

Introduction

1918

*Woodrow Wilson, Crisis,
and the Arc of Public Health*

On July 1, 1918, during a summer that saw the United States Armed Services sending more troops to strengthen the western front in Europe, President Woodrow Wilson released a short but consequential executive order concerning the US Public Health Service. While most eyes were focusing on the war effort, Wilson was looking to streamline and professionalize the nation's domestic affairs. On the recommendation of his surgeon general of public health, Dr. Rupert Blue, Wilson ordered that "all sanitary or public health activities carried on by an executive bureau, agency, or office, especially created for or concerned in the prosecution of the existing war, shall be exercised under the supervision and control of the Secretary of the Treasury."¹ The development of a public health service began 120 years earlier when President John Adams established a Marine Hospital Service to raise funds to care for sick seamen and to build hospitals in river and port cities by taxing sailors' wages 20 cents per month. The role of the service within the Treasury Department broadened in 1870 in an effort to improve sanitation and curb infectious disease by means of quarantine and disinfection. It was retitled the Public Health and Marine Hospital Service in 1902, and its name was shortened to the Public Health Service ten years later. Wilson's executive order of July 1918 went further than ever before to ensure the service had a central role in the life of the nation and would work collaboratively with state and local health departments, as Congress had approved it should in 1902 when it also passed the Biologics Control Act to regulate vaccines and antitoxins.²

However, all was not well in summer 1918, even though US and French troops were counterattacking the Germans in the European war zone. At home, members of the American Public Health Association (now approaching its fiftieth year) viewed the improvement of public health in idealistic terms, not just for “the strenuous times” of war “in which we are now living” but also for building “robust citizens of tomorrow.”³ Secretary of the Treasury William Gibbs McAdoo (Wilson’s son-in-law) was not so idealistic. McAdoo wrote to President Wilson a few weeks before the article appeared in the *American Journal of Public Health* to warn him that “the situation regarding public health work in this country is serious and is steadily becoming worse . . . due to an acute shortage of sanitary and medical personnel and an impending disintegration of the Federal, State and local health organizations.”⁴ High on the list of problems was poor inner-city sanitation, a critical issue that led Theodore Roosevelt to sign the Pure Food and Drug Act and the Federal Meat Inspection Act in 1906, the same year that Upton Sinclair (an advocate of “new hygiene”) graphically portrayed the unsanitary conditions and poor health of Chicago meatpackers in his muckraking novel *The Jungle*.⁵ Opinions were divided on who was accountable for public health: Wilson believed that local authorities should take primary responsibility for sanitation and hospital conditions, whereas some medical leaders thought this was the moment to launch a national health department.⁶

Wilson’s first year in the White House appeared to be quiet on the medical front, yet a number of health-related issues were escalating behind the scenes. For example, in December 1914 Congress passed the Harrison Narcotics Tax Act to prevent the distribution of opium and curb cocaine addiction by limiting the opium content of domestic products. The Harrison Act was not what the American Medical Association (AMA) had hoped for in its mission to eradicate quackery and improve health care and medical education, including AMA’s endorsement of the landmark Flexner Report, *Medical Education in the United States and Canada*, which pressed for a modernization of facilities.⁷ Rupert Blue and AMA leaders worried there was a degree of “uncertainty and indefiniteness as to just what the [Harrison] law really means and how its provisions will be applied,” especially as the law enforcement and public health aspects of the legislation seemed to be in tension with each other.⁸ This period of uncertainty with respect to the new law lingered for four years, until a 1919 amendment prevented physicians from prescribing narcotics to addicts, followed by

the Anti-Heroin Act five years later that outlawed the chemical synthesis of narcotics.

