Failures do not occur Douglas. There is not a single case on record of a woman fitted with the Gräfenberg ring becoming pregnant.¹

Ethel Mannin, 1930s

The excerpt above is reproduced from the correspondence between Ethel Mannin and Douglas Goldring — two literary figures of the interwar years. Ethel Mannin, a British novelist, recommended the Gräfenberg ring, an early version of what later became known as an intrauterine device (IUD), to her friend Douglas Goldring as an effective method of contraception for his wife, Malin Goldring.² Mannin had been fitted by Norman Haire, a Jewish-Australian gynaecologist and sexologist and a well-known, if eccentric, figure within London’s elite medical community; he had an exclusive, private clinical practice on Harley Street. Norman Haire was not alone in experimenting with the ring. The female gynaecologist Helena Wright, with the backup of the Birth Control Investigation Committee (BCIC), was testing the ring in her private practice, while Dr Margaret Jackson also fitted her patients with the device in her private practice in Devonshire up until the 1960s, at which point she started testing other new intrauterine devices as well.

The last chapter of this book takes the testing of the Gräfenberg ring and later forms of intrauterine devices as a case study through which to explore the crucial contributions of Helena Wright and Margaret Jackson to the assessment of new contraceptive technologies, from a transnational perspective. Despite its short-lived use in the 1930s, the success of the ring constituted evidence that new contraceptive technologies were much needed. As I have shown in Chapter 1, female
doctors became increasingly engaged with the testing of contraceptive devices and the broader production of medical contraceptive knowledge from the 1930s onwards. Finding an efficient, reliable and easy-to-use contraceptive method was one of the key goals of birth control activists in the interwar years and onwards. Indeed, birth control advocates agreed that contraceptives prescribed in birth control clinics remained unsatisfactory in terms of reliability, and difficult to use for certain clients. The Gräfenberg ring was seen as a promising reliable method; it only needed to be re-inserted once a year, and therefore was less constraining than the cap or the diaphragm. It had the particular appeal of preventing pregnancy without interfering overtly with the sexual act. In addition, the ring had to be inserted by a physician, preferably a gynaecologist, giving it greater medical credibility.

However, before being endorsed and widely prescribed in birth control clinics, the ring had to be tested and approved. Drawing on the archives of the National Medical Birth Control Committee, articles published in medical journals, proceedings of international conferences and reports on contraceptive tests and trials, this chapter explores these clinical trials in detail, and places them within the wider British and international medical and professional context. It examines the criteria deemed essential for the assessment of a new contraceptive technology and therefore the ways that medical authority and expertise were obtained and secured. Wright, Haire and Jackson had divergent medical authority and visions of expertise, evident in the networks that supported them and the criteria they used to assess the ring. Wright tested the device with the support of the research-driven elite of the BCIC and adopted the standardised clinical assessments and laboratory-based evidence promoted by the BCIC; she also provided a careful statistical analysis of her patients’ records. Haire, on the other hand, was well connected and respected internationally, but had difficulties in being accepted by the BCIC. He did use statistical analysis, but did not provide a careful analysis of his patients’ records, and his clinical expertise seems to have been based on accumulated experience and expert observation rather than sound statistical analysis. From the mid-1930s, Jackson fitted her patients with the device in her own private practice and collected information on these patients’ experiences. In the mid-1960s, her clinic was one of the four international centres of the Co-operative Statistical Programme, a large-scale study on the safety and
efficacy of IUDs directed by Austrian-American physician Christopher Tietze and funded by the Population Council.5

This chapter first focuses on the ways the Gräfenberg ring became internationally debated before turning to its testing in Britain in the interwar years, and the testing of new forms of intrauterine devices in the postwar era.

Transnational experts on the Gräfenberg ring

Invented by Dr Ernst Gräfenberg, a German gynaecologist who owned a private practice in Berlin and started experimenting with intrauterine contraceptives in the early 1920s, the Gräfenberg ring was made of silver or gold wire, twisted and inserted in the uterus.6 Gräfenberg presented this new device at the Third International Congress of the World League for Sexual Reform (WLSR), which took place in London in 1929. He started by stressing that the assessment of a good contraceptive method rested not only on medical and hygienic considerations but also on women’s ‘subjective experience’.7 The ring answered a demand from female patients, since it required no preparation or touching of the genitals – what Gräfenberg qualified as common ‘psychological repugnance’.8 He first differentiated the ring from other intrauterine pessaries available at the time, such as the stem pessary, the Put’s pessary, and various silkworm guts held together by silver wire. These intrauterine pessaries lay in the uterus but maintained contact with the vagina, and as such ‘provide[d] a path whereby germs from the vagina might enter the uterus’.9 The Gräfenberg ring, by contrast, was a ‘genuinely intrauterine method’10 with no open path between the uterine cavity and the vagina or cervical canal. Gräfenberg then reported on his first attempts at developing the intrauterine device: he had tested star-shaped devices with coils of silkworm gut, but faced a high number of failures due to their expulsion from the uterus. He eventually settled for a ring of coiled silver wire, trialled on 150 patients; he estimated the failure rate at 0.66 per cent, since only one ring was expelled, resulting in a pregnancy.11 Gräfenberg vigorously emphasised the contra-indications of the ring: any infections were identified through a thorough examination of genital secretions, inflammation of the pelvis and menorrhagia. Finally, he provided a detailed step-by-step guide for inserting the ring under careful aseptic conditions. The procedure
relied on sterilised specialised surgical equipment including a uterine sound, a vaginal speculum, volsellum and tenaculum forceps, and Hagar’s dilator (a series of cylindrical bougies of graduated sizes used to dilate the cervical canal). These instruments were all in routine use by gynaecologists from the turn of the twentieth century. The position of the patient during the fitting – lying on her back with knees bent, legs spread apart and feet in stirrups – also marked the use of the Gräfenberg ring as an ordinary part of gynaecology. While Gräfenberg claimed that ‘the operation involved only the slightest pain’ and that anaesthetic was unnecessary, he nevertheless acknowledged that slight pain and slight bloody discharge ‘invariably’ followed the insertion of the ring. If these side effects lasted more than a couple of days and the pain increased, the ring had to be removed.

