

# The introduction of diagnostic and treatment innovations for syphilis in post-war VD policy: «L'expérience belge»

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## SUMMARY

1.—Pre-War Conditions. 1.1.—A «modern plague». 1.2.—Science-based prophylaxis. 2.—Post-War Policy. 2.1.—Professional objections. 2.2.—Collaboration with «corps medical tout entier». 3.—«L'expérience belge?» 4.—Conclusion.

## ABSTRACT

In this article, the introduction of the Wassermann Test and arsenic-based drugs in Belgian post-war venereal disease (VD) policy is discussed (for the period 1900-1930). Pre-war advances in clinical medicine, the development of the Wassermann Test and arsenical drugs, as well as war conditions, were important in putting syphilis onto the public agenda in Belgium. However, the way in which new diagnostic and therapeutic techniques and devices were incorporated within post-war VD policy depended on the reconciliation of a range of political, professional and moral agendas of interested health-political parties. Finally, a successful post-war VD policy depicted in terms of «The Belgian Experience» is discussed.

**Keywords:** Syphilis, VD policy, Belgium, Wassermann Test, Salvarsan, medicalisation.

**Palabras clave:** Sífilis, política anti-venérea, Bélgica, Test de Wassemann, Salvarsán, medicalización.

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On 28 November 1925, at a meeting of the Belgian Royal Academy of Medicine, Dr Adrien Bayet reported the results of the post-war anti-syphilis campaign in Belgium. Five years after its introduction, Dr Bayet (1), one of the protagonists in this campaign, gave a glowing account of the impressive reduction of syphilis in Belgian society (2). He triumphantly revealed to his foreign colleagues a reduction of new syphilitic cases to a fifth and even a tenth of the 1920 figures, in contrast to more modest declines in other European countries (3). Dr Bayet attributed this successful «Belgian experience» to the combined efforts of a large-scale «medical» prophylaxis, i.e., free, anonymous and accessible treatment with new arsenic-based drugs, and an intense «moral» prophylaxis through the mass propaganda and educational efforts of the *Ligue Nationale Belge contre le Péril Vénérien*.

However, «medical» prophylaxis was both more controversial and perhaps less successful than claimed by Dr Bayet. This paper argues that the availability of the Wassermann Test and arsenic drugs per se were not enough to transform syphilis from a moral issue related to debauchery into a medical problem that could be detected and neutralised. As Conrad argues, the implementation of new medical technologies depends upon a broader definitional process of medicalisation in which varying medical and non-medical actors are involved, and hence is not necessarily the result of intentional expansion by the medical profession (4). Pre-

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- (1) Dr Bayet in 1901 became chief of the *Service de Dermato-syphiligraphie* of the official Saint Peter's Hospital in Brussels, one of the first dermatological centres in Belgium, and conducted clinical research on the diagnosis and treatment of syphilis during the first decades of the 20<sup>th</sup> century. He was member of the *Académie Royale de Médecine* from 1920. He was part of the freethinking-liberal intellectual elite in Brussels and after WWI was appointed extraordinary professor at the «free» University of Brussels. In 1921, he founded the *Ligue Nationale Belge contre le Péril Vénérien* that organised anti-VD propaganda and was president of the *Union Internationale contre le Péril Vénérien* (1922).
- (2) BAYET, Adrien. La lutte contre la syphilis en Belgique. Son organisation et ses résultats. *Bulletin de l'Académie Royale de Médecine de Belgique (série V)*, 1925, 5, 608-637.
- (3) BAYET, Adrien. *Les principes et les méthodes de la lutte sociale contre la syphilis. «L'expérience belge»*, Nanci-Paris-Strasbourg, Berger-Levrault, 1929.
- (4) CONRAD, P. Medicalisation and social control. *Annual Review of Sociology*, 1992, 18, 209-232.

war advances in clinical medicine and new bacteriological-scientific equipment, as well as war conditions, were important in putting the medical treatment of syphilis onto the public agenda. Post-war implementation of diagnostic and therapeutic innovations uncovered latent conflicts between central and local authorities and between various factions within the medical profession, which compromised the medicalisation of syphilis treatment. This complex negotiation process between various medical and non-medical actors may put the Belgian success story into perspective.

## 1. PRE-WAR CONDITIONS

### 1.1. A «modern plague»

Syphilis was endemic in Western societies from the 16<sup>th</sup> century. However, the last decades of the 19<sup>th</sup> century foreshadowed a new era of syphilis prevention in European history (5). The public view of syphilis gradually changed from that of a personal infringement on sexual morality to that of a collective health menace. By the late nineteenth century, new clinical studies revealed the syphilitic origins of chronic cardiovascular disorders, loss of muscular coordination, partial or complete paralysis, insanity and damage to internal organs (6). This body of knowledge changed the concept of syphilis from that of a dermatological disease with predominantly external symptoms into a «maladie d'imprégnation», an invisible «poison» secretly attacking the human organism in previously unexpected ways (7). In June 1887, in a report to the French *Académie de Médecine*, Fournier characterised syphilis as a «modern plague», creating the image of an «individual», «hereditary» and «social» danger that menaced the individual, the nuclear family

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(5) TEMKIN, Owsei. On the history of «morality and syphilis». In: *The double face of Janus and other essays in the history of medicine*, Baltimore, The Johns Hopkins University Press, 1977, pp. 472-484.

(6) BRANDT, Allan. M. *No magic bullet: a social history of venereal disease in the United States since 1880*, New York, Oxford University Press, 1985, p. 11.

(7) BAYET, Adrien; MALVOZ, Ernest. *La prophylaxie sociale de la syphilis devant les récents progrès de la syphiligraphie*, Bruxelles, Hayez, 1911, pp. 4-7.

and the human race. He related new clinical knowledge to serious social consequences — for example an inability to work, poverty, inaptitude for the army, the compromising of conjugal relationships, sterility of marital relationships, depopulation and degeneration of the race (8). Fournier presented new statistics to show the considerable numbers of infected «innocents», consisting of the respectable wives and children (and wet nurses) infected by the husband, and individuals non-sexually infected at the workplace and through everyday contacts. This view undoubtedly reflected the personal tragedies of syphilitic infection and disease and its congenital effects that Fournier encountered among his patients, but it simultaneously reflected wider ideological debates on race degeneration and population decline (9). Syphilis joined alcoholism and tuberculosis as a «social scourge», this triad being assumed by the Belgian medical world to represent the gravest causes of social decay and the deterioration of the race (10). In this political context, so-called «Syphilis insontium» (the infection of innocents) was at odds with the traditional dominant definition of syphilis as «un frein providentiel mis aux excès de la chair» and also provided an argument for the extension of public health measures to at-risk groups other than «debauched» prostitutes.

