold marketing represented the loosening of censorship from the early twentieth century, in which even films of good intention were subject to intense scrutiny. Conversely, films such as *Sex Madness!* (1938), filled with parties, sexual contact, female homosexual erotica and drug use, abused the thin veil of social hygiene as the critics had feared.

Concerns and Consequences

Film producers working with social hygiene councils were concerned that venereal disease campaigns would lose legitimacy via sexploitation films posing as sex education films. *Mom and Dad* (1944) went so far as to use unauthorized photographs meant for the United Stated Public Health Service and misappropriated its official seal in the credits (Parascandola 1996). Under the guise of education, this was meant to justify scenes of unwed pregnancy and graphic birth, and shocking cases of VD, designed to make money by exploiting the public's curiosity about 'forbidden subjects'. Inspired by *Mom and Dad*, Canada released its own film, *Sins of the Fathers* (1948 Jarvis and Rosen, directors, Saint-Hyacinthe, Québec), about a young medical health officer trying to deal with venereal disease in a sexually corrupt town. However, it was unsuccessful in generating commercial sales due to its limited local release (Graham 1989).

In the latter cases, the intentions of the filmmakers are transparent. Instead of disseminating an informative social message as had their predecessors, filmmakers of the mid-twentieth century attempted to capitalize on cultural taboos and the allure of scandal. Despite this, films produced by the social hygiene movement were rooted in education and they played a significant role in acclimatizing audiences and critics to sexual content wherever they were shown, including Hamilton. According to the newspaper article 'Guarding Public Health', in just ten weeks 260,000 people paid to see *Damaged Lives* (The Globe

1935). This exposure provided greater public awareness of venereal diseases, and the public discourse necessary to begin successful prevention.

The Audience as a Moving Target

It is important to remember that public health films in the early twentieth century were not targeted toward the general public. As previously stated, films such as *Damaged Lives* were presented in separate screenings for each gender. In other sectors of society, such as the military, demographic separation occurred along the lines of gender and race. When well-received, male-targeted films were introduced to mixed-gender audiences, they were required to delete many scenes explicitly depicting genitalia and contraception (Paransacolada 1996). *Know For Sure* (1941) was edited to remove shots of male sex organs and information about the use of condoms, effectively removing a large scientific portion of the film in lieu of a moral tone deemed appropriate for both men and women.

Female targeted films about venereal disease failed to treat women as valuable recipients of scientific education. Instead, women were fed moral codes detailing how to behave virtuously; women were subject to a unique brand of socially constructed values. Films with hyperbolic titles, such as *The End of the Road* (1919), *Road to Ruin* (1934) and *L'Âge Ingrat (The Ungrateful Age)* (1945), present stories about the self-induced consequences faced by women who adopted improper lifestyles. Chastity and obedience are depicted as a woman's only ways to prevent venereal disease. Instead of providing scientific content, the films are presented as narratives, fables by which women may learn a moral lesson rather than acquire information about the disease (as the men would). This gender binary phenomenon is also present in medical literature. In Harrison's monograph *Modern*

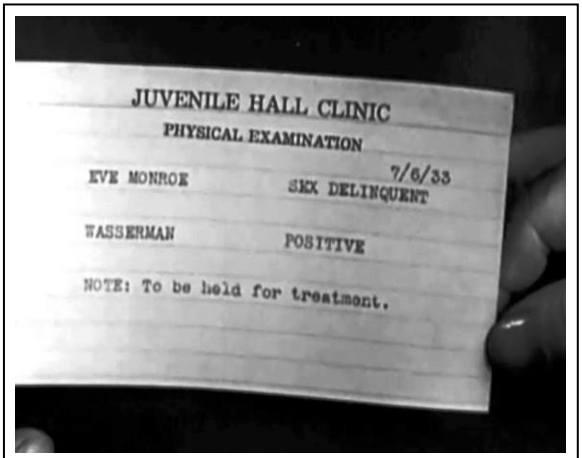


Figure 8.2: Screen caption of the Wasserman card in *Road to Ruin* (1934).

Diagnosis and Treatment of Syphilis, Chancroid and Gonorrhoea (1925), there are separate chapters for men and women on how the disease is contracted and spread. The chapter for women is not only significantly shorter, but focuses on congenital complications and instructions for appropriate social behaviour.

Spotting the Clues

Symbolic clues in the narrative reveal the general state of public awareness, or expectation of public awareness, by the film makers. Directors often placed visual clues for the audience to discover. For instance, in *Road to Ruin*, the character Eve leaves the doctor's office holding a card (Figure 8.2) which reveals to the audience that she has a positive Wassermann test (see Chapter 2). At no point in the film is this card explained, nor is there an explicit mention of venereal disease, but the young girl is distraught at this result of her 'lascivious' actions depicted earlier in the film, which include drinking, drug abuse and most importantly, premarital sex. This signifies that both men *and* women at the time were familiar enough with the Wassermann test, and all its implications, that no further explanation is necessary to indicate that Eve had contracted syphilis. In addition, her card identifies her as a 'sex delinquent'. The lack of narration surrounding the consequences for the men in the film serves to further isolate Eve's responsibility for her immoral actions, while exonerating the men from blame.

The Fear Factor: Gender and Race in the Military

The incidence of venereal disease had reached sizable levels during both the First and Second World War. By 1943, Hamilton alone had 726 instances of VD, including syphilis, gonorrhea, and related congenital disorders (Report of the Health Department 1943). To combat the growing numbers of cases, the United States and Canadian military used films to supplementtheir disease education programs. Unlike the scientific approach of male targeted films (*Know For Sure*) or the moral approach of female targeted films (*Road to Ruin*), the army employed "fear, intelligence, pride and patriotism to motivate men to use the knowledge they had been given" (Parascandola 2008).

Fear had been the dominant motivator for venereal disease prevention, as appeals on strictly moral grounds were considered of limited value. There was little evidence that these military films were successful in converting audience behaviour from 'promiscuous' to 'virtuous'. *Sex Hygiene* (1941) featured soldiers at an army base as characters within the film, one of whom had contracted syphilis from a prostitute. The film has graphic depictions of the effects of secondary and tertiary syphilis, including ravaged skin and crippled limbs. In a navy production, *The Story of D.E. 733* (1945), the same basic narrative is expanded with the addition that the sailors on shore leave were given condoms by the ship's pharmacist, but did not use them. In these examples, we see neither moral nor religious implications, but instead a direct cause and effect relationship between enlisted men consorting with prostitutes and acquiring the disease.

Figure 8.3: Frames from *Easy to Get* (1947 Army Pictorial Service).

Significantly, while the military was a unique and independent audience for these public hygiene films, there were further separations within this audience. In movies such as *A Message to Women* (1944) shown to the Women's Army Corps, there was no discussion of mechanical or chemical prophylaxis in the 'social hygiene' course given to the women. For women, abstinence was the only means of protection from venereal disease. Eberwein (1999:72) suggests that leaders were confident that because of the "high type of women" admitted into the Corps, other preventative measures would not be necessary.

Racial bias was clearly evident in

productions aimed at African American soldiers. Pejorative black stereotypes in film were not uncommon. In the United States, authoritative perspectives on race were expressed through public and military films. The 1943 film *Easy to Get* stressed the sexual ignorance of the black soldiers, as the narrator explains how a black soldier thinks that 'whores' must be disease free simply because they are supposed to keep clean. While white soldiers were sometimes depicted in other military films as ignorant about certain aspects of sexual hygiene, Eberwein (1999:73) emphasizes that the comments about black men in this film are "pronounced by a white male," and "inflected with the ironic voice of white authority". Additionally, portrayals of black lasciviousness and sexual excess are emphasized through symbolic cultural behaviour, specifically dance. Although swing music had become popular with whites in the 1940s, *black* swing still "carried a whiff of impropriety and sexual endangerment" (Yom 2003:82). In *Easy to Get*, the symbolic association between swing music and black sexuality is established by rapid cuts between the alluring stares of the black prostitute and the dancing couples on the bar floor. Yom believes this highlights the physicality of black people, alluding to the possibility of the black contamination of white culture. Immediately in the next scene, a black man lies in bed incapacitated, as the white narrator explains that the man contracted syphilis from a whore overseas. The implied consequences of black dance culture are very clear, reflecting the authoritative values and ideologies of the film makers.

More than Just a Movie

With so many cultural, physical and economic factors that contribute to rising and falling rates of sexually transmitted disease, it is difficult to determine exactly how successful social hygiene films were in educating the public. Nevertheless, officials of the Public Hygiene Service were convinced that they were effective tools in the effort to control VD (Dolce 1942). This belief is maintained today, as educational films are still a medium of choice for the dissemination of health messages, whether in school, television documentaries, or hyperbolic Hollywood interpretations. Accessible education and public dialogue are key components in distributing knowledge and preventing contemporary sexually transmitted diseases. Unlike societies commonly studied by anthropologists, western cultures in the twenty-first century are rich with unique sources of film and print media

that give otherwise unobtainable insights into society. Public service announcements and full length feature films play a significant role in acclimatizing audiences to sexual content, thereby creating greater opportunities for education, and also for public discourse about the diseases plaguing cities like Hamilton.

