In November 1934 the Columbia Broadcasting Company scheduled a radio address by New York State Health Commissioner Thomas Parran, Jr., on future goals in the area of public health. Parran planned to review the major problems confronting public health officers in their battle against disease. But the talk was never delivered. Moments before air-time, CBS informed him that he could not mention syphilis and gonorrhea by name; in response to this decision, Parran refused to go on. Listeners who had tuned in to hear the address heard piano melodies instead. Parran, reacting angrily to being censored, pointed out the hypocrisy in the standards for radio broadcasting. In a press release issued by his office the next day, he commented that his speech should have been considered more acceptable than "the veiled obscenity permitted by Columbia in the vaudeville acts of some of their commercial programs."

Fifteen years earlier, during the anti-venereal crusade during World War I, the conspiracy of silence had appeared to be defeated. Newspapers and magazines had dramatically publicized the problem; Congress and the military addressed it forthrightly. In the following years, however, the anti-venereal campaign had faltered. After the radical interventions that the war brought on—not only in politics and economics, but socially as well—America returned to a "normalcy" that also prevailed in public health efforts. The 1920s, despite their apparent frivolity, marked less of a watershed in the area of sexual morality than has often been assumed. Though among the young there was a distinct increase in sexual activity, a strong countercurrent of demands for moral rectitude and gentility persisted. While women took champagne baths at speakeasies and couples went on jaunts in roadsters along country lanes, respectability was reasserted in many quarters. It is important to remember that if the twenties marked the decade of bathtub gin, so, too, was it the decade of prohibition. In spite of the new openness towards sexuality, the sexually transmitted diseases were drawn once again behind a veil of secrecy. Until the 1930s the venereal problem would go largely unheeded.
ication of venereal disease by dramatically bringing these infections to the cen-
ter of public consciousness. Indeed, rarely, if ever, in the twentieth century has a
public health campaign created such a public furore. In this process, venereal
disease once again would be redefined. Parran, barred from the radio in 1934,
found his picture on the cover of *Time* in 1936. His was a mission whose suc-
cess, however, would never be complete. Parran's efforts reveal the tension be-
tween scientific and moralistic approaches to the venereal problem as well as
the strengths and limits of New Deal reform.

2

In 1921 Congress failed to renew the Interdepartmental Social Hygiene Board's
appropriation, despite the protests of Progressive reformers and social hygien-
ists. The Board, created by Congress in 1918 to protect the troops from the
dangers of venereal disease, had developed a comprehensive program. Many
predicted that the end of the ISHB would result in a moral debacle. "Are we
to keep up and finish the fight?" asked Dr. Rachelle Yarros. "Are we to make
this idea that man can and must abstain from promiscuous relations a perma-
nent contribution in morals and health, or is it to be only a war measure?" The
League of Women Voters, the Women's Christian Temperance Union, the
Parents-Teachers Association, and the National Federation of Women's Orga-
nizations all lobbied in favor of the Board's continuance, but to no avail. Neva
R. Deardorff of the Survey explained their concern: "The question that citizens
and parents of service men have a right to ask Congress is whether it is less
worthwhile now to protect boys and girls than it was a year ago." By October
1922 the ISHB, the war's most ambitious experiment in social engineering, had
been dismantled. The Program of Protective Social Measures—the anti-
prostitution crusade designed to insure a single standard of morality—was trans-
ferred to the Department of Justice.

The demise of the Interdepartmental Social Hygiene Board marked the first
critical sign of the decline in efforts to combat venereal disease after the war.
The Board came under attack from several fronts shortly after the armstice was
signed. The Venereal Disease Division of the Public Health Service argued that
the Board constituted an unnecessary duplication of their activities; this, despite
the fact that the Division's budget was merely ten percent of the Board's. The
most powerful critic, however, was the American Medical Association, which
claimed that the ISHB had overstepped its mandate, invading the province of
public health, and more importantly, the medical profession. With the war-
time emergency weathered, an AMA editorial argued, the nation should return
to more traditional means of disease prevention. "The Board," declared the AMA
"has shown an inability to distinguish between measures for the proper regu-
lation of public health and those intended for the control of public and indi-
vidual morals." Although elements of the AMA's response were justified, their
ongoing concern about the growth of "state medicine" informed their critique.
The excesses of the ISHB notwithstanding, the failure to renew government
funding for venereal disease control marked a significant shift away from the
nuition of federal responsibility for health and disease prevention that the war had encouraged.

The reaction against the war's vigorous social hygiene campaign, however, was not small to injury; the film "Fit to Fight" — the centerpiece of anti-veneral propaganda during the war — was declared obso-

In New York State by the Board of Censors, a ruling upheld by the Cen-
sor Court. "The fact that a small body of specialized medical opinion supports the picture ... does not free a given picture from the vice of violating the standards of morality," Commissioner Al Smith's top adviser, Belle Moskowitz, also tes-
tified against the film, noting: "Only a wrenched, coarsened scientific zeal could condone it as fit for indiscriminate use." In Pennsylvania the State Board of Cen-
sors banned any film that mentioned the word "veneral disease." Catholic lay

organizations bitterly protested the public release of "Fit to Fight" throughout

the nation. The more conservative social hygienists and purity activists centered their attack on the film's advocacy of chemical prophylaxis. "If you can't be moral, be careful." By 1922 the Public Health Service had withdrawn all its

anti-veneral films. The arguments of expediency framed during the war now hold little weight; public health grew to concerns about public morals.

The fate of chemical prophylaxis against veneral disease in the years after

the war is the best indication of this shift in attitudes. During the war the ad-
mnistration of this treatment had greatly reduced the incidence of venereal infection among the American Expeditionary Forces, as well as troops stationed in the United States. With the armistice, however, opponents of this procedure fully mobilized and forced public health officials to draw back. State boards of health now suggested that the use of prophylaxis was "not practical," although treatment could easily be administered without medical assistance. The American Social Hygiene Association remained strongly opposed to the use of chemical prophylaxis as a veneral disease control measure, charging that its institution would lead to a drastic increase in prostitution and disease.

Public health officials recognized the benefits of prophylaxis for preventing disease, but in most cases succumbed to the ravages of the ASHA and other forces. In 1924 the Veneral Disease Division of the Public Health Service yielded

state health officials on these issues regarding prophylaxis. Most suggested

that public opinion did not permit its use. "It might be disastrous to our work
to disseminate information on venereal prophylaxis and we cannot afford to take

crances of possibly closing their doors to entrance to the public mind," wrote

Dr. Roy X. Fleschman of the Virginia State Board, despite his firm belief in the efficacy of the procedure. Shortly after the war, the Pennsylvania Health

Department had undertaken the widespread provision of prophylactic packets

as part of their anti-veneral program. But the failure to produce a verified de-

cline in cases coupled with objections from moral reformers brought the project

to a quick conclusion.

The debate over prophylaxis revealed an ongoing division in approaches to

the veneral problem. Dr. George Bigelow, commissioner of public health for

the State of Massachusetts, directly confronted the issue, stating, "Why not

through this means (prophylaxis) win [veneral disease] off the list of
community significance, and stop the sneering reference to us as "hypochondriac people."" Bigelow provided an answer: "If we see it, the reason is because we are behinds, we health officers, and dare not face the charge that we are using public funds to make promiscuous intercourse safe." Bigelow's forthright approach demanded a response; it issued from the very top of the public health bureaucracy. "It must be borne in mind that persons in need of protection are usually the most irresponsible groups in a community and under the circumstances often would not have sufficient foresight to provide the protection which Dr. Bigelow recommends," countered Surgeon General H. S. Cumming, expressing a frequently cited argument.

The surgeon general's reply had actually been drafted by a young lieutenant in Cumming's service, Dr. Thomas Parran, Parran, appointed chief of the Venereal Disease Division in 1923, argued that the distribution of information concerning prophylaxis might have a deterring effect on his anti-venereal program. "It is believed," he explained, "that such propaganda reaching all ages would have an ill effect which possibly would counterbalance the cases prevented." Parran repeatedly insisted that his resistance to prophylaxis did not rest exclusively on moral grounds. "Not only are large groups of 'morals' opposed to this method of prevention," he noted, "but there are some thoughtful scientific men who take the position that the evil results of a campaign in promoting promiscuous sexual intercourse will more than counterbalance the good of prevention." But it was the power of public opinion coupled with a general decline in state activity that negated the possibility of widespread education and provision of prophylaxis.

Parran, who had joined the Public Health Service at the beginning of World War I, had directly witnessed the decline of federal support for venereal disease control. Born in 1892 on a Maryland farm where his ancestors had first settled in the seventeenth century, Parran received his medical degree from Georgetown University in 1915. Two years later the Public Health Service commissioned him as an assistant surgeon; for the next decade he performed a variety of services in that position, investigating epidemics and administering vaccination programs around the country. By the time he was appointed to head the Venereal Disease Division, he had established himself as a leading figure in the public health bureaucracy.

When Parran took over the reins of the division, however, the halcyon days of public efforts to control venereal disease had long passed. Although the Venereal Disease Division won the bureaucratic battle for exclusive jurisdiction over these infections from the Interdepartmental Social Hygiene Board, it nevertheless lost the war. Congress reduced appropriations for work in this area so significantly that it had become, in Parran's words "a dying operation." Yearly spending had dropped from $4 million in 1920 to less than $60,000 in 1926. Dr. O. C. Wenger, director of the USPHS Venereal Clinic in Hot Springs, Arkansas, complained, "With our present appropriations, Federal and State and private, we might just as well try to empty the Pacific Ocean with a teaspoon." With the onset of the Great Depression, funding for venereal disease control became even more scarce. The Venereal Disease Division little more than a
holding operation. It was thus with few regrets that Thomas Parran left the federal government in 1930 when the governor of New York, Franklin D. Roosevelt, appointed him state health commissioner. In March 1933, as the depression hit bottom and FDR assumed the presidency, Parran wrote to his successor at the Public Health Service, Dr. Taliaferro Clark: "I am very pessimistic about the future of worthwhile governmental activities of all types."

The venereal problem, once the subject of national debate and federal efforts, had receded from the public consciousness.

Rather than attributing the persistence of venereal diseases to the decline in public health measures, many social hygienists argued that the prevalence of infection derived from the "new morality" of the 1920s. The increasing sexual candor of the decade alarmed them rather than impressed them as an opportunity for bringing the seriousness of the venereal disease problem into the open. Critics of the so-called "sexual revolution" feared that a freer sexuality would lead to license—and more infections.