Members of the BCIC attended the conference and were impressed by the method. As a result, they decided to finance a study trip to Berlin for Wright to obtain training and information on the method from Gräfenberg directly. At that time, Wright was chief medical officer of the North Kensington Women’s Welfare Centre. She was therefore in a position where she could travel internationally and learn new skills that she could bring back to Britain. Upon her return, she started fitting her patients with the rings at her private clinic in London. The BCIC devised a questionnaire that centred on the medical and technical aspects of the ring, with the idea of setting out a practical guide for inserting and removing it. The first questions referred to the number of cases where the method had been tried, its potential side effects, as well as its contraindications and ways to identify them. Wright covered issues around the length of time that the ring could be left in situ, whether it might become embedded in the endometrium, and the extent to which a follow-up system had been in use. Questions focused also on the attitude of the medical profession in Germany, experience of the patients and available literature on the subject. These questions reflected the scientific approach of the BCIC, namely ‘to establish facts and to publish these facts as a basis on which a sound public and scientific opinion can be built’.

Wright added questions related to her own personal interest in the physiological effects of the ring on the endometrium and the uterus, and whether its insertion was painful for the patient. This interest in the patient’s experience was illustrative of Wright’s understanding
of what mattered when assessing the ring: side effects, efficiency and potential pain. She wrote that ‘overall, patients were enthusiastic about the method’. Regarding the potential pain induced by the ring, she seemed to be extremely cautious, as she underlined that the insertion of the ring only seemed to be painful when Gräfenberg placed the ring with the help of the volsellum forceps. Yet, she underscored that speed and comfort when placing the ring might greatly depend on the dexterity, gentleness and skill of the doctor.\textsuperscript{18} She compared the smooth experience of Gräfenberg’s patients with one patient in England, ‘who found the insertion of the ring so painful that it had to be stopped and was not finished’\textsuperscript{19} The patient was most probably Norman Haire’s. Haire had discovered the Gräfenberg ring while attending the Congress of the International Society for Sex Research in 1926 in Berlin, and attended a course of lectures on birth control given by Gräfenberg himself in 1928.\textsuperscript{20} In July 1929, Haire started fitting the ring for his patients in his own private practice and at his Cromer Welfare and Sunlight Centre, and he gave a talk on his preliminary results at the 1929 WLSR congress.

As Ivan Crozier has argued, his advocacy of the new device offered Haire a strategy for positioning himself as a British specialist in a novel and promising scientific method. Haire was ‘stamping out a territory for himself’.\textsuperscript{21} A gynaecologist by training, Norman Haire was nevertheless an outsider in interwar London as a Jew, an Australian and a homosexual. He struggled to be accepted among the members of the birth control movement, due partly to his difficult personality. He argued with many figures in the movement such as the leaders of the Malthusian League, Dr Charles Vickery Drysdale and his wife Bessie Drysdale.\textsuperscript{22} He was appointed as the Medical Advisor to the Walworth Women’s Welfare Centre, set up by the Malthusian League, but after a few months he resigned or was forced to resign, ‘leaving bad feelings behind him’.\textsuperscript{23} Haire opened his own birth control clinic in 1927, and the Cromer Welfare and Sunlight Centre in St Pancras, which was not, however, part of the established Society for the Provision of Birth Control Clinics. Further, Haire had a problematic relationship with the feminist Stella Browne, a leading figure in the birth control movement. Therefore, when he started fitting the ring, he did it on his own terms, without the financial support of the BCIC. He did try to apply for funding from the BCIC, but his request was flatly refused, possibly due
testing iudS

to his conflictual relationship with several birth control advocates and because Wright was already carrying out a clinical trial with the method.24 At the 1929 conference, Haire basically replicated Gräfenberg’s talk by flagging up the differences between the ring and other intra-cervical pessaries. In particular, he described the wishbone pessary as very dangerous, since it involved a v-shaped spring that was held against the cervix by a metal plate, with the spring extending into the uterus.25 Haire had some previous involvement with this method in 1922 when he was asked by the famous birth control activist Marie Stopes to accept two patients who wanted to be fitted. He declined, warning Stopes that it could act as an abortifacient by inducing miscarriage.26 The Gräfenberg ring, by contrast, did not induce miscarriage, Haire explained, but he still recommended inserting the ring during a menstrual period. He also detailed the instruments used during the insertion of the ring and its contra-indications. He presented the ring as a modern medical method that required a sound understanding of gynaecology for its use. The medical office was the appropriate place for the fitting procedure, placing the ring under the responsibility of the medical profession and, he suggested, ‘the gynaecologist only’.27 Having tested the ring in his private clinic but recognising its limited experience, he nevertheless shared his enthusiasm for the method he deemed ‘superior to any previously available’.

Assessing the ring

By the end of 1929, both Haire and Wright were fitting clients with the Gräfenberg ring in their medical practices. Eager to assert his mastery of the device, Haire wrote a letter to the British Medical Journal to draw attention to the ring. The choice of the BMJ was not arbitrary; the journal was highly respected both nationally and internationally. By using the BMJ as a platform, Haire presented himself as the expert on the device. In his 1929 letter, referencing an article on the ‘revocable sterilisation of the female’, Haire took the opportunity to present the ring as a means of temporary sterilisation.28 The choice of vocabulary is relevant; by emphasising the reversibility or temporary effect of the ring, Haire was trying to bypass the potential contemporary criticisms of contraception as leading to sterility.29 Haire advocated the use of the device based on both Gräfenberg’s and his own personal experiences,
at this point limited to 100 cases in his private practice and in the Cromer Welfare and Sunlight Centre. He attributed the reliability of the method to ‘the skill of the medical attendant, and not (as in most other contraceptives) on the skill or care of the patients.’\(^3\) In addition, he emphasised the safety of the ring in the right hands: ‘the procedure appears to be harmless in the absence of genital infection, provided it is carried out with strict aseptic precautions. The absence of harmful irritative effects is apparently due to the fact that the uterine mucosa is cast off at each menstrual period.’\(^3\) His hands-on professional experience, coupled with reports of positive results, highlighted his position as the major clinical advocate for the device.