Perhaps the most urgent of the health challenges was the spread of venereal disease in the armed forces. The response to this challenge was the Chamberlain-Kahn Act of July 1918, the formation of a new Division of Venereal Diseases in the Public Health Service to oversee extra-cantonment zones for the treatment of venereal disease, and federal grants for the forty-eight states, including a fifth of \$4 million of new appropriations directed toward improving sex education.⁹ The health education campaign included a 1918 War Department film *Fit to Fight* (which blended “clear statement, impressive emotional appeal, inspiration, action, moral incentive, and . . . genuine entertainment”), “Keeping Fit” exhibits targeted at teenage boys (these 1919–22 Public Health Service and the American Social Hygiene Association exhibits were seen by over two million Americans), a surgeon general’s warning of December 1918 that the “scourge” was likely to spread if demobilized soldiers did not show restraint (“the time from now on is the most critical of all”), and interventionist measures aimed at women who could be examined involuntarily if suspected of carrying a sexually transmitted disease.¹⁰ These campaigns were fueled by fear and anxiety, leading Montana lawmakers to respond to the Chamberlain-Kahn Act by stating that “syphilis, gonorrhoea and chancroid” are “contagious, infectious, communicable and dangerous to the public health” and by making it “unlawful for anyone infected with these diseases . . . to expose another person to infection.”¹¹

Such responses suggested that crisis, or at least the fear of crisis, was the key stimulus for the Wilson administration to invest in health programs. In this respect, Wilson’s July 1, 1918, executive order reprised President Grover Cleveland’s annual message of 1894 delivered in response to a series of hookworm crises in the South. In this speech, Cleveland proclaimed that “the inauguration of a national board of health,” in collaboration with local health boards, was a necessity as a “precaution against contagious disease and in the interest of the safety and health of our people” and a source of “constant and authentic information concerning the health of foreign countries and all parts of our own country.”¹² In 1879, Rutherford Hayes introduced a temporary National Board of Health to help track disease following a yellow fever outbreak in Mississippi, but this experiment lasted for only four years due to disagreements about whether the governance of health should sit at the federal or state level.¹³

Cleveland's picture of a disjointed system was at odds with the growing optimism that modern medicine could eradicate disease. Coordinated planning was necessary, such as the Treasury Department's effort to give manufacturers involved in the war effort free smallpox and typhoid fever vaccinations for their workers.¹⁴ However, each time a reform group argued for a federal public health department (such as a 1912 campaign by the Committee of One Hundred on National Health), their proposals failed to gain traction in Congress, even though President William Taft had championed a Bureau of Health in 1910 for "the preservation of public health."¹⁵ In fact, despite periodic calls by the White House and reform groups for an "omnibus health agency" that could work in tandem with the Public Health Service, it was not until 1953 that the Department of Health, Education, and Welfare was formed in an effort to "give the human problems of our people the highest priority."¹⁶ This cabinet-level initiative followed earlier attempts at government reform: during the Hoover administration to more tightly coordinate federal public health activities; in the mid-1930s to interlink health and welfare in the hope that this would lead to what President Franklin Roosevelt called "complete coordination of the Government's activities in the health field"; and a proposal in the aftermath World War II to form a department of health, education, and security.¹⁷

It is difficult to argue that Franklin Roosevelt's vision of "complete coordination" has ever been realized, despite the aims of the organizers of a July 1938 National Health Conference to put momentum behind Roosevelt's goal of a "national program of action" and to enhance health promotional campaigns, such as the National Negro Health Week that had been an annual event since April 1915.¹⁸ A year after the conference, Bertram M. Bernheim, a professor of surgery at Johns Hopkins University, claimed that despite advances in laboratory science "modern medicine has outgrown the structure erected to house it." To fix this, Bernheim argued that "a national public health policy" was required that could be "directed toward all groups of the population" by means of a "functional consolidation of all federal health and medical activities, preferably under a separate department."¹⁹

The lack of long-term federal strategy that Bernheim bemoaned is a major reason why health reform has tended to be piecemeal in the century since 1918. The Chamberlain-Kahn Act, for example, laid the groundwork for research into venereal disease at the Hygienic Laboratory in Washington, DC, a precursor to the more expansive National Institutes of Health that was formed in 1930. Yet health was not the

primary focus of the legislation. Instead, it sought to police prostitution in an effort to ensure that contagion did not spread through the US Army, reinforcing President Wilson's proclamation that soldiers should be "good men" who are "fit and straight in everything and pure and clean through and through."²⁰ And, at a time when the American Association for Labor Legislation was pitching for a better insurance deal for sick workers, Wilson simply instructed Rupert Blue to inspect sanitary conditions to gauge how the nation was "safeguarding the health of workers" compared to Europe.²¹

