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"Unreliable Observations": Medical Practitioners and Venereal Disease Patient Narratives in Victorian Britain

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<1>In 1863 Sir William Lawrence, surgeon at St. Bart's and Serjeant [sic] Surgeon to Queen Victoria, wrote about a less than royal patient of his, Sarah Woodruff, who lived in Goswell Street near St. Bart's Hospital in London (Lawrence 393 & 473). Sarah was a servant employed by a family not far from the hospital, and was between sixteen and twenty years of age. She was, he wrote, "a healthy girl", but she came to the hospital seeking treatment for a "sloughing sore" due to sexual contact with a man she met at a fair (Lawrence 393; 473). Her privacy was not an issue for Lawrence, nor apparently was the fact that a young female servant known to have contracted a venereal disease would have lost her reputation – "her only capital" Josephine Butler called it – as well as her job if the fact became widely known (Butler 30). All other concerns were secondary to the fact that this was an interesting and rare case because it showed that "the venereal poison may destroy the vitality of the part to which it is applied, without exciting surrounding disturbance, or disordering health" (Lawrence 473) and writing about it could only add to the doctor's own prestige. She was confined to bed and had a poultice applied to the affected part but evidently was treated with no form of mercury which was the standard treatment until the twentieth century. Sarah's particular case was medically rare, but her treatment by the medical community was not at all unusual in terms of her age, gender and class. However, Lawrence went to the extraordinary length of publishing her name, age, occupation and address in his *Lectures on Surgery* published in 1863, a practice not usually seen in the pages of medical books and journals. He did not believe the story of infection she told him, and only accepted her account because he found corroboration of the truth of her narrative in "the state of her sexual organs" (474); this method of interrogation was far from uncommon: doctors suggested that while their patients might lie in their accounts of venereal infection, the bodies themselves would offer the skilled practitioner the truth of the situation.

<2>Sarah Woodruff's case clearly demonstrates the way that discussions of venereal disease in medical texts in Victorian Britain articulated many powerful assumptions about gender and class which were embodied in the person of the venereal disease patient. These assumptions were eventually codified in the 1860s into the Contagious Diseases Acts, which made working-class women's bodies and sexuality a national issue, and characterised them all as suspect of sexual immorality and infection. This article focuses on the case histories of working-class women – those most affected by the Contagious Disease Acts – and uses as a point of comparison case histories of middle-class men, members of the same social sphere as the medical practitioners

who were writing about them. A working-class woman was in a different category in respects to truth-telling and credibility than a man of the upper or middle classes. Case histories were stories of infection, transmission and transgression presented to the reader in the language of dispassionate scientific reporting. However, the interpretation made of those "facts", in the words and bodies of patients, was very much the individual doctor's, and was constrained by the social, sexual and moral expectations of the period.

<3>Venereal diseases, particularly syphilis and gonorrhea, were a particularly stigmatized class of diseases, often described in this period as foul, loathsome and secret. Doctors writing about this "most important subject" had to emphasize the scientific value of their subject, rationalize their interest in it and defend themselves against charges of prurience, even when speaking to an audience of their peers in medical meetings, lectures and journals ("Disputed Points" 512). Robert McDonnell, a former army and prison surgeon and at that time surgeon at the eminent Dr. Steevens' Hospital Dublin, remarked in 1868 to his students at the beginning of a lecture series: "The range of your studies offers few subjects at once so interesting and so perplexing as that of venereal diseases" ("Lecture I" 87). A year earlier, in 1867, a reviewer in the *Lancet* commented upon the "peculiar interest" which had drawn "men of the greatest eminence" to the study of venereal diseases over the centuries ("Reviews" 413). However, William Acton, one of the most well-known of medical commentators on matters relating to sex in this period, acknowledged in the *British Medical Journal* in 1870 that bringing the subject of venereal disease into general discussion had been a complicated and lengthy process: "It has been a matter of some difficulty to induce, first the profession, and subsequently the public, to entertain the subject at all. We have not far to look back to the time when the whole question was so tabooed, and considered so uninviting, that scarcely any one but a conscientious enthusiast dared to allude to it" (Acton 76). Charles Drysdale, well-known physician to the Metropolitan Free Hospital, likewise acknowledged the problems experienced by these "conscientious enthusiasts" and praised Acton's role in making "the subject of prostitution and the contagious diseases parasitic upon it a subject of positive science" (Drysdale "Shall We Find" 106). Yet even if venereal disease was now a part of "positive science", medical writers continued to justify their choice of subject matter in terms of both scientific interest and the moral judgments accepted by society at large.