Not all doctors, however, agreed with Haire’s positive assessment of the ring. Another letter in the *BMJ* from one Dr Richard Fawcitt, for instance, described a patient who had experienced ‘nasty discharge’ following the insertion of the ring by a colleague in London – plausibly targeting Haire, who identified himself so closely with the device.\(^3\) Fawcitt asked whether other practitioners had experienced difficulty with the method. In his letter of reply to Fawcitt, Haire did not yield much ground, although his tone softened somewhat in underlining the precautions to follow before and after inserting the ring to ‘avoid such a condition [nasty discharge]: He argued that neither the ring nor the process of insertion were necessarily responsible for the discharge, since ‘it must be remembered that pelvic disturbances which occur subsequent to the introduction of the ring are not necessarily caused by the ring.’\(^3\) Haire nonetheless acknowledged that if the risk of ‘such complication [pelvic disturbances] is too great to compensate for the advantages of the method it must be abandoned’.

Alongside Haire’s response, the *BMJ* also published a letter in response to the doctor’s concerns from Wright. By taking part in the debate on the ring, Wright positioned herself as an alternative interlocutor. She made sure to mention her travels to Berlin to visit the inventor of the ring, relying on her international expertise: ‘The letters of Haire and Fawcitt … raise points which need emphasis, in view of the possibility that the method may become widely used in this country. I have just returned from a visit to Dr Gräfenberg in Berlin.’\(^3\) Wright emphasised the contra-indications established by Gräfenberg and the care with which he selected his cases. Furthermore, she explained that patients were closely followed up by Gräfenberg after insertion of the
device, insinuating that the culprit doctor did not do his job properly and had put his patient’s safety at risk. Further debate took place between Haire and Wright. The 1930 Zurich international conference on contraception provided an initial forum for discussing their results, positioning both of them as international experts of the ring and bringing their different views on the subject into the international sphere.

A focal point in these debates was the use of statistical data and the determination of what considerations had priority in assessing the method. In the 1920s the BCIC joined the International Medical Group for the Investigation of Contraception in leading the quest for careful trials with laboratory support and detailed statistical assessment for contraceptive methods.35 For these two organisations, developing a scientific birth control method through sound clinical trials was an important step toward establishing birth control as a legitimate endeavour of medicine. Their work took place at a time when the Medical Research Council (MRC) – set up in 1913 as a single research organisation for the whole of the UK, with funds provided under the National Insurance Act for medical research – increasingly defined the laboratory as indispensable to the work of medical trials, and progressively made statistical analysis a major consideration.36 The BCIC financed much of the research on fertility carried out in laboratories by physiologists, thus helping to promote the new vision adopted by the MRC. Trials with the same methods were also carried out in birth control clinics or private practice headed by women doctors. These methods met with resistance, however, from a segment of the medical profession, who called for a more ‘individualised conception of illness and its treatment’, made possible by the critical eye of individual doctors acquired through long experience at the bedside.37 In such struggles, rhetoric was especially valuable in negotiating boundaries, particularly among the circle of people working on the contentious topic of physician-controlled contraception.38 Haire and Wright drew from different visions of medicine in their efforts to take ownership of the processes for evaluating the Gräfenberg ring.

A primary difference between Haire’s and Wright’s approaches to evaluation lay in how they presented their results. At the 1930 Zurich conference, Haire relied heavily on his first-hand experience with the method. He introduced himself as the follower of Gräfenberg and as the only other expert physician working on the subject. Illustrating his
priority, he pointed out that, apart from Gräfenberg, he was the only doctor contributing to the compilation of sound data: ‘There are few statistics yet available about this method. The only ones I have been able to find in the literature are those of Gräfenberg ... I am offering a preliminary report of my own cases.’\(^{39}\) Noting with restrained modesty that ‘my own cases are only 270 in numbers’, he pronounced himself ‘very pleased with the method.’\(^{40}\) He then outlined the results, in a fashion that served to diminish the failure rates. He explained that in 13 per cent of the 270 cases, the ring had fallen out. However, he added, after reinserting the ring, he obtained a final figure that looked much better, since ‘the actual failure rate was 1 in 270.’\(^{41}\) It is unclear to what extent Haire’s rhetorical turns with the numbers supported his case, but this probably gave the report a more promotional character. Presenting alongside Haire, in her discussion of substantially fewer cases, Wright adopted a cooler tone, although without rejecting the potential value of the ring. She emphasised contraindications to the use of the method and noted Gräfenberg’s careful attention to the process of selecting appropriate cases for use of the ring. She took special care to underscore the precautions that had to be taken to avoid complications. She offered a more critical perspective on the efficacy of the device, which was in part unavoidable given the high rate of failures she had witnessed, with the expulsion of the ring in four cases out of fifteen. What was problematic for Wright was the potential for the expulsion of the ring to lead to an unwanted pregnancy. She discussed the unreliability of the method, explaining that in one case of expulsion the ring was of the correct size and perfectly in place: ‘I have both the X-ray and the ring, and anyone can see it was not the fault of the size or the position ... The ring is sitting there in its perfectly round position.’\(^{42}\) In another case, the ring broke inside the uterus: ‘that may have been due to faulty construction in England.’\(^{43}\) These rings were made by Down Bros Ltd., surgical instrument makers, and were copied from those supplied by Gräfenberg, but were cheaper. Having collected detailed accounts of individual experiences, she offered to share her reports with ‘anyone interested’. She continued to support the cautious use of the ring. As shown in the previous chapter, the Zurich conference had helped to make women doctors legitimate experts on birth control. Alongside other interventions on the cap and pessary and on the work carried out at the North Kensington Women’s Welfare Centre, Wright contributed
to the debate on the ring, therefore strengthening her credentials not only as an international expert on birth control in general but more specifically on the Gräfenberg ring; she challenged Haire’s results through her careful presentation of her own results.