Unsurprisingly, the Wilson administration had its eye on social hygiene in light of antisputting laws in the 1890s to prevent the spread of tuberculosis, on quarantine practices on the Texas-Mexico border to contain smallpox, and on better public education to ensure that citizens were responsible in their health habits.²² In 1909, the Army Medical Department claimed sanitation to be "a new science" that would vanquish germs if practiced rigorously. This germ theory circulated widely until advocates of "new public health" such as Canadian bacteriologist Hibbert Winslow Hill started to argue in the early 1910s that medical science should pay as much attention to healthy carriers as it did to germs and dirt.²³ However, not all health issues were out in the open, so much so that in 1918 the editor of the *Municipal Journal* pressed Surgeon General Blue to communicate more effectively to the American people the aims of the Public Health Service.²⁴ It was odd, for example, that there was no national reporting of influenza in spring 1918, following detection of the virus in rural Kansas. A local doctor notified the Public Health Service of the February outbreak, but not until the virus had spread to thirty cities in late spring did it arouse attention—and then not seriously until a second wave in August and September hit the Northeast, carried by soldiers returning to Boston after serving in Europe.²⁵ Chapter 4 focuses on the influenza pandemic of 1918–19, but the crucial point is that the juxtaposition of careful planning based on principles of hygiene, medical scientists eager to speak to the public, and a seeming federal disregard toward early cases of influenza, is emblematic of what this book calls "panic and planning" health cycles.

As an uncontrollable fear leading to a kneejerk reaction, panic is not the legitimate province of responsible governance. This is especially the case in the twentieth century when "so much government infrastructure and information stand between populations and unfettered panic," as a 2013 *New York Times* opinion piece, "A Brief History of Panic," describes it, by looking back to panic reactions to waves of yellow fever

in the late nineteenth century. Thus, a dual focus on panic and planning can help us to evaluate the effectiveness of health policies as well as to understand better the evolving relationship between federal politics, medicine, and the media over the hundred years of this study.²⁶ This triangular relationship is often fraught though, given that acute emotional responses are as often fueled by the misplaced words of public figures or incendiary news headlines as they are by legitimate safety warnings or carefully researched health journalism.

Crises can lead to swift action by shortcutting bureaucratic inertia and providing an opportunity to think how to improve coordinated responses in the future. Yet they can also reveal base fears about loss, invasion or disgust that can erupt in different kinds of panic response: a heightened level of general anxiety, a loss of control due to an acute stress reaction, or the kind of panic buying and hoarding that epidemic outbreaks can often trigger.²⁷ Rather than leading to rational yet responsive measures, crises can provoke what Stanley Cohen has called a “much deeper and more prevalent condition” that stems from fantasies and fears or what “A Brief History of Panic” describes as a “a swirl of confusion and frustration.”²⁸ To untangle these discourses, and set against New York governor Andrew Cuomo’s view that “the fear, the panic” is often a “bigger problem” than the actual emergency, it is crucial to interlink historical, psychological, sociological, and cultural aspects of health crises to see how public fears have reemerged—as this book shows—often in repeat mode.²⁹

1918 AND NEW PUBLIC HEALTH

With the war raging in Europe, 1918 was an important year for American health for two further reasons. The first was the modernization of the hospital system. The director of the American College of Surgeons between 1913 and 1924, John G. Bowman, was keen to ensure hospitals would never be breeding grounds for cross infections, but in 1919 Bowman also made a grand moral statement about patients receiving honest care as a right rather than as a privilege.³⁰ This view aligns with the federal government’s move to recruit additional doctors and nurses to the armed forces, to make preventive medicine more effective, and to ensure that hospital ships were better equipped so that the “wounded or sick, the officer, bluejacket or marine will be tenderly and efficiently looked after,” as the president’s physician, Cary T. Grayson, described in a 1916 speech on advances in the US Navy’s Medical Corps.³¹ John

Burnham argues in his 2015 study *Health Care in America* that this drive to modernization was both technological and organizational, leading to more systematic medical records, new research and treatment facilities, and better training opportunities.³² Though this did not prevent variability of conditions and standards among hospitals, 1918 saw the opening of the Johns Hopkins School of Hygiene and Public Health in Baltimore, which developed immunology and virology programs and provided research training for physicians and administrators.³³