<4>The Contagious Diseases Acts forms the background for most of the medical discussion of venereal disease from the 1860s through to the 1880s; by naming venereal disease as a major threat to the nation's health, the Acts made it more acceptable to speak and write about syphilis and gonorrhea. Doctors writing in this period, whether supporters or opponents of the Acts, were at last legitimized to speak about the topic that William Acton had found so hard to bring to public consciousness. Sir John Simon, the first Medical Officer for London, wrote in 1889 that the reign of Queen Victoria had marked a period when "[h]ealth necessarily began to take rank as an object of practical politics" (Simon 180). The Acts, an excellent example of Simon's "practical politics", were introduced in 1864, amended in 1866 and 1869, and finally repealed in 1886. They were a response to the problem of the health of the military, which in the years after the Crimean War had attracted much attention in the press and Parliament as part of the growth of the public health movement in the nineteenth century. The Acts permitted the inspection and hospitalization of women suspected of being prostitutes within certain protected districts near army and naval bases throughout the country. Supporters of the Acts saw them as part of the great project of public health reform, which with its promise of creating order out of chaos,

reached many middle-class Britons beyond the government and the public service. Writing in a letter to *The Times* in 1870, Berkeley Hill, Assistant-Surgeon to University College Hospital and Surgeon for Out-Patients to the Lock Hospital, believed these Acts were designed with the object of "protect[ing] the public health (which in the persons of the innocent as well as the guilty, is widely deteriorated by venereal poison…)" (Hill, Letter 4). Opponents of the Acts saw them as an affront to all Britons, and a challenge to political rights enshrined in the Magna Carta and the Constitution. They variously described the Acts as a form of pollution – "I thanked God at that moment that Queen Victoria had washed her hands of a stain which she had unconsciously contracted in the first endorsement of this legislation" (Johnson and Johnson 139) – or an infection: "[t]he Contagious Diseases Acts were themselves a local disease caught from the contagion of the Continent" (Stead 77). The Acts dominated medical writing about venereal disease in this period and how doctors shaped and understood the case histories of their venereal patients.

<5>Much of what we know of the patients' experiences of venereal diseases in nineteenth-century Britain comes in the form of the medical case study. In these accounts of the transmission of venereal diseases the medical practitioner mediated the voices and stories of his patients. He (and all the texts I am concerned with here were written by men) extrapolated from and arranged the information presented by the patient. In this process "authority [was] displaced from the patient giving the history to its recorder, and ultimately to the text itself" (Epstein 59). From what may have been a lengthy and discursive conversation, a possible contest between doctor and patient about revealing information felt to be private, we are left with the basic skeleton of a life: name, age, profession, symptoms and diagnosis. A whole life, the effects of illness on the patient's friends, family, lovers and workmates became reduced to discursively defined "essentials". The narrative of illness was shaped into a form appropriate to medical discourse, and was indeed shaped by the discourse itself. It is easy to consider such case records as true and objective accounts of what really happened in the interaction between doctor and patient, but it is important to remember that what they represent is "a profound, ritual act of transformation through which illness is made over into disease, person becomes patient" (Kleinman 131).

