Introduction

In 'One Woman's Mission', an article in the *Sunday Times Magazine* in 1973, pioneer birth control activist and female gynaecologist Helena Wright recalled the pivotal moment in her career. In 1928, Wright intrepidly dedicated herself to making contraception both acceptable and accessible. Looking back on this decision, she explained: 'It seemed to me in a prophetic way, that birth control was the single subject that women doctors had to get hold of.'[1] The implications of Wright's vision for women doctors – to 'make contraception respectable' – cannot be overstated. Perhaps more than anyone in her generation, Wright contributed to the spread of birth control at both national and international levels; however, she was not alone in that endeavour. As her crusading remark underlines, women doctors 'got hold' of the subject of birth control from the 1920s onwards.

But how did women doctors undertake this campaign at a time when contraception was a contentious topic that divided the medical profession and, indeed, the broader public? This question has received surprisingly scant attention.[2] I tell this story by exploring the key role that British female doctors played in the production and circulation of contraceptive knowledge and the handling of sexual disorders. I focus first and mostly on Britain and then on the international and transnational levels between the 1920s and the 1970s; I take France as a point of comparison. This study charts the accomplishment of several women doctors as they made their way through the predominantly male-dominated medical landscape. They sought to establish the use of birth control – that is, any practices, methods, and devices that could prevent pregnancy – as a legitimate field of medicine. Alongside their work to medicalise and legitimise birth control, they promoted family planning,

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or the provision of contraceptive methods to plan and space births, and offered counselling on sexual disorders, fertility and sub-fertility. These areas of practice, which would become a new career path for many women doctors, emerged from women doctors' experiences and encounters with patients in birth control and family planning clinics. Looking at the difficulties experienced by many female patients with planning and spacing births, getting pregnant and having satisfying sexual lives, women doctors tried to address these issues by developing new forms of expertise and practice and thus creating a common professional identity. In so doing, they were especially careful to present these new fields as medical and impart this new knowledge to their colleagues. Their claim to authority was therefore based on their practical experience in the clinics.

These forerunners included Helena Wright (1887–1982), Joan Malleson (1899–1956), Margaret Jackson (1899–1987), Gladys Cox (1892–?, professionally active between the 1920s and 1930s), and Sylvia Dawkins (1904–95). I shed light on the strategies British women doctors used, and the alliances they forged to forward their medical agenda and position themselves as experts and leaders in birth control and family planning research and practice. This book is part of a growing field of research on the medical history of birth control and sexuality.

The medicalisation of birth control is one aspect of the broader history of the medicalisation of the female body, a history that has attracted considerable attention from feminist historians since the 1980s in the context of the feminist health movement.[3] Medicalisation means 'defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem or using a medical intervention to treat it.[4] Feminist critics have identified medicine and gynaecology as central to the oppressive regulation of women's bodies.[5] Historical analysis has often depicted the female body as a site of ideological intervention for numerous actors, be they medical professionals, the Church, traditional healers, the state, or health campaigners.[6] Historians have shown that prior to the Enlightenment, the female body was medically perceived as an inferior version of the male one.[7] More generally, women's bodies were represented as volatile, dangerous, and in need of medical intervention and monitoring.[8] Several scholars have offered a nuanced account of the medicalisation of the female body over the last two centuries. They

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emphasised the social, medical and political context in which this medicalisation took place and foregrounded the agency of female patients who were not necessarily the passive victims of male doctors.[9] The issue of the medicalisation of birth control in the twentieth century has also been cast in different historical lights. In narratives on the 'long sexual revolution' it has often been presented as an emancipatory process, freeing women from the burden of pregnancies,[10] whereas in feminist criticisms of medicine, this process has been depicted as oppressive, and as part of a more general male-dominated medicalisation of control over women's bodies, symbolised by the use of the stirrups in childbirth or the coerced sterilisations of women.[11]

Hence, the medicalisation process has usually been described as one in which the institution of medicine acted as an agent of social control. However, recent research has challenged this unilateral view. Nikolas Rose went as far as to call 'medicalisation' 'a cliché of critical social analysis'.[12] Nonetheless, Peter Conrad, while acknowledging that 'medicalisation' is too often used in a negative way, suggested that analysing the medicalisation process could be useful if it is done to highlight and articulate the complicated process of medical knowledge construction.[13] Following Conrad's advice, this book moves beyond this dichotomy by re-evaluating the medicalisation process through the contribution of women doctors to the production of medical knowledge on birth control and family planning. I explore the production of medical knowledge in paying attention to the social, medical and cultural setting, but also to the scientific background in which knowledge is produced. In other words, I operate on the cusp of social, cultural and intellectual history. This study focuses on the environment in which women doctors lived, emphasising the opportunities they encountered and the constraints they faced. It examines the contemporary dynamics of scientific controversies around birth control, the way through which scientific practices and procedures around birth control and family planning were implemented and stabilised, and the way that interactions with patients affected women doctors' production of medical knowledge on family planning.

The novelty of this book lies in three key elements. First, the specific focus on female doctors illuminates their agency in the male-dominated field of medicine and reveals their significant role in the medicalisation process. It corrects the narrative of women's reproductive bodies being

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dominated and controlled by male doctors. The subject of women in medicine has attracted growing interest. Scholars have explored the history of women's entry into the medical profession and into specific medical fields.[14] Clare Debenham's recent study has contributed to the understanding of the relationship between the Society for the Provision of Birth Control Clinics and feminist activism.[15] However, she pays little attention to the contribution of women doctors to family planning centres and to the medicalisation of birth control. While the role of women doctors has not been wholly neglected, the significance of their contribution has been underestimated and obscured by more famous and controversial figures in birth control, such as the British botanist and birth control activist Marie Stopes or the nurse and American birth control activist Margaret Sanger.[16] This book acknowledges women doctors' contributions and examines how they supported, in crucial ways, the medicalisation of birth control and family planning. While particular attention is paid to patients' experiences, this book does not adopt a patient-centred focus but instead offers the first systematic analysis of female doctors' participation in the scientific development of contraception and family planning. Their role in these transformations, which has hitherto been understudied, deserves closer attention since they were at the forefront of the birth control movement, even though they were a minority within the medical field. I argue that they capitalised on the fact that they were assigned to a low-status, feminine field of medicine and turned their practical experience into an asset at both national and international levels. So this book contributes to wider debates about the way female practitioners used particular forms of specialisation – in this case, contraception and family planning – to carve out a territory for themselves and to formulate claims to authority.[17] They medicalised birth control and family planning with a triple agenda in mind: fighting ignorance around contraception in the medical profession and among the public so as to free women from the fear of pregnancy; securing a new expert understanding of the subject that reinforced their authority as doctors; and using this new power to secure job opportunities. Hence, the medicalisation of contraception and family planning was not a dualistic process of good or bad outcomes; rather it encompassed both the notions of emancipation and control. By teaching women how to avoid pregnancy, women doctors empowered them with knowledge. Paradoxically, at the same time, they