The acknowledgement of Wright’s expertise and her sound approach to contraceptive methods on the international scale was not limited to the Zurich conference. In 1931, the International Medical Group for the Investigation of Contraception published a report compiling three articles on the Gräfenberg ring by Wright, Leunbach (a Danish general practitioner who tested the ring in his own private practice on 178 patients) and Haire. This report, as well as the correspondence between Haire and the report’s editor, Blacker, shows how the issue of reliable results, and the handling of statistical and numerical evidence, worked in favour of Wright. In the foreword to the report, Blacker underlined contradictory results between Haire, on the one hand, and Wright and Leunbach on the other. Haire submitted, Blacker noted, ‘in general terms a favourable account of his findings … [but] abstains from giving any but the vaguest figures’.44 In comparison, Wright and Leunbach presented ‘detailed and exact figures’ that conveyed a ‘less favourable impression of the ring’.45 Furthermore, Blacker expressed his gratitude to them for ‘the trouble they have taken in submitting their material to such searching scrutiny and for presenting it with such candidness’.46

Indeed, Wright provided a detailed account of the thirty-eight patients she fitted with the ring in her private practice in London. She laid out her cautious assessment of the methods in a thorough appraisal of individual cases. She was careful to emphasise the recurring problem of ejection of the ring out of the cervix, since only nine of the thirty-eight patients she had fitted still had the ring in place at the time of publication. Despite these unconvincing preliminary results, she laid considerable stress on the satisfaction felt by the nine patients who still had the ring, which encouraged her to ‘persevere’. She called for the systematic collection of data on the subject: ‘large numbers of accurate, detailed records will have to be collected before the laws of behaviours of the ring could be deduced’.47 This request offered a stark contrast to the methods of Haire, who had referred to his results in vague terms, using words such as ‘a few’ or ‘many’ to describe his experience with the use of the ring in more than 400 cases.48
Haire wrote to Blacker to express his disapproval. Arguing defensively that his results should not be compared to work by inexperienced clinicians, he took a backhand swipe at Wright’s record: ‘I think that you and your committee or sub-committee are putting yourselves in a ridiculous position when you adopt this omniscient attitude about birth control methods. When I look through the list of names I still fail to see anybody who has any considerable knowledge about contraceptive techniques at all.’

Haire spoke with the backing of extensive experience in the use of the ring, as well as a notable clinical position as a medical officer-in-charge at the Walworth Women’s Welfare Centre and a physician who operated his own birth control clinic. Haire also referred to an unnamed colleague who fitted ‘rings of inferior quality’ that broke within the cervix. It is worth noting that in the original letter that he submitted to the editor, Haire identified the culprit as a ‘woman doctor’, targeting Wright specifically. The editor altered the text and suggested the word ‘colleague’ instead of woman doctor, which reveals how Blacker was protecting Wright.

Haire went on to announce that he was buying rings from a Dutch firm, since he found the rings supplied by the German and English firms ‘far from satisfactory’. Moreover, he implied that clinical experience provided the gynaecologist with a certain ease in recognising ‘the sort of uterus from which the ring is likely to escape’, implying that his good results with the ring were a result in part of greater expertise and superior judgement. Haire adhered to a traditional vision of medical expertise that was grounded in experience and in cultivated observational skills. Indeed, he valued his own experience with patients as his main source of knowledge and authority.

However, Blacker had a different vision of what he considered to be good research practices, consistent with the more straightforward and restrained character of laboratory-based medicine. In his letter in reply to Haire, this conception was implicit:

I wrote what I did because I did not wish the report to be construed as an advertisement for you which at the same time would injure the other two contributors on the Gräfenberg ring [Wright and Leunbach] who submitted detailed statistical reports which reflected somewhat unfavourably on their results and present them impartially in my contribution. I did not want them to suffer for it. I am myself persuaded that the results of all birth control methods, including the Gräfenberg ring, turn
out to be less favourable when they are carefully analysed than when they are judged by general impression.\textsuperscript{54}

Given the strong disapproval of medical advertisement at the time, Haire had to read Blacker’s note as a subtle criticism against his promotional uses of the data he had collected in experience with the ring.\textsuperscript{55} The doctor was supposed to show a less self-interested commitment to medical research.\textsuperscript{56}

Haire replied and ‘was forced’ to acknowledge the downsides of the method: ‘I quite agree that careful analysis reveals less favourable results for all birth control methods than one would think from general impressions.’\textsuperscript{57} However, as a defence, he strongly emphasised that he privileged the care of his patients as his main concern: ‘It seems to me that there is a fundamental difference in the emphasis we place on two aspects of birth control work – you are primarily concerned with collecting reliable statistical data about the efficacy of various methods, and only secondary is the individual woman who is in need of advice. I am primarily concerned with the urgent need of individual women.’\textsuperscript{58} Indeed, according to Haire, the main advantages of the ring were that it was ‘free from the aesthetic disadvantages of all the other methods of birth control … does not interfere at all with the spontaneity of intercourse and requires no preparation before intercourse.’\textsuperscript{59} Such concerns were likely to be central to the choice of birth control methods among the middle-class women who constituted the clientele of private practices such as those of Wright and Haire. The oral history study by Szreter and Fisher on birth control practices in Britain between 1918 and 1963 demonstrates this point convincingly. Middle-class women found that barrier methods were at odds with the spontaneity that they valued so deeply, and was offered by natural methods of birth control. Szreter and Fisher also found that barrier methods went against the ‘expectation that women should play a relatively passive role in sex.’\textsuperscript{60} Wright was no less deeply concerned with the quality of her patients’ sex lives, as she made evident in the several sex manuals that she had authored. But her allegiance to the BCIC, and the associated desire to make birth control work a ‘scientific’ enterprise, restrained her attention to the aesthetic qualities of sex. She underscored, instead, efficacy and a lack of side effects as the major criteria for judging a good birth control method. These requirements were the utilitarian criteria developed by
the BCIC: a good contraceptive method needed to be effective, harmless, easy to use and cheap. Haire found himself under attack by members of the BCIC for a lack of scientific rigour and a lack of attention to the requirements for statistical evidence.

