INTRODUCTION

Sex, Disease, and Medicine

The most remarkable change in patterns of health during the last century has been the largely successful conquest of infectious disease. Less than one hundred years ago diphtheria, tuberculosis, pneumonia, typhoid, and dysentery constituted this nation's greatest health threats; epidemics could devastate a city or town with tragic speed. In 1918 an outbreak of Spanish influenza claimed more victims than did combat in World War I. Today these diseases are largely under control if not virtually unknown. Although there is considerable debate about the reasons for the decline of these infectious—some credit medical advances while others have stressed a rising standard of living, better nutrition, and natural changes in the host-parasite relationship—there is no doubt that we have much less to fear from infectious disease than we did even a generation ago.

Yet, strikingly, venereal diseases are inadequately controlled, if controlled at all. Given the power of the contemporary media, it seems impossible to be unaware of the current problem. Herpes, a viral infection that is often transmitted sexually, is according to most reports epidemic, affecting perhaps as many as 20 million Americans. With no effective treatments available, it threatens to become endemic. Even more ominous is the new disease known as Acquired Immune Deficiency Syndrome (AIDS). Found primarily among homosexual males, in most cases this disease poses a lethal threat. Again, there is no known effective treatment. Yet even syphilis and gonorrhea, diseases for which cures have been developed, remain in dramatically high proportions. Gonorrhea constitutes the most prevalent bacterial infection on earth, with over one hundred million cases occurring annually; more than two million of which occur in the United States. Why, if we have been successful in fighting infectious disease in this century, have we been unable to deal effectively with venereal disease?

To answer this question, we must examine venereal disease not only as a biological entity, but as a disease that engages certain attitudes and values; beliefs about its causes and consequences that in turn affect responses to the problem. A society's response to those who are ill, its employment of medical discoveries and resources, is closely related to its most basic assumptions and
beliefs. I have attempted, therefore, to trace shifting attitudes and perceptions concerning venereal disease among both laypeople and physicians during the last century. In addition, I have sought to evaluate the impact of these beliefs and values upon medical practice, public health and military programs, and social behavior in general.

Although no single agency regulates sexuality—social reformers, families, and public institutions, as well as popular culture, all exert influence in this area—in the twentieth century, Americans increasingly turned to physicians for advice, counsel, and treatment for sexual diseases and problems. Physicians throughout the last hundred years have presented divergent views concerning the meaning of venereal diseases and approaches to their control. Recent studies have rightly cautioned against seeing the medical profession as a monolithic entity. Yet despite disagreement and internal debate among doctors, the debate over venereal disease increasingly took place within professional circles, rather than between professionals and laypeople. Contention among physicians did not call into question their essential authority in sexual matters.

But the response to venereal disease was not always limited to private exchanges in the doctor's office; in the twentieth century there have been major public interventions that provide the central focus for this study. As the costs of venereal disease became clear, both public health and military officials sought to address the problem of these infections, transforming a previously secreted medical issue into a social dilemma. Their public pronouncements and policies—from municipal ordinances requiring doctors to report cases to authorities to military orders calling for compulsory chastity—reflected prevailing views of the problem at various historical moments. To what extent were the responses of physicians, public health officials, and the military to venereal disease determined by social values, sexual concerns, and scientific advances? Because of my concern with the relationship of scientific and medical advances to social attitudes and professional practice regarding venereal disease, this study begins in the last decades of the nineteenth century, when researchers made the first dramatic breakthroughs concerning the specific causative agents of the venereal diseases.

The social history of venereal disease reveals major trends in the development of modern medicine. Perhaps more than any other single theme, twentieth-century medicine has been characterized by the search for "magic bullets"—specific treatments to root out and destroy infecting microorganisms. This biomedical model has come to define the role and nature of the medical enterprise. In this paradigm, individuals become infected with a parasite that causes dysfunction of some sort; disease is defined as a deviation from a biological norm. Social conditions, environmental phenomena, and other variables are generally discounted as causes of disease. The physician dispenses "magic bullets" that restore the patient to health. This book suggests that this paradigm is too restrictive; to find the solution to problems of disease we must look beyond the model of the magic bullet.

Although I have been concerned with professional and institutional issues, I have attempted to link these activities to social definitions of venereal diseases.
This focus on disease as it is socially defined forces a reorientation in historical approach, a different set of priorities; the frame of reference is expanded beyond the narrower field of clinical medicine. This study, therefore, directs attention to various "social constructions" of venereal disease—the particular symbols which American society came to associate with these diseases and their victims. By assessing the symbols and images which diseases attract we can come to understand the complex phenomena of illness. The symbols reflect social values—patterns of judgment about what is good or bad that guide perceptions and practice. They tell us how a disease is regarded, how we believe it is caused, who its victims are, and what they are like. Some diseases are viewed as the result of a sinister environment beyond our control; others are blamed on the individual victim and his or her personality and behavior. Examining these constructions can help us to recover the values at the core of medicine, and to make decisions about their meaning for the medical task. Our ability to recognize and interpret these symbols substantially affects medical practice and public health. 

Fundamental to the notion that disease is socially constructed is the premise that it is profoundly shaped by both biological and cultural variables. Attitudes and values concerning disease affect the perception of its pattern of transmission, its epidemiological nature. Only if we understand the way disease is influenced by social and cultural forces—issues of class, race, ethnicity, and gender—can we effectively address its biological dimensions. A "social construction" reveals tacit values, it becomes a symbol for ordering and explaining aspects of the human experience. In this light, medicine is not just affected by social, economic, and political variables—it is embedded in them.

Since the late nineteenth century, venereal disease has been used as a symbol for a society characterized by a corrupt sexuality. Venereal disease has typically been used as a symbol of pollution and contamination, and cited as a sign of deep-seated sexual disorder, a literalization of what was perceived to be a decaying social order. Venereal disease makes clear the persistent association of disease with dirt and uncleanness as well, revealing pervasive cultural attitudes and values. We have known since the late nineteenth century that venereal diseases are caused by microorganisms, and yet the persistent association of dirt and disease is remarkable. The very term which the venereal disease control movement took for itself in the twentieth century—social hygiene—makes explicit this association.

Within the social constructions of venereal disease in the last century a number of important values have been expressed; themes that reflect longstanding historical traditions regarding sexual behavior. In particular, venereal disease came to be seen as an affliction of those who willfully violated the moral code, a punishment for sexual irresponsibility. These infections were employed to argue for a more restricted sexuality. So long as these social uses of the diseases have dominated medical and public approaches, therapeutic approaches to the problem have necessarily remained secondary. Because of the nature of these diseases, individuals often have suffered a double jeopardy: the physiological consequences of the disease itself, as well as the deep psychological stigma.
Venereal disease provided evidence for those seeking to demonstrate—for a variety of reasons—that attempts to regulate sexuality had failed, that the idealized unified social values of American society were threatened. In this respect, many discussions of venereal disease became a rhetorical vehicle for demanding reform of American sexual mores. Much of the writing about venereal disease was, therefore, prescriptive. But venereal disease also is indicative of actual sexual behavior and practice, and programs and policies for its treatment often forced physicians to confront the disquieting distance between ideals and behavior.

This book, then, poses two related questions about venereal disease in American society. First, what does venereal disease reveal about sexual attitudes and practices, as well as larger social values? And second, how have attitudes and beliefs concerning sexuality affected medical and public health practices for the control of these infections? I want to demonstrate that the symbols that we use not only affect the way we come to think about a problem, but also dramatically affect the material reality; practice and policy are fundamentally influenced by the symbols we attach to a particular disease. I have sought to investigate the impact of values on health care, as well as the impact of medicine on social values and behavior.

Since the late nineteenth century, the venereal diseases have raised a number of deeper social conflicts which continue to generate controversy in American society. First, the tension between morality and secular rationalism: moral approaches have frequently clashed with scientific instrumentalism in the debates concerning venereal disease. Second, venereal disease fundamentally broached the modern dilemma of individual versus social responsibility. The problem of venereal disease made these conflicts explicit; addressing venereal disease forced a consideration of the notion that in modern society the sacrosanct, private world of sexuality might indeed have social implications of enormous moment, inviting the interest and control of public institutions. In this respect, the social history of venereal disease has significant implications not just for health policy, but for the polity as well.

If the three elements of this study—sex, disease, and medicine—could be considered seriatim, the problem of venereal disease would be far easier to assess. Venereal disease, however, by its very nature has historically been defined by the interrelation of these three issues. The basic contention of this work is that venereal disease has engaged a number of social fears about class, race, ethnic identity, and in particular, sexuality and the family. Venereal disease—in its social constructions—has been used during the last century to express these anxieties. In turn, the social and cultural uses of venereal disease as a means of controlling sexuality have greatly complicated attempts to deal effectively with the diseases from a therapeutic standpoint. Venereal disease became a rallying point for concerns about sexual mores and a more generally perceived social disorder. In its transformation from a biological entity to a social symbol, venereal disease has defied control.
Progressive reformers and social critics identified a myriad of ills surrounding the dramatic alterations in American life during the late nineteenth and early twentieth century. Few problems evoked more fear than the perceived “crisis of the family.” During the Victorian years the middle-class family had become, preeminently, an institution devoted to child-rearing and the maintenance of the home. No longer fulfilling the basic economic functions of earlier periods, the home had become a private place, given over to motherhood, childhood, and domesticity. Acute observers at the turn of the century saw trends within the family itself that threatened this ideal. Medical doctors in particular came to share these concerns when it became accepted that venereal disease constituted a special danger to the family.

The growing tendency toward later marriages and smaller families and the precipitous rise in the number of divorces foretold the demise of the middle-class family, the bulwark of American society, in the minds of Progressive social critics. The depressed economic conditions of the late nineteenth century led members of the middle class to postpone marriage in order to support their families in their accustomed manner. Family size was often limited to maintain this standard of living: by 1900 the average American family had only 3.56 children, down from 6.14 in 1840. In addition, the heightened emotional demands placed upon the family caused more marriages to end in the courts. In the years between 1870 and 1920 the divorce rate increased by a factor of fifteen. Moreover, a growing number of women, particularly the best educated, passed up domestic life altogether to pursue careers.

Critics charged that the American family, in a flight of selfishness, was failing in its primary responsibility, the "reproduction of the race." When social scientists reported that couples of Anglo-Saxon descent were falling behind their immigrant counterparts in producing children, Theodore Roosevelt raised the pitch of concern by proclaiming that the great white middle class was committing "race suicide," borrowing the phrase from the noted sociologist E.A. Ross. Roosevelt argued that men and women were "shirking" their most important
duty to the state. "Shame to those who choose to lead their lives in a round of cheap self-indulgence and vapid excitement," declared the former president in 1911. Although Roosevelt suggested that both men and women must bear the responsibility for this trend, he agreed with most observers, especially physicians, who blamed women for this "unnatural" inclination to suppress the maternal instinct.  

American physicians, dedicated to the ideal of a domestic, affective family, assessed these trends with considerable anxiety. Indeed, in the new urban-industrial, secularized world many physicians viewed the "health" of the family as a primary professional domain. "No apology will be required," noted an editorial in American Medicine in 1911, "for presenting certain phases of the question (of marriage) as topics for medical discussion, and it will be freely conceded that the modern physician should be as concerned with these as with anything else that has any bearing whatever on the mental and moral as well as the physical welfare of human beings." The new trend for women to seek careers, the editorial suggested, reduced the numbers of suitable brides, concluding that "marriage should be encouraged, never discouraged."

Within the profession, the specter of venereal disease—and new knowledge about the impact of these diseases on the family—fueled anxieties regarding the future of domestic life. Venereal diseases provided a palpable sign of degeneration, as well as a symbol of a more general cultural crisis. Recent scientific advances concerning the pathology and treatment of venereal diseases granted physicians new stature and increased authority in the assessment of a variety of related problems from the changing role of the family and marriage to sex roles and morality.

Physicians devoted to the venereal problem became an influential force in Progressive reform. "Progressive physicians" were generally those doctors who committed themselves to the larger political and social currents of reform during the first two decades of the twentieth century. Progressivism was no single movement, but rather a diverse configuration of principles, ideas, and practices for social reform. Although these ideas attracted professionals from a number of fields, the input of the medical profession has yet to be fully explored; reformers tended to emphasize how social problems affected their particular domain, and doctors were no exception. These Progressive physicians helped to pull together two of the most significant threads of the complex Progressive ideology: the desire for a rigorously defined moral order and a growing reliance on technical expertise. Indeed, Progressive physicians were quick to suggest the relationship of social pathology to medicine. In their evaluations of health and disease, these doctors reflected larger concerns about the major transformations in American life in the postbellum years. Many of these concerns—the growth of the cities, the increase in immigration, as well as the changing nature of the family—could be seen in their assessment of venereal disease, as well as other medical problems such as tuberculosis and mental illness. Venereal diseases offered physicians an opportunity to develop a comprehensive approach to health and disease, for here was a massive problem that clearly demanded the broadest possible view of the doctor's task from an educational, social, and clinical per-
spective. In fact, venereal disease, as a social construct, provided a means of organizing and explaining many of the social dilemmas which Progressivism sought to address.

For physicians who treated venereal diseases, claims of the family's decline rang true. A generation of scientific progress had clarified the devastating impact of syphilis and gonorrhea within the family unit. Though most physicians had long accepted the social stigma attached to these maladies, considering them just rewards for moral turpitude, the knowledge that profligate men “visited” these sins upon their wives and children led to a dramatic reversal in professional attitudes. The “discovery” of venereal insontium—infections of the innocent—in the last decades of the nineteenth century generated a movement to prevent these diseases and to demand adherence to a strict sexual code. There followed a virtual redefinition of venereal disease from the classic “carnal scourge” to “family poison,” a redefinition that would illuminate the relationship of science, morals, and disease in the new century.

The physician’s new approach proceeded from a growing body of evidence detailing the pathology of venereal diseases. From the sixteenth century until well into the nineteenth century, most doctors assumed gonorrhea and syphilis were manifestations of the same disease. Only in 1837 did the eminent French venereologist Phillipe Ricord establish the specificity of the two diseases through a series of experimental inoculations from syphilitic chancres. Ricord was also among the first physicians to differentiate primary, secondary, and tertiary syphilis, the three stages of infection. By the late nineteenth century the systemic dangers of syphilis had been identified in a series of pathbreaking studies. Because syphilitic infections appear to resolve after the initial inflammatory reaction, chronic ailments resulting from the disease had long been thought to be distinct clinical entities. Rudolph Virchow, one of the leading figures in the development of modern germ theory, established that the infection could be transferred through the blood to the internal organs, and that syphilis was in fact a systemic condition.

Subsequent research demonstrated syphilis to be the cause of a variety of serious illnesses. By 1879, cardiovascular syphilis had been clearly documented in the medical literature. If spread to the spinal cord, the infection could cause muscular recoordination and partial paralysis (tabes, locomotor ataxia, paralytic) or eventually complete paralysis. Ultimately affecting the brain, syphilis also led to insanity in some cases. By the early twentieth century, doctors reported that mental institutions were filled with patients whose illnesses could be traced to syphilitic infections. “The elimination of these diseases,” remarked one physician, “would render one-third, possibly one-half, of our institutions for defectives unnecessary.”

