1

Giving birth control medical credentials in Britain: 1920–70

> [W]omen clients came to us because we were all women. Women doctors, women nurses, women running clinics.[1]
>
> Helena Wright

From the opening of birth control clinics in the early 1920s to the Family Planning Act in 1967, women have been central actors in the campaign for birth control and contraception in Britain.[2] Female doctors, in particular, played a unique role in the practicalities of birth control. They introduced birth control as a field of medical research and practice because they wanted to give their female patients power over their reproductive bodies and because birth control clinics provided them with job opportunities. Indeed, women were disproportionately represented among doctors interested in birth control, and they dominated this field due to their active participation in birth control clinics, the development of training in contraception and the production of medical and scientific knowledge on birth control and contraception. In a nutshell, they colonised birth control and contraception.

This chapter sheds new light on some well-known aspects of the history of birth control and the Family Planning Association, with a focus on the medicalisation process and the initiatives and strategies women doctors used to position themselves as respectable experts in the new field. They developed a specific form of communication with colleagues that relied heavily on specialised medical vocabulary; this discourse was aimed at improving their status and securing new job opportunities within the medical field. When addressing lay audiences, women doctors conveyed a narrative that emphasised the benefits of birth control for society and the family. They made birth control a medical service by offering a detailed description of contraceptives

available on the market, providing women with the knowledge to avoid unwanted pregnancies.

While historical analysis of the establishment of birth control clinics in Britain has focused on the discourses of the birth control movement, the production of medical knowledge by those engaged in the movement has attracted little scholarly interest.[3] The most valuable work on this subject is a short article by Lesley Hall which has analysed women doctors' engagement in public debates on birth control. Kate Fisher and Hera Cook have researched sex manuals to identify the public discourses around sexuality and the gendered norms prevailing between 1920 and 1970.[4] They have mentioned the role played by some women doctors, especially Helena Wright and Joan Malleson; however, they have referred to them mainly as sex manual writers rather than as experts who published scientific and medical knowledge of modern birth control methods. This aspect is central to the following section. I examine sex and medical manuals in order to show the type and nature of knowledge that women doctors conveyed, rather than the extent to which the information provided in these manuals was widely available to working- or middle-class readers. While successive editions of a manual might testify to its success with the lay public, this chapter is not concerned with the reception of these books. Rather, what is of interest here is the fact that women doctors took the time to write books to spread scientific information about birth control, and the way they framed this knowledge. These sources are contrasted with other scientific publications in the *British Medical Journal* and the *Lancet*, as well as the archives of the Medical Women's Federation and the Family Planning Association to better understand how women doctors framed contraception when they talked to their professional colleagues.

First, this chapter briefly provides a historical overview of the rationales and common features of women doctors' participation in the birth control movement and birth control clinics. I then move on to exploring the strategies that female doctors developed for medicalising birth control.

Women doctors' involvement with birth control

Until the First World War, and with the exception of doctors involved in the neo-Malthusian and eugenics movements, scholars have shown

that many doctors were still ignorant about contraception; some were reluctant to recommend contraception to their patients because they were afraid of undermining their scientific credentials given the enduring Victorian distaste for sex. These doctors thought that their role was to cure illnesses, and they believed that abstinence was the best way to limit family size.[5] Historian Richard Soloway has argued that the medical profession in Britain 'reacted to the early birth control movement with avoidance, animosity, moral injunction and dubious scientific pronouncements'.[6] He has underlined that, until the mid-1920s, there were diverging opinions in the medical profession between opponents of birth control, who condemned it based on moral considerations, and supporters of the dissemination of birth control. While medical journals opposed birth control, the population census of 1911 revealed that doctors had the smallest families of all occupational categories. During, and after, the war, a few high-profile medical figures started to endorse birth control publicly – such as Charles Killick Millard, medical officer for health in Leicester, who called for his colleagues to examine birth control scientifically and leave aside 'moral considerations',[7] and Lord Dawson of Penn in his 1921 address to the Church Congress in Birmingham.[8] Meanwhile, the paleobotanist Marie Stopes, who was not a doctor, opened the first Mothers' Clinic for Constructive Birth Control, in Holloway Road, London, which was run by midwives with the help of consulting doctors. She also founded the Society for Constructive Birth Control and Racial Progress (SCBCRP) to campaign for birth control. This clinic was quickly followed by others opening across London and the rest of Britain. In November 1921, members of the Malthusian League opened the Walworth Women's Welfare Centre behind the Elephant and Castle public house in one of London's poorest neighbourhoods. In 1924, the Society for the Provision of Birth Control Clinics (SPBCC) was created to campaign for municipal clinics, and won its first battle in July 1930 when the Ministry of Health, through 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.

In 1926, a compilation titled *Medical Views on Birth Control* was published in which most of the authors repeated their moral reluctance to accept birth control and affirmed that its use caused sterility. This publication, Soloway explains, marked a turning point within the

medical profession; in response to their elders' objections, younger physicians stated that 'opposition to birth control had become counter-productive', making the profession appear 'reactionary or inhuman'.[9] Conflicting stances linked to a generational gap within the medical community characterised the first decade of the expansion of birth control clinics.

In this controversial context, a limited group of vocal female doctors, drawing on their own experience in birth control clinics, alongside male doctors such as Lord Dawson of Penn, Norman Haire and C. P. Blacker, tried to convince their medical colleagues that birth control was a legitimate, effective and medically harmless means for preventing conception in order to fight poverty and reduce the incidence of abortion. Albeit a minority in the medical field, British women doctors engaged with birth control issues in relatively high numbers.[10] The fact that birth control could become a female medical specialty was recognised by male doctors as early as 1923. For instance, in a special issue of *The Practitioner* dedicated to birth control, the editor explained that medical schools did not teach birth control, and he suspected that this situation would not change for male doctors; however, he predicted that for women doctors, training would take place, thus placing birth control under their responsibility.[11]

Clinics set up by the SPBCC were all headed by medical officers who were women. Female lay activists and women doctors were thus pivotal in the creation and running of the birth control clinics,[12] as Helena Wright, a female gynaecologist at the North Kensington Women's Welfare Centre and an important birth control activist and central figure of this book, explains in the quotation opening the chapter. This quote implied that there was a common and obvious understanding that female patients would turn to female doctors for birth control advice more easily than to male doctors. Wright, who was born Lowenfeld, came from a wealthy London family and graduated as a medical doctor from the London Royal Free Hospital School of Medicine for Women in 1915, where she had been trained by Winifred Cullis, Professor of Physiology at the University of London and a future member of the Birth Control Investigation Committee. During the war, although a pacifist, Wright worked in a military hospital in Bethnal Green, where she met the captain and surgeon Henry Wright. They were married in 1917, and Wright soon found herself pregnant. In 1918, Henry Wright

was invalided from the army due to possible tuberculosis of the lungs. To help Henry recover from the disease, the couple and their firstborn, Henry Beric, went to Cornwall. Staying in the same hotel were Marie Stopes and her husband, Humphrey Verdon Roe. The two couples got along well, and Wright and Stopes had long discussions while walking along the beach together. Wright had previously read Stopes' notorious book, *Married Love*. Stopes had the manuscript of her forthcoming book, *Wise Parenthood*, with her, and asked Wright to review it. Wright accepted, provided that she could 'point out anything that she thought was rubbish'. Wright recalled the horrified look on Stopes' face, but the latter eventually agreed.[13] That was her first formal encounter with birth control. In 1919, along with her husband and their two sons, Wright left for China, where she would serve as Associate Professor of Gynaecology at the Shantung Christian University Hospital. There, Wright witnessed and treated the dramatic consequences of repeated and consecutive pregnancies, gaining intimate knowledge and experience of the subject. In 1927, the family, now with four sons, returned from China for what Wright thought would be a short period, as their plan was to return. However, due to the Japanese invasion of the north of China, Wright's family was forced to stay in the UK. At this stage, she had to figure out what she wanted to do and where she wanted to work. As she explained in an interview in 1978, she thought: 'birth control is under the horizon. It's time it came up. I'm going to do it.'[14] This decision was undoubtedly influenced by her previous experience in China.

One of the many reasons underpinning women doctors' commitment to the provision of birth control was the desire to improve women's health. During the first quarter of the twentieth century, as explained in the introduction, women doctors were primarily working in community health, in the voluntary state-sponsored welfare centres, or in the field of gynaecology and obstetrics, where they witnessed the difficulties faced by overburdened working-class mothers.[15] The hostility female doctors met within the male-dominated field of medicine, as explained in the introduction, meant that they specialised in 'feminine areas of work' where they had greater and closer contact with working-class women than their male colleagues. As a result, many female doctors joined the birth control movement aimed at providing information about, and access to, birth control to every poverty-stricken married woman via maternal welfare centres. Indeed, their own

experience of witnessing working-class mothers' poverty, social misery and difficulties drove their strong commitment to provide safe contraceptives. Their commitment to birth control originated from humanitarian motives to help other women in need. This particular experience might explain why female doctors outnumbered male doctors in their support for birth control, the latter being less in contact with working-class women's struggles.

There was a clear influence from feminism here, as women setting up and working in birth control clinics were also members of feminist associations.[16] Many important feminist activists who were committed to suffrage activity were also involved in the birth control movement; for example, Eva Hubback was a founding member of the National Birth Control Association, Dora Russell was involved in setting up the Worker's Birth Control Group,[17] Mary Stocks and Charis Frankenburg founded the Manchester, Salford and District Mothers' Clinic, and Stella Browne actively campaigned for birth control and was a co-founder of the Abortion Law Reform Association.[18] Clare Debenham has argued that the SPBCC should be considered as a feminist organisation founded by women for the good of women[19]. Moreover, the birth control clinics favoured female-oriented methods and strongly condemned withdrawal and abstinence, which were not only unreliable but detrimental to the sexual happiness of married couples. To gain acceptability, birth control had to be presented as supporting the stability of the institution of the family. Therefore, an important argument was to explain how birth control contributed to the sexual happiness of a couple by relieving the fear of pregnancy, allowing spouses to enjoy each other, which in turn strengthened their union. Women patients attending the clinics were fitted with devices that, according to the female staff that populated the clinics, gave them control and power over their own reproductive bodies. The feminist orientation of the birth control movement was also acknowledged by contemporary male medical colleagues. For instance, C. P. Blacker, honorary secretary of the Birth Control Investigation Committee, wrote an article on methods of birth control published in *The Practitioner* in 1933. He explained that the sheath was the method commonly used, despite its lack of support from the birth control movement. The unfavourable disposition towards the method, in his view, rested on the fact that 'among the most vigorous of the proponents of birth control are to be found women with

strong feminist convictions who regard the male sex collectively as lacking in consideration for the feelings of their womenfolk and therefore as incapable of taking the primary responsibility in the matter of controlling reproduction.'[20]

The goal of the birth control movement was to reduce the suffering of working-class women and improve their health and living conditions through the provision of efficient female-controlled birth control methods via welfare centres. It is not surprising then that a fair number of these women doctors were on the left side of the political spectrum, since they were in favour of state involvement in the provision of birth control.[21] For instance, Joan Malleson wrote an open letter in 1924 with other Labour members in *Labour Woman*, 'appealing to all party members who realise the need for [contraceptive] knowledge among the workers, to raise the matter for discussion at their branch of meeting; to send resolutions to our Labour Minister of Health, and to the forthcoming Party Conferences, and to sign a petition that such information should be given'.[22] The same year the Workers' Birth Control Group was set up by women from the Labour Party. The group campaigned for the provision of information about birth control by local authorities through maternity and child welfare centres. They specifically framed birth control as a working-class issue and argued that birth control methods would improve the health of working-class mothers. The Labour women promoted a feminism that valued marriage and motherhood and, as a result, tried to raise the status of these occupations.[23]

Eugenic rhetoric was also part of the narrative supporting female doctors' participation in birth control clinics, since the main targets of birth control were overburdened working-class mothers who had too many children.[24] For instance, Stopes was a convinced eugenicist. In her famous sex manuals, *Married Love*, *Wise Parenthood*, and *Radiant Motherhood*, she presented birth control as a way of creating a 'new and irradiated race'. There were also clear connections between members of the Eugenics Society and the SPBCC and SCBCRP. The Eugenics Society formally promoted birth control as a negative eugenic measure, primarily targeting the poor, from 1926. Eugenicists were afraid that working-class people were reproducing at far greater rates than their middle- and upper-middle-class counterparts. Members of the Eugenics Society were involved with the governing boards of SPBCC and SCBCRP. The Eugenics Society also financially supported the BCIC.