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wielded their medical power over the female body by being the sound voice of knowledge and the main providers of contraceptives.

Second, the transnational perspective allows me to reassess the issue of birth control from a new perspective that emphasises the circulation of scientific knowledge between Britain and France. Taking a transnational perspective on issues related to sexuality and reproduction involves simultaneously considering two levels of analysis, while trying to address their relationships: both national and international.[18] The history of birth control is intrinsically linked with that of population control movements, and has already attracted considerable attention, whether from a eugenic, neo-Malthusian, birth control, or family planning perspective.[19] The focus mainly rests on the national level of analysis, though regional differences were also important and analysed, and the involvement of political, institutional and medical authorities, or activists in debates around these issues, thereby reflecting the 'biopolitics' of Foucault (the power to regulate both individual and social bodies).[20] Recent scholarship has begun to explore the interplay between the aims of these different population control movements.[21] Whereas scholars have identified the transnational networks and actors in associations created before and after the Second World War, and in the circulation of knowledge about sexuality and birth control across national borders, they have mainly focused on the associations that targeted developing countries.[22] Similarly, there is a growing scholarship on internationalism, the history of international health and hygiene and the role of doctors as international experts, as well as that of women as international agents.[23] However, the participation of women doctors as international agents of birth control still deserves a thorough exploration.

Yet much still needs to be done to better understand the reconfiguration of discourses, practices, and scientific knowledge of birth control, family planning and sexuality produced by female medical experts at both national and international levels, targeting the European population. The main focus of this study is Britain, but it takes France as a point of comparison in the last two chapters. While regional differences existed in Britain and France, and in oversea territories, I focus on Britain and France 'at home'. Separated only by the Channel, and yet known for dramatically opposing reproductive policies, Britain and France continue to invite comparison.[24] In the present context,

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this comparison sheds new light on the way knowledge circulated between the two countries, each with different institutional contexts. This comparative perspective is interesting since Britain and France were pioneers in the fight for birth control, before France became a pronatalist country in the 1920s and enacted a restrictive policy on contraception and abortion. British and French doctors, as well as British and French experts (though some under a pseudonym) were present at international conferences on birth control, and this offers an interesting case study in understanding the impact of reproductive politics on the stances taken by these doctors in two countries which, until then, had a strong Malthusian minority. The study examines the scientific knowledge produced not only at the national level but also at international conferences, as well as the network of actors involved in these conferences; it eventually looks at the mechanisms by which knowledge circulated between countries. This perspective explains why it is difficult to disentangle women doctors' contribution at one specific level without considering their position in another. Their contribution to the medicalisation of birth control and family planning resulted from a dynamic process between their social, political, scientific and medical positions at both the national and international levels. This book argues that there was a constant relationship between the national and international levels that helped women to position themselves as experts. The practical knowledge that women doctors acquired at the national level, which at first was not recognised, was pivotal in making them experts in birth control issues at the international level. While recognising that women doctors worked at both levels, this book considers their contribution separately and does so to ensure the clarity of the argument.

Finally, this research is the first systematic analysis of the production and circulation of scientific knowledge of contraception, family planning, and sexual disorders spanning an important period (1920–70) for each area in terms of legitimisation and institutional stabilisation. Social and cultural historians interested in gender and sexuality have offered fresh narratives on the use of contraception, development in sexual behaviours, norms and mores and the history of intimacy in twentieth-century Britain and France.[25] In particular, the oral history studies of birth control practices by Simon Szreter and Kate Fisher provided insights into the sexuality of ordinary people and their favourite methods of birth control for the period 1920–60.[26] These studies have

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challenged common assumptions about who oversaw birth control. For the French historiography, Christine Bard and Janine Mossuz-Lavau analysed the history of the development of the Family Planning Association in France, while Bibia Pavard offered an in-depth analysis of the struggles for the provision of contraception and abortion in France. She focused on the actors involved and the strategies they developed to make contraception legally available.[27] However, these historians have mainly focused on one specific aspect of birth control or family planning, analysing, for instance, abortion, contraceptive techniques or practices, infertility or specific sexual disorders.[28] This book extends this body of research by further examining the story of the ways that women doctors shaped the medicalisation of contraception and family planning in Britain and France. It is a much-needed addition to this growing body of research in that it focuses primarily on female medical contributions while avoiding the pitfall of concentrating only on discourses, thanks to a close examination of medical and scientific practices. As a result, it is part of a broader effort to uncover the many different actors and individuals involved in birth control and family planning practices and policy.

The aim of this book is to analyse the overall contribution of women doctors in the broad field of contraceptive methods and family planning which encompasses advice about contraceptives, marital and sexual disorders. This book contributes to recovering a female medical understanding of changing notions of marital sexuality. It argues that women doctors were pivotal in developing a more holistic approach to family planning, playing a more prominent role in shaping scientific and medical knowledge than previously acknowledged. What this book offers, however, is not a narrative of liberation or a Whiggish analysis of scientific discovery from darkness to enlightenment. It is a narrative of struggles, with steps forward and steps back – a story where forming alliances and developing strategies were as important as combatting ignorance around sexuality. It is a narrative that underlines the fact that women doctors' involvement in birth control issues resulted in an increasing 'burden' on women's shoulders, since women had to take responsibility for birth control, though this was at first perceived by these women doctors as empowering.