Side effects and risks of pregnancy

The debates over the ring also shed light on the significance of side effects as a key element in assessing the contraceptive method. Here again, Haire’s and Wright’s results differed. In his 1931 report, Haire vigorously, but in general terms, supported the reliability of the ring: ‘Of the catastrophic complications which are supposed by many critics to be an inevitable consequence of the use of this method, I have had no experience ... Many of my patients have been wearing the ring for over two years, and the greater my experience with the method the more I am convinced of its value in suitable cases.’ At that time, Gräfenberg was still recommending that the device should be replaced once a year. Without mentioning this admonition, Haire did note that ‘in a few cases he removed the ring as its presence cause[d] pain or discomfort’. Importantly, he did not consider these side effects as ‘catastrophic complications’, although pain might well be considered a legitimate motive for advising against the method.

In comparison, Wright presented a detailed assessment of the full range of specific side effects. Among her patients, many had experienced bleeding and menstrual irregularity. She also scrupulously followed the guidance offered by Gräfenberg on contraindications, and noted that in one case a patient who seemed to have a healthy pelvis at the first medical examination did not inform her of her history of pelvis sepsis, a contraindication to use of the ring. As a result, an infection occurred and the patient had to undergo a hysterectomy, a risky operation before the widespread availability of antibiotics. The fact that Wright shared this negative experience was typical of her commitment to systematic disclosure of results. As she had done at the 1930 Zurich conference, she again stressed the unreliability of the method: ‘the great obstacle to the spread of the method is obviously the uncertain protection against pregnancy which it affords.’ In an attempt to address the defects of the method, Wright devised two strategies. First,
she designed her own ring and asked Dr H. M. Carleton, a physiologist from Oxford University, to test it. This experiment was funded by the BCIC. Carleton was tasked with investigating the ‘effects of foreign bodies in the uterine cavities of animals, with a view to ascertaining the possible effect of the much discussed Gräfenberg ring’. Using animals and carrying out trials in laboratories became common in the 1930s under the influence of the MRC. Carleton presented his results in the *British Journal of Obstetrics and Gynaecology* in 1933. The ring devised by Wright was made of a silver ring, the coils of which were covered by India rubber, which should ease the process of insertion owing to its smoothness and avoid the ring breaking in situ. The downside of the smoothness of the material was that it facilitated the expulsion of the ring. Apart from this expulsion, the ring was as efficient as the Gräfenberg ring, with the advantage that it seemed to avoid the creation of histological changes in the cells of the uterine lining. The second strategy devised by Wright was to fit the patients with the ring on the condition that they would practise other forms of contraception (such as spermicide) continuously during the first, trial year. Then, if after one year it was still in situ, the patient could rely solely on the ring.

Regarding the expulsion of the ring from the uterus, Haire also briefly alluded to this in vague terms: ‘in a certain number of cases’. Nevertheless, Haire also engaged with the risk of pregnancy, since he mentioned his previous accident with one patient who had delivered a baby despite the presence of the ring. According to Haire, the ring did not provoke a miscarriage and, as such, should not be considered an abortifacient, a recurring accusation against intrauterine devices.

This incident was used again by Haire in a debate in the *British Medical Journal* in 1932. Colonel Green-Armytage, professor of obstetrics and gynaecology at the Medical College in Calcutta, wrote a letter to the journal complaining about a ‘London physician who is a protagonist of birth control’ who had fitted the ring and assured his patient of its reliability. The patient became pregnant. In his reply, Haire avoided any acknowledgement of involvement in the case. However, he once more used the occasion to position himself as a ‘reliable’ expert on the ring. Using the case to air his own experience, Haire presented himself as a pioneer in handling such complications: ‘until August, 1930, no such case was reported in the literature, but in that month I
read a paper before the International Society for Sexual Research at the B.M.A. in London, in which I reported a case of pregnancy in one of my own patients while wearing a Gräfenberg ring. Haire then added that the pregnancy, under careful observation, went well: ‘The normal nature of this pregnancy would appear to be a reply to Colonel Green-Armytage’s speculation whether pregnancy could continue to full term without damage for the mother or the foetus.’ Clearly, a failure of the ring was perceived not only as a threat to the woman but also to the foetus in cases of pregnancy. As criticisms against the method began to appear, Haire sought to rectify claims, putting his own expertise at the centre of the discussions. Nevertheless, increasing concern about side effects and efficacy made this tactic difficult. The ardour on Haire’s part to defend a method that seemed less promising than previously began to weaken his position. Haire gradually became ostracised by the medical birth control establishment in Britain due to his lack of adherence to careful statistical analysis and his difficult personality; plausibly, this may also have been due to bias against his Jewishness and homosexuality.

His absence from the programme of the 1932 conference on medical contraception testified to his colleagues’ hesitations. In July 1932, the National Birth Control Association held a conference in London on Medical Problems of Contraception. Among the speakers was Wright. The correspondence between Blacker, leading organiser of the conference and honorary secretary of the Birth Control Investigation Committee, and Wright is instructive. Due to her national and international recognition, Wright was gaining a position as the expert on the value of the ring, and she began to employ her growing reputation to the detriment of Haire. Wright was invited to the conference to present her latest results on the Gräfenberg ring. She wrote back to share concerns about the possible presence of Haire, pointing out that ‘last time we met by accident at a public meeting, at which he was only a member of the audience, he took the opportunity to be personally and publicly offensive, to such an extent that the audience protested.’ After hearing her concerns, Blacker made the necessary arrangements to remove Haire’s name from the programme, reassuring Wright of the BCIC’s opinion: ‘the general feeling is that official speakers at the Conference whose names appear on the program should be people in whom the committee has confidence and whose report they regard as trustworthy.’
subsequent review of the conference published in the *British Medical Journal* added insult to injury. The article emphasised growing disillusionment about the method:

Every new method in medicine passed through three stages: first, being new, it was scoffed at, then there followed a phase in which it received passionate support of the suggestible elements in the community, who, very naturally, were disillusioned by the immediate results; and finally there came the time when critical intelligences went to work and assessed the method as its true value.  