Moreover, the Eugenics Society and the FPA shared headquarters on Eccleston Square, London, from 1938 to 1949. Despite the official endorsement of birth control by the Eugenics Society, and the fact that several members of the society, such as Joan Malleson, were also members of the SPBCC, studies have shown that daily practice at the clinics tended to marginalise eugenic ideas; women patients came from both the working and middle classes, and every woman was welcome in the clinic.[25] Nevertheless, eugenics considerations around differential fertility were used to support women's efforts to campaign for improving the health of working-class mothers. Reminiscences of eugenic rhetoric, while uncommon, were sometimes found in the archives, especially when it came to explaining the failure of some contraceptive methods – there sometimes existed a class bias against the inability of working-class women to follow instructions and commit themselves to one method[26]. In fact the majority of women doctors working in the clinics came from the upper middle class. These 'lady doctors' were sometimes disconnected from the living conditions of working-class women; living in overcrowded housing with a lack of privacy and sanitation, many poor and working-class women found it difficult to use contraceptive methods that needed to be inserted, removed and washed every day. Kate Fisher has argued that the clinics therefore failed to encourage working-class women to successfully use female methods of birth control, but that, despite this, they did not tailor their service to better consider patients' individual preferences.[27] As Fisher has convincingly demonstrated, working-class women considered that it was their husband's responsibility to take care of birth control, and they valued ignorance and spontaneity in the sexual act. As a result, taking the lead and responsibility for birth control, as well as undertaking some form of preparation such as putting in a cap, ran counter to their expected gender and marital role of being sexually passive and ignorant. This discrepancy between female doctors' views on the suitability of female contraceptives and the lived experiences of working-class women remained a contentious issue before the advent of the pill, and might account for the long-lasting use of traditional methods of birth control. As I will show, this situation could be explained by the belief that the cap or diaphragm, combined with spermicide jelly, met the medical criteria developed by female doctors to assess birth control methods at a time when birth control became a

field of medical research. In addition, while these middle- and upper-middle-class doctors might have sometimes been more concerned with prescribing efficient means of birth control than ascertaining that the methods could be successfully used, this did not mean that they did not take their patients' experiences into account. Indeed, in their views, reliable and efficient methods were key to limiting births and, as I will show in Chapter 2, they also developed sexual counselling as an answer to their patients' needs.

Many of the women doctors working in birth control clinics were also members of the Medical Women's Federation, such as the above-mentioned Joan Malleson, who worked as a psychosexual counsellor at the Telford Clinic; Dr Olive Gimson, medical officer for the Manchester, Salford and District Mothers' Clinic; and Dr Phoebe Bigland, founding doctor of the Mothers' Welfare Centre in Liverpool. Membership of the MWF also shows that women doctors were aware of their marginal position and actively developed ways of supporting each other. Although several individual members of the MWF increasingly backed birth control, especially from the mid-1920s onwards, this was not the case for all members. The main opponents of birth control were doctors who had started practising at the end of the nineteenth century and were 'strongly influenced by turn-of-the-century eugenicist anxieties and social purity feminism'. The female doctors in favour of birth control were 'characteristic exponents of the welfare feminism of the era following the achievement of the suffrage'.[28] For instance, conflicting stances were expressed in the first meeting on birth control organised by the MWF in 1921, during which three contributions were made. The first, a eugenic plea for state birth control, was offered by Dr Elizabeth Wilks, who had qualified in 1894 and was a committed suffragette and member of the Women's Tax Resistance League. Indeed, she underscored that the 'classes superior in intelligence and capacity practised birth control whereas the less intelligent and the degraded had neither the prudence nor the initiative to take any measure for limiting their offspring'.[29] The second contribution was that of Dr Mary Scharlieb, born in 1845 in London, who belonged to the first generation of women doctors to obtain medical degrees. Scharlieb first went to Madras, then came back to London in 1878 and entered the London School of Medicine for Women, where she obtained her Bachelor of Medicine (MB) in 1881 and a gold medal for obstetrics. She then was

appointed senior surgeon at the New Hospital for Women and later at the Royal Free Hospital. Scharlieb was a convinced eugenicist and Anglo-Catholic who was 'highly conventional in her moral attitude', since she was part of what historians call social purity feminism.[30] As such, during her speech in front of the MWF, she clearly laid out her reluctance about birth control based on the fear that it would encourage husbands towards 'too frequent sexual intercourse' by removing the 'fear of consequences'.[31] Florence Barrett (Lady Barrett), a distinguished obstetric and gynaecological surgeon, was the third contributor to this conference. She was also one of the first women to graduate in medicine. Lady Barrett acknowledged that 'medical women should think out their own views'.[32] A resolution was passed that strongly disapproved of 'the public propaganda now being carried on in favour of Birth Control'. This disapproval was plausibly targeting Marie Stopes and the launch of her Society for Constructive Birth Control and Racial Progress. This was the only conference on birth control by the MWF before the Medical Women's International Association organised an international conference on the subject in 1934, as we shall see in Chapter 3. In October 1921, the president of the MWF, Louisa Martindale, gave her presidential address on 'Birth Control' to the London association of the federation. She shared the same concern as Scharlieb about the excessive sex drive of men. Martindale recognised that the legitimate aim of the birth control movement was to improve the conditions of women's lives, but held the opinion that there were 'worthier ways' to achieve this aim.[33]

Scharlieb reaffirmed her reluctance to support birth control at the session on 'Medical Women and Public Health Problems' during the 1922 Congress of the Royal Institute of Public Health. She explained that 'artificial prevention of conception was injurious both physically and morally'.[34] While Scharlieb's condemnation was based on social purity feminism, Barrett's concerns about birth control drew on eugenics rhetoric. At the same session, as well as during her presidential address to the MWF in November 1922, she urged that it should be left up to individual medical practitioners to decide whether birth control should be recommended to a patient. She stressed the need to discourage 'normal healthy individuals'[35] from using birth control while encouraging 'the unfit – not by propaganda, because that would not touch them – but by state interference' to use it. However, during the

1922 congress, others supported the birth control movement provided that patients were already parents.

Training of doctors, nurses and medical students

Valuable tactics in medicalising birth control and making it a legitimate field of medicine were to teach it as such and to emphasise that, as in other medical fields, contraception required medical competences that could only be acquired through specific training. Women doctors proved successful in doing this, and they trained doctors, nurses and medical students at women's welfare centres. The initial decision to offer classes on contraceptive methods represented an attempt to fill a perceived gap in medical knowledge, as well as to make birth control a specialty for which doctors needed particular training. In Britain, contraception was not part of the medical curriculum during the period under study. As Sylvia Dawkins, a family planning doctor from the end of the Second World War onwards, recalled in an interview for Television History Workshop in 1988, 'contraception just was not regarded as a medical subject' during her training at the London Hospital School of Medicine at the end of the 1920s. She stressed her lack of knowledge: 'I did not know anything about it and it was only when patients began to ask about it later that I realised the need […]. So the demand of the patient made me, forced me eventually into learning, so I went to North Kensington and I was taught by Helena Wright.'[36]

In 1922, the MWF advocated that women doctors and students receive improved training of 'sex hygiene and the methods commonly in use for control of conception'[37] while condemning any public propaganda on the subject. As a result, the MWF decided to publish leaflets on the issue, while denying any responsibility for the content expressed in such leaflets. Three publications were issued by members of the federation. *The Eugenic Aspect of Conception Control*, by Elizabeth Wilks, was a eugenic appeal 'for the limitation of the family in the case of its inferior stocks and greater productiveness among those of superior quality'. However, no mention was made of the methods to be used to limit the size of the family. The second leaflet, by Lady Barrett, a distinguished obstetric and gynaecological surgeon who feared that contraception might encourage sexual excesses on the part of the husband, was entitled *General Questions of Sex and Marriage*, and omitted any

mention of contraception. The third leaflet, by Rhoda H. Adamson, was designed for doctors. *Methods of Conception Control* presented the reader with a brief overview of the pros and cons of available methods of birth control: 'Medical practitioners today are compelled by their patients to consider the question of control of conception and are expected by them to be acquainted with the main facts of its practice.' However, the leaflet offered minimal practical description of the fitting of birth control devices. As a result, the only way for women doctors to gain practical information, before the setting up of lectures by the women's welfare clinics, was to write to the birth control activist Marie Stopes.[38] By 1930, the MWF seemed to have reached an agreement on the need for medical training in contraception, as shown by the following resolution that was accepted in 1931: 'That instruction in birth control methods with the medical reasons for and against be included in the ordinary gynaecological curriculum.'[39]

In 1932, the NBCA carried out a survey on training in contraception among London's twelve hospitals. The poor results encouraged the NBCA to offer its own training programmes at birth control clinics. It was not until 1936 that the first medical school, the British Postgraduate Medical School, provided an annual lecture on contraception. The inaugural speech was given by Wright.[40] Hence, given the lack of training, women doctors proactively taught the basics of contraception to medical students, doctors and nurses. From 1929, training sessions for doctors (at first just women doctors) and nurses were provided at the North Kensington and Walworth Women's Welfare Centres on Wright's initiative. Indeed, when Wright returned to London after her five years as a missionary in China, she decided that she would work in birth control. To do so, she 'tried to find out what was already on' in London by visiting the three clinics that were open at that time. In the Marie Stopes clinic, she discovered that Stopes had been altered by years of struggle with the Catholic Church, who had warned her that the caps used by the Walworth and North Kensington clinics were causing cancer. 'It was paranoid nonsense', remembered Wright. She then went to visit the Walworth clinic, headed by a female general practitioner, who told her: 'Dr Wright, you must be very careful. You must only use this kind of cap. We have heard that Marie Stopes uses another one and she is causing cancer of the uterus.' Wright described this moment as the point when she made a 'far-reaching conclusion', which was that

birth control work 'could not be done by general practitioners, only by specialists. It had to be a specialty which was specially trained for and which gained its own respect.'[41]

Since medical schools refused to teach birth control, Wright, who was the medical officer in charge of North Kensington Women's Welfare Centre, took the issue into her own hands and taught birth control to medical students and doctors. The centre soon became a hub for training,[42] and in 1933 it wrote to postgraduate colleges[43] and deans of medical schools to offer help in the matter. To Wright, training medical and postgraduate students was an 'urgent necessity' in a context of 'growing demand amongst the public for scientific advice'.[44]

In 1934, medical students from Guy's Hospital, King's College Hospital, London Hospital, St Thomas' Hospital, Royal Free Hospital, St Mary's Paddington Hospital, and Charing Cross Hospital received training at the North Kensington and Walworth Women's Welfare Centres.[45] An anecdote illustrates the public attitude that prevailed at that time. A young gynaecologist, William Nixon – who would become Professor of Obstetrics and Gynaecology at University College Hospital and would open the first family planning clinic in the outpatient department of a London teaching hospital in 1948 – brought his students to the session held at the North Kensington centre. However, he did this during the evening, 'under the cover of darkness', as coming to the birth control clinic in daylight was too adventurous. Women doctors also appealed to the nursing profession and taught them on the subject. Wright, Malleson, Dr Gladys Cox, Dr Greta Graff, Dr Cecile Booysen and Dr Mary Redding, all members of the Society for the Provision of Birth Control Clinics and the MWF, taught medical students who had completed their gynaecological courses, medical practitioners, and nurses between 1933 and 1939. Dr Mary Macaulay, who was the medical officer for the Liverpool branch of the FPA, also trained doctors at the Liverpool clinic who were willing to teach birth control in private practice, and those who wished to become medical officers for voluntary or municipal clinics.[46]

The requirements for training sessions were listed in a memorandum issued in 1934 by the medical committee of the North Kensington centre, headed by Helena Wright. This memorandum resulted from the observation that methods recommended and taught in the clinics varied from clinic to clinic and from one medical officer to another. In

an attempt to overcome this problem and harmonise the information given at birth control clinics, close cooperation was sought between clinics and the laboratories where birth control methods were tested. This cooperation was believed to guarantee that the lectures provided in clinics were at the forefront of contraceptive knowledge. Lecturers were expected to be au fait with the latest clinical updates to birth control methods that informed clinical practice: 'it is essential that only up-to-date methods should be used and that these should have been as thoroughly tested as possible both clinically and in the laboratory to ensure that they are both effective and harmless'.[47] This aspect was significant, as it ascertained that contraceptive methods were to be considered from a scientific and medical angle, placing the issue under the scope of a new field of medicine and research that was quickly developing and improving. Moreover, this requirement also reflected the female doctors' intense commitment to improving the effectiveness of birth control. The objective of this training was to familiarise students with birth control techniques and to introduce them to the placement of contraceptive devices. The memorandum was meant to encourage the National Birth Control Association to set up a 'small working medical sub-committee'[48] to shape the work done in various clinics based on the guidelines devised by the memorandum.