These discoveries of the nefarious spread of syphilis to the internal organs, made clear that the disease was much more dangerous than many doctors had previously assumed. The late indications of syphillis, often seemingly unrelated
to the initial symptoms, prompted William Osler, then the most distinguished clinician in the United States, to tell his students at the Johns Hopkins Medical School, “Know syphilis in all its manifestations and relations, and all other things clinical will be added unto you.” “In one direction our knowledge was widened greatly,” he noted in 1909. “It added terror to an already terrible disorder.”

Because of misunderstandings of the pathology of the disease, as well as a desire to avoid the moral opprobrium attached to venereal infection, physicians often ascribed deaths due to syphilis to other causes. “A convenient and somewhat elastic medical nomenclature lends itself to this policy of concealment,” explained one doctor. “A vast number of morbid conditions which should be charged to venereal infection are entered under some non-compromising name which does not indicate its real value.” As Osler remarked, “Men do not die of the diseases that afflict them,” at least in the reports of many physicians.

Long after the ravages of syphilis had become clear, physicians continued to consider gonorrhea a relatively minor, nonspecific, inflammatory disorder. Doctors practicing in the mid-nineteenth century frequently suggested that excessive sexual intercourse was a primary cause of infection and, with interesting logic, often recommended marriage as a cure for the afflicted. Indeed, many doctors believed that gonorrhea need not always originate from another infection. The asymptomatic nature of the disease in women even led to the idea that virtually all women carried gonorrhea without damage and could transmit it to their partners. “One denied the right of a woman not to have gonorrhea; she possessed it permanently, incommunicably,” wrote a French physician. “She was contagious without having been contagioned.”

Victorian notions of motherhood and domesticity in the United States, however, would not long accommodate such suggestions. By the end of the nineteenth century substantial progress had been made toward a fuller understanding of gonorrhea. In 1879 Albert Neisser, a German dermatologist, made a fundamental contribution not just to venereal research, but to the germ theory of disease when he identified the gonococcus as the organism responsible for infection. The bacteria that Neisser viewed under the microscope—small, bead-like growths—were among the first to be identified with a specific disease. In subsequent studies of the pathology of gonorrhoea, it was soon demonstrated that the bacteria could cause arthritis, as well as a variety of systemic ailments including meningitis, puerperitis (inflammation of the tissues lining the walls of the abdominal and pelvic cavities). Gonorrhea, previously considered a “trivial disease” no worse than a common cold, now joined syphilis as a serious venereal malady.

Even though it had been known for centuries that these diseases could be communicated through sexual contact, only in the mid-nineteenth century did physicians come to center attention on the devastating impact of syphilis and gonorrhoea within the family. Two of Ricord’s students, Paul Diday and Alfred Fournier, examined the pathologic effects of syphilis upon pregnancy and newborn children. Diday described the deformities of infants born of syphilitic parents, the mother, he suggested, usually infected the fetus, after receiving the
DAMAGED GOODS

In 1872 an American physician, Emil Noeggerath, demonstrated the disastrous results of gonorrheal infections in women. Noeggerath discovered the so-called "latency period" of gonorrhea, in which an asymptomatic man actually still harbors the infection, and can communicate it in sexual relations. Latent gonorrhea in men, according to Noeggerath, explained "why so many healthy, blooming young girls begin to suffer and fail as soon as they enter the bonds of marriage." He also attributed high rates of sterility to gonorrhea, estimating that "about ninety per cent of sterile women are married to husbands who have suffered from gonorrhea either previous to, or during marriage." Given the fact that gonorrhea remains today a leading cause of sterility, it is likely that in the late nineteenth century, before the introduction of any effective treatment, it was among the most significant causes.

Noeggerath's work was exceptional in that Europeans dominated most research concerning the transmission and pathology of venereal disease during the late nineteenth century. American physicians, however, avidly followed the results of these studies. Indeed, during these years, when American medical education was substantially inferior to European, many Americans traveled overseas to augment their training and participate first-hand in scientific research. A young American dermatologist, Prince Albert Morrow, spent a year in Europe after completing his medical training at New York University Hospital in 1873. Morrow contacted some of the leading figures in venereal research, including Alfred Fournier, whose Syphilis and Marriage Morrow translated into English in 1880.

Fournier posed questions raised by the new knowledge of the pathologic impact of syphilis. When could a syphilitic man marry without endangering wife and offspring? Was the physician's responsibility to the patient or society? Vividly outlining the potential dangers of introducing infection into the family, Fournier argued that professionals must take action to prevent the spread of syphilis. These themes had particular resonance for American physicians, who were already concerned about the future of the family. In Morrow's preface to the American edition of Syphilis and Marriage, he explained:

There is scarcely a subject in the entire domain of medicine of greater practical importance to the profession and to the public, not only on account of the nature of the pathological questions presented, but also on account of the family and society interests involved, and which it is the physician's manifest duty to protect.

Although substantial progress was made during the nineteenth century toward an understanding of the etiology and pathology of the venereal diseases, physicians, despite their increasing apprehension, could offer little therapeutic hope for those afflicted. Most physicians treated syphilis with mercury, either orally, in vapor baths, or topically. They based the use of mercury on the ancient theory of humors and health. Mercury caused salivation, which, it was
believed, removed the humors causing the ailment. Hot vapor baths worked in a similar fashion by causing profuse perspiration. Modern observers have suggested that high doses of heavy metal therapy probably neared lethal rates, with many symptoms attributed to syphilis likely the result of mercury intoxication. Patients with gonorrhea probably fared little better from the efforts of physicians. Most doctors employed oral medications which, they argued, when excreted through the urethra would have an antiseptic effect. Some injected chemicals directly into the urethra, but usually this had no beneficial impact, and may actually have been harmful. Until the advent of the sulfa drugs in the late 1930s, Ricord's dictum held true: "A gonorrhea begins and God alone knows when it will end." Treatments at this time indicated the nature of prescientific therapeutics as well as professional attitudes toward sexually transmitted diseases. For a therapy to be considered effective by both doctor and patient it had to elicit some outward, empirical effect. In this regard, most venereal treatments certainly fulfilled and exceeded expectations. Massive doses of mercury and iodides of potassium often led to serious complications: loss of teeth, tongue fissures, and hemorrhaging of the bowel. The initial chancre, however, naturally disappeared in the course of the disease, and doctor and patient usually credited the treatment. These therapies, however, also entailed considerable pain, demonstrating the punitive position of the profession regarding diseases communicated in "immoral congress." One New York physician suggested at mid-century a "Hot Water Retrojection" therapy in which he injected quarts of water heated to 180 degrees Fahrenheit until "sometime after the point of toleration had been reached." Another well-known physician, Frederick Hollick, prescribed a measure, no less heroic, for the treatment of a complication of gonorrhea known as chordee, a curvature of the penis which caused pain upon erection. Hollick recommended that the organ be placed "with the curve upward on a table and struck a violent blow with a book ... and so flattening it." By the end of the nineteenth century, better informed physicians had abandoned such efforts, leaving patients to suffer only from the disease, not the "cure." Indeed, as doctors sought to discourage premarital and extramarital sex, cure of the venereal sufferer became a questionable goal, and many argued with increasing frequency that the diseases were treatable but incurable.

The state of venereal therapeutics in the late nineteenth century explains, in part, the high estimates of the incidence of infection. In 1901 the New York County Medical Society appointed Prince Morrow to chair a Committee of Seven to assess the problem of venereal disease in New York City. After an investigation of local practitioners, the Committee presented absolutely staggering rates of infection in their report. Quoting statistics from a variety of sources, Morrow contended that as many as 80 of every 100 men in New York City had been infected at one time or another with gonorrhea. He considered it to be the most prevalent of all diseases in the adult male population. According to his report, from 5 to 18 percent of all men harbored syphilitic infections. Because few hospitals or health departments collected venereal statistics, seeking to spare patients and families from the social stigma attributed to them, doctors frequently
cited the figures collected by the military as the most reliable. The admission rate for venereal disease in the Army in 1909 reached 200 per 1000 men, and over one-third of all days lost from duty resulted from these infections. Morrow pointed out that these statistics, because they counted only new infections, did not reflect total venereal morbidity, which probably reached much higher rates due to the chronic nature of syphilis and gonorrhea. Indeed, he argued that venereal infections were more prevalent—and dangerous—than all other infectious diseases combined. "It is a conservative estimate," he later declared, "that fully one-eighth of all human suffering comes from this source."

Critics within the profession challenged these figures, charging that fanatics and moralists inflated venereal statistics to generate publicity and fuel the public's fears. "Here we might see the hopeless amateur," wrote Dr. John S. Fulton, "beginning without a knowledge of whole numbers, proceeding without a sense of fractions, achieving a childish confusion of ratios, factoring and developing out of those miraculous numbers which seem to be the chief sustenance of a crusading zeal." Richard Cabot, the renowned Boston physician, concluded in his study of venereal incidence that Morrow's figures were "wild guesses published for campaign purposes."

The perception of a venereal epidemic, however, prevailed in the medical literature. Morrow, responding to Cabot's critique, noted caustically that, if his figures on venereal morbidity in Boston were correct, "the citizens of Boston and vicinity... are vastly more virtuous than the citizens of New York and Baltimore." Even Cabot had reported that 35.5 percent of his sample at the Massachusetts General Hospital had admitted having had gonorrhea. Morrow discounted personal testimony as certain to produce a low count. "It is never safe to array a man's honesty against his sense of shame," he explained. "The venereal specialist perhaps more than any other is impressed with the adage, 'the world is given to lying.'" Many physicians continued to endorse the assessment of the Committee of Seven that "morbidity of venereal disease exceeds that of all other diseases combined."

The debate about the rates of venereal disease reveals the uncertain nature of diagnostics during this period. In the years just prior to the introduction of stained smear microscopy to detect gonococcus and complement fixation tests for syphilis, venereal diagnostics were based on a number of highly subjective criteria. Given the widespread concern about venereal disease and its impact on the family, it seems likely that many symptoms, particularly involving the genitals, probably led to the diagnosis of venereal infection. The suggestion, knowledge, or inference of immoral behavior by a patient also may have led to a tendency to identify non-specific infections as venereal. In any event, the poor state of therapeutics accounts for rates of venereal infection that far exceed contemporary estimates, because there was no effective treatment, there was more disease. Even today, venereal disease is underreported and rates of infection are only projected on the basis of collected data. As William Osler noted in 1917, "Syphilis... remains the despair of the statistician." Nevertheless, in this era before the advent of effective therapeutics, the venereal diseases clearly constituted a health problem of enormous dimensions.
New knowledge concerning the pathology of venereal disease, coupled with the reports of its epidemic proportions, galvanized the American medical profession to take action. Already uneasy about the future of the family, Progressive physicians suggested that the impact of "innocent infections" gave the crisis greater immediacy. Their suggestions evoked an inevitably repeated scenario, in which a married man, or one about to be married, would visit a prostitute and acquire a venereal infection. Ignorant of the nature of his new affliction, he would infect his wife; soon pregnant, she would pass the disease to the newborn. American doctors examined the sequelae of venereal disease spread in this fashion with growing alarm.

Prince Morrow became the leading figure in publicizing the problem among his medical colleagues. Born in Mt. Vernon, Kentucky, in 1846, the son of a prominent planter and politician, he had graduated from Princeton College (Kentucky) in 1863. After returning from Europe in 1874 he began practicing dermatology and syphilology in New York City. In 1882 he was appointed clinical lecturer at New York University, and two years later he became clinical professor of genito-urinary diseases. After completing the report of the Committee of Seven, Morrow returned to Europe to attend the Second International Conference on Venereal Disease in Brussels, at which the continent's leading experts discussed the venereal problem in all its ramifications. Morrow returned to the United States committed to founding an American group to educate the profession and the public to the dangers of the venereal peril. First, however, he set out to write a full exposition of the disastrous implications of introducing venereal disease into marriage.

Published in 1904, Morrow's *Social Diseases and Marriage* attracted a wide medical audience to the problems of venereal disease in American society. Morrow chronicled the potential danger to women, children, and "the race," a danger he called the "morbid irradiations into family and social life." Progressive physicians like Morrow came to view venereal disease as a threat to the very foundations of the Victorian, child-centered family; the susceptibility of innocent women and children seemed not only criminal, but treasonous.

Morrow outlined the impact of syphilis upon children in considerable detail in *Social Diseases and Marriage*. Physicians at this time conceptualized of any ailment passed to the newborn as "hereditary," even though not necessarily the result of genetic defect. As Morrow observed: "No other disease is so susceptible of hereditary transmission, and so fatal to the offspring." Those children who survived infections at birth, he suggested, faced lives of suffering. Syphilis, Morrow argued, because of its effects on offspring, "is an actual cause of the degeneration of the race." Fournier had demonstrated the predisposition of these children to meningitis, severe mental retardation, and hydrocephalus, in addition to any number of serious constitutional disorders. "The souls of infants born only to die or suffer, cry out against the infamy of uncured syphilis," announced one well-known venereal specialist.

