Syphilis and Society

problems of control in the United States 1912–1964

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FOREWORD

VARIOUS diseases require widely different strategies for their handling as public health problems. The natural history of each disease and the technical medical aspects of dealing with it once the patient and the physician are brought together dictate the medical armamentarium that is necessary. Once the natural history of a disease and the treatment and control methods are known, however, basic though such knowledge may be, only a beginning has been made for the treatment and control of the disease in the general population. What also must be known is who has the disease; what is the likelihood of his seeking treatment; if he seeks treatment will he stay with his physician until the treatment period is over; what kind of a treatment and control apparatus is necessary and possible given political and social values, and so on?

The story of the attempts to control syphilis in this country appears to be a suitable example of the necessity of studying disease control in both a medical and social context. I would hope that this story will inspire others to make similar studies of attempts to deal with other diseases, such as poliomyelitis, malaria, typhoid, cancers of various body sites, and types of heart diseases. There is a great deal of data on purely physiological, pathological and vital statistical aspects of almost all diseases but little has been done yet to show the social context of attempts to handle these diseases in the general population. Unless we do study the social context and plan our control strategies accordingly, we will continue to be less efficient in our disease control programs than necessary—to be mystified when there are failures and equally ignorant when there are successes.

This was the background of the thinking on disease and society which led the members of the Research Committee of the National Tuberculosis Association to suggest to me the possibility and value of making a study of the development of the syphilis control program. In view of the diminution of funds for and interest in syphilis control programs and the subsequent rise in the incidence of syphilis, the National Tuberculosis Association felt that in facing parallel experiences in tuberculosis, a review of the syphilis control program might have lessons for tuberculosis control. With this objective I received a research grant from the National Tuberculosis Association to conduct the study reported here, for which I am grateful. As a sociologist I found this modest investigation quite interesting and it has spurred me to consider more or less similar studies of other diseases.

The main sources of information for some understanding of the political and social context in which public policy was formulated were found in the

detailed and valuable annual budget hearings of the House Appropriations Committee from 1938 to the present time. These voluminous hearings were analyzed for me by Mr. Glenn L. Anderson during the academic year 1962–1963 when he was a student in the Graduate Program in Hospital Administration, University of Chicago. Other sources were as indicated in the body of the report, but particularly useful were the Joint Statements sponsored by the American Social Health Association, the Association of State and Territorial Health Officers, and the American Venereal Disease Association. Added background information was obtained from interviews with people who had been closely associated with the Venereal Disease Control Programs officially or in some other capacity. They all spoke freely of their impressions and experiences, and were pleased that a survey of the syphilis aspects of the development of the Venereal Disease Program was being made.

The people I interviewed were: Dr. Raymond A. Vonderlehr, Dr. James K. Shafer, Dr. Theodore J. Bauer, Dr. John R. Heller, Dr. Clarence A. Smith, and Dr. William J. Brown. Dr. Brown is the present Chief of the Venereal Disease Branch, and the others were former chiefs of this unit. Other persons interviewed were: Mr. T. Lefoy Richman, formerly a member of the staff of the Venereal Disease Program, later on the staff of the American Social Health Association, and now Assistant Executive Director, National Commission on Community Health Services, and Mr. Conrad Van Hyning, Executive Director of the American Social Health Association. Mr. Edward F. Tuerk, Chief, Operations and Development Unit, Venereal Disease Branch, Communicable Disease Center, U.S. Public Health Service was of considerable assistance in providing sources of information and data. It goes without saying, of course, that I take full personal responsibility for the report, interpretations, and conclusions.

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PROLOGUE

ALL diseases are products of particular times and circumstances. Many diseases can be prevented, controlled, contained, or eliminated by systematic public health measures and an enlightened and cooperative general public employing existing knowledge of causation, cure, and prevention. Syphilis is one of these because medically syphilis is easy to diagnose, symptomatically it causes little pain in the early and highly communicable stages. Patients need, therefore, a fairly sophisticated level of health knowledge to be induced to seek medical care. Syphilis is transmitted almost solely by sexual intercourse. The techniques of cure have been perfected and are relatively quick and simple although there is as yet no method of immunization. The only known absolute preventive is abstinence from sexual intercourse and kissing. Yet, syphilis is regarded as being near-epidemic in our society. Syphilis is transmitted in the most morally and emotionally charged life circumstances possible, hence case-finding founders, exhortation abounds, and incompatible objectives are set with the utmost sincerity—and frequently with naïveté.

After forty-five years or so of more or less systematic efforts by the U.S. Public Health Service, the State and Local Health Departments, and the Armed Services to control and, hopefully, to eradicate syphilis as a public health problem, and with this goal within their grasp during the mid-Fifties, the incidence of syphilis is rising again. Overoptimism and false economy resulted in the premature dismantling of the control apparatus. After some sober second thoughts, it now appears that the U.S. Public Health Services and the State and Local Health Departments are quietly and determinedly settling down for the long haul with sober optimism that syphilis can be controlled as a public health problem with due respect to individual rights and concepts of privacy. This report will attempt to report this story in its medical, public health, political, and social context, and to demonstrate the value of so doing for the formulation of public policy.[1]

[1] I am presuming that my description of the characteristics of syphilis is adequate for a study dealing with the social control aspects of this disease. My sources are: E. Gurney Clark, M.D., "Natural History of Syphilis and Levels of Prevention," *British Journal of Venereal Diseases*, 30: 191–197, 1954; and Walsh McDermott, M.D., "Syphilis" In: Paul B. Beeson and Walsh McDermott, eds., *Cecil-Loeb Textbook of Medicine* (Philadelphia: Saunders, 1963), pp. 349–362.

I

INTRODUCTION

SYPHILIS has been a scourge for centuries in Europe and the Western Hemisphere, but only during the last forty years has its eradication been theoretically possible. This is a report of the attempts to deal with the control and eradication of syphilis in a systematic manner in the United States since 1912, but particularly since 1938.

In the early Fifties many people in authority felt that syphilis would disappear, and that the control programs set up to deal with it from 1938 to 1950 could be dismantled considerably, leaving only a skeleton program as a holding action to control the remaining residue of infectious cases. As such cases decreased further, thereby reducing the probability of infection, syphilis would cease to be a public health problem.

Because syphilis is again on the increase, following the low case rate during 1955–1957, I am reviewing the venereal disease program in the United States as a case study of the seeming paradox of possession of near-perfect medical technology for syphilis control and eradication and so far unsuccessful applications for permanent control. Hopefully, this case study will be of value in comprehending the problem of disease control in general, particularly where control methods have been perfected, where both cause and cure are known. Usually taken for granted has been eagerness of the patient to seek treatment and cure providing he was "educated." We are finally learning that disease, treatment facilities and physicians, and people are interacting entities which must be understood in a context. It is now some time since the triad of host, environment, and agent became recognized as of relatively equal importance for the understanding of communicable disease transmission.

As long ago as 1876, the same year that the American Public Health Association was established, Dr. J. M. Sims of Alabama and President of the American Medical Association proposed that the State Boards of Health be given the same power to control the venereal diseases as they possessed

for the control of other communicable diseases.[1] Even had this power been granted it would have been quite meaningless because in 1876 neither the specific cause of, nor the cure for, syphilis and gonorrhea were known, although they were regarded as communicable.

Shortly thereafter, however, in 1879 Neisser discovered gonococcus, the bacillus causing gonorrhea. Some time later, in 1905, Schaudinn and Hoffman discovered the cause of syphilis in the form of the *Spirochaeta pallida.* The next few years were epochal. In 1906 Wassermann developed a blood test, and Ehrlich introduced a cure called Salvarsan, also known as 606, in 1910.

It is, then, no wonder that 36 years passed before Dr. Sims' recommendations were heeded. In 1912 California passed the first state law requiring physicians to report cases of venereal diseases. By 1917 nine states had adopted similar measures. Now all states require such reporting.

Because of the advances made in the knowledge of venereal disease in the first decade of the Twentieth Century, the War Department, on May 31, 1912, published General Orders No. 17 specifying measures for venereal disease control. Among the measures ordered were those providing for compulsory prophylaxis, disciplinary action, physical inspections, education of the troops, and early treatment. It is reported that the venereal disease rate went down in the armed forces thereafter until World War I when it began to rise.[2]

In the military recruitment during World War I it was discovered that venereal disease constituted one of the leading causes of rejection for the armed services. Accordingly, Congress passed the Chamberlain-Kahn Act in 1918 which created the Venereal Diseases Division of the U.S. Public Health Service. Appropriations amounted to $1 million a year for the fiscal years 1919 and 1920. After this emergency, annual appropriations dwindled and interest fell off. As one retrospective observer commented:

> Congress apparently thought the spirochetes of syphilis were demobilized with the army. More accurately, no further thought whatever was given to syphilis and this first national public health effort came to an untimely end.[3]

By 1935 the annual budget appropriated by Congress had fallen to a low of $58,808, barely enough to keep the Venereal Diseases Division alive.

[1] Thomas Parran, *Shadow on the Land: Syphilis* (New York: Reynal & Hitchcock, 1937), p. 78.