In 1880 the Belgian doctor-hygienist Kuborn had argued in vain to the *Société Royale de Médecine Publique* (11) — as Fournier did in 1887 in his report to the French Academy — for the establishment of specialised hospitals and the multiplication of VD centres to provide free treatment (12).

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(8) PROPHYLAXIE de la syphilis. *Le Scalpel*, 1887, 39 (51), 302.

(9) DE VRIES, Petra. The «shadow of contagion»: gender, syphilis and the regulation of prostitution in the Netherlands, 1870-1914. In: Roger Davidson; Lesley A. Hall (eds.), *Sex, sin and suffering. Venereal disease and European society since 1870*, London - New York, Routledge, 2001, pp. 44-60.

(10) NYS, Liesbet. De Ruiters van de Apocalyps. Alcoholisme, tuberculose, syfilis en degeneratie in België, 1870-1940. *Tijdschrift voor Geschiedenis*, 2002, 115 (1), 26-46.

(11) The *Société Royale de Médecine Publique* was the most important hygienist association in Belgium in those days and existed from 1879 until 1914.

(12) JACQUÉ, Léon; CRAPS, Maurice. La dermatologie et la syphiligraphie en Belgique pendant un siècle. In: *Cent Ans de médecine en Belgique 1830-1930*, Bruxelles, Vromans, 1931, pp. 193-268.

The issue of free treatment would gain more medical and political attention in the first decade of the 20<sup>th</sup> century as the network of Belgian dermatologists-syphilologists evolved and revolutionary drugs were developed. In 1900, the *Société Belge de Dermatologie et Syphiligraphie* was founded. In addition, the first international conferences on the prophylaxis of syphilis and venereal diseases were organised in Brussels in 1899 and 1902 on the initiative of Belgian dermatologist Dubois-Havenith (13). These two congresses focussed international medical and government attention on the question of VD prevention but their practical consequences in Belgium were afterwards assessed as being disappointing. In their communication to the *Société Royale Belge de Médecine Publique* in October 1911, Dr Bayet and Dr. Malvoz (14) regretted the lack of firm congress conclusions due to the then-insurmountable disagreement between advocates of the regulation of prostitution and so-called «abolitionists» (15). Dr Bayet depicted the former debates as a «logorrhée» (in analogy with gonorrhoea), and denounced the reiteration of traditional arguments pro and contra regulation while the crucial issue of anti-syphilitic therapy was marginally discussed (16). However, in 1911, radical changes in the diagnosis and treatment of syphilis were taking place.

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- (13) DUBOIS-HAVENITH, Emile (ed.). *Conférence internationale pour la Prophylaxie de la Syphilis et des Maladies vénériennes, Rapports préliminaires*, Bruxelles, Lamartin, 1899 (vol 1), 1902 (vol 2).
- (14) Ernest Malvoz was Professor at the state university of Liege and a renowned bacteriologist. He played a key role in the Belgian fight against contagious diseases and was initiator of social hygienist institutions subsidised by the progressive provincial authorities of (industrialised) Liege, such as the free distribution of anti-diphtheria serum (1894), the first Belgian anti-tuberculosis dispensary (1900) and anti-syphilis dispensary (1912) in Liege.
- (15) This regulation, though with many local variations, required the entering of prostitutes on a police register, periodic medical inspections of registered prostitutes and their obligatory hospitalisation in case of VD infection. This regulation aroused heavy criticism in all European countries by heterogeneous «abolitionist movements», attacking the infringement of civil liberties, the double standards of sexual morality, its ineffectiveness and its implicit acceptance of prostitution. The issue of regulation was heavily debated in Belgium in sessions of the *Académie Royale de Médecine* in 1886 and 1887, a special parliamentary commission in 1888, the two international conferences in Brussels, and again after World War I.
- (16) PROCES-VERBAL de la XXXIIe réunion du corps médical belge tenu a la Maison

## 1.2. *Science-based prophylaxis*

The discovery of the syphilis microbe, and the development of the Wassermann test and Salvarsan (see below) radically changed the science of syphilology. Fournier's authoritative *Treatise on Syphilis* in 1901, which had become a standard work, suddenly became outdated and was succeeded by syphilology studies that combined clinical observation with laboratory research. The discovery of the *Spirochaeta pallida* in 1905 by Schaudinn and Hoffman concluded a bacteriological quest for the syphilis microbe that had been going since the 1880s and which had been characterised by various claimed, then rejected, «discoveries» of the syphilis microbe (17).

The development of a serological test by Wassermann and his colleagues Neisser and Bruck in 1906 corroborated the older syphilological redefinition of syphilis as a latent, «impregnating» disease that was framed analogous to the way in which alcohol «poisoned» the human constitution (18). The Wassermann test provided an important improvement in diagnosis and made the detection of unknown syphilis victims possible. Dr Bayet estimated that these accounted for 25% of all syphilitics, since syphilitic symptoms often passed unnoticed, were perceived as benign, and often disappeared spontaneously or were concealed by ashamed syphilitics (19). Tracing of the hidden syphilitic origin of numerous grave «tertiary» effects after years of dormancy also became possible. At the official Saint-Peters Hospital in Brussels, 1300 patients were systematically tested in the department for internal medicine and 28% of them showed positive Wassermann reactions (20). On the other hand, the Wassermann

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des Médecins, le 22 octobre 1911. *Bulletin de la Société Royale de Médecine Publique*, 1911, 24, 295-341.

- (17) BAYET, Adrien. *Le spirochaète de la syphilis*, Bruxelles, Severeyns, 1905.
- (18) BAYET, Adrien. *Le traitement actuel de la syphilis*, Courtrai, Beyaert-Sioen, 1913.
- (19) BAYET, Adrien. Observations sur 2250 cas de syphilis observés à Bruxelles. Contribution à l'étude des conditions sociales de la syphilis. *Bulletin de la Société Belge de Dermatologie et de Syphiligraphie (BSBDS)*, 1906, 7 (1), 18-36 ; DOSSIN, Félix. De l'utilité de la réaction de Wassermann dans la pratique médicale. *Le Scalpel*, 1913, 66 (6), 87-90.
- (20) DUJARDIN, Benoit. *Le bilan social des affections vénériennes. Leur prophylaxie sociale*, Bruxelles, Maurice Lamertin, 1919, p. 30. After World War I, some Belgian

Test was cumbersome, theoretically ambiguous and neither very sensitive nor very specific (21). Hence, clinical expertise remained important since a considerable amount of syphilis patients tested negative (22).