The tragic results of gonorrheal infections in children evoked a powerful re-
action within the profession. The discovery that the gonococcus could cause blindness in the newborn was, perhaps, the most frequently cited repercussion of venereal insontium. "The public should know," Morrow declared, "that ophthalmia neonatorum [blindness at birth] is the fateful expression of ignorance and criminal carelessness, the working of that relentless law of Nature which visits the sins of the fathers upon the children." In 1884 Karl S. F. Corde, a German obstetrician, had found that the infection that caused blindness occurred as the infant passed through the birth canal. Corde demonstrated that neonatal gonorrheal blindness could be prevented by introducing a drop of 2 percent silver nitrate solution into the child's eyes immediately after birth. Almost thirty years later, however, large numbers of children still lost their eyesight from these infections because this prophylactic measure had not been universally adopted. According to the most commonly cited figures, 25 percent of all the blind in the United States had suffered from ophthalmia neonatorum. The impact of gonorrhea on women appeared even more ominous to Progressive physicians. Morrow, anxious to dispel the notion that gonorrhea was a minor disease in women, argued that it was more dangerous to them than syphilis. "In the female the local and general effects of gonorrhea are apt to be much more serious and permanent, owing to the character and extent of the structures involved," he explained. Following the work of Noeggerath, Morrow discussed the grave constitutional complications of gonorrhea. Though previously assumed to be limited to the urinary tract, the infection, recent research had demonstrated, could be spread to the cervix, uterus, fallopian tubes and ultimately through the blood stream, endangering the lives of its victims. In particular, Morrow directed attention to the effects of gonorrhea on the woman's reproductive function, estimating that 50 percent of all women infected eventually would become sterile. Gonorrheal infections, he argued, "extinguish her conceptional capacity, and condemns her to a lifelong invalidism or the sacrifice of her reproductive organs to save her life." A similar concern led E. L. Keen, one of the most prominent venereologists in the United States, to attribute 60 to 80 percent of pelvic inflammations in women that required hysterectomy or removal of the ovaries to gonorrhea. The serious repercussions of untreated venereal disease for the individual woman created grave concern for womanhood itself within the medical profession. In 1906 the American Medical Association responded by sponsoring a "Symposium on the Duty of the Profession to Womanhood." Dr. Albert H. Burr of Chicago explained, "However unfortunate the effects may be on the male offender, the pathologic relations of gonorrhea to the pelvic organs of the helpless wives is a stupendous calamity. If this one disease could be eliminated from wedded life, gynecology as a specialty would shrink to small proportions." Viewing gonorrhea as the primary cause of sterility, members of the profession sought to defend motherhood from its effects. "The flower of our land, our young women, the mothers of our future citizenship," noted Dr. Abraham Wolfhart, "are being mutilated and unsexed by surgical life-saving measures because of these diseases." Burr concluded that venereal disease posed a greater threat to the family than did the much-detested practices of birth control and
abortion. "The ban placed by venereal disease on fetal life outrivals the criminal interference with the products of conception as a cause of race suicide." 16

For Morrow, the impact of venereal diseases upon a woman’s ability to conceive called into question the very notion of "race suicide." He criticized the term because it implied that the low birth rate resulted from voluntary dispositions to limit family size. "There is ample reason for believing," he noted, "that in a large proportion of cases the low birth rate is not a result of choice but of incapacity." Morrow described cases of "one-child sterility" in which a woman, infected by her husband, had an uneventful, chronic, latent infection which, through the birth of the first child, was spread throughout the uterus, becoming virulent. The first born thus became the last born. Small families thus stemmed not from a selfish desire for a higher standard of living, as many social critics had suggested, but rather from the father’s philandering. Morrow recorded a series of case histories riddled with tragedy:

It is common to hear women who constantly suffer from uterine torture employ such words as these: "When I was a young girl I was quite well. It is only since my marriage that I have become ill!" And every day this confidence, this plaintive refrain saddens the gynecologist. It is continual and inexorable. From the discolored and suffering faces we may guess a whole past of debility, and the origin is always marriage. 17

On the basis of the 1890 census, Morrow estimated that one in every seven marriages would prove sterile due to venereal infections. By suggesting that infertility was typically involuntary, Morrow denied the reality that many American women had begun to limit family size by choice. 18 Morrow’s view demonstrated the widespread medical concern about the declining size of the white, middle-class family and provided a means for members of the profession to join the debate about the future of domesticity.

In these discussions of the impact of venereal disease upon the family, physicians endorsed a traditional Victorian view of the nature and role of women. Though their defense of women and the concomitant attack on immoral men could be mistaken for an incipient feminism—indeed, the public campaigns attracted a number of feminists—in reality, these doctors accepted a common image of women as innocent, weak, and helpless. The belief that gonorrhea wreaked special havoc in women substantiated the popular view of the biologically determined shortcomings of the female species. 19 Widespread notions of woman as innocent victim were repeatedly conveyed in the medical literature on venereal disease. "While she may not appreciate its pathological significance," wrote Morrow, "she suffers most keenly from the knowledge that her husband has soiled her with an impure disease.” Most importantly, venereal disease often made it impossible for a woman to fulfill what Progressive physicians saw to be her primary domestic responsibility, motherhood; “in missing maternity,” Morrow explained, “she has missed her highest destiny in being created woman.” 20 These views make clear the way in which disease functioned metaphorically to define gender roles. Venereal disease had specifically different meaning for the infected man or woman, meanings that revealed pow—
eful assumptions about the nature of the family and sexuality. These infections served as yet another means of defining the separate spheres of gender identity. When physicians came to the defense of women, it was to a sentimental, domestic, objectified ideal, one that bore little resemblance to the emerging "new woman." Women suffered both the consequent dangers of venereal infection as well as the constraints of medical belief concerning gender.

As venereal disease became a focus for Progressive fears concerning the future of the family in the first years of the twentieth century, physicians increasingly considered it their responsibility to protect the institution of marriage from the introduction of disease. This new duty, however, generated a crisis in contemporary medical ethics. In the past, doctors had assisted the male patient in concealing their ailments; indeed, some hid the nature of the disease from the patient himself. Action of this sort, however, based on the premise of the confidentiality of the physician-patient exchange, held the risk of promoting infection of the innocent woman and her children. As Prince Morrow observed, "The medical profession has not appreciated its share of the responsibility for these tragic results." Was it the doctor's obligation to see that a spouse be treated or a prospective bride warned of potential contamination? Physicians on both sides of the Atlantic debated this question with some vehemence.

Traditionally, all transactions between doctor and patient had been deemed strictly confidential. In no instance had the so-called "medical secret" prevailed so completely as in cases of venereal infection. In the era before scientific therapeutics, the confidence of the doctor-patient relationship had provided the fundamental basis for professional authority; medical care was predicated on this intimacy. The questioning of the primacy of the medical secret marked a subtle yet significant shift in the role of the physician from protecting the patient from social conventions to demanding his or her allegiance to these mores.

During the course of the nineteenth century, the principles of confidentiality had been widely codified. More than one-half of the states forbade testimony from physicians in legal proceedings without the patient's consent. Many doctors suggested that revealing a patient's venereal infection violated this principle—not to mention the tenets of Hippocrates. Indeed, many doctors argued, to label a patient a venereal carrier inflicted irreparable harm, given the stigma that accompanied these diseases. Some physicians expressed concern that if the nature of a man's infection were fully explained to his spouse, many marriages would be terminated. Dr. John Fordyce, a genito-urinary specialist at the College of Physicians and Surgeons in New York, claimed: "If the etiological element of many of the diseases which arise after marriage ... were known to the wife, what domestic calamities would follow!" Other physicians suggested that a weakened dedication to confidentiality would encourage venereal patients to turn to quacks—already a common practice—or to conceal their infections.

Progressive physicians, however, increasingly pointed to the tragic results in
cases in which the carrier refused to reveal his infection to his spouse, Dr. John Stokes of the Mayo Clinic characterized the medical secret as a "blind policy of protecting the guilty at the expense of the innocent." Prince Morrow emphasized the doctor's obligation to prevent further infections. "Does not his silence and inaction," he asked, "make [the physician] an accomplice, a particeps criminis?" A prominent New York attorney, William A. Purtmington, argued that a physician acted within the law if protecting an innocent from possible infection. "A physician who knows that an infected patient is about to carry his contagion to a pure person, and perhaps to persons unborn, is justified both in law and morals, in preventing the proposed wrong by disclosing his knowledge if no other way is open." 49

On the issue of the medical secret, American doctors achieved no consensus. Morrow, for example, despite his inherent sympathy for the innocent woman, argued that the secret "was in the interest of the social order." Some physicians suggested the possibility of "sitting" a history of extra-genital infection and then informing the wife, "to take the keen edge off the situation." E.L. Keys cautioned that in some cases preventing a diseased man from marrying could be worse than allowing him the risk of infecting his new wife. "To prohibit matrimony in a given case may wreck a man's life even more completely than syphilis could blast his wife's." Charlotte Perkins Gilman, the well-known feminist writer and theorist, dissected the problem of the medical secret in her novel, The Crux, published in 1911. When Dr. Bellair, a woman physician, tries to convince Dr. Hale, a male colleague, to reveal a patient's infection to his fiancee, he responds, "You know how I feel about this. It is a matter of honor—professional honor. You women don't seem to know what the word means. I've told that good-for-nothing young wreck that he has no right to marry for years yet if ever. That is all I can do. I will not betray the confidence of a patient." An exasperated Dr. Bellair replies, "Not if he had smallpox, or scarlet fever, or the bubonic plague? Suppose a patient of yours had the leprosy, and wanted to marry your sister; would you betray his confidence?" 50 She marches off to tell the unfortunate woman to break off her engagement. As Gilman made clear, the medical secret was closely tied to the ideology of male supremacy and loyalty in Victorian America. Clearly, many physicians acted to uphold a double standard at the same time that they decried its impact on the family.

The unmasking of the medical secret often did bring marriages to an end. Just as physicians ascribed falling birth rates to venereal infections, so, too, did many attribute a large percentage of the growing number of divorces to these diseases. Doctors noted that the venereal diseases often served as les maladies revelatrices, providing proof of infidelity. Commenting on the consequences, Morrow explained:

No other commentary upon the intolerable situations created by the introduction of these diseases into the family is needed than the fact that so many women, loyal to the highest ideals of marriage, devoted to home and family, are driven to the divorce courts as a refuge. No one can condemn a self-respecting woman for separating from a man who has disdained her with a shameful disease.
As Dr. Robert N. Willson of Philadelphia observed, "Many a divorce comes as a godsend to an already infected wife who can no longer cherish the transmitter of an eternal woe." The image of woman as victim inspired the reform of divorce laws during the late nineteenth century; by the first years of the twentieth century, courts increasingly recognized the introduction of venereal disease into marriage as proper grounds for dissolution. Women often disguised, however, these grounds in their petitions; "cruelly" or "non-support" frequently concealed the true cause. Morrow called this a "shame that cannot be named for a shame," because of the humiliation it would cause the woman. "Divorce increasing?" asked Dr. William Lee Howard, a popular medical commentator. "Of course, cannot you all see why? Divorce increases in direct ratio to the increase in venereal diseases. We cannot stop the effect until we stop the cause."

Fears about the impact of venereal diseases on the future of the family led physicians to ally with the nascent eugenics movement in the first decades of the twentieth century. The initial impetus behind eugenics was the differential in birth rates between native-born Americans and newly arriving immigrants. Morrow, noting that "degenerates" were multiplying at faster rates than the "respectable" middle class, attributed this problem to the high incidence of sterility caused by venereal disease, thereby making a connection between "respectability" and disease that would seem to contradict the very premises of the eugenics movement. "The function of eugenics is to produce a race healthy, well-formed and vigorous by keeping the springs of heredity pure and uninfected, and improving the inborn qualities of the offspring," wrote Morrow. "The effect of venereal diseases is to produce a race of inferior beings, by poisoning the sources of life, and sapping the vitality and health of the offspring."

Physicians now frequently asserted that their expertise should be consulted prior to any hasty marriages. Morrow cautioned against unions based solely on emotion and romance. "Young women should know," he wrote, "that marriage is not all romance and sentiment, that dissipated men make unsafe husbands and unsound fathers, and that the halo of romantic interest thrown around the man with a profligate past by fiction writers is a symbol of shame, a signal of danger for his wife and children." Recognizing this threat to the family, several states enacted "eugenic marriage laws" that required that a prospective groom be examined by a physician and receive a certification of health before obtaining a marriage licence. In 1899 Michigan became the first state to make venereal disease a bar to matrimony, directing that all men swear to their health before taking marriage vows. By 1913 a total of seven states had laws designed
to eliminate venereal contagion in the family. Although some of these enactments required men to undergo medical examination, none of these states required that prospective brides be examined, on the premise that such a procedure would be an affront to a respectable woman.57

Because diagnostic procedures were imperfect and many practitioners untrained, physicians were forced to admit that these laws were less than fully effective. As Edward L. Keyes explained, "In the present state of medical knowledge, a few weeks of preparation and a willingness to perjure himself, may enable the patient with infectious syphilis to defy the most conscientious examination."58 Supporters of these statutes argued that they nevertheless sewed an important educational purpose. In fact, the existence of these so-called "eugenic marriage laws" indicate that medical authority had been invoked prior to the development of effective diagnostics and therapeutics. Indeed, most states did not require serologic and microscopic tests even after they came into practice, continuing to rely on the personal credibility of the doctor, rather than laboratory diagnosis. The growing stature of the medical profession was clearly a function of shifting cultural precepts as well as scientific advance.59

Though some physicians centered attention on the eugenic implications of venereal disease in marriage, others emphasized the dangers posed by venereal disease among the influx of immigrants entering the United States in the last years of the nineteenth century and early twentieth century. From 1897 to 1907 more than 650,000 Europeans per year crossed the Atlantic.60 The fear expressed by nativists that these "degenerate racial stocks" from Southern and Eastern Europe would pollute the Anglo-Saxon gene pool or soon outnumber the respectable middle class attracted a considerable audience. The Immigration Act of 1891 excluded "persons suffering from a loathsome or dangerous contagious disease," which the Public Health Service interpreted to include venereal infections. Because of the great expense, however, only those immigrants who showed external signs of infection—open chancres, ataxia, dementia—received full examinations for syphilis and gonorrhea. Though the actual number of immigrants found to be infected remained low, critics suggested that this was the result of inadequate exams. In 1907 the United States Immigration Commission noted that "it seems probable that a considerable number of persons afflicted with venereal disease are admitted to this country, and that such diseases have been spread in many communities as a result of immigration." Lax diagnostic procedures came under increasing attack. As one observer remarked upon learning that all aliens did not receive mandatory venereal tests: "Why, that is just as if a man were to pay for a strong gate for his wheat field and not put a fence all the way around."61

Some physicians, influenced by nativist views, singled out immigrant populations as particularly prone to venereal infection. A widely circulated theory held that some immigrants, following a common folk remedy of intercourse with a virgin, raped their own children as a means of attempting to rid themselves of infection. "It has been brought to my notice many times that among certain classes, especially ignorant Italians, Chinese, and Negroes, it is an accepted belief that, if a man infected with an obstinate venereal disease have
intercourse with a virgin the latter will develop the disease and he will be cured," explained Dr. W. Travis Gibb, examining physician for the New York Society for the Prevention of Cruelty to Children. Other doctors suggested that poor conditions in American cities contributed to immorality and the spread of venereal diseases. "Much of the vice we see around us," noted Dr. Howard Kelly of Johns Hopkins, "is bred in the pestilential hot house atmosphere of dark, dirty, ill-ventilated homes, which induces abnormal cravings in ill-conditioned bodies." Fear of sexually transmitted diseases became closely tied to growing anxieties about the city and urban masses. As Dr. L. Duncan Bulkey reported:

Syphilis is everywhere seen to be a disease more especially belonging to communities, and flourishing most luxuriantly wherever there is crowding or massing together of individuals. . . . Syphilis is, therefore, most abundantly met with in cities, and its frequency is commonly seen to diminish in a pretty direct ratio to the suburban or rural character of the people.