Despite isolated incidents that attempt to capitalize on the success of the forbidden, these early films hold a wealth of information not only for the original audiences, but for those of us who wish to study consumer culture. Hygiene messages that have been sanitized for women undermine the efficacy and defeat their purpose for half of the population, acting instead to reinforce the subjugated role of the virtuous female. Similarly, the consequences of 'lascivious black lifestyles' are sold as inevitable. In these ways, we learn less about venereal disease than we do about institutional perspectives on gender, race and morality, and these authoritative voices indeed reveal how people see, feel and think about the world.

9

Entering the Nation's Bedrooms: Venereal Disease and the Law

J. Paul

Law is a record of the gradual development of the moral conscience of the nation. Law is the offspring of morality. Morality is not the child of law. If all of the ills which affect mankind socially could have been cured by placing a few lines in our Statute Book, this world long ago would have been a Paradise of Angels. (McFadden 1922:25)

The social stigma attached to venereal disease pervaded the fabric of society even as the blight was dragged into the public sphere. As venereal disease became an increasingly pressing concern, the government was required to legislate ways in which to fight it. However, the campaign against venereal disease intersected with anxiety over marriage and divorce, gender, the control of sexual behaviour, mental health and 'feeble-mindedness'. To what extent did social morals bleed into the laws and policy surrounding venereal disease? Critical medical anthropologists understand that engaging with political economy, and the larger political, economic and social issues, is necessary to understand health policy (Scheper-Hughes 1990). This chapter addresses two main themes as they relate to the laws governing venereal disease: the control of sex and mental health. Two

pieces of legislation serve as the focus of this chapter: the proposed federal *Act to Make Venereal Disease an Impediment to Marriage* and the provincial *Act for the Prevention of Venereal Disease.* Issues of health operate on multiple scales (Singer 1995) and, in the case of venereal disease, policies had federal, provincial, local, and individual consequences that were fundamentally entangled. The government, medical profession, and public had distinct perspectives on the appropriate response to venereal disease. Deliberations between these three groups revealed the remarkable sway the public had over policy surrounding venereal disease. The power of public perception dictated which groups were appropriate to target for treatment and punishment. Criminals, prostitutes, and the mentally deficient were singled out as appropriate centres of blame, whereas the rest of society was largely spared.

Act for the Prevention of Venereal Disease

Hamilton was ground zero for control over venereal disease in Ontario. In 1917, the Medical Society of Hamilton called in a delegation from Toronto to present evidence on venereal disease to the Conservation Commission (Buckley and McGinnis 1982). The Royal Commission on Venereal Disease and Feeble-mindedness was born from these recommendations (Buckley and McGinnis 1982). As commissioner, the Honourable Justice Frank Egerton Hodgins published two interim reports, one which inspired the *Act for the Prevention of Venereal Disease* passed in 1918, and another which made further recommendations subsequent to its passing. Justice Hodgins' objective was impartiality, but his report was inevitably tainted by social convention and class-based conceptions of morality. He cited the stigma of venereal disease as the primary reason for the failure of previous generations to address the venereal disease problem (Hodgins 1918a). However, he readily stigmatized groups that did not adhere to moral 'norms': criminals, prostitutes, and the 'feeble-minded'.

A significant portion of the *Act for the Prevention of Venereal Disease* dealt with the standardization of treatment (Hodgins 1918a). However, it also treated venereal disease as a crime (McFadden 1922). The *Act for the Prevention of Venereal Disease* allowed anyone detained, arrested, or convicted under the Criminal Code of Canada to be tested and forcibly treated for venereal disease (Hodgins 1918a). A Medical Officer, or a medical practitioner acting under his

authority, could enter the house of anyone suspected to be infected with venereal disease (Hodgins 1918b). Medical Officers were also granted the power to detain and test anyone from the general populace they suspected to be carrying VD. However, the Act, and the report upon which it was founded, made special notice of already marginalized groups whom they viewed as degenerate. Criminals, especially prostitutes, were seen as being in perpetual states of moral decay (The Globe 1918a). They were not always deemed culpable in their immorality; it was a popular assertion that the majority of them were 'feeble-minded' (Adams 1994, Buckley and McGinnis 1982, Burnette 1922, The Globe 1918b, 1918c).

'Feeble-mindedness', Mental Deficiency and Morality

Feeble-minded or mentally deficient individuals were described as a category of people who did not respond 'normally' to education (Burnette 1922). Their abnormality, their inability to be structured by society, was a source of anxiety. Feeble-mindedness was connected to immorality, both in sexual and criminal behaviour, because this deficiency was believed to leave individuals without the restraint necessary to follow a moral path (The Senate of Canada 1928). Studies at the time reported that the mentally deficient composed 60 percent of the prostitutes infected with venereal disease and 30 percent of all those incarcerated in prison (Burnette 1922).

The connection between feeble-mindedness and venereal disease was further amplified because these individuals were also seen to be the product of the affliction itself. Parosis, a form of insanity caused by chronic syphilis, was a condition for which an individual could be confined to a mental hospital (Avery and Conacher 1938). The media also blamed feeble-mindedness on venereal disease. Newspapers reported that the state of many of the feeble-minded resulted from the ravages of venereal disease. The mentally ill were an already stigmatized group for which there were profound social reservations and the wave of fear and moral fervour that accompanied the campaign against venereal disease allowed this group to be essentialized as intrinsic carriers of the scourge.

The 'good' feeble-minded were those under the paternal hand of the state (Burnette 1922). 'Guidance' took a number of forms, punitive and otherwise. Hodgins (1918b) argued for segregation and incarceration, and for the removal of the feeble-minded from society to mental hospitals, detention centres, or prisons.

In Hamilton, feeble-minded children were separated into a class specifically designed for their moral and social education (Hincks 1921). If the children were beyond the control of their parents, they could be sent out of Hamilton to the Orillia Hospital (Chupik and Wright 2006). Patients required a "certificate of idiocy", proof of their feeble-mindedness provided by a family doctor or mental health expert, in order to gain admittance at Orillia. Gaining access to the institution was difficult (Chupik and Wright 2006).

Many of the feeble-minded, particularly those with criminal records, were left in the local insane asylum (Chupik and Wright 2006), the Ontario Hospital in Hamilton. Feeble-minded criminals were relegated to these institutions because they were considered to represent a particularly dangerous class of society. Liberal institutions like Orillia, where re-integration into society was a possibility and sometimes a goal, refused to admit this particular group (Chupik and Wright 2006). Supervising the mentally deficient was deemed to be of paramount importance. Under the *Act for the Prevention of Venereal Disease*, the Provincial Board of Health was given the power to create a set of regulations under which the Act operated. One provision was that every hospital, including mental hospitals, was required to report cases of venereal to the local Medical Officer of Health daily (The Globe 1918c). The surveillance of the feeble-minded was perpetuated by the *Act for the Prevention of Venereal Disease*.

Gender and the Politics of Blame

Justice Hodgins' (1918a) described two immoral classes as the primary sources of venereal disease: prostitutes, and the 'occasional prostitute' who engaged in illicit sex for advancement or physical enjoyment. He advocated for the expansion of the "laws of immorality", those associated with sex for hire (Hodgins 1918b). For Hodgins, prostitutes were the primary nexus for the spread of the contagion. His report recommended that an official be appointed to monitor the criminal courts on solicitation, bawdy houses, and venereal disease (Hodgins 1918b). What is remarkable is his assertion that the women's and juvenile courts must also be observed. His purpose becomes clear later as he discusses the 'protection of girls'. Justice Hodgins (1918b) states that young women who are required, for the sake of employment, to live in boarding houses away from their homes must be safeguarded from falling into 'vice'. Those who do must be reformed in female

detention centres for convicts from the female and juvenile courts. Detention centres would serve the purpose of providing respectable role models and connections to employment (Hodgins 1918b). It is clear that when Hodgins warns of children falling prey to the lure of vice, he is implying the danger lies with girls.

Venereal disease legislation disproportionately affected and restricted women (Buckley and McGinnis 1982). Prostitutes were understood to be the breeding ground for venereal disease and, as a result, the law was strictly enforced. Women who evaded compulsory treatment were more avidly pursued than men guilty of the same offence (Buckley and McGinnis 1982). According to Adams (1994), Hodgins' description of the second class of prostitute as women who engaged in sex for personal enjoyment or advancement reveals a moral value placed on the 'norm' of female sexual passivity. Women were dichotomized in the public eye as either pure or fallen. A married woman who contracted the disease was innocent, whereas a single woman was automatically a prostitute. There was no gradient of blame for women, the entire class of the 'fallen' was infested with sin and disease.

