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CHAPTER 6

The Contagious Diseases Acts and the lock hospital

*Unhappily I was no stranger to the
scandalous, pestiferous and miserable
operation of these Acts.¹*

The second part of this book will consider how those with money and power in Colchester tried to deal with the problems that prostitution presented. The story revealed by our sources is complex and contested because those who might have made a contribution to suppressing the vice trade operated from competing perspectives and motives and were inclined to attempt to disguise any unacknowledged support of immorality. Legally there was room for a great deal of discretion and as a result the problem itself was not clearly identified. It was the anti-social and health implications of prostitution that were targeted, rather than the activity itself. Dealing with anti-social behaviour and venereal disease involved public expenditure and neighbourhood issues, and from time to time the newspaper reported small eruptions of disquiet and disgust that more was not done to acknowledge and deal with the problems. Most people did not go to such lengths to express their disapproval, but others were galvanised to try to avert the tide of immorality in more constructive ways, albeit small in scale.

Both syphilis and gonorrhoea were included in the term venereal disease, having been distinguished in 1838 by a French physician, Philippe Ricord. The power of syphilis to cause epidemics in populations not previously affected is well known. In the eighteenth century, for instance, several towns in Norway suffered in this way.² By the mid-nineteenth century the prevalence of syphilis outbreaks among the general population had weakened, although the army, responsible for a good deal of its incidence (until penicillin was discovered to be a cure in the 1940s), continued to attempt to combat its ability to cause

epidemics in barracks.³ While the more unlucky patients passed directly from primary to secondary forms of the disease, suffering and dying from the symptoms of acute syphilis in a short period of time, most individuals survived the primary symptoms and lived for years before the disease reappeared in its final form. But unless the individual's immune system was very robust, both syphilis and gonorrhoea caused chronic symptoms, could infect sexual partners and wore away the vital organs, eventually causing death.

The bacterium causing syphilis was identified in 1905 and the Wassermann test to identify its presence in the body was developed in 1906. When Colney Hatch Asylum in Middlesex first used the test in 1912 it was discovered that 10 per cent of its male patients were suffering from the symptoms of brain degeneration caused by tertiary syphilis.⁴ Salvarsan, the first antibacterial (arsenic-based) drug used against syphilis, was marketed from 1909. The nineteenth-century medical profession understood the infectious and fluctuating nature of syphilis and employed a variety of treatments, such as calomel (mercurous chloride). Unfortunately this remedy had toxic side effects, including disabling dental and neurological symptoms. Some doctors experimented with new ideas such as inoculation and mercury administered through steam; others discussed ways of dealing with the side effects of mercury poisoning. Most practitioners put their trust in mercury applied orally or directly to a lesion, its poisonous effects reduced with sarsaparilla and chlorate of potash.⁵

As we saw in Chapter 1, a Royal Commission report of 1857 gave Colchester's garrison a poor record for venereal disease, and by 1862 almost half its servicemen had been affected. The 1857 report caused consternation in Colchester. The camp's military hospital treated venereal soldiers, but venereal women were the town's responsibility. At this date infectious patients were normally treated at home, the medical practitioner doing what he could to reduce cross infection in the family and neighbourhood. Only in cases of smallpox or cholera did the town authorities attempt to set up special isolation arrangements. It is unlikely that Colchester would have made any special arrangements for venereal women without pressure being exerted by the garrison. Using Treasury funding, Colchester's Board of Guardians set up a temporary foul ward (syphilis was known colloquially as the 'foul disease') in 1860 in a building at the back of its Union workhouse site. The Board's meeting minutes reveal that a letter written by the garrison's commanding officer offered financial assistance for the provision of an 'outhouse with a separate entrance' at the workhouse where the Union medical officer could treat venereal women.⁶ Although this outhouse arrangement makes it sound as though the prostitutes were to be treated as moral outcasts too polluting to use the main entrance or infirmary ward at the workhouse, it is more likely that the

Guardians were anxious to placate the rate payers (who might have objected to money being spent in this way) and to emphasise the women's non-pauper status by providing them with a separate entrance into the workhouse.⁷ The poor law was intended to support only the destitute and a working prostitute was not considered to be in this category.

Meanwhile, parliament was under pressure from the army to legislate to control prostitution. The first Contagious Diseases Act (CDA) was passed in 1864 in an attempt to reduce syphilis among soldiers and sailors. The act was passed at 2am with virtually no parliamentary or public debate by a secret armed forces committee using friendly witnesses.⁸ Two further CDAs in 1866 and 1869 extended its scope. The CDAs empowered police to arrest prostitutes in selected ports or army towns such as Colchester and to compel them to undergo medical examinations at fortnightly intervals. If the lock hospital medical officer saw symptoms of venereal disease the woman was placed in a lock hospital until the symptoms disappeared, which might take several months. The police drew up lists of women they observed to be prostitutes and sometimes they overstepped the mark. *Reynold's Newspaper* reported an incident in Colchester in which a respectable domestic servant was observed talking to a friend who was on the list drawn up by the lock hospital police. Despite her claim that she was a respectable woman, she was swiftly compelled into the CDA system and had great difficulty extricating herself.⁹ Most respectable women caught up in such circumstances refused to be medically examined and relied on a relative or employer to provide the necessary testimonial.¹⁰

The aim of the act was to protect men from infected women; it made no reference to protecting women from infected men. The rationale for imprisoning only women with the disease was based on cultural double standards and the current state of medical understanding about pathology and the female body, which included the idea, supported by *The Lancet*, that the prostitute was the conduit of venereal infection. As Finnegan explains, the myth of the natural sinfulness of women was a function of 'the middle-class Victorian male's ignorance, fear, prejudice and guilt'.¹¹ The army had its own ways of humiliating and punishing soldiers who were found to have venereal disease, including loss of pay and leave for soldiers hospitalised with venereal disease. Medical officers also organised what were colloquially known as 'dangle parades', in which soldiers drawn up in lines exposed their genitals for medical inspection. Next of kin were also sometimes informed if a soldier was diagnosed with venereal disease. Such punishments had the effect of reducing the incidence of cases reported and they were discontinued after 1910.¹² Army medical statistics show that venereal disease was a major cause of soldiers' hospitalisation at this time. Reducing this drain on manpower was the sole purpose of the CDAs.