Social hygienists responded to the incursion of Freudian thought in America with a combination of fear and loathing. "The advent of Freudianism has been attended, together with a few benefits, by numerous evils," declared Dr. Paul E. Bowers, a consultant to the Public Health Service. He suggested that the "perverse sex emphasis" of Freudian psychology and the ensuing fad of psychoanalysis were bound to "lead to promiscuity in those social levels where we ordinarily expect to find the highest types of sexual ethics and culture." Up-to-date social hygienists tended to emphasize the theory of sexual sublimation, which argued that the sexual drive could be converted into productive activity or work, while they discounted Freud's attack on genteel strictures against sexuality. At the All-American Conference on Venereal Disease—a convocation called by the USPHS shortly after the war to set venereal policy for the 1920s—the assembled group of physicians and public health officials attempted to confront the implications of Freudian theory for their program. After considerable debate, they endorsed a resolution:

Resolved, that although there is danger that a superficial and erroneous interpretation of the Freudian psychology in regard to the repression of the sex instinct may be detrimental to the successful development of the program for the control of venereal disease, a more thorough-going, complete and scientific interpretation tends to aid such a program in that it places the emphasis upon the practical means for guiding the sex instinct into socially useful and constructive activities.

Clearly, the social hygienists considered themselves to be professional sublimators. Already the American pattern of the convenient selection of Freudian thought could be seen at work.

To those who sought to control venereal disease by controlling behavior, the activities of American youth were viewed with particular alarm. The new, faddish dances, from the toddle to the black bottom, were cited as both a moral and a medical threat. "It is certain that the dance of today, as performed in the majority of places, does not have a tendency to diminish or regulate the normal
Rules and Regulations for Public Dance Halls

1. No shadow or spotlight dances allowed.
2. Moonlight dances not allowed where a single light is used to illuminate the Hall. Lights may be shaded to give Hall dimmed illuminated effect.
3. All unnecessary shoulder or body movement or gratuitous dances positively prohibited.
4. Pivot reverse and running on the floor prohibited.
5. All unnecessary hesitation, rocking from one foot to the other and see-sawing back and forth of the dancers will be prohibited.
6. No loud talking, undue familiarity or suggestive remarks unbecoming any lady or gentleman will be tolerated.

POSITION OF DANCERS
1. Right hand of gentleman must not be placed below the waist nor over the shoulder nor around the lady’s neck, nor lady’s left arm around gentleman’s neck. Lady’s right hand and gentleman’s left hand clasped and extended at least six inches from the body, and must not be folded and lay across the chest of dancers.
2. Heads of dancers must not touch.

MUSIC
No beating of drum to produce Jazz effect will be allowed.
Any and all persons violating any of these rules will be subject to expulsion from the hall, also arrest for disorderly conduct.

By Order of
CHIEF OF POLICE

(1) Regulations such as these posted in Lansing, Michigan, dance halls around 1920, made explicit the fear that the new dances and new morals of the post-war decade could lead to sexual license.
sex urge," commented Dr. Bowers. Indeed, he concluded, "The reverse is quiet true in many cases." Henry Ford, the self-styled cultural critic, added his voice to the chorus of concern, suggesting that in contemporary music "monkey talk, jungle squawks, growls and squeals and purrs suggestive of cave love are connoted by a few lecherous notes." In response to such criticism, the American National Association of Masters of Dancing developed a series of rules and regulations to prevent moral declension on the dance floor. The Association recommended prohibiting "older, cheap jazz music" which "almost forces dancers to use half steps and invite immoral variations." After considerable (and graphic) discussion of a variety of situations to be discouraged, the organization cautioned its teachers "not to teach any movements that cannot be controlled." **66**

Although many social critics such as Henry Ford looked with horror upon the new dances, it was, in fact, the automobile that many identified as the principal cultural culprit. The automobile provided the dangerous combination of solitude and privacy that invited new sexual mores. "Since the "red light" district is practically a thing of the past, the entire situation has changed," explained Dr. O. C. Wengler. "The automobile has replaced the room of the prostitute." Prostitutes reportedly complained about competition from "amateurs" as male sexual initiation more frequently took place in the back seat than the back room. **77** As more women engaged in premarital sex, the prostitution became something of an anachronism.

In retrospect, all this may seem somewhat far afield from the problem of venereal disease, but such matters were followed with avid interest by the American Social Hygiene Association and the Venereal Disease Division of the USPHS during the 1920s. A circular distributed to dance hall managers under the signature of the surgeon general noted: "The unregulated dance hall became a source of worry to authorities because of the number of infections originating from contacts made at such amusement places." **78** As the ideal of premarital sexual continence eroded, social hygienists directed their efforts to the reinstatement of the code. Those interested in controlling the incidence of venereal disease during the twenties centered attention on sexual mores rather than medical approaches.

All too often, accounts of the shift in sexual behavior during the 1920s have failed to detect the essential conflict surrounding the change. Though it is true that the "revolution in morals" led to a new openness of discussion and activity regarding sexuality, these changes met sharp criticism. As a growing number of men—and women—rejected the notion of chastity, the conservative middle-class reformers who dominated the social hygiene movement watched with anxiety. Moreover, the reaction against the idealized sexuality of the 1920s was not merely voiced to punish Bourbon. Leaders of the social feminist movement of the prewar years often found the "new women" of the 1920s to be conspicuous and indulgent. Charlotte Perkins Gilman, for example, asserted that women were following "the solemn philosophical sex-mantra of Sigmond Freud." She deplored the indecency of the flapper, noting that women were accepting the "masculine" assumption that "the purpose of sex is recreation." **79**

Social hygienists who had ultimately been more concerned with preserving
sexual ethics than preventing disease could not countenance the changes they observed. In their reaction, however, they would move further from the center of American life. As sexuality did emerge more openly in the 1920s there was nevertheless also a palpable disinclination to examine with any care the less pleasant aspects of this transformation. The wartime venereal disease campaign had been an aberration; these infections could only be directly addressed in times of crisis. The war had demanded unprecedented interventions by the federal government that, it was argued during the 1920s, should properly be abandoned. In peacetime, public mores held no place for the apparently unseemly subject of venereal disease. In this respect, America had returned to the Victorian era; the conspiracy of silence regarding these diseases had been reconstituted.

Although the 1920s witnessed little progress in combatting sexually transmitted diseases, the staggering dimensions of the problem had nonetheless been clarified. Increased reticence, declining government commitment, and a continued insistence on solving the venereal problem through moral uplift rather than medical means all combined to ensure that these diseases reached epidemic proportions. The Public Health Service conducted a series of surveys of cases under treatment in an attempt to project levels of infection. By the early 1930s the most frequently cited figures suggested that approximately one out of every ten Americans suffered from syphilis. Each year, citizens of the United States contracted almost half a million new infections—twice as many cases as tuberculosis and a hundred times the number of cases of the dreaded infantile paralysis. Gonorrhea, statistics showed, proved to be even more extensive, with close to 700,000 new infections annually. Among blacks, the poor, and the young, rates of venereal infection reached disproportionately high levels.

The long-term pathology of these infections, in the past often hidden under other classifications, now became more apparent. Syphilis could affect the cardiovascular system, leading to a variety of serious heart ailments. According to one study, 18 percent of all deaths from organic heart disease could be attributed to syphilis. If it reached the nervous system, syphilis could cause insanity, paralysis, or blindness. Reports suggested that as many as twenty percent of all mental institution inmates suffered the consequences of tertiary syphilis. Of the deaths occurring in these hospitals each year almost 9,000 were tied to advanced syphilis. In addition, syphilis remained a leading cause of miscarriage, congenital defects, and sterility; each year 60,000 children were born with congenital syphilis in the United States. Only one indication of the seriousness with which the medical profession regarded the impact of syphilitic infections was the fact that life insurance companies refused to issue policies to any persons known to have been infected.

These remarkable statistics, numbers indicating personal, familial, and social tragedies, stood in the face of the fact that medical science had a good deal to offer the individual infected with syphilis. Even in these pre-antibiotic years,
the epidemic levels of venereal disease could not be attributed to the limitations of medical knowledge. The discovery by Paul Ehrlich of Salvarsan in 1910 gave physicians a treatment that offered victims of syphilis a definite benefit although physicians still debate whether it offered a complete cure. Admittedly, the arsenical compounds with which physicians treated syphilis —stilled some risk and the course of injections was lengthy and unpleasant, but most patients could be rendered non-infectious through these means and avoid the dangerous consequences of late and tertiary syphilis.22

Despite the consensus regarding the effectiveness of arsenomime within the profession, therapy for syphilis remained subject to considerable debate and conflict. Correct dosage, duration of treatment, definition of cure, as well as accompanying medicaments were bitterly contested among even the most noted syphilographers during the 1920s. "Syphilography... in 1925 was a chaos of different dosages, of private preference for different variations of the arsenical compounds," explained Thomas Parran. "There were many case-report case studies but not accurate data upon which the scientist could judge the relative efficacy of these methods."23 Parran hoped to remedy this situation by promoting clinical research.

In 1928 a group of young philanthropists, influenced by the impact of syphilis upon several of their friends, offered to establish a fund to encourage laboratory and clinical research to expand and refine scientific approaches for dealing with the infection. The stigma attached to syphilis had not only excluded public discussion of the problem, but had discouraged funding for research work as well. Few prominent philanthropists wanted their names tied to these diseases. With the assistance of the American Social Hygiene Association and the Public Health Service, a group of distinguished scientists were brought together to establish the Committee for Research in Syphilis. Charter members included William H. Welch of Johns Hopkins and Hans Zinsser of Harvard, Surgeon General H. S. Codding appointed Parran to the Committee to represent the USPHS and he was elected chairman. W. Averell Harriman, who provided the Committee with $100,000 on an anonymous basis, served on the Board of Directors.24 Despite sizable grants to prominent syphilographers and research scientists, the stock market crash brought the demise of the Committee for Research in Syphilis to a quick end.

The CRR, however, led to the formation in 1929 of the Cooperative Clinical Group, which consisted of the directors of the five leading university syphilis clinics in the United States. This group was able to stay afloat, pooling data and information in an attempt to establish uniform treatment regimens for a variety of syphilis-induced ailments. Between 1931 and 1940 these investigators published some fifteen papers documenting a preferred course of syphilitic therapy, among the areas investigated were syphilis in pregnancy, congenital syphilis, and cardiovascular syphilis, as well as a number of technical therapeutic problems relating to the length of treatment and innocuity. The CCG marked the first such cooperative venture in the history of American medical research, and the success of the group set a valuable precedent for future joint ventures in American clinical medicine, laying the basis for the new orthodox cooper-
According to the American Social Hygiene Association, the disruption in traditional family ties created by the Great Depression generated sexual and marital disloyalty, immorality, and higher rates of venereal disease. Mass searching for work, as well as women leaving home to assist in the support of their families, involved neglected children, sexual chaos, and increased disease, in the opinion of the Association. Moreover, the Association speculated that, as men lost jobs and women sought to support their families, masturbation would increase during the depression. Syphilis and gonorrhea were seen as the consequences of social instability and decay, the manifestations of an essential failure of traditional social controls. Again, the propensity to view these infections as symptoms rather than diseases became clear. Any disturbance to the familiar status quo, in this view, could lead to higher rates of infection.