The teaching syllabus developed by Wright in 1939 for the British Postgraduate Medical School, based at Hammersmith Hospital, explains the theoretical content of the training. She started her lecture by presenting the three elements through which to assess contraceptive methods, which were based on the criteria put forward by the BCIC: the mechanical dimension, which should be a protection of *os uteri* against direct insemination during ejaculation; the chemical aspect – that is, the need for the method to kill the sperm; and the psychological dimension, which requires that the method advised should be acceptable for both parties. She stressed the necessary characteristics of all good methods: 'effective, easy-to-learn, harmless and cheap'.[49] The patient's preferences and subjective experiences were therefore central to the prescription of a 'good birth control method'. She then displayed the methods that were used at the time and provided a short description of how they worked. The training was not only theoretical, but also applied and practical. Students were required to bring along rubber gloves – a clear indication they were not to remain passive while acquiring scientific

knowledge of birth control, but to be engaged in active learning. Demonstrations were initially carried out on the patients who happened to be there seeking contraceptive advice. However, it quickly became clear that this solution was not ideal, even with the careful selection and consent of the patient beforehand. The instructing doctors felt that they were violating 'the personal confidence and the purely disinterested charity which animated the clinics'.[50] Hence, it was decided to pay each patient five shillings for her help. The training session, therefore, helped to define the women's welfare centre as a centre of expertise, making it the first and primary source of systematised medical knowledge of contraception. While the onset of war might have slowed the teaching process, Wright continued to give lectures on birth control in the North Kensington Women's Welfare Centre.

Female doctors pursued this engagement after the Second World War. Wright, Dr Redding and Dr Jackson, as members of the medical subcommittee of the FPA, drafted a memorandum for training clinics in 1950. Indeed, developing the methods of teaching contraception and family planning to medical personnel remained a key objective for the FPA and for female doctors who wanted to enhance their working conditions by making contraception and family planning a recognised specialty. Female doctors developed the requirements for a training clinic and, more specifically, set the qualification standards for both the medical officer in charge of teaching and the trainee. The medical officer in charge should have experience involving at least a hundred clinical sessions, while the trainee should have a pleasant personality and previous gynaecological experience, as assessed by her/his ability to perform a rapid and accurate pelvic examination and to spot any gynaecological abnormalities, and by her/his familiarity with the use of a vaginal speculum. A considerable number of gynaecological ailments could be identified in a thorough gynaecological examination, highlighting the necessity of performing such examinations as a preventive measure. Owing to this procedure, a large number of women who attended the clinics and who suffered from gynaecological disorders were treated, reducing the incidence and severity of their diseases. Wright placed considerable stress on the necessity of using a speculum,[51] an efficient instrument for visually examining and assessing the cervix and the condition of vaginal mucous membranes. 'Fingers and especially fingers in rubber gloves could not accurately detect the same conditions as

the eye could see', she argued.[52] The speculum enabled future medical officers to become 'scientific observers with a unique opportunity to collect detailed-facts about the pelves of thousands of healthy women, and this opportunity no other branch of medicine had at the moment. Full and accurate records should be kept as an authoritative source of data about healthy women.' The main strategy used by female doctors is stated in this excerpt: to present themselves as the guardians of sound, objective scientific facts. These facts contributed to the positioning of contraception as a new field of medicine. The emphasis on scientific objectivity echoed the growing importance of data collection in ascertaining medical statistics during the interwar years, as shown in the following section.[53]

In 1953, to complete the 1934 memorandum on training, Wright developed a detailed teaching syllabus to be used in every training clinic. Considerable emphasis was placed on practical skills. She first demanded that the 'pupils' should have read in advance the book she had written for medical students. This element is interesting insofar as it showed how deeply committed Wright was to spreading scientific knowledge of birth control within the medical community. Not only did she provide training, but she also wrote a practical manual aimed at educating medical students on the subject. For the first visit, Wright recommended the display of different caps and pessaries. Following this, the students were taught the characteristics demanded of each type of cap. The students should therefore deduce which method would be the best suited to each individual patient. Medical students were next instructed to undertake a full manual pelvic examination for every new patient, followed by one carried out with the help of the speculum. While practising this examination, the students were enjoined to describe – in words and out loud, to the medical officer – the position, size, and any other characteristics of the cervix and the fundus, and their relationship to one another, as well as the condition of the ovaries.[54] The pupil was advised to mentally review what contraindication existed for each type of cap. While examining a patient who had come for a second visit, the trainee should make sure that the patient had inserted the cap correctly, that the size of the cap was adequate, and that the patient understood how to wash and care for the cap. For routine patient visits, the students were instructed to check whether the patient had inserted the cap properly and whether there were any alterations

of the vaginal conditions; they were also told to perform a full pelvic examination. After having completed the training sessions, the pupil would be able 'to do at least one correct fitting of all the types of caps and understand the doses and functions of the various types of chemical'. Hence, the aim was to provide the student with the best chance of becoming familiar with the practical and theoretical dimensions of the different methods.

Wright's work to ease and reinforce the training of medical students on birth control did not end with the training syllabus. In 1956, she designed a body model on which 'actual caps can be fitted and [that] has a transparent tummy so that trainees and patients can both feel and see how the cap is placed'. In the leaflet presenting this pelvic model, anatomically correct in shape and proportion, it is underlined that its aim was twofold: 'the demonstration and teaching of contraceptive techniques to doctors, medical students and patients, and the teaching of bi-manual palpation of the uterus to medical students'. The central portion of the abdomen can be removed, allowing for detailed observation of the placing of contraceptive appliances. By designing such a model, Wright committed herself not only to the teaching of birth control methods but to the *accurate* teaching of the methods. Indeed, with such a model, medical students could be trained in the placing of contraceptive devices, thus avoiding any harm when done on real female bodies.[55] The use of the body model reflected a change in teaching from passive observation to active participation. With this new technology, students would gain applied and practical experience, mastering their skills.

Meanwhile, from 1948 onwards, members of the medical subcommittee made inspection visits to family planning centres and clinics to control the quality of the service offered, as well as to determine the suitability of these centres for training.[56] In 1955, there were twenty-nine training centres, and 256 doctors and nurses received training during the year.[57] Dr Mary Redding, a member of the medical subcommittee and instructing doctor, set the standard for training centres.[58] She assessed the premises of the centres, and took care to make sure there were enough rooms and spaces to protect the patients' privacy. The medical equipment was specified as follows: vaginal specula, Cheatle forceps, disinfectant, steriliser, and other elements. Cards and a card index cabinet for collecting information about new patients also had

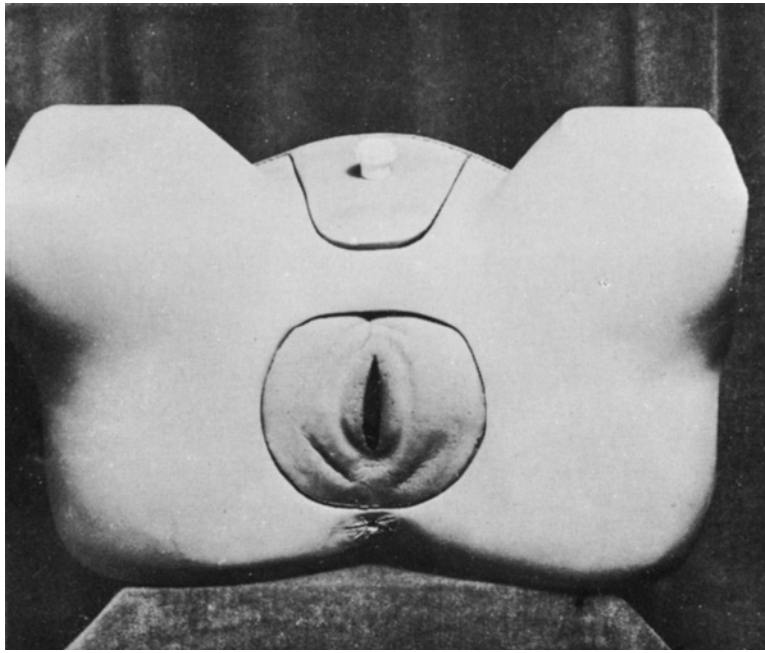

Figure 1 Pytram Pelvic model: demonstration pelvic front view

to be available for lay staff. Besides assessing the premises and interior space of the clinic, Redding scrupulously verified the quality of the professional service and the atmosphere of the clinic. She would take a full professional history of the clinic's members and was sensitive to smoothness in the running of the clinic. The competence of the doctor and the way she instructed the patient and ascertained the latter's gynaecological condition through a thorough gynaecological examination with the use of the speculum was central to good professional practice. Interpersonal skills such as kindness, gentleness and the ability to explain technical principles and methods clearly were essential qualities for creating a 'nice atmosphere' where the patient would feel at ease and could overcome her feelings of shyness or fear about specific methods of birth control.[59] These elements show that women doctors were preoccupied with the well-being of their patients,

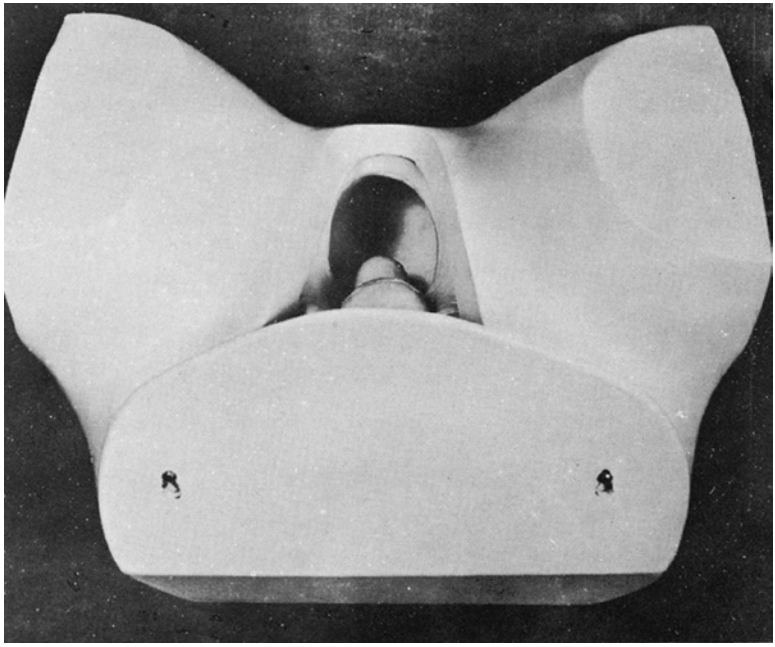

Figure 2 Pytram Pelvic model: top view showing the interior cavity, with the removal wall

as well as with their lived experience and attitudes towards birth control.