For men, the stain of blame was transitory. Men were, to some extent, expected to engage in illicit sexual activity, especially before marriage. A man who suffered this understandable lapse in moral judgement and contracted venereal disease was only a scoundrel if he shirked treatment. If a man sought treatment and believed himself cured, he was as innocent a victim as the wife he later infected (Dale 1922b). How did this transformation occur? His choice to enter a wholesome family life redeemed him in the eyes of society. Men infected with venereal disease could not only live in the shades of grey between morality and immorality, they could transition in and out of each throughout their lives.

Bill D, ***Act to Make Venereal Disease an Impediment to Marriage***

In Ontario, every effort was made to ensure that syphilitics did not corrupt the sanctity of marriage. Under the Provincial Board of Health under the *Act for the Prevention of Venereal Disease*, infected individuals were not permitted to marry until they were free of the disease (The Globe 1918c). This provision was expanded when, in 1928, a federal bill came before the Senate intending to bar all syphilitics from the institution of marriage. Doctors supported the bill, but it was

not passed due to concern that it would be ill-received by the public, particularly if women had to submit to a gynecological exam. However, the Senate debate exposed prevailing ideas about sex, marriage and gender, and unease about the mentally ill.

The bill was heavily influenced by the Social Hygiene Movement and the stigma associated with the mentally deficient. Three doctors gave evidence to the Senate, Dr. Gordon Bates from the Canadian Social Hygiene Council, Dr. C. M. Hincks from the Canadian National Committee for Mental Hygiene, and Dr. F.N.G. Starr from the Canadian Medical Association (The Senate of Canada 1928). The proposed act required each party be certified by a medical practitioner to be free of venereal disease within ten days of their marriage (The Senate of Canada 1928). Ensuring an individual was free of gonorrhea and syphilis required a physical exam and a blood test. However, the doctors believed testing women would alienate the public. They used epidemiological data to justify excluding women. Drs. Bates and Hinks concurred there was "no question that there are more males affected at the time of marriage than females" (The Senate of Canada 1928:16). Aligning with dominant values of female sexual passivity, Dr. Starr stated women should not be subjected to a physical exam on the "grounds of modesty" (The Senate of Canada 1928:28). The law would provide an educational benefit even if it did not prevent all the infected from marrying (The Senate of Canada 1928). By requiring testing for the grooms, more couples would become aware of the consequences of venereal disease and begin to police themselves.

Marriage Anxiety

In the course of the proceedings, the Senate learned that in State of Utah, a marriage was void if a party was infected with venereal disease (The Senate of Canada 1928). The senators were wary that syphilis might be used as a tool to dissolve marriages and they wanted clarification that the marriage was only nullified if the disease existed at the time of marriage. Later, Dr. Starr became concerned that venereal disease certification would prevent couples from getting married altogether (The Senate of Canada 1928).These examples reflect a prevalent anxiety over the disintegration of the institution of marriage. Social upheavals associated with industrialization, urbanization and immigration appeared to compromise the traditional integrity of Canadian society (Snell and

Abeele 1988). Venereal disease was a further threat because it represented vice and decay. As a method of controlling sexual behaviour, marriage was a line of defense against both venereal disease and social corruption. Matrimony was a pinnacle of tradition and morality and therefore it was upheld as a way of preserving the values of society. Preventing bad marriages was of paramount importance. Venereal disease was linked to an unhappy family life, still births and the ill health of parents and children (Snell and Abeele 1988). The threat that venereal disease posed to a happy family life and procreation encouraged legislation that regulated nuptuality.

Marriage was sacrosanct and therefore divorce was a difficult endeavour. Prior to 1930, when Ontario gained provincial jurisdiction for divorce, each divorce was passed as a private act in Parliament (Snell 1991). The difficulty and expense of the proceedings made it inaccessible to the lower class and consequently, it was a rare event (McFadden 1922). In 1892, the Atkinson divorce in Hamilton was so scandalous and unusual it was reported in a national paper (The Globe and Mail 1892). The church had a similar propensity to uphold ratified marriages (Sneel and Abeele 1988). In Hamilton, the Presbyterian, United, and Anglican churches publically disavowed divorce and refused to marry divorced individuals (The Globe 1921, 1929, 1930, 1932b).

Contention over divorce rates reached a peak when Ontario gained jurisdiction in 1930, a move which many felt facilitated a 'callous' disregard for marriage (The Globe 1929). Venereal disease contributed to rising divorce rates because infection was evidence of adultery. If one party contracted venereal disease, the other simply had to prove the guilty party had been infected after the time of marriage and that they were not responsible for the infection (Snell 1991). Justice Hodgins, the commissioner for the *Act for the Prevention of Venereal Disease*, presided over the Jackson divorce case in 1932. Mr. Jackson's venereal disease infection was used as evidence of adultery and, when questioned, he admitted to have contracted it from a woman in Hamilton (The Globe 1932a).

Eugenics and the Preservation of Society

Marriage was important for the production of family (Sneel and Abeele 1988). Due to anxieties over the degradation of the state, however, there was a push to breed morality by promoting traditional, normal families. Marriage became the

privilege of those who lived up to societal ideals. The medical community was not satisfied with government measures to safeguard the general populace from the mentally ill and to preserve 'race integrity'. In the debate of the *Act to Make Venereal Disease and Impediment to Marriage*, Dr. Bates argued that the Act be expanded to anyone who had venereal disease, suffered from tuberculosis, mental deficiency or insanity (The Senate of Canada 1928). Dr. Hinks argued that anyone with a form of hereditary mental illness, including insanity, epilepsy, mental deficiency, and nervous ailments, should be prevented from marriage (The Senate of Canada 1928). This type of restriction existed in Ontario, however individuals were taken at their word and they did not require medical certification to get married (The Senate of Canada 1928). The feeble-minded were again put on trial.

In the *Act for the Prevention of Venereal Disease* in Ontario, the feeble-minded were marked as a primary source and consequence of venereal disease. In the proposed *Act to Make Venereal Disease an Impediment to Marriage*, 'feeble-minded' and 'syphilitic' became effectively synonymous. Both were determined to be undesirable stock for the genetic quality of the Canadian race. Both were targeted as unfit for the preservation of society. Both became the victims of the ever popular Eugenics Movement. Labelling individuals as feeble-minded was a method of preventing them from having children. In Ontario, this label allowed for the segregation of this group in mental institutions where they could be surveyed and prevented from procreating (Radford and Park 1995). The *Act to*

The Eugenics Movement was a small faction of the larger Social Hygiene Movement anxious about social decay and racial purity (Radford and Park 1995). The goal of this movement was to prevent the mentally deficient, feeble-minded or otherwise 'unsuitable' citizens from producing offspring. The movement was most popular in Alberta, which in 1928 became the first province to sanction the sterilization of feeble-minded individuals (Radford and Park 1995). Sterilization of these groups was never officially sanctioned by the Ontario Government, however parental consent was given to perform numerous sterilizations on juveniles in institutions (Radford and Park 1995). For Hamilton, the movement was close to home. The Eugenics Society of Canada was founded in southern Ontario (Radford and Park 1995).

Box 9.1: Eugenics in Canada and Hamilton

Make Venereal Disease an Impediment to Marriage echoed the message of the Eugenic Movement by controlling who could and could not access the state-sanctioned method of reproduction, marriage.

The Law and Morality

What is the relationship between the law and morality? According to J.W. McFadden, the Assistant Crown Attorney for the City of Toronto, the law changes as the "moral conscience of the nation" develops (1922:25). However, he critiques the *Act for the Prevention of Venereal Disease* for treating a disease like a crime and bestowing punitive powers on medical officers. James Roberts, a Hamilton doctor and medical officer, supports this position (1922). McFadden argues that imprisoning individuals with venereal disease goes against the spirit of the law. His assessment of the Act suggests that the law is not the offspring of morality but, rather, that the two exist in a reciprocal relationship. Morality begets law and law begets morality. McFadden believes better laws would spontaneously develop as the nation acquires a better moral code. This assumes a universal and hierarchical progression of moral thought through time. Adams (1994) correctly integrates power into this model and asserts that the government chooses what morality it adopts into legislation. Many moralities exist within a nation, she argues, and are differentially integrated into the law as the result of power and popularity. The policies the government enacts establish 'normalcy' and therefore what citizens may aspire to emulate or revolt against. Moral trends from the citizenry are chosen by the government and the laws enacted, in turn, affect morality.