In one way, without question, the economic crisis did lead to greater prevalence of infection: fewer individuals could afford the required treatment. The depression greatly increased the number of individuals seeking free care for venereal disease; demand at public health clinics rose by at least 20 percent between 1929 and 1937. According to estimates of the New York State Division of Social Hygiene, fully one-half of all newly infected cases now sought treatment in public clinics. Health economists Leon Rosenberg and Michael H. Davis argued that eighty percent of the population could not afford the cost of adequate care for syphilis from private physicians. Treatment for an uncomplicated case of syphilis required expected visits to a physician for the injection of arsenical compounds alternated with injections of benzyl alcohol to reduce the chance of toxic reaction. Sometimes this necessitated weekly appointments for more than 4 years. The cost of such treatment with a private physician in the early 1930s averaged between $300 to $380, yet could range as high as $1,000. Even public clinics often charged as much as $50 for a course of therapy. These costs were often mitigated by the fact that typically more than one member of a family needed treatment if an infection was diagnosed.

The expense of treatment often caused infected individuals to forget a complete regimen, taking placebo and continued carriage. According to one study, more than 80 percent of all syphilis patients failed to complete an effective therapeutic course. As Dr. Albert Kastel, a renowned expert at Johns Hopkins, explained: "I believe that one of the chief reasons for failure to continue is the
high costs of medical care, and that the element of costs prevents not only the proper treatment of many patients, but even the recognition of the syphilitic condition. "Tragically, some doctors refused to continue treatment when patients failed to pay their bills. "It is indefensible," declared Keidel, "to treat the patient until his funds are exhausted and then drop him." Some physicians argued that failure to act responsibly in the conduct of venereal cases would lead to state controls on the profession, if not to socialized medicine. "The medical profession must at this time provide cheaper and better medical treatment or else this will be taken out of our hands and we will be directly facing state medicine," noted Dr. J. Frank Schamberg.

In addition to the high costs of treatment, the poor quality and scarcity of public clinics also discouraged individuals from seeking medical attention. Many hospitals, continued to refuse admission to patients with venereal infections, tacitly endorsing the assumption that these individuals were morally tainted and less deserving of care. Public clinics devoted to the treatment of venereal disease were noted for their unpleasant and crowded environs. A study conducted by the Bureau of Social Hygiene reported grossly inadequate facilities with long lines of individuals waiting for injections. Even pay clinics set up for the exclusive treatment of venereal infections at costs below those of private practitioners were often shunned by the diseased; the powerful stigma of venereal infection discouraged their use. As Albert Keidel explained: "The classification of syphilis as a venereal disease and the fact that it is associated in lay and medical minds with the sexual act make it impossible for a pay clinic for syphilis or for venereal disease in general to attract patients as can similar institutions with more general medical aims." Once again, social attitudes constrained medical practice.

Failure to provide sufficient education, of course, led to poor practice. "There is, I think, no use in blinking the fact that, by and large, syphilis is badly managed by the average practitioner," concluded Dr. J. E. Moore, who empha-
sized the high proportion of missed diagnoses. This explained, in part, the critical fact that only one in ten cases of syphilis received treatment during the early stages of the disease when a cure was possible. In an attempt to escape the stigma of venereal infections, many individuals turned away from orthodox practitioners to quacks and patent medicines promising quick cures. In a poll of almost five hundred men in San Francisco, randomly selected on the street and asked for advice about venereal care, only 41 percent recommended seeing a doctor; most suggested home remedies, nostrums, and quacks. Another study found that 65 percent of Chicago drug stores offered over-the-counter "cures" for all venereal diseases. Although one of the attractions of unscrupulous practitioners was the prominently advertised promise of confidentiality, a number of stories circulated about quacks who not only bilked their patients but blackmailed them as well.

The reservoir of untreated and inadequately treated infections thus grew, generating a national health problem of immense proportions. The high costs and poor quality of most treatment exacerbated the problem. Finally, the powerful stigma of the sexually transmitted diseases limited both the public and the profession's ability to respond effectively. As N. A. Nelson concluded: "It is inconceivable that an intelligent program can be developed for the control of the genito-infectious diseases by those who adhere to the traditional notion that infection is, in itself, evidence of sexual misbehavior."

The traditional argument—that venereal victims got what they deserved, and therefore should not receive assistance—came under attack during the 1930s as public health officials like Thomas Parran began to calculate the larger social costs of these diseases. Estimates suggested that more than $15 million was spent annually for the ambulatory care of venereal patients (in both private and public clinics). The cost of not treating syphilis went even higher as the complications of the disease developed. Experts argued that syphilis cost taxpayers between $40 and $50 million each year for the institutional care of the insane, paralyzed, and blind.

The cost of venereal disease, however, extended beyond that of taking care of the ill. During the depression years, physicians and public health officials placed increasing stress upon the cost to American industry in diminished productivity, industrial accidents, and workmen's compensation. As Dr. Morris Fishbein of the American Medical Association explained:

In industries the costs of venereal disease are tremendous. It has been estimated that from 8 to 10 million workers lost 21 million working days each year at an average of $4 a day in the result of infection with these conditions. The cost may well be more than $100,000,000 annually.

Thomas Parran calculated that such losses were the equivalent of every American man between the ages of 15 and 45 missing a half-day of work each year.
According to the American Social Hygiene Association—well-known for its somewhat liberal use of statistics—losses from syphilis and gonorrhea came to more than $285,000,000. (They did not provide the basis for this figure.) These projections reflected the general concern during the 1930s about restoring and maintaining the nation’s industrial capacity. If venereal disease could be shown to have great economic costs, public health officers reasoned, the government and business would be more willing to bear the financial burden.

Officials appealed to enlightened capitalist self-interest in their campaigns for expanding public health facilities for venereal disease. In this mode of thought, men became machines; venereal disease a deadly, but more importantly, a costly corrosive. As Parran explained to a group of businessmen:

“This is a day of intensive organization, of specialization, of expert talent, of complicated machinery; and most industrial plants see to it that their machinery is constantly inspected and kept in the very best running order. But all too many of us rely on the natural course of events as regards the most important element in the success of that business, namely, the human machine.”

The costs of venereally infected workers could often be hidden beyond the loss columns of the business ledger. Industrial accidents were often attributed to syphilis, with its dire impact on the neurological and cardiovascular systems. Public Health officials frequently reminded businessmen of the costs of workers’ compensation for injuries incurred by syphilis. Even more ominous, however, were the dangers of accidents not only to workers but to the public. A number of major train wrecks during the 1920s, for example, were attributed to advanced syphilis in the engineer. Officials typically cited workers who traveled as being at greater risk for infection (due to unstable homes and few communal ties). State health departments enjoined railroad operators to ensure that their workers were free of infection, and many railroads began to require that all employees be examined.

Some corporations responded by creating anti-venereal programs for their workers. The American Social Hygiene Association offered a consultant service to businesses seeking to educate employees about the menace of venereal disease. E. I. du Pont de Nemours and Company established a full program for venereal detection among its workers beginning in 1934, under which all new employees received Wassermann tests as well as all old employees who agreed to be examined; only ten percent refused. Four percent of all employees were...
found to be infected. At first, DuPont did not provide treatment for these individuals, choosing instead to refer them to private physicians. They soon found, however, that these men often did not complete their treatment; the company then undertook to provide therapy for them. Though DuPont promised not to dismiss employees found to be infected, this was not always the case with other companies that examined their workers. Applicants for employment found to be diseased rarely were hired. Oftentimes companies whose employment benefits paid for the case of almost all serious illness specifically excluded syphilis and gonorrhea, maintaining the view that these diseases only afflicted the immoral and willful. All too often, workers already strapped by paying for expensive syphilitic treatment would find themselves out of work if their employers gained knowledge of their infection. In many such cases the patients had long become non-infectious, yet the contagion of stigma persisted.

The issue of the costs of venereal disease to business nevertheless had considerable impact. Much as the notion of extra-genital infection was used during the Progressive years to suggest that venereal infections could reach any segment of society, now the calculus of social costs suggested that no matter who became infected, all society would bear the financial burden. This argument, of course, reflected heightened concern during the depression about increasing industrial capacity while lowering the costs of business. Public health officials sought to make the business community their ally in the fight against these infections. As Dr. Ray D. Dixon of the Detroit Venereal Clinic concluded: “When we can convince the business world that the venereal diseases are an obstacle in its path of progress the venereal problem will be in a fair way of becoming solved.”

Before the problem of the venereal diseases could be addressed, however, the restraints upon public discussion had to be lifted. These taboos not only kept Parran off the air, but more generally handcuffed public health efforts in the years after the war. Newspapers and magazines that had broadly publicized the wartime anti-venereal crusade now looked askance at the venereal problem. As Judge Anna Moscovito Kross later commented, “We spoke of social diseases, we spoke of social evils. None of us dared even think of uttering the words syphilis and gonorrhea.” The essential medical problems raised by the diseases were obscured by the emphasis on rectitude.

Criticism of the reticence surrounding the venereal problem emerged only in the 1930s, with blows falling most heavily on the American Social Hygiene Association. Though it was the central voluntary organization dedicated to the control of venereal disease, it had opted for a moralistic, circumspect educational campaign that emphasized the menace of prostitution and promiscuity. Medical and public health approaches to alleviate the problem, however significant, had remained secondary. In the 1930s, the tenets of the ASHA regarding sex education, for example, were held up for ridicule: “The Sex Hy-
gianists, with their irrelevant gabble about dahlias and philo-progenitive bees, only make the essential mystery more mysterious, and hence more baffling.” Michael M. Davis, the eminent health economist, wrote to Parran decrying the ASHA’s conservative approach: “If after the war the ASHA had only had the courage to deal with the problem boldly, as you have, instead of always treading softly, we should have been a lot further along.”

By the early 1930s, a number of critics, influenced by the liberalization of sexual mores during the 1920s, cited the prudishness of the social hygiene movement as a central cause of the high venereal rates. As one writer in the American Mercury noted:

Unfortunately . . . in Puritanical America, babies are still brought by storks, decent people copulate only in wedded antisepsis, and the public region is mentionable nowhere except in alleys and medical colleges. If the existence of sexual diseases is at all recognized, the approved method of dealing with them is by assuaging the population with ecclesiastical oils and moral salves. But since pathogenic germs are more sensitive to chemicals than to homilies, they have managed to multiply with little interference.