Despite the efforts made by birth control clinics to encourage training in contraception, the 'official' training – i.e. that offered by medical schools – did not substantially improve in the years immediately following the Second World War due to the inception of the NHS, which did not integrate contraception within its prerogatives. In 1949, the MWF asked the deans of twenty-seven medical schools whether they provided instruction on contraceptive techniques; their responses revealed that only four schools provided special lectures on this topic, while the majority of schools claimed to give 'some sort of instruction, in the course of ordinary obstetric and gynaecological teaching'.[60] Hence, the need to instruct medical students did not disappear.

This need was recognised by the Royal Commission on Population, appointed in 1943, which reported in 1949 that 'the giving of advice on contraception to married persons who wanted it should be accepted as a duty of the National Health Service (and) the initial duty to give advice should rest with the family doctor'.[61] The Royal Commission also acknowledged the lack of medical training in this field, but hoped that this could be remedied through an adjustment of the medical curriculum. However, there seems to have been a lack of willingness to adjust the medical curriculum – which could be partially explained by the fact the creation of the NHS meant that the medical curriculum was already under pressure from other areas of medicine, since a survey carried out in 1957 by the FPA showed that no change had taken place: 'out of 36 medical schools, 12 gave a formal lecture in contraception and 7 schools arranged clinical instruction, 6 of these at FPA clinics'.[62]

In 1956, Dr Sylvia Dawkins replaced Joan Malleson for a lecture-film demonstration on contraceptive techniques for the final year students of all London medical schools at University College Hospital Medical School. Professor Nixon chaired the session and paid tribute to the pioneering work of Malleson, who had recently died. Sylvia Dawkins then discussed the medical, social and economic indications for contraception and described the methods available and the technique of fitting caps. The class was such a success that 200 students were turned away from the lecture due to a lack of space.[63] Women doctors, therefore, carried on teaching contraception to medical students; however, despite repeated calls to include contraception in the medical curriculum, no compulsory adjustment occurred until the incorporation of family planning into the NHS in 1974.

Expertise and the medicalisation of birth control

In a context in which medical training on contraception was not compulsory and did not fare particularly well in attracting medical students and support from the medical profession, British women doctors were particularly active in disseminating information on the techniques of contraception to their colleagues in order to compensate for this lack of information. The spread of technical knowledge was meant to familiarise doctors with birth control methods, ultimately encouraging them to prescribe these methods in their private practice. Until the 1930s, as

the introductory section showed, moral arguments were often invoked in public and medical debates on birth control, and unproven claims were made about the detrimental effect of contraceptives on women's fertility. Women doctors first needed to shift the signification away from the 'moral' to the 'medical' by configuring birth control and contraception as a medical subject and technique. Second, they refuted the unfounded affirmation that contraception led to sterility. As a result, women doctors asserted their authority in this new field of medicine by wrapping themselves in a technical and medical rhetoric and committing themselves to the accuracy of medical knowledge on birth control and contraception. This, in turn, enhanced their credence and credibility, as well as that of the field.

Four books were specifically written for a readership of professionals, aiming to provide doctors with a better understanding of the different methods of birth control. However, to be taken seriously, women doctors first needed to show their expertise in the subject. They proved it on the basis of their extensive private experience in birth control clinics and private practices. Joan Malleson published *The Principles of Contraception: A Handbook for General Practitioners* in 1935. Born in 1899 in Leicestershire, Malleson first undertook medical training at University College London, but soon moved to the Charing Cross Hospital due to the hostility against female students she faced at the first institution. She graduated as MB, BS (Bachelor of Science) in 1926, at which point she was already the mother of two sons with the actor Miles Malleson, whom she had married in 1923. Among her friends were many progressive personalities, such as the philosopher Bertrand Russell, and the author, feminist and socialist campaigner Dora Russell. Malleson was also a close friend of the sexual reformer Havelock Ellis, who seemed to have exercised a great influence on her career. She was later a clinical assistant at the West End Hospital for Nervous Diseases, before becoming the medical officer in charge of the birth control clinic at Ealing Borough Council. She was also a member of the National Birth Control Association, which later became the Family Planning Association. Specifically dedicated to her medical colleagues, her book referred to her private practical experience as a source of scientific legitimacy: 'having considerable experience of contraceptive work, both in birth control clinics and in general practice, I propose, where authorities differ, to offer my own technique, believing it to be

fairly representative'.[64] Thus, this experience provided Malleson with the credentials among her colleagues to teach them contraception: 'this is strictly a clinical manual, a work on methods that have proved useful in general practice, and that any practitioner can learn easily, and can equally teach to patients'.[65] Wright similarly drew on her medical experience in her many books on birth control and sexuality. For instance, *Contraceptive Technique* (1950) specifically targeted a medical audience. The second edition of this book was published in 1959 with the subtitle *A Handbook for Medical Practitioners and Senior Students*, and a third edition was published in 1968. In the first edition, she ensured her practical medical experience was central to her argument: 'Every doctor who spends any time teaching patients contraceptive technique develops her own or his own ideas about the choice and type of appliances. This handbook therefore only claims to be the embodiment of the principles and practices I have found effective in my experience over the last twenty years.'[66] These women doctors never relied on their 'shared' experience as women and doctors to justify their writing but rather drew on their professional experience only. They medicalised birth control by placing their expertise at the fore. Their professional credentials in birth control were therefore grounded in real-life clinical experience.

Two women doctors also used the credentials of famous established male individuals to endorse their books and their medical credibility, mirroring the persistent gender dynamic in which women were invisible in the medical field and women doctors struggled to be considered as experts. Thus, making strategic alliances by using the credentials of eminent men who were birth control advocates was a way to shed light on women doctors' scientific work. Furthermore, these alliances attested to women's ability to move in different networks, from all-women associations to groups of high-profile doctors. Dr Gladys Cox published *Clinical Contraception* in 1933; it was re-edited in 1937.[67] Lord Horder, Physician to the Prince of Wales, a 'progressive with impeccable establishment credentials',[68] president of the Eugenics Society from 1935, and future president of the FPA, wrote the introduction. He presented the need to address birth control medically as a key new objective of modern medicine. He also underlined the professional experience of the author, deeming her 'qualification for the task therefore undoubted'.[69] Some thirty years later, this strategy was still used by Mary Pollock, a

gynaecologist at the North Kensington Marriage Welfare Centre (the name was changed from North Kensington Women's Welfare Centre in 1953), who edited a book titled *Family Planning: A Handbook for the Doctor* in 1966. Lord Brain, president of the FPA, wrote the foreword, while Norman Morris, Professor of Obstetrics and Gynaecology at the Charing Cross Hospital Medical School, wrote the introduction. Two influential male allies contributed to acknowledging the scientific orientation of the book, illustrating the fact that even after thirty years of female doctors' practical engagement with contraception they still needed the support of male professionals. Norman Morris explained that the book 'includes contributions by many distinguished writers, all of whom are well-known experts in their particular subject'.[70] Out of the sixteen contributors of the book, fourteen were women doctors.[71]

Framing their work within contemporary international debates on birth control and reproduction was another efficient way for women doctors to display their mastery of medical debates. Several women were part of the international movement for birth control that developed in the 1920s and culminated with the 1930 Zurich International Conference on Birth Control (see Chapter 3). In Zurich, they presented their experiences in birth control clinics and learnt the latest developments in birth control methods. They used this new knowledge in their handbook. In her 1933 book, Cox carefully reviewed each method of birth control available at the time and quoted research carried out by other scientists and medical researchers that she had met in Zurich, such as Ernest Gräfenberg and the American gynaecologist and birth control advocate Robert L. Dickinson. She addressed the issues of the time: ovulation, the 'duration of life of the extruded ovum', and the effect of 'orgasm on fertility', a hotly debated issue at that time. Malleson also referred to the work of other foreign practitioners. Moreover, women doctors updated their books according to the latest scientific advances and medical developments in contraceptive methods. For instance, in the third edition of *Contraceptive Technique*, Wright explained how she had integrated two new chapters according to the new advances made since the second edition: 'Notable projects in research have been mainly along two lines: the inhibition of ovarian activity by the administration of synthetic hormones, and the prevention of unwanted conceptions by the introduction into the uterine cavity of various shapes of

inert plastic materials. Details of both these methods are new additions for the book.'[72]

Complementing the spread of knowledge through books, women doctors participated in medical conferences in order to share the knowledge they had gained through their experiences in birth control clinics and to assert their command of the subject. In 1932, the National Birth Control Association held a conference in London. Among the speakers were Helena Wright, Dr Gladys Cox, Dr Margaret Jackson, and Mrs Francis Ivan Knowles (the surgeon in charge of the women's clinics in Waltham Town), alongside prominent medical men such as Dr Killick Millard, Dr Lancelot Hogben (professor of social biology at the London School of Economics), Dr John R. Baker, and Dr H. M. Carleton from the University of Oxford. While most of the male doctors and scientists presented their most recent research on developing an effective means of birth control, women doctors mainly presented the work that they carried out in women's welfare centres, based on their practical experience. These medical conferences were integral to contraception being presented and accepted as a medical field. Cox situated contraceptive work within the spectrum of gynaecology by underlining the fact that contraceptive methods were not 'chosen arbitrarily, but [the choices] were based on the patient's medical history and the knowledge obtained as a result of the gynaecological examination'.[73] Meanwhile, Wright presented her results with the Gräfenberg ring, an intrauterine device (see Chapter 4). In 1933, the NBCA organised a second conference on contraception. Wright and Knowles were again in attendance, alongside other women doctors working in welfare centres, such as Dr Lilias Jeffries of Brighton, who qualified as MB in 1908 and MD (Doctor of Medicine) in 1915 at the University of London, and Malleson. They all underlined the need to provide medical birth control advice, and Malleson explained that she approached the subject of birth control in her private practice even when 'she was being consulted on quite different matters'.[74] In addition, they placed the delivery of birth control advice and devices within the scope of preventive medicine by highlighting its benefit to public health. Since prescribing contraception required a gynaecological examination, gynaecological disorders and lesions could therefore be discovered and cured, enabling women to regain 'their health and vitality'.[75]

Their medical colleagues represented one audience that women doctors needed to target in order to medicalise contraception and make it acceptable. The second audience was the lay public. Women doctors imparted practical knowledge of birth control methods to the lay public through the publication of sex manuals. Here, again, they relied on their experience in birth control clinics and family planning centres as a primary source of knowledge. Wright wrote *Sex Factor in Marriage* (1930) and *Birth Control, Advice on Family Spacing and Healthy Sex Life* (1935). The former sold over one million copies and was considered a bestseller from the year of its publication.[76] The latter was published in the Cassell's Health Handbooks series. The jacket presenting the series underlined the fact that 'each of these health handbooks has been specifically written by a qualified physician from personal knowledge and experience. These medical authors have been chosen because they have living, day-by-day contacts with the sick and the well, and are in a position to understand the problems of ordinary men and women when ill-health visits them or their family.'[77] After the Second World War, the need to educate the lay public did not disappear, and three more books were written by female doctors who worked in family planning clinics and relied on this expertise; each of these books contained a small chapter on contraception.[78] In sum, women doctors drew on their clinical experiences as a way of evidencing their expertise to justify the fact that they published on the subject. Women doctors working in birth control clinics therefore shared a similar professional identity based on first-hand accumulated experience.

Producing accurate scientific and medical knowledge on birth control

Once they had asserted their expertise, women doctors further wielded their authority by using highly expert medical language. Fisher and Szreter have shown the inaccessibility of interwar birth control manuals to women (and men) without a secondary school level of literacy. In this section, I argue that this inaccessibility reflects women doctors' will to position birth control as a medical subject, mastered by specialists. Of course, communicating sexual knowledge to wider audiences and discussing birth control were problematic due to the very nature of the subject, which was often associated with taboo and embarrassment;

using scientific and medical rhetoric helped to keep the subject decent and prevented potential charges of obscenity. Consequently, they presented themselves as experts in this new medical field and improved its status by positioning it as a technical specialty. The readership they targeted – their fellow colleagues – explained their emphasis on medical rhetoric. However, simpler leaflets designed for female patients containing basic information on birth control and contraceptive devices were available in the birth control clinics.