Venereal infections among immigrants might well have been considered of little concern to the native-born middle class if not for two reasons. First, many observers suggested that the foreign-born furnished the bulk of prostitutes in American cities, and physicians believed prostitutes to be the primary locus of infection. And second, doctors now asserted that venereal diseases could be transmitted without sexual contact in any number of ways. The most innocent behavior could lead to venereal infection, according to many physicians. Metal drinking cups attached to public water fountains, eating utensils, towels and bedding, all were noted as possible points of transmission of both syphilis and gonorrhea. "The methods by which non-venereal syphilis may be acquired are innumerable," explained Bulkey in his definitive study of syphilis sine coitu, "and relate to every conceivable circumstance surrounding life." Bulkey catalogued records of extra-genital infections caused by whistles, pens, pencils, toilets, medical procedures, tattoos, and toothbrushes, to name only a few. Physicians most often noted epidemics of vulvo-vaginitis among young girls—a gonorrheal infection—which they usually traced to the school lavatory. Innocent acquisition of a venereal disease did nothing to relieve the personal anguish of the venereal victim. In an anonymous short story in a popular monthly magazine one woman poignantly described the agony and stress that accompanied an innocently transmitted infection. After manifesting the standard symptoms of early syphilis, the woman visited a physician:

At first it was unbelievable. I knew of the disease only through newspaper advertisements (for patent medicines). I had understood that it was the result of sin and that it originated and was contracted only in the underworld of the city. I felt sure that my friend was mistaken in diagnosis. When he exclaimed, "Another tragedy of the public drinking cup!" I eagerly met his remark with the assurance that I did not use public drinking cups, that I had used my own cup for years. He led me to review my summer. After recalling a number of times when my thirst had forced me to go to the public fountain, I came at last to realize that what he had told me was true.
She lived in fear of transmitting the catastrophe to another innocent:

Every day I expected to be accused of unspeakable things and turned adrift. . . . Even though I was not discovered I had perhaps a more direful possibility to face. Daily, hourly, momentarily, I was haunted by the dread of passing on the disease to another. . . . Every act of my life was carefully weighed under the influence of that feverish fear. . . . I was strained, tense—afraid, afraid. Night and day, day and night I bore my burden of fear.

Venereal disease remained a stigma; the possibility of innocent infections only implied a larger susceptible population. The woman concluded by arguing for the total social isolation of the infected, all the more ironic for her own torment: "If each state would pass and enforce stringent laws causing persons so diseased to be isolated, just as lepers are, there would be more hope in repelling the evil." Despite the contributions of germ theory to the understanding of venereal disease, it continued to be an essentially morally-defined malady. Since it is now known that syphilis and gonorrhea are almost never communicated in non-sexual ways, it seems that the frequent diagnosis of extra-genital infections around the turn of the century reveals certain professional and public value-laden assumptions about sexuality and disease. In some cases, physicians pointed to these infections as a means of attempting to reduce the stigma of venereal disease, both for patients and doctors. Until the "discovery" of these innocent infections, some members of the profession had refused to treat venereal diseases, and those who did held little professional stature. Members of the American Urological Association, founded in 1902, complained of being considered only "clap doctors." The belief in non-sexual transmission served to make treatment more respectable. For members of the middle class, these infections provided a safety-valve; patients could acquire a venereal disease within the boundaries of Victorian morality. Many physicians who became infected, for example, suggested that they had received the contagion in the course of treating their patients—a possibility that today would be considered highly unlikely.

The substantial professional interest and popular anxiety that extra-genital infections generated also reflected concern about the changes in American society during the late nineteenth century, particularly the heterogeneity and unhygienic nature of the burgeoning cities. Innocent infections promoted apprehensions of the city, the working class, and the new immigrant populations, ultimately encouraging racism and nativism. Progressive unease about hygiene, contagion, and cleanliness were evoked in the belief that in the brief contacts of everyday life—at the grocery, in the park, at the barber shop—these infections, originally obtained in "immoral" circumstances, could be passed to native, middle-class "moral" Americans. Fear of contamination justified a distaste for social contact with the urban masses. As one commentator suggested: "It is not well to use such articles (wash-basins and towels) in public places, as for instance, in shops or railway stations where they are free to all." If venereal disease could be spread so easily, no one was safe from contagion. As Dr. Howard Kelly, one of the nation's most distinguished gynecologists, noted in tidy metaphorical language:
The personal services of the poor must daily invade our doors and penetrate every nook in our houses; if we care for them in no wise beyond their mere service, woe betide us. Think of these countless currents flowing daily in our cities from the houses of the poorest into those of the richest, and forming a sort of civic circulatory system expressive of the life of the body politic, a circulation which continually tends to equalize the distribution of morality and disease. 59

L. Duncan Bulley cited these infections as a motivation for public anti-veneralea campaigns in the urban ghettos:

Venereal diseases, with their manifold and dreadful results so frequently reaching to and working havoc among those who are innocent, will never be checked until in some way even the lowest levels of society are influenced toward their prevention. Until disease and immorality were controlled within the working class, these physicians argued, the entire society would be imperiled. “The tide [of venereal disease] has been raising [sic] continually,” concluded Kelly, “owing to incessant importing of a large foreign population with lower ideals.” 70 Venereal disease had become, preeminently, a disease of the “other,” be it the other race, the other class, the other ethnic group.

69 Though the medical profession discussed the impact of venereal disease on American society with increasing vigor in the first years of the twentieth century, the public had remained largely ignorant on the subject. The tenets of Victorian respectability precluded open debate on these diseases, heavily cloaked in what physicians now called “the conspiracy of silence.” Some doctors admitted that they had actually contributed to this state of affairs by hiding diagnoses of syphilis and gonorrhea from their patients and upholding the “medical secret.” Dr. Robert R. Willson described the nature of the conventions that surrounded sexually transmitted diseases:

Medical men are walking with eyes wide open along the edge of a slough of despair so treacherous and so pitiless that the wonder can only be that they have failed to warn the world away. Not a signboard! Not a caution spoken above a whisper! All mystery and seclusion. . . . . . As a result of this studied propriety, a world more full of venereal infection than of any other pestilence.

Prince Morrow concluded succinctly: “Social sentiment holds that it is a greater violation of the properties of life publicly to mention venereal disease than privately to contract it.” 71

The press remained reticent on the subject of sexual diseases, refusing to print accounts of their effects. The only references to venereal ailments that ever punctuated their pages were euphemisms like “rare blood disease.” These same magazines and newspapers accepted, however, advertisements for venereal nostrums and quacks. Morrow accused such periodicals of an unabashed hypocrisy: “Many newspapers which do not hesitate to speak freely of prostitution,” he wrote, “which lay bare disgusting details of private intrigues in language which conveys a distinct conception of an immoral act, yet shrink from mentioning
the pathologic consequence of that act as something unprintable." When Ed-
ward Bok, editor of the Ladies' Home Journal, broke convention and published
a series of articles on venereal disease in 1906, he lost some 75,000 subsci-
bers.\footnote{Although several Progressive social welfare journals such as Survey and
Charities and Commons followed the Journal's suit with accounts of the vener-
eal menace, newspapers refused to join the anti-venereal campaign. In 1912
the silence received official endorsement when the U.S. Post Office confiscated
copies of Margaret Sanger's pamphlet, What Every Girl Should Know, because
it considered the references to syphilis and gonorrhea "obscene" under the
Comstock Law. "The mention of these diseases is interdicted by the best
forms of good society," lamented Morrow.\footnote{Physicians increasingly sought
publicity for the venereal problem, insisting that public enlightenment would
have an immediate ameliorative impact on the incidence of venereal diseases. "No evil
ever flourished long in the world's history after the limelight of knowledge had
uncovered it," declared Grandin, "and I am convinced that neither gonorrhea nor
syphilis can thrive in any community where force of public opinion is exerted against
them." A heightened public consciousness, doctors argued with undaunted optimism, would
alleviate the venereal problem. "Venereal disease must be made a subject of
gossip," commented Dr. William A. Evans, "a gossip which must be instruc-
tive and elevating."\footnote{In this spirit Prince Morrow founded the American Society for Sanitary and
Moral Prophylaxis in early 1905 to "prevent the spread of diseases which have
their origin in the social evil." Morrow envisioned the organization as a center
for the diffusion of information about venereal disease. The grandiose title,
had, however, belied an inauspicious beginning; only twenty-five physicians at-
tended the meeting of the Society at the New York Academy of Medicine. This
group, discouraged by the number of empty chairs, adjourned to a smaller room.
Though the organization drew its first members primarily from the ranks of the
medical profession, it soon attracted a number of prominent social reformers.
Morrow encouraged lay membership, explaining, "To correct these evil con-
ditions there should be a union of all the social forces which work for good in
the community." Venereal disease, he contended, could not be considered solely
within the physician's domain. "The evil is composite in its causes," Morrow
argued, "and to be successfully combated the cooperative efforts of different
members of the medical profession must be united."}
social groups is required.” Like many Progressive voluntary organizations, the ASSMP attracted a coalition of support from those involved in the settlement movement, charity groups, moral reformers, and the church, in addition to physicians. Morrow, who became the first president of the ASSMP, sought to make it “the medium of communication between the medical profession and the public.” Membership in the Association doubled between 1906 and 1910, from 344 to almost 700, with women comprising 30 percent. Soon other cities including Philadelphia, Baltimore, Detroit, and Milwaukee established similar groups, and together they formed the American Federation for Sex Hygiene in 1910 under Morrow’s leadership. The ASSMP remained, however, the most active and powerful affiliate.

True to Progressive precepts, the ASSMP viewed education and publicity as a radical force, a virtual panacea. “An aroused public conscience would no longer tolerate such social infamies,” declared Morrow. Citing the recently exposed scandals of the trusts, the insurance companies, and the proprietary medicines, he attempted to place the campaign against venereal disease in the mainstream of contemporary reform. Morrow advocated that the ASSMP become the vehicle for piercing the “conspiracy of silence”:

Now the role of muck-raker is considered neither dignified nor desirable, the work of delving in the filth of human weakness and depravity is unsavory, even repulsive; it can be undertaken only from a sense of duty, but the muck is there and needs to be raked. The public should know that the introduction of venereal infection into marriage constitutes its chief social danger and at the same time makes up the saddest chapter in the martyrdom of women.

Although the Association directed attention to the related issues of prostitution and public health, it initially concentrated on publicity and education to stay the tide of venereal disease. These physicians and reformers argued that, once enlightened about the causes and impact of venereal disease, citizens would realize their moral duty to remain chaste and healthy. Morrow believed that “sexual errors are due largely to this enforced ignorance.” Robert N. Willson, the leader of the social hygiene movement in Philadelphia, called for the “same, quiet, complete sex-education of the American people,” as the only means of eliminating venereal disease.

Although the ASSMP contended that parents should teach their children about sex, members frequently asserted that most parents were incapable of this task. Their failure to fulfill the responsibility of sex education left their children to the dubious wisdom of the streets. “If [curiosity] is not satisfied from pure sources,” Prince Morrow explained, “it will be fed from impure and tainted sources.” Willson endorsed this view, noting, “The gutter-nip is far more apt in gaining the ear of your boy than his pastor, his lesson sinks deeper and is more lasting.” Reformers, therefore, increasingly demanded professional sex education in the school. In its first year the ASSMP established a Committee on Education which sponsored a full program including lectures and conferences, as well as pamphlets for parents and children. Morrow argued that sexual enlightenment was similar to other “former parental duties . . . [now] relegated to the
Late-Victorian notions of sexual morality infused all educational efforts. In particular, physicians considered the male sexual drive with foreboding. Among Progressives concerned with order and control, few instincts created so much apprehension. As Dr. Frederic H. Gerrish explained to the Massachusetts Medical Society, "If one is justified in ascribing motives to Nature, it may be fairly said that, in her anxiety to provide for the preservation of the race, she has over-sexed mankind." Instruction for men thus centered on their duty to repress impulse, as well as their responsibility to women and "the race." Sex, many physicians had come to argue, should be limited exclusively to marriage and then, only for procreation; otherwise, it was merely a self-indulgent act. Rose Wood-allen Chapmen detailed this view of male sexuality for her readers in the Ladies' Home Journal: "You will readily understand that power fraught with such tremendous consequences was not instituted for the gratification of the lower nature, but for procreation." Eliminate sex outside marriage, physicians suggested, and a host of social maladies—from venereal disease to prostitution—would disappear.

Continence, therefore, became the hallmark of all sexual prescription. Members of the medical profession sought to dismiss the frequently cited view that men required sex to maintain their physical and psychic health. During the nineteenth century some commentators on sexual matters had advised that failure to "exercise" the sexual organs could lead to atrophy and weakness, eventual impotence, and physical decline. Morrow and most late-Victorian physicians came to reject this view outright. Morrow pointed to instances of celibate laybrothers who, after leaving the convent and marrying, were "exceptionally prolific." Indeed, most doctors now emphasized the necessity of not expending too much semen. According to these physicians, the testes secreted "cells" from the semen into the bloodstream that caused the development of masculine features, and reaching the brain, provided for intelligence, inventiveness, and imagination. Though they no longer suggested that masturbation could lead to debilitating physical illness, as some earlier experts had argued, they nevertheless warned that the practice did lead to loss of "self-respect, will-power, and mental force." Morrow concluded that "perfect inhibition is the sign of perfect health.

In addition to violating values of discipline, restraint, and deferred gratification, the double standard contributed to the high incidence of venereal disease and innocent infections. "The double standard of sexual living is subversive of every standard of right and justice," claimed Dr. Winfield Scott Hall in his widely circulated primer, Instead of Wild Oats. According to an overwhelming consensus of physicians, both partners should reach the marriage bed as virgins. Morrow, for instance, called for an end to the traditions of bachelor life, especially the raucoous parties preceding marriage. All too often, he argued, these festivities would lead to a fateful liaison in the waning hours of bachelorhood, whose impact could be traced in a series of subsequent familial tragedies.
Physicians and educators urged that demands for sexual restraint be placed in the context of eugenics, and that restraint be considered a responsibility to the future of the race. Frank D. Watson of the New York School of Philanthropy reminded his students of the "sacredness of the germ-plasm": It was the man's "obligation and privilege," he contended, "to pass on that germ-plasm uncontaminated and unimpaired." The noted psychologist G. Stanley Hall remarked, "Man is prone to mortgage posterity by consuming, in his own self-gratification, energies that belong to the future." In sum, Victorian physicians and psychologists had developed a highly-defined physiological argument for the need for sexual control.

Instructors did not, however, always base their appeal for sexual restraint on such high-minded premises. They often invoked the dread of infection as a powerful control on immorality and disease. In devising an educational approach, Morrow believed it valuable to describe the impact of venereal diseases in considerable detail. "I have always felt that the doctrine of consequences should be fully expounded as the fear of infection will sometimes restrain men from an evil life when educational or moral considerations fail," he explained. "As a matter of fact all hygienic precepts are based upon the consequences which result from the infraction of Nature's laws." Morrow considered fear—"fear of microbes"—the "protective genius of the human body." Only a well-developed awe of infection, suggested Dr. Abraham Wolbarst, could control the sexual drive in men. "The sexual instinct is insatiable and will only listen to fear," he noted. "Ninety-nine out of one hundred persons could be frightened into being good by the fear of evil consequences." If educators established the proper attitude, physicians believed, men would think twice before pursuing the temptations of the double standard. "There should be taught such disgust and dread of these conditions," declared Dr. Margaret Cleaves, "that naught would induce the seeking of a polluted source for the sake of gratifying a controllable desire." Seen by doctors as an authoritative ally in venereal disease control, the specter of unseemly infection would be raised throughout the twentieth century.