Principles of decorum were, as some critics observed, hypocritically defined. Newspapers, for example, generally refused to print the words “syphilis” and “gonorrhea,” but these same publications carried advertisements for feminine napkins, hemorrhoid nostrums, and hernia supports, many more explicit than those found in today’s publications. When the New York State Department of Health sought to change the name of the Division of Social Hygiene to the Division of Syphilis Control, a title that specifically defined its mandate, state legislators balked. “I may be old-fashioned, reactionary, and a Bourbon,” remarked one state senator, “but I say this word is not decent and should not be spread among the children and the youths.” This gentility, however, had its impact on public health measures directed against the venereal problem. Health officers suggested that in honoring public sentiment, constraints were placed upon their activity. As public health expert Haven Emerson explained: “We have hinted, and hidden, and yet hoped for results; and still this malign infection flows almost unrestricted through marriage as through brothel, in childhood, in maturity, in age.”

Physicians and public health officials in the 1930s went on the attack against the moralistic precepts of social hygiene, an attack that Thomas Parran was to lead. Doctors urged that the time had come to reject euphemism, reduce moralism, and address the venereal problem on the level of science and medicine. Although Parran sought not to alienate those social hygienists who had previously worked against venereal disease, he nevertheless hoped to redirect priorities within the movement.

It is true that the control of syphilis and of other venereal diseases would be accomplished if the ideal of a monogamous sex relationship were universally attained. Efforts toward this ideal are commendably commendable, both on account of their influence on the prevalence of disease and because of the sociological result in-
volved, but it should be possible to control syphilis by direct medical measures long before any considerable change in the sex habits of the population normally can be expected. . . . Greater progress . . . will be made by concentration of effort on the medical aspect of control rather than through continued scattering of effort on the medical aspect of control rather than through continued scattering of effort in an attempt to carry out the 'ideal program' of the social hygienists for moral prophylaxis.40

In Panan's view, the public health establishment—medical experts—should now assert their authority over the venereal problem.

A number of physicians contended that the very names used to describe these ailments tended to make them more difficult to deal with from the perspective of public health. The metaphorical meanings attached to the venereal diseases—the connotation of immorality, evil, infidelity, taboo—actually obstructed medical efforts. Because these infections were considered apart from other communicable diseases, as unique infections limited to the immoral, traditional public health approaches had been overlooked. As Herman Bundesen, commissioner of health for the City of Chicago, explained: "When you treat syphilis as you treat smallpox, then we will control syphilis as we control smallpox, and not until then." Not only did euphemistic expressions such as "social hygiene" and "social diseases" come under attack, but the term "venereal disease" as well. Physicians frequently pointed out the nature of so-called "innocent" infections: congenital syphilis, familial infections, extra-genital transmission—to demonstrate that the diseases were not always communicated through "venery." An editorial in the Journal of the American Medical Association noted: "One of the principal obstacles to the conquest of syphilis has been squamishness about facing the problem and the unfortunate classification of syphilis as a venereal disease. It is, of course, a venereal disease only in part." Doctors sought to strip venereal disease of its immoral connotations. "Do we think of syphilis as a 'venereal' disease?" asked Nels A. Nelson. "If we do, how do we propose to convince the public, to which venery is synonymous with lasciviousness, that syphilis is altogether not a venereal disease?" As a replacement for "venereal disease" Nelson offered "genito-infectious diseases" which, not surprisingly, failed to attract a following. Even the conservative American Social Hygiene Association came to advocate the abandonment of the term "venereal disease." "Scarlet fever acquired from a prostitute is not called a 'venereal' disease," noted medical director Walter Clarke in a somewhat labored argument, "but gonorrhea acquired from a woman by her lawful husband is called a venereal disease."43 In the 1970s, "sexually transmitted diseases"—STDs—became common medical parlance in yet another attempt to take the venereal out of VD.

The debate over how to identify venereal disease reflected two related themes. First, it signified an attempt to reduce the moral stigma attached to these infections in order to make it possible for physicians to deal with them more dispensation, in a manner similar to the way other infectious diseases were approached. Second, it revealed a larger conflict over the jurisdiction of these
ailments. Passed from the theologian to the social reformer, the concern over venereal disease, it was argued, should henceforth be placed exclusively in the domain of the physician. This, of course, reflected a more fundamental transformation regarding sexuality in American culture.44

Soon after his appointment as surgeon general by President Franklin D. Roosevelt in the spring of 1936, Thomas Parran resolved to bring the venereal diseases to national attention. In July Parran outlined the extent of the venereal problem in an article entitled, “The Next Great Plague To Go,” tearing away the veil of secrecy. Although the medical profession had been directing increasing interest in their journals to the problem, Parran's article, appearing first in the Survey Graphic and then in Reader's Digest, was among the first to reach such a broad audience. At a time when most newspapers and magazines still prohibited the mention of syphilis and gonorrhea, Parran's message reached some 500,000 subscribers to the Reader's Digest. In this article, the surgeon general reviewed facts well known among his medical colleagues in simple, direct prose. The time had come, he argued, to bring the problem into the open; without this essential step, syphilis would continue to have a serious, detrimental impact on the health of the American people. “First and foremost among American handicaps to progress against syphilis,” Parran observed, “is the widespread belief that nice people don't talk about syphilis, nice people don't have syphilis, and nice people shouldn't do anything about those who have syphilis.” Parran ascribed this view to hypocrisy, pure and simple. “Scratch a scamp who is too sanctimonious to say syphilis and, usually, you find an ex-syphilisic,” he remarked.45

“The Next Great Plague To Go” contained a number of illustrations, graphically depicting the dimensions of the problem of syphilis in the United States. These pictographs of critical statistics, designed by Rudolph Modley, included the ages of those most likely to become infected, the impact of treatment and the effect of syphilis on pregnancy, as well as comparative rates of infection. These illustrations dramatically communicated to readers the extent of the problem and the necessity of committing the resources of public health to the eradication of syphilis.

Parran brought a scientific, bureaucratic approach to the venereal problem. As a career public health officer, he came from a tradition different from that of the social hygienists who had heretofore directed most anti-venereal efforts. Parran made clear that it was not the limits of medical science that explained the high levels of syphilis within the United States. As a veteran of the modern public health movement, he had witnessed the precipitous decline of major communicable diseases, including tuberculosis, diphtheria, and typhoid, through the techniques of isolation, case finding, treatment, and immunization; techniques for the most part available and yet not employed in the attack against syphilis. “Syphilis does a hundred times as much damage annually as polio-
OUTCOME OF
LATENT UNTREATED
SYPHILIS DURING PREGNANCY

HEALTHY
CHILDBORN

DISASTROUS
OUTCOME


myelitis,” noted Parran, “yet we can cure most of it. We still do not know how
to cure poliomyelitis, only how to mitigate it.”

Parran advocated a five-point program for controlling syphilis largely based
upon traditional public health precepts. First, and most important, was the need
to find cases of the disease. For this purpose, Parran called for free diagnostic
centers where individuals could obtain confidential blood tests. For high-risk
populations, especially the young and blacks, the surgeon general suggested
“Wassermann dragnets” that could administer hundreds of tests. The rationale
behind locating these cases, of course, was to bring infected individuals under
immediate treatment. Prompt therapy for the diseased constituted the second of
Parran’s recommendations; delay after infection made treatment much more
slow.
difficult and less successful. Third, Parran argued that all contacts of infected patients must be identified, located, tested, and treated if infected to stop the perpetual spread of the disease. In order to prevent congenital syphilis, Parran offered as his fourth recommendation mandatory blood tests before marriage and early in all pregnancies. Although these techniques were not new, Parran's public proposal generated demands for a comprehensive program. In the surgeon general's judgment, public efforts to combat syphilis had until this time been "scattered, sporadic, and inadequate."

Parran modeled these proposals on the programs of several European nations that had taken concerted action to bring venereal diseases under control after the war. Great Britain reduced its rates by half through the establishment of government supported clinics. In little more than a decade, new admissions to British venereal clinics dropped from 40,000 to 20,000 annually. The Scandinavian countries, in particular, devised public health measures that were remarkably successful in stemming the tide of venereal infection. In 1935 at the suggestion of New York Mayor Fiorello LaGuardia, Parran led a commission to Norway, Sweden, and Denmark to investigate their venereal programs. In Sweden, where the population of 6,105,000 approximately equaled that of upstate New York, there were only 431 cases of syphilis in 1934. If this rate of infection were applied to the United States there would have been 8,620 new cases annually; instead, the Public Health Service estimated there were 420,000. Sweden's rate had fallen by ten times in just fifteen years. Denmark and Norway reported similar declines in the years following World War I. All three nations provided public clinic facilities of high quality, required reporting of all cases by physicians and compulsory treatment. In addition, Sweden had devised rigorous measures for the investigation of all sources of infection. Although he was aware of the fundamental political and cultural differences between these nations and the U.S., their ability to deal effectively with the venereal diseases had a major impact upon Parran. He returned from abroad confident that similar, well-organized and supported public health measures would meet with success in the United States.

Explicitly missing from Parran's program was the traditional moral call to arms. Though he sought to avoid offending the social hygienists, Parran downplayed the moral argument. "After careful scrutiny of our reform efforts to date," he explained, "I have come to the conclusion that it is much easier to control syphilis by making Wassermann tests routinely for the age groups needing it, and seeing that treatment is obtained by all people who require it, than it is to alter the way of life of a people." Indeed, Parran's approach to the problem of venereal disease marked an attempt to wrest control from the social hygienists with their emphasis on behavioral reform. Shortly after the publication of the "Next Great Plague To Go" he noted, "In an effort to emphasize the fact that syphilis is a contagious disease and should be treated as such, I deliberately minimized the morality issues... We doctors and health officers have been derelict in doing the things which obviously are our first responsibility in the
control of syphilis." At the very heart of Parran's effort was an attempt to transform the discourse of venereal disease. As Parran indicated upon submitting his manuscript to the Survey Graphic: "So far as has been possible in dealing with a subject held intrinsically lurid by most people, I have avoided the lurid description and overstatement." Significantly, the surgeon general personally shared many of the moral precepts of the social hygienists, but he resolved not to let this hinder the public health battle.

By the fall of 1936 the popular press had responded to Parran's challenge by broadly publicizing the problem of venereal disease. In October Time featured Parran on its cover to accompany a story on the extensive public concern about the venereal problem. "The ice of journalistic reticence," had been shattered, the magazine declared. "To break down this taboo in the U.S. and tackle syphilis scientifically rather than usually is the high and burning purpose in the official life of Surgeon General Parran." Articles explicitly calling attention to syphilis and gonorrhea appeared in such newspapers as the New York Herald Tribune, the St. Louis Post-Dispatch, and the Chicago Tribune. In all, some 125 papers broke precedent, carrying articles outlining the problem of dealing with the sexually transmitted diseases. In 1937 the Pulitzer Prize Committee accorded an honorable mention to the New York Daily News for "the most disinterested and meritorious public service rendered by any American newspaper" during the year 1936. The Committee specifically cited the newspaper's "campaign covering venereal diseases and prophylaxis." Monthly subscription journals proved to be a more difficult barrier. Paul De Kruif, the well-known science writer, attempted repeatedly to place an article on venereal disease in the staid Ladies' Home Journal without success. He explained to Parran that "certain of the lady sub-editors are abstain [sic] in their belief that this is a subject too hot for a great fireside lady's magazine to touch." But editor Bruce Gold soon relented, and in August 1937, the journal carried an article on syphilis jointly authored by De Kruif and Parran. The Journal now became the leader among women's magazines supporting the campaign to control venereal disease. A self-congratulatory full-page advertisement in the New York Herald Tribune declared: "The Ladies' Home Journal, believing that a publishing force can and should be a great social force, is proud to have played its part as the focal point for this great social revolution."