Birth control manuals contained technical medical language to describe the female and male genitals and the techniques for inserting contraceptives. These books were real practical manuals for doctors and medical students from which they could obtain medical information and detailed explanations of how to choose and fit the suitable method of birth control, especially for patients suffering from gynaecological conditions. For example, the first page of Cox's book displays a diagram illustrating the types of mechanical contraceptives available and their proper position within the vagina.[79] She presented each method in great detail, elaborating on the methods' advantages, inconveniences and possible harmful effects. The main caps and pessaries available on the market were also presented to the readers. She then offered a thorough explanation of how she taught her patients the correct way to fit the pessary. Patience was, in her view, an essential component of good teaching practice. First, she instructed the patient, already fitted with a pessary, to digitally explore her own vagina and to note the 'loose rubber diaphragm'. Cox continued by explaining to the patient how to remove the pessary by hooking her fingertips under the rim and pulling on it. The patient would then observe the pessary while listening to the description of its place within the vagina. The fourth step, which Cox described as the most important part of the procedure, was the patient's exploration of her own vaginal cavity and the identification of the cervix. Finally, the patient underwent her own fitting of the pessary and the doctor checked that its position was correct. Importantly, this procedure meant that, for some women patients, it was the first time that they had touched their own sexual organs, which empowered them with knowledge of their own bodies, even though some of them found it off-putting.

Following the same type of argumentation, in her book Malleson reviewed each method of birth control and included diagrams that she

drew herself – based on her own clinical experience – depicting the right and wrong position of each contraceptive appliance.[80] Similarly, Wright took the reader of her *Contraceptive Technique* step by step through the technique for fitting caps; the position of the patient in the medical office was described, as well as the necessary manual and speculum examinations to ascertain the 'position and size of the fundus, cervix and ovaries'.[81] Finally, Wright provided a practical and detailed outline on the insertion of the device.[82] This explanation was aided by drawings and a clear diagram, which ensured that these explanations were understood by the reader. The common layout of the books, with step-by-step descriptions and visual depictions, was seemingly intended to equip fellow colleagues with basic contraceptive knowledge so that they could advise their own patients. Malleson's and Wright's books were positively reviewed in the *Journal of the Medical Women's Federation*. The reviewers stressed the clarity of practical information that enabled doctors to use contraceptive techniques: 'This book is to be warmly recommended to all general practitioners who wish for reliable information as to the best method of birth control now in use';[83] 'Dr Wright has explained so carefully the method of fitting these contraceptives that it would be possible for doctors unable to attend training for this work, to be confident to fit patients.'[84]

In addition to disseminating medical information on the different contraceptive methods and devices, women doctors played an active role in the medical debates surrounding birth control and contraception that took place in the columns of the main medical journals. Indeed, they responded to other medical stances that they did not find scientifically and medically accurate. Constantly confronted with unfounded claims on the disastrous side effects of contraception, they adopted the rhetoric of laboratory-based medicine to refute these claims, which favoured sound and objective facts. Relying on statistical evidence,[85] a tool from the social sciences that was still new for medical investigation, consequently reinforced and expanded the scientific dimension of their work and was strongly promoted by the BCIC – notably through the publication of Enid Charles's statistical analysis of the results of the practice of contraception.[86] They criticised the position of the medical opponents to birth control by deconstructing their methodology and their lack of scientificity. This strategy seemed to be particularly dictated by their need to position themselves as legitimate and scientific

experts of contraception. Of course, this was not the only reason they sought reliable data and results; they also wanted to assure physicians and female patients of the efficacy and harmlessness of available contraceptive products and to support access to reliable contraception.

The following examples illustrate that male doctors who were opponents of birth control tried to undermine the credibility of female doctors by engaging them in debates, but in so doing they paradoxically strengthened the female doctors' credentials because, in the course of the debates, women doctors displayed their expertise. First, as early as 1930, Jackson, who would become a member of the BCIC in 1935, wrote a letter to the *British Medical Journal* entitled 'Birth Control and the Medical Opinion', as an answer to a statement made by a male colleague in the House of Commons in a debate on maternity and child welfare. The male colleague asserted that 'all medical authority was overwhelmingly opposed to birth control'. Jackson called for the avoidance of emotional arguments, breaking with the feminine stereotype of women's emotional reasoning, and instead advocated for a scientific examination of the evidence supporting birth control: 'It is surely time that members of the medical profession should cease to make such rash statements and should weigh this matter from a scientific standpoint unbiased by any personal, ethical or sociological considerations [...] any public utterances emanating from doctors should be supported by reliable statistics based on scientific investigation.'[87]

Similarly, in 1930, Lella Secor Florence, the honorary secretary of the Cambridge Women's Welfare Association, published *Birth Control on Trial*, and presented the book as a 'dispassionate and honest inquiry into the methods of contraception advised'. This study, which she wrote with the help of the medical officer of the clinic, Mrs Robson, relied on the analysis of the first 300 cases at the Cambridge Birth Control Clinic from 1925 to 1927. Humphry Rolleston, Physician in Ordinary to the King and Regius Professor of Physic at the University of Cambridge, wrote the foreword; he presented Florence's work as an 'unbiased investigation into various problems connected with birth control'[88] and praised her study as 'a model example of how the data should be obtained and marshalled'. Here, again, the fact that a high-profile medical man with indisputable credentials endorsed this study provided it with legitimacy. While the search for accurate scientific knowledge of methods of contraception had been a key task for women

doctors, this search for objective data was not a straightforward successful enterprise. They acknowledged the limitations of the data they collected, particularly while trying to assess the efficiency of contraceptive methods. For example, Florence warned the reader of *Birth Control on Trial* that her aim was not to undertake 'a conclusive statistical study of the relative merits of contraceptive methods' but rather to 'offer a precise and scrupulous examination, case by case, of the experience of women who have attempted deliberately to limit their families'.[89] Specific statistics were hard to attain, and several factors prevented the adequate statistical analysis of data collected in the clinics.

One issue that limited the use of data collected in clinics was that the term 'failure' in itself seemed to be understood differently across clinics. While carrying out the statistical analysis of the first 300 cases of the Cambridge clinic, Florence referred to failures where 'the appliance was being properly used, or after it had been given up either because the patient's condition was not sufficiently normal to permit of its use, or because the appliance caused pain, or because the patient found it so distasteful that she could not continue, or because she was too nervous and frightened to use it and had no confidence in it, or even because she was too stupid to apply it successfully'[90]. The Manchester clinic, meanwhile, recognised cases where women got pregnant, despite using the method correctly on all occasions, as failures. Stopes' clinic based their percentage of failure on the number of women who returned to the clinic and announced an unwanted pregnancy. Hence, Stopes misleadingly considered women who never came back for a follow-up appointment as successfully practising contraception. Cox, in her 1933 book, shed light on the discrepancy of this definition, which made the comparison of information and data a rather complicated enterprise, especially since the follow-up of the patients was a difficult task and undermined the representativeness of the data collected. She nevertheless quoted data collected in London and Cambridge women's welfare centres to illustrate her argument, as did Malleson.

In 1936, in order to improve the quality of the data and to standardise the information collected, Dr Margaret Jackson designed, with the help of C. P. Blacker, a standard case-card for every women's welfare centre to use to record patients' information. The cards contained space for details relating to 'age, parents, siblings, occupation, education, religion and income of both spouses, date(s) of marriage,

details about pregnancy, use of contraceptives, sexual habits and frequency of intercourse, medical history, general and pelvic examination, and records of subsequent visits and progress of the case'.[91] This standard procedure should have permitted the collection of accurate data that was comparable between the various clinics and that eased statistical analysis. This type of data collection was similar to those in venereal disease clinics, with one main difference being that in VD clinics data were anonymised.[92] However, two years later, Helena Wright still acknowledged the difficulty in gathering any reliable statistics due to 'the large numbers of factors concerned; the difficulty of comparison between them and the intractable nature of the material, i.e. patients'.[93] Nonetheless, by ascertaining these limitations, women doctors showed their drive to collect reliable and honest information.

Using statistics and data collected in birth control clinics served to refute negative claims about birth control and contraception, and they positioned the latter as a matter of scientific applied research. Moreover, Jackson and Malleson participated in the debates about fertility, sterility and contraception that took place in the *Lancet* and the *British Medical Journal* in 1938 and 1943. They wrote letters to the two journals to rectify statements made by Dr Green-Armytage at the West London Medico-Chirurgical Society on 7 January 1938; he published in those journals that 'contraceptive measures in the early days of marriage were inimical to pregnancy later'[94] and that chemical contraception 'upsets the physiological pH of the vagina that lead to erosion and endocervicitis'.[95] They also reacted to the reply of George Alabaster, published in the *Lancet*, supporting this statement and adding another charge against birth control related to chronic changes in the cervix uteri. Steering the debate towards medical science, they attacked the lack of evidence for the idea that the use of contraceptives before the first pregnancy increases the incidence of cervicitis:

> Mr Green-Armytage has replied to our remonstrance that statistics can be made to prove anything … and they are naturally biased. But is it not scientific custom to consult statistics and records in the expectation of finding at least as high a degree of dependability as that gained by the personal impression of an observer? Particularly must this be so when the subject is one such as this, which invites prejudices of a social or ethical nature.[96]

They based their rebuttal on the pitfall of Green-Armytage's statistical demonstration: 'without a control series of observations on nulliparous women who have used no contraceptives and an estimate of the percentage of newly married couples, using contraceptives, he is expressing no more than a pious opinion.'[97] In contrast, the data they utilised to support birth control were presented as highly scientific, since they came from 'direct clinical observations of thousands of cases and scientifically conducted experimental work'.[98] They underscored the care with which contraceptive devices were being tested: 'Methods are submitted to controlled clinical trial; rubber appliances and chemical products are subjected to stringent tests for efficiency and harmlessness before they are placed on the list of approved goods.'[99]

In 1943, Malleson wrote to the *BMJ* in support of an article that questioned the assumption that contraception in women who did not yet have a child was liable to cause sterility. She stressed how difficult it is to eradicate this idea since it was deeply rooted in 'people's superstitions'.[100] She then reacted to the statement of Green-Armytage that contraception induced sterility due to lack of semen absorption from the vagina. She urged that scientific data be used to test such a hypothesis: 'Its verification would clearly rest with the research worker and statistician.'[101] Therefore, she suggested using the data collected in birth control clinics: 'Among the contraceptive clinics there are some hundreds of thousands of case records from which part, at least, of the data could be deduced' and offered to carry out 'a statistical inquiry into the advent of pregnancy among couples who have and have not used previous contraceptive measures'. In addition, she also rectified Green-Armytage's quotations of colleagues' textbooks by providing longer excerpts of them which included 'the whole relevant context'.[102] Likewise, Margaret Jackson, as an expert in sterility, responded to a 1943 article published by a male general practitioner, Dr R. H. P. Hick, who reported successfully treating his sterile patients by sending them to one of his local gynaecologist colleagues.[103] Jackson flagged up the vague definition of sterility: 'it might be pointed out that if a couple is by them ranked as sterile "after even a few months" this may account for a proportion of their success', and made a plea for a scientific assessment on treatment that relied on 'accurate recording of observations over a period of many years'.[104] This strategy of discrediting opponents of birth control by resorting only to scientific consideration had already

been used by female doctors to contest the hitherto medically dominant paradigm of menstrual illness.[105]