Given the emphasis on the "loathsome" aspects of venereal infection, some physicians expressed concern that sex education could have the undesired effect of causing "impure" thought. Max J. Exner, a well-known expert on sex education, cautioned that undue attention to the "sordid aspects of the sex question" would undoubtedly have a deleterious impact on impressionable adolescents. Exner suggested that in many colleges "sex thoughts and sex imaginations are allowed to dominate the stage." Sex educators hoped that instruction would curb "morbid curiosity," and erase sexuality from consciousness. Maurice Baglow, who taught sexual hygiene at Columbia University Teachers College, considered day-dreaming about sex to be more dangerous than actual masturbation because it could be practiced constantly. Dr. B.S. Talman called this "mental masturbation." For certain individuals, Dr. Ferdinand C. Valentine contended, any education in sexual matters could be dangerous:

Each venereologist has met psychopaths to whom each curve in nature or art suggests female breasts, nates, or genitalia. For such not even the slightest education
would be advisable. Indeed, it would be harmful, because every step thead would to them contain luscious suggestions.

Even so strong an advocate of sex education as Dr. Woods Hutchinson cautioned that much of the material produced by the sex hygiene campaign smelled of "rank sensationalism, hysterical overstatement, sloppy sentimentality and eroticism disguised as mandarin pseudoptics." Even so strong an advocate of sex education as Dr. Woods Hutchinson cautioned that much of the material produced by the sex hygiene campaign smacked of "rank sensationalism, hysterical overstatement, sloppy sentimentality and eroticism disguised as mandarin pseudoptics."90

Educators proposed that instruction in sex should be integrated into existing courses so as not to attract undue interest. A frequent suggestion was the inclusion of sex hygiene in courses on biology and zoology. Doctors recommended teaching about reproduction of plants in elementary education, eventually moving on to animals. "The normal processes of reproduction in plants and lower animals should be taught," wrote Morrow, "unfolding the beauties and mysteries of the great law of reproduction which runs through out all animate nature." The essential goal was to impart new knowledge while maintaining an illusion of non-communication. "Sex knowledge . . . can often be conveyed without the slightest consciousness on their part that what they are receiving is sex instruction," explained Maurice Bigelow.91

The educational campaign confronted Victorian notions of "pure" womanhood. The "conspiracy of silence" had reigned supreme regarding women, and many doctors felt women should be spared the "degrading" experience of receiving sexual knowledge. According to many reports, women often entered marriage with no knowledge about sex. In the early years of the twentieth century, some doctors continued to suggest that sex education might disrupt marriages, because women might come to understand the cause of many of their gynecological ailments.92 Physicians of the Progressive years, however, now questioned the wisdom of the feminine tabula rasa in sexual matters. "For centuries, we, as physicians, have been covering up the fact that [the wife's] trouble lay at the door of her newly wedded husband, who, though demanding chastity and purity of womanhood at her hands, brought to her the filthy gonorrheal virus," wrote Dr. D.E. Standard.93 Education for women threatened a significant break with the Victorian tradition which had placed a premium on modesty and innocence among mothers.

Although physicians, reformers, and feminists called for the sexual enlightenment of women, educational precepts differed considerably from those devised for men. Just as education for men followed the Victorian assumption that men were sexually aggressive, instruction for women focused on the notion of the passionless, dutiful woman. Because many doctors presumed that most women were sexually anesthetic, they placed little emphasis on the need to instill control in the prescriptive literature directed to women. "There are but few Messalinas, hopeless sexual perverts," noted Dr. Frederic H. Cernik. "The vast majority have no very pronounced sexual feelings; and a majority are altogether deficient in this respect." Indeed, this apparent lack of interest in sex among women was typically cited as an aspect of their moral superiority.

Women, physicians urged, should be taught to demand a higher moral standard from men. Though sexual education for men centered on repression of
the sex drive, for women it concentrated primarily upon warnings about men. "Shall the mother advise her girls of their high privilege in life, or shall they learn first of these things in gossip, or as sometimes occurs, from an infected or infectious husband?" asked Dr. Robert N. Willson. "The woman, at least, must be given the opportunity of knowledge, and the right to intelligently choose between the diseased and the clean." Prince Morrow argued that only with informed motherhood could the crisis of the family be resolved: "These crimes against the family will continue until women know, as they have a perfect right to know, the facts which so vitally concern their own health and the health and lives of their children." Feminists joined the physicians in the sex hygiene movement, insisting upon their right to defend themselves against the hazards of the double standard of morality. As Charlotte Perkins Gilman told a meeting of the American Society for Sanitary and Moral Hygiene: "With motherhood we should have maturity and that knowledge which is power and protection." 93

Doctors expressed the greatest concern about women of the working class, who they believed could more easily be led astray. In 1908 the Massachusetts Association of Boards of Health published a circular for young women, warning them of the possible consequences of premarital sex. "Among the most serious dangers which threaten young women, especially those of the wage-earning class," noted the pamphlet, "is the danger of sexual relations outside of marriage to which they are led by such harmless pleasures as dancing." Moreover, conditions in factories and slums often made prostitution seem an attractive alternative, according to many social workers. Doctors suggested that admonitions about illicit disease and unwanted pregnancy would prove valuable to women tempted to try the life of the streets. "The inducements in the way of dress, jewelry and amusements which are used to overcome the scruples instinctive to every woman would have far less weight if the consequences of indulgence were clearly understood," explained Dr. Margaret Cleaves. 96

Although sex education during the Progressive years remained for the most part on a highly superficial and euphemistic level, it nevertheless provoked critics who decried the end of reticence in sexual matters regarding women. They particularly objected to the introduction of sex hygiene instruction in the schools, which the ASSMP advocated. When the Chicago School Board vetoed the inclusion of such a course in 1913, one critic explained their reasoning: "While there are certain things that children ought to learn it is far better that they should go wholly untaught than that the instruction should be given to them outside the family circle. There are some kinds of knowledge that become poisonous when administered by the wrong hands and sex hygiene is among them." Dr. George Whiteside suggested that sex education was inappropriate for girls of a genteel background. "Let us spare the sympathetic sensibilities of girls of the better class," he declared. "Why tell them of venereal disease or loathsome perversions of the sex drive?" 97 Whiteside conceded that instruction should be offered for "girls who must protect themselves, who have no one to look out for them."

Critics charged with some justification that sex education programs could lead
to a phobic response among women toward marriage and men. As Mabel S. Ulrich commented:

I deplore the custom of many "sex lecturers" of dealing out to girl audiences representing all ages, overwhelming statistics as to the probable immorality of fathers, brothers, lovers, and friends. To convince a sensible adolescent girl that ninety per cent of all the men she has loved and trusted are tainted physically and mentally is a sorry victory for our "cause"—even if it were true.

Miriam C. Gould, a psychologist at the University of Pittsburgh, studied the reaction of a class of adolescent girls to instruction about venereal disease, pregnancy, and prostitution. In the class of twenty-five, eight were "astounded" by a discussion of illegitimate births because they had "supposed it impossible for unmarried people to have children." After learning about venereal infections and their repercussions, the girls responded as follows:

Three were so disgusted that they have avoided the acquaintance of any further knowledge on the subject. Three claimed they were impossibly curious and deliberately sought further information. Ten were impelled to be cautious in frequenting public toilet rooms, in using public drinking cups, in kissing or permitting any other bodily contact with men. Six of these mentioned they thereafter regarded dancing as dangerous. Two were extremely anxious for assurance of their own non-infection. Eleven developed a pronounced repulsion for men, although prior to this they had enjoyed their companionship.

Gould's message was clear: fear of sexuality could have effects which even the social hygienists did not desire. As Talcott Williams concluded, "It is a very serious responsibility to exaggerate the perils of social diseases in such manner as to increase the obstacles to marriage."

The American Society for Sanitary and Moral Prophylaxis insisted, however, on the benefits of their educational programs. Morrow assured the public that the sex hygiene campaign was "not intended to ride rough-shod over conventional propriety or break down the barriers erected by good taste." Physicians asserted that well-informed women would not become victims of the double standard of morality when they entered matrimony. "When the girl reaches the nubile age she will demand a certificate of sexual cleanliness—and it is her right to have it—from the man who seeks to become her lord and master, and too often becomes her inoculator with gonorrheal virus," wrote Dr. Egbert Grandin. Indeed, Morrow contended that women required this knowledge if they were properly to fulfill their domestic duties. Education, he argued, would not violate Victorian propriety but restore "civilized" morality:

Women—modest, refined, the most womenly of women—are not offended by our plainness of speech, their feeling is not one of outraged modesty, but of indignation ... that matters which so materially concern their health and life and that of their children have always been concealed from them by the medical profession."

The efforts to institute sex education during the Progressive years had considerable success. A study conducted by the U.S. Bureau of Education in 1922 indicated that 46.6 percent of all secondary schools offered some form of in-
struction in sex hygiene. The ASSMP maintained figures on the number of pamphlets they distributed as carefully as if they were for vaccinations. By 1913 the Association and its branches had published and distributed hundreds of thousands of flyers with such titles as "How My Uncle, the Doctor, Instructed Me in Matters of Sex," and "A Straight Talk with Employers and Leaders of Organized Labor." Members of the educational crusade reported that, as a result of their efforts, immorality—presumably sexual activity—was on the wane, especially among the young. Dr. James Pedersen, a leading member of the ASSMP, stated that "immorality in many colleges had been reduced by 20 to 40 per cent." The medical director at Columbia University, for example, suggested that because of the sex hygiene program there the rate of venereal infection never reached more than 4 percent of the student body. Ultimately, however, the necessity for sexual control underpinned all educational efforts. In the perceived high rates of venereal disease, physicians saw not only dangers to the family, but a more general and ominous collapse of late-Victorian morality. The constellation of sexual values which the social hygienists prescribed—repression, continence, discipline—mirrored the values of middle-class Victorian society and economy. Educational programs were designed less to enlighten than to shore up standards they considered under attack to return restraint and order to the relations between the sexes. These physicians, trained in a time thought to represent the height of civilized morality, offered no new solutions to the venereal peril. They destroyed the conspiracy of silence—a seemingly radical act—to uphold the conservative sexual mores of their time.

Although social hygienists looked to education as the ultimate means of combating venereal disease, Progressives centered their immediate attention on the repression of prostitution. Physicians and social reformers associated venereal disease, almost exclusively, with the vast population of prostitutes in American cities. They agreed that when a man left the moral path the road usually led to the prostitute, who they argued was the most prolific source of venereal infections. In comparison to prostitution, explained Dr. Ludwig Weiss, "all other modes of propagation [of sexual diseases] are almost nil." Estimates suggested that from 75 to 90 percent of all prostitutes harbored infections. Dr. Katharine Bennett Davis, Commissioner of Corrections for New York City, reported, for example, that 70 percent of all women sentenced to the city workhouse for prostitution had either gonorrhea or syphilis. At the Bedford Hills State Reformatory for Women more than 80 percent of the inmates between the ages of sixteen and thirty were found to be venereally diseased. Davis labeled these women "plague spots." These reports of the high rates of infection among prostitutes confirmed for many the notion of two types of women—good and bad, pure and impure, innocent and sensual. Venereal epidemiology was socially constructed upon this bifurcation. Accordingly, an "innocent" woman could only get venereal disease from a "sinful" man. But the man could only
get venereal disease from a "fallen woman." This uni-directional mode of transmission reflected prevailing attitudes rather than any bacteriologic reality.

The knowledge that prostitution was not just a moral threat to the civilized sexual code but also a health threat to the family gave the social purity crusade new impetus. Reformers now added the authoritative voice of science and hygiene to the moralistic claims against prostitution sounded in the nineteenth century. Physicians had come to realize an ugly irony: that the double standard of sexual morality— which countenanced periodic visits to prostitutes to spare the "pure" woman from the "animal" passions of the man—actually led to the woman's demise through venereal infection. Indeed, Prince Morrow coined the euphemism "social disease" because the infections were spread through the "social evil," namely, prostitution. These infections, Morrow declared, "link the debased harlot and the virtuous wife in the kinship of a common disease."03

In the first decade of the twentieth century virtually every American city possessed a so-called "tenderloin" district where prostitutes openly solicited customers. Bordellos often operated under the protective eye of city and police officials. San Francisco's "Barbary Coast," Washington D.C.'s "Hooker's Division," Chicago's "Lever," and New Orleans's "Storyville" constituted only the nation's most notorious red-light districts. During the late nineteenth century, municipal governments anxious to segregate vice activities officially designated such discrete areas so as not to offend the moral sensibilities of those respectable citizens who wished to avoid this commerce. Purity crusaders had long fought against these enclaves, but without great success. Now armed with the medical knowledge of the impact of venereal disease on the family, as well as new sociological methods to investigate and root out the evil, vice crusaders unleashed a full-scale attack on urban prostitution. "No great wrong has ever risen more clearly to the social consciousness of a generation," noted Jane Addams of Hull House in 1911, "than that of commercialized vice in the consciousness of ours."05

Nearly every American metropolis organized vice commissions between 1910 and 1916 to investigate and combat prostitution. These groups relied heavily on expert medical testimony in developing their indictment of urban vice. All reports emphasized the impact of prostitution upon the health of the family. "The effect of vice upon the physical health of the community is receiving at present more attention than any other feature of the problem," noted New York's Committee of Fifteen, the first major vice commission established in 1900. The group concluded that it was the community's responsibility to "disembarrass" itself from venereal diseases by controlling vice.06 The Chicago Vice Commission, which conducted a nationally publicized investigation a decade later, expressed a similar idea in more lurid prose:

Prostitution is pregnant with disease, a disease infecting not only the guilty but contaminating the innocent wife and child in the home with sickening certainty almost inconceivable; a disease to be feared as a leprous plague; a disease scattering misery broadcast, and leaving in its wake sterility, insanity, paralysis, and the blinded eyes of little babbles, the twisted limbs of deformed children, degradation, physical rot and mental decay.07
The vice commissions unanimously condemned the notion of sexual necessity for men as a myth that encouraged vice. The commissions' reports identified the moral crisis as one peculiar to urban life. The theme of the anonymity of urban existence recurred in their assessments of the prostitution problem, which frequently recounted the plight of the young man who came to the city only to find loneliness and low wages. As the Committee of Fifteen explained:

"The main external check upon a man's conduct, the opinion of his neighbors, which has such a powerful influence in the country or small town, tends to disappear. In a great city one has no neighbors. No man knows the doings of even his close friends; few men care what the secret life of their friends may be. Thus, with his moral sensibilities blunted the young man is left free to follow his own inclinations." 108

These inclinations, according to the commissions, all too often led to the brothel and ultimately to medical and moral degeneration. Moreover, in cities, where the cost of raising and supporting a family was high, eligible bachelors often postponed marriage, which many doctors now suggested contributed to more frequent premarital associations with prostitutes and a rising incidence of venereal infections. 109

The commissions insisted that America's burgeoning metropolises provided ubiquitous opportunities for social contacts which could lead to moral decline. Not only were dance halls and theaters suspect, but parks, hotels, and department stores were also cited as providing outlets for debauchery. As Dr. J.H. Landis commented, "The occasional contact of the sexes found in rural districts has given way to practically constant contact in the cities." Landis feared what he called "sexual explosions" in the urban environment. The vice commissions lamented the passing of what they believed had been a rigorous, uniform moral code. Although much of their rhetoric appears anti-urban in retrospect, most of the members of these committees were long-time city dwellers, businessmen and civic leaders, alarmed by the changes they had observed in their midst. 110 Venereal disease, reported in epidemic proportions, seemed to confirm the existence of this more general cultural crisis, the chaotic, alien nature of the modern city.