The laws and policies enacted by the government in response to venereal disease were heavily influenced by prevailing concepts of morality. Morality was revealed in the politics of blame. Single women infected with venereal disease were relegated to the class of prostitutes and labelled the primary spreaders of the affliction. Their violation of the ethical code of female sexual purity and passivity allowed them to be targeted by the *Act for the Prevention of Venereal Disease*. Both the *Act for the Prevention of Venereal Disease* and the proposed *Act to Make Venereal Disease and Impediment to Marriage* were biased by the popular Social Hygiene and Eugenics Movements. Both bills endeavoured to prevent people with venereal disease from marrying and producing children. Feeble-

minded people were described as a reservoir of venereal infection. They were understood as incapable of adhering to the moral codes of society and therefore composed a significant portion of the criminal and prostitute classes. Their genetic material was considered to be a threat to the integrity of a society many believed was in a state of moral decay.

Relationships of power determined which groups of people are targeted in legislation. Criminals, prostitutes, and the feeble-minded were already disadvantaged and socially stigmatized groups prior to the introduction of these acts. They did not adhere to the particular notions of normalcy or tradition that the powerful classes were craving amidst the 'collapse' of their society. In the case of venereal disease, the law had to balance morality and necessity. The debates over the proposed *Act to Make Venereal Disease and Impediment to Marriage* reveal that even though the government was advised on policy by medical practitioners, legislators were hesitant to implement the full measures due to a fear of the public reaction. Legislation concerning venereal disease had hitherto only targeted stigmatized groups. Legislating that 'pure' and moral women be examined was entirely different. In the mind of the public, venereal disease had been effectively confined to moral and social degenerates. The stigma of the disease likely meant that its prevalence was underestimated, a fact acknowledged by public authorities (Hodgins 1918a). However, this fear would have been minuscule compared to the anxiety created if the disease was found to be rampant in the general, morally upright populace. Women existed in a precarious state between pure and fallen, and being free of syphilis was a crucial aspect of this moral class. Testing 'pure' women could precipitate the realization that society was rife with sin and syphilis.

Medical practitioners advocated for stricter measures to control venereal disease, however the wishes and anxieties of the public were considered before this recommendation. Despite the fact that these pieces of legislation were designed to control people and their behaviour, Canadian citizens exhibited a degree of control over their government. Three groups: the public, the government and the medical community, negotiated their concepts of gender, sexuality and purity and their disagreements and compromises shaped the law.

10

An Imagined Antagonism: Prostitution and the Ideal Family

Alex Rewegan

…the feeble-minded prostitute is so dangerous a type, so devoid of responsibility and such a spreader of disease that she constitutes an important part of the general social hygiene question. This type of prostitute should be dealt with rigorously. (Bates 1922:62)

Interpreting the role of prostitution during Hamilton's venereal disease crisis is essential to highlighting the reality behind the taboo, stigma, and prejudices toward prostitution at the time, and to elucidating the social, cultural, and political histories that influence our past and present notions of human sexuality. Contemporary social attitudes are embedded in the past, thus this discussion offers an important lens through which to view modern concerns regarding sex and the socio-political regulation of sexuality. During the venereal disease crisis of the early twentieth century, "normative ideas about sex were created, examined, weighed, transformed, and translated into cultural practices" (Frühstück 2003:1). These normative ideas influenced the way people thought about sex, gender, health, and their bodies.

As venereal diseases are transmitted through sexual acts, prostitution becomes a useful medium through which to think about the ways in which the people of Hamilton reacted to a health problem that was facilitated by human sexuality. In this chapter, I interpret reactions of the Canadian state and society to prostitution during a time of rising concerns about venereal disease in which prostitutes became a major target in public health discourse. I reveal the ways in which the medical and political powers of the time influenced the collective moral consciousness of society in an attempt to rid the people of disease and prostitution. Finally, I demonstrate how the cultural construction of an immoral 'other', in this case, 'the prostitute', was an unjust tactic that only worsened the stigmatization and marginalization of vulnerable women.

The Socio-Political Construction of Immoral Prostitution

Throughout the nineteenth and twentieth century, governing institutions across the Western world (and Japan) began to collect statistics, survey populations, and produce bureaucratic assessments about different groups of people (Lock and Nguyen 2010). Within the context of a surge in urbanization, industrialization, and immigration, the control of mass societies became an economic and political priority for the state (Chunn 1997, Rutty and Sullivan 2010a, Mawani 2006). This increasing rationalization of the management of people and their bodies represents what Michel Foucault has deemed "biopower". He argues that the governing powers of the time developed "an explosion of diverse techniques for achieving the subjugation of bodies and the control of populations" (Foucault 1978:141). In exercising this biopower, authorities grouped individuals into distinct sub-populations which became entities for state management, regulation, and surveillance. The aim of this project was to transform people into idealized citizens who would adhere to particular methods of thought, live a particular lifestyle, and act in accordance with the expectations of the institutions in power (Foucault 1978, Mawani 2006). In a time of health crisis, the population could be broken up into manageable, measureable sub-populations in order to control, manipulate, and cure minds and bodies. Prostitutes became one of these sub-populations.

Different interpretations of prostitution have existed across the social and political realms of society. What it meant to be a prostitute at different times and

places was "constantly shifting, and [was] socially, politically, and culturally constructed" (Davis 2009:1). However, the negative attitude towards prostitution and 'immoral sex' was relatively consistent across these constituencies. The prostitute was looked down upon as an object that destabilized society. More specifically, during the early twentieth century, liberal states became increasingly interested in regulating reproduction (Chunn 1997, Mawani 2006). Policy makers and social institutions linked 'sexual promiscuity' to – in the words of eugenics – 'race suicide', and prostitutes were held up as the root of this problem (Chunn 1997, Mawani 2006).

Because venereal disease was spread through sexual activity, 'sexual deviancy' came to be framed as a public health concern. Being chaste, avoiding sex-for-pleasure, and maintaining a monogamous relationship with the sole purpose of reproduction was thought to be the only way to prevent infection (Chunn 1997, Davis 2009, Mawani 2006). In order to produce a society in which the population adhered to these expected sexual norms, people were encouraged to aspire to live in a conventional, middle class family (Chunn 1997:63). Reproducing this ideal middle class family became the focus of legislation, health care, and education. The ideal family, consisting of a breadwinner man, nurturer woman, and morally attuned children, was thought to guarantee the "moral, mental, and physical fitness of the population" (Chunn 1997:64). As venereal disease emerged as a major public health concern, in concert with World War I, sexually transmitted diseases shattered this image of the ideal middle class family.

In order to control their reproductive habits and align their behaviour to the expectations set forth by political and medical authorities, women became the primary targets of the social hygiene movement. Thus, if a woman were to engage in so-called 'uncommitted, promiscuous sex' with the interest of financial gain and/or pleasure, she was subjected to the disapproving gaze of governing eyes. 'The prostitute' came to represent the opposite of the ideal woman or the ideal mother; she represented a deviant body that undermined the permanence of the monogamous middle class family.

During the venereal disease crisis, Dorothy Chunn (1997) explains that there were three different groups into which women were slotted, depending on their social status. The first category consisted of innocent, yet potentially deviant women who were quickly educated and protected from 'immoral sex'. The second category was made up of already deviant women who could be saved by

immediate intervention, either by forcing compliance with state laws (see chapter 9), and/or by attempting to influence them to live a 'more virtuous' life. The last category consisted of irredeemable women, the already deviant and immoral not worth the effort to rescue, who became the subject of criminal, political, and social scrutiny. Women were thus imagined to exist along a moral spectrum with the innocent, ideal, hardworking citizen at one end, and the scum who catalyzed society's misfortunes at the other. The prostitute inhabited this latter category.

While venereal diseases were classified as a moral problem – in which 'sexual deviancy' contributed to the contraction and spread of infection – there were some cases where disease was excused as innocent and without moral shame. It was recognized that some individuals were not responsible for their affliction. Their personal form of disease was diagnosed as being separate from the type of venereal disease which was contracted by more common, 'immoral' modes of infection. Supposed forms of 'syphilis in the innocent' were cases of congenital syphilis (see Chapter 6) and, most noted in the primary literature, was the passing of disease from infected husband to an 'unaware' and innocent wife (De Forest 1894).

Box 10.1: Syphilis in the innocent

In one of Gordon Bates' (see Chapter 7) first publications on the venereal disease crisis, for example, he states, "the control of prostitution, and the control of venereal disease itself…[are] both perfectly legitimate public health fields" (Bates 1922:62). From the onset of the social hygiene movement, it is apparent that 'the prostitute' was viewed to be such a serious contributor to disease that she deserved to be recognized as the subject of an entire field of public health. Although some authorities discussed the male prostitute, the majority of the literature focused on women.