In 1909, Paul Ehrlich and Sahachiro Hata discovered «606», named after the 606<sup>th</sup> preparation they had created in the laboratory in their search for a specific therapy against syphilitic bacteria. It was an arsenical compound that was commercialised in 1910 under the name of Salvarsan. Ehrlich depicted this chemotherapeutic discovery as a «magic bullet» that attacked specific syphilitic «targets» in the body (23). As the first effective therapy, it was internationally heralded in the popular press, and it aroused in the Belgian medical field both enthusiasm and scepticism. In 1910, Ehrlich sent a quantity of Salvarsan to many VD clinics to allow the study of its clinical effects and the collection of a sufficient number of observations prior to its commercialisation (24). Nevertheless, at the end of the year, Dr Bayet deplored the premature commercialisation of Salvarsan, whose curative effects and administration techniques were not yet adequately tested (25). In a series of reports to the medical community he criticised from a scientific perspective the enthusiastic public reception of Salvarsan as a «panacea» in medical and popular

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syphilologists criticised the exaggeration of the number of unknown syphilitics by systematic testing with the Wassermann Test, due to the lack of representativeness of tested patient populations in dispensaries and hospitals that were situated in crowded, urban areas. Similar research in various Brussels health services revealed a more restricted proportion of at most 5% of unknown syphilitics. See BERNARD, R. Contribution à l'étude de la lutte antivénérienne en Belgique. *BSBDS*, 1924, 11-33.

- (21) At the end of the 1920s, this serological test still missed an enormous number of clinically diagnosed syphilitics, but clinicians viewed it as adequate after having used it for decades. See MAZUMDAR, Pauline M. H. «In the silence of the laboratory». The League of Nations standardizes Syphilis Tests. *Social History of Medicine*, 2003, 16 (3), 437-459.
- (22) BAYET, footnote 18.
- (23) BRANDT, footnote 6, p. 40.
- (24) BAYET, Adrien. *L'arsénobenzol (préparation «606» d'Ehrlich-Hata) dans le traitement de la syphilis*, Bruxelles, Severeys, 1910.
- (25) BAYET, Adrien. *L'état actuel de la question de l'arsénobenzol dans le traitement de la syphilis*, Bruxelles, Severeys, 1910.

publications. On the other hand, Dr Duhot vigorously defended in the name of scientific progress the curative force of «606» administered as early as possible through one injection. However, the *Collège des Médecins de Bruxelles*, an important medical union in Brussels, suspended Dr Duhot from membership in the face of serious allegations. The College reproached him for what it felt was his tendentious and vulgarising contribution to popular press coverage of Salvarsan, his dissemination of brochures to pharmacists that transgressed the professional ban on medical publicity, his elevated fee while having received free Salvarsan for experimentation from Ehrlich, and the «immoral» content of his brochures. Hence the «Duhot case» reflected scientific, professional and moral tensions in a context in which public and commercial pressures were high. In retrospect, the optimistic belief in a «one-injection-cure» was premature and even caused harmful effects due to incomplete treatment (26).

The prophylactic usefulness of Salvarsan was quickly established as it resulted in the quick disappearance of the contagious syphilitic lesions (27), but the use of arsenical compounds also entailed some risk and the course of injections was lengthy and unpleasant. In 1912 Ehrlich launched a less toxic but also somewhat less effective «909» or «neosalvarsan», which was less painful, more convenient to prepare and administer, and avoided lethal accidents (28). Various side-effects of arsenical therapies diminished from 1922 when the *Administration de l'Hygiène* established an official and obligatory control of anti-syphilitic drugs that led to quality improvements (29). Bismuth-based preparations, introduced in the 1920s, were more convenient and less dangerous but also had a significant slower effect, and were preferably used in combination with arsenic compounds (30). Despite the consensus regarding the

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(26) JACQUÉ; CRAPS, footnote 12, pp. 233-237.

(27) BAYET, Adrien. *Le traitement de la syphilis par l'arsénobenzol*, Bruxelles, Hayez, 1911.

(28) BRANDT, footnote 6, p. 40-41.

(29) BERNARD, footnote 20, pp. 25-29.

(30) DAUBRESSE, Fernand. Encore le traitement de la syphilis. *Le Scalpel*, 1927, 80 (17), 385-395.

effectiveness of Salvarsan and its arsenical derivations within the medical profession, therapy for syphilis in the 1920s remained subject to considerable debate and conflict over correct dosages, length of treatment, definitions of cure and accompanying medications (31).

Finally, methods of «individual» prophylaxis also existed — namely the use of condoms and self-treatment after coitus through chemical products such as calomel ointment, which received little attention either in Belgian medical networks before World War I or during the war in the Belgian army.

In contrast to the American Army, which installed «prophylactic stations» in every army division for the disinfection of recently infected soldiers — a model followed by other Allied and German forces (32) — and provided «prophylactic packets» for individual disinfection, the Belgian Army did not implement strategies of «individual» prophylaxis. At the *Congrès International de Médecine et de Pharmacie Militaire* in July 1921 in Brussels, Belgian army medical officers accepted the effectiveness of these prophylactic means but also acknowledged that it was a delicate matter to install and distribute them in the Belgian army (33). Moreover, an extension to the civilian population was not under consideration since it produced in Bayet's words a «regular clientele for prostitutes» (34).

In this contemporary scientific-moral confluence, effective medical diagnosis and treatment proved to be a reliable alternative to the heavily controversial issues of the regulation of prostitution and «individual» prophylaxis. Laboratory research had made infectious diseases «visible» and subject to preventive intervention. However, it was not laboratory discoveries in themselves but the framing of contagious diseases as

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(31) BRANDT, footnote 6, p. 130.

(32) BRANDT, footnote 6, pp. 110-115; BALDWIN, Peter. *Contagion and the state in Europe, 1830-1930*, Cambridge, Cambridge University Press, 1999, pp. 461-468.

(33) LUTTE antivénérienne à l'armée. *Congrès internationale de Médecine et de Pharmacie militaire. Palais Mondial - Bruxelles, du 15 au 20 juillet (La)*, Bruxelles, Imprimerie du Ministère de Défense Nationale, 1921.

(34) BAYET, Adrien. *Défense vénérienne en Belgique - Mesures à prendre* (Note du 31 janvier 1919). *BSBDS*, 1920, 71-77.

social dangers by social hygiene organisations such as the Belgian Red Cross, the *Société Royale Belge de Médecine Publique*, and, later on, the leagues against alcoholism, tuberculosis, and VD, that was crucial to the implementation of disease prevention initiatives (35).