Women doctors' contribution to the provision and development of modern contraception and scientific knowledge of sexual disorders

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occurred at a time when the very meanings of reproduction and medicine were being transformed. The half-century covered in this book saw birth control finally becoming widely accepted in the medical profession. The years after the First World War were characterised by the consolidation of modern birth control movements, both in Europe and the United States. This story ends at the point when the Family Planning Act allowed local authorities to provide free birth control to all women (married or single), the Abortion Act legalised abortion by registered practitioners in Britain, and contraception became legally available in France with the enactment of the Neuwirth Law. It was during this shifting context that women doctors' contributions resonated. Therefore, the book locates the productive roles of women doctors within this changing landscape of national and international reproductive politics. It links their involvement in birth control clinics with broader issues surrounding power relationships and expertise within the national and international medical profession. Although this study explores scientific knowledge production and scientific practices around birth control and family planning from 1920 to 1970, the period of 1930 to 1960 is predominant. These were the decades when the medical landscape around birth control and family planning was changing dramatically, and, with the advent of the Family Planning Association (1939), the new focus was on infertility, sexual disorders and new reproductive technologies. Hence, I suggest that the key to understanding women doctors' paths towards birth control and family planning issues lies in the historical relationship between reproductive politics, gendered medical practices, contraceptive culture and the production of scientific knowledge.

Reproductive politics

The subject of birth control has been studied in relation to the history of reproductive politics and has received historical attention for many decades. From 1870 onwards, nearly every European country faced a decline in fertility, known as the 'demographic transition'. While in France the demographic transition started a century earlier than in any other European country, the trend in Britain followed the average pace. From the end of the nineteenth century, an increasing number of

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British married couples used birth control, which resulted in a decline in average family size. Many historians and demographers have studied this decrease in fertility and its timing, underlining its diversity across 'communication communities'[29] and its impact on society and family life.[30] In particular, Simon Szreter's comprehensive study of fertility decline in Britain challenged the idea of a unified theory behind the fertility decline across Europe. Several scholars have tried to identify the birth control methods used by ordinary individuals and the extent to which access – or lack of access – to contraceptive information shaped individual behaviour.[31] One of the major research strands resulting from these research questions has been the emphasis on reproductive politics and the role played by experts in campaigning for or opposing birth control.

In Britain and France, this context of declining fertility gave rise to increasing anxieties among contemporary commentators about racial and national degeneracy, and depopulation, though these anxieties were more acute in France.[32] Consequently, the quality and quantity of the future population became a central concern to contemporary experts, including doctors. These anxieties led to different answers in the two countries. Eugenics – a term coined by Francis Galton in his 1883 *Inquiries into Human Faculty* to describe a science 'that focused on manipulating heredity or breeding to produce better people and on eliminating those considered biologically inferior'[33] – was one of the main tendencies before 1920 in Britain, partly due to concerns about colonial expansion. The Eugenics Education Society was formed in 1907, and the majority of its members were recruited from among middle-class professionals.[34] The goal of the society was to improve the quality of the race through two strategies. The first was the implementation of positive eugenic measures aimed at increasing the fertility of people from higher social classes – those considered to be socially valuable. The second was the application of negative eugenic measures designed to prevent the working classes – i.e. the socially worthless or the 'unfits' – from giving birth to too many offspring through birth control or voluntary sterilisation. However, the society achieved limited success in terms of implementing policy since politicians were afraid of alienating part of their parties by supporting a eugenic position, even though eugenic ideas permeated a large part of British society between

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the wars.[35] Researchers have emphasised the different and conflicting connections that eugenics developed with feminism, religion, politicians, and – of particular relevance to this study – medicine.[36]

In France, pronatalism was the dominant school of thought, though some pronatalists were greatly influenced by eugenics. Pronatalist organisations were created at the turn of the twentieth century, and included the Alliance Nationale pour l'Accroissement de la Population Française (1896), which aimed at raising public awareness of the French demographic deficit and its alleged threat to French military power, and the Groupe Parlementaire pour la Protection de la Natalité et de la Famille (1911), which supported large families.[37] French doctors were numerous and actively engaged in the pronatalist movement, 'contributing to pronatalism's symbolic capital', as well as in the eugenics movement.

In both France and Britain, a birth control movement mainly led by neo-Malthusians was active before 1920. Neo-Malthusians were inspired by Thomas Robert Malthus's famous *Essay on the Principle of Population* (1798) in which he argued that population growth, especially among the poor, would outstrip resource growth unless reproduction was contained through 'moral restraint' and postponement of marriage. Neo-Malthusians shared the same motives to limit family size, but advocated different means to achieve them: the use of contraceptive devices. In Britain, the Malthusian League was formed in 1877, following the Bradlaugh-Besant trial, to campaign for information about family limitation. The French educator and scientist Paul Robin had discovered the neo-Malthusian movement during his exile in London, and imported this movement to France. He founded La Ligue de la Régénération Humaine (The League for Human Regeneration) in 1896, and distributed contraceptives until the 1920s.[38]

In both countries, working-class mothers became the target of increased surveillance by official and voluntary agencies concerned about child welfare.[39] For instance, social hygienists – middle-class reformers working in voluntary organisations – promoted education in 'mothercraft', disseminated information on the risks of venereal diseases and encouraged sexuality to be confined within the heterosexual monogamous family. After the First World War, the national landscape around reproductive politics underwent dramatic changes

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in Britain and France, resulting in two contrasting policies on the two sides of the channel. Campaigns for birth control spread across Britain, and it became a topic of discussion, while a restrictive and pronatalist policy was enacted in France in 1920 that hindered the provision of contraception.