<6>Charles Drysdale, a well-known opponent of the Contagious Diseases Acts, considered the problem posed to doctors by the patient narrative in his 1872 work *Syphilis: Its Nature and Treatment*. In a chapter on female gonorrhea patients he described the difficulties facing the doctor in constructing case histories of venereal disease: "we have only the patient's own observations of her symptoms to guide us; and they, of course, are very unreliable" (25). This definition of the patient's observations as "unreliable" was common in nineteenth-century medical writing and contains within it prevalent assumptions about the medical encounter made by doctors in this period. "The patient as a rule has but slender comprehension of the aims of medicine", wrote one doctor in 1903, "and is therefore little likely to be in sympathy with them" (Carter 135). In Victorian medical writing, patients were not characterized as the most accurate readers of their own bodily experiences which required the interpretation of the skilled professional. Their words were rarely trusted, but their bodies were believed to reveal the truth about infection and sexual activity to the medical practitioner. Doctors attempted to subsume conflicts over definitions of health and illness into an "invariate biological reality" in their published case histories (Armstrong 2) and could not, in most cases, comprehend that they and

their patients might have "conflicting expectations" of consultation and treatment (Katz 98). The patient was supposed to be a "passive and uncritical" subject of medical knowledge (Jewson 235) ready to be transformed into clinical evidence in medical publications. The authoritative narrative of illness became the medical one, and the Victorian period saw the medical profession claim "epistemological sovereignty over the bodies and minds of others" (Laqueur 188). By the end of the nineteenth century the medical profession established its diagnoses of the body in sickness and in health as authoritative.

<7>The sick body is the body of the patient, and as such the bodily experience of the nineteenth-century venereal disease patient should not be overlooked. "The body is not just a bag of bones", writes Roy Porter, "it is an expressive medium. We feel and experience through our bodies, they negotiate the boundaries and crossings of self and society" (R. Porter 35). Patients struggled with the physical symptoms of their disease, whether syphilis, gonorrhea, chancre or one of the many other types of this group of afflictions. For the syphilitic there were sores, rashes, and excruciating pains. The nineteenth-century French novelist Alphonse Daudet wrote that this pain 'finds its way everywhere, into my vision, my feelings, my sense of judgement' (Daudet 23). Even the treatment had side-effects which could identify the sufferer as a syphilitic. Mercury could cause excess salivation, bad breath, the loss of teeth and hair and a gradual poisoning of the entire system. As the disease progressed over many years there was the probability of paralysis and perhaps later of insanity, although the link between syphilis and these later conditions was not made until late in the nineteenth century. For patients with gonorrhea there were the initial symptoms of the disease; later complications for men included the extreme pain of stricture, for women the constant agony of pelvic inflammatory disease. Patient narratives of venereal disease are narratives of pain, discomfort and usually of shame. They are insights into a subjective bodily experience and the peculiar social ramifications of these diseases.

<8>The experience of being a venereal patient varied greatly depending upon class in the Victorian period. Middle and upper class patients could enjoy the services of private doctors and the discreet but often expensive treatments offered by mail-order quacks. Even if the middle-class patient made an appearance as a case study, they were protected by a degree of anonymity. Hidden behind initials and the description "a gentleman", they would not have feared the physicians and surgeons they were paying for discretion would violate that trust. Publication of identifying details of middle-class patient's cases would not have been good for business. However, the working classes, including servant girls like Sarah, could only expect treatment in a public hospital, if they were able to gain admission, and may have had little notion that they were furnishing the raw material for the research and publications which would increase a doctor's reputation and standing within his field. Most doctors were fortunately not as explicit as Sir William Lawrence in their publications, affording their working-class patients some privacy; however, class played a large role in the degree of trust they invested in their patients' stories of infection. The narrative of the lower-class sufferer was constantly under scrutiny. In one case recounted by Jonathan Hutchinson of a young women he had examined at Moorfields Eye Hospital he wrote, "[s]he was apparently very respectable, but she was good-looking and unmarried…The girl at length getting to know what we suspected, begged that she might be examined in any way that would clear her character" (Hutchinson *Syphilis* 278). Upon examination it was indeed proved that she did not have venereal disease of any kind, but her

account was considered unbelievable because she was young, single, good-looking and poor. Her body and the doctor's reading of it was the absolute arbiter of truth.