[2] U.S. Army, Medical Department, *Communicable Diseases Transmitted through Contact or by Unknown Means* (Venereal Diseases Chapter by Thomas H. Sternberg, Ernest B. Howard, Leonard H. Dewey, and Paul Padget) (Washington, D.C.: Office of the Surgeon General, Department of the Army, 1960), V, 139–331.

[3] Thomas Parran, *ibid.*, p. 85.

Even so, the number of reported cases of syphilis per 100,000 population was greater at this time than during the Twenties. The same was pretty much true for gonorrhea. Henceforth, however, I will deal solely with syphilis because it is a much more serious disease than gonorrhea and it presents more challenging and quite different control problems.

After the passage of the Social Security Act and Title VI authorizing Federal grants-in-aid to the State health departments for certain types of public health programs, the stage was set for a renewal of the attack on venereal disease, and particularly syphilis. The newly appointed Surgeon General, Thomas Parran, formerly Commissioner of Health, New York State, was particularly interested in this endeavor and launched a nationwide publicity program calling attention to the ravages of syphilis. He succeeded in making the term syphilis an acceptable word in polite society. Illustrative is the number of references made to venereal disease in the *New York Times* between 1932 and 1940. From 1932 to 1935 there were only five allusions to venereal disease. During the next five years the *New York Times* had 255 items on this topic! The number of magazine articles on venereal disease—such media being not as immediately responsive as news media—increased, according to the *Reader's Guide*, from 29 in 1932–1935 to 129 during the next five-year period.[4]

The kick-off was the calling of a national meeting of about 1,000 persons —public health officers, social workers, epidemiologists, and workers in voluntary health agencies—in Washington, D.C., December 28–30 in 1936.[5] The gist of this meeting was that it was now in the power of man to eradicate syphilis if current treatment methods were systematically applied.[6] A participant made the eradication of syphilis seem simple by pointing out that syphilis could be prevented by avoidance of exposure to infection. He adopted the standard suggestion for the need for health education, since "exposure being usually the result of voluntary action it is believed that education which influences conduct has a place in the program."[7]

The Surgeon General transmitted the recommendations of the national conference to Congress and the country. They stemmed from the knowledge of the causes and methods of transmission of syphilis which had been

[4] Based on a count made by the author and his associates.

[5] U.S. Public Health Service, *Proceedings of the Conference on Venereal Disease Control Work, Washington, D.C., December 28–30, 1936* (Washington: Government Printing Office, 1937), Supplement No. 3.

[6] Alan M. Chesney, M.D., Dean of the School of Medicine, Johns Hopkins University, *ibid.*, pp. 63–72.

[7] Walter Clarke, M.D., Director, Bureau of Social Hygiene, New York City, Department of Health, *ibid.*, p. 23.

known for 25 to 30 years: (1) Find, report, and interview for sex contacts every early case of syphilis; (2) mobilize enough money, drugs, and doctors to treat every case regardless of cost; (3) align health agencies and private physicians in a united front against syphilis and educate them to use scientific and modern methods. In addition there were general recommendations to give people the necessary information about the nature of syphilis for individual and public self-protection. It is obvious that these recommendations were concerned with administrative mechanisms within the contemporary social values and structure since the medical technology had been perfected.

National attention was being aroused regarding the venereal disease problem. Two years later, in 1938, Senate and House Committees held hearings preparatory to the passage of a venereal disease control bill that same year. Many people came to Washington to testify in favor of this bill, S. 3290. The sponsors were Robert M. La Follette (D., Wis.) in the Senate and Alfred L. Bulwinkle (D., N.C.) in the House.

The hearings emphasized the social investment aspect of venereal disease control in that increased expenditures would result in great savings in time lost from work, cost of treatment in hospitals and so on. As expressed by Senator La Follette:

> I believe that before these hearings are concluded, men and women who are much more competent and much more expert in this field than I am will convince this Committee that a national campaign is sound economy, and it is false economy to permit not only the devastation among the victims of this disease but that it is also false economy to permit it from the standpoint of hard, cold dollars and cents.[8]

In a similar vein the Acting Secretary of the Treasury, Wayne C. Taylor, wrote to Clarence F. Lee, Chairman of the House Committee on Interstate and Foreign Commerce: "The venereal diseases assumed national importance because of the heavy demand on Federal, State, and local-tax funds in the care of end results."[9]

Public Health measures have frequently been couched in economic terms and with a great deal of justification. Syphilis strikes and incapacitates largely young adults who have long and productive lives ahead of them. In any case, the emergency concept implicit in the Chamberlain-Kahn Act of 1918, stimulated by the war-time emergency, and subsequent dwindling of Federal funds to a trickle by 1936, was replaced by the La Follette-Bulwinkle Act of 1938 which implied a long-term attack on syphilis during peacetime. It built on the now firmly established basis of Federal grants to the States with matching grants by the State, as spelled out in a national health policy in Title VI of the Social Security Act. However, World War II intervened in the form of military conscription before Pearl Harbor on December 7, 1941, and in full force after the United States was an active ally mobilizing over 12 million men and women. This mobilization of a high proportion of young men in the general population had tremendous implications for venereal disease control.

[8] U.S. Congress, Senate Committee on Commerce, *Hearings before a Subcommittee of the Committee on Commerce (75th Cong., 3d sess), on S. 3290, February 14–15, 1938*, p. 4.

[9] *House of Representatives Report No. 2174* (75th Cong., 3d sess., April 21, 1938), p. 3.

II

BUILDING THE CONTROL APPARATUS, 1938–1945

A. Prior to the Selective Service Act, 1938–1940

The Venereal Disease Control Act raised the Federal appropriation from $80,000 a year in 1936 to $3,080,000 in 1939 and in 1940 to over $4.5 million. Meager as were the appropriations prior to 1939, there was still a rather impressive number of V.D. clinics in operation in the United States: 1,746 in 1938 treating 197,000 first-time patients for both syphilis and gonorrhea. In that same period over 480,000 cases of syphilis and 198,000 cases of gonorrhea were reported to the U.S. Public Health Service by the State Health Departments,[1] indicating that probably over one-half of the cases were treated by private practitioners in their own offices. The true extent of venereal disease seems impossible to determine, however, because of incomplete reporting by physicians and the difficulty of determining the number of patients who did not seek treatment at all.

Prior to the Venereal Disease Control Act of 1938, which became effective in 1939, the U.S. Public Health Service used the $80,000 appropriation mentioned primarily for (1) some clinical and laboratory research and (2) a limited amount of publication and dissemination of information. There were no grants-in-aid to the States. In other words, the state and local governments supported the 1,746 clinics mentioned above. Nevertheless, it was obviously felt that Federal stimulation and coordination, in addition to state and local participation, was necessary to attack what was regarded by many as a national problem.

The impact of the Venereal Disease Control Program was immediate and massive. Within a year the number of clinics had increased from 1,746 to 2,405, almost 38 per cent, and the number of new cases treated had

[1] U.S. Public Health Service, Publication No. 341, *V.D. Fact Sheet 1962* (1962 Revision), p. 8.

jumped from 197,000 to 314,000, an increase of almost 60 per cent. Some other figures are of interest.[2]

1. The number of diagnostic and treatment services in V.D. Clinics increased from 4,767,000 to 6,864,500—up 49 per cent.
2. The number of doses of arsenical drugs administered in V.D. Clinics increased from 1,800,000 to 3,100,000—up 70 per cent.
3. Doses of arsenical drugs distributed free to physicians increased from 2,700,000 to 4,600,000—up 67 per cent.
4. Patients discharged, presumably from clinics, increased from 78,000 to 102,000—up 31 per cent.
5. State laboratories performed 4,400,000 tests in 1938 and 6,200,000 in 1939—up 40 per cent.

An amusing sidelight to this House Committee hearing was the Committee's surprise that an increase of Federal funds from $80,000 to $3,080,000 (almost forty-fold increase) produced only a 59 per cent increase in new cases reaching treatment.[3] Dr. Raymond A. Vonderlehr, the Chief of the Venereal Disease Control Program, tried to justify this lack of direct one-to-one relationship by explaining that the base was not really $80,000, but much higher because previously almost all the money had been state funds. The Committee then requested a comparison of activities between 1938 and 1939 as shown above in order to have some measure of the impact of Federal funds.

It was estimated that around one-half of the syphilis cases had been treated by physicians in private practice. In this regard the health departments were of assistance by providing (1) free laboratory services, (2) free drugs, (3) reporting forms and free mailing service, and (4) facilities for the hospitalization of indigent patients. Necessary as was the treatment provided by the private practitioners, a disadvantage was the low proportion of treated syphilis cases reported by physicians.

Case-finding and tracing of contacts were extremely important techniques in venereal disease control; unless private physicians reported the cases under treatment to the health departments, control was seriously hampered. One of the primary values in medical practice, and particularly private practice, is the confidentiality of the patient's records.

[2] U.S. Congress. House Committee on Appropriations, Department of Labor—Federal Security Agency Appropriation Bill for 1941, *Hearings before the Subcommittee of the Committee on Appropriations, House of Representatives* (76th Cong., 2d sess), pp. 522–524.