The second progressive move was to offer better care and health education for children as part of a “Modern Health Crusade” that the National Tuberculosis Association helped kick-start in the first decade of the century.³⁴ Its volunteers worked alongside women’s reformist groups (such as the National Congress of Mothers and the General Federation of Women’s Clubs) and the American Red Cross (of which Wilson was the first honorary president from 1913) at a time when the nation was looking to conserve its natural resources, which included infants and children.³⁵ A landmark 1909 White House Conference on the Care of Dependent Children set the groundwork for the formation of the US Children’s Bureau in 1912, a federal agency focused on improving infant mortality rates, teaching “hygiene in elementary schools,” ensuring parents took “community responsibility” seriously, and enforcing the child labor regulations that Wilson signed into law in 1916.³⁶ Children’s health was so important that the Children’s Bureau designated 1918 Children’s Year to raise awareness of high infant mortality, to increase birth registration, and to expand state medical services.³⁷ Herbert Hoover, Wilson’s director of the US Food Administration, championed children’s health in war-torn European countries via his new role as head of the American Relief Administration. But Hoover was not a fan of the Children’s Bureau, nor the direct use of federal funds for aid, as mandated by the Promotion of the Welfare and Hygiene of Maternity and Infancy Act of 1921 (this scheme lapsed in 1929 after sustained criticism on behalf of the AMA).³⁸

It is clear that in 1918 health politics often had a moral cast. For example, when Woodrow Wilson addressed the AMA in June 1912, the year of his first presidential campaign, he pictured physicians as the “guardians of communities not only with regard to those general sanitary problems which are summed up under the head of sanitation and general hygiene...but of a great many moral problems also.”³⁹ This view of physicians as guardians contrasts with the moralistic emphasis of social hygienists on cleaning up vice and with laboratory medical

science that typically requires more resources and patience than can be afforded in the face of crises. Wilson recognized these deep tensions at the close of his speech: “the whole problem of modern society is infinitely complicated, just because it is variously specialized, and it should be our object to avoid the separation of interests...so that heat, hostility, and friction may be taken out and all the sweet and wholesome processes of life may be restored.”⁴⁰ This description might seem fanciful at a time when an arms race was mounting in Europe and with discourses of eugenics and population control circulating at home.⁴¹ Wilson’s emphasis on public health and his belief that it is “our duty to see that endeavor is not swallowed up by the government” echoed the optimism in medical advances and techniques of containment practiced under previous administrations (such as the control of yellow fever when it reemerged in Louisiana in 1897 and 1905), now bolstered by the AMA’s advocacy work, the annual publication of vital statistics, the development of local health units, routine school inspections, and the work of public health nurses who were thought to carry “the lamp of knowledge into the front line trenches.”⁴² Some health officials were concerned that inevitably “public health would become enmeshed in politics,” but most thought that efficiency and scientific reason would triumph over narrow interests.⁴³ Such optimism took its impetus from Progressive-era speeches such as one given in 1906 by New York health commissioner Eugene H. Porter, in which he convinced a meeting of insurers that “we are living in the midst of a great remaking of medical history” that would see a new dawn for the nation.⁴⁴

President Wilson did not move as quickly as the AMA and others would have liked. Following a meeting in Atlanta in November 1916, the president of the Southern Medical Association, Robert Wilson Jr., wrote to the US president to say that “a department of public health with a cabinet head is one of the most pressing needs” confronting him in his second term. He also recommended the development of a “preparedness policy” to address the fact that 600,000 Americans were dying annually from “unnecessary diseases” (malaria, polio, tuberculosis, typhoid fever) and five million a year were sick. Robert Wilson’s letter credited the federal government for passing “constructive legislation,” but Wilson also tacitly criticized the administration for its lack of a coordinated health policy when it came to “sanitary preparedness.”⁴⁵ There was no evidence that the Southern Medical Association received a reply from the US president to its conference invitation, let alone its recommendations, which is surprising given that New York City had

faced another outbreak of polio just a few months earlier. In fact, it was not for two more years that high-level coordination began to emerge, following the July 1918 executive order when William McAdoo beseeched Woodrow Wilson to increase spending and to better integrate national health services in his claim that “adequate protection of the health of the civil population is essential to winning the war.”⁴⁶