The vice commissions also examined the reasons why women became prostitutes. Some suggested that they were either enticed or forced into commercialized prostitution through the subterranean "white slave trade." The idea of "slavery" conformed with Victorian notions of feminine purity which held that no woman would enter such a life except under bondage. Muckrakers and purity crusaders frequently drew an analogy between the white slave trade and the cold efficiency of American industry which had recently come to light in press exposés. Borrowing from the anti-monopoly rhetoric of Progressivism, the Survey referred to commercialized prostitution operations as "vice trusts" that, they believed, should be "busted." 111 George Kibbe Turner, a well-known Progressive journalist, explained that prostitution in Chicago had been organized "from the supplying of young girls to the drugging of older and less salable women out of existence—with all the nicety of modern industry." He concluded, "As
in the stockyards, not one shred of flesh is wasted." The white slave hysteria that swept the nation between 1907 and 1911 culminated in the passage of the Mann Act by Congress in 1910, which forbade the transportation of women across state lines for immoral purposes.* Just as the interstate commerce clause had been used to attack the trusts, so too was it invoked to attack vice.

Upon investigation, however, little solid evidence of a fully organized traffic in women ever materialized, and reformers looked to somewhat more complex causes to explain prostitution. As the prominent vice investigator George J. Kneeland noted, "The psychology of the relation of prostitute to pimp is a complicated one, difficult to understand. . . . A spark of affection lives at the heart of this ghastly relation." Kneeland reported virtually no indication of locked doors and barred windows in his detailed studies. But the image of enforced labor remained prominent, especially among feminists who recognized the essentially exploitative nature of prostitution. Maude E. Miner, secretary of the New York Probation Association, though admitting that girls were rarely physically abducted, contended that "through the loss of freedom and will of action, they have been bound to prostitution." Miner concluded, "Their demoralization of character has constituted moral enslavement."13

Reformers increasingly looked to the social and economic conditions of the city to explain a woman's turn to prostitution. Again, the anonymity of the city was cited as an important element. Jane Addams noted with sympathy:

Laziness and detachment which the city tends to breed in its inhabitants is easily intensified in such a girl into isolation and disheartening feelings of belonging nowhere. . . . At such moments a black oppression, the instinctive fear of solitude will send a lonely girl restlessly to walk the streets even when "she is too tired to stand" and where her desire for companionship in itself constitutes a grave danger.

Other observers emphasized that poor housing conditions, particularly in the immigrant ghettos, often led to prostitution. "Who will dare to deny that the thin partition walls and often promiscuous mixing of the sexes in the crowded quarters tend to the demoralization of the young girl blossoming into womanhood?" demanded the prominent New York physician Adolphus S. Knopf. The vice commissions suggested that the transformation of American industry, which brought more women to the workplace, also encouraged prostitution. "Another form [of prostitution] is closely connected with industry," explained the Committee of Fifteen. "A season of non-employment presents them with the alternatives of starvation or prostitution." Moreover, prostitution offered more lucrative rewards to women forced to support themselves and their families than did employment in industry. "Is it any wonder," asked the Chicago Vice Commission, "that a tempted girl who receives only six dollars per week working with her hands sells her body for twenty-five dollars per week when she learns there is demand for it and men are willing to pay the price?" Dr. Ludwig Weiss stressed the problem of the single woman separated from her family, concluding, "The strife of self-support has exposed her to dangers against which she must develop defensive measures."13a

Although the vice commissions often expressed sympathy for the plight of
the prostitute, rarely could they offer substantive assistance. The environmental
determinants which they identified as contributing to vice were beyond the scope
of the commissions that concentrated on exposing conditions. They gave little
if any consideration, for example, to the impact of venereal disease on the health
of those women forced to take to the streets. The life expectancy of prostitutes
was reportedly very short, for many suffered from the consequences of the sex-
ually transmitted diseases that they were attacked for communicating.\textsuperscript{15} Al-
though many of the commissions suggested that women were victims of
prostitution, most of the proposed remedies, especially the repression of street
solicitation, labeled them as criminals.\textsuperscript{16} The vice commissions operated un-
der the Progressive assumption that the revelation of evil would, in itself, have an
immediately positive impact.

By the first years of the twentieth century, two opposing strategies for dealing
with prostitution had evolved. First, many physicians who believed that pros-
titution could never be eliminated argued in favor of state regulation. This system,
which many French and German cities had adopted, called for registration and
periodic medical inspection of all prostitutes to insure their health. Under this
plan, known as regulationism, houses of prostitution were limited to a specific
section of the city and registered women, "clandestine" prostitutes, were sub-
ject to arrest and fine. Some prominent doctors argued that regulation was the
only sanitary, scientific means of controlling venereal disease.\textsuperscript{17} In seeming
disagreement with Victorian moral notions of perfectibility and self-control, these
physicians, many of whom had trained in the European capitals where inspec-
tion of prostitutes by public health officials constituted modern hygienic prac-
tice, accepted the indomitable nature of the male sex drive and the age-old rec-
novation of the inevitability of prostitution. During the last decades of the
nineteenth century, under the influence of these doctors, several American cit-
ies proposed ordinances requiring official examinations, and such a system was
actually adopted in St. Louis for a brief period in 1870.\textsuperscript{18}

The idea of regulated prostitution, however, could not withstand the force of
public opinion, and was soon held increasingly suspect by physicians and re-
formers alike. The complete repression of prostitution emerged as the social re-
formers' primary goal. When Prince Morrow founded the American Society for
Sanitary and Moral Prophylaxis in 1905, for example, he was firmly opposed
to regulation. This coalition among reformers on the prostitution problem was
probably the result of a growing body of medical literature that suggested the
inadequacy of medical inspection—a prostitute could become infected between
exams—as well as a desire to attract non-medical reformers to the social hy-
giene movement. These reformers, veterans of the purity crusades of the late
nineteenth century, the settlements, and urban Progressivism, refused to com-
promise with evil.

They found regulation, quite simply, anathema to the Progressive moral code.
First, it suggested a tacit acceptance of the double standard of sexual morality.
Second, state regulation of prostitution essentially endorsed the exploitation of
women to meet the sexual needs of men. And third, it implicitly validated the
notion that the male sex drive could not be controlled, a view subversive of
Progressive ideals of education and reform. As the Committee of Fifteen explained, "State recognition and regulation of prostitution would unquestionably tend to confirm the already common opinion that secret indulgence is an imperative need." In addition, physicians came to realize that regulation threatened their rising professional status by offending public opinion and lowering professional standards. "If there is a lower, more contemptible role that could be played by a medical man than that of official inspector of bawds, I do not know what it is," wrote Dr. G. Frank Lydston. "As compared with such an occupation, that of professional abortionist or the advertising newspaper fakir would be kingly." The vice commissions unanimously rejected regulation in favor of complete repression of prostitution. The Chicago group devised the oft-cited motto: "Constant and Persistent Repression of Prostitution the Immediate Method: Absolute Annihilation the Ultimate Ideal.

Despite the consensus among social hygienists against regulating prostitution, the debate erupted again in New York in 1910. On June 25, the same day that Congress enacted the Mann Act, the New York State Legislature passed the Inferior Courts Act, devised to deal more effectively with prostitution. In addition to establishing a night court for women and requiring the fingerprinting of convicted prostitutes, the act, popularly known as the Page Law, included a provision that called for the medical examination of women found guilty of soliciting. If infected with a venereal disease, the woman would be detained during treatment until she was determined to be noncontagious. This provision—section 79—created a furor within the social hygiene campaign and among women's groups because it was interpreted as tantamount to state-regulated prostitution.

"Is there any distinction between the details of the French system and the details of the Page Law? . . . I fail to see it," declared Columbia University economist E.R.A. Seligman, a member of the Committee of Fifteen. Seligman formulated his critique on the basis of the theory of supply and demand. The solution to the venereal problem, he contended, was not to treat prostitutes only to return them to the streets. Public belief in the health of these women would have the effect of raising demand for their services. "The imagined improvement in the quality of the services offered for sale will tend to attract purchasers who would otherwise be somewhat suspicious or on their guard," Seligman explained. He advised measures such as education, which he hoped would lower demand, and better economic opportunities for women to contract the supply of prostitutes.

Supporters of section 79 claimed that comparisons with regulation were spurious; prostitution remained illegal, and the act merely provided for diseased women to obtain medical care. Prostitutes, they contended, had a right to be restored to health. Social hygienists and feminists, however, recognized that the law's penalties fell exclusively on women and viewed this as a tacit endorsement of the double standard of sexual morality. Women were punished for engaging in prostitution, men were not; no law required that infected men be treated. As an impassioned Prince Morrow explained:
The Page Law is directed against a particular class of women for the protection of a particular class of men. Not the good citizens who lead regular lives and to whom the prostitute with her cortege of infections carries no menace, but for the protection of the licentious class of men who seek these women for immoral purposes.

The fatal defect of every sanitary scheme to control venereal disease has been that the masculine spreader of contagion has been entirely ignored as mythical or practically nonexistent; the woman has been regarded not only as the chief offender against morality, but the responsible cause of disease; all repressive measures to stamp out the diseases of vice have been directed against the woman alone. Morrow called this the "double standard of sanitation."

Despite the clear merits of Morrow's argument, a basic assumption lurking behind the attacks on section 79 was that venereal disease among prostitutes served as an effective discouragement to immorality. Fear of venereal disease, according to those reformers, contributed to sexual morality and therefore should not in all cases be removed as a threat—even if at great personal cost to the prostitute. In this light, venereal disease was seen as serving the sexual order by deterring "immoral" behavior. Indeed, the debate regarding the Page Law and regulation in general suggested the possibility that venereal disease—usually acquired through a voluntary or "immoral" act—was of a totally different nature than other infectious diseases which found their victims on an apparently random basis. "Venereal disease seeks no man," declared Morrow, "it must be sought in order to be acquired." This belief, that the individual must in the end be responsible for the risk of visiting a prostitute, had the effect of separating venereal disease from most other public health campaigns.

In June 1911 the New York Court of Appeals found section 79 unconstitutional, ruling that it violated due process by making the physician's diagnosis binding on the court. The legal battle had been supported by the social hygiene movement and organized women's groups. Although the rejection of all forms of regulation meant that repression of prostitution became official policy in most cities, on the eve of World War I prostitution still flourished, if less openly.
the social hygiene movement, controlled by physicians and sanitarians, was likely to accept vice as unalterable and to address it solely as a medical problem. Through the vice commissions and the Page Law controversy these two groups were brought together, and reformers began to see the problems of venereal disease and prostitution as inextricably linked.

Calls for a national organization to unite these movements began to be heard. Prince Morrow's death in March 1913 cleared the way for vice crusaders and medical reformers to strike an official alliance. In October, leaders of the American Vigilance Association and the American Federation for Sex Hygiene met in Buffalo to form the American Social Hygiene Association. Grace Dodge and John D. Rockefeller, Jr., two vigorous supporters of the anti-vice crusade, engineered the merger. Rockefeller suggested that consolidation would increase efficiency. "As a business man I naturally appreciate the gain which combination effects," he explained. Charles W. Eliot, former president of Harvard University, agreed to become the first president of the organization at Rockefeller's request. Eliot, however, only served as a titular head. Daily operations were directed by James Bronson Reynolds, a New York attorney active in vice investigations, and William F. Snow, a California physician and public health official. Their joint leadership reflected the organization's foundation in compromise, as well as a residual tension between the two forces.129

Rockefeller provided the greatest financial assistance to the Association during its early years, contributing $5,000 per year between 1913 and 1916 and $10,000 from 1916 to 1918, as well as helping to raise the remainder of the ASHA's $60,000 annual budget. Rockefeller's interest in the problems of vice and disease dated back to 1910, when he acted as foreman of a special grand jury appointed to investigate the white slave trade in New York. The jury heard testimony from a wide variety of sources; although evidence was developed that showed that girls had been abducted and sold, no proof of a syndicate was ever demonstrated.130 His experience on this jury, however, brought young Rockefeller to the center of social hygiene activities.

Rockefeller had come to believe that the hysteria surrounding white slavery did a disservice to responsible concerns about venereal disease and prostitution. After his service on the grand jury, he began to devise plans for a public commission to study prostitution and the "frightful ravages of venereal disease." He soon became discouraged, however, by the significant political considerations involved in the forming of such a group. Instead, he proposed a permanent organization to investigate the problem and formulate public policies. Together with Paul Warburg, a well-known banker, and Starr Murphy, a prominent lawyer, he established the Committee of Three to review potential projects. In 1911 they created the Bureau of Social Hygiene, which Rockefeller explained would be a permanent, non-political organization dedicated to studying prostitution and venereal disease "scientifically", and "continuously making war[] against the forces of evil."131

The Bureau emphasized rational, efficient investigations by experts and scientific management as the primary antidote to vice and disease. As a press release explained, "The name 'Rockefeller' stands for a type of efficiency and
In its first years, from 1911 to 1917 the Bureau sponsored and later published four major studies that were prototypical works of Progressive social science: first, George J. Kneeland’s Commercialized Prostitution in New York City, a monograph which resembled the vice commission reports without the lurid prose and pat answers; second, Abraham Flexner’s Prostitution in Europe, a forceful attack on continental systems of regulated prostitution which put to rest, once and for all, debate regarding the viability of regulation in the United States; third, Raymond B. Fosdick’s European Police Systems, a study which suggested that professionalization of police offered the best opportunity to uproot graft and vice; and fourth, Harold R. Woolston’s Prostitution in the United States, a comprehensive survey of vice conditions on the eve of World War I. These books provided the informational base that Rockefeller contended was the first step in formulating a public response to vice. Rigorously researched and dispassionately written, they shaped opinion within the social hygiene campaign and encouraged a more “professional” approach to reform.

The Bureau also sponsored a variety of experimental social programs in an attempt to illuminate new methods for civic institutions to adopt in the battle against prostitution. In 1912 the Bureau underwrote the establishment of a Laboratory of Social Hygiene at Bedford Hills, under the direction of Katharine B. Davis, agreeing to allocate up to $200,000. Women sentenced to this reformatory underwent a battery of physical and psychological tests aimed at isolating factors which contributed to prostitution. Through these studies, the Laboratory hoped to develop categories of women deemed capable of reform. Moreover, the Bureau attempted through this research to develop successful methods for the treatment and rehabilitation of female offenders reflective of an emerging trend toward definition of criminal activity in therapeutic terms.