Starting in 1921 in North London with the opening of the first birth control clinic by Marie Stopes,[40] a woman scientist, feminist and ardent eugenicist, several clinics opened across Britain under the auspices of the Society for the Provision of Birth Control Clinics. At the same time, some suffragettes began to fight for sexual equality and fertility control, as did female members of the Labour Party. This happened after women aged over thirty, who met specific qualifications, obtained suffrage in 1918; the right to vote was extended in 1928 to all women on the same terms as men. Raising the topic of birth control before women had the vote might have prevented its introduction. The birth control movement was driven by multiple goals – namely, fighting against poverty, the feminist crusade and eugenic aspirations.[41] Recent work by Stephen Brooke has shown that the birth control movement received limited support from the Labour Party at first, the latter fearing it would alienate its Roman Catholic voters.[42] Arguments drawing on claims about sexual rights or sexual freedom did not fare well within the party. An argument that seemed to have attracted greater backing was that of improving the economic and health condition of working-class mothers – burdened by pregnancies and poverty – through birth control. This argument, as I show in Chapter 1, was also used by women doctors to advocate for the recognition of birth control as a medical field as part of an attempt to reappropriate male narratives.

Richard Soloway has argued that the medical profession was mostly against birth control, with notable exceptions such as the Australian gynaecologist Norman Haire or Lord Dawson of Penn.[43] However, medical stances began to shift as birth control gained in legitimacy after July 1930 when the Ministry of Health (by Memorandum 153/MCW) allowed contraceptive advice to be given in local maternity clinics to married women for whom further pregnancy would be detrimental to health. That same year, Anglican ministers legitimised birth control within Christian marriage at the Lambeth Conference. In 1931, the National Birth Control Council that coordinated the different societies for birth control became the National Birth Control Association

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(NBCA). By 1932, eighteen voluntary birth control clinics were operational in Britain.[44]

Fears over population decline in the late 1930s saw the NBCA change its name to the Family Planning Association (FPA) in order to emphasise the positive side of its work. Priority was given to family spacing instead of the limitation of births, and emphasis was put on the 'wanted' child. The outbreak of war in 1939 prompted a slowing down of FPA activities; it created a shortage of rubber, among other issues. During the war, key initiatives began, such as the setting up of the sterility clinics that would define the new orientation of the work of the FPA. By the end of the war, the coalition government had set up the Royal Commission on Population for investigating the fertility of the British population in order to plan for the postwar situation. Based on the work of the Population Investigation Committee, and under the supervision of the Royal College of Obstetricians and Gynaecologists, the survey revealed a growing use of appliance methods of birth control by married women. In 1946, the National Health Service was implemented, but because the legislation made no mention of family planning, the provision of contraception was still being directed by Memorandum 153/MCW. After the war, Britain, like most countries in Europe, experienced a baby boom, which was initially described as temporary. By the start of 1955, the FPA was opening a new clinic at the rate of one every two weeks.[45] The same year, the Conservative Health Minister Iain Macleod visited one of the clinics for the FPA's Silver Jubilee. This visit received great media coverage, precipitating the acceptability of contraception. In 1961, the contraceptive pill arrived on the British market under medical prescription, establishing contraception as the responsibility of the medical profession. In 1967, Labour MP Edwin Brook's Family Planning Act allowed local authorities to provide birth control to all women (married or single), and in the same year the Abortion Act legalised abortion by registered practitioners. In 1974, the National Health Service, some thirty-six years after its founding in 1948, incorporated family planning, and contraception became free to all women regardless of age or marital status.

Meanwhile in France, in 1920, a new law was enacted that forbade the sale, distribution and advertisement of contraceptive devices, making it punishable by fines and imprisonment. Condoms remained permitted since they prevented venereal diseases. This clampdown found its moral

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expression in Catholic France with the publication of the encyclical *Casti Connubii* in 1931. Natalism inhabited the political centre-ground of interwar France, attracting supporters from both the right and the left, and from all sections of society including the majority of medical professionals.[46] In 1939, the Code de la Famille established a comprehensive system of state support for families, and the 1920 law was strengthened, abortion being now considered a 'crime against the fatherland'. In 1942, in Vichy France, abortion became a crime against the state, on a par with treason. After the war, abortion remained a major issue.[47] Although the birth rate started to increase again from 1942 onwards, demographers remained reluctant to acknowledge the baby boom and maintained pronatalist stances.[48] However, some doctors began actively supporting family planning policies. In 1956, the female gynaecologist Marie-Andrée Lagroua Weill-Hallé created the Association Maternité Heureuse, aimed at spreading information on contraception as a means to avoid abortions. This association became the Mouvement Français pour le Planning Familial (MFPF), a national branch of the International Planned Parenthood Federation. The College des Médecins, the progressive alternative to the conservative Ordre des Médecins, was created in 1962 to gather doctors in favour of the spread of contraceptive knowledge. In conjunction with the left-wing parties, the MFPF led the campaign to abolish the 1920 contraception law, which, in 1967, was superseded by the Neuwirth Law, marking another dramatic change to the political and social landscape of France.[49]

Political campaigners and feminist activists are only one side of the story, and putting women doctors back in the picture allows for a more nuanced account of the supposed success of, and the main actors behind, these birth control and family planning movements. Indeed, focusing on women doctors and the constraints they faced reveal the resistances at play among the medical body. While their work was mainly directed towards their fellow medical colleagues and their potential women patients, and was maybe not as visible as those of their contemporary political campaigners, I argue that British female doctors played a greater pivotal role than previously acknowledged. They helped the birth control movement to shift from a free-thinking radical movement to a professional body that produced knowledge of the requirements of birth control methods and of the handling of sexual disorders in Britain. In addition, British female doctors greatly

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contributed to spreading the gospel of family planning in France since they became a channel of training and information for French doctors.