Consequently, while the medical realm of the early twentieth century was celebrated as embracing secular and positivist scientific methods, moral and religious ideologies continued to influence the medical discourse on venereal disease (Cassel 1987, Chunn 1997, Mawani 2006). Though it was scientifically understood that these diseases had biological causes, the manner in which they

were contracted placed them within the sphere of morality and framed them as problems of individual responsibility rather than socio-economic systems. Indeed, the norms of social morality pervaded the secular realm of positivist medicine. As the Canadian Social Hygiene Council (1922) claimed, the prostitute was a "*sinister figure* in the background of every case [of disease]" (35, emphasis mine). It was the prostitute's imagined moral misguidance and lack of sexual control which contributed the most to the venereal disease crisis and she was therefore depicted as evil and the antithesis to a virtuous woman.

Further, the council stated that "[the sex instinct]…seeks satisfaction and expressions which are at times at variance with our social institutions…the monogamous family institution [is] the institution which safeguards…the interests of childhood, motherhood, and society at large" (43). Delivered from the persuasive voice of respected scientific authorities, this statement unifies moralism and science. It asserts that, in the interests of society, "the sex instinct" should be mediated by a desire for moral purity and that sexuality is a malleable object of state affairs: the 'wrong' sexuality would damage the nation's integrity. If science could cure the biological form of disease, it could 'cure prostitution' by teaching the dangers of 'immoral sexuality' (Bullough and Bullough 1987, Chunn 1997).

Regardless of the political response to prostitution, it is important to consider how the views of these governing bodies translated into public perceptions of prostitutes. I suggest that the state succeeded in ensuring that prostitutes were effectively demonized. Canadian law and the social hygiene movement blended the ideals of a middle class, monogamous life and a moral, disease-free sexuality, ultimately making them appear as one and the same (McLaren 1986). By instilling this ideal into the minds of citizens, it legitimized the biosurveillance and control of the lower classes, including the 'feeble-minded' prostitute (Chunn 1997). To live outside the boundaries of the monogamous middle class family was to oppose everything that made society flourish.

In its goal to eradicate prostitution, the public health movement aimed not only to rid the nation of disease, but to restructure the very core of society itself (Bates 1922a). "The more closely men, women, and children adhere to the norms governing their respective roles in the white, middle class, nuclear family, the more freedom from state surveillance they [would] enjoy" (Chunn 1997:63). Regulating the way people lived helped to reinforce the state-produced fear of the

lower class. People were afraid to engage in activities deemed immoral because this meant being associated with supposed disease vectors, such as prostitutes, criminals, and more generally, the poor.

Foucault calls this 'othering', a process through which social distance is created between one group and another. This brings the respectable classes together under a common motive of protection and liberty from the wrongdoers of society (Carpenter 2011). Political theorists Laclau and Mouffe (1985) have claimed that 'othering' takes place by generating binary oppositions, such as good/evil. Concerning 'the prostitute', this binary relationship could be labelled as moral/immoral. In constructing an immoral enemy or antagonist, an ideal moral self is simultaneously created (the 'good', monogamous woman). Ann Davis (2009) has said, "in the process of representing her, those who produced the prostitute simultaneously constructed new and changing meanings about themselves" (xvi). Therefore, the nation-state's negative construction, stigmatization and marginalization of the prostitute was, at the same time, co-creating a citizen acceptable to political, economic, and medical interests.

I find it useful to juxtapose the situation in Canada to that of Japan in the same time period because of the parallels between them. Writing about Japan, Sabine Frühstück (2003:119) suggests that "at a time when women were refused political rights, the idea of lending their bodies to larger political goals and thus aligning their uterus with the [state] was too alluring". Thus, to be chaste, to protect the ideal family, was to be a strong political supporter. At a pivotal moment in the history of the suffrage movement, the venereal disease crisis gave women in Canada an opportunity to stand out as politically engaged. This was one of the first times women are believed to have played such a major role in a disease crisis. Therefore, not only were respectable and vulnerable women afraid of being looked upon as the immoral 'other', they also had political reasons for aligning themselves with the goals of the state, whether consciously or not.

The Hamilton Prostitute

At the beginning of my research I set out to tell the story of a Hamilton prostitute and to discuss the venereal disease crisis through the perspective of a stigmatized sex worker. 'The prostitute woman', however, did not exist as a single entity. Women often became engaged in the sex trade because of economic troubles

(Bullough and Bullough 1987, Diana 1985), but "[p]rostitution was caused by seduction, neglect of parents, idleness…the employment of young men in place of women…the prevalence of intemperance, music, and dancing in public houses, saloons, and theaters, female love of dress and of superior society, the seductive promises of men, the idea that prostitution is indispensable, poverty, want of education, ignorance, misery, innate licentiousness, and the profligacy of modern civilization" (Bullough and Bullough 1987:198). Clearly, it is an impossible task to identify and draw a boundary around 'the prostitute'. Gordon Bates (1922), however, believed prostitutes were a deviant category of people of minimal intelligence, who lacked the ability to take responsibility for their actions, their health, and the health of their customers. Bates' perspective seemed to have the greatest impact on social and medical policy. In a lecture given in Hamilton, he stated, "among women who can be definitely classed as prostitutes, undoubtedly a large portion are feeble-minded. Indeed estimates as high as 60 percent" (62).

Bates and other advocates of the public health movement associated feeble-mindedness, immorality, and prostitution with poverty. Yet, in a lecture to the same Hamilton audience, the Assistant Crown Attorney for the City of Toronto, J. W. McFadden suggested: "To allow young women to appear before judges and to be condemned without any effort being made to ascertain the cause of their downfall, their previous environment, their mental condition, is, in the light of modern thought, a most unwise and costly mistake. There is no necessary relationship between poverty and immorality…The American born white is better housed and has a better environment than the foreign born white, yet the American born white contributes more to the ranks of prostitution than the foreign born" (McFadden 1922:23-26).

It is clear that delegates to the Hamilton conference had differing opinions about what constituted 'the prostitute'. While it was certainly true that – especially in the United States – immigrants comprised much of the streetwalking prostitute population (Bullough and Bullough 1987, Pivar 1973), people engaged in the sex trade came from all walks of life, from all ethnicities, and worked from within and between all socio-economic classes (Bullough and Bullough 1987). This further supports McFadden's argument that "there is no relationship between poverty and immorality", although the state and other public health campaigners, along with the public, believed otherwise. McFadden, moreover, recognized that larger structural forces contributed to the disease crisis beyond prostitution.

The perception of the immoral prostitute permeated the Hamilton media and would have certainly influenced public attitudes toward the sex trade. Most notably, the majority of Hamilton's newspapers used Bates' rhetoric. On 16 February 1918, right at the onset of the venereal disease crisis, the Hamilton Herald (1918a) published an article stating: "It was not the middle class man who spread disease. It was the irresponsible, easily led lower class, domestics, the clandestine prostitutes who probably did not know they had the disease". From the beginning of the crisis, the Hamilton media played a role in perpetuating the idea that there was a relationship between poverty, disease, irresponsibility, and prostitution. In April of the same year, the Hamilton Herald (1918b) published another article quoting Bates that also claimed "I have figures here to show that these meetings between soldiers and women and girls which result in infection take place right here in Hamilton on James street, Main street, and your mountain stands out very prominently as a place where such infections occur".

It is clear that the process of 'othering' was taking place in Hamilton. These ideas further permeated the views of Hamilton's local authorities. The police chief, for instance, was reported to have said, "as soon as a woman is suspected of being a street walker, she should be examined" (The Hamilton Herald 1918b). Not only was it unjust to conclude that all streetwalkers would be infected, but he seems to imply that Hamilton authorities – including public health workers – were ignorant to the fact that other forms of non-street prostitution existed(brothels and escorts to name a few common examples).

However, according to Hamilton newspapers, the sex trade was a real phenomenon in Hamilton, although it is difficult to confirm how common it was: "Street Walkers: Police Active but Girls Are More So" (The Hamilton Spectator 1912a), "Street Walking Prevalent Here: Chief Smith Says Orders to Close All Such Places in City" (The Hamilton Herald 1914), "Police Start A Crusade Against The Street Walkers" (The Hamilton Times 1911). The root of the problem came not simply from blaming 'the prostitute' for venereal diseases, but from forgetting that the sex act involves two people.

A mistake made by many local and national social hygiene advocates was to argue that 'immorality' and prostitution only existed amongst the lower classes (Bullough and Bullough 1987). While it may be true that many prostitutes came from a poorer class, the sex trade infused all levels of society. Clients were drawn primarily from the middle and upper classes (Cassel 1987, Bullough and

Bullough 1987, Finch 1993). I suggest that this lies at the very core of why the venereal disease crisis and prostitution became such a prominent public health concern. If the hardworking, middle and upper class men who afforded Canada its economic successes – and therefore supported the power of the state – were to be struck with disease, the ideal monogamous family would be in jeopardy, along with the legitimacy of the government and its social institutions. "It was much easier to deal with such a visible symptom as prostitution" (Bullough and Bullough 1987:197) and to construct her as an enemy of the state (the immoral 'other') because this protected the moral, hardworking man from having to bear that label.