Finally, the last contribution of women doctors in the production of scientific and medical knowledge was their involvement in clinical trials, either as the main investigator of the trials or as a member who liaised with laboratory experts. In the interwar years, trials on contraceptive methods were carried out by the Birth Control Investigation Committee as well as by the medical subcommittee of the National Birth Control Association, of which many women doctors were members. Contemporary surveys and inquiries carried out by members of the NBCA and the Family Planning Association highlighted the reluctance of patients to use the female-controlled contraceptive devices prescribed in the clinics. They shed light on the underlying reasons that made the use of barrier methods difficult, such as the aesthetic disadvantages of the method, the fact that women were shy and uncomfortable touching their own genitals, and the notion that sex should be spontaneous and something for which women did not want to prepare. In addition, learning how to fit a cap was not always easy, since it involved two medical appointments. Sylvia Dawkins, who taught contraception, remembered: 'You see, if you gave a barrier method you had to instruct the people how to use it. You fitted them, say, with a diaphragm, instructed them, asked them to go home and practise putting it in and out, come with it in, so we could ensure they've got it right, you see, and knew what they were doing.'[106] The search for other reliable contraceptives therefore remained a key goal for birth control clinic members. As explained in the introduction, the BCIC specialised in the testing of contraceptive substances and devices within the laboratory; many of its members were scientists, such as Dr John R. Baker of the Department of Zoology and Comparative Anatomy at the University of Oxford, Dr H. M. Carleton of the Department of Physiology at the University of Oxford, and Dr Cecil Voge, a chemist from America. The BCIC established the criteria for the base standards of efficacy, safety and harmlessness that contraceptive devices and products had to meet. They also tried to find the 'ideal chemical contraceptive' and developed the spermicide Volpar.[107] The way such work on contraceptives was allocated within the BCIC was highly gendered: male scientists worked in the laboratory developing new contraceptives and testing spermicides on animals, while female doctors were the intermediate agents

liaising between the laboratory experiment and the lived experiences of the patients; female doctors were also key to supporting the provision of contraception. This gendered model of contraceptive science was one in which prestigious positions of highly technical experts belonged to men while the responsibility for applying the research, and conducting clinical trials and their follow-ups, fell on women.

Many women doctors carried out clinical trials in family planning and private practices on new contraceptive products tested by the BCIC to assess their quality, efficacy and safety. Among them were Wright, Dr Cecile Booysen, Jackson, Dr Greta Graff, Dr Eleanor Mears, Dr Mary Peberdy, Dr Denise Pullen and Dr Ellen Grant. For instance, Booysen was tasked with gathering information on quinine, a drug first used to treat malaria but which had been used as a spermicidal jelly. She presented a report based on the collection of results of the original work by various research workers and on her own clinical experience. The recommendation made by Booysen was to give up quinine as a chemical component of spermicide jelly due to its irritating effect, lack of efficiency, difficulty in dissolving and side effects.[108] Dr Jackson did the same type of inquiry into the 'spermicidal power of various proprietary results' in 1935. She underlined the lack of a standard method for testing and stressed the subsequent variability of results.[109] Hence, women doctors participated in informing the medical community about the efficiency and safety of contraceptive methods available on the market. Jackson and Wright conducted many interviews with members of the BCIC and shared with them their requirements, worries, and accounts of problematic encounters with patients and contraceptive methods. Based on the work of the BCIC, Wright and Malleson developed the first 'Approved List of Proprietary Contraceptives' in 1934, which was to be amended 'as clinical evidence accumulates'.[110] This list gained authority and was regarded as the only list of informed medical information regarding contraception and its efficacy.

After the Second World War, a new medical subcommittee was established to coordinate trials on contraceptive products and to collect updates and report on contraception, sub-fertility, training and publications. The committee was made up, mostly, of women doctors. In 1954, trials were carried out on new spermicides soon to be available on the market, and, in 1959, oral contraception was tested. Meanwhile, in 1957, the US Food and Drug Administration approved Enovid for

the treatment of menstrual disorders; the same pill was branded Enavid in Britain. Controlled clinical trials of some of the available oral progesterone pills were instituted under the auspices of the Council for the Investigation of Fertility Control (CIFC), established in 1957 by the FPA (chiefly undertaken by Dr G. I. M. Swyer and Jackson) thanks to the financial support of Captain Oliver Bird, a Conservative MP with a strong interest in family planning. The history of the pill and its connection with population issues, the Cold War, and the threat of overpopulation is well known, and the first clinical trials of the pill in Britain have been thoroughly analysed by Lara Marks. One important element to remember is the active role played by women doctors in the British trials. After having ascertained the harmlessness of the pill on rats and mice, large-scale trials were initiated, first in Birmingham, then in Slough, London, Barnet, Exeter, Manchester, Liverpool, Leicester and Brighton.[111] These trials were 'design(ed) to find out how acceptable such a method of birth control is to women in this country, to find the lowest dose which would be effective and reduce costs and side effects and to find the simplest method of administration'. Consent forms were signed by every patient participating in the trials, as well as their husbands. The women doctors carrying out these trials followed a strict experimental methodology and were asked by the CIFC to give feedback every month to help assess the efficiency and possible harmful effects of contraceptive products. They reported any side effects experienced by patients and accordingly updated trial procedures. For instance, urine tests became mandatory when women doctors realised that oral contraceptives could induce a decrease in glucose tolerance. The North Kensington Marriage Welfare Centre also carried out a trial on oral contraceptives under the supervision of Dr Margaret Blair and Dr Eleanor Mears. Besides carrying out clinical trials, several women doctors also sent the methods used by their patients at the time when a failure occurred to be tested in a laboratory. In 1954, Wright received a patient who had a miscarriage, even though she was using a birth control method. Dr Wright sent a batch of three tubes of Volpar paste used by the patient, because 'she was anxious that the tubes of paste used should be tested'. Several similar occurrences were found in the archives which testify to Wright's commitment to determining the efficiency of the methods her patients used.[112] Thus, female doctors

functioned as a channel between lived experience of patients, doctors and laboratory experiment.

Women experts in contraception

The extent to which women doctors succeeded in being recognised as experts could be assessed by their growing participation in medical conferences, external committees and working groups appointed by the government. This recognition was intrinsically connected with their ability to construct alliances and utilise negotiation skills. Indeed, to do their work, they needed to be able to reach a consensus and ally with important groups and politicians to gain support for their cause.

In 1930, Wright was asked to speak at a major public conference on 'Birth Control by Public Health Authorities', in the Central Hall, Westminster, on 4 April. The conference was organised by the Society for the Provision of Birth Control Clinics, the Workers' Birth Control Group, the National Union of Societies for Equal Citizenship and the Women's National Liberal Federation. Its aim was the withdrawal of the ban on the provision of birth control advice in public health welfare clinics. Delegates attended from public health authorities, maternity and child welfare centres, Labour Party women's sections, Women's Cooperative Guilds, birth control clinics, and other local bodies. The chairman and chairwoman were Dr Killick Millard, and suffragist, feminist and eugenicist Mrs Eva Hubback, a close friend of Wright. Wright spoke as medical officer for the North Kensington Women's Welfare Centre. She presented her experience with her patients to stress the positive effect of birth control education and training on the health of working-class women, and focused on two recent cases she had handled. The first was a working-class woman, a mother of four children, who was in good health, but who financially could not afford an additional child; she therefore lived in perpetual anxiety due to her ignorance of the means to avoid pregnancy. The second case was a patient who had had six abortions and had eight living children. Wright presented birth control as the best way to help these mothers and improve their well-being:

> What can be hoped for from the dissemination of adequate Birth Control Instruction? We can free mothers entirely from the fear of unwanted

> pregnancies. We can free them from the danger of the fact of repeated pregnancies, and so conserve their health to a very large extent. We can free the sex life of these people from the unnatural and bad psychological restrictions that are at present happening. We can produce the state of happiness, stability and normality which we have observed very often in the cases of our patients who have been our patients for two or three years and have had a chance to see what a difference it makes to their lives.[113]

The chairman, Dr Killick Millard, acknowledged the important role of Wright in the conference: 'In some respects Dr Wright's paper is the most important we have heard this morning. Dr Wright is the officer in the fighting line. She has given us a sort of "Journey's End" story direct from the trenches.'[114] The conference ended with the following resolution sent to the Minister, Arthur Greenwood: 'to call upon the Minister of Health and Public Health Authorities to recognise the desirability of making available medical information on methods of Birth Control to married people who need it'.[115] This was partially effective: the Ministry of Health permitted local health authorities to provide birth control advice for married women, but only for women whose lives would be endangered by a further pregnancy.

Wright also played a decisive role in the outcome of the Lambeth Conference, where she spoke for the newly formed National Birth Control Council. She recalled her contribution at a conference she attended in 1978:

> In 1930, I was summoned to address the bishops at the Lambeth Conference. I went alone, the only woman present, and described to the platform of puzzled elderly gentlemen exactly what we were doing. They listened politely, slowly woke up and had become interested in being told about conditions of which, up till then, they had heard nothing. When I ended by summing up our activities in one sentence, 'We teach poor, overworked mothers how to free themselves from further unwanted pregnancies. Who could possibly object to that?', there was silence.[116]

Wright demonstrated that she had the skills to interest her audience as well as to attract support from these 'elderly gentlemen'. These skills might have been developed through necessity, as women doctors had to make their way in a male-dominated profession and learn how to gain the backing of male peers.

Joan Malleson is another salient example of the growing presence of female doctors in working parties; she was a witness at both the Birkett Committee and the Royal Commission on Population. In 1937, the Birkett Committee was set up by the government to clarify whether doctors could perform an abortion to save a woman's life. Malleson was a member of the Abortion Law Reform Association (ALRA), established in 1936 to campaign for legalisation on abortion.[117] She presented evidence in front of the committee and supported contraception as a preventive measure against abortions. In 1945, Malleson, alongside Margaret Pyke, secretary of the Family Planning Association, was invited to present evidence to the Royal Commission on Population. Prior to this, in 1943, the Ministry of Health had announced the appointment of a commission tasked with the gathering of evidence on the state of the British population and suggestions for measures to be taken in the national interest to influence its future trend. The commission asked several bodies, such as the FPA, the Eugenics Society, and the Population Investigation Committee, to present memoranda and evidence on issues related to population. Malleson's participation revealed the fact that she was held in high esteem by the members of the commission and was regarded as an expert in family planning. The memorandum of the FPA urged the establishment of 'small friendly centres at which married couples could find help in their difficulties and problems' and made the plea for the financial support of the government in the setting up and running of such centres. To a question asked about the possible influence of widespread provision of contraceptives on the decrease in the birth rate, Malleson replied by underlining the long-term positive effect of efficient contraceptive methods: 'I should say there is little doubt if you look over a decade with decent contraception available, you will have young people marrying sooner than they would dare to marry otherwise, and that in itself is generally a good thing for the birth rate taken again another decade because those people have not risked, they have not tried living in celibacy for another five years and risked venereal diseases and abortions and a lot of bad things which arrive from marrying so late.'[118] Therefore, she clearly connected the provision of contraception with the reduction of the incidence of abortion and the improvement of the well-being of the individual, which would ultimately benefit society.

After the war, Margaret Jackson was the keynote speaker for the sixth Oliver Bird lecture in 1962 on 'oral contraception in practice'. The Oliver Bird lecture was inaugurated following Bird's financial donation to the FPA for the development of research in contraception in 1957. Annual lectures were subsequently given by eminent research workers, including Dr Gregory Pincus from the US, father of the contraceptive pill, who spoke on 'Fertility Control with Oral Medication' in 1958; Alan Parkes from the National Institute for Medical Research UK; Albert Tyler from the California Institute of Technology; and Alan F. Guttmacher, an eminent obstetrician-gynaecologist and president of the Planned Parenthood Federation of America. This talk reflected the prominent role Jackson played in the scientific community at that time, and she was well-aware of the importance of the conference as a space for elite research. As she noted, 'My five predecessors have all been high-powered scientists with considerable reputations and academic records.' The aim of her talk was to bring the audience 'up-to-date' with the latest clinical work on oral contraception. She described in detail the components of the diverse contraceptive pills tested and available on the market.