«Pour synthétiser en une phrase ce qui, à notre sens, doit être réalisé, nous dirons: Il faut agir avec la syphilis comme on a agi avec la tuberculose, la malaria, la maladie du sommeil, et s'inspirer des succès qu'on a enregistrés dans la lutte contre ces affections pour organiser la résistance à la propagation de la syphilis»,

wrote syphilologist Bayet and bacteriologist Malvoz in *La prophylaxie sociale de la syphilis devant les récents progrès de la syphiligraphie* (footnote 7, p. 3). This blueprint for a new, science-based prevention policy aimed to make «carriers of germs» germ-free by early Salvarsan treatment. Early treatment with Salvarsan that resulted in a quick disappearance of contagious lesions was heralded for its prophylactic rather than its curative force:

«Diminuer de moitié la durée de la période contagieuse de la syphilis, c'est au point de vue de la propagation du mal, comme si l'on diminuait de moitié le nombre des syphilitiques contagieux, c'est diminuer de moitié le nombre des transmissions» (36).

After the publication of Bayet's and Malvoz' manifesto, indications of a new medical approach started to appear. Recently-established university laboratories and provincial bacteriological institutes were ordered by central and local governments to provide serological and microscopic research results to doctors from 1912. The *Administration de l'Hygiène* also sent to all members of the Belgian medical corps an *Instruction sur*

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(35) NEVEN, Muriel; ORIS, Michel. Santé et citoyenneté dans la Belgique contemporaine. *Dynamis*, 1996, 16, 399-426.

(36) BAYET; MALVOZ, footnote 7, pp. 7-8. Especially doctor Bayet as a proclaimed abolitionist seized this new scientific approach to contrast it with the — in his view — outmoded «administrative prophylaxis» that focused on medical inspection, isolation and compulsory treatment of prostitutes.

*la syphilis et la blennorrhagie* to inform them of novel diagnostic and therapeutic advances. The Great War interrupted the development of prevention efforts and at the same time extended the scope of the problem.

## 2. POST-WAR POLICY

The First World War marked an important break with inherited prophylactic assumptions, because VD epidemiology transcended the traditionally separate circuits of the military and the household and the boundaries between urban, industrialised areas and the countryside and between men and women, who were both deprived of marital sex, with the latter becoming economically emancipated by filling the jobs of the men who had been mobilised. Unparalleled prevention and treatment efforts were launched in different armies during World War I (37). A variety of statistics from the American Red Cross and allied national armies revealed considerable numbers of syphilis cases within both the military and civil population (38). The extension of VD within the civilian population was associated with war conditions such as the concentration of young men in army quarters, the passage of contaminated foreign troops and post-war demobilisation of infected soldiers, and decreased morality, a search for material pleasures, misery, unemployment and

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- (37) From 1915, every Belgian army division had an anti-VD health service for ambulatory treatment and, later, VD treatment centres in the hinterland were established for the hospitalisation of patients with generalised syphilis and severe gonorrhoea. See DUJARDIN, Benoit. La lutte antivénéérienne à l'armée. In: *LUTTE antivénéérienne à l'armée. Congrès internationale de Médecine et de Pharmacie militaire. Palais Mondial - Bruxelles, du 15 au 20 juillet (La)*, Bruxelles, Imprimerie du Ministère de Défense Nationale, 1921, pp. 3-15.
- (38) A national registration of syphilis was non-existent in Belgium and remained concealed in national mortality statistics because of its taboo character. See VELLE, Karel. Statistiek en sociale politiek: de medische statistiek en het gezondheidsbeleid in België in de 19de eeuw. *Belgisch tijdschrift voor nieuwste geschiedenis*, 1985, 16 (1-2), 213-242. Doctor Bayet estimated a proportion of 5% syphilitics in Brussels, which, he argued, was lower than in other European capitals. See BAYET, footnote 19, p. 71.

emptiness, social conditions that were especially harmful for adolescents entering puberty (39).

In the context of heightened public concern about VD, syphilologists' claims about the morbidity and mortality of syphilis, as well as their estimates of VD prevalence, gained in authority and compelled the government — a coalition government of Catholics, Liberals and Socialists — to fully support the medical campaign against this «plague that compromised the future of the race» (40). The objective of the «stérilisation» of as many infected people as possible, as put forward in Bayet and Malvoz' blueprint, implied the large-scale generalisation in the medical field of «modern» testing and treatment of the infected through a state subsidy scheme. «Voluntary co-operation» with the Belgian population was the aim, using persuasion rather than the coercion applied in German and Scandinavian countries, where mandatory notification and treatment of syphilis and the «offence» of contamination was established by law. Belgian physicians and officials almost unanimously repudiated such interventions, which were at odds with then-popular suspicions about any kind of state infringement of individual liberty. Doctor Delcroix-Decoster depicted Belgium as situated between two opposite regimes of legislation, the interventionist «mode communautaire» in Germany and the liberal «mode particulariste» in Anglo-Saxon countries, with the latter prevailing in Belgium (41). However, after World War II, Belgium like France would participate in the «health statism» trend in continental Europe (42); and a VD prevention Act on 24 January 1945 established interventionist measures such as mandatory notification, mandatory treatment, contact-tracing and the offence of contamination.

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(39) BAYET, footnote 34, p.73.

(40) ADMINISTRATION DE L'HYGIÈNE. *Rapport sur l'Activité de l'Administration de l'Hygiène. Année 1921*, Liège, Imprimeries nationales des militaires mutilés et invalides de la guerre, 1923, pp. 18-19.

(41) DELCROIX-DE COSTER. *Projet de lutte antivénérienne. Bulletin de la Société Belge de Dermatologie et de Syphiligraphie*, 1920, 48-62.

(42) Baldwin distinguishes three different approaches during the interbellum: regulationism, tempered by its eventual reform, in French and Germany, abolition and a strictly voluntary approach in Britain, and «health statism» in Scandinavia, emulated after 1927 in Germany as well. See BALDWIN, footnote 32, p. 483.

The institutional resources for public health intervention in Belgium were deficient in those days and perhaps more so than in neighbouring European countries, where health legislation restricted local autonomy and individual liberties and gave the central authorities new powers. In 1911, a health law bill was discussed in parliament but not adopted, mainly due to a reluctance among the medical profession to compulsorily report contagious diseases, and the aversion of the Catholic majority in parliament to state-organised medicine (43). In this context, local authorities were inescapable partners for the very modest *Administration de l'Hygiène* in the domain of public health (44). However, local authorities, with the exception of the largest cities, demonstrated political indifference, obstinacy and incompetence or lacked the financial resources to intervene (45). With the exception of some clinics and two anti-syphilitic dispensaries in city centres, health inspectors of the *Administration de l'Hygiène* were given the task of promoting the establishment of free VD services among local authorities and private institutions. In a letter to the *Administration de l'Hygiène* in February 1919, Dr Bayet provisionally agreed to this cautious approach:

«Vous m'avez objecté qu'il existe, même pour les maladies vénériennes, une autonomie communale, qu'il fallait tenir compte des résistances, qu'en tout cas, pour les vaincre, il faudra dépenser beaucoup de temps et que l'essentiel, en ce moment, était d'aller vite et d'utiliser les organisations existantes (...) je tiens, dis-je, à déclarer que seule est viable et efficace une organisation centralisée, unique, dont tous les efforts coordonnés seront dirigés dans le même sens, chose dont le système d'autonomie communale est l'antipode» (46).