In 1918, The Hamilton Herald (1918c) published a front page article which referenced a statement by Hamilton doctor R. H. Paterson. Based on annual medical reports, Paterson suggested that 60 percent of the adult male population had already contracted a venereal disease (primarily gonorrhea). This is indeed revealing. If up to 60 percent of the male population in Hamilton had recently contracted a venereal disease, why was the blame so heavily placed upon prostitutes? Surely the number of prostitutes did not match Hamilton's total adult male population. This either means that each and every prostitute from streetwalkers to high paid escorts infected many men each day, or, as I would argue, that the middle and upper class man was equally, if not more responsible – either by adultery, casual extramarital sex with non-prostitutes, and the passing of their disease to an unaware wife (and from wife to unaware husband). 'The prostitute woman' was no more deserving of her immoral conviction than was any other member of society.

To claim 'the prostitute' was the source of the venereal disease crisis was inherently flawed because, as I have argued, such a homogenized 'other' did not really exist. Women existed in a multi-layered, multi-faceted, intersecting social world crowded with diverse subjectivities that could never be branded by what the governing powers envisioned as the objective qualities of an 'impure', 'immoral' body. To blame prostitutes for spreading venereal disease entirely neglected the other actors at play, all the while criminalizing and stigmatizing an already marginalized group of people. I argue that state intervention during the venereal disease crisis violently misrepresented 'the prostitute' by constructing her image to manipulate, control, and 'cure' the minds and bodies of the people of Hamilton, Canada, and the West.

11

Holy Intervention: The Church and Disease

Grace Carruthers

Fools because of their transgression, and because of their iniquities, are afflicted. (Psalms 107:17)

And ye shall serve the LORD your God, and he shall bless thy bread, and thy water; and I will take sickness away from the midst of thee. (Exodus 23:25)

Syphilis is a disease that is imbued with moral implications. The disease was stigmatized because it was believed to be transmitted through 'improper' sexual contact. At the turn of the twentieth century, morality issues were still very much under the jurisdiction of the churches, and so Christianity found itself in possession of a voice in discussions about venereal disease. Here, the churches had a choice: they could use their position of moral authority to demonize what they considered to be deviant sex and those who participated in it, or they could reach out in the name of Christian charity and offer aid. It appears that they often opted for the latter.

Protestant churches in Hamilton such as Knox Presbyterian Church and Barton Street Methodist Church were influenced by the same trends that affected other Ontario churches, and shaped the way they dealt with the scourge of venereal disease. The structure and purpose of churches themselves were

changing in the face of an industrializing and increasingly stratified society. As they offered Christian aid, each Christian sect was modernizing and identifying the areas of life over which they held dominion, such as morality related to family structure and sex. In attempting to address the often taboo topic of sexuality, Protestant churches operated as catalysts of social work and education to better ensure the safety and health of cities like Hamilton. As instructional literature distributed by the Anglican Church stated, "every dictate of modesty and delicacy bids us close our eyes and seal our lips, but on which paramount duty bids us look and speak" (Tucker 1916). Instead of remaining silent or expending church efforts on damning the afflicted, as might be expected, clergy and congregations of different denominations put their efforts towards disseminating information, some of it cautionary, and some of it downright encouraging.

The Changing Face of the Canadian Church

As the twentieth century dawned, Canada was experiencing economic, social, political, and many other kinds of change, and its churches were forced to adapt, or become obsolete. Cities like Hamilton faced a growing working class as industrialism advanced. The promise of work in the factories of these industrial cities drew in immigrants and rural people, and as they arrived, the cities grew. This process of urbanization had another effect; the growing working class found itself distinct from, and looked down on, by the middle class (Christie and Gauvreau 1996, Christie and Gauvreau 2010).

Various denominations in urban Ontario found members of the middle class to be desirable congregation members. Secularization loomed, and the middle class could provide funds to keep the churches operating. As time went on, however, it became clear that this system was flawed. In spite of middle class prejudices, the members of the working class desired a church presence in their lives (Gauvreau and Hubert 2006: 229).

In turn, churches came to realize they were serving a minority population when they limited themselves to the middle class in industrial cities like Hamilton and Toronto, which would lead them even further into irrelevance in these urban centers. Protestant church leaders also came to feel that the working class was in the greatest need of Christian teachings. Lacking access to respectable kinds of leisure, working class men were believed to be more susceptible to drink and

gambling and the churches felt it was their responsibility to present them with more respectable choices (Marks 1996: 29, 151). This change in perspective brought actual changes to church structure, and allowed congregations to grow in industrial cities like Hamilton. Barton Street Methodist Church, for instance, brought in Reverend H. G. Livingston, who was applauded by The Globe as being "Not a Mere Preacher but a Man Who Will Work," as he engaged with the issues affecting the industrial worker (Globe and Mail 1908). The changes were so effective that the Barton Street Methodist Church reached the status of third largest Methodist church in Canada (see Figure 11.1) (Christie and Gauvreau 2010: 65).

Family structure was also of key importance. By integrating the working class into their congregations, the clergy hoped to increase attendance. Their hope was that as a man arrived for Sunday service, he would bring along his wife and children, which would further bolster congregation numbers with members of a proper Christian family, a product of the churches' effective teachings. In the nature of the Victorian 'separate spheres', a mother and father would have different Christian responsibilities, inside and outside the home (Christie and Gauvreau 2010:82-83).

Figure 11.1: A group congregates outside Barton Street Methodist Church (Henleys Hamilton 1).

The Christian family was structured in such a way that parents were expected to imbue everyday proceedings with Christian morality. Though they would lead proper Christian lives as a good example to their children, they would leave the majority of the actual moral

teaching to the church and to the newly established Sunday schools (Christie and Gauvreau 2010: 82). With families following these guidelines, the churches could emphasize that every day of the week, not just Sunday, was to be lived in a moral fashion.

These guidelines also extended to the bedroom. The churches, still trying to market themselves, were recognizing that people responded better to positive reinforcement. Slowly, the churches' stance on sex changed. After all, the next generation of Christian children, on whom the churches relied, could not be made without sex. Instead of condemning any sexual act, they began to preach healthy sex, sex that supported the concept of social purity (Marks 1996:151).

Pure and Simple

It was a new century and the churches were willing to change, but they were unwilling to sacrifice stringent, Christian regulation. It was within these parameters that the social purity movement took the interest of Canadian churches. The social purity movement was intended to regulate society (and sex) in keeping with high moral standards. It followed all of the same parameters as the social hygiene movement discussed elsewhere in this book, but drew its motivation from devotion to Christ. The driving force behind it was that if an individual lived his or her life as Christ would wish, they (and the society with which they interacted) would not be at risk of societal pollution like venereal disease.

The social purity movement progressed through the integration of non-denominational Christian groups, such as the Women's Christian Temperance Union (WCTU). The WCTU campaigned tirelessly against such moral failings as unwed mothers, prostitution, abortion, pornography, and any other instance that might lead to impure sexuality. The concerns of the social purity movement extended beyond issues related to sex and sexuality. For instance, as their name suggests, the WCTU strongly opposed the consumption of alcohol, to the point that members would pray loudly outside of bars and taverns in hopes that men would be too ashamed to enter (Valverde 1991: 59). Of course, the problem with alcohol was not the drink itself; it was the inebriated actions that followed that caused strife to the members of the WCTU. A drunken man was believed to be more susceptible to the advances of prostitutes or immoral or 'feeble-minded'

women (Valverde 1991:62). This kind of impure sexuality lead to venereal disease, and it was this impure sexuality that the WCTU sought to eradicate.

Interestingly, and perhaps unexpectedly, organizations explicitly attached to certain churches did not condemn or shame people on the same scale as organizations such as the WCTU. Wholesome societies such as the Epworth League, for instance, were instituted for young people. The league was a tool of the Methodist church and offered activities that not only kept youth off the streets and out of trouble, but improved the Methodist community. Instead of cavorting with undesirables, members of the league planned and attended dances and sports held on church property, combining fun with morality (Globe and Mail 1920b). Its members could run the Epworth League newspaper, the Canadian Epworth Era, or participated in missions where they disseminated literature, both of which widened awareness of the Methodist church. To give an idea of the scale of these ventures, in 1902 alone the league was commended for handing out 45,680 volumes of Methodist literature in Ontario (Globe and Mail 1902). By reaching people when they were young, the Methodist church could ensure that they grew up instilled with Christian morals, and spread the message to others. The type of person involved in the Epworth league would never be seduced by the debauchery that led to diseases like syphilis.