Finally, Sylvia Dawkins, who was trained as a general practitioner and left general practice to work in a family planning clinic in 1948, featured, alongside William Nixon, Professor in Obstetrics and Gynaecology, in the short film *According to Plan*. The film was produced for the London Foundation for Marriage Education by Eothen Films Ltd, a film production company specialising in medical films, and was released in 1964.[119] The short film was aimed at promoting family planning by giving medical information on methods of contraception and means of obtaining contraceptive advice. The fact that both Professor Nixon and Sylvia Dawkins appeared in the film shows that they were held in high esteem and considered experts in contraception.

The film's inaugural scene showcases a family at play; the father laughs and plays with his two children, and the mother reads a book to the youngest before the parents put them to bed. During this scene the narration underlines the benefit of family planning for society and stresses that 'children should be wanted'. An animated diagram then presents the functioning of the reproductive system, providing detail about the different methods of contraception. Sylvia Dawkins then

appears in her consultation room at the Royal College Hospital with a female patient. Dawkins is dressed in her medical uniform and is shown asking questions of the patient while carefully taking notes. The voiceover explains that the doctor's role is to help the patient plan her family, and in order to achieve this task successfully she will 'need to get to know all about you and about how you feel about it all; that is very important, your feelings, so don't pretend if you want the best advice'. Dawkins's expression is one of empathetic interest, as she is shown nodding and smiling to the patient. She is then shown performing a thorough pelvic exam and later presenting the patient with the different types of caps. The narrator continues with the description of the pill and stresses that the patient must get a doctor's prescription to obtain it, while Dawkins examines the patient to determine whether she will be suitable for the pill. The voiceover then instructs the viewer to see her doctor regularly for assessment to ensure there are no side effects from the contraceptive pill. This scene not only places contraception under the responsibility of the doctor but also presents Dawkins as a specialist with skills in gynaecology who listens to and advises her patients.

Conclusion

From the early establishment of birth control clinics to the Family Planning Act in 1967, female doctors were at the forefront of medical research on birth control and contraception. Birth control clinics, or women's welfare centres as they were called in the 1920s and 1930s, represented a job opening for women doctors. In a context where female doctors generally held less prestigious positions in the medical hierarchy and where birth control divided the medical profession, women doctors campaigned to make birth control a focus of scientific research and were pivotal in the medicalisation of birth control. These fights had their ups and downs. Women doctors positioned themselves as experts in birth control and contraception by publishing books and articles in highly prestigious journals and by engaging in scientific debates on the side effects of birth control. This expertise was credited, as evidenced by their inclusion as members of committees and working parties. Thus, they greatly contributed to steering the medical debate towards scientific observations of the effects of birth control. They also

developed a specific form of communication that relied on expert medical and scientific rhetoric fuelled by terms such as 'objective facts', 'careful observation', 'clinical data' and 'reliable statistics based on scientific investigation'. The adoption of the new tool of statistics not only represented a strategic move to enhance the perception of contraception as a medical field directed by specialists, but also proved successful in allying important scientists to their side, as I demonstrate in Chapter 5. Clinical trials were instituted to test the efficiency and safety of new contraceptive methods, and though women doctors enabled the medicalisation of contraception, their ultimate goal, which was the formal integration of contraception into the medical curriculum, failed. Medical schools and university hospitals proved very resistant and continued to ignore the call for basic training in contraception. Female doctors seemed to lack the formal support of medical schools. Yet this failure was only partial, since they instituted formal training in birth control clinics and family planning centres which medical students and doctors could attend.

A second restraint on their enterprise was how they were paid for their work. Though family planning clinics were populated by women doctors – representing a job opening for them – until 1974, when the NHS took over family planning, they were paid for each session of work. This meant that they had no paid leave and no superannuation arrangement. Furthermore, their travel expenses and travel time were not covered.[120]

A third downside of this struggle rested on the fixation on female methods of contraception, such as the cap with spermicide jelly, which were presented as the only effective methods of birth control until the release of the contraceptive pill. While their efficiency was without doubt highest between the 1920s and 1960s, female patients were reluctant to use these methods, resulting in subsequent nonattendance at follow-up appointments. Women doctors were convinced that teaching the patient how to fit a cap, and explaining the advantages of this method, gave women power over their reproductive health; they expected women patients to happily embrace these new methods. The first generations of women doctors who facilitated the provision of contraceptives and related information believed that contraception, and more specifically female methods, freed women from the burden of involuntary pregnancies. However, what they perceived as

empowering would, with the advent of the contraceptive pill and new IUDs, be denounced as a new form of oppression by feminist health activists.

Notes

1 B. Evans, *Freedom to Choose: The Life and Work of Dr Helena Wright, Pioneer of Contraception* (London: The Bodley Head, 1984).
2 Some arguments in this chapter appeared in *Medical History*. See C. Rusterholz, 'English women doctors, contraception and family planning in transnational perspective (1930s–70s)', *Medical History*, 63:2 (2019), pp. 153–72.
3 Soloway has focused on the birth control movement: see Soloway, *Birth Control*; Soloway, *Demography and Degeneration*. See also Hall, *Sex, Gender and Social Change in Britain*; L. A. Hall, *The Life and Times of Stella Browne: Feminist and Free Spirit* (London: I. B. Tauris, 2011).
4 Fisher, *Birth Control*; Cook, *The Long Sexual Revolution*.
5 Soloway, *Birth Control*, pp. 259–60. A. McLaren, *Birth Control in Nineteenth-Century England* (London: Croom Helm, 1978); McLaren, *Twentieth-Century Sexuality*.
6 Soloway, 'The "perfect contraceptive"', p. 639.
7 Charles Killick Millard quoted in Soloway, *Birth Control*, p. 257.
8 Peel, 'Contraception and the medical profession'. Although this article is dated, it remains the reference for a historical overview of doctors' stances on birth control.
9 Soloway, *Birth Control*, p. 275.
10 Hall, 'A Suitable Job for a Woman'.
11 'Contraception' in *The Practitioner*, 111 (1923), p. 5.
12 Debenham, *Birth Control*; Leathard, *The Fight for Family Planning*.
13 Wellcome Collection, London, PP/HRW/B.21, 'Brian Harrisson, Confidential discussion with Helena Wright, 27 Feb 1977'.
14 *Ibid*.
15 Anne Digby argued that women doctors, when entering the field at the turn of the century, 'operated in [a] semi-detached professional-sphere'. See A. Digby, *The Evolution of British General Practice*, p. 154. For the history of maternal and infant welfare centres see Oakley, *The Captured Womb*. For this history but in London see L. Marks, *Metropolitan Maternity*.
16 Debenham, *Birth Control*.
17 L. Hoggart, 'The campaign for birth control in Britain in the 1920s' in A. Digby and J. Stewart (eds), *Gender, Health and Welfare* (London:

Routledge, 1996), pp. 143–66. She pointed out the role played by working-class women in the campaign for birth control.

18 On Stella Brown see Hall, *The Life and Times of Stella Browne*.

19 Debenham, *Birth Control*.

20 C. P. Blacker, 'The choice of a contraceptive', *The Practitioner*, 131:3 (1933), p. 256.

21 On the interactions between the Labour Party and the issue of sexuality see Brooke, *Sexual Politics*. See also L. Hoggart, 'Socialist feminism, reproductive rights and political action', *Capital and Class*, 24:1 (2012), pp. 95–125.

22 *Labour Woman*, 12:3 (1924) quoted in Brooke, *Sexual Politics*, p. 50.

23 Hoggart, 'Socialist feminism'. On maternalism and socialist feminism see P. Thane, 'Visions of gender in the making of the British welfare state: the case of women in the British Labour Party and social policy, 1906–45' in G. Bock and P. Thane (eds), *Maternity and Gender Policies: Women and the Rise of the European Welfare States 1880s–1950s* (London: Routledge, 1991), pp. 93–118.

24 On the relationship between eugenics and motherhood see Davin, 'Imperialism and motherhood'.

25 Cohen, 'Private lives in public spaces'.

26 Some reports of women's welfare centres emphasised the failure of certain methods due to the inability of women to follow the instructions received at the birth control clinics.

27 K. Fisher, 'Contrasting cultures of contraception: birth control clinics and the working-classes between the wars' in M. Gijswijt-Hofstra, G. M. van Heteren and T. Tansey (eds), *Biographies of Remedies: Drugs, Medicines and Contraceptives in Dutch and Anglo-American Healing Cultures*, Clio Medica 66 (Amsterdam: Rodopi, 2002), pp. 141–57.

28 Hall, 'A Suitable Job for a Woman', p. 135.

29 'Reports of societies', *British Medical Journal*, 2:3157 (1921), p. 11.

30 On her relationship with eugenics see Jones, 'Women and eugenics in Britain'. On the relationship between Mary Scharlieb and religion see J. R. deVries, 'A moralist *and* moderniser: Mary Scharlieb and the creation of gynecological knowledge, ca. 1880–1914', *Social Politics*, 22:3 (2015), pp. 298–318.

31 'Reports of societies', *British Medical Journal*, 2:3157 (1921), p. 11.

32 *Ibid*.

33 *Lancet*, ii (1921), p. 75, quoted in Hall, 'A suitable job for a woman', p. 133; Wellcome Collection, London, SA/MWF/B.2/1, 'Birth Control', *Medical Women's Federation Newsletter* (Dec 1921).

34 Wellcome Collection, London, SA/MWF/B.2/1, *Medical Women's Federation Newsletter* (Jul 1922).

35 Wellcome Collection, London, SA/MWF/B.2/1, *Medical Women's Federation Newsletter* (Nov 1922).
36 Wellcome Collection, London, GC/105/26, 'Transcript of the interview with Sylvia Dawkins', Television History Workshop, 1988.
37 Wellcome Collection, London, SA/MWF/B.2/1, *Medical Women's Federation Newsletter* (Nov 1922).
38 Lesley Hall has shown that several women doctors got in touch with Stopes on this issue. Hall, 'A Suitable Job for a Woman', pp. 139–40.
39 Wellcome Collection, London, CMAL SA/MWF/A 11/4, 'Minutes of the meetings of the Council of the Medical Women's Federation, 8 May 1931'.
40 Helena Wright's private archives, held at the Wellcome Library, show that she gave lectures on contraception to various medical students and nurses at the clinics. For instance she trained nurses on 'Sex hygiene and the family' during a Special Course in Public Health and General Nursing on 12 June 1933 at the College of Nursing. See Wellcome Collection, London PP/HRW/B.13.
41 *Ibid*.
42 The clinics under the supervision of Marie Stopes also provided a practical demonstration for doctors and medical students, and Stopes collaborated with the Royal Institute for Public Health to offer training sessions in 1930 and 1931. On this aspect see C. E. L. Walker, 'Making Birth Control Respectable: The Society for Constructive Birth Control and Racial Progress, and the American Birth Control League, in Comparative Perspective, 1921–38'. PhD dissertation, University of Bristol, 2007.
43 The postgraduate medical institutions were established in the final decade of the nineteenth century and tailored to meet the educational needs of the general practitioners. A. Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720–1911* (Cambridge: Cambridge University Press, 1994), pp. 100–1.
44 Wellcome Collection, London, SA/FPA/NK 41, 'Copy of letter sent to deans of medical school, 5th September 1933'.
45 Wellcome Collection, London, PP/HRW/B13, 'List of training', and Wellcome Collection, London, SA/FPA/NK41, 'List of training'. See also Wellcome Collection, London, MS.9178/3/1, 'Walworth 70th anniversary historical material'; Wellcome Collection, London, SA/FPA/A13/85B, 'Association of Inspectors of Midwives, programme of conference and post-graduate week, May 1936'.
46 Wellcome Collection, London, SA/FPA/A19/1, 'Report of the Second national conference of branches, 1.12.1939'.
47 Wellcome Collection, London, SA/FPA/NK41, 'Memorandum from the North Kensington Women's Welfare Centre to the National Birth Control Association, July 5th 1934'.