<9>Assumptions about class and gender were also made when the patient was obviously a gentleman. Besides the different attitudes to the disease in men and women, there was also a definite class difference in the presumptions surrounding a diagnosis of venereal disease. Young men of the upper and middle classes might contract a venereal complaint in the "sowing of wild oats" before settling down to respectability, a belief which was being challenged by feminists and social purity campaigners in this period. Berkeley Hill drew attention to the differences in morality between the classes, describing lower-class morals in some of the areas registered under the Contagious Diseases Acts as "extremely vicious" and regretting that in these areas there was no "fixed population of gentry to give a tone and set an example to society" ("Illustrations I" 84). Middle-class manners and expectations about respectability were prescribed as one cure for an unrestrained and unhealthy proletariat. In the lower classes the stigma of the disease was believed to be an explicit indication of a lack of respectability, and was frequently linked to alcoholism: "[a] relationship or affinity appears to exist between syphilis, alcohol, and prostitution which unites them in a trio of great and evil menace to health" (Dock 25). Gentlemen were believed to speak honestly to their doctors and masculine codes of honor forbade their accounts being queried. No questions were asked of the history given by the Reverend T.R., aged fifty-two, who "was, when eighteen years of age, seduced, and had a sore and a bubo" (Hutchinson, *Syphilis* 316). Likewise the case of Dr. A., who "on one single occasion went astray" (Hutchinson, *Syphilis* 104). William Lawrence, so ready to identify Sarah Woodruff, showed his discretion when he recounted the case of "[a] gentleman, about sixty, of good fortune and regular habits, who could not have contracted the disease from any low source" (Lawrence 393). In a gentleman, venereal disease meant youthful indiscretion; in a lower-class woman it meant sexual immorality. The case of Mr. D. which Angus Porter described in a paper read before the Ulster Medical Society in 1868 and later published, further clarified the role of class in patient-practitoner communications. Mr. D. was a gentleman of "regular habits, and unimpeached character…beyond suspicion of impurity of mind or body" (50). This "most temperate and regular man" was unable to explain how he had contracted syphilis, so Porter supplied him with an explanation which avoided any mention of sexual impropriety: "I reserved judgement, and suggested the likelihood of his having contracted the disease in a foul privy, which hint he willingly accepted, as furnishing a respectable *fons et origo mali*" (51). For middle-class patients their words were given credibility, no matter what their bodies might reveal.

<10>Patients of the lower classes were rarely afforded this sort of consideration by their doctors. A young woman who offered the very same "foul water-closet" as a source of infection was rejected summarily by the unnamed author of "Disputed Points in the Doctrine of Syphilis" as a liar. E.L., a young, female, single school-teacher, "proper but not prudish", went on holiday with some friends to the Isle of Man ("Disputed Points" 570). While there, she assured her doctor, "she was never out of sight of one or other, except when at the water-closet" (571). E.L. contracted some sort of venereal sore. The doctor not believing her claim of virginity examined her to find that her "hymen was unbroken". He concluded the case history with the comment "[a]s I cannot yet make up my mind to believe that the sore was contracted by sitting on a foul water-closet, I will not ask my readers to do so" (571). Young women were particularly suspect

and “not considered reliable witnesses to their own past: only when their history had been verified by parents, friends or employers was it believed” (Bartley 37). In E.L.’s case, her words not being believed, her body was consulted to establish the truth. Yet even when her body confirmed her story, her age, gender and class were the doctor’s proof of guilty infection. She was not afforded the same consideration a gentleman like Mr. D received from his physician.