[3] *Ibid.*, p. 517. (Note: Hereafter all references to House Committee Appropriations Hearings will be abbreviated: "House Committee on Appropriation Bill for 1942, and so forth.)

This problem was recognized by the Conference of State and Territorial Health Officers and the Conference recommended that:

> Notification of these diseases is essential; but legally qualified physicians should have the privilege subject to the approval of the health authority, of reporting any case by initials, date of birth, and community, instead of by name and exact address, provided the name and address are immediately supplied if the patient fails to observe all precautions for protection of other persons, or lapses from treatment before being rendered permanently non-infectious.[4]

It is not known how these recommendations worked out, but it would seem that the physicians' dilemma was not thereby removed. The least that the health departments could insist upon is expressed in the same minutes of the Conference:

> As syphilis and gonorrhea constitute a public health problem the rights of the Community supersede the rights of the individual. These diseases know no class distinction. The same fundamental principles of control apply to the patients under the care of private physicians or public clinics.[5]

Of interest here are the assertions about class distinctions which were made. They certainly stem from differential concepts of privacy in public medicine and private medicine revealing some of the difficulties that public health departments encounter in controlling venereal disease. Later, the concept of personal privacy became quite irrelevant in another context—the armed services.

B. THE ARMED FORCES—1940–1945

The Venereal Disease Control Act of 1938 was passed and implemented during peacetime conditions. I would assume that Surgeon-General Parran and his Chief of the Venereal Diseases Control Program, Dr. R. A. Vonderlehr, were planning a peacetime crusade to set the stage for ridding the country of the scourge of venereal disease, particularly syphilis, within twenty years—a goal they set forth. By the time the Program was getting into its second fiscal year, the Selective Service Act was passed mobilizing the young men into the armed services, and a little over a year later our pose of neutrality regarding the War in Europe was shattered by the attack on Pearl Harbor. Mobilization brought hundreds of thousands of young men to army camps scattered throughout the country. Clusters of honky tonks and brothels sprang up in the vicinity of these camps, and the combination resulted in an increase in the reported venereal disease rate.

[4] *Minutes of the Conference of State and Territorial Health Officers, 1937*, p. 122.

[5] *Ibid.*, p. 119.

The classic association of venereal disease and war was mitigated only by the ability of society to control men and their behavior in military situations. Induction centers and the military camps after induction became gigantic screening and control clinics for prophylaxis, detection, and treatment not possible in normal peacetime society in this country. In fact, it can be fairly said that the civilian sector of society—prostitutes, pickups, etc.—infected the men, and the armed services cured them.

A *modus operandi* of sorts was worked out between the armed forces authorities and the civilian public health authorities as formulated in the Joint Agreement by the War and Navy Departments, Federal Security Agency (now the Department of Health, Education, and Welfare) and State Health Departments, and adopted by the Conference of State and Territorial Health Officers in May 1940. This agreement became known as the Eight Point Agreement. Abbreviated, it promulgated the following:[6]

1. The Army and Navy agreed to report probable sources of venereal disease infection of enlisted men to the civilian health authorities.
2. In turn, the civilian health authorities would report to the Army and Navy all contacts of enlisted men with infected civilians.
3. Forcible isolation of recalcitrant infected persons during the period of communicability.
4. Repression of prostitution and organized vice.

Regarding the last stipulation, by the end of 1940 it became evident that local law-enforcement facilities for the repression of prostitution were inadequate in many communities where there were military camps and large defense plants. Congressman Andrew J. May (D., Ky.) Chairman of the House Committee on Military Affairs, on January 20, 1941, introduced a bill designed to suppress prostitution in military camps and defense industry areas through Federal agencies, i.e., the F.B.I., when local law-enforcement agencies were unable to do so. H.R. 2475, which became known as the May Act, was supported by the Armed Services and the American Social Hygiene Association (later the American Social Health Association) and was a result of spontaneous Congressional sentiment even though the Act enabled Federal intervention in local areas. The Act was invoked only twice, however—in Tennessee and North Carolina.

Since it was recognized that suppression as such could be only partially successful, the provision of prophylaxis against venereal disease through

[6] Thomas H. Sternberg, M.D., Ernest B. Howard, M.D., Leonard A. Dewey, M.D., and Paul Padget, M.D., "Venereal Disease," In: U.S. Army, Medical Department, Preventive Medicine in World War II, *Communicable Diseases Transmitted through Contact or by Unknown Means*, Vol. V (Washington, D.C.: Office of the Surgeon-General, Department of the Army, 1960), p. 140 and Appendix B.

stations and sale at post exchanges had been accepted Army control procedure for many years before World War II. This policy was criticized by church and other civilian groups as an inducement to promiscuity and "inconsistent with the educational program which emphasized continence." Characteristic of this concern was a letter from Bishop John F. O'Hara, Military Delegate to the Military Ordinariate of the Roman Catholic Church in the United States, to the War Department in 1941. The Bishop criticized the sale of contraceptives at post exchanges. Equally characteristic was the reply prepared by the Surgeon General of the Army revealing a moral and a practical dilemma:

> You may be assured that there is no inclination on the part of the War Department to minimize the importance of the moral aspects of the venereal disease problem. However, in the interest of military efficiency this problem must also be considered in the same manner as any other disease. The men are in the Service for training, and time lost is a serious matter.
>
> It must be recognized that regardless of what advice is given, an unknown proportion of men will expose themselves to the hazard of venereal contagion. For such individuals the Army advocates the use of mechanical and chemical prophylactics, *not as contraceptives*, [italics mine] but solely as an effective procedure for the prevention of infection.

The Surgeon General further justified the open sale of prophylactic kits at post exchanges in order to assure the enlisted men quality products, instead of availing themselves of shoddy products found in vending machines in poolrooms and filling stations. In conclusion, he wrote:

> I assure you that while individual officers may have expressed personal views to the contrary, the War Department recognizes that the only perfect method of preventing venereal disease is continence, and that for moral and physical reasons it is officially in favor of chastity among troops.[7]

This exchange of views took place in 1941 when over 68,000 primary and secondary cases of syphilis were reported to health departments. Six years later over 106,500 cases were reported. Undoubtedly some of this increase was due to more complete reporting as well as to a real increase in incidence. The break—a dramatic one—came in 1948 when the number dropped to 80,500. It took some time for the control apparatus to be set up and take effect. The Armed Services provided the chief framework for this control apparatus in cooperation with the civilian Venereal Disease Control Act.

By the end of the War over 12 million men (and a small number of women) had been inducted into the armed services. The progression was as follows:[8]

[7] Sternberg *et al.*, pp. 196–197.

[8] *U.S. Statistical Abstract, 1963*, p. 262.

	Number in Armed Forces
1940.....	488,000
1941.....	1,801,000
1942.....	3,859,000
1943.....	9,045,000
1944.....	11,452,000
1945.....	12,123,000

Roughly one-half of the men in the Armed Forces were between 18 and 24 years of age, 75 per cent between 18 and 29. At peak strength 70 per cent of all males in the age-group 18 to 24 were in the Armed Forces, and about 60 per cent of males in the age-group 25 to 29.[9] It is thus obvious that the age-group most likely to acquire syphilis was in an environment that could be controlled to a high degree. Furthermore, although in the early period of mobilization persons known to have venereal disease were rejected for military service because facilities and personnel were inadequate, this policy was changed in December 1942 when facilities did become adequate.[10] It was estimated that 170,000 men with known cases of syphilis were inducted into the Army where they were reported to be cured before being trained and placed in active service.[11]

There was also a control during discharge from the Armed Forces. It is estimated that between November 1944 and October 1946, 50,000 men were treated for syphilis before being released to civilian status.[12] The extent to which discharged service men with active syphilis slipped through this control net and inflated the civilian rate of reported syphilis cases is speculative.

An aspect of venereal disease control in the Armed Forces deserves mention because of the change in climate of opinion it demonstrates. In 1926, Congress passed a law making it an offense for a person in the Armed Forces to contract a venereal disease. The penalty was automatic loss of pay for the duration of the disease period.[13] The armed forces were apparently never happy with this law because many men who knew they had con-

[9] *U.S. Statistical Abstract, 1946*, p. 27.

[10] Sternberg *et al.*, *ibid*, p. 148.

[11] Quoted from B. D. Karpinos, "Venereal Disease among Inductees," Bulletin of the U.S. Army Medical Department 8.806–820, Act, 1948. *In*: Paul Padget, M.D., "Diagnosis and Treatment of the Venereal Diseases." U.S. Army Medical Department, Internal Medicine in World War II, *Infectious Diseases*, Vol. II (Washington, D.C.: Office of the Surgeon General, Department of the Army, 1963), p. 433.

[12] Sternberg *et al.*, *ibid.*, p. 186.

[13] U.S. Army Medical Department, Internal Medicine in World War II, *Infectious Diseases*, Vol. II (Washington, D.C.: Office of the Surgeon General, 1963), p. 433.

tracted a venereal disease failed to report it and frequently resorted to self-medication. The law tended to drive venereal disease underground, as it were, and hampered the control efforts of the Army medical department. Further, it was felt that, insofar as the law was intended to reduce illicit sexual intercourse, those who did not contract venereal disease as a result of such activities got off scot-free whereas those unlucky enough to become infected were the only ones punished. By 1944 enough pressure had been brought to bear on Congress to repeal the law passed in 1926.