The Laboratory’s research soon came under the influence of eugenicists anxious to demonstrate that most prostitutes showed a genetic predisposition to sexual promiscuity and “psychopathic tendencies.” Reports circulated that more than half of all women who became prostitutes were feebleminded and required lifelong custodial care. Charles B. Davenport, the leader of the American eugenics movement, endorsed these findings, noting, “Evidence is accumulating to show that the primary factor is an inherited predisposition toward an exceptionally active sexual life... The heightened licentiousness is favored by an additional germinal determinant that less licentious persons do not have.” Eugenics use of the Bureau’s research signaled an important change from the socioeconomic explanations for the causes of prostitution voiced by the vice commissions.

The Bureau of Social Hygiene marked a shift from the moralistic, dramatic objectives of the purity crusades toward an emphasis on instrumental reform that was efficient, scientific, elitist. Scientific, hereditarian notions of crime and disease largely displaced explanations which gave weight to environment and individual choice. Ultimately, the Bureau betrayed a fundamental mistrust of public efforts, which Rockefeller had come to believe rested on the whimsy of politics. Though Rockefeller had few objections to the moralistic elements of
the social hygiene movement, he sought to rationalize the claims of the movement by adding a rigorous social science component. Enlightened philanthropy, he contended, would identify the programs and lead to the scientific achievements necessary to end vice.

In the first decade of the twentieth century a series of pathbreaking discoveries in German laboratories revolutionized the American medical profession's ability to deal with syphilis. These advances, in conjunction with the efforts of the social hygiene movement, enhanced the status of scientific medicine in matters of sexuality and disease. The instrumental ideals of efficiency, prevention, and cure soon began to influence professional thinking concerning the sexually transmitted diseases. In 1905 Fritz Schaudinn and Eric Hoffmann, two German laboratory researchers, identified the causative agent of syphilis, a pale, spiral microorganism, which they called Spirocheta pallida. The following year August Wassermann and his colleagues, Albert Neisser and Carl Bruck, published an account of their successful efforts in developing a diagnostic test for syphilis. The exam they devised made it possible to detect the spirochete in blood samples through the employment of a complement-fixation reaction, a chemical process based on recent advances in immunology. American physicians greeted the reports of this work with praise. "Where formerly we were guessing at the nature of a given lesion or condition," explained Homer F. Swift, "we are now able to state with a fair degree of accuracy whether the condition is syphilitic or not." Advances in microscopic technique had also moved gonorrhea diagnostics out of the nether world of medical subjectivity. As late as 1912, however, few physicians had the necessary laboratory and technical facilities to conduct these tests.

The therapeutic coup came in 1909 when Nobel laureate immunologist Paul Ehrlich, working with the assistance of Sahachiro Hata, discovered Salvarsan, the first effective treatment for syphilis. Ehrlich had searched for methods of assisting the body's natural immunologic response to disease. "The antibodies are magic bullets," he explained, "which find their targets by themselves." In the laboratory, he sought to create chemical compounds which would serve as "magic bullets" against specific diseases. The 606th experiment resulted in an arsenic compound which, when injected into syphilitic rabbits, caused the dramatic disappearance of symptoms, and subsequent research with human subjects confirmed the drug's effectiveness. With the discovery of Salvarsan, also known as "606" or arsphenamine, Ehrlich initiated the modern age of chemotherapeutics.

Physicians greeted Ehrlich's announcement of his work in 1910 with tremendous enthusiasm and a dash of circumspection. By early 1911, a number of American physicians had experimented with the drug on their syphilitic patients. Though most reported the miraculous effect of Ehrlich's compound, a number of untoward side-effects also came to light. Some patients suffered from the agent's high toxicity, and by 1914, 109 deaths attributed to Salvarsan treat-
ments had been recorded in the medical literature. Salvarsan required intravenous injection, a technique involving surgical procedures with which many American general practitioners had little experience. Physicians who could not locate a suitable vein often had the effect of discouraging patients from complying with the required course of injections which treatment demanded. As Dr. John Stokes noted, "Even the poor can scarcely be expected to submit with good grace to repeated barbarities offered in the name of medicine." In 1912 continued research by Ehrlich resulted in a less toxic but also somewhat less effective compound which became known as Nonavalvar or "914." This agent was widely available in the United States by 1915, and many of the best-trained physicians introduced it into their practices with great success. Universal acceptance, however, probably did not occur until the 1920s, and some physicians continued to rely on mercury.

If syphilis could be properly diagnosed and effectively treated, as physicians now claimed, then it could be placed on the same footing by boards of health as other contagious diseases. Scientific advances opened the way for state and local public health officials to take a more aggressive stand in the fight against venereal diseases and to encourage the growth of the public health field. In the period around the turn of the century, public health had been transformed from a broadly based movement dedicated to environmental reform to a more narrowly defined program emphasizing science, technique, and professionalism. As venereal disease came to be perceived as a scientific problem with a scientific solution, officials centered attention on communicable diseases and the bacteriological revolution that promised their demise. Specific remedies for specific diseases became the hallmark of the modern biomedical approach to public health. This shift, however, resulted in a conflict between private practitioners and new, highly trained professionals who were committed to public health and disease prevention. As public health boards attempted to assert their authority over the venereal problem, this battle over the proprietary right to the responsibility for health care escalated.

Although state and city governments had taken action to combat some infectious diseases, venereal infections had remained outside their jurisdiction, and certainly had not received attention on the federal level. Even after diagnostic and therapeutic techniques had been developed, many physicians and laypeople continued to assert that in cases of sexually transmitted diseases the medical secret must remain inviolate, precluding any involvement by state or municipal officials. "It seems incredible that up to the present syphilis and gonococcus infection are, officially speaking, non-existent, and that as far as the national, and to a greater extent the municipal, authorities are concerned, are deserving only of contempt or complete disregard," noted Dr. Robert Willson in 1912. Increasingly, however, health reformers and public health officials suggested that venereal diseases—like other serious communicable diseases—should be placed under the purview of boards of health. As Dr. Louis Chargin of the New York City Board of Health argued, "Venereal diseases should be classed and dealt with exactly as is any other group of communicable diseases." Public health officers contended that venereal disease should be considered
scientifically and dispassionately as a health threat rather than a moral threat.

"It is said to advertise the marvelous effects of Salvarsan, and to place it within the reach of the poor is to place a premium upon vice and to absolve the syphilitic from the just punishment of his sins," observed Dr. Allan J. McLaughlin, a Massachusetts public health authority. "As health officers let us be practical and consider syphilis as a public health problem, leaving the academic discussion of its moral and social aspects to others." Dr. Hermann Biggs, director of the New York City Board of Health and a leading figure in the American scientific hygiene movement, concurred with McLaughlin, explaining, "The moral and social aspects of the problem do not primarily concern the sanitary authorities." The program Biggs devised for New York emphasized laboratory diagnostics and care only for the indigent so as not to offend private physicians who believed public health activities a threat to their practices.

The primary method employed in public efforts to control infectious diseases required that physicians report cases to the authorities. In the last decades of the nineteenth century many municipal and state boards of health demanded that doctors notify them of all patients with serious communicable diseases. This provided officials with the information necessary to locate sources of infection, trace epidemics, and quarantine infectious persons. Moreover, with statistical indications of the rates of disease, local and state governments could better allocate their health care resources. By 1907 Massachusetts had stipulated that some sixteen diseases were reportable, including tuberculosis, measles, meningitis, and whooping cough. Venereal diseases, however, remained unaccounted.

Public health officials soon began to demand that venereal diseases should be subject to these regulations. As William F. Snow explained, "All the general arguments for complete reporting of other communicable diseases apply with equal force to venereal disease." In 1911 under Snow's leadership, California became the first state to take action, requiring all physicians to report cases by number to protect the patient's identity. The New York City Board of Health enacted a regulation in February 1912 that obligated all public hospitals to report venereal cases under their care, and under which physicians were requested to report by number. Although anonymous reporting precluded rigorous case-tracing, officials hoped it would deflate the possible objections of practitioners. Moreover, the emphasis on the treatment of indigent cases as the proper domain of public health also sought to reassure physicians. The implicit assumption behind the New York ordinance was that patients who could afford to pay for treatment could be trusted not to spread their infections. In justifying the requirement for institutional reporting, Dr. Charles Bolduan noted, "It may be assumed that the institutional cases constitute the poorer and more ignorant class, and the class most in need of supervision." By July 1913, five states had enacted regulations requiring that venereal diseases be reported. Vermont devised the most unusual plan, calling for the reporting of all cases, as well as providing a twenty-five cent fee to physicians for each case.

Public health authorities quickly found that few physicians cooperated with these requirements. "The ten year long opposition to the reporting of tubercu-
loss will doubtless appear a mild breeze compared with the stormy protest against the sanitary surveillance of the venereal diseases," commented Hermann Biggs. He estimated that 90 percent of the city's physicians objected to the regulation. Only 1,500 of the city's 8,000 doctors reported treating cases of venereal disease during the first year that the ordinance was in effect, and even this number soon decreased. Despite frequent assurances that the Board of Health had no interest in treating cases already under proper care, private physicians reported only 103 cases of venereal disease to authorities in 1915.146

Doctors in private practice contended that venereal reporting held no benefits and, indeed, would ultimately hinder the control of these diseases. Unlike cases in which registered patients could be quarantined during the infectious stages of their diseases, most venereal patients remained ambulatory and treatment could be lengthy. "No man is going to subject himself to quarantine which would expose his immoral conduct and which in most instances would cast him in domestic litigation," commented the New York State Journal of Medicine in an editorial protesting reporting. Physicians also frequently suggested that reporting of venereal cases would encourage patients to turn to quacks and unscrupulous drugsmen for assistance. As a doctor from Buffalo explained, "The treatment of venereal diseases has too long been left in the hands of charlatans and leeches who suck out the gold while they frighten their victims into silence." Most often, critics of reporting, overlooking the claims of anonymity in reporting measures, complained that the regulations demanded the abrogation of the "medical secret." Dr. A. T. Bristow, a prominent New York City physician, argued that "the statute which forbids a physician to divulge the secrets of a patient would prevent the physician from complying with the order of the Board of Health." Hugh Cabot, a urologist well-known for his progressive views, nevertheless harshly criticized venereal reporting. He expressed a central concern, noting, "If physicians are required to report these patients by name, they will in short time, if they are honest, have no patients to report."

Even if physicians did report their cases of venereal disease, facilities for treatment were not generally available. Nothing testified to the opprobrium still attached to syphilis and gonorrhea at the turn of the century so much as the fact that many hospitals and clinics refused to accept patients suffering from these ailments. During the nineteenth century when lay trustees established hospital policy, venereal patients were often prohibited admission on the grounds that they were not worthy of assistance. "There is an old-fashioned feeling in Boston that venereal disease is not a respectable thing to have to do with under any circumstances," explained the Boston Medical and Surgical Journal, "that the victims are suffering for their sins or those of their fathers, and that it is almost flying in the face of providence to assist them." In 1822 for example, the Massachusetts General Hospital excluded all venereal sufferers from admission; from 1831 to 1881, syphilitics were admitted upon the special approval of the board of trustees, but required to pay doubled rates. Revised rules in 1881 again forbade admission.148 Similar policies denied venereal patients access to medical care in other cities. "It is certainly most discreditible that out of many
thousand hospital beds in the city of New York only less than two hundred are available for the care of the venereal patients,” observed Dr. Charles Bolduan in 1913. A Philadelphia physician explained that highly contagious cases of syphilis were “treated in some out-of-the-way corner by the least thoughtful and most uncouth junior member of the hospital’s surgical staff, with little or no supervision or enforced sense of responsibility.” The growing evidence of innocent infections had convinced many physicians of the injustice of these prohibitions. “A school teacher living in a boarding house in New York innocently acquired a chancre of the lip,” wrote Dr. Sigmund Pollitzer. “It was impossible to place her in any hospital ward in this city, unless she was willing to go to the City Hospital and mingle with the dregs of the metropolis found in that institution.”

Though some physicians had objected to such policies during the late nineteenth century, hospitals remained under the control of trustees anxious to distinguish between patients deserving and undeserving of care. Only when science achieved some competence in dealing with venereal disease did physicians begin to determine hospital policy and overturn these restrictions. From 1905 through 1910, the Massachusetts General’s venereal admissions rose from 5 to 45; but in 1911, after the introduction of Salvarsan, 133 were treated, and 194 in 1912. By 1913 the hospital actually recruited venereal patients, and beginning in 1915 all patients admitted to the medical ward of the newly established Peter Bent Brigham Hospital received routine Wassermann tests. More than 12 percent of the first 1,700 patients had positive reactions. At the Johns Hopkins Hospital the noted obstetrician J. Whitridge Williams instituted mandatory Wassermann tests for all women at the prenatal clinic. By the mid-1920s, this procedure had been widely adopted as the best means of preventing congenital syphilis.

Efforts to establish hospital facilities often revealed medical prejudices against venereal patients. In July 1911 New York City allocated funds to construct a venereal ward at the Riverside Hospital on North Brother Island. This facility, although it was connected to the city’s tuberculosis hospital, was used primarily to treat convicted prostitutes suffering infections. Dr. Ernest Lederle of the New York City Department of Health argued: “So far as venereal diseases are concerned, the persons who are the most undesirable as hospital patients are frequently the ones who constitute the greatest menace to others if left at large.” Lederle urged the construction of special facilities for venereal patients; others suggested the necessity of locked wards for venereal patients who were non-compliant. “Certain of the hospital accommodations to be provided . . . should be under the control of the health authorities and conducted as a ‘lock-hospital’ to which patients, dangerous to the public health, can be removed, by force if necessary, and retained until no longer infectious,” wrote Charles Bolduan.

Physicians recognized the need to make hospital beds available to venereal patients, but members of the profession bitterly opposed the establishment of out-patient clinics and dispensaries by boards of health. Realizing the need for improved venereal diagnostics and treatment, some state and municipal departments of health had begun to provide these services to patients who lacked
resources. Doctors argued that now that they could effectively deal with venereal disease, public health officials were luring away patients by creating social hygiene clinics. The New York Academy of Medicine, for example, passed a resolution objecting to the organization of municipal venereal clinics in February 1913, successfully blocking a board of health proposal. Members of the Academy cited a limited study by the New York City Medical Society that indicated that 10 to 20 percent of dispensary patients did not qualify for free care.122

In cities where private physicians were not as well organized, public health officials encountered less resistance. Health economist Michael M. Davis developed a particularly well-run venereal clinic at the Boston Dispensary. Davis castigated members of the profession who objected to the establishment of such facilities. "We must ... bear in mind that just because the treatment of syphilis and gonorrhea is in the financial sense profitable from a practitioner's point of view, we are likely to find an antagonism to the establishment of any large number of evening clinics," he declared. "Doubtless there will be definite opposition in the future ... between the point of view of the practitioner who sees an immediate personal interest, and the point of view of the public health officer who sees the public interest. Davis's clinics provided low-cost treatment and social services for patients to encourage compliance, as well as home instruction to prevent further infection. Such facilities pioneered in the techniques of contact epidemiology, attempting to locate and treat recently infected individuals.153 Davis concluded that "the needs of the community must pre- vail."