<11>Practitioners treating venereal patients constantly bemoaned the difficulty of acquiring an accurate – and what they would regard as a truthful – case history of venereal disease. Jonathan Hutchinson wrote in 1863 that obtaining an accurate and truthful case history from sufferers of venereal disease was an exercise of “great difficulty” (*Clinical Memoir* 203). Charles Drysdale noted in 1872 that with most patients “we are left in the most profound doubt…as to when and where they contracted the contagion” (*Syphilis*, 39). C.F. Marshall wrote with palpable frustration in his 1906 publication *Syphilology* that “[a]s regards anamnesis or ‘history’, the patient’s statements are often misleading and exposure to syphilitic contagion is often wilfully denied” (24). What medical practitioners themselves often willfully ignored or denied were the patient’s own reasons for denying or attempting to hide a venereal disease until the suffering grew extreme enough to require assistance. I have already mentioned that for a working-class woman a case of syphilis would mean loss of respectability, perhaps loss of a position if she was a domestic servant like Sarah Woodruff, unless she could prove that it was innocently acquired from a notoriously licentious husband. The economic and social cost was described by Josephine Butler who wrote that a poor woman’s honor was “often her only capital; it is in fact that part of her property the loss of which is ruin to her” (Constitution 30). Frederick Lowndes, surgeon to the Liverpool Lock Hospital, understood the concern of the friends of a patient who had recently died of tertiary syphilis (727-29). Her friends wanted the true cause of this woman’s death of this woman to be concealed “on the grounds that it might lead to forfeiture of burial-club money” (729). Burial clubs were formed to enable the working-classes to contribute to a fund to provide for a respectable funeral and burial. However, Lowndes refused their request on the grounds of scientific accuracy, while acknowledging the difficulties such a diagnosis could lead to: “I certified the death as due to tertiary syphilis; but now that this word is so familiar to the public, or even its abbreviation (syp.), it would be as well if practitioners could, by some modification of our death-registration system, be spared the invidious choice of stating the cruel truth, or of suppressing it at the risk of giving an incorrect certificate” (729). Lowndes was prepared to recognize the profound moral resonances of a diagnosis of syphilis, but lacked empathy with the social consequences of this diagnosis to the poor who depended on organizations like burial clubs to ensure their respectability after death. In a contest between empathy and science, the latter always won. In their published case histories doctors often refused to understand not only the social, but also importantly, the economic implications a venereal diagnosis could have. Hutchinson, who, at his death in 1913, was regarded as one of the great authorities of the period in the fields of ophthalmology, dermatology and especially syphilis, achieved great professional eminence even while working and publishing on the subject of venereal disease. His writing is notable among much of nineteenth-century medical discourse for its compassionate quality. He was aware of the difficulties that patients experienced in admitting to venereal disease and also the problems that arose when a spouse had unknowingly contracted it from a partner, writing: “In most cases the surgeon is precluded either by moral obligations or by motives of kindness from asking any direct questions, or even such as may excite suspicion” (*Clinical Memoir* 203). He warned his fellow doctors about the sense of

betrayal felt by the infected partner, the shattering of trust and the breakdown of marriages to which it could lead. In his 1887 text *Syphilis* he wrote more extensively of the problems of extracting, often painfully, and decoding a patient's history of venereal disease. He wrote, "[o]ur patients often have reasons for not telling the exact truth, and still more often, they are not themselves cognisant of it" (*Syphilis* vii). Doctors, in his opinion, faced the dual problem of being willfully misled by their patients or being misled by their patients' ignorance. While exhibiting a considerable degree of empathy with his patients, he was also a man of his times and shared many of the conventional beliefs of his profession and society regarding venereal disease and sexual morality. That doctors, he wrote, "cannot trust the statements of our patients is well known. These statements may be erroneous either through ignorance, or from unwillingness to confess the truth" (497). Hutchinson's use of the term "confess" in this context is very revealing, and not just because it highlights what Foucault has identified as the nineteenth-century science's redefinition of the confession as a vital element in the therapeutic relationship (Foucault 59-67). The confession was understood as an expression of truth, and science wanted to be the pre-eminent source of true theories of all humanity. Criminals or sinners in the past had confessed to the forces of social authority embodied in church and state, but by claiming the confession as central to the authority of medicine and the construction of the case history in the Victorian period, the medical profession made statement about the pre-eminence of the scientific model. Patients confessed a transgression understood as morally and socially wrong, but one that took unquestionable corporal form. The symptoms of venereal disease became a form of scientific stigmata which could not be denied. Of one case of congenital syphilis Hutchinson wrote "[h]is mother denied all history of syphilis, but she did not appear to speak openly, and against her denial were the facts" (*Clinical Memoir*, 139). The 'facts' were in the appearance and the poor health of her nine-year-old son. He was her confession.