Gendered medical practices

British women doctors' involvement in the development of birth control provision and practices took place in a context in which they remained a minority in the male-dominated field of medicine, occupying only a peripheral position. In 1914 there were only 1,000 women on the Medical Register of Britain, but this number increased to 6,300 by 1939, 7,520 by 1951, and 13,271 by 1971.[50] The latter figure represented around 16 per cent of the medical population.[51] The subject of women in medicine has attracted growing interest. We know a lot about the famous women doctor pioneers and their paths towards medicine, and several scholars have investigated the history of British and Irish medical women's entry into the medical profession and subsequent developments, and into specific medical fields, such as surgery. The main narratives from these different stories are about the mountains that women had to climb to gain equal opportunities with their male colleagues.[52] Male doctors fought women's entry into the profession, driven by anxieties about overcrowding and a resistance to working under the supervision of female doctors.[53] For instance, in Britain, between 1870 and 1914, the majority of women doctors were trained in single-sex institutions such as the London School of Medicine for Women. The latter was founded in 1874 by the then soon-to-be woman doctor Sophia Jex-Blake, a leading British campaigner for women's admission to the medical profession who experienced difficulties in obtaining training in Britain and decided to start her own place of training.[54]

The need to protect their gains and promote their interests led these female doctors to create professional associations. The British Medical Women's Federation (MWF) was created in 1916 by a fusion of pre-existing local associations of registered medical women. The MWF sought to defend the position of women in the medical profession, and it published a journal and organised lectures and conferences. As Kaarin Michaelsen has argued, 'The MWF was intended to act as a bridge "between the values of scientific professionalism and those of social feminism", projecting an image of the "woman professional" as "equal

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but not identical" to male physicians and therefore having "responsibilities and interests that are not exactly the same as men".'[55] Its central function was to be a professional body, publicly defending the opinion of medical women on public policy affecting them. In 1924, 700 women were members of the federation, and membership had more than doubled by 1928. In Britain, by 1930, women had overcome a number of obstacles. For example, several hospitals had finally admitted women onto their honorary staff. Significantly, nearly two decades later, all medical schools were opened to women with the inception of the National Health Service in 1948.

Several studies have already shown how women doctors were assigned to fields that were supposedly in line with their 'feminine nature' and to more precarious positions within the medical hierarchy since women graduates had limited access to clinical appointments. There is a body of scholarship on the contribution that women made as women doctors and how their gendered identity was central to their access to medicine and 'constrained' choice of specialties.[56] However, some women also actively chose and exploited these 'constraints' to carve out their own professional space. The argument about the 'feminine nature' was used by the first generation of women doctors in support of their access to medical education. Among them was Sophia Jex-Blake, who drew on the gendered assumptions about women's emotional nature: 'Women have more love of medical work, and are naturally more inclined, and more fitted for it than most men.'[57] Hence, as explained by Laura Kelly, 'those arguing in favour of women's admission to medical schools claimed that there was a demand for women doctors to treat women patients, a role for which they would be eminently suited'.[58] The argument that women doctors were particularly good for women patients and their children was one of the strongest arguments supporting women's access to medical education. Women doctors claimed that their dual experience as women and physicians lent them privileged knowledge to deal with aspects of women's intimate and family lives. It was a way to reconcile the Victorian division of labour – where middle-class women were the guardians of the family's and nation's morality and, as such, had a special role in medicine since they allowed women patients to avoid losing their delicacy and virtue by submitting to male treatment – with women's emancipatory claim to access to education. As a result, women predominantly worked in the

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less popular fields of welfare provision, public and community health, and in obstetrics and gynaecology in Britain.[59]

Women doctors thus worked in 'feminine fields', and their clinical work focused on children and on women.[60] Their professional orientation was therefore seemingly shaped by their gender. They were developing expertise in neglected and marginalised areas of medicine such as geriatric care and finding effective treatment for the common diseases of slum children.[61] Birth control, mainly aimed at women, was an area that was not yet considered medicine as such and consequently not taught in medical schools. Like obstetrics and gynaecology, birth control was low status. It is not surprising that women doctors were also represented in great numbers in birth control clinics. For instance, in 1932, with the exception of one institution briefly run by Norman Haire, all birth control clinics were headed by women doctors. Yet if, in the late nineteenth century, women doctors used their gendered qualities as a tool to access medical education and to find clinical work, we cannot assume as self-evident the fact that they continued to rely on the argument of their dual experiences as women and doctors to justify their involvement in birth control work. Indeed, as I argue in Chapter 1, women doctors medicalised and colonised birth control in order to make it a field of medicine and more specifically a legitimate one. In so doing, it was not so much their experience as women that they put forward but rather their professional experience as doctors – even if this experience was deeply shaped by their gendered identity within the medical field – appropriating the male medical authority language of 'scientific facts'. By relying on their clinical experience, women doctors created a new form of professional practice and identity where birth control methods were assessed through sound criteria based on statistics and evidence accumulated via first-hand experience. This resort to clinical experience supported their claims to authority. Furthermore, it seems that women doctors were willing to embrace this topic as it could provide them with a new field of work. But women doctors' sympathy and interest in birth control was also a generational issue. Indeed, the women pioneers who fought to access education and make female doctors respectable and legitimate were often initially reluctant to engage with birth control, fearing that it would encourage excessive sexual attention from husbands.[62] Hence, as Lesley Hall has argued, it was younger women doctors who were often in favour of birth control:

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'a younger generation of women doctors by contrast were characteristic exponents of the welfare feminism of the era following the achievement of the suffrage. In general practice and maternity welfare work they encountered what they saw as a crying need for reliable and healthy forms of contraception.'[63] As I will show, women doctors mainstreamed the diffusion of information on contraception by publishing sexual and medical manuals and medical articles in medical journals, and campaigned for the better provision of reliable and safe contraceptives. These activities made birth control a legitimate topic within medical circles and increased public discussion on the subject.

Thus, birth control clinics offered important job opportunities for British female doctors, even though the pay was minimal. This was especially true for married female doctors. Usually held in the evening, birth control sessions suited married women doctors seeking to reintegrate into the labour market or to work part-time. This convenience was put forward by several women doctors, such as British doctor Prudence Tunnedine. Born in 1928, she studied medicine at Guy's Hospital, qualifying in 1953. She explained her decision to join a family planning clinic as follows:

> Well by the time my fourth child was born, and married to a country doctor, it was fairly clear that my ambitions to be a hospital obstetrician were getting increasingly unrealistic, and I was just asked if I would start a family planning clinic by a clergyman in the nearby town which wasn't so served then with my gynaecological experience. So it was largely accident in a way. It was evening work, to look after my children myself as far as possible when they were little. […] You see, we married women with children were virtually regarded as unemployable. We were thought to be sort of a side issue and lots of us did occasional clinic work either in family planning or in child welfare.[64]

I contend that this situation explains why women doctors were so adamant in promoting the spread of scientific knowledge about the subject. Indeed, their active contribution stemmed not only from their will to help and care for women – by ascertaining the efficiency and suitability of contraceptive methods – but also from their lived experiences in the male-dominated field of medicine where they struggled to find clinical work. Women doctors no longer claimed a specific understanding of women's needs due to their common experience as women.