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- (43) VELLE, Karel. De centrale gezondheidsadministratie in België voor de oprichting van het eerste ministerie van volksgezondheid (1949-1936). *Belgisch Tijdschrift voor Nieuwste Geschiedenis*, 1990, 21 (1-2), 162-210.
- (44) The law on municipalities of 1836 attributed the competence for intervening in public health matters to the municipalities and secondarily to provincial authorities.
- (45) SCHEPERS, Rita. Een wereld van belangen. Artsen en de ontwikkeling van de openbare gezondheidszorg. In: L. Nys; H. de Smaele; J. Tollebeek; K. Wils (eds.), *De zieke natie. Over de medicalisering van de samenleving 1860-1914*, Groningen, Historische Uitgeverij, 2002, pp. 200-218.
- (46) BAYET, Adrien. Lettre de M. Le Dr. Bayet du 16 février 1919. *BSBDS*, 1920, 77-78.

The Administration seized on Dr Bayet's provisional advice to form a body of competent doctors through practical courses in VD treatment provided by the few Belgian syphilologists, anticipating a more centralised and coordinated approach (47). In the view of Catholic Minister of Interior Renkin, the inclusion of private clinics compensated for the lack of initiative on the part of local authorities and in addition offered a good alternative to specialised VD clinics and dispensaries, since many syphilitics refrained from visiting centres that they felt lacked absolute discretion (48). Hence, in a context of a deficient national public health infrastructure and uncooperative local authorities, the involvement of private medical practice in an effective national campaign against VD was inevitable.

### 2.1. *Professional objections*

Post-war emergency measures consisted of: the free and anonymous treatment of anyone —man or woman, prostitute or not— who did not have the means to pay for expensive treatment; the reorganisation of existing health services; the foundation of a network of new VD clinics; and the dissemination of clinical expertise through in-service training for medical practitioners (49). State subsidised treatment with arsenical compounds met physicians material interests and their desire for scientific authority in society. It made possible the conquest of the field of VD care, traditionally dominated by quacks and misleading advertisements for self-treatment in the popular press, because mercury treatment by the physicians was ineffective, protracted and painful, and patients avoided consulting a doctor for such a «maladie honteuse». Precise diagnostics and new arsenic-based therapies were seized on to frame the prevention of syphilis as a «simple therapeutic question»:

«On le voit: le problème de la lutte contre la syphilis, grâce aux progrès de la médecine, se réduit à une pure question de thérapeutique.

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(47) BAYET, footnote 46, pp. 77-78.

(48) RENKIN. Première dépêche et deuxième dépêche du 4 mars 1920. *BSBDS*, 1920, 81-84.

(49) ADMINISTRATION DE L'HYGIÈNE, footnote 40, pp. 20-21.

Il semble même permis d'espérer voir rayer ce fléau social de la pathologie humaine ou du moins de le restreindre à quelques cas sporadiques, nouveaux foyers réduits à l'impuissance dès leur apparition, si la vigilance médicale ne s'endort pas sur les lauriers» (50).

Therefore, VD policies that financed free medicaments, subsidised new VD clinics, and launched public propaganda campaigns significantly increased professional jurisdiction over syphilis treatment. In addition, physicians unanimously saw the fight against quack medicine as a central component of national VD policy.

Although the free medication regulation clearly matched general professional and material interests, its modalities were subject to intense debate within the medical profession because they involved thorny questions of practitioner competence and medical specialisation, clashed with fundamental principles of professional autonomy and self-regulation, and aroused latent professional fears regarding a state organised medicine. All these issues coalesced in the medical debates on the government's free treatment campaign and compromised its implementation.

The medical profession was internally divided on the question of expertise in syphilis. Professor Troisfontaines of the University of Liege questioned Dr Daubresse's assumption that general practitioners were able to diagnose unwitting sufferers or those with hidden symptoms and to use mercury- and arsenic-based products in appropriate doses over a prolonged period of time (51). «Specialists» often complained about general practitioners' ignorance and ill treatment of syphilitic patients in private medical practice. The question of competence was often debated at the meetings of the *Société de Dermatologie et de Syphiligraphie* in the 1920s. In anticipation of mandatory courses in venereology in university and hospital education (52), the meeting on 24 October 1920

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(50) DAUBRESSE, Fernand. A propos du Péril vénérien. Mesures d'application immédiate et d'une efficacité certaine pour enrayer l'extension de la syphilis. Voeux à transmettre aux pouvoirs publics. *Le Scalpel*, 1919, 72 (21), cccxci-cdx.

(51) TROISFONTAINES. A propos de la lutte contre l'extension de la syphilis. *Le Scalpel*, 1919, 72 (22), cdxix-cdxx.

(52) In 1926 the attendance of clinical courses in venereology in uniform medical education was made mandatory, but other suggestions by syphilologists regarding

argued in favour of a practical formation of doctors in VD clinics and a certification of their competence by an examination board as necessary conditions for obtaining the right to deliver free VD care (53). However, VD policy would change in the opposite direction from mid-1920 when criteria for selecting «competent» doctors were abolished (see below). Meanwhile, the *Administration de l'Hygiène* planned a provisional in-service training course for physicians in advance of more structural educational reforms. Lectures on the diagnosis and treatment of syphilis were organised in cooperation with local medical organisations, but their implementation was in practice very modest (54).

In 1919, the Administration defined criteria for «competent» physicians who could benefit from delivering state-funded free care. The aim was to engage doctors who were familiar with the clinical knowledge of syphilis, interpretation of the Wassermann test and specific techniques such as the collection of blood samples for laboratory testing and administration of Salvarsan by intravenous injection. This distinction between «competent» and «not competent» doctors aroused latent conflicts within the medical field regarding the issue of medical specialisation, an irreversible tendency in medical practice driven by expanding scientific knowledge but lacking any satisfactory professional or legislative regulation in the interwar period. During that time, physicians made themselves more competent by self-study or by practical training in hospitals staffed by renowned doctors, since there were no mandatory clinical courses in venereology at university medical faculties (55). Doctors were granted the power to prescribe state-funded medications if an application was made and positively assessed — based on a report of the health inspec-

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the organisation of a theoretical preparatory course and internship in VD clinics were not adopted. See JACQUÉ; CRAPS, footnote 12, pp. 264-266.