C. Congress and the Civilian Sector—1940–1945

From the beginning of the Venereal Disease Control Program authorized in 1938 and through the War, the members of the House Appropriations Committee were very sympathetic with the operation and the objectives of the program and the Congress. The questions asked the Surgeon-General and the staff of the Venereal Disease Control Program at the annual budget hearings were direct and pertinent, but the atmosphere was on the whole friendly. During the first two years of the Act, for instance, Congress appropriated the full amounts requested. For the fiscal year ending July 1, 1941, the Budget Bureau cut $4 million from the $7 million requested, sending a recommendation for $3 million to the House Appropriations Committee. When the measure came out on the floor of the House, it was raised to $6,200,000, the amount finally approved by Congress. Surgeon-General Parran and his Chief of the Venereal Disease Control Program were naturally happy about the show of support and they wrote:

> It is not usual in Washington for recommendations of the Budget Bureau to be revised upward by the Appropriations Committee. It is even less usual for the recommendations of the Appropriations Committee to be revised upward when the item reaches the floor of either House in Congress. It is significant that this occurred without political pressure and without lobbying. Congressmen of all shades of political opinion rallied to support of the work because they knew what was going on in their home communities where control programs had been started.[14]

When the Act was passed in 1938 no requirements were established for states to match Federal funds according to stipulated amounts. The degree of matching by the states was apparently at the discretion of the Surgeon-General. If the matter of required matching of funds was an issue in the House Appropriations Committee before the War, it appeared to become irrelevant after the War started. Scattered and huge concentrations of men in army camps throughout the country created a national problem in which

[14] Thomas Parran and Raymond A. Vonderlehr, *Plain Words about Venereal Disease* (New York: Reynal & Hitchcock, 1941), p. 12.

the Federal Government was heavily involved. As related by Dr. Vonderlehr reporting on his experiences with the Deficiency Appropriations Committee for 1942, the Committee

> asked specifically that we not compel the several States to maintain matching credits for the supplemental appropriation at the same high level as for the regular appropriation. In other words, the attitude of that Committee . . . was that we have a war problem and the important thing to do is to meet that problem and not argue about matching credits.[15]

Dr. Vonderlehr went on to say that the Surgeon-General used the discretionary power residing in him "to drive the best bargains we could with the States."[16] Quite naturally, then, the Venereal Disease Control Program became a national program in that the U.S. Public Health Service in effect designated high-priority and hence target areas in conjunction with the State Health Departments and the armed forces installations. The House Appropriations hearings in 1943 revealed the policy implications of the discussion by its members. They felt that the venereal diseases should be attacked at the source, particularly in areas with high incidence rates, to prevent contamination of low rate areas through migration. At this hearing, Surgeon-General Parran said that the $2.5 million supplemental appropriations being sought would be applied with such a policy in mind.

This viewpoint on the part of the Committee can hardly be interpreted to mean that its members were unmindful of the extent to which states put up state funds for venereal disease control. In the hearings held in 1941 the Committee was reported as not pleased to learn that state funds had not increased at the same rate as Federal funds. By the time of the 1942 Appropriations Committee hearing, however, we were approaching an armed forces contingent of 4 million men which a year later would be swelled to over 9 million men. States rights had now become quite academic and remained so for the duration.

Quite obviously the House Committee Appropriations Hearings during the War and the activities of the State Health Departments were conditioned by the activities of the armed forces establishments and the defense plants throughout the country. A working relationship was established between the military and the civilian venereal disease control agencies. Primary attention was directed to the prevalence of prostitution in the vicinity of military establishments and even defense plants. The operating agreements were as follows:

[15] *House Committee Appropriations Hearings for Appropriation Bill, 1943*, p. 494.

[16] *Ibid.*, p. 496.

1. An infected soldier reports to the military prophylaxis station the name and address of the sexual contact.
2. Such contact is reported by the medical officer to the local health officer.
3. The local health officer is supposed to follow up and treat the civilian sex contact while the military treats the soldier.

In effect, then, the military treated the men and the local health officers treated the women, i.e., prostitutes and pickups. This division of functions became increasingly clear as the armed services mobilized the great majority of the young men in the country.

In this context state and local autonomy had another setback. The House Appropriations Committee, especially in the person of Malcolm C. Tarver (D., Ga.), was unhappy that local steps to abolish prostitution were feeble. He experienced a conflict of incompatible objectives when he pointed out that public funds were used to treat prostitutes with little other effect than to enable them to continue their activities in better health! In his view—logical given his priorities—the only benefit was a slight reduction in the risk of infection.[17] Tarver felt that if State and local authorities were unwilling to act in discouraging gambling, sale of liquor, and prostitution (due to "the desire to have more money spent in their locality"), the Federal Government ought to step in and enforce the May Act, described previously.

The hearing in the spring of 1943 reflected a compounding of problems; rapid mobilization of men in the armed forces, and creation of military camps, the swift shift to defense plant employment in various areas, and the depletion of technical personnel in health departments. Public health nurses were no longer available for follow-up work on syphilis cases. The States were encouraged to get other types of personnel whose medical qualifications might not be so technical and train them specifically for venereal disease case finding and follow-up. In any case, the amount of money authorized and appropriated by Congress reached a peak for the War years in the 1943 appropriation, effective for fiscal year 1943–1944. During the three war years the appropriations had doubled from roughly $6 million in 1941 to $12.5 million in 1943. The amount stayed at approximately this level through 1945.

As part of the contribution of the civilian side of the attack on venereal disease the American Social Hygiene Association deserves special mention, because it was the only nongovernmental voluntary agency active in venereal disease control since its founding in 1912. The ASHA had been

[17] *House Committee Appropriations Hearings on Appropriations Bill for 1943*, pp. 410–411.

active in this and related endeavors in World War I as well as World War II. The moving spirits were Drs. William F. Snow and Walter Clarke. The ASHA assisted the Armed Forces and Health Departments by investigating and reporting on prostitution activities.[18]

Within the Federal Government, in addition to the U.S. Public Health Service, there was established a Division of Social Protection early in 1941 as a subdivision of the Office for Emergency Management until April 1943. Later it was transferred to the Office of Community War Services, Federal Security Agency, until its dissolution on June 30, 1946. This agency worked mainly on the problems of prostitution and related matters. It attempted to work with all groups which would have some direct relationship with prostitution. Obvious groups were the police and even cab drivers' associations for their assumed knowledge of places where sex was sold. The Division of Social Protection also worked with the hotel associations to obtain assistance in controlling organized prostitution in hotels. The assistance of the Brewing Industry Foundation was enlisted presumably because of the popularly assumed association of liquor and vice.

It is quite impossible to assess the effectiveness of these anti-prostitution activities, but a history of venereal disease control in the Army for World War II is confident enough to report that in over 600 cities and towns segregated areas of prostitution were eliminated.[19] It is of more than passing importance that the word "segregated" was used because the extent to which prostitution flourished outside of such areas is not known.

In 1943, again as a wartime emergency measure, over twenty special hospitals were established to provide intensive arsenic-bismuth treatment for patients with infectious syphilis and sulfa treatment for those with gonorrhea. Most of these were operated near army and navy training facilities or important war industry cities by Federal or State health agencies. Perforce, since these treatment facilities were for civilians the great majority of patients were women. Full treatment in these hospitals required only five to ten days as compared to the 70 weeks required when treatment was given in out-patient clinics.

Use of these rapid treatment centers, as they were soon called, had the dual advantage of allowing the clinic personnel more time to devote to case-finding, according to Parran, and of making it easier for patients to complete the full course of treatment. Parran reported further that under the traditional schedule of 70 weekly injections as given in clinics, 75 per cent of the patients with early syphilis failed to complete the full course of

[18] Its annual budget of $500,000 shows how much visibility a relatively small voluntary agency can give to a problem when it has a well-directed program.

[19] Sternberg, *op. cit.*, p. 173.

treatment.[20] Obviously, the disadvantages of treatment with arsenic-bismuth in an out-patient department or private practice setting were enormous. The rapid treatment center provided a total control situation once the patient was admitted, impractical in out-patient departments or private offices.

By 1944 there were 47 rapid treatment centers in operation. A medical discovery was to change both the site and method of treatment of syphilis, however, creating new possibilities and problems for syphilis control.