Churches offered moral alternatives to those adults considered to be most susceptible to immorality, such as recent immigrants or the 'feeble-minded', including lazy and poor people. Methodist pamphlets and speaker series on social and sexual purity were arranged to keep adults aware and entertained (Christie and Gauvreau 2010:63-72). Even the Canadian Journal of Public Health went as far as to promote church activities in church buildings as measures that could prevent venereal diseases. It was suggested that church members could "canvas their neighbourhoods" and by approaching at-risk youths to inform them that they were welcome in a wholesome community, prevent them from turning to the kind of life that might lead to syphilis (Canadian Public Health Association 1910:172).

To further reach their target audience, churches sent out city mission volunteers (like those in the Epworth League) to underprivileged areas of industrial cities like Hamilton. As was the case in overseas missions, these city missions sought to bring the 'uncultured' into the Christian fold. One might claim that the city missions were more crucial to the churches than overseas missions, as these initiatives had the potential to grow the congregation at home and

improve the atmosphere in the churches' own cities (Gauvreau and Christie 2010:99). It was a case of mutual benefit. The churches could boast full pews, and the previously unchurched would learn to live a Christian life and enjoy social purity, free from diseases caused by immorality.

Educating the Christian Masses

Though the clergy believed that living a Christian life went a long way toward preventing disease, it was evident that it took more than attending church on Sunday to squash syphilis entirely. Unlike medical and military efforts to treat syphilis, the church's actions were almost purely preventative. It would have been pointless to preach social purity to a person who had already contracted the disease. Whether or not the churches felt an individual with syphilis deserved their help, there was simply little that could be done without the aid of science. The healthy, however, still stood a chance.

Even though syphilis was a "secret plague" (Cassel 1987), dissemination of information was essential to combat it. It was in this spirit that the churches joined the sex education movement. Early sex education was similar to the social purity movement, but focused more on spreading the message than on the actions that were taken, and as such resembled sex education conducted in public schools today. For instance, roving Methodist "purity educators" (Valverde 1991:53) were sent forth, under the leadership of Reverend Samuel Dwight Chown, General Superintendent of the Methodist Church (1910 to 1925) and Secretary of the Department of Temperance and Moral Reform. They taught young Canadians that sexual feelings were natural and, if dealt with responsibly, would not result in negative consequences like syphilis. Despite the fact that these teachers were openly discussing such a forbidden topic, they maintained the propriety expected by the church. Girls and boys were taught separately, mirroring the separate spheres in which their parents lived their lives. It is important to emphasize that while these teachers were affiliated with the church, they were not clergy. Perhaps because of this, teachers gave their lessons with their own personal style, unimpeded by any restrictions other than their own moral codes (Valverde 1991:67-76). Arthur W. Beall from the WCTU, for example, presented a dissuasive attitude towards sex, while William L. Clark and Beatrice Brigden from the Methodist church (see Box 11.1) presented more positive attitudes.

They were not alone. Churches worked in tandem with other institutions in addition to the WCTU, such as the Canadian Social Hygiene Council, the Canadian Association of Social Workers, and the Social Service Councils of Canada and Ontario. Influential clergy took the reins of certain institutions and ran them as extensions of their own religious denominations, such as Methodist Reverend Samuel Dwight Chown's involvement with the Department of Temperance and Moral Reform (mentioned above), and Reverend John G. Shearer from Knox Presbyterian Church in Hamilton, who lead the Moral and Social Reform Council of Canada (Valverde 1991:54).

Denominations varied when it came to their perspective on sex education. For every encouraging piece of literature Chown and the Methodists set forth, Shearer would produce a bigoted piece decrying Jews and immigrants, blaming them for the prevalence of venereal disease (Valverde 1991:53-54). Still, even Shearer managed to spread the positive message that by following Christ's teachings and abstaining from excessive drink and immoral sexuality (here meaning acts like adultery or prostitution) one could be safe and healthy within the institution of the church. Both Chown and Shearer recognized that syphilis was an issue that needed addressing through sex education reforms, and the church could be one of the structures through which lessons were taught.

Beatrice Brigden (1888-1977) began as a Manitoba farm girl and as an adult taught a generation of girls and women that their sexuality was not a source of shame. Her sex education lectures eschewed the harsh intimidation tactics of some of her male colleagues, instead discussing how purity could increase one's enjoyment of life (Christie and Gauvreau 1996:53). She developed curriculums for different age groups, mixing simple biological science for young people with critical preventative measures about venereal disease for adults (Valverde 1991:73). Women flocked to her entertaining, but never crude lectures in such droves that it was said local men complained that when Beatrice came to town, as there were no women left to pay attention to them (Christie and Gauvreau 1996:53)! Brigden went on to make great strides for women's rights in Canada, but she got her start ensuring that women understood that sexual disease was the enemy; not their own bodies.

Box 11.1: Beatrice Brigden

There were many institutions based on healthy living during the period covered by this book and they were not necessarily always based in Christianity or on disease control. Even when not affiliated directly with a specific denomination, this union of church and health institution to disseminate health information could take place directly in the churches themselves. The Toronto Social Hygiene Council held weekly meetings in a church and hosted influential speakers, adding to the sex education speaker series organized by churches (Canadian Public Health Association 1910:525-526). Here, efforts were being made by both religion and science to improve sexual health in cities. Ministers were also encouraged to inform their congregations about the dangers of venereal disease. "If life is to be kept right we must begin at the very source, whence springs all that tends to life and action", affirmed an informational pamphlet on venereal disease for clergy, indicating that the problem was being acknowledged and handled with gusto (Ingles, date unknown). The churches and social institutions were happy to work alongside each other to try to quell the advance of venereal disease, and were pleased to do so from a place of charity and hope.

A Positive Christian Hamilton

This unexpected air of general positivity (notwithstanding the negative positions taken by Rev. Shearer) was crucial in a city facing an epidemic of both disease and social stigma. Instead of demonizing the working class for perceived moral failures, the churches welcomed the working class by offering positive aid in response to the problems that plagued them. This approach would have drawn people into churches experiencing dwindling congregations, and would have provided frightened, uninformed people with a haven in which to learn and belong. Though it broke with earlier traditions, Christian sex education was a mutually beneficial process.

In fact, it could be claimed that nearly all of the churches' participation in the venereal disease crisis was mutually beneficial to those institutions and to society in general. The social taboo surrounding discussions of sex and venereal diseases had been far outside of the realm of the nineteenth century church, and that was part of the reason why churches were facing a declining presence in society at the dawn of the twentieth century. When the churches recognized that they needed to change, they did so. The people of Hamilton and other parts of

Ontario faced the threat of venereal disease and sought comfort from the fear of sickness and shame associated with it. A gap existed in the culture of the city that was letting venereal disease through, and it needed to be filled with ‘moral’ alternatives and clear, non-judgmental information. Fortunately for the city and churches of Hamilton, this gap was breached and both found a way to help the other.

12

Effects of Perception on Treatment

Dhananjay Tomar

During the great war, the Venereal diseases were brought out in light...people learned how innocent women and children suffered through no fault of their own; how gonorrhoea sterilized the race and syphilis destroyed it...but, even today it is difficult for many to consider that these are two communicable diseases and should be treated as such, by the health department. (Fleming 1933:30)

Until the First World War (WWI), venereal diseases (VD) in North America, and by extension in Hamilton, were considered a punishment suffered by those who transgressed the moral code. Religious beliefs formed the basis for this code and VD was rarely discussed in the public domain. Media such as newspapers, for instance, rarely carried medical articles related to VD. This changed during WWI when public discussions of VD became more frequent, with the intention of dispelling myths and ignorance regarding these diseases. But, ideas regarding moral transgression were so embedded in the minds of the general public that even after this, VD could not be seen simply as a set of communicable diseases but rather was viewed as a massive breach of moral conduct (Fleming 1933).

This chapter considers the effects of perception on syphilis treatments available in the early to mid-twentieth century. Because medical professionals were also part of the wider society, they must have been influenced by the moral

codes that stigmatized patients with VD, an influence that may have extended into their practice of medicine. I suggest that treatment regimes – which contained toxic materials with known detrimental effects – may have continued to be used after the discovery of penicillin because of physicians' negative perceptions of their patients.

Code of Conduct

According to Sayer and Corrigan (1985), morality refers to behaviours considered normal, natural and obvious. In reality, such behaviours are ontological (referring to the nature of being), and epistemological (referring to the nature of knowledge), and arise from social history (Adams 1994). The moral code is a scale along which behaviours are determined to be acceptable or unacceptable and forms the basis upon which formal laws are enacted within a society. These moral codes, and the laws derived from them, determine whether individuals, on the basis of their actions, are considered to be victims or offenders. Individuals abiding by these codes are extended help, whereas those considered to be breaching them are often prosecuted (Adams 1994).