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Rather, they relied on their professional experience of working with women patients and framed birth control as a medical and technical field. They established birth control as a new form of medical specialty. The spread of scientific and medical knowledge should also be understood as a strategic move to support the institutionalisation and visibility of this new field of medicine in which many of them had invested their time and expertise.

Contraceptive culture and the production of medical knowledge of birth control

The productive role of women doctors took place in a changing medical context in which laboratory-based medicine was becoming common practice, especially in relation to the testing of birth control methods.[65] With the professionalisation of the birth control movement – from a secularist, free-thinking movement aimed at eradicating poverty with eugenic and feminist aspirations, to an institutionalised movement gathering together doctors and scientists by 1930 – and the expansion of birth control clinics in interwar Britain, efforts to develop better scientific means for contraception grew rapidly.[66] Until the end of the nineteenth century, methods for controlling fertility ranged from coitus interruptus and abstinence, to diverse substances ingested or placed into the vagina, to barrier methods such as the cap, pessary, diaphragm and male condom.[67] Abortion was also widely practiced when contraception failed, despite being illegal except where necessary to save the mother's life. Studies have shown that women did not consider 'bringing their period back' an abortion as such, or a moral fault. Early abortion and contraception were intertwined and understood 'on a fertility regulation continuum'.[68]

The first half of the twentieth century brought the development of chemical contraceptives as well as a number of new intrauterine devices, among them the Gräfenberg ring, which blocked implantation of the egg by inducing a thickening of the uterine lining (endometrial hyperplasia). Despite the development of these new contraceptive technologies, recent studies have underlined that the decrease in marital fertility had more to do with the resort to traditional methods of birth control, such as abstinence and withdrawal, than the adoption of modern methods of contraception. In particular, the landmark study of Simon

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Szreter on the decline in fertility in Britain stressed the importance of abstinence as the main method of birth control in Britain up until the 1950s. Kate Fisher's oral history study of birth control behaviours among the working class challenged the common historical assumption that the decline in marital fertility reflected a widespread use of new 'modern' birth control methods as well as the adoption of a 'rational contraceptive behaviour', in which couples discussed and made a 'calculated choice about the number of children they desired'. Couples relied on 'traditional' methods of birth control such as abstinence and withdrawal, and Fisher showed that gender roles were of particular importance to understanding negotiations regarding these issues. She reported that men were deemed responsible for birth control within the marriage because they were typically the initiators of sexual relations; women were expected to be ignorant as a sign of their respectability. Similarly, Szreter and Fisher's comparative study on middle-class and working-class married couples reveals that working-class couples did not discuss birth control together. In practice, this situation made men responsible for contraceptive practices. This type of implicit arrangement was less likely to prevail among middle-class couples, but even so such couples did not necessarily agree on the choice of a particular method; couples regularly reported tensions and disagreements as well as sexual dissatisfaction.[69] Contemporary surveys on contraceptive practices, such as the Lewis-Faning report for the Royal Commission on Population, also noted that as late as 1949 married couples mostly relied on withdrawal or the sheath.[70] The use of traditional birth control methods such as withdrawal or abstinence was also the norm in France during the period covered by the book.[71] Yet, while individuals were reluctant to employ more efficient but more constraining birth control methods, there existed, as early as the 1920s, a strong push towards the spread of information on the advantages of 'modern' and mechanical methods of birth control.

From their opening, the voluntary British birth control clinics favoured female-oriented methods and strongly condemned withdrawal and abstinence, though both were widely practised. Yet tensions developed over the best form of contraception to prescribe. Differences in opinion among members of the voluntary clinic movement about the preferred method soon gave way to open debate. Marie Stopes, who set up the first birth control clinic in London in 1921 and subsequently

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five others across Britain, recommended use of a greasy suppository in combination with the 'pro-race cap' she had designed. She rejected the diaphragm recommended by the Walworth Women's Welfare Centre, a rival clinic set up by the Malthusian League, on the grounds that it caused cancer, and she was opposed to the sheath.[72] Stopes was looked upon with suspicion by the medical establishment since she was a biologist and did not hold a medical degree. The Australian sexologist Norman Haire also designed his own Haire pessary, a modified version of the vaginal diaphragm that Dr Mensinga had invented in Germany in the 1870s.[73] However, the first inquiry into patients' practices made by the staff of these clinics revealed that the female-oriented methods recommended in birth control clinics – the doctor-fitted diaphragm used with a spermicidal jelly – did not meet with strong enthusiasm on the part of patients, and some women failed to return for follow-up appointments. Hence, the quest for the 'perfect contraceptive' triggered clinical research. Indeed, developing a cheap, easy-to-use, reliable and pleasant contraceptive became a target for birth control activists in the interwar years.[74] In addition, little information was available on the clinical aspect of the methods developed. To examine 'the sociological and medical principles of contraception', certain lay members of the North Kensington Women's Welfare Centre and Cambridge Birth Control Clinic took the initiative of forming the Birth Control Investigation Committee (BCIC) in 1927.[75] An article sent to the *British Medical Journal* (BMJ) presented the aims of the committee: 'The committee serves no propagandist function and desires only to establish facts and to publish these facts as a basis on which a sound public and scientific opinion can be built.'[76] The committee received the financial support of the British Eugenics Society, the Bureau of Social Hygiene – a private body aimed at preventing social problems through scientific research established by the American John Rockefeller, which received contributions from a number of organisations including the Rockefeller Foundation (RF)[77] – and private donors. Sir Humphry Rolleston, physician-in-ordinary to George V and Regius Professor of Physic at Cambridge, acted as the chair, while the psychiatrist, convinced eugenicist and secretary of the Eugenics Society, Carl Paton Blacker, was a founding member. Many other famous male scientists were also members of the committee, such as the British evolutionary biologist and eugenicist Julian Huxley and other members of birth control clinics.