It presented the research carried out by Wright and Dr Carleton of the Department of Physiology at the University of Oxford. The latter outlined his main results based on over 100 experiments with rabbits. Both researchers shared their concerns around the efficacy of the method. Haire was mentioned, but only as an ‘enthusiastic follower’ of Gräfenberg and as the only doctor who ‘applied extensively’ the ring in a birth control clinic. Haire had been pushed outside the bounds of that third category described in the introduction, where ‘critical intelligences went to work’.

Haire was fully excluded by 1933, when the BCIC and the NBCA held a second conference at British Medical Association House on medical problems with contraception. His name did not appear on the programme, and no mention was made of his work in the published reports. Wright was present and chaired a session. Carleton presented a paper on the after-effects of using the Gräfenberg ring, and Wright was named as the other expert working on the subject. In addition, the conference ended with a call to stop fitting patients with a contraception method that was deemed unreliable and harmful: ‘it could hardly be doubted that there was a potential danger in introducing into the uterine cavity a foreign body which was apt to undergo both chemical changes and physical fragmentation’. In 1932, Haire had fitted more than 400 patients and this number had extended to 1,000 by 1939. However, in his book, published in 1936, he was less enthusiastic about the ring, emphasising its lack of reliability. This led him to recommend the combination of the ring with a spermicide jelly. Hence, in his view, the ring lost one of its main advantages, namely the absence of preparation before intercourse that guaranteed the spontaneity of the sexual act.
Legacy of the ring and new IUD clinical trials

Despite medical warnings and data on side effects and unreliability, the Gräfenberg ring retained its appeal for a number of patients. Wright asserted in a 1936 letter to the physician and birth control advocate, Gladys Cox, that she would insert the ring ‘only if the patient insists in spite of knowing the disadvantages of the method’74 This shows a demand on the part of patients, and suggests that Wright’s patients occasionally insisted on being fitted with the ring – with interesting hints at the concerns about proper informed consent that would stir a decade later.75

Similarly, Margaret Jackson explained that, in spite of being taught as a student that ‘the Gräfenberg ring was [the] devil’s work’76 and that its insertion was ‘unethical’, she returned to this method ‘in desperation as long ago as 1939’ and prescribed it for ‘cases where orthodox methods had failed, sometimes repeatedly, because of non-use or misuse’. In her view, the method was best suited for ‘feckless and hyperfertile couples’ since it was the only method ‘free of patient error’.77 This assertion was based on eugenic considerations towards the fertility of specific women.

After the Second World War and with the fear of global population growth, intrauterine devices regained their popularity. Feminist scholars have provided accounts of IUDs as an oppressive technology and a means for coercive population policy in the 1960s, targeting the Global South especially.78 IUDs were presented as a potential solution for slowing population growth. In 1959, two key publications, by Oppenheimer in Israel and Ishihama in Japan about their positive experience with the Gräfenberg ring or a modified version of it, put intrauterine devices back under the spotlight. By the 1960s, two new plastic intrauterine devices had been designed in the US and proved reliable: the Lippes Loop and Margulies Spiral, named after their inventors.

As was the case with the Gräfenberg ring, these new devices found their way to Britain by way of international conferences. In 1961, Alan Guttmacher, Chief of the Department of Obstetrics and Gynaecology at Mount Sinai Hospital in New York and the new president of the Planned Parenthood Federation of America’s World Population Emergency Campaign, was tasked by the Population Council in tandem with the International Planned Parenthood Federation to undertake a study trip to review ‘efforts at conception control around the world’.79
in 1952 by John D. Rockefeller III, the Population Council, which still exists today, is an international non-governmental organisation that conducts biomedical research on contraceptives and social science research on decision-making for contraception.\(^{80}\) Guttmacher toured India and Southeast Asia and came back convinced that ‘the reason the restraint of population growth in these areas is moving so slowly is the fact that the methods which we offer are Western methods, methods poorly suited to their culture and to the control of mass-population growth. Our methods are largely birth control for the individual, not for a nation.’\(^{81}\) As a result, he recommended intrauterine devices as promising methods for the so-called ‘war on population’ and urged the Population Council to invest money in developing knowledge on the subject in order to ascertain their efficacy and harmlessness. Following this recommendation, the First International Conference on Intra-Uterine Contraception was held in New York under the auspices of the Population Council to analyse the ‘effectiveness, the safety and the possibility of widespread use of intra-uterine contraceptives as a method of regulating fertility’.\(^{82}\) The organisers of the conference, Guttmacher, Warren O. Nelson (medical director of the Population Council) and Dr Christopher Tietze (director of research at the National Committee on Maternal Health), invited only forty participants from eleven countries. Jackson was one of them, and presented her experience with the Gräfenberg ring. Between 1939 and 1962, she had fitted 192 patients with the ring for a total of 10,711 menstrual cycles. The average patient fitted with the ring was a woman of 34 with six children; many of them ‘were problem patients and mothers of problem families’. While at first the ring had been advocated and tested for middle-class patients in interwar Britain, its demographic had evolved over time to be, as flagged up by Jackson, almost exclusively what were called ‘problem families’. The term ‘problem families’ had been popularised by the Eugenics Society in the late 1940s through its Problem Families Committee. Problem families were perceived as a threat to society due to their ‘intractable ineducability’, ‘squalid homes’, ‘multiple social problems’, and mental and physical deficiencies. Their fertility was a particular concern.\(^{83}\)