The massive reaction to his article surprised Parran. Indeed, the surgeon general seemed somewhat embarrassed to find himself the center of so much attention. "The facts seem so commonplace to persons like you and me," he wrote to a medical colleague, "it seems remarkable that the public should be so much interested." Those active in the battle against venereal disease when it was, by necessity, fought sub rosa, shared the surgeon general's astonishment. "After all the years of choke tactics one feels positively embarrassed to read a present-day news sheet," noted Dr. John Stokes with a touch of irony. Parran's initial article in the Survey Graphic was repeatedly cited as the impetus for this emergent crusade. "The article will go far towards making the 'hush-hush' end their mental sit-down strike," remarked the New Yorker's "Talk of the Town." Interest in Parran's campaign reflected, in part, an important shift in popular
notions of science and medicine that occurred in the 1920s and 1930s. Parran typified for many the dispassionate, rational medical scientist, dedicated to the public welfare, above moral and political concerns. A public that acclimated Sinclair Lewis’s medical hero, Arrowsmith, and Paul De Kruif’s Microbe Hunters saw in Parran the epitome of a new medical spirit. Physicians and public health officials were increasingly viewed as highly skilled technicians, applying a science of miracles. The anti-venereal movement drew heavily upon this positive perspective. Just as Martin Arrowsmith’s research had foundered on the rocks of politics and bureaucracy, public health officials emphasized the fact that they had the necessary scientific knowledge to wipe out syphilis but were prevented by prudishness and lack of funding.

In 1937 Parran published a book detailing the themes of his campaign against syphilis, Shadow on the Land. The book attracted a wide audience and soon became a bestseller. Clearly, a significant shift in public opinion concerning the venereal diseases had occurred. Paul Kellogg, editor of the Survey Graphic, wrote to Parran, “Newspapers throughout the country carried the nib of your challenge. We broke the taboos of a women’s magazine of three million circulation; and the whole movement you were initiating took on new drive.” Parran, eager to solicit federal aid for his campaign, noted this transformation in a letter to President Roosevelt: “During recent months there has been a great change in public attitude toward syphilis, particularly in the willingness of the newspapers to open their editorial pages and editorial columns to a discussion of this important public health problem.” Science and medicine, it seemed, had overwhelmed the forces of reticence.

The Gallup Poll, only recently initiated, recorded the impact of Parran’s campaign. When asked by the pollster: “Would you be in favor of a government bureau that would distribute information concerning the venereal diseases?” over 90 percent answered yes, the largest majority Gallup had registered on any question put by his Institute of Public Opinion. The poll also found overwhelming support for free clinics and premarital venereal testing. Indeed, over 70 percent favored punishing those syphilitics who failed to take a full course of treatment. The very fact that Gallup questioned people about the campaign testifies to the new importance of venereal diseases in the public mind. Parran’s campaign had opened a flood-gate; the battle against venereal disease had been legitimized. The surgeon general had paved the way for government action.

Defining venereal disease as the most pressing of all public health problems, Parran devised a “New Deal” for its victims, one that he hoped would rid society of its dangers within a generation. In December 1936, Parran called a national meeting of state and local public health officials and venereal experts to set an agenda for the fight against venereal disease. The National Conference on Venereal Disease Control concluded that available facilities could serve only a quarter of those patients needing treatment. Delegates to the meeting...
advocated a national commitment, especially the allocation of federal funds to support anti-venereal work. "Public health is purchasable," explained the surgeon general, "as has been proved in the past when aroused public interest has stamped out plague after plague which once ravaged the population as syphilis does now." Officials took hope that support might be forthcoming when Franklin Roosevelt became the first president to address the question of sexually transmitted diseases directly. FDR sent the following message to the Conference:

The recent increase in public interest in the problem before the conference is extremely gratifying. The federal government is deeply interested in conserving the resources of the country by all appropriate methods. The attainment of your objectives would do much to conserve our human resources and would reduce considerably the present large costs for the community care of the disastrous end-results of the venereal diseases.

"No President," noted Time, "had ever said or written so frankly."56

Under Parran's direction the PHS expanded its programs and services, broadening what had in the past been a tangential role in American life. Parran put public health on the map of national priorities; during his tenure, food and drug regulations were extended, the National Institutes of Health dramatically expanded, and the federal government became committed to the battle against infectious diseases. The Social Security Act of 1935 made this explicit; through Title VI the PHS was provided with $8 million to disburse to the states for health care. This was the first money the state boards of health had received from the federal government since the years immediately after World War I.57

The distribution of Title VI funds reflected Parran's overriding concern about the venereal diseases. Ultimately more than 10 percent of this money was channeled to the fight against syphilis, the largest percentage allocated to any communicable disease. These funds served as a major impetus for venereal disease control work. States used the money to establish diagnostic facilities, clinics, and epidemiological programs. "The worthwhile attainments of the States now adopting new measures for venereal disease control," explained Raymond Vonderlehr of the PHS, "will without doubt serve as an increased incentive to the rapid expansion of this work."58 The Social Security appropriation alone increased the budgets of state health departments by an average of 10 percent.

The crowning achievement of Parran's campaign against venereal disease, however, came in May 1938 when Congress passed the National Venereal Disease Control Act. Senator Robert LaFollette of Wisconsin and Congressman Alfred Bulwinkle of North Carolina, the sponsors of the bill, offered the legislation as an amendment of the World War I act that created the Interdepartmental Social Hygiene Board and the Venereal Disease Division of the Public Health Service. This made explicit the relation between the unprecedented activities during World War I and the New Deal.59 Just as the war had demanded the expansion of the federal government, so now the crisis of the depression had brought forth the need for a more powerful centralized State.

Supporters of the legislation emphasized the national nature of the venereal
problem. As Herman M. Baker, president of the Indiana State Medical Society, declared: "These germs do not know state lines and you have simply got to handle the thing as a problem that is national in scope." LaFollette reiterated this point to his Senate colleagues:

It is obvious that if this battle against syphilis is to be won, it must be fought on 48 fronts. A program must be carried on in every state. The germ that causes syphilis does not respect state lines. It does not take into consideration the financial ability of states or communities.  

Although some states had developed successful public health programs for dealing with the venereal diseases, facilities continued to vary considerably from state to state; Parran’s publicity had served to make clear the national dimensions of the problem and the need for a national solution. This theme was consistent with the manner in which the New Deal sought to address other problems. Just as they could not handle directly unemployment and relief, the states simply could not bear the burden of what was clearly a national crisis. This realization laid the foundation for the expansion of the federal government to provide new services and attack issues heretofore viewed as within the domain of the states. The National Venereal Disease Control Act marked—an as did other New Deal welfare legislation—a shift in notions of federal responsibility for ameliorating social problems.

The Act provided for federal grants to the state boards of health to develop anti-venereal measures. As part of the requirements of the legislation, each state submitted to the surgeon general a comprehensive summary of current venereal disease control activities as well as plans for improving services on both the state and local levels. Money could then be allocated by the PHS to set up diagnostic and treatment facilities and train necessary personnel. In addition, the Act called for research into the treatment and prevention of the diseases. As originally written the bill provided for the allocation of $271 million over a thirteen-year period—a national blitz against the diseases. But the bill was soon revised to a more realistic $15 million over a three-year period: $3 million in the first year, $6 million in the second, and $7 million in the third year when health departments would be in a position to spend additional appropriations to greatest benefit. In the first year, the Act mandated the PHS to spend $600,000 to conduct field studies, and develop educational programs for public health officials.  

Individuals testifying before Congress in support of the legislation consistently stressed that the expenditures that the bill required would ultimately save the nation greater expense. As Herman Bundesen, commissioner of the Chicago Health Department, noted: “It costs more money not to do the job than it costs to do the job.” Legislators clearly found such logic compelling. Thomas Parran explained to a group of senators, “We are paying for syphilis now, whether we control it or not. We are paying for it in our relief rolls; we are paying for it in our institutions for the crippled, the blind, and the insane.” When the surgeon general expressed concern that FDR was not providing sufficient support for the bill, his ally in the campaign, science writer Paul De Knief re-
"SHADOW ON THE LAND"

sponded: "The President does not yet see this simple arithmetical relationship that the more you spend fighting a communicable disease, the more you save."

De Kruif concluded: "This one thing I know: that his strongest allies would be the financial overlords of our country. Against this enemy there is the one chance of a true, united people's front—of all the people, haves and have-nots."62

The anti-venereal battle did indeed have broad appeal. Heightened consciousness of venereal diseases had opened the way for legislation. The publicity of the preceding years helped to create a groundswell of support. Parran recounted the history of these efforts before a Senate committee:

As I see the problem broadly, during the past 10 or 12 years we have built the foundation. Then, we moved ahead on to the first stage: that is, the stage of public education, the stage of talking about it. I would like to point out to you that we cannot talk syphilis out of the United States; the spirochete does not listen to us. Men and munitions are needed on a national scale to deal with this problem.

Education, however, had generated support for these measures, and groups such as the National Junior Chamber of Commerce, the American Legion, and the General Federation of Women's Clubs now came forward in support of the bill. Fiorello LaGuardia, mayor of New York, commented on the new awareness of the venereal diseases in his testimony supporting the legislation: "Now you remember some 15 or 20 years ago when ladies met they would ask, 'Have you had your blood pressure taken?' and talk about their blood pressure. Now, they ask about their Wassermanns."63

Even the American Medical Association, noted for its attempts to keep the government out of medicine, offered no resistance to the anti-venereal legislation. Apparently the AMA decided its priorities rested with the battle to defeat provisions under consideration for national health insurance. Fee-for-service, the bedrock of the American medical profession, was not threatened by the Venereal Disease Control Act. Moreover, venereal diseases had never constituted a particularly lucrative element of medical practice. Preventive medicine and public health programs, especially those devoted to specific infectious diseases, did not usurp the economic position of the profession as would the more comprehensive proposals. As Dr. Hugh Hampton Young, the eminent Johns Hopkins urologist, explained to the House committee: "I myself am opposed to socialized medicine, but I think that this [National Venereal Disease Control Act] is different, and I think as long as it can be accomplished in this clearly outlined method, dealing with this kind of disease, I think it has its place."64 Young noted that only the PHS could properly coordinate the activities of local institutions, clinics, and hospitals to achieve results against the venereal diseases. In addition, he pointed out that private physicians needed state assistance to provide the facilities for sophisticated diagnostic work. He compared the campaign against venereal disease to those that had been waged against other epidemic infections like yellow fever and typhoid.