The question addressed in this chapter is what role did moral codes play in the perception of VD? And, is there any evidence that the moral code influenced the kind of treatment people suffering with these diseases received? Venereal diseases were considered to reflect a breach of the moral code (see Chapters 10 and 11). The moral fabric of the Judaeo-Christian world, and by extension of Hamilton, was largely determined by Biblical interpretations, which prescribed that sexual relations only occur within marriage (Hefner 1993: 25). The subject of non/extramarital sex began to be discussed more openly during the First World War (WWI) when the prevalence of venereal diseases became a concern, even though there was general uneasiness about publicly discussing the topic of sex. The problem at the end of the day was that VD was considered to be different from other communicable diseases. From a scientific point of view, however, syphilis, gonorrhea and chancroid were simply communicable diseases whose mode of transmission involved intimate sexual contact (Fleming 1933). The mode of transmission became the central issue; more specifically, unacceptable forms of sexual behaviour, such as sex outside of marriage or with numerous partners, were considered improper. Together, these factors resulted in VD

becoming synonymous with moral transgression in the early part of the twentieth century.

Perception

Public perception is inherently associated with societal beliefs which in turn are derived from moral codes. Certain ideas and actions seem more appealing because they are perceived to align with the moral code, the prerequisites of social norms. Others are unappealing because they go against the moral code, the social norms, of what is acceptable. In the case of VD, social shame and stigma were strongly attached to the diseases, not only for the patient but also for the doctors treating the patient. The embarrassment of being diagnosed with a venereal disease meant that many people who could not afford to pay a private physician were less likely to get treatment because they were required to attend public clinics (see Chapter 5).

According to MacDougall (1994), doctors also felt embarrassed to deal with patients with VD, an activity which itself was stigmatized, and they often felt undervalued in comparison to their more prestigious counterparts who were working, for example, as neurologists or surgeons. This perceived stigma and discomfort meant that both patients and doctors terminated the treatment as soon as the patient felt better. This reluctance to treat and receive treatment was especially problematic because, nationwide, the number of STD (sexually transmitted disease) clinics had increased from 54 in 1922 to 102 in 1932. During the same period, Hamilton also saw a rise in these clinics but no substantial reduction in the numbers of cases of VD infected individuals (see Chapter 5). Efforts were made during and after WWI to change the public perception of VD but since moral values are the determinants of public perception, it was a very difficult task.

The Law

The Venereal Disease Prevention Act introduced by Dr. John M. S. McCullough (1918), public health officer in Toronto, was a major step forward in efforts to change public perceptions of VD. This Act was the first formal document in Ontario with an educational purpose at its core by telling people that having VD

did not necessarily translate into moral transgressions because individuals could become infected through no fault of their own (see Chapter 9). One of the objectives of this Act, which can be deduced from its contents, was to protect the identity of individuals afflicted with VD because of the social stigma associated with these diseases.

Penicillin, discovered by Sir Alexander Fleming in 1928, refers to a group of antibacterial drugs which are also known as antibiotics. Fleming was studying the plate culture of the bacterium, *Staphylococcus aureus*, which was contaminated by a mould, penicillin mould, and in its presence the bacterial culture was dissolved. This led Fleming to deduce that the chemical produced by the mould has antimicrobial properties and this deduction led to the discovery of penicillin. It was one of the first drugs to be effective against infections such as syphilis and is used to this day as an effective treatment against it.

The discovery was difficult to translate into a tangible treatment. The first large-scale production of penicillin only occurred after 1943, but it was not large enough to satisfy the needs of North America and was reserved specifically for treating soldiers during WWII. It was only after the mid-1940s that the production of penicillin could adequately satisfy the general needs of the North American population.

Box 12.1: Brief history of the discovery and development of penicillin (Fleming 1945).

Treatments

Syphilis, chancroid and gonorrhea, the three diseases that made up the medical category of venereal disease in the early twentieth century, are indeed dangerous if not treated in time but so is any other communicable disease arising from bacterial or viral infections. The emphasis placed on VD, it seems, was especially strong because it was distinguished by its stigmatized mode of transmission from other non-sexually communicable diseases. Given the fact that VD was accorded undue attention, the ways to prevent it were also much publicized. An information booklet called National Health Series no. 25 claimed that VD could be acquired from towels, toilets and bed linens, in addition to sexual intercourse (Publicity

and Health Education Division, Ottawa 1942). The chances of contracting VD by these routes is extremely remote (West Virginia 2014) and therefore a lot of ignorance existed among the public because of misinformation.

From the time of the ancient Greeks to the mid-twentieth century, heavy metals such as mercury and arsenic were used to cure venereal diseases (le Riche 1964). In earlier centuries, patients were secluded in hot rooms and were massaged with mercury ointments and left close to a fire to sweat in the hope that diseases such as syphilis would be curbed. But, such treatments often resulted in terrible side effects such as neuropathies, kidney failure, ulcers, loss of teeth and in many cases, death was the final result. These toxic effects, even in trace amounts, were well known and well publicized. In 1823, for example, Dr. William Burnett published reports on the dangers of heavy metal poisoning, which in humans generally results from the bioaccumulation of trace amounts of metals, such as mercury, lead, and cadmium.

Heavy metals, mercury and other substances with toxic effects were nevertheless used as treatment options for VD in Hamilton, as can be seen in Tables 12.1 and 12.2. According to Martin's (1916) study, diarsenol resulted in alarming symptoms among patients such as nausea, vomiting and apparent collapse. But, these symptoms were limited only to the patients who took a specific batch of this drug and therefore the drug was considered to be generally effective in treating syphilis. Diarsenol (Martin 1916), Novarsan (Khaimovskii and Saitbaeve 1950), and Tryparsamide (Hawking 1941) were all made of arsenic, which is toxic to humans (Singh, Goel and Kaur 2011).

The important point here is that venereal diseases were considered so very dangerous that treatment regimens consisted of substances of a highly toxic nature whose effects were well known. A case can be made for a risk-benefit trade-off in that emphasis was placed on making sure that a patient was treated for VD (hoping for a possible cure because the individual was seen as a danger to the public), even if that treatment represented potential danger for the patient.

Treatment	Number of Treatments Provided
Diarsenol	1652
Novarsan	1197
Tryparsamide	328
Mercury	778
Bismuthic	2999
Medicine	895
Others	717
Total	8566

Table 12.1: Treatments for syphilis in Hamilton, 1931-1932 (City of Hamilton 1932:23)

Treatment	Number of Treatments Provided
Arsenic	66
Mercury	839
Penicillin	781
Total	1686

Table 12.2: Treatments for syphilis and gonorrhea in Hamilton, 1950 (Clarke 1950: 38)

It is difficult to understand why mercury and arsenic continued to be used as treatments for syphilis and gonorrhea after 1943 when penicillin became available in Hamilton (ABC 1998). Hamilton's VD clinics continued to use heavy metals and arsenic until 1950, as Table 12.2 shows. The report by Dr. L. A. Clarke (1950) of the Department of Health, Hamilton, Ontario never discussed the reason why this practise continued until 1950. The production of penicillin increased exponentially by the late 1940s (ABC 1998) which meant that Hamilton must have had sufficient quantities of it; the number of patients who were administered penicillin were indeed very large, according to Table 12.2.

There are at least three possible explanations for the continued use of toxic treatments for VD after penicillin became available. The first possibility is that older doctors who had lived through the times of extreme negative perceptions toward VD had internalized those perceptions. This could have led them to continue to use the old mercury- and arsenic-based drugs in addition to penicillin because of their negative perceptions of patients who had venereal disease. The second possibility is that doctors were not entirely convinced of penicillin's ability to cure patients of syphilis and other venereal diseases. This would have motivated them to use mercury- and arsenic-based drugs in addition to penicillin.

The third possibility could be that it was the younger doctors who were using penicillin exclusively because they were not influenced by the stigma of VD to the same extent as their older colleagues.

These three possibilities are by no means mutually exclusive, in that a combination of them, or all of them together, could have resulted in mercury- and arsenic- based drugs being used to treat VD until 1950 in Hamilton. It is also important to note that these are possibilities which are deduced on the basis of evidence presented in Tables 12.1 and 12.2 and knowledge of the social atmosphere of early twentieth-century Hamilton. The evidence is by no means extensive but I judge it to be adequate to support these conclusions.

The ideas that persist in a society, which are considered to be the norm, become prevalent only because a majority of the society internalizes those ideas. After all, what is a society if not its inhabitants: humans. All of the ideas, laws and systems, therefore, are created based on a general acceptance that certain behaviours are morally correct. Sex outside of marriage was, and in many cases still is, a morally illegitimate behaviour, which is why VD was considered to be objectionable and, by extension, so were the patients who had contracted it. Perhaps in Hamilton, the stigma of VD led to faulty treatments that had dangerous effects on people considered to have behaved in socially objectionable, dangerous ways.

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