Arguably, this two-year period—between 1916 and 1918—is emblematic of other episodes in the twentieth and early twenty-first century when chances were squandered to better prepare the nation for potential health crises. There is always the benefit of hindsight in stating what could have been done better, but in 1918—and in other cases discussed in these pages—signs of a health crisis loomed on the horizon even as Wilson was preparing a blueprint for world peace. Crises can escalate suddenly and can throw into sharp relief inadequacies in leadership and support systems, but there are usually warning signs about the interplay of human and environmental factors that make some communities more vulnerable than others. On the surface, 1918 was a triumphant year. Internationally, the United States emerged from World War I more favorably than European countries: loss of life among US troops was 116,000 (53,000 in combat, 63,000 to disease) compared with 750,000 soldiers and 600,000 civilians in Britain. This was, in part, because the US Army Medical Department had prepared itself for the conditions of war, including extra personnel, a Medical Reserve Corps, and with assistance from the American Red Cross. Yet the fledgling health care infrastructure was under strain on the domestic front. A series of seasonal polio crises in major cities and the influenza pandemic of 1918–19 were major shocks to a federal government that firmly believed modern medicine and purposeful politics would only strengthen Progressive-era optimism.

Instead, I would argue that this 1918 moment is illustrative of a series of subsequent health crises in which panic, planning, and politics intertwine. While my focus is on the rhythm and recurrence of panic and planning cycles, the political sphere is an important third vortex. When it operates effectively, political leadership can mediate between a rationalistic and efficient administrative view of planning (which can often neglect the humanity of the citizens it serves) and emotionally charged rhetoric that can win over hearts and minds (but in some circumstances can scramble senses). This is not to say that such mediation is easy or that a public health approach and the economics of governance align easily. In 1918, for example, the Wilson administration and

Congress, which were focusing their energies on winning the war effort, only acted when confronted by a crisis that could no longer be ignored.

It is pure speculation to ask how many lives might have been saved had the influenza pandemic been curbed in late summer 1918 or had an effective vaccine for polio emerged in the 1920s, but when the president and first lady visited US soldiers at the American Hospital of Paris just before Christmas 1918, Wilson's response and the news coverage masked these health crises, as well as medical personnel shortages back at home.⁴⁷ Wilson was concerned about the wounds of the 1,180 hospitalized US soldiers in France, but he found this group to be "without exception in excellent spirits," noting that "only a few of them looked really ill." He pressed on the soldiers how grateful the nation was for their service.⁴⁸ There was an element of festive stagecraft in the president's visit, and reports of the exchanges made no mention of shell shock or of the emotional toll of warfare, just physical wounds to the legs and lower body.⁴⁹ Nevertheless, Wilson's "very human" response (according to the *New York Herald*) suggested that he cared genuinely about health issues. However, it is also fair to say that prior to the war his political and legislative priorities impeded the development of a health system that could better prepare the nation for domestic and international crises.

This inaugural moment of 1918 set the terms for the sequence of health crises over the next hundred years, a moment that Cary Grayson foreshadowed when he spoke to the Southern Medical Association in late 1916: "We question ourselves on the measure of our preparedness. Some believe we are ready, but there are others who realize that there is much to be done."⁵⁰ It is unclear from President Wilson's papers whether he became more attentive to the influenza pandemic after his own bout of debilitating flu in spring 1919, but it is likely that memories of his visit to the American Hospital of Paris prompted him to ask Congress in December 1920 to approve "a more complete programme" of veterans' health care.⁵¹ The establishment of the League of Nations Health Organization in Paris in 1919 (a precursor to the World Health Organization) was an indirect legacy of Wilson's foreign policy, but his second term was sparse when it came to domestic health topics. For example, he made only passing mention in March 1921 of the role of the Public Health Service in quarantining and "disinfecting" European immigrants to reduce the risk of disease spreading, a heated topic with rising numbers of new immigrants arriving from Eastern Europe.⁵² The lack of policy detail was in part because Wilson's health was failing in