Other physicians frequently suggested, however, that venereal disease control programs might well become the entering wedge for socialized medicine. "It may be frankly said," wrote Dr. John Stokes, "that at no point in the entire
practice of medicine does the profession in the United States face more directly the issue of so-called socialization than in the case of the venereal diseases. Some doctors argued that if they were to maintain their stature in the care of venereal diseases they must provide better care to venereal patients, even those who could not afford their full fees. "If the private practitioner wishes to maintain his control of this field he must raise his standard to that of the public service," Stokes concluded. A number of physicians advocated the establishment of pay clinics as the proper alternative to public medicine. "The stress are in the wind," commented the prominent syphilographer Dr. I. E. Moore. "Failure to solve it means that the problem will be taken from the hands of the medical profession by outside sources with state medicine as the forced alternative." But few physicians shared these concerns; most seemed willing to concede the venereal diseases to the state so long as their larger economic interests remained secure.

Only organized religious groups raised any significant objections to the bill. One of the few individuals to offer questions concerning the propriety of the legislation was William F. Montovon of the National Catholic Welfare Association. First, Montovon suggested that the legislation would allow the state to usurp the role of the medical profession. "I think everybody would accept the statement that we do not want to make the medical profession dependent upon the State," he explained. "Everybody is desirous of preventing the extension of State medicine to interfere with the present work of the private physicians and private clinical agencies, particularly medical schools." Montovon's primary doubt was about the moral issue that the bill represented. In his view, the proposed bill could actually have a deleterious impact on sexual ethics. "The moral standards must reach a point where the relationship which exists between the sexes is on a higher plane," he declared. In a veiled reference to chemical prophylaxis and the use of condoms, the two principal venereal preventives, he noted, "Now, if we are going to unload on the population a lot of gadgets and contraptions, and ideas for protecting themselves against contamination, we are not going to remedy or solve the problem that will follow the enactment of this legislation." The social hygienists also expressed some concern that in the new emphasis on attacking venereal disease through medicine, science, and public health, their larger goals concerning sexual mores and family life would be lost.

Dr. William F. Snow cautioned: "While it seems important once more to concentrate attention and effort on the medical and public health division of the [American Social Hygiene] Association's work, there should be no lessening of our determination to continue the established education and protective divisions of the Association's program.... Education is the method by which we may ultimately expect to make permanent gains through the promotion of normal, unaffected attitudes and practices in relation to sex."

Though tension persisted between moral and medical approaches to the problem, the voices of apprehension could not match the rising chorus of support for a national venereal disease program. On May 24, 1938, after its overwhelming approval in both the House and the Senate, FDR signed the National Venereal Disease Control Act, calling it "a major piece of social
Raymond Vonderlehr, chief of the Venereal Disease Division, told reporters that the Act "makes possible a continuous scientific, coordinated attack which undoubtedly will materially reduce the incidence of syphilis and gonorrhea in the United States within the next decade." The federal government was now committed to the alleviation of this previously taboo problem. The legislation had a substantial impact upon the problem of venereal disease in American life. By 1940 the effects of programs that the federal funding helped to establish could be partially measured. Clinic facilities for the treatment of venereal disease had grown from 1,750 in July 1938 to almost 3,000 in July 1940. Moreover, the improvement and expansion of existing treatment centers had also served to make therapy more accessible. The $15 million appropriation helped to provide private practitioners with diagnostic and epidemiological services, as well as with free drugs when necessary to assist in the treatment of disadvantaged patients, and in some cases for all their patients regardless of income. As a result of the increase in facilities and public subsidies, the number of patients receiving the minimum required therapy jumped from 15 to 58 percent. Another indication of the value of the legislation was the fact that the number of blood tests performed to detect syphilis increased by some 300 percent between 1936 and 1940; funds from the Act helped to make the necessary diagnostic facilities available. "Since the detection of syphilis is to a large extent dependent upon mass blood-testing," noted Vonderlehr, "this increase in laboratory tests for syphilis is perhaps the best index of the effort which has been made to discover and bring to treatment infected individuals." More cases now came under treatment during the early stages of the disease when therapy proved most effective. The "shadow on the land" had begun to lift.

Many states took action to join the federal campaign, passing legislation designed to protect the family from venereal infections. By the end of 1938, twenty-six states had enacted provisions prohibiting the marriage of infected individuals. Although by the end of World War I almost half the states had statutes whose ostensible purpose was the prevention of venereal disease in marriage, these laws typically had little impact. Most merely required a note from a physician or, remarkably, for the groom to sign an affidavit assuring that he was free of infection. As a physician, let alone a layperson, cannot identify a syphilitic infection without laboratory exams, such oaths really constituted character references; a premarital ritual of little benefit for health. Some of the penalties for failure to comply with these laws were severe—in Oklahoma and Michigan it was a felony with fines and imprisonment—but they were almost never enforced. Moreover, these requirements rarely applied to women, reinforcing the sense in which they were truly half-measures. Without the requisite of scientific diagnosis—the Wassermann test—these laws had reflected social convention and educational precepts more than any epidemiological reality. In 1935 Connecticut passed the first law requiring a blood test and physical examination for all prospective brides and grooms; if one party
Beginning with Connecticut in 1935, many states began to require premarital blood tests. If an individual was found to be infected, a marriage license would not be granted until the individual was found to be non-infectious, a process that could take a number of years. Women's magazines became the strongest advocates of these enactments, frequently publishing articles and short stories detailing the tragic consequences of syphilis in the family. "Premarital tests aim at averting tremendous economic loss . . . as well as avoiding needless anguish and suffering," explained the Literary Digest. Several states, however, continued to require only the examination of the bridegroom, arguing that a mandatory test of
fronted "pure" women. This, of course, compromised the laws' effectiveness in finding infections and protecting the family; in addition, it reflected a somewhat anachronistic view of the "double standard" of morality. Only the widespread acceptance within the medical community of serologic examination made the laws feasible; indeed, many physicians noted the advantage of this newly required, mandatory visit to their offices.

Although public health officials typically suggested that one in ten Americans carried a syphilitic infection, statutory blood tests revealed a much lower rate. In New York City during the first year in which the law took effect, premarital testing exposed only 1.34 percent positive for syphilis. Officials accounted for this figure by suggesting that individuals who knew of their infections postponed seeking marriage licenses until determined to be non-infectious. This may well have been the case, but it seems more likely that the low rates of infection reflected the fact that some claims of prevalence had been inflated, or that the premarital exam was not the optimal locus for screening. When the tests did reveal infections, officials assumed with some justification that new, unknown infections had been discovered. As William F. Loomis of the Wisconsin Board of Health explained: "In every instance, those . . . individuals had no knowledge that they had syphilis; otherwise they would not have taken the chance of stigmatizing themselves by applying for a marriage license and then having the license refused them."

According to some reports, many applicants for marriage licenses sought to evade the premarital tests. After Connecticut passed its law in 1935, and before the New York State Legislature had taken action, weekend marriages in New York counties bordering Connecticut rose by 55 percent. Moreover, the number of marriages in some states reportedly declined after premarital exams became legally required. After the New York law went into effect in July 1938, there was a 41 percent decrease in marriages, which many commentators attributed to the new statute. In New Jersey some state legislators expressed concern that premarital laws that restricted marriage to the healthy could lead to an increase of free love, illegitimacy, and common law marriages. Although no organized opposition to the bill emerged, it passed by only one vote.

In addition to provisions for premarital exams, public health officials also supported legislation requiring pregnant women to undertake prenatal tests to prevent congenital transmission of syphilis. Congenital infection of the newborn often had disastrous consequences; children born with the infection often died or suffered from a number of serious repercussions including blindness and paralysis. As already noted, some 60,000 infants were born yearly with syphilis, most of whom died shortly after birth. As early as 1916 Dr. J. Whitridge Williams, the noted obstetrician at Johns Hopkins Hospital, required all women at his prenatal clinic to receive a routine Wassermann test. Williams found in investigating 700 fetal deaths among 10,000 deliveries at the Hospital that 26 percent could be attributed to syphilis. Early, continuous treatment of pregnant syphilisics, he demonstrated, prevented the infection of the infant in almost all cases. Williams's findings nevertheless went largely unheeded for the next two decades. In 1938 New York and Rhode Island enacted laws requiring prenatal...
New York's law, popularly known as the “baby health bill,” was signed by Governor Herbert Lehman in March 1938. The law required all persons caring for women in pregnancy to submit a blood test to an approved laboratory. At the time of the bill’s passage only half of New York City’s practicing obstetricians made such tests as a matter of course. Many doctors reportedly suggested that the recommendation of the test might offend their patrons. According to one study, women who attended public clinics, where serologic exams were routinely performed, were less likely to give birth to syphilitic babies than moderately “well-to-do” women under the care of private physicians.79

The prenatal laws had a powerfully positive impact on the incidence of congenital syphilis within the United States. Indeed, unlike the premarital laws, which turned up few new cases, the prenatal legislation led to the decline of congenital transmission even before the advent of antibiotics. A study of the impact of the prenatal exams in California, for example, showed that the infant mortality rate for syphilis fell from 6.50 per 1000 in 1938 to 0.15 in 1945; cases of congenital syphilis dropped from 1.60 to 0.54 in the same years.75

The American Social Hygiene Association and public health organizations heralded both the premarital and the prenatal laws as a major triumph in the battle against venereal disease. “If these laws are administered satisfactorily, there can be no question about the great benefit to the people and the nation,” the ASHA commented. “We may indeed see the day when syphilis is outlawed.”76

The assumption behind these measures—clearly expressed by the ASHA—was that through these statutes syphilis would eventually be conquered. This, in turn, reflected a view of sexual relations not substantiated in practice. Everyone, they assumed, would pass through the sieve of marriage and pregnancy; all infections would then be discovered and treated. These laws marked the dramatic incursion of the state into public health and the family. Unlike the statutory tuberculosis testing has rivaled these massive screening programs for a communicable disease in the twentieth century.