Sensitive to professional criticism, states and municipalities did not immediately allocate funds to establish facilities for the diagnosis and treatment of venereal disease. In New York the funds needed to set up a public venereal diagnostic laboratory were provided by the Bureau of Social Hygiene in June 1914. Although the Board of Estimate had refused to budget the laboratory in January 1914, Rockefeller agreed to continue to support it through the year. Under this grant the department of health also created a clinic that provided only diagnoses and counseling so as not to arouse the wrath of the professional community. Louis Chargin, a member of the department, emphasized, "Under no circumstances is treatment of any character given." The board of health encouraged physicians to avail themselves of the diagnostic service, establishing 600 stations at pharmacies and hospitals where needed materials could be obtained and left for examination. In 1914 the laboratory examined almost 58,000 specimens.154

The Bureau of Social Hygiene withdrew its support in 1915, contending that the value of the diagnostic program had been demonstrated and that the city should now underwrite the continued expense. Although the city did equal Rockefeller's past contributions, other demands on the laboratory, especially the need to produce antitoxins to aid the war in France, forced the department to restrict the venereal program. A survey conducted in 1915 found New York City clinics deficient in their care of venereal patients; of twenty-seven clinics investigated, only seven met minimum standards.155

On the eve of the United States entry into World War I public health efforts
against venereal disease remained haphazard and inconsistent. Physicians refused to pass their newly gained scientific and sexual authority to public health officials anxious to lead the fight against disease. Indeed, the failure of private practitioners even to report cases of venereal disease to public health departments persists today and has proven to be the nemesis of venereal control. Before World War I venereal disease, despite the remarkable scientific progress made in its diagnosis and treatment, was still distinguished from other infectious diseases because it was sexually transmitted and thus evoked a certain moral repugnance. In fact, public health campaigns had come under attack for ignoring the moral aspects of the venereal problem. Concerned social hygienists suggested that a purely "sanitary" approach to control of these diseases could have alarming social ramifications. Even physicians, nominally dedicated to scientific medicine, expressed concern that with the advent of effective therapy the value of venereal disease as a restraint against sexual license would be lost.

Salvarsan, the only effective treatment for syphilis, had been quickly accepted into the practice of many American physicians, but also found detractors in the ranks of social hygiene. Even Prince Morrow at the end of a career devoted to fighting venereal disease through education and moral reform—end near the end of his life—refused to grant Salvarsan the status of effective therapy. "It is a preparation of arsenic which does not cure syphilis, although it has remarkable effects in suppressing certain manifestations," noted Morrow. "Unfortunately, they always come back, and often with a train of disagreeable symptoms that were not present at first." Morrow betrayed his fear of effective treatment when he concluded, "So, for the present at least, men and women cannot sin with impunity." Howard Kelly of Johns Hopkins offered similar sentiments, noting the valuable role that venereal disease played in controlling sexuality: "I believe that if we could in an instant eradicate the diseases, we would also forget at once the moral side of the question, and would then, in one short generation, fall wholly under the domination of the animal passions, becoming grossly and universally immoral." According to Dr. E. L. Keyes, Jr., Morrow's successor as president of the Society for Sanitary and Moral Prophylaxis, the moral basis of the movement should remain paramount. "We transcend the campaign against venereal disease in our aspiration to purify by every means, moral, religious, hygienic, the morals of the race," he declared. Tension within the social hygiene movement between Victorian moral norms and a new secular, scientific paradigm had emerged. Outlining the distinctions between sanitation and morality, Richard Cabot observed, "Some of our profession are not profoundly interested in whether people are moral so long as they are healthy, and because that distinction can be sustained, morality is thereby discouraged." Social hygiene drew together two prominent Progressive contingents: those demanding a homogeneous moral order and those dedicated to a new scientific, technocratic vision. The social hygiene campaign, committed both to health and sexual morality, attempted to negotiate the inherent conflict between these emphases. With medical advances, this friction became increasingly explicit. The debate between moral and scientific contingents, however, actually reflected a continuum of opinion, with doctors and public health workers
In 1913 the social hygiene campaign came to Broadway in French playwright Eugene Brieux's Damaged Goods. This play reenacted the movement's major themes, accomplishments, and limitations. Just as the crisis of the family had generated new professional interest in venereal disease in the late nineteenth century, Damaged Goods centered public attention on the threat of sexually transmitted disease to the family unit, and asserted the professional and social responsibility for restoration of the sanctity of the institution of marriage. The play followed the tragic story of George Dupont, who, though warned by his physician that a recently incurred syphilitic infection forbids his forthcoming society marriage, ignores this advice after consulting a quack. His infection is traced as it ruins his brief domestic bliss. George's newborn child, his wife, and the wet-nurse all suffer the mournful consequences of his folly.¹⁴

The appearance on Broadway of a play that dealt frankly with the impact of venereal disease marked a significant exception to the conspiracy of silence regarding sexuality. In 1905 Anthony Comstock had closed George Bernard Shaw's Mrs. Warren's Profession, a play about prostitution, after only one performance. In an effort to head off such opposition, the Medical Review of Reviews established a Sociological Fund to solicit contributions from prominent citizens to produce the play. Edward L. Bernays, a pioneer in modern public relations technique, directed these efforts, raising $11,000. After a successful New York performance, the Sociological Fund commissioned a special showing in Washington, D.C., for President Wilson, his cabinet, and members of Congress to acquaint them with the social pathology of venereal disease.¹⁵ Damaged Goods, which was, remarkably, not only a play about sexuality but about the possible effects of sexuality, became a symbol of a new sexual openness. A financial success, it spawned a series of dramas on sexual themes.

The play revealed the concerns and tensions that characterized social hygiene in the years prior to World War I. Though noting the opportunities for successful treatment, Damaged Goods emphasized a heightened sense of morality and argued that rejection of the double standard was the best means of combating venereal disease. Unprecedented in its open confrontation of sexual issues, the play nevertheless endorsed the civilized sexual code of the late nineteenth century. Attacking hypocrisy and silence, Brieux's message suggested that patients—not physicians—must bear the ultimate responsibility for protecting the family from contamination. The doctor in the play, who endorses the concept of the medical secret, insists that he cannot defend the family from a man's immorality. "Science is not God Almighty," he shouts at George. Individuals, Brieux argued, must take responsibility for protecting themselves and their families from the ravages of disease. With Damaged Goods sexual immorality had been defined as what is today deemed a "voluntary health risk."¹⁶

Damaged Goods, however, raised another corollary: the modern state could...
no longer stand idle if individuals refused to act responsibly. The costs to so-
ciety were simply too great. So all the while stressing the need for personal mo-
rality, this generation of reformers at the same time refused to let the problem
of venereal disease rest with the vicissitudes of irresponsible individuality.
Therefore, they demanded state intervention as a means of encouraging, if not
corricing, a sense of individual morality. The doctor in *Damaged Goods* excor-
iates the legislator (the sorry bride's father) for not facing his civic responsibili-
ties. The "future of the race" depended upon the intervention of the state. This
tension between personal morality and public order—a central aspect of Pro-
gressive ideology—lay at the heart of debate concerning venereal disease; it would
continue to characterize the problem in the years ahead.

Critics hailed the play as a culmination of the attack on Victorian sexual
reference. "Even the hidden subjects of prostitution and sexual disease may be,
and have been, treated on the stage... with a noble purpose and without
the slightest effect of arousing evil passion or satisfying prurient curiosity," com-
mented Outlook. John D. Rockefeller, Jr., claiming the play would "awaken
a new conscience," contributed funds for its production. "It put to shame and
ridicule and to contempt all those people whose mental inertia is far worse than
ignorance and whose pathetic habit of turning blind eyes to the truth has been
like a dragging anchor on progress," explained Rockefeller. "Is this play de-
cent?" asked Henry's *Magazine*'s drama critic. "My answer is that it is the de-
centest (sic) play that has been in New York for a year. It is so decent it is
religious." Insinuations of impropriety nevertheless persisted. The *New
York Times*, though praising *Damaged Goods*, noted politely that "the play deals with
a subject which hitherto has practically been confined to medical publica-
tions," and obliquely referred to the subject of the play as a "rare blood dis-
 ease."

With Broadway plays, vice commission reports, white slave exposés, sex ed-
ucation, and the publicity campaign of the social hygiene movement, the ve-
nereal problem had achieved a new prominence, especially among the urban
middle class. Issues of sexuality intruded in unprecedented fashion into the public
consciousness. These discussions opened the way for a transformation in sexual
attitudes and practice. H.L. Mencken caricatured the emergence of a "new
woman" in 1915:

"Life, indeed, is almost empty of surprises, mysteries, horrors to this Flapper of 1915...
She knows exactly what the Wassermann reaction is, and has made up her
mind that she will never marry a man who can't show an unmistakable negative...
She is opposed to the double standard of morality, and favors a law prohib-
iting it...

This Flapper has forgotten how to simper; she seldom blushes; it is impossible to
shock her. She saw "Damaged Goods" without batting an eye, and went away
wondering what the row over it was about."

The emergence of sexuality into the public realm, however, did not go un-
noticed by those who looked wistfully to the civility of the past. As Mencken
suggested, *Damaged Goods* had also attracted its share of critics who questioned
the value of public discourse on issues of sexuality. "I doubt very much that any blithe young libertine tripped gaily into the Fulton Theatre and learned to his consternation that certain painful and disgusting diseases were frequently the result of sexual immorality," argued poet Joyce Kilmer. The prominent journalist Agnes Repplier decried what she called the "repeal of reticence." "Why this fresh enthusiasm in dealing with a foul subject?" she asked. The end of the conspiracy of silence, she explained, had resulted "in the obsession of sex which has set us all a-talking about matters once excluded from the amenities of conversation." Repplier found the frequent sexual allusions in movies, theater, literature, and the popular press especially alarming. "All these horrors," she concluded, "are offered for the defense of youth and the purifying of civilized society." Even the Medical Times expressed concern over these new freedoms:

With books on sexual topics queer
We're duly swamped from year to year;
Imaginative and erotic
They're yellow 'nough to tinge sclerotic

Noting the profusion of sexual literature, Current Opinion declared it "Sex O'Clock in America." Although those who took comfort in Victorian proprieties found the social hygiene campaign offensive in its openness concerning sexuality, there were also critics who took the movement to task for its emphasis on moral rectitude. The silence had lifted, but the proponents of "civilized morality" continued to speak. Indeed, the emergence of venereal disease into public discourse led these proponents to demand adherence to genteel sexual codes. Dr. William J. Robinson, a prominent urologist, attacked those who continued to cite venereal infections as a proper retribution for immorality, a common theme among social hygienists. "It is truly sickening to hear a scientist in the twentieth century make such a statement," he declared. "It is truly a prostitution of the sacred function of science to be guilty of such statements." Robinson castigated social hygienists who sought to invoke venereal disease to control sexuality. Writing in 1910 to Mary Cobb, an important financial supporter of the social hygiene campaigns in Boston, he explained:

You speak the language of the tenth century; I speak the language of the 20th, or perhaps the 25th. You speak the language of gloom and reaction; I speak the language of joy and progress. You speak the language of the shackled theologian; I speak the language of the free scientist. . . .

You believe that the sexual instinct was given to man and should be used by him for procreation purposes only. I believe that such a belief borders on insanity for it limits the man and the woman to but one or at most a dozen acts during their lives. For nobody would care, of course, to have more than a dozen children. You believe that extramarital relations are a sin and a crime. I believe they are dangerous on account of the fear of infection and may be unwise for many reasons, but are not more sinful or criminal per se than the gratification of any other natural instincts, such as eating or drinking.
Attorney and free-speech advocate Theodore Schroeder joined Robinson, accusing the social hygiene campaign of being a "conscious fraud . . . thriving on prudish ignorance." He noted the "freakish results" the first decade of the movement had wrought. Keys expressed concern that social hygiene publicity may have overstressed the dangers of infection:

Many people today have a very exaggerated idea as to ease of infection and especially as to symptoms of syphilis. Gonorrhea, which used to be likened to a cold in the head, is now-a-days likened to leprosy and cancer; while the innocent victim of acne, shingles, or poison ivy looks upon himself as doomed to locomotor ataxia.

Keyes's father, also a well-known urologist, suggested that one of the results of social hygiene publicity had been the creation of "syphilophobia." The position of Keyes and his father anticipated in many ways the problems that the social hygiene movement would face as the century progressed.

Sigmund Freud's attack on "civilized" morality had come to America, finding supporters such as Robinson and Schroeder. Freud had suggested that the emphasis on fear of sexuality, embending morality, and strict continence as means of preventing venereal infection had significant psychological and social costs of its own. Among those who came under the influence of Freud's writings was young Walter Lippmann. In 1913 during the same spring that Damaged Goods opened on Broadway, Lippman's persuasive critique of the moralistic tracts of social hygiene appeared in his first book, A Preface to Politics. In two closely reasoned chapters, Lippman dissected the report of the Chicago Vice Commission, which he correctly considered representative of such efforts. He contended that in their blind moralism commission members had developed a program divorced from reality. "In outlining a ripple," he explained, "they have forgotten the tides." The time had come, Lippman argued, to accept the sex impulse rather than continuing to attempt to deny it outright. "Instead of tabooing our impulses," he urged, "we must direct them." Sublimation, not prohibition, Lippmann argued, held the key to overcoming vice. "The commission did not face the sexual impulse squarely," concluded Lippman. "The report is an attempt to deal with a sexual problem by disregarding its source." In this broadside against Victorian morality, Lippman expressed his faith in scientific management as the best means of addressing all social ills. In this respect, he articulated a strain of Progressivism that advocated a rationalistic industrial order rather than the rigidly moral order promoted by the vice crusaders. As Prince Morrow had made clear, morality, not venereal disease, was the campaign's priority. Lippman justifiably realized that, as long as social hygiene accepted the legacy of the Victorian sexual code, it would never find an answer to the venereal problem.

Although the tensions between a scientific, secular approach to venereal dis-
care and a strictly moral attitude would persist, a clear shift in cultural authority had occurred. Physicians had accrued prescriptive powers that previously resided primarily with the church. Anna Garlin Spencer's college to Prince Morrow made this transformation explicit: "I look upon Dr. Morrow as a prophet and a priest, using that word priest in the highest sense, a dispenser of ideals organ- ized to work."

Indeed, in an increasingly secular culture, dedicated to health, science, and efficiency, much of the status previously allotted to religious leaders had passed to the medical profession. Doctors had become the arbiters of sexuality in both its scientific and moral realms. In this respect, figures as diverse as Prince Morrow and Sigmund Freud met on a common stage.