<12>The notion of confession as truth-telling was complicated by patients' denial of any contact with syphilis or other forms of venereal disease. This was one of the most frequently expressed sentiments in Hutchinson's published case histories and in most other of these medical accounts. These denials constitute a tension within Victorian science's construct of the confession as a "therapeutic operation" (Foucault 67). They confounded the notion of truth-telling demanded by the confessional model that shaped the doctor-patient relationship and the case history. It is a recurring motif through these texts, but one the doctors challenged with the truth they read in the bodies of their patients. In the case of Emily C., aged three months, Hutchinson wrote, "Her mother denied having had sores or other suspicious symptoms"; of Anna L., "an infant Jewess" aged three years old, "[h]er mother denied having ever had venereal disease"; and the father of Henry P., "a pale cachectic man…denies with warmth any history of syphilis" (*Clinical Memoir* 5, 7 and 52). Equally recurrent was Hutchinson's refusal to believe such denials. In fact, Hutchinson noted in his 1863 work on the complications of congenital syphilis that only in 29 out of the 109 cases he reviewed for this text did parents give "a free admission" that one or both of them had had venereal disease (*Clinical Memoir* 119). Fortunately, where he could not trust their words he believed he could trust the physical evidence. Such reticence was due to the variety of social and cultural pressures and stigmas surrounding the diagnosis of venereal disease.

<13>Medical texts and journal articles about venereal disease revealed many of the assumptions Victorians made about masculinity and femininity that had been codified into the Contagious

Diseases Acts. As in the Acts, the men constructed in these texts are highly vulnerable to infection and liable to suffer more profoundly from venereal complaints than women. They thus stand in need not only of the physical protection of prophylaxis, but also of the formal protection provided by legislation. All men were perceived to be under threat from any woman with whom they had sexual relations. One writer warned in 1864, the year the Contagious Diseases Acts were brought into force, that "a purulent urethritis may be obtained from [even] a virtuous woman" ("Modern Syphilography -- II" 543). If a respectable wife and mother could so infect her husband, the possibilities of infection and contagion embodied by the prostitute were even greater. James Lane, surgeon to St. Mary's and the Lock Hospitals, wrote that "purulent discharges in the female are, as a rule, attended with so little pain or inconvenience, that the patient has but slight inducement to apply spontaneously for relief" (139). Male lust and its potential as a threat to respectable women of all classes was identified by feminists, social purity campaigners and, later, New Woman novelists and suffragettes as a devastating problem throughout this period: from Josephine Butler writing in disgust in 1870 of the Contagious Diseases Acts as legislation forcing women "into the ranks of vice" in order to serve "the lusts of men" (Butler 68) to Christabel Pankhurst calling for "Votes for Women and Chastity for Men" in 1913 (qtd. in Bland 247). However, it was women who were more often characterized as polluters in these medical narratives. Medical journals abounded in case studies of patients in Lock Hospitals whose poverty, and their compulsory hospitalization under the terms of the Acts, made them available for study. These women appear in these articles not as individual patients but as a contagious and contaminating horde, "the masses of animated infection" ("Royal Commission" 131). These working-class women were differentiated from the middle and upper classes by a lack of cleanliness, moral laxness and a susceptibility to venereal diseases. Berkeley Hill noted that "the moral character of women suffering from gonorrhea is seldom free from reproach" (*Syphilis* 460-61).

<14>In this construction the penis is painted as incredibly fragile and easily overwhelmed by the torrents of infection dripping from the average working-class woman. Langston Parker, a consulting surgeon in Birmingham, warned his mostly male readers that "the sexual organs of the male, more especially the penis, are liable to several important diseases and accidents, which are directly due to sexual intercourse" (Parker 476). In 1887, the year after the repeal of the Contagious Diseases Acts, retired Brigade-Surgeon William Curran recounted in the pages of the *Medical Press and Circular* the case of a young soldier who contracted a particularly vicious syphilitic sore which "went so far as to destroy, from its root up, the penis" (Curran 339). In this narrative, syphilis, through the means of the infamous "frightfully diseased" public women of Aldershot camp, had completely emasculated this young soldier (Hill, "Illustrations III" 94). Even this soldier's voice and facial features had been feminized by the disease: "he had a somewhat feminine expression of countenance and his voice, too, partook of this same shrill or falsetto feature" (Curran 339). It was impossible for the army to keep him once this condition was discovered – he was no longer the symbol of the manly defender of the Empire. "We had in short", wrote Curran, "to get rid of him as soon as we could" (339). His masculinity was rendered perilously fragile in the presence of a diseased femininity. The Contagious Diseases Acts were seemingly embodied in this one patient whose masculinity had been destroyed by an infectious female body.