In addition to the laws, the other significant public health innovation of the 1930s—case-finding—also marked the expansion of public health into areas previously considered to be in the private sphere. Public health officials now emphasized the need to identify a venereal patient’s sexual contacts. These individuals would then be apprised of the possibility of infection, tested, and, if need be, treated. On this in this way, officials argued, could the geometric progression of infection be stopped. “Contact epidemiology,” a traditional approach to communicable disease, was now applied vigorously to the venereal diseases. As Thomas Parran commented:

A physician would not consider treating a case of smallpox without investigating fully the source of infection. He would either undertake this himself or report to the health department to make the investigation. On the other hand, one does not
feel any such responsibility in cases of early syphilis. Yet the tracing of the source of syphilis is no more difficult than tracing the source of smallpox and is just as important. As a matter of fact, it is easier, for the person knows more definitely the source from which he may have acquired the disease.^^

This assessment, however, was essentially naive, for syphilitic patients often did not wish to reveal the names of their sexual contacts. Public health officials and social workers devised techniques to encourage patients to identify their sexual intimates. The University of Pennsylvania Hospital, through a grant from the Milbank Foundation, worked to develop "persuasion" methods to get the cooperation of venereal patients. "The clinic, by friendly sympathy, persuades the syphilitic patient to disclose the identity of his recent sexual intimates," explained social worker Louise Brown Ingraham. Through these interviews, case workers reported that 80 percent of all contacts were located, although their ability to quantify this rate seems doubtful. "The approach dips deep into the heart of the individual and society, slowly bringing into the community a realization of the ominous presence of syphilis and makes possible a more intensive medical attack," noted Ingraham. Case workers in the field, following up reports of contacts, coined the term "shoe-leather epidemiology" to describe the unflagging rigor with which they sought out potential venereal victims for examination and treatment. Physicians advocating the need for "public health sleuths" repeatedly told stories of massive epidemics originating from a single source, developing into a pyramid of infection.^^

The ultimate impact of case-finding remains difficult to evaluate. The search for infections required sensitive and difficult probing; it demanded that an individual discuss intimacies with strangers, secrets which could wreak havoc in the infected person's life. Contact epidemiology clearly brought many unsuspecting individuals into treatment before they could spread their infections to others. But the knowledge that information regarding contacts would be sought by public health professionals also had the effect of encouraging some individuals to seek the aid of quacks or private practitioners who guaranteed absolute confidentiality. Indeed, most private physicians have resisted public health requirements that they report individuals suffering from venereal disease to public officials so that contacts can be approached.^^ Venereal disease posed the fundamental dilemma of individual privacy versus the public good, a conflict that remains largely unresolved.

The notion of finding cases through screening and bringing infected individuals under treatment nevertheless became the basis for the modern campaign against syphilis initiated during the 1930s, nowhere was it pursued with as much vigor as in Chicago. With the assistance of the Chicago Tribune, which provided necessary publicity, the local, state, and federal health bureaucracies developed a comprehensive plan to rid the city of syphilis. The Works Progress Administration, and Title VI of the Social Security Act provided funds to undertake a massive effort to uncover and treat cases of syphilis beginning in 1937. In July more than a million questionnaires were mailed to Chicago families to ascertain their interest in such a campaign. More than 261,000 persons indi-
cated their desire to receive a free blood test. At the height of the program, ten to twelve thousand individuals daily were tested in what Parran had called a "Wassermann dragnet."

The Chicago project contained all the elements of a full-scale crusade against syphilis. There was widespread publicity encouraging individuals to be tested. On August 13 a syphilis parade marched from the Loop to City Hall carrying signs declaring, "Friday the thirteenth is an unlucky day for syphilis." An airplane with an anti-syphilis banner circled the city, newspapers carried announcements, and the radio filled the airwaves noting locations for free exams. Even the Federal Theatre Project got into the act with the production of Arnold Sundgaard's "living newspaper," Spirochete. The "fictionalized-documentary" reviewed the history of medical treatment for syphilis, attacked the conspiracy of silence, and urged on the Wassermann campaign. During intermission, theatre-goers were invited to be tested in the lobby. Paul De Kruif, writing to Parran about the plans for the program, exclaimed: "If nothing else it is the most audacious and spectacular public relations move that has ever been made in syphilis. It will enormously increase syphilis consciousness." Spirochete later opened in Boston, Seattle, and Philadelphia.

Officials expanded diagnostic facilities to meet the tremendous demand the publicity generated. Between 1937 and 1940 over 31 percent of the city's population received Wassermann tests. The "dragnet" uncovered and provided treatment for some 56,000 individuals infected with syphilis—all at public expense. The program had particular benefit for the city's black population, for whom health care facilities had been grossly inadequate in the past and among whom rates of infection ran especially high. In fact, more than 60 percent of all cases tested came from Chicago's black wards. Under the program, the number of cases of syphilis under treatment in Chicago increased by 300 percent. The fact that Chicago had the lowest syphilis rate of all major cities during the selective service physicals for World War II revealed the program's striking impact. With funds, facilities, and the support of the press, a major attack on syphilis could be waged to great effect.

All public health programs directed against syphilis, from Chicago's dragnet to statutory prenatal exams, rested upon the ability of the profession to detect cases accurately—in other words with the Wassermann test. Many colleges initiated campaigns to test their students. At the Illinois State Fair of 1938, free blood tests for syphilis proved to be a big attraction. The Wassermann test and subsequent variations were, no doubt, extremely helpful in determining cases of syphilis and furthering efforts to track down infections, but these exams were often subject to error. Some physicians indicated that between 2 and 14 percent of all Wassermann tests produced false positives, and thus should be frequently repeated. Dr. John Stokes explained: "They [serological tests] are not the infallible things that the laity especially is inclined to think they are." In fact, some contemporary researchers have suggested that the Wassermann test was so overly sensitive that it typically turned up as much as 25 percent false positives. Many individuals during the 1930s suffered the consequences of the toxic syphilitic
13. Arnold Sundgaard's Spirochete, produced by the Federal Theatre Project, was the centerpiece of the 1938 Chicago campaign against syphilis.
treatments although they were never infected; in some cases, these individuals were barred from marriage because of an incorrect Wassermann reading. They suffered the stigma associated with a disease they never had.

While massive testing for syphilis was undertaken in the 1930s, little interest in the other major venereal disease, gonorrhea, was expressed by public health officials. Although the federal legislation and public health efforts addressed the problems of all the venereal diseases, in reality they centered attention—as did Parran’s publicity—on syphilis. Syphilis made headlines, while gonorrhea, four times more prevalent than syphilis, remained deeper in the public consciousness. Several factors explain why little effort was directed to gonorrhea. First, most physicians argued that the long-term pathology of the disease, though serious, was far less dangerous than syphilis. Second, diagnostic procedures for gonorrhea remained more complex and difficult to administer than the simple complement-fixation reactions that could identify syphilis through a blood test; microscopic smears were required to detect gonorrhea, a procedure few physicians could easily perform. Finally, medical science had little to offer an individual suffering from gonorrhea prior to the availability of the sulfonamides in the early 1940s. As Dr. William F. Snow pointed out: “Probably this disease will not be dramatized as syphilis has been in recent years unless some new and spectacular method of cure is devised.” Aware of the fact that gonorrhea was receiving short shrift in the anti-venereal campaign, however, doctors argued for the need to address the problem with equal force. N. A. Nelson cautioned Parran that his approach “seems to push gonorrhea another peg or two down the ladder.” Accordingly, he suggested “it would not be out of place to carry the problem of gonorrhea into the public consciousness along with syphilis, since they have a common epidemiological background.” This critique, however, went largely unheeded during the 1930s. The American Journal of Public Health noted an alarming attitude toward gonorrhea: “Too many of our young men, for example, boast of having gonorrhea and regard it, if not as a matter of pride, as one showing that they know their way about and are men of the world.” But to raise gonorrhea in the public mind, only to assert its untreatability, would have been a blow to the growing authority of science, medicine, and public health—the very authority behind the campaign against syphilis.

Thomas Parran’s campaign against syphilis during the 1930s differed substantially from the reforms of the Progressive years and even the significant programs of World War I. Three essential themes characterized his effort. First, Parran rejected the traditional emphasis within the anti-venereal movement on sexual morality and ethics. Second, he hoped to place his crusade on the plane of science and medicine, to incorporate the battle against venereal disease within the tradition of efforts to combat infectious disease. And third, the surgeon general sought to force the State to accept certain fundamental responsibilities for the care of venereal sufferers. In each of these respects his program marked a
watershed, a rejection of Progressive notions of voluntarism, charity, and morality. Parran's campaign against venereal diseases represents the most positive elements of New Deal reform. Refusing to be limited by social conventions and political precedents, Parran clearly identified the problem and the available instrumentalities for its resolution. The straight against venereal disease and the strong commitment of federal funds demonstrated the New Deal's resolve to expand the role and functions of the federal government to identify social problems of a magnitude that only a national government could effectively mitigate.

The struggle against venereal disease and the strong commitment of federal funds demonstrated the New Deal's resolve to expand the role and function of the federal government; to identify social problems of a magnitude that only a national government could effectively mitigate. The anti-venereal campaign is a neglected but important element in the history of New Deal social reform.

But just as the New Deal broke precedent, expanding the parameters of reform, so too, it met severe limitations and constraints. This, unfortunately, was also true in the case of the crusade against sexually transmitted diseases. Undercutting the dramatic success of Parran's battle were a number of subtle yet powerful views of the venereal diseases that continue to this day to limit our ability to deal with them effectively. These views, which were often at odds with the new sexual candor concerning the venereal diseases expressed during the 1930s, existed side-by-side with Parran's more dispassionate outlook, often undermining his goals.

The central problem that limited the potential of Parran's program to rid the nation of venereal infection was what became known as "syphilophobia"—the fear of syphilis, or for that matter, any venereal disease. In "The Next Great Plague To Go," Parran had actually advocated that "syphilis ignorance" be replaced by "syphilophobia." Though admitting that this might "create some neurotics" or aggravate some already strained family relationships, he suggested it would help to uncover unsuspected cases, bring new cases to treatment, and render many non-infectious. "Syphilophobia never killed anyone," declared Parran, "never brought a handicapped child into the world, never infected an innocent person." The fear campaign contradicted, in many respects, the very tenets of Parran's effort. Though education about the dangers of venereal diseases clearly was necessary, Parran often noted that the real emphasis should be placed on the medical profession's ability to treat syphilis effectively. Creating syphilophobia could only work against the goal of getting individuals in for treatment by heightening the stigma associated with the disease. Underlying the emphasis on
first, it seems, was a more traditional censure against permissiveness sexuality. The explicit message in repeated descriptions of the "vriages" of syphilis was the prescription: do sex risk infection.

A number of contemporary writers noted the deleterious impact of syphilis on the anti-machine movement. One critic observed in the Survey: "The public itself must recognize the seriousness of many of its ills of syphilis. It must use its influence."