In 1943 Dr. John F. Mahoney of the U.S. Public Health Service discovered that a large number of penicillin injections (penicillin having just appeared and in limited supply) over a period of eight days was apparently as effective in killing syphilis germs as were the older drugs without the side effects frequently experienced in treatment with arsenic-bismuth. As soon as the effectiveness of the penicillin treatment was confirmed, rapid treatment centers financed by Federal and State funds were expanded to include beds in general hospitals. Approximately 150,000 cases of syphilis annually, more than one-third of the cases reported, including a major portion of the cases of early syphilis among civilians were being treated in these facilities.[21]

Penicillin quickly became the magic word in the armed forces as well. The Chief, Preventive Medicine Service, Office of the Surgeon-General, U.S. Army, Brigadier-General James S. Simmons, hearing about this miracle cure on April 5, 1944, requested advice as to the earliest possible time penicillin treatment of syphilis might be applied in the army. It can be readily assumed that the Brigadier-General had visions of saving hundreds of thousands of days of disabled manpower in the forthcoming campaign in Europe which everyone knew was imminent. He addressed this seemingly laconic request to Dr. Moore, Chairman, Subcommittee on Venereal Disease, National Research Council. The chronicler of these events for the Army, one of the medical officers of the Army active in venereal disease control, reveals the atmosphere of wartime:

> This was a staggering request. Arsphenamine and its derivatives had been employed in the treatment of syphilis for nearly 35 years without reaching satisfactory agreement on the details of its utilization, yet here was a request for advice regarding the large-scale application of an entirely new therapeutic agent which had first been used in the treatment of syphilis only nine months before

[20] Thomas Parran, "Are We Stamping Out Syphilis?" Reprint: *Journal of Social Hygiene*, April, 1948. Publication No. A708.

[21] *Ibid.*, pp. 3–4.

and for which experience in any statistically significant scale was only six months old.[22]

The sequel to this request for advice on April 5, 1944, is that penicillin treatment for syphilis in the Armed Forces was in full swing by June, 1944, only three months after the original query.

The House Appropriations Committee hearings held in 1944 and 1945 were quite routine. Mention is made for the first time of rapid treatment centers and the introduction of penicillin therapy. The number of cases brought to treatment at the centers was increasing year by year. The appropriation requests were being authorized quite routinely and there was little questioning, even in the face of a continuing high case rate, which probably could be explained by the greater effectiveness of bringing patients to treatment and case reporting than previously. There was a clearly demonstrable decline in the mortality rate from syphilis, however, from 10.7 deaths for 100,000 population in 1940 to 7.9 in 1945. Deaths of infants under one year of age due to syphilis was more than cut in half during the same period. Another mark of improvement was a reduction in the number of first admissions to mental hospitals due to syphilis.[23]

The War ended in August, 1945, and the armed forces, as mentioned previously, were at a peak strength of over 12 million. Within a year this stupendous military machine was reduced to three million, but the Venereal Disease Control Program was to continue at full force until there was an appreciable drop in venereal disease cases, particularly syphilis. With nine million men back home and a reduction in defense work, we re-enter a peacetime period of venereal disease control.

[22] Paul Padget, M.D., "Diagnosis and Treatment of the Venereal Diseases." *In*: U.S. Army, Medical Department, *Internal Medicine*, Vol. II (Washington, D.C.: Office of the Surgeon General, Department of the Army, 1963), p. 424.

[23] U.S. Public Health Service, Publication No. 341. V.D. Fact Sheet, 1962. Rev. ed. 1962.

III

THE CONSEQUENCES OF OVEROPTIMISM: WEAKENING OF THE CONTROL APPARATUS: 1946–1955

THE total appropriation by the Federal Government for venereal disease control was not revealed entirely in the appropriations through 1945 because the crest of over $12 million reached that year did not include the funds from the Lanham Act to operate rapid treatment centers. The Lanham Act was an early wartime measure for operating medical facilities for civilians near military installations and defense plants. Questioning by the Appropriations Committee resulted in lumping the funds from the Lanham Act and from the case finding and treatment activities. Consequently there was a jump of around $5 million in the 1947 appropriation resulting in an earmarked appropriation of almost $17 million.

As portents of peacetime psychology, in the Appropriation hearings held early in 1946, remarks about the propriety of the Federal Government engaging in activities properly belonging to the States began to appear. This observation came from Rep. Tarver, who early in the War had advocated the enforcement of the May Act, a law enabling the F.B.I. to move into law enforcement traditionally left to the States. Peacetime atmosphere was beginning to restore the traditional sparring between State and Federal jurisdictions.[1]

Another sign of a return to a peacetime atmosphere was the discussion between Rep. Frank B. Keefe (R., Wis.) and Dr. J. R. Heller, who had replaced Dr. Vonderlehr as Chief of the Venereal Disease Control Program, of the Federal-State relationship in the execution of the program. Keefe was after evidence to refute criticisms of the rapid treatment centers as a "step in the direction of federalized control of medicine and socialization

[1] *House Appropriations Committee on Appropriations Bill for 1947*, pp. 16–17.

of medicine."[2] It will be recalled that Congress had had some form of compulsory health insurance bill on the docket since 1939 and public debates on these measures were at a fever pitch.

The Appropriation hearings held in 1947 were of importance because by this time the patients in rapid treatment centers were reaching a peak of 185,000 annually, falling thereafter. This was apparently unanticipated in the budget hearings in 1947 (where $600,000 had been cut in the V.D. budget). A shortage of funds was imminent. The U.S. Public Health Service requested a deficit appropriation of $881,000 prior to the 1948 hearing, but the prospect of receiving it did not appear promising. The Committee naturally wanted to know what the effect on the program would be if the requested funds were not authorized. The staff of the U.S. Public Health Service thought that in the face of curtailment of Federal funds the States would not be able to take on the added expenditures. A letter from Surgeon-General Parran attempted to answer the Committee's query.[3] He said that the states would close or curtail services at the rapid treatment centers if Federal funds ran out. And, Surgeon-General Parran wrote, if the centers did close, "there would be a serious lapse, a serious interruption in the constant progress which it has been possible for us to make during recent years."[4]

Because States had tended to shift funds from clinic operations to rapid treatment centers, as the greater effectiveness of the latter was demonstrated, clinic activity was limited mainly to case finding. Treatment was shifted to the centers. Consequently, state budgets for clinics were reduced and apparently an increase from the States for clinics was not forthcoming.

It is seen quite clearly that the war emergency resulted in Federal funds being spent largely for treatment, and the States could not or would not take up the slack as the emergency conditions receded. It seems that Rep. Keefe grasped the horns of the dilemma at this point and tried to break the impasse with the following remarks:

> If we decide the V.D. Program should be maintained in the United States of America, all right, then it should be an uninterrupted program and a continuous one. And if we decide we do not want this program, then let us not spend any money on it at all; let us quit. But if it is what the Congress has adopted—and the responsibility, as I say, is up to the Congress and not to any intermediary group to set it up—why, give us the best you have. . . .[5]

[2] *Ibid.*, pp. 205–207.

[3] *House Appropriations Committee Hearings on Appropriation Bill for 1948*, pp. 542–543.

[4] *Ibid.*, p. 544.

[5] *Ibid.*, p. 284.

After suggesting a premise he hazarded a policy which had never been stated so directly before:

> I think the members of this committee are pretty well sold on the general philosophy and necessity for the treatment and control of venereal disease as a Nation-wide project. It goes beyond State line barriers, county line barriers, or anything else; it is a matter that concerns the whole people of this country, because these populations are floating around.[6]

Less as a rebuttal than as a rhetorical question, Rep. Schwabe asked:

> Why cannot the States be imbued with the idea that they should spend more money? They are better off today financially than the Federal Government.[7]

In any case the Federal appropriation for the fiscal year of 1949 was the highest before or since, a total of almost $17,800,000.

The hearings held in 1948 continued in much the same vein as the previous year's hearing. The Committee attitude as expressed by Rep. Keefe appeared to be unchanged. He said: ". . . This program like every other program of similar character to be effective must be continuous and everlasting and without lapsation of effort. . . ."[8]

This idea was carried through into the Committee recommendations in reporting the bill. The report contained the statement that ". . . the situation boils itself down to the proposition of either providing adequate and sustained support or abandoning the program. . . ."[9] For the first time during the past year there had been a quite dramatic drop of cases of primary and secondary syphilis from 106,500 to 80,500. The number of early latent cases had also dropped appreciably.

At the 1949 hearings there was a big change in the representation from the U.S. Public Health Service. Surgeon-General Parran had left the service, and had been replaced by Dr. Leonard Scheele. Presumably each Surgeon-General has personal interests to pursue in the public health field. Parran was certainly interested in a wide range of problems, but his name and that of Vonderlehr are associated with the drive to eradicate syphilis. When the Venereal Disease Control Program was at its peak and syphilis case rates began to fall, the leadership changed. Consequently there was a new Surgeon-General and a new Chief of the Venereal Disease Control Program. How aggressively these men were willing to pursue venereal disease control cannot be assessed with any precision. Suffice it to say, however, that the new Surgeon-General threw his interest and energy into developing a research center and medical research grants mechanism. The result was expansion of the National Institutes of Health.

[6] *Ibid.*, p. 289.

[7] *Ibid.*, p. 290.

[8] *House Appropriations Committee Hearings on Appropriation Bill for 1949*, p. 215.

[9] *Ibid.*, p. 22.

At any rate the hearings held in 1949 seem to reveal that U.S. Public Health Service interest had abated and the venereal disease control activity was now one of mopping up. The glamor was certainly gone. Testimony revealed that the U.S. Public Health Service had submitted an estimate of $17.4 million to the Administration, but the Bureau of the Budget had lopped off $1.4 million. Neither the representatives of the Service nor the Committee members protested. Within the protocol of government, employees are not privileged to raise a protest unless specifically asked for their opinions. In this connection Dr. T. J. Bauer, Dr. Heller's successor as Chief of the Venereal Disease Program, revealed that the result of the cut in appropriations would be curtailment of case-finding.[10] This activity is regarded as crucial in syphilis control.