<15>Yet, while stressing that female venereal disease patients were "seldom free from reproach", doctors also had to admit that ignorance of the real nature of their complaint could also be a factor surrounding refusal to admit to venereal disease, particularly in middle-class women. Alfred Fournier, the leading French venereologist, wrote in his 1880 publication *Syphilis and Marriage*, published for the Royal College of Surgeons in translation in 1881: "For, in the vast majority of cases, things occur in such a way that the woman is ignorant of the disease which affects her, and it is your moral duty to deceive her in this matter by hiding from her the name and the nature of her malady" (169). Sexual and social proprieties decreed that venereal disease was not supposed to figure in women's epistemological universe, and in reinforcing ideals of female innocence the authority of male medical discourse claimed even further legitimacy and power. The New Woman novelist Sarah Grand blamed society's perpetuation of a double standard of sexuality and of sexual knowledge. In her 1893 novel *The Heavenly Twins*, a character protests against social conventions which required respectable women's ignorance of venereal diseases: '"Why are women kept in the dark about these things?"'(Vol. 6 662) Ignorance of venereal disease in society was blamed by one nurse writing in 1910 on "the veil of silence and the cloak of embarrassment drawn over the subject of sexuality and sexual health" (Dock 134). Henry Sewill, in a plea for a royal commission on quackery, suggested that women were more vulnerable to exploitation because "women, with rare exceptions, have no scientific knowledge whatever" (19). However, Fournier suggested that women often knew much more about their condition than their doctors and husbands might wish to believe. The force of the conviction that women were ignorant of sexual matters was written into the texts and subtexts of much of the literature of the period, yet it existed alongside a belief that women, particularly of the lower classes, were a major locus of infection and moral corruption.

<16>Victorian doctors believed that "unreliable observations" were the best that their working-class venereal patients offered them, and were reluctant to acknowledge the reasons patients might have had for misleading them. Medical case histories of the "shameful maladies" were written under the influence of the whole range of images of corruption, filth and sexual excess associated with syphilis, but these images were also codified in this period as the proper concern of the medical profession and subsequently vital to the nation's health (Hill, *Syphilis* 1). In the mid- to late-Victorian period all writing about venereal diseases was influenced by the Contagious Diseases Acts. This legislation had shaped attitudes to gender and class within the medical profession as well as in the general public. The venereal disease patient was often blamed for bringing their afflictions on themselves through immoral and illicit sexual activity. Syphilis, wrote Sarah Woodruff's over-informative surgeon William Lawrence in 1863, "may be regarded as a punishment falling appropriately on those who disregard what has been called the obvious design and intention that the sexes should cohabit in single pairs" (Lawrence 345).

<17>Case histories contained a modern kind of scientific confession that occurred in the interaction between doctor and patient. To receive treatment, venereal disease patients were obliged to admit their transgressions and to submit to the diagnoses of the medical profession. The medical profession apportioned credibility according to class and gender, believing that while words could be false, bodies rarely lied. When bodies seemed to confirm the truth of the patient's story, class and gender had a role to play. The interactions between doctor and patient, taking place in "the private and confidential space of the doctor's surgery or consulting room" can be hard to recover, but can be glimpsed in the case histories of venereal patients published in

the Victorian period (Hall 3). In these case histories we find the assumptions about gender, class and sexuality that dominated Victorian society, but we also discover the patients, their stories mediated by a medical profession who needed their bodies and histories to make their own reputations and livings. Despite this mediating intervention, we can still recover Sarah Woodruff and her tale of transgression, infection and treatment, and through this discovery we can acquire an increased awareness of the complexities inherent in the relationship between doctor and patient, especially in the context of sexually transmitted diseases.

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