Dr. Charles B. Rice of the Indianapolis Department of Health concurred, cautioning that the emphasis on syphilis might "lighten the population into a state of hysteria rather than to lead them into a constructive attitude toward the whole matter of sex." An acridly critical article from Chicago, Dr. Ben Reissman, proved to be one of the most striking critics of syphilis. Reissman, who closed his office to see the sick in the same room with a group of hobos, dedicated his practice to winning the poor, prominent, and the down and out. Addressing the problem of fear and the venereal section, he wrote:

"The social syphilis is mote severe and dangerous today than a disease pic-
losing that has ever been experienced in Europe. From time to time we have been ponerie-striking [sic] by smallpox, typhoid fever, and poliomyelitis, but surely there was some health officer to re-enforce to put on the soft pedal. But in the syphilis propaganda the crime reaches all the more incident is that it is bound to produce a serious reaction."

Parson's approach to the venereal problem, emphasizing its dangers, was then fought with a series of tracts. It raised the spectre of fear of syphilis gener-
atly public attention and funding, so, too, it could create attitudes that could hinder the campaign as well.

Critics of syphilis often accused that the anti-machine campaign played fast and loose with statistics, vastly overinflating the extent of the problem. Although vast numbers of active in the anti-machine campaign often cited the figure that one in ten Americans harbored an infection, actual rates for preval-
ce usually re-calculated a significantly lower number. The New York State Jour-
ral of Medicine remarked in an editorial: "No one will negotiate the money spent to combat venereal disease in recent years. Nevertheless, we may question whether it is wise to base health measures on few fostered by exaggerated inciden-
tial figures." Ben Reissman also argued that reported statistics were probably inflated to small fees in the public. Perhaps overestimations of the number of infections did aid the campaigns to generate funds, but the problem with inflating such statistics and increasing fears of epidemic contagion was that sexuality itself was under attack.

The prevalence of certain beliefs about contagion long after they had been disproved was summarized by another attempt to syphilis. City and state health departments continued to pass ordinances requiring the examining for ven-
eral disease of domestics and food handlers, although it was well-known that infections were rarely, if ever, transmitted without intimate sexual contact. Walter Clarke, executive director of the ASA, explained, "Health officers are practically unanimous in denying the fluke impartiality upon which much of the public
demand for the sterilization of food handlers is based, namely that syphilis and gonorrhea are spread by contact of infected persons with articles of food or food utensils." Nevertheless, Clarke advocated the continued use of such sterilizations as a case-finding method. "I have not felt it desirable personally to discourage communities whose public opinion favor sterilization of domestic and food handlers," he concluded. But this view had the effect of endorsing the myth of non-genital infections. As one doctor testifying before the Senate explained: "I would suggest, if there is any doubt about this bill, that you have Dr. Farrar see to it that the senators of all Congresses of Congress are given first ten. I think they will find it sufficiently enough connected with their lives to pass the bill very quickly." 383

Oddities such as those directed at domestic and food handlers stereotyped sexual victim, encouraging fears of social contact between racial classes and ethnic groups. Although Farrar's campaign had gone far toward making the point that venereal diseases reached all segments of society, the view persisted that these infections particularly affected the working class, the unwed, and certain racial and ethnic groups. "There may be from seven to ten out of every hundred persons in the United States who are infected, but among the criminal element and the very depths of human society from thirty to forty out of every hundred are found to be infected," observed Dr. Morris Rubinstein without offering any substantiation for his statistics. Some individuals considered to argue that these infections could reach into the upper classes. As one physician exclaimed: "But even granting that syphilis were a reservoir of disease in the lowest social class of the population, scientists agree that such diseases always filter through and affect higher strata of society." 49 Again, the mode of such transmission remained a mystery.

Attitudes towards black and venereal diseases especially revealed the tension between the scientific-public health approach and the stereotyping marking of syphilis and gonorrhea. Since the early nineteenth century, physicians, particularly those in the South, had suggested that blacks were unusually prone to venereal disease, a "syphilis-sainted race." 426 Typically, high rates of infection were attributed to the premise that blacks were promiscuous; moreover, physicians argued that it was difficult to treat blacks because they could not be convinced of the danger that these diseases posed. Socioeconomic arguments for the prevalence of venereal infections among blacks were generally discounted. As a group generally, Farrar worked diligently to erase these views, but his nevertheless fell under the weight of their tradition.

It is an ironic tragedy that while the Public Health Service participated in a program that greatly benefited the black citizens of Chicago, it was at the same time conducting an experiment in Alabama that insured that some 400 black sharecroppers would never be treated for their syphilis infections. In 1932 the PHS initiated an experiment known as the Tuskegee Syphilis Study that sought to determine the impact of syphilis if left untreated. The experiment was based upon two essentially racist premises. First, the doctors who designed the study believed that virtually all southern blacks were infected. Second, they concluded that the men involved would never be treated anyway. Over a forty-year
period, the Public Health Service actively sought to prevent the men from receiving therapy, all the while telling the subjects that they were being treated by the government doctors. Many of the men—perhaps more than 100—died as a result of tertiary syphilis.

The attitudes and opinions within the medical profession that made possible the Tuskegee Syphilis Study and its continuation were strikingly persistent. In 1943 Dr. R. W. Williams of the Yazoo County Health Department wrote:

I have one criticism to make about the treatment of the Negro in the South; he is babied too much. . . . It is my firm opinion that if the Negro right at this time was cast off from the white race, the majority would starve to death. His sense of responsibility is practically nil.

During the forty years that the Tuskegee Study continued, it was widely reported in medical journals without raising any significant objections on the part of the profession. Indeed, only reports of the study in the general press in 1972 finally brought it to an end.

Blacks justifiably took exception to the typical assessments of the venereal problem among their race. Many black physicians disputed the frequently cited statistics that blacks suffered from syphilis at rates five to six times that of whites. As Lester B. Granger, executive secretary of the National Urban League, commented:

The National Urban League has constantly hammered on the point that it is not only unrealistic, but it is vicious to compare disease and death rates among Negroes with those among whites, unless careful pains are taken to compare groups of similar income levels and living conditions. . . . In the meantime, constantly harping on a disproportionate rate of increase among Negroes merely intensifies a distorted picture that white society has of Negro family life, and makes it more difficult than ever for Negroes to find satisfactory adjustment in housing and employment situations.

Moreover, black doctors raised objections to the notion that venereal disease had a fundamentally different pathological impact upon blacks because of biological differences between the races, a view held, for example, by Thomas Parran. These assumptions about race and venereal disease, like syphilophobia, had the effect of making these infections a problem of morals rather than medicine.

The final supposition underlying syphilophobia was that it was better to fear syphilis than to prevent infection. The campaign against venereal diseases during the 1930s consistently emphasized their dangers without ever giving serious attention to their prevention except through sexual abstinence. "Syphilis is always painted as a horrible, loathsome disease by medical men," declared Ben Reitman. "It is never explained that syphilis and gonorrhea are preventable." Reitman repeatedly returned to this point in his critiques of the public health campaign. Despite the emphasis on science and medicine that Parran's efforts engendered, chemical prophylaxis was seldom advocated. Moreover, public health officials refused to encourage the use of condoms, also known to be effective preventives against disease. Even washing with soap and water after intercourse,
shown at least to reduce the possibility of infection, never received the sanction of public health officials in their fight against venereal disease.

The response of the anti-venereal campaign to birth control is suggestive of the constraints upon the movement. The American Social Hygiene Association, concerned about the possibility of alienating their Catholic constituents, sought to avoid the issue of birth control altogether. This position, however, created concern among their primary sponsor, the Rockefeller-funded Bureau of Social Hygiene, which simultaneously sponsored some birth control research. The BSH believed that the ASHA was side-stepping an issue significantly related to their avowed interest in the American family. Though it was well-known that the condom served as both an effective preventive against pregnancy and venereal disease, the ASHA continued to refuse to endorse their use.

As Ruth Topping of the BSH noted in a report: "Surely this is a strange position on the part of an organization with the avowed aim to reduce the menace of venereal disease."95

By 1940 the ASHA had still failed to promote, or indeed, even mention, the use of condoms in their educational literature. The Birth Control Federation of America bitterly noted this omission. Dr. Woodbridge Morris, general director of the Federation, wrote to the ASHA criticizing its defensive posture:

> In my strong conviction, as a citizen and as a physician, that venereal diseases must be controlled by every available means, I appeal to you to take a positive stand in this matter [condoms] before the public finds out that you are, in fact, permitting the spread of venereal disease because the most effective method to control it happens to be a method of contraception.

Walter Clarke of the ASHA sought to bury the issue, noting: "I believe that if we proceed cautiously we may continue to avoid battles on this touchy subject."96 Thomas Parran also avoided the issue of condoms, although the advocacy of their use would have been consistent with his desire to approach the problem of venereal disease free of moral consideration. Indeed, Parran admitted fearing a decline in American morals:

> Whatever the causes for the double standard of morals . . . and its encouragement to commercial prostitution, it appears that our present trend is to a single standard unhappily in the direction of the old male standard of promiscuity rather than towards the woman's standard upon which was built the monogamous marriage."97

Parran, a Catholic, had perhaps already pushed his morality to the breaking point through his campaign against venereal disease; on the issue of prophylaxis, he simply could go no further.

In its response to birth control, the anti-venereal movement revealed its implicit outlook on American sexual ethics. Rather than accepting the fundamental changes that had occurred in American sexual life toward a more permissive premarital sexuality, many still hoped to turn back the clock. In this respect, prophylaxis was considered in much the same light as birth control; unwanted pregnancy and venereal disease had been used for some time as the principal means of controlling sexuality. To take the fear of these potential consequences
out of sex was to many social critics to risk a breakdown of restraints on family and society. With the growing use of birth control in the 1920s and 1930s, the threat of venereal diseases became an even more potent injunction against casual sex. Thus syphilophobia, rather than prophylaxis, became an elemental aspect of the campaigns against the venereal diseases.

Thomas Parran and the New Deal’s campaign nevertheless made dramatic strides against the venereal diseases. Parran had boldly defined the problem and acted to commit the federal government to its resolution. Before the 1930s, venereal disease had largely been viewed as a problem of personal willfulness and individual turpitude. Parran led the fight to see venereal disease as a social problem, worthy of government intervention. The times were attuned to such an effort, for the Great Depression had called into question—as few events could—Progressive notions of individual responsibility. The traditional view of the venereal victim as undeserving of aid was significantly weakened during the 1930s. Moreover, the social and economic costs of not dealing with the problem were, at last, made explicit. Parran’s campaign thus clearly fits into the larger corpus of New Deal reform.

During the Progressive years the definition of venereal disease had changed from carnal scourge to family poison. During the 1930s the representatives of modern science and public health attempted to redefine venereal disease as a curable disease, but met with only partial success. Parran’s goal of a nation freed from the burdens of sexually transmitted diseases was never reached, despite the subsequent advent of more effective medical treatment. Venereal disease remained—in spite of Parran’s efforts—a symptom of social decay and sexual evil. The discourse about the diseases reinforced this view, making venereal disease that much more difficult to deal with effectively. Even Thomas Parran failed to discern the close alliance of fear, stigma, and taboo an alliance whose power continues to hold sway.