- (53) SEANCE du 24 octobre 1920 commune aux Société Belge de Dermatologie et de Syphiligraphie et Société Belge d'Urologie. *BSBDS*, 1920, 90-91.
- (54) In 1919 20 lectures, in 1920 57 lectures and in 1921 15 lectures were organised but were geographically concentrated in some provinces. See ADMINISTRATION DE L'HYGIÈNE, footnote 40, p. 38.
- (55) SCHEPERS, Rita. Om de eenheid van het medische beroep. Het debat over de specialisatie in België (1900-1940). *Gewina*, 1993, 16, 155-170.

tor — by the provincial medical commission concerned, which was, amongst others, charged with the task of disciplinary control over professional medical practice.

In the view of *Le Scalpel*, the most important professional journal in those days, the government had taken the medical profession by surprise and replaced syphilologists who had failed to anticipate the new situation (56). Since practitioners' competence was assessed by «official» doctors in the Provincial Medical Commissions and the health inspectors of the *Administration de l'Hygiène*, this «imposed» official recognition became a highly debated issue at assemblies of the *Fédération Médicale Belge* and its associated medical unions during 1919 and 1920. The editor-in-chief of *Le Scalpel* supported medical unions' claims that free medication should be available to all medical practitioners, who must assess their own competence following their «conscience médicale» (57):

«Le projet du Gouvernement suppose l'agrégation de quelques médecins. Ce principe est absolument contraire à la conception qui a présidé à la conception dont l'union médicale n'a cessé de s'inspirer dans tous ses actes. Nous avons tous le même diplôme, il nous confère à tous les mêmes droits. A nous à ne pas outrepasser ces droits et à ne pas nous lancer dans un domaine que nous ne connaissons pas bien. Mais ce dernier point ne peut dépendre que de notre seule conscience» (58).

Hence, individual professional ethics were put forward to resolve the question of expertise. This resembled the professional ideology of the *Fédération Médicale Belge*, a federation of local medical unions founded in 1863, which gained increasing influence within the *Administration de l'Hygiène* towards the end of the 19<sup>th</sup> century (59). The *Fédération Médicale*

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(56) REFLEXIONS médico-sociales. *Le Scalpel*, 1920, 73 (44), 961-973.

(57) DEJACE, L. La lutte antivénérienne. *Le Scalpel*, 1920, 73 (3), 56-58.

(58) FRANCOTTE, P.; WAROUX, J. Rapport présenté par la Commission antivénérienne de l'Union Médicale de Liège sur le projet du gouvernement envisageant la lutte contre la syphilis. *Le Scalpel*, 1919, 72 (23), cdxliv-cdlii.

(59) Representativeness of the *Fédération* was delicate since the *Fédération* consisted of a heterogeneous body of local medical unions. However, membership rose over

*Belge* united a heterogeneous majority of physicians in defence of «la médecine libérale», focusing on the material situation and professional autonomy of private practitioners. Transactions between doctors and patients were governed by principles of fee-for-service, unrestricted free choice of a doctor by the patient, direct agreement between patient and practitioner, medical confidentiality, clinical freedom and self-regulation. Nevertheless, the general assembly of the *Fédération Médicale Belge* on 18 December 1919 resolved that the medical profession could not refuse to support the government's anti-VD campaign. Union action was more successful in obtaining various fee payments to recognised doctors for a range of autonomously defined treatments (60). In this context, it was emphasised that the reimbursement of variable fees was fundamentally distinct from the fixed salaries of «civil servants-doctors», an important obstacle for medical unions at that time. Another debate centred on which patients would qualify for free treatment. Medical unions saw the means testing of patients as an autonomous competence of the general practitioner. This was already adopted in the circular letter of April 1919 on the recognition of practitioners in the free care system.

## 2.2. *Collaboration with the «corps médical tout entier»*

On 5 August 1920, Dr Bayet proposed in the *Conseil Supérieur de l'Hygiène Publique* a final report aiming for a more co-ordinated and comprehensive plan to fight venereal disease that reorganised previously existing measures (61). It extended the scope of the Belgian VD policy by including all medical practitioners along with vice squads, hospital

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years from 1767 out of 3676 medical practitioners (ca. 48 per cent) in 1901 to 3119 out of 4200 Belgian practitioners (ca. 75 per cent) in 1914. In 1932, the *Fédération Médicale Belge* counted 4587 members among 5494 physicians (ca. 84 per cent). See SCHEPERS, Rita. The Belgian medical profession, the order of physicians and the sickness funds (1900-1940). *Sociology of Health & Illness*, 1993, 15 (3), 375-392.

(60) ADMINISTRATION DE L'HYGIÈNE, footnote 40, p. 31.

(61) The *Conseil Supérieur de Santé Publique* (1849) was the main advisory council for the government in public health matters but its authority was compromised by medical unions' opposition to radical and innovative public health measures.

and polyclinic doctors and recognised «specialists». It was argued that the general spread of syphilis in society required a similar dispersion of the medical «forces antagonistes», one that included the «médecin isolé», «le médecin du quartier» and «le médecin du campagne» who were confronted with most syphilitic cases in the countryside but lacked instrumentation and technical knowledge. Moreover, the high prices of medicines hampered preventive action by the general practitioners (62). From then on, every medical practitioner who was part of a medical union — as an indication of his professional reliability — was allowed to prescribe specific therapies of «606» and «914» for indigent patients (63). This new regulation clearly reflected professional demands. While Salvarsan and Neo-Salvarsan were not «magic bullets» from a scientific point of view (no definite cure), they were, perhaps, «professional bullets» that targeted quack medicine.

Another spearhead of Bayet's plan was the dispensary, a scientific-organisational device that guaranteed adequate diagnosis (via a laboratory service) and treatment (clinical service), followed up patients' completion of protracted treatment, collected data about patients' social and family situations and delivered health advice. Bayet's plan explicitly focused on the delicate relationship between the general practitioner and the dispensary, since scepticism about these social hygiene organisations was deeply rooted among the majority of individual practitioners. Their clinical and laboratory services were placed at the disposal of general practitioners to support their diagnostic and therapeutic actions when necessary. In order to increase medical practitioners' confidence in the dispensary, medical unions were given places on the dispensary board (64).

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(62) BAYET, Adrien. Prophylaxie de la syphilis. Conseil Supérieur d'Hygiène Publique, séance du 5 août 1920. *Bulletin de l'Administration de l'Hygiène (BAH)*, 1920, 1 (3), 131.

(63) Circular letter, 27/06/1920. *BAH*, 1920, 1 (3), 136-139. The extension of free medications to all physicians was compensated in the budget by the curtailment of the number of subsidised medicaments and the abolition of the remuneration of doctors' fees, which was susceptible to abuse.

(64) See BAYET, footnote 62, pp. 133-134.