When the hearing appeared to be ending, Rep. Keefe began a series of direct questions designed to bring out the effect that the proposed cut would have on the program. Testimony from the U.S. Public Health Service was to the effect that perhaps the case-finding efforts could be maintained or increased by curtailing research activities since research had already provided as nearly perfect a mode of treatment as could be expected. The appropriation finally authorized was over $16,000,000, the first major reduction since 1938.

In the 1950 hearing there was again a reduction of close to $3 million, pushing the Federal appropriation down to slightly over $12,863,500. The perennial question of the ability of the states to assume a larger share of the costs was posed this time by Rep. John E. Fogarty (D., R.I.).[11] Dr. Bauer indicated that the number of patient days in rapid treatment centers had decreased because of the shift of patients from in-patient to out-patient therapy made possible by penicillin. Dr. Bauer warned, however, that this shift was not to be construed as justifying further reductions in appropriations. He predicted that the increase in out-patient facilities thus required would necessitate corresponding increases in costs. It will be recalled that because of the shift from clinics to rapid treatment centers the States had reduced the use of clinics, and if these centers were to be curtailed the clinics would need to be reactivated.

The tone of the hearings, nevertheless, seems to be one of economizing.[12]

[10] *House Committee Appropriations Hearings on Appropriations Bill for 1950*, p. 137.

[11] *House Appropriations Committee Hearings on Appropriations Bill for 1951*, p. 328.

[12] *Ibid.*, pp. 329, 334.

And, in any case, the venereal disease case rate was falling comfortingly. At least one reliable observer, however, outside of Congress and the U.S. Public Health Service, was beginning to plead for caution in decreasing funds:

> Along with the decline in the incidence of reported syphilis, there is properly occurring a reduction of funds allotted to the venereal disease control program. However, there is evidence that the reduction of funds is resulting in a deceleration of control activities to such an extent that it may be impossible to maintain the gains that have been made.[13]

The reductions in appropriations continued at the hearings held in 1951 even though the effects of the Korean War mobilization were being felt. Dr. Bauer opened the hearing with a statement on the military implications of venereal disease that is reminiscent of World War II. During the past year grants-in-aid to the States were reduced and case-finding projects were curtailed. Dr. Bauer continued to emphasize the importance of maintaining control efforts and the danger of failure to do so.[14] In the face of continuing cuts it was decided to alter the control program. According to Dr. Bauer,

> it was determined that, in order to meet the problem in high-prevalence areas as well as problems where there has been developed new concentrations of young people, because of mobilization, it would be necessary to increase project grants.[15]

He explains the new philosophy as "a change to areas of high prevalence rather than attempting to blanket the entire country . . . to seeking out and eliminating the pockets of resistance."[16] It would seem that with the cut in grants-in-aid to States, and an emphasis on projects, the U.S. Public Health Service was now virtually in charge of venereal disease control in the country to a degree not true previously.

Both the syphilis case rate and the appropriations for the Venereal Disease Control Program continued downward. The reduction in the syphilis case rate was quite dramatic and it would seem that asking for appropriations on the level of previous years would be difficult to justify. Dr. Bauer did his duty and explained how venereal disease could be reduced further on an even smaller budget:

[13] John J. Wright, M.D., "Venereal Disease Control" *Journal of the American Medical Association*, 147: 1408–1411, Dec. 8, 1951.

[14] *House Appropriations Committee Hearings on Appropriations Bill for 1952*, p. 498.

[15] *Ibid.*, p. 501.

[16] *Ibid.*, p. 502.

> The development and introduction of a shortened acceptable out-patient schedule of treatment for syphilis will enable States to provide, with the funds requested, decentralized out-patient diagnostic and treatment services, and to continue case-finding and prevention activities. As in-patient facilities are closed it will be necessary to develop or re-establish out-patient centers for the diagnosis and treatment of venereal diseases.
>
> The in-patient facility was a highly-centralized operational unit often serving the entire State. Out-patient centers, on the other hand, will be established in various parts of the State. As in-patient expenditures are reduced it will be necessary to increase expenditures for out-patient services. *However, the net result will be an over-all reduction in expenditures for diagnosis and treatment.*[17] [Italics mine.]

In the course of the Hearing, testimony revealed that the Bureau of the Budget had authorized $10,224,000 which was $1,082,000 less than the $11,306,000 requested. Dr. Bauer was quite candid in the face of this cut to testify that "this cut will decrease the rapidity of reducing the venereal disease rate, in my opinion, because only by the hunters or the investigators can we ferret out these cases."[18] Expenditures in State and local areas remained at a relatively stable level of $14 to $15 million, but there was certainly no attempt to make up for the decreases in the Federal appropriations. To the extent that this slack was not taken up there naturally had to be a corresponding reduction in activities.

The shift in the administration from President Truman to President Eisenhower brought about a great change in the climate of the hearings. There is much more discussion of financing and the respective roles of the Federal and State governments. The new chairman of the Appropriations Committee, Rep. Fred E. Busbey (R, Ill.), took the lead in espousing the policy of reduced appropriations from the Federal government and increased responsibility on the part of the States. He was in favor of venereal disease control, but he wished to push the problem back to the states where he felt it belonged. Examples of his views in his own words follow:[19]

> I cannot understand why at this stage of the program the States should not support the program entirely, except for the cooperative and consultative work of the Public Health Service.
>
> I have mentioned in all the hearings my feeling that many of these grant programs must be terminated and eliminated altogether and that the States have got to assume their responsibility.

The questions were generally directed to Dr. J. K. Shafer, who had replaced Dr. Bauer. He was thus put into the position of defending a budget

[17] *House Appropriations Committee Hearings on Appropriations Bill for 1953*, p. 421.

[18] *Ibid.*, p. 430.

[19] *House Appropriations Committee Hearings on Appropriations Bill for 1954*, p. 599.

which was already appreciably lower than the one for the previous year. Part of his reply was:

> Our appropriation has gone down rather sharply, largely because of our ability to close rapid treatment centers . . . but so as not to make the cutback too precipitous at the same time, we have been forced to cut off case-finding personnel, and the fewer case-finding personnel we have, the longer it will take to wipe out our reservoir of untreated syphilis.[20]

To placate Rep. Busbey, Dr. Shafer remarked that it was estimated that there would be a saving of $414 million in the financial burden imposed by institutional care due to syphilis and resulting mental disease. Rep. Busbey used this reply to reinforce his position by saying:

> Now for the most part these mental institutions are operated by the States; therefore, the savings would accrue to the States. So why should they not bear the expense of this program?[21]

In any case, the final amount reached a low of $5 million—and it was due to go even lower.

While this was going on, however, a citizens group began to fear for the program. It seems that no health and welfare program, at least, can survive without the active interest outside of the government apparatus—so we turn to the American Social Health Association, mentioned earlier.

While the syphilis case rates were on the way down the American Social Health Association was wondering if it could properly withdraw from active concern with stimulating interest in venereal disease control programs. It had been engaged in this activity since its inception in 1912. For once it seemed that a voluntary health agency was about to see its objectives realized, enabling it to move to other problems. Before succumbing to the prevailing optimism, however, the ASHA sought the counsel of leading venereologists and public health personnel. According to Conrad van Hyning, the Executive Director of ASHA at that time and still in that post, the general agreement was that although the syphilis case rate was falling gratifyingly, this was no time to reduce efforts, but to continue the attack.[22]

After a conference among the members of the Association of State and Territorial Health Officers, the American Venereal Disease Association, and ASHA, a joint policy statement was issued in February, 1954, the first of

[20] *Ibid.*, p. 602.

[21] *Ibid.*

[22] Personal interview in New York City, February 20, 1964.

an annual series of such statements up to the present year. The Association of State and Territorial Health Officers, as the title suggests, is an association of state health commissioners which meets periodically for policy discussions on matters affecting the public health. It is a quasi-official body created by an act of Congress in the early 1900's. The American Venereal Disease Association is a professional organization of persons engaged in venereal disease research and related matters. It is not an action group but it lent its influence to the joint statement.

The statement appears to be a direct result of the cut in the Federal appropriation for venereal disease control from $9,800,000 in 1953 to $5 million in 1954 with the prospect of a further cut in 1955. The Joint Statement pointed out that although the national V.D. rate was falling, there was an increase in seventeen states in 1953. The joint sponsors felt that although there had been great strides in V.D. control, complete control was not imminent; accordingly:

> The continuing program for the next several years should intensity specific control efforts by identifying and reducing pockets of high resistance, emphasizing early primary and secondary syphilis, giving more attention to the latent aspects of syphilis and concentrating some effort against gonorrhea.
>
> And we further urge that the federal government do not now, in a spirit of over-optimism or short-sighted economy, prejudice the eventual success of a program undertaken in high hopes and carried forward with brilliant success. Too early and too abrupt reductions in federal support for venereal disease control have already jeopardized the nation's tremendous investment in money and effort.[23]

More specific recommendations were that the Federal budget should be maintained at a minimum of $10 million until a thorough study of needs had been made by Congress, and that a long-term plan for reducing Federal support selectively and gradually, on the basis of local needs, should be adopted. This is a counsel of reason, but by this time the Venereal Disease Program was in a vortex of forces which was to drag appropriations still lower before they were to go up.