Jackson provided a careful description of her experience based on statistics and the assessment of side effects. She found the degree of protection offered by the method ‘quite high’: eighteen unwanted
pregnancies had occurred and twenty-four patients did not tolerate the ring. Calculated using the Pearl Index, a technique used in clinical trials for assessing the effectiveness of a birth control method, the pregnancy rate was 2.8. The method was harmless as long as strict obedience to ‘Gräfenberg’s meticulous criteria’ was respected, in particular the need for a normal, healthy pelvis. Furthermore, Jackson insisted on close follow-up of patients since the ring had to be removed and replaced once a year. She recommended fitting and changing the ring during the first half of the menstrual cycle. Nevertheless, she reckoned that there were side effects, such as painful insertion, strong pelvic disturbances, menorrhagia, discharge and pain, which would lead to the removal of the ring. Other patients found the insertion and removal so painful that they went back to their previous methods of birth control. All in all, Jackson emphasised that ‘the woman’s fertility was not disturbed by this method’ and that no ‘pelvic inflammatory conditions had developed’. 

At the conference, Jackson also learnt of the existence of the two new plastic devices and was impressed by their seemingly good results. When she returned to Britain, she started fitting her patients with these new plastic devices. In 1963, she published a paper in *Family Planning* that reviewed her experience with the Gräfenberg ring and the new plastic IUDs. She experimented with 116 patients, over 504 cycles, who were from the same social milieu as her Gräfenberg ring patients. She praised the new IUDs’ flexible material, which made insertion less painful for the patient since it reduced the need for dilatation. In addition, discharge and menorrhagia seemed to have reduced. She explained that she had removed five devices, and four others had slipped out. She also emphasised that there was no infection introduced, due to the nylon thread which extended through the external os.

Jackson’s support from the FPA, the IPPF and the Population Council reinforced her expertise and gave her credentials to the extent that her clinic served as one of the four international centres (the others being Puerto Rico, Fiji and Sweden) of the Cooperative Statistical Program, a study of the safety and efficacy of IUDs funded by the Population Council and headed by Austrian-American physician Christopher Tietze. Jackson carefully collected data on her patients and gathered information on 3,600 IUD users in southwest England. Therefore, she played a key role in popularising IUDs in Britain and advancing knowledge on their reliability and safety. In July 1965, the *BMJ*
published a lead article about the new IUDs, claiming that ‘evidence is growing that in skilled hands the method is safe, giving rise to relatively few and trivial complications’.87

Meanwhile, the FPA-affiliated Council for the Investigation of Fertility Control (CIFC), of which Jackson was a member, had quietly begun a trial, fitting the Lippes Loop, Margulies Spiral, and a new model, the Birnberg Bow, in 341 women in order to assess their suitability for use in FPA clinics in Birmingham.88 The North Kensington Women’s Welfare Centre also hosted a trial of intrauterine contraceptive devices under the joint supervision of Dr Blair and Dr Sara Field-Richards.89 The method ‘had a great success with the extreme ends of the social scale: the desperate ladies brought by Health Visitors who think this is an acceptable alternative to sterilisation, and the highly sophisticated ladies who have read about this in the Guardian and are determined to have the newest wear in contraception’.90 In spring 1965, the Medical Advisory Council of the FPA recognised the safety and reliability of IUDs and agreed to recommend the method in FPA centres.91 Therefore, while immediately after the Second World War IUDs had originally been perceived as acceptable for women who could not use other contraceptive methods, or who could not be trusted to use them correctly, their users eventually expanded to include women from a wide range of backgrounds. By 1970, IUDs were used by 5 per cent of British female contraceptive users, including middle-class mothers and childless professionals.92

Conclusion

By contextualising and tracing the evolution of a device from its appearance in limited medical circles to its testing, its brief championing, and progressive condemnation, and its resurfacing after the Second World War, this chapter outlines broader issues in the diverging means for judging the value of new medical devices, in a period that saw the consolidation of accepted mechanisms for clinical assessment.93 This chapter identifies the key forebears of IUDs in Britain: Norman Haire, Helena Wright and Margaret Jackson. Identifying their respective positions within the national and international medical landscape – where networks, alliances and interpersonal relationships took shape – helps to explain whose voice was heard and legitimated within the medical
circles. Haire built up an exclusive private clinical practice on Harley Street, but he seems to have been out of touch with the research-driven elites of the BCIC, to which Helena Wright belonged. Indeed, the BCIC declined to finance Haire's research and gradually ostracised him. Wright, instead, became the trusted voice on questions about the Gräfenberg ring within this influential community as well as the international birth control group. After the war, Jackson was influential in popularising new IUDs in Britain.

Haire’s and Wright’s different positions of power within the medical establishment and birth control movement were reinforced in part by divergent visions of medical expertise, perceptible in the criteria they used to assess the ring. While Wright embraced the clinical and laboratory-based evidence promoted by the BCIC, Haire adhered to traditional criteria based on accumulated experience and expert observation, but also heavily invested in an individual understanding of clients’ needs. The predominance in scientific publications of the issue of the efficacy of the ring heightened the latent tension between Wright and Haire. Wright provided a detailed, objective account of results and adopted a cautious approach to the new method, presenting her negative results alongside positive ones. Haire, on the other hand, generalised from his experience, providing only imprecise numerical results, relying on the strength of his clinical reputation to carry his points. He expressed little interest in statistical analysis, instead privileging his extensive experience with the method and advocating for the needs of his patients. There was evidence of such a demand among patients for contraceptives that did not interfere with the spontaneity of the sexual act. Haire proved reluctant to give up on a method that was drawing increasing criticism, but he sustained a busy practice, testified to by the numbers of procedures he could report. Despite the potential appeal of this strategy, however, Haire gradually lost professional credibility in favour of Wright, who developed a transparent approach to assessing the use of the ring that was based on the critical and judicious interpretation of clinical evidence. After the Second World War, Jackson became a central figure in the testing of new IUDs in Britain. She had the backup of the powerful Population Council and provided a thorough assessment of her experience with the new devices.