48 *Ibid*.
49 Wellcome Collection, London, PP/HRW/B 13, 'British Postgraduate Medical School, birth control by Helena Wright, 22nd of June 1939'.
50 Wellcome Collection, London, PP/MCS/B.2, 'Information for the National Birth Control Association Committee, 1932'.
51 These gynaecological instruments have been widely discussed in gynaecology manuals, such as D. B. Hart and A. H. Freeland Barbour, *Manual of Gynaecology* (Edinburgh: W. & A. K. Johnston, 1890). For information about medical opposition to the speculum, see Moscucci, *The Science of Woman*, pp. 112–30.
52 Wellcome Collection, London, SA/FPA/NK 69, Helena Wright, 'the use of a speculum' in 'Report of a conference of clinical medical officers and nurses, 7th November 1953'.
53 Cunningham and Williams, *The Laboratory Revolution in Medicine*.
54 Wellcome Collection, London, SA/FPA/A14/96.2, 'Teaching syllabus'.
55 On the pelvic model see Wellcome Collection, London, SA/FPA/A14/196, 'Letter from the Secretary of the Clinics Medical Sub-Committee to Dr Evelyn Roberts, 26 January 1956'; SA/FPA/A19/9, 'Demonstration model of the teaching of contraceptive techniques, designed to the specification of Dr Helena Wright, approved by the FPA. Produced exclusively by Pytram LTD'.
56 Wellcome Collection, London, SA/FPA/A5/4, 'The Family Planning Association, Eighteenth Annual Report, 1948–49'.
57 Wellcome Collection, London, SA/FPA/A5/7, 'Family Planning Association Annual Report, 1955–56'.
58 Wellcome Collection, London, SA/FPA/A14/160/2, 'Suggestion for inspection reports, 1952'.
59 For detailed assessments of the different visits see Wellcome Collection, London, SA/FPA/A14/160/2, 'Mary Redding'.
60 'Memorandum on Family Planning with particular reference to contraception', *British Medical Journal*, 1:4758 (1952), p. 595.
61 Royal Commission on Population, Report, Cmd. 7, 1949.
62 Wellcome Collection, London, SA/FPA/A10/10 IPPF, 'Eleanor Mears, "The Medical Student and Sex Education", paper presented to I.P.P.F. Conference at the Hague, 1961'.
63 Wellcome Collection, London, SA/FPA/A16/5/1, *The Journal of Family Planning*, 5:4 (1957), p. 18.
64 J. Malleson, *The Principles of Contraception: A Handbook for General Practitioners* (London: V. Gollancz Limited, 1935), p. 9.
65 *Ibid*., p. 10.

66 H. Wright and H. B. Wright, *Contraceptive Technique: A Handbook for Medical Practitioners and Senior Students* (London: J&A Churchill Ltd., 1951), p. 5.
67 There was also a long tradition of women doctors using their medical expertise to write manuals of health guidance for laywomen. For instance, Scharlieb wrote *Health and Fitness* in 1921. Lesley Hall has shown that women doctors also wrote many sex education manuals. See L. A. Hall, 'In ignorance and in knowledge: reflections on the history of sex education in Britain' in L. D. H. Sauerteig and R. Davidson (eds), *Shaping Sexual Knowledge: A Cultural History of Sex Education in Twentieth Century Europe* (London: Routledge, 2009), pp. 19–36; L. A. Hall, *Outspoken Women: An Anthology of Women's Writing on Sex, 1870–1969* (London: Routledge, 2014). See also Elston, 'Women Doctors in the British Health Services', p. 249. See also G. Jones, *Social Hygiene in Twentieth Century Britain* (London: Croom Helm, 1986).
68 Hall, 'A suitable job for a woman', p. 109.
69 G. Cox, *Clinical Contraception* (London: Heinemann, 1933). Cox graduated MB, BS in 1923, and then was the medical officer to the Walworth Women's Welfare Centre. She also published *The Woman's Book of Health* in 1933 and was a member of the medical subcommittee appointed by the NBCA in 1934.
70 M. Pollock (ed.), *Family Planning: A Handbook for the Doctor* (London: Tindall & Cassell, 1966).
71 The women doctors contributing to the book were Sylvia Dawkins (medical officer at the Islington Family Planning Clinic), Rosalie Taylor, Eleanor Mears, Josephine Barnes, Margaret Moore White, Margaret Neal-Edwards, Mary Egerton, Margaret Blair, Jean Passmore, Elizabeth Draper, Alison Giles, Margaret Pyke and Helena Wright.
72 H. Wright, *Contraceptive Technique: A Handbook of Practical Instruction*, 3rd edition (London: Churchill, 1968), p. 5.
73 'Medical problems of contraception', *British Medical Journal*, 1:3726 (1932), p. 1047.
74 'Medical problems of contraception', *British Medical Journal*, 2:3784 (1933), p. 120.
75 *Ibid*.
76 Evans, *Freedom to Choose*, p. 154.
77 H. Wright, *Birth Control: Advice on Family Spacing and Healthy Sex Life* (London: Cassell, 1935), p. 3.
78 See in particular: M. Moore White, *Womanhood* (London: Cassell, 1947); M. Macaulay, *The Art of Marriage* (London: Delisle, 1952); S. Dawkins, *Planning your Family* (London: Foyles Health Handbooks, 1959).

79 Cox, *Clinical Contraception*, p. 10.
80 Malleson, *The Principles of Contraception*.
81 Wright and Wright, *Contraceptive Technique*, p. 22.
82 *Ibid*., p. 31.
83 K. Murphy, 'Joan Malleson, the principles of contraception', *Medical Women's Federation Quarterly Review*, (1935–6), p. 65.
84 E. H. 'Margaret Moore White, *Womanhood*', *Medical Women's Federation Quarterly Review* (1959), p. 37.
85 Donald Mackenzie has shown the relationship between the development of statistics and the eugenics movement. Indeed eugenics was a driver in motivating the development of the discipline. All of its founders – Galton, Pearson, Fisher – were convinced eugenicists. See D. Mackenzie, *Statistics in Britain, 1865–1930: The Social Construction of Scientific Knowledge* (Edinburgh: Edinburgh University Press, 1981).
86 E. Charles, *The Practice of Birth Control: An Analysis of the Birth-Control Experiences of Nine Hundred Women* (London: Williams & Norgate, 1932).
87 M. Jackson, 'Birth control and the medical profession', *British Medical Journal*, 1:3621 (1930), pp. 1022–3.
88 L. Secor Florence, *Birth Control on Trial* (London: George Allen and Inwin Ltd., 1932), p. 3.
89 *Ibid*., p. 12.
90 *Ibid*., p. 71.
91 M. Jackson, 'A medical service for the treatment of involuntary sterility', *The Eugenics Review*, 36:4 (1945), p. 117.
92 On this subject see Hanley, *Medicine, Knowledge and Venereal Diseases*. See also A. R. Hanley, '"Sex prejudice" and professional identity: women doctors and their patients in Britain's interwar VD service', *Journal of Social History* [online], shz066, available at: https://doi.org/10.1093/jsh/shz066 (accessed 25 June 2020).
93 *Ibid*.
94 M. A. Pyke, 'Contraception and fertility', *Lancet*, 231:5972 (1938), p. 405.
95 M. Jackson, 'Contraceptives and fertility', *British Medical Journal*, 1:4026 (1938), p. 539.
96 J. Malleson, 'Contraceptives and fertility', *British Medical Journal*, 1:4025 (1938), p. 484.
97 *Ibid*.
98 Jackson, 'Contraceptives and fertility', p. 539.
99 *Ibid*.
100 J. Malleson, 'Contraception and sterility', *British Medical Journal*, 2:4317 (1943), p. 434.
101 *Ibid*.

102 J. Malleson, 'Contraception and sterility', *British Medical Journal*, 2:4328 (1943), pp. 796–7.
103 R. H. P. Hick, 'Advice on sterility', *British Medical Journal*, 1:4300 (1943), p. 707.
104 M. Jackson, 'Advice on sterility', *British Medical Journal*, 1:4303 (1943), p. 803.
105 J. Malleson, 'Contraception and sterility', *British Medical Journal*, 2:4322 (1943), p. 587; J.-M. Strange, 'The assault on ignorance: teaching menstrual etiquette in England, c.1920s to 1960s', *Social History of Medicine*, 14:2 (2001), pp. 247–65.
106 Wellcome Collection, London, GC/105/26, 'Transcript of the interview with Sylvia Dawkins, Television History Workshop, 1988'.
107 See in particular J. R. Baker, 'The spermicidal powers of chemical contraceptives: II. Pure substances', *Journal of Hygiene*, 31:2 (1931), p. 211. On the development of contraceptive research see Löwy, '"Sexual chemistry" before the pill'; Soloway, 'The "perfect contraceptive"'.
108 Wellcome Collection, London, PP/EFG/A.2, 'The national birth control association, medical sub-committee, the present position with regard to the sale and distribution of contraceptives 1936'.
109 Wellcome Collection, London, PP/EFG/A.2, 'Minutes of the Medical sub-committee, 3rd March 1935'.
110 Wellcome Collection, London, SA/FPA/A7/5, 'Approved List, October 1937'.
111 Wellcome Collection, London, SA/FPA/A14/188, 'Letter from the General Secretary of the FPA to Greta Graff, 6 April 1954'; E. Mears, 'Clinical trials of oral contraceptives', *British Medical Journal*, 2:5261 (1961), pp. 1179–83; P. Eckstein et al., 'The Birmingham oral contraceptive trial', *British Medical Journal*, 2:5261 (1961), pp. 1172–9; M. Jackson, 'Oral contraception in practice', *Journal of Reproduction and Fertility*, 6:1 (1963), pp. 153–73. See also Wellcome Collection, London, SA/FPA/A4/A1.3, 'C.I.F.C Trials Branches Barnet'; SA/FPA/A5/158B, 'Minutes of the fourth meeting of doctors conducting Council for the investigation of fertility control, oral contraceptive trial, 30 June 1964'; 'Letter from Eleanor Mears to all medical officers conducting contraceptive trials, 13 January 1965'; E. Mears, 'Oral contraception: the results', *Family Planning*, 10:4 (1962), p. 4.
112 Wellcome Collection, London, SA/FPA/NK/69/638, 'Letter from the Secretary of the North Kensington Women's Welfare Centre to Dr Carruthers, 16th of July, 1954'.
113 Wellcome Collection, London, PP/EPR/B3: Box 2, 'Report of the Conference on the Giving of Information on Birth Control by Public Health Authorities, London, 4.4.1930', pp. 14–15, 17.

114 *Ibid*., p. 15.
115 Evans, *Freedom to Choose*, pp. 136–7.
116 Wellcome Collection, London, PP/HRW/B.14, H. Wright, 'What women have done through medicine not by medicine, Osler Club, October 12th 1978'. The private papers of Wright held at the Wellcome Collection reveal that, between 1929 and 1958, she spoke at more than 105 conferences on the topics of 'birth control', 'family spacing', 'sex education' and 'sex problems', in many different places such as the Midwife Institute, Presbyterian Church, Kings College, Sheffield City Hall, Marriage Guidance Council etc. She was indefatigable.
117 She was a witness for the defence of Aleck Bourn when he was on trial, in 1938, for having induced a miscarriage in a 14 year-old girl who had been raped by soldiers. Malleson had referred the girl to him.
118 Wellcome Collection, London, SA/FPA/A18/1, 'J. Malleson, "Report of Evidence given to the Royal Commission on Population", 27th of April 1945'.
119 See https://wellcomelibrary.org/item/b2847868x#?c=0&m=0&s=0&cv=0 (accessed 11 November 2017). On the use of mass media to build support for contraception see M. Parry, *Broadcasting Birth Control: Mass Media and Family Planning* (New Brunswick: Rutgers University Press, 2013).
120 Wellcome Collection, London, SA/MWF/H.41/8, 'NHS regulation circular with comments from the MWF'.