The House Appropriations Committee Hearings held early in 1954 ranks among the most significant so far. The discussions appear almost as a duel between the representatives of the Administration and the U.S. Public Health Service, and the Democrats on the Committee. Further, the representatives of the American Social Health Association appeared in person for the first time to testify against the proposed cuts. The Joint Statement

[23] Joint Statement by the Association of State and Territorial Health Officers, American Venereal Disease Association, and American Social Health Association, February 1954.

described was read into the record, and the Democrats had a citizen-group ally.

Dr. Shafer led off with an excellent summary of the program to date.[24] He reported that from 1938 to 1949 the grants-in-aid had facilitated the development, testing, and adaptation of venereal disease control techniques and skills in the various States and communities throughout the nation. From 1949 to 1953 the policy became one of directing an increasing proportion of the grants to States on the basis of projects in specific problem areas. Then in 1954 all forms of grants-in-aid were eliminated and only special project grants were being made to meet the venereal disease problems in the 24 States that had not brought syphilis under control and in other selected high prevalence areas in States that had reached control.

In the estimate for the fiscal year under consideration, even these special project grants were eliminated. The 1955 estimate provided for field operations in only the most critical venereal disease problem areas, primarily around military camps, defense industries, and recreational areas. The problems in these areas were largely the result of defense activities which were the direct responsibility of the Federal Government. This last, of course, emerges as the ultimate and generally accepted policy of the obligations of the Federal Government for the problem of venereal disease control. The consequences of this philosophy seem rather drastic, as Dr. Shafer further pointed out, in that the elimination of special grants would reduce the number of critical military areas, defense-industrial and defense-recreational areas receiving epidemiological services from 255 areas to 107. Federal support would continue for laboratory services, research, consultative, and related services.

The budget request for the fiscal year 1955 was $2.3 million as compared to the appropriation of $5 million in 1954. In the Committee, Reps. Antonio M. Fernandez (D., N. Mexico) and Fogarty were vigorously opposed to such a cut, whereas Rep. Busbey, whose stand was expressed clearly in the hearing held a year earlier, favored the cut. Rep. Fernandez sought to determine whether the proposed cut was recommended by the U.S. Public Health Service or was imposed on it by the Bureau of the Budget. He was obviously trying to push the blame back on the Administration. Surgeon-General Scheele was present and he could do no less than "take full responsibility" for the cut, but given the manner of budget allocations for the U.S. Public Health Service, the Service had some discretion in determining priorities among their many responsibilities and interests. The U.S.

[24] *House Appropriations Committee Hearings on Appropriations Bill for 1955*, pp. 112–113.

Public Health Service assigned a low priority to venereal disease (the simple fact of falling incidence gave plausibility to this decision) and the National Institutes of Health and the medical research center took precedence. To a direct question from Fogarty: "Is the problem of the control of venereal diseases under control?" Dr. Scheele answered:

> No, sir; we still have the problem, and, as a matter of fact, there is some evidence that the problem is increasing slightly at the present time. But, again, in the case of our budget, which shows substantial reductions, we believe that within the funds available to us and which are available within this total budget, to cover the whole range of problems that we should cover in the Public Health Service—this was a lower priority item. Treatment techniques are well developed and useful drugs are available—and we believed that this was an area where we could begin withdrawing Federal assistance several years ago, and on down to the point now where we proposed $2 million for State grants for 1955.[25]

Heart disease, cancer, and mental illnesses are important, too, the syphilis mortality rate being only 2.4 per 100,000 population. The mortality rate due to heart disease was 361 per 100,000 and cancer 148 per 100,000!

Surgeon-General Scheele brought out the fact that there was an increase to the States for public health work of $1.6 million which was not designated for any specific purpose but was to be used as they saw fit. Dr. Scheele felt that the States would not reduce expenditures on venereal disease control by the amount corresponding to the reduction in State grant funds for venereal disease control.[26] Reps. Fernandez and Fogarty were not mollified, however, having little faith in the States taking up the necessary slack.

Fogarty felt that some members of Congress had been led to believe that because of the discovery of penicillin and other drugs the venereal disease problem was gone. According to the statistics, however, it was still very much a problem. He sounded like an expert epidemiologist when he said for the record:

> The way I look at an infectious disease is that we have to stay with the problem until it is licked. I do not think we can say, with the record as it is and the statistics as we receive them, that this is the time for the Federal Government to get out of this program; but, when something like this is getting under control, *that is the time we ought to police it more* [Italics mine] and we ought to continue appropriating at a fair rate in order to keep up this good policing system.
>
> . . . I think we are cutting this program too far; that is my feeling. If anyone could prove to me that the States were going to take up this slack, as we decreased these appropriations, I would be the first one to say amen to that type of control.

[25] *Ibid.*, p. 54.

[26] *Ibid.*, p. 62.

But no one has proven to me or to this Committee or to the Health, Education, and Welfare Agency that the States are doing that, or are going to do it. And if they do not do it, I do not think that it is right for the Federal Government to say "All right, let it go." I think the Federal Government has a responsibility in an area like this. I think it is a lot different than saying in general terms "We ought to let the States take care of these particular problems."[27]

Rep. Fernandez expressed similar sentiments:

Is it not only logical to conclude that some of that marked slowing up or decline is due to the cutting down of this program?

And yet the cures and the causes of the disease are well-known, and when it seems that we are about to lick the problem, we begin to slow down.

That does not seem sensible to me.[28]

You further say that there is a current reservoir of about 2 million people who suffer with syphilis and who need treatment, and who, without treatment, are candidates for disability and premature death.

We know the problems, and we know how big the problem is, and we know where it is, but yet we will say, "Now we need this money somewhere else, and you let them die."[29]

I thoroughly agree with you that we should stimulate the States into doing it, but what you are doing here by drastically making these reductions is discouraging them when they come up against a situation like this where they are not going to be able to do even a fairly good job in the first place.

The reduction should be more gradual.[30]

There followed an exchange of views between Reps. Busbey and Fogarty regarding the relative responsibilities of the Federal and State governments in health and welfare. Their differences were largely a matter of degree rather than kind. Rep. Busbey was all for quickly returning the sole responsibility for venereal disease control to the states. He said, for example:

All too often the Federal Government is expected to carry on an operation long after the need for centralized operation and control has passed.[31]

It would seem that the representatives of the U.S. Public Health Service were over a barrel and, given the circumstances of the period—falling venereal disease rate, economy drive in the administration, other interests of top policy makers in the U.S. Public Health Service—a reversal of policy was not yet possible.

[27] *Ibid.*, p. 132.

[28] *Ibid.*, p. 125.

[29] *Ibid.*, p. 126.

[30] *Ibid.*, p. 128.

[31] *Ibid.*

Even with the advantage of hindsight, it is difficult to conceive that experienced public health officers and epidemiologists seriously believed that the Federal Government could withdraw from venereal disease control programs as fast as it was preparing to do without some unfortunate consequences. The question was, of course, not only a medical-epidemiological one, but also one of economy and political philosophy with a dash of calculated risk that the venereal disease rate would continue its downward course. The budget authorized was the lowest since 1939—$3 million. Thereafter it began to climb slowly for reasons to be described in due course.

IV

REFORMULATION OF THE CONTROL APPARATUS: 1956–1964

REP. FOGARTY was again Chairman of the Subcommittee during the hearings held in 1955. Even though there was now evidence that the venereal disease rate was increasing, or at least not continuing downward, Public Health Service testimony in the main justified the past decline in Federal support. The Service emphasized that there were special project grants designed for hardship areas created by the location of a military post, by virtue of being close to areas of high incidence, urban areas, and depressed areas. Dr. Scheele did not appear to be spurred to ask for more money based on his observation of the activities of the State health departments:[1]

> The program of the health departments today has been declining some, and we are sorry that this has happened. We wish the States would pick this up more. . . . Some States have been able to replace the Federal funds with State appropriations, and others have not been as fortunate.
>
> We do have the continuing problem of finding the cases. In V.D. we have good treatment if we find the cases. But the unfound cases are a great hazard in the community because they will spread it to other people. We do have to keep the case-finding going. Some of the case-finding efforts have fallen off in some areas.

Dr. Scheele's net conclusion, however, was:

> Mr. Chairman, we could spend much more money on the problem. . . . On the other hand, it seems to me that this represents a reasonable approach from the side of the Federal Government.

Rep. Henderson Lanham (D., Ga.), the author of the Lanham Act mentioned earlier, felt that the Budget Bureau was bringing undue pressure on the U.S. Public Health Service in order to save money:

> I am afraid they have got the budget too much in mind instead of the welfare of the American people.[2]

[1] *House Appropriations Committee Hearings on Appropriations Bill for 1956*, p. 237.

[2] *Ibid.*

Dr. Scheele:

> We could spend more funds, and I think do a more effective job. On the other hand, we are, I think, content that we can do a reasonably adequate job.

Mr. Lanham:

> We have to be content with what the Budget Bureau will let us have.