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The BCIC functioned as the organ of reference for contraceptive research. It financed clinical research on contraceptive substances and devices carried out in private laboratories and clinics, as well as in birth control clinics. For instance, it supported the work of the Oxford zoologist and eugenicist John Baker on the spermicidal effectiveness of a variety of chemicals.[78] Recent work concentrating on the BCIC has highlighted the prominent role of male scientists in the development and testing of chemical contraception, and in the short-lived distinction the BCIC drew between pure science (the knowledge produced in the laboratory) and applied research (the research confined within clinic and separated from the laboratory)[79]. The book shows that women doctors blurred this distinction between pure and applied research since they liaised between laboratory and patients' needs and conducted clinical trials within birth control clinics.

At around the same time, the International Medical Group for the Investigation of Contraception was set up in London in 1928 by the British suffragette Edith How-Martyn. This organisation aimed to disseminate applied and scientific knowledge of contraception through a network of women physicians, social workers, and birth control activists. In 1930, the office was reorganised into the Birth Control International Information Centre (BCIIC), of which the famous American birth control activist Margaret Sanger was honorary president and How-Martyn was honorary director. The centre published pamphlets, newsletters, bulletins and other information about contraception, new research, and clinic updates. Between 1929 and 1934, five reports were issued by the BCIIC. Blacker, the secretary of BCIC, was in charge of statistical investigations – namely the analysis of data collected in birth control clinics and reviewing the latest progress in contraceptive research.

In 1934, the NBCA set up a medical subcommittee. It functioned as a working subcommittee of practising medical men and women for the 'interchange of ideas and experiences and collection and coordination of the experience of other[s] engaged in the teaching of birth control methods and for the formation and presentation of reports to the executive committee'. Among its members were several women doctors.[80] Dr Cecil Voge, Dr John Baker and Dr Blacker were the consultants on all matters relating to rubber manufacturers, on the spermicidal and chemical properties of contraceptives, on the statistical work, and on

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the form of leaflets or other literature. The minutes of the committee show that they tested specific brands of contraceptive methods and accordingly wrote to the birth control clinics in order to advise against or in favour of them.

Hence, this book argues that during the emergence of contraceptive methods as a legitimate field of medicine, the imperative for doctors working in this new area, such as women doctors, was to position contraceptive methods as a new specialty and field of research. They did so through careful analysis of statistical evidence from clinical trials and patients' experience with contraceptive methods and family planning. However, I argue that this move towards laboratory-based medicine did not necessarily imply that this new 'scientific' and 'objective' approach meant the loss of the human component of the doctor–patient relationship. Indeed, as I will show, women doctors built on both approaches in order to develop their work in birth control clinics and promote this field of research according to their circumstances and necessities. Patients' individual experiences with birth control and family planning were as determinant as a sound analysis of collected data in choosing a form of birth control. Women doctors heavily relied on their encounters with their patients' sexual needs and tailored their work accordingly. However, women patients were also, to borrow from Nancy Theriot's expression, 'active participants in the process of medicalising women'. They actively sought effective birth control methods, but refused and resisted some forms of birth control that interfered with the sexual act and did not preserve its spontaneity. They also embraced the contraceptive pill, which had become available on the market in 1961.

While taking lived experiences into account, a detailed analysis of the personality and individual attitudes to sexuality, as well as the emotions that guided women doctors' commitment to family planning, is beyond the scope of this book.

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Based on a qualitative thematic analysis of a diversity of sources that either have been barely exploited or have been analysed for a different purpose, five chapters track the many ways in which British women doctors contributed to the issues of birth control and family planning.

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These sources range from medical texts written by and about female doctors (scientific articles, proceedings of international and national conferences, medical and sex manuals, audio recordings of sexual counselling sessions, autobiographies and interviews) to archival material from medical associations in both the UK and France (Eugenics Society, International Planned Parenthood Federation, Family Planning Association, Maternité Heureuse, Mouvement Français pour le Planning Familial, Medical Women's Federation, and Association Française des Femmes Médecins). These chapters are organised thematically and chronologically. In Chapters 1 and 2, I concentrate on women doctors' involvement in birth control at the national level through their work in birth control clinics, the production of scientific knowledge, the carrying out of clinical trials and the setting up of sexual counselling. These chapters build on previous studies on the organisation and aims of birth control clinics, and the motivations behind the birth control movement. Such studies argue that feminist, eugenic and humanitarian motives were often intertwined in the creation and running of the clinics. I do not reject these analyses, but, taking them into account, I argue that by shifting the focus on the role played by women doctors, a different picture appears in which the main imperative was to help other women access reliable contraception. Doing so required a new form of expertise: the service offered in birth control clinics was to be presented as medical, scientific and technical.

In Chapter 1, I focus on the relationship between British reproductive politics and gendered medical practices. I show that while women doctors were being assigned to a peripheral position within the medical hierarchy and to fields that were supposedly in line with their 'feminine nature', they developed their scientific credentials by disseminating scientific knowledge of birth control. This chapter argues that women doctors used the scientific rhetoric from the emerging field of laboratory-based medicine as a strategic move to position both birth control as a legitimate field of medicine and themselves as experts in this domain. They wrote related books based on their extensive personal experience, and engaged in contemporaneous debates on the side effects of birth control. They conducted trials on new methods of contraception and published their results in scientific journals. In so doing, they became a central channel for well-informed, reliable and scientific considerations on contraceptive methods.

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In Chapter 2, I explore the way women doctors set up sexual counselling in family planning clinics. I analyse the professional training undertaken by doctors and the kind of knowledge on which they drew to help couples facing sexual disorders. Here, I argue that women doctors developed a holistic approach to family planning, mainly in response to the difficulties faced by their patients. Female sexual pleasure, or the lack thereof, became increasingly important in the advice provided in the clinics. In this way, they helped to challenge what was considered 'abnormal' or pathological in couples' sex lives. I highlight the way women doctors took into account their patients' sexual experiences and desires in order to help redefine the medical understanding of phenomena such as frigidity.

In Chapters 3, 4 and 5 I address the international and transnational dimensions of women doctors' work, and show the setting up of an international movement for birth control and family planning. I analyse British women doctors' influence on French doctors and show the key role played by women doctors in developing the understanding of new contraceptive devices on the international scene.