Already in 1912, the establishment of the first anti-syphilis dispensary in Liege set the tone for professional objections. In a letter to all doctors of the province of Liege, the *Société Médico-Rurale de Liège* protested against this new competitor that provided free treatment. The objection in the first place was a matter of principle given patients' moral characteristics:

«Enfin, les syphilitiques d'une façon générale ne sont pas les patients les plus intéressants, car la plupart du temps ils ne payent que les conséquences de leurs vices» (65).

At that time, the dispensary filled a gap in medical care, since a special clause in the regulations of sickness funds, factory medical services and public assistance bureaux due to «debauchery» excluded syphilitic patients from the benefit of paid medical care (66). The «official» character of the dispensary, which was funded by provincial and local council authorities, also aroused the spectre of the so-called «socialisation de la médecine», the development of a state organised health care system in which physicians became «civil servants» with a fixed salary. Hence, anti-VD dispensaries were at odds with the model of the private relationship between doctor and patient (and his family) promoted by medical unions. Furthermore, their usefulness and effectiveness was questioned. It was argued that dispensaries typically reached the working classes in industrialised, urban areas rather than the country population; their popular label frightened many syphilis sufferers, and they were «usines à piqures», dispensers of impersonal care. Moreover, preventive medicine was claimed to be a competence of general practitioners, who knew their patients' situations well and were better able to put effective moral pressure on their clients (67). Significantly, Dr Rulot, architect of the

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(65) SOCIÉTÉ MÉDICO-RURALE, U. P. R. DE L'ARRONDISSEMENT DE LIÈGE. A Messieurs les Médecins de la Province de Liège. *Gazette Médicale Belge*, 1912, 25 (43), 422.

(66) DEJACE, L. La prophylaxie sociale de la syphilis à Liège. *Le Scalpel*, 1912, 65 (4), 61-62.

(67) LUTTE sociale contre les maladies vénériennes (La). *Le Scalpel*, 1920, 73 (44), 957-961. However, many people probably stayed away from their «family doctor»

governmental anti-syphilis campaign at the *Administration de l'Hygiène*, also downplayed the contribution of VD dispensaries in medical prophylaxis, which could not compete with the geographical dispersion and adaptability of the one-man clinic and its guaranteed absolute discretion (68).

Against a background of significant government budget cuts and impressively decreased VD incidence statistics, treatment with free drugs from October 1926 became restricted to dispensaries and hospital services. The exclusion of general practitioners and of VD clinics that depended on public assistance committees resulted in a reduction of VD treatment facilities to a fifth of the original number (from 400 to 80) (69). In 1928, doctor Bayet reported the results of an inquiry conducted by the *Ligue Nationale Belge contre le Péril Vénérien* that revealed a stabilisation of infection rates and localised increases. Bayet argued for the re-establishment of previous prevention efforts in order to avoid a general rise in the incidence of syphilis as was the case in France. The *Société de Dermatologie et Syphiligraphie*, however, put the observed rise into perspective (70). Nevertheless, the *Société* warned that drastically reduced prevention efforts were just as harmful and recommended an increase in the number of VD dispensaries and hospital services, as well as free treatment by physicians after assessment of their competence. The latter was once again a controversial issue among syphilologists, of which many criticised general practitioners' incompetence in this matter. The free medication regulation was temporarily re-established between 1929 and 1931 (71).

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in their own community. It is striking that the regulation for recognising VD centres stipulated that all patients, regardless of their domicile, had to be accepted in order to avoid the exclusion of patients by communal services.

- (68) RULOT. Bilan de la lutte antivénérienne par le service d'hygiène du gouvernement en 1919-1920. *BSBDS*, 1921, 120-124.
- (69) BAYET, Adrien. *L'Endémie syphilitique en Belgique. Communication faite à l'Académie Royale de Médecine, le juillet 1928*, Bruxelles, Ligue Nationale Belge contre le Péril Vénérien, 1928.
- (70) DEKEYSER, Léon. Le syphilis, est-elle en recrudescence. Convient il de délivrer à nouveau au corps médical tout entier les médicaments syphilitiques? *BSBDS*, 1928, 94-104.
- (71) Circular letter, 03/07/1931. *BAH*, 1931, 11 (3), 106.

### 3. «L'EXPÉRIENCE BELGE?»

What were the results of the free medications campaign during the period 1919-1926? Statistics on syphilis prevalence were drawn up for the first time in 1919, when recognised health services and doctors were obliged to report their patient numbers. These official statistics revealed an immense decrease from 6143 recent syphilitic cases in 1920 (191,942 consultations) to 4311 cases (301,507 consultations) in 1922, 1149 cases in 1924 (263,543 consultations) and 682 cases (167,404 consultations) in 1926 (72). However, they applied only to patients who had qualified for free treatment, omitting prosperous patients who paid for their treatment. Moreover, the accuracy of these statistics can be questioned since the provision of statistics by recognised doctors encountered delay and included less meticulous figures from other doctors after 1921 (73). In general, difficulties with the provision of statistics by physicians to official agencies must be seen in the context of several decades of professional protest against the obligatory notification of contagious diseases.

On the other hand, the decrease in VD prevalence reflected the therapeutic effectiveness of arsenic-based treatments, since the differences between the impressively reduced syphilis rates and the rather more stable gonorrhoea rates were striking (74). Peak rates for 1921 and 1922 were also boosted by the establishment of an unparalleled supply of treatment provided by 23 dispensaries, 40 polyclinics, 41 hospital clinics and about 300 physicians. For Belgium, depicted as a «laboratoire sociale» (75) within Europe, with its small territory, social homogeneity and concentrated population, this supply of VD facilities seemed comprehensive in comparison to the 395 VD clinics in France, the approximately 200 VD treatment centres funded by national and local Britain authorities and the 56 dispensaries in

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(72) DEKEYSER, Léon. Le bilan de la syphilis. *BSBDS*, 1928, 56-91.

(73) RULOT, footnote 68.

(74) DEKEYSER, footnote 70, p. 97.

(75) BAYET, footnote 3, pp. 4-5.

Spain in 1928 (76). Moreover, intensive VD mass propaganda, media coverage and government instructions heightened VD awareness among both the medical profession and the public at large, raising the medical supply and demand for syphilis treatment. Mass propaganda weakened the formerly strong moral label of syphilis as a «maladie honteuse» and informed and encouraged unaware and hidden syphilis sufferers, although it also frightened healthy civilians, and created «des faux vénériens» who suffered from «syphilophobie» (77).