This chapter thus offers a fresh look at the successes and failures of the Gräfenberg ring, showing how evolving scientific criteria for
evaluation impacted the device’s reception among the medical community, internationally and in Britain. A division emerged among members of the birth control movement who prescribed and assessed contraception, between the circle of doctors and scientists that welcomed Helena Wright (and her fellow female colleagues) and her developing command of scientific clinical assessments, and individuals such as Norman Haire and Marie Stopes who, although popular with clients, came to be treated as eccentrics, poorly versed in proper scientific method. In addition, the tensions between Haire and Wright revealed professional dynamics whereby some individuals were marginalised in order to assert medical authority and professional power. The impersonal approach towards collecting scientific data seems to have won out in this instance, with the publication by the BCIC in 1937 of a list of approved contraceptives, which ratified the required methods for use in assessing contraceptive methods as shown in Chapter 1. Jackson followed these recommendations when she evaluated the potential of new IUDs in the 1960s.

Notes
1 See University of Victoria, British Columbia, Douglas Goldring papers, Acc 95–012: Series 1, files 78–9 correspondence from Ethel Mannin c.1920s–1930s. ‘Letter from Mannin to Douglas Goldring, undated’. I am very grateful to Lesley Hall who kindly transmitted these letters to me. In the same correspondence Mannin complained about the price that Haire charged patients for fitting the ring. She had used to be fitted by him for £33, but was once fitted by Gräfenberg himself in Berlin for £7 with anaesthetic.
3 Löwy, “Sexual chemistry” before the pill; Soloway, “The “perfect contraceptive”.
8 Ibid.
9 Ibid.
10 Ibid.
11 Ibid., p. 616.
12 Although their initial use met with medical opposition, especially the speculum. See Mosucci, The Science of Woman, pp. 112–30.
15 Wellcome Collection, London, SA/FPA/A13/S/2, ‘Minutes of the Eighth meeting of the BCIC, 23 November 1927’.
17 Wellcome Collection, London, SA/FPA/A13/S/2, ‘Helena Wright, Report of visit to Berlin to investigate Dr Gräfenberg’s silver ring contraceptive’.
18 For more information about the issue of skills see the special issue N. Whitfield and T. Schlich (eds), ‘Skills through history’, Medical History, 59:3 (2015), pp. 349–85.
19 This patient was probably Malin Goldring, the wife of Douglas Goldring. See University of Victoria, British Columbia, Douglas Goldring papers, Acc 95–012: Series 1, files 78–9 correspondence from Ethel Mannin c.1920s–1930s, ‘Letter from Mannin to Douglas Goldring, undated’.


Minutes of the meeting of the Birth Control Investigation Committee January 16th 1930, in SA/EUG/ L/6/6/6, Wellcome Collection, London.


N. Haire, ‘Sterilisation, birth control and abortion’, p. 111.


The idea that contraception led to sterility was common in medical circles at that time. See the debate in the *British Medical Journal* in 1938 (Chapter 1).

Haire, ‘Revocable sterilisation of the female’ (1929).

Ibid.


Clinical trials as a form of objective knowledge have a long-contested history. The resort to clinical trials as a way of acquiring objective medical knowledge first appeared in the second half of the nineteenth century, when doctors, through the British Medical Association, tried to fight secret remedies prescribed and sold by charlatans, quack doctors and patent medicine manufacturers, in order to assert their power over this domain and hence reinforce their professional credentials and position. To do this, they promoted clinics as the best place in which to judge
therapeutic efficacy. Many authors have emphasised the resistance from elite doctors to the laboratory expansions: see Cox-Maksimov, ‘The Making of the Clinical Trial in Britain’; Toth, ‘Clinical Trials in British Medicine’.


38 Crozier convincingly argued that rhetoric, social power and symbolic capital are key elements in understanding the construction of medical knowledge. See his excellent article: I. Crozier, ‘Social construction in a cold climate: a response to David Harley, “Rhetoric and the Social Construction of Sickness and Healing” and to Paolo Palladino’s comment on Harley’, Social History of Medicine, 13:3 (2000), pp. 535–46.

39 Sanger and Stone, The Practice of Contraception, p. 50.

40 Ibid.


42 Ibid.

43 Ibid.


45 Ibid.

46 Ibid.


49 Wellcome Collection, London, SA/FPA/A22/1, ‘Letter from Norman Haire to Blacker, 29.03.32’.

50 Haire, ‘Clinical experience of the past year’, p. 69.
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51 Wellcome Collection, London, SA/FPA/A22/1, ‘Letter from Norman Haire to Blacker, 29.03.32’.
53 Cunningham and Williams, The Laboratory Revolution in Medicine.
54 Wellcome Collection, London, SA/FPA/A22/1, ‘Letter from Blacker to Norman Haire, 07.04.1932’.
56 Toth, ‘Clinical Trials in British Medicine’.
57 Ibid.
60 Szreter and Fisher, Sex before the Sexual Revolution, p. 256. See, in particular, chapter 6 on this issue.
61 Haire, ‘Clinical experience of the past year’, p. 69.
63 Wright, ‘Notes on the 38 cases fitted with Gräfenberg ring’, p. 65.
64 Wellcome Collection, London, SA/FPA/A13/S, ‘Memorandum on work of the Birth Control Investigation committee, 1931’.
67 Ibid.
69 Wellcome Collection, London, PPCPB/C/1/16, ‘Letter from Blacker to Wright, 14 April 1932’.
72 *Ibid.*, p. 120.
74 Quoted from a private letter exchange between Gladys Cox and Helena Wright, in Cox, *Clinical Contraception*, p. 118.
80 On the Population Council and its role in the international campaign for family planning see Connelly, *Fatal Misconception*, pp. 159–220.