Chapter 3 turns to women doctors' contribution at the international level between 1920 and 1935 through an explicit comparison between British and French women doctors. In the interwar years, British women doctors, although not numerous, were nevertheless agents of the legitimacy of birth control. Indeed, they were vocal and indispensable in the transnational movement for birth control. Owing to their somewhat peripheral position in the national medical field, they took up the task of the practical aspects of birth control; they opened clinics and fitted individuals. This practical experience paradoxically gave them specific female expertise and power, relative to men, in international associations. While birth control tended to be framed in eugenic/neo-Malthusian terms by male doctors before 1930, it gradually became a medical subject in which scientific vocabulary and concern for individual welfare predominated. Women doctors played a major role in this shift. The international conferences on birth control and population issues positioned women as experts in this medical field, but, as I will show, also revealed national differences between Britain and France. I argue that the two different conceptions of feminism, population policy and reproductive health greatly contributed to positioning British women as comparative leaders in reproductive knowledge.

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In Chapter 4, I explore British women doctors' involvement in the transnational movement for family planning. The leading role of British women is not restricted to the interwar years. Indeed, they proved successful in rebuilding a transnational family planning movement after the Second World War. Due to the connections they established before the war, they managed to gather experts on family planning in order to redefine a new 'planned parenthood' movement. Furthermore, British female doctors became a channel of information on family planning training. The last section of Chapter 4 analyses the way in which French female and male doctors used the training provided by British female doctors, such as Helena Wright, to implement family planning services in France. French female doctors eventually supported the family planning movement and learnt from their British colleagues.

Finally, in Chapter 5, I use the case study of the Gräfenberg ring, the first intrauterine device, and later forms of these devices, to exemplify the new expert position acquired by Wright and Jackson in both the international and national spheres. The chapter shows that the social organisation of medicine matters when explaining which voices were heard and who was considered expert in birth control methods during the interwar years and after. It adds to the scholarship on the history of technology by focusing for the first time on the history of the first IUD in Britain and the criteria used to assess a new contraceptive device.

In all, by adopting a comparative and transnational approach with a sustained focus on the role of female doctors over the longer 'mid-century' period, I contribute to the understanding of the role of women doctors in family planning, of the history of family planning (not only in Britain but also in France), of the history of sexual counselling and infertility, and of the professionalisation of women doctors. In so doing, I reinstate the role of some women doctors who have previously been left out of the historical narrative.

Notes

1 S. Raven, 'One woman's mission', *The Sunday Times Magazine* (6 May 1973), p. 28.

2 Lesley Hall and Cornelie Usborne have both focused on the role played by women doctors, but their work mainly opened up new lines of inquiry. See L. A. Hall, 'A suitable job for a woman: women doctors and birth control

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to the inception of the NHS' in A. Hardy and L. Conrad (eds), *Women and Modern Medicine*, Clio Medica 61 (Leiden: Brill Rodopi, 2001), pp. 127–47; C. Usborne, 'Women doctors and gender identity in Weimar Germany (1918–1933)' in Hardy and Conrad, *Women and Modern Medicine*, pp. 109–26.

3 For a good introduction to the feminist health movement see W. Kline, *Bodies of Knowledge: Sexuality, Reproduction, and Women's Health in the Second Wave* (Chicago: University of Chicago Press, 2010).

4 P. Conrad, 'Medicalisation and social control', *Annual Review of Sociology*, 18:1 (1992), p. 211.

5 B. Ehrenreich and D. English, *Witches, Midwives and Nurses: A History of Women Healers* (New York: The Feminist Press, 1973).

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7 T. Laqueur, *Making Sex: Body and Gender from the Greeks to Freud* (Cambridge, MA: Harvard University Press, 1990).

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9 B. Duden, *The Woman Beneath the Skin: A Doctor's Patients in Eighteenth-Century Germany* (New Haven: Harvard University Press, 1991); O. Moscucci, *The Science of Woman: Gynaecology and Gender in England, 1800–1929* (Cambridge: Cambridge University Press, 1990). Another body of scholarship has focused on the *social* construction of medical knowledge. But some historians have failed to analyse scientific practices and procedures in medicine, or to recognise that male bodies were also pathologised. See in particular C. Benninghaus, 'Beyond constructivism?: Gender, medicine and the early history of sperm analysis, Germany 1870–1900', *Gender & History*, 24:3 (2012), pp. 647–76.

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11 A. Oakley, *The Captured Womb: A History of the Medical Care of Pregnant Women* (New York: Basil Blackwell Publisher Ltd., 1984); C. Takeshita, *The Global Biopolitics of the IUD: How Science Constructs Contraceptive Users and Women's Bodies* (Cambridge, MA: MIT Press, 2012); A. Clarke, *Disciplining Reproduction: Modernity, American Life Sciences, and 'the Problems of Sex'* (Berkeley: University of California Press, 1998). On the feminist appropriation of reproduction see M. Murphy, *Seizing the Means of Reproduction: Entanglements of Feminism, Health, and Technoscience* (Durham, NC: Duke University Press, 2012); K. Ratcliff, *Women and Health: Power, Technology, Inequality and Conflict in a Gendered World* (Boston, MA: Allyn and Bacon: 2002).

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13 P. Conrad, *The Medicalisation of Society: On the Transformation of Human Conditions into Treatable Disorders* (Baltimore: Johns Hopkins University Press, 2007); Conrad, 'Medicalisation and social control', pp. 209–32.

14 See for instance L. Kelly, *Irish Women in Medicine, c.1880s–1920s* (Manchester: Manchester University Press, 2013); A. Crowther and M. Dupree, *Medical Lives in the Age of Surgical Revolution* (Cambridge: Cambridge University Press, 2010); C. Brock, *English Women Surgeons and their Patients (1860–1918)* (Cambridge: Cambridge University Press, 2017); E. S. More, E. Fee and M. Parry (eds), *Women Physicians and the Cultures of Medicine* (Baltimore: Johns Hopkins University Press, 2009).

15 C. Debenham, *Birth Control and the Rights of Women: Post-Suffrage Feminism in the Early Twentieth Century* (London: I. B. Tauris, 2014).

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