Doctor Bayet argued that the inclusion of the entire medical profession was crucial in explaining the Belgian success, in contrast to French VD policy that had restricted the provision of free treatment to «isolated» hospital services, dispensaries and VD treatment centres (78). However, in the 1919-1926 period, about 350 doctors out of more than 4000 medical practitioners — less than one in ten — prescribed free medication (79). It was observed within the *Société de Dermatologie et Syphiligraphie* with «great satisfaction» that the public at large only consulted a small group of assumed «specialists» (80). In a historical review in 1931, the syphilologist authors described the collaboration with the «corps médical tout entier» as minor when compared with practitioners'

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(76) BALDWIN, footnote 32, pp. 472-473; HALL, Lesley A. Venereal diseases and society in Britain, from the Contagious Diseases Acts to the National Health Service. In: Roger Davidson; Lesley A. Hall (eds.), *Sex, sin and suffering. Venereal disease and European society since 1870*, London - New York, Routledge, 2001, pp. 120-136 (p. 128); EVANS, David. Tackling the «Hideous Scourge»: the creation of the Venereal Disease Treatment Centres in Early Twentieth-Century Britain. *Social History of Medicine*, 1992, 5 (3), 413-433; CASTEJÓN-BOLEA, Ramón. Doctors, social medicine and VD in late-nineteenth-century and early-twentieth-century Spain. In: Roger Davidson; Lesley A. Hall (eds.), *Sex, sin and suffering. Venereal disease and European society since 1870*, London - New York, Routledge, 2001, pp. 61-75.

(77) BERNARD, footnote 20.

(78) BAYET, footnote 3, pp. 21-22.

(79) DEKEYSER, footnote 72, p. 66.

(80) POIRIER; HALKIN; GLIBERT; RULOT; BERNARD. Directives pour la lutte antivénérienne en 1925. Médications - recherches sérologiques - subsides. *BSBDS*, 1925, 17-24.

fight against VD in the colony of the Congo (81). In 1926, 128 doctors declared themselves as having specialised syphilology-dermatology knowledge (82). Besides physicians' lack of new skills for diagnosing and treating syphilis, it would be surprising, as also David Evans argued, if doctors suddenly ignored the moral connotations associated with these «maladies honteuses» (83). In addition, official dispensaries and specialised hospital services were established by non-catholic local authorities. Under the regime of «liberté subsidiée», Belgian health care and other aspects of everyday life in the 20<sup>th</sup> century became increasingly compartmentalised along ideological lines into catholic, socialist and (limited) liberal factions (84), who all launched after World War I similar campaigns of moral reform. In particular, the catholic faction — under the direction of the Catholic Church — aimed at a «re-Christianisation» of a secularising Belgian society, which probably restricted participation in the anti-VD campaign by catholic doctors and institutions (85). For example, the Catholic right in Spain strongly influenced national policy that restricted prophylactic intervention to the military, brothels and dispensaries (86). In Belgium, new legislation adopted in parliament in 1923 on the initiative of Catholic politicians, which banned publicity about contraceptives to curtail growing «neo-Malthusianism», seems exemplary. Socialist politicians were divided on this issue and some of them protested in vain against the bill, with the health argument that «specific» contraceptives also protected against VD (87).

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(81) JACQUÉ; CRAPS, footnote 12, p. 248.

(82) FÉDÉRATION MÉDICALE BELGE. *Annuaire Médicale Belge et du Grand-Duché de Luxembourg*, Liège, La Meuse, 1926.

(83) EVANS, footnote 76.

(84) DE MAEYER, Jan; DHAENE, Lieve. Sociale emancipatie en democratisering: de gezondheidszorg verzuild. In: J. de Maeyer; L. Dhaene; G. Hertecant; K. VELLE (eds.), *Er is leven voor de dood. Tweehonderd jaar gezondheidszorg in Vlaanderen*, Kapellen, Uitgeverij Pelckmans, 1998, pp. 151-166.

(85) This is however difficult to track since physicians barely organised themselves on the basis of respectively catholic, liberal and socialist ideology.

(86) CASTEJÓN-BOLEA, footnote 76, p. 71.

(87) CELIS, Karen. Socialisme en seksuele fraude. De houding van de Belgische socialisten tegenover abortus en anticonceptie (1880-1990). In: D. de Weerd

#### 4. CONCLUSION

Belgian post-war VD policy consisted of free, anonymous, and voluntary treatment for the Belgian public at large, which the pre-war scientific innovations of the Wassermann Test and arsenic-based drugs had made possible. It overshadowed previous traditional measures for the medical control of prostitutes, although the regulation of prostitutes would — as in France — only be abolished by law after World War II. Contrary to German interventionist VD policy (88), medical treatment was provided on a voluntary basis as in France and Great Britain, although the Belgian approach distinctively focused on private medical practice, and especially the group of individual practitioners, through the delivery of free medication (and remuneration of fees during 1919 and 1920). This contrasted with the French system of VD centres and the British state-funded treatment services in larger cities. The Belgian approach must be seen within the political-ideological context of «liberté subsidiée» — the dominant model for government intervention mainly defended by the catholic political majority —, the general lack of public health infrastructure and the widespread inertia of local authorities. Hence, the quick spread of «modern» techniques for the diagnosis and treatment of syphilis over a geographically small country was made possible by the involvement of private medical practice and undoubtedly had considerable effects, although the accuracy of the epidemiological statistics can be questioned.

Nevertheless, the initial free medications regulation in 1919-1920 aroused latent conflicts within the medical field about doctors' competence and medical specialisation, and its «interventionist» aspects were seen to be at odds with the liberal professional principles and material interests of the majority of private practitioners. Furthermore, professional

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(ed.), *Begeerte heeft ons aangeraakt: socialisten, sekse en seksualiteit*, Gent, Provinciebestuur van Oost-Vlaanderen, 1999, pp. 179-205.

(88) SAUERTEIG, Lutz D. H. «The fatherland is in Danger, Save the Fatherland!»: venereal disease, sexuality and gender in Imperial and Weimar Germany. In: Roger Davidson; Lesley A. Hall (eds.), *Sex, sin and suffering. Venereal disease and European society since 1870*, London - New York, Routledge, 2001, pp. 76-92.

reactions to the establishment of anti-VD dispensaries disrupted the initial social hygienist plans drawn up by Dr Bayet and Dr Malvoz, who argued in favour of specialised VD dispensaries. What Dr Bayet afterwards triumphantly depicted as the «Belgian experience» was not the result of a comprehensive, long-term, social hygienist program but seems the result of pragmatic and opportunistic decision-making that necessarily met professional interests within a context of «liberté subsidiée» and, of course, depended upon budgetary concerns. Finally, the extension of medical jurisdiction to the previously uncontrolled domain of VD treatment through new scientific techniques does not appear to have been mainly a result of professional efforts to establish a professional monopoly, except for amongst syphilologists. It was the *Administration de l'Hygiène* rather than the medical profession that was the driving force in this process, through the establishment of a lucrative (although temporary) subsidy scheme, in which only approximately one in ten practitioners actually participated.