Then Dr. Scheele made this curious statement:

> We think they know better than we do.

Nevertheless, the 1956 budget was increased by $600,000 over the previous year's budget, and now stood at $3,626,000.

The ASHA continued to produce the Joint Statement with the Association of State and Territorial Health Officers and the American Venereal Disease Association. The 1955 Statement asserted:

> All three of the organizations sponsoring this statement are firmly convinced that so long as there is uncontrolled venereal disease anywhere in the United States, the federal government must be an active partner in its control.[3]

The Appropriation Hearings held in 1957 were very short. There was questioning of Dr. C. A. Smith, Dr. Shafer's successor as Venereal Disease Control Officer, on the adequacy of the current request for funds which was $500,000 or so over the appropriation for the previous fiscal year. Rep. Lanham tried to get Dr. Smith to testify to the need for more funds. The protocol of his position permitted little discretionary opinion were he in disagreement with the budget as proposed by the administration. Dr. Smith thus had to be somewhat vague:

> I think that there are always unmet needs in public health programs, and I feel that the present request will meet the most pressing needs of the venereal disease program.[4]
>
> Of course, I think a person who is primarily responsible for venereal disease can see many unmet needs in this particular program.[5]

When asked point-blank whether the appropriation cuts of previous years were a mistake, Dr. Smith could do little else than say: "I think that decision has to be weighed in terms of the total needs of the country."[6]

The Joint Statement of 1956 issued by the American Social Health Association provides documentation of increasing syphilis rates in many parts of

[3] *Joint Report, 1955*, p. 4.

[4] *House Appropriations Committee Hearings on Appropriations Bill for 1957*, p. 369.

[5] *Ibid.*, p. 369.

[6] *Ibid.*

the country. The appropriation for fiscal year 1957 was $4,195,000, reflecting an increase by the Senate of the request of the Administration and the House allowance. It appears that the total appropriations by the States continued to hover between $13.5 and $14.5 million, but some states had reduced their expenditures.

The Appropriations hearing held in 1958 is notable because the increase in the number of reported syphilis cases was recognized officially for the first time. In the face of this increase Dr. Smith said:

> We feel that these are real increases in the population because they are not related to activity reporting. It occurs in many different areas, as well as we can interpret it, and it is a real increase.[7]

Rep. Lanham continued his interest of the last two years and moved in with these leading questions:

> We rather dropped our guard, did we not, a few years ago when Congress cut the appropriations for your work? Immediately we saw a reversal of the trend downward, is that not true? We were too hopeful of the situation?[8]

Again Dr. Smith had to hedge:

> Yes, I think people were proud of the success of the venereal disease control program and tended to hope that no resurgence would occur.
>
> We have every hope that this added appropriation (the extra $500,000 given for 1957) will at least dampen the increases in infectious syphilis.

Rep. Lanham did not like the word "dampen" and asked:

> Have you asked for enough increase for this year? Do you think this increase is sufficient to handle the problem? You said something about just dampening the increase.[9]

Dr. Smith answered:

> I have every hope that the increases given to the venereal disease program last year will control the increases in infectious syphilis.[10]

During the few years just previous the U.S. Public Health Service apparently felt that a low level of Federal funds was adequate. Now, the Service requested an increase, asking for $4,821,000 of which the Bureau of the Budget allowed $4,415,000.

[7] *House Appropriations Committee Hearings on Appropriations Bill for 1958*, p. 471.

[8] *Ibid.*, p. 471.

[9] *Ibid.*

[10] *Ibid.*

The American Social Health Association was stepping up its attacks in its annual Joint Statement:

> Five years ago, the forces of V.D. Control were on the offensive. In state after state aggressive control programs were gaining the advantage. Before an integrated system of information, case-finding, referral, and rapid treatment, the venereal diseases were melting away. The resulting optimism proved disastrous. Panacea was spelled p-e-n-i-c-i-l-l-i-n! Forgotten, even by some health officials, was the carefully perfected epidemiological apparatus that brought the patient and the penicillin together. The infectious syphilis rate was pitched so sharply downward (and gonorrhea rates had also started down) that it was inconceivable they would stop, even if all programming ceased. Anybody could get and take penicillin.
>
> The intervening years and the painful review of some carefully documented hindsight have established the fact that drugs alone do not stop venereal disease.[11]

The 1959 hearing appears to be basically a re-evaluation of the venereal disease program. There were many questions from the Committee regarding control methods, efficacy of mass blood testing and similar matters. For the first time the Joint Statement of the Association of State and Territorial Health Officers, the American Venereal Disease Association, and the American Social Health Association appeared to have some impact.[12] It may be symbolic that this was the first time the Joint Statement was published in a printed and dignified format. Previous Statements were mimeographed, having the appearance of "throw-aways."

It might be inferred that the American Social Health Association was now settling down for the long pull. The record reveals that each member of the Committee received a copy of the report, although, undoubtedly copies had been received in previous years beginning with 1954, the first year of the Joint Statements. It is of interest that the budget of $5.8 million recommended by the Joint Statement was approximately the budget under consideration. Furthermore, Dr. Smith testified as to the accuracy of the venereal disease statistics presented by the Joint Statement.

Since the Public Health Service was asking for a reduction in the face

[11] "Today's V.D. Control Problem," *Joint Statement, 1957*, p. 2.

[12] A prominent syphilologist, Dr. J. E. Moore, takes spirited issue with this Joint Statement in an editorial in the *Journal of Chronic Diseases*, 6:280–283, 1957. He felt that the Joint Statement was using statistics too loosely in claiming that there was a rising tide of infectious syphilis. Dr. Moore wrote this editorial when the national rate was still downward, dismissing small increases in various local areas of the country as of little significance epidemiologically. He felt that the alarming tenor of the Joint Statement "seems hardly justified by the cold, bare epidemiologic facts." He elaborated, however, as follows: "Still further effort is, of course, necessary in order to maintain the gains already made and to provide a 'stand-by nucleus' of venereal disease control organization in the event of a major increase in incidence from any cause. Those who seek funds from philanthropic or governmental sources, however, weaken their case, rather than strengthen it, by exaggeration and misleading interpretation of data."

of rising morbidity, Mr. Fogarty asked Dr. Smith to submit a detailed summary of the difference between the final amount approved and the original request of the U.S. Public Health Service and the administration.[13] Asked what he would do with more money, Dr. Smith said he would spend it on "case-finding."[14] The appropriation for 1959 was $5.4 million, representing an increase over the President's budget request, the Senate increasing it over the request and the House allowance.

The House Appropriations Committee continued to put the U.S. Public Health Service representatives on the defensive during the 1960 hearings. Mr. Fogarty was distressed that the budget should attempt to justify a cut of $900,000 in the face of the admitted need for "continued vigilance" and for an "intensification in control activities."[15] Further, the rise in the syphilis case rate was now getting into the daily newspapers. Fogarty quoted an article in the *New York Times* headlined "Venereal Disease Studies Show an Increase among Teenagers." The information for the article was drawn from the Joint Statement. Another Representative, Fred Marshall (D., Minn.) spoke for the record:

> It seems to me until we get the people to give you more cooperation in testing, that from a public standpoint we will be frittering away our money. It seems to me this is a disease that could be so readily cleared up by resorting to mass tests, in a comparatively few years, yet we go at it in a piecemeal fashion, doing a little here and a little there. When the infection breaks at one place we get disturbed about that one locality, but I do not see how we will get the disease cleaned up the way we are going after it now. The goal should be to get it eradicated.[16]

Rep. Marshall said, further, that the techniques were available, but that they were not being applied effectively. Nevertheless, the 1960 appropriation was the same as the one for the previous year: $5.4 million, though the Administration budget requested a reduction. The number of reported cases of primary and secondary syphilis had almost doubled since 1955!

Year by year the House Appropriations Committee seemed to take the offensive, and year by year the appropriation was a little higher. In 1961 the appropriation was $5,814,500; 1962, $6 million; 1963, $8 million, and in 1964, $9,588,000.

At the 1961 hearing the Committee demanded of the U.S. Public Health Service a complete reassessment of the Venereal Disease Control Program.

[13] *House Appropriations Committee Hearings on Appropriations Bill for 1959*, p. 71.

[14] *Ibid.*, p. 73.

[15] *House Appropriations Committee Hearings on Appropriations Bill for 1960*, p. 91.

[16] *Ibid.*, p. 95.

As is common practice when a government agency wants to broaden the base of judgment and recommendations, the newly appointed Surgeon-General, Luther L. Terry,[17] appointed a Task Force under the chairmanship of Dr. Leona Baumgartner, then the Health Commissioner of New York City. In so doing, Dr. Terry acted on the recommendations of the Public Health Service Advisory Committee on Venereal Disease Control. Surgeon-General Terry asked the Task Force to review the syphilis problem and the control programs designed to control it and to recommend a course of action which would lead to the eradication of syphilis as a public health problem.

The Task Force met for the first time in New York City on September 13, 1961. In addition to Dr. Baumgartner, the members were:

ARTHUR C. CURTIS, M.D.
Professor and Chairman, Department of Dermatology
College of Medicine
University of Michigan

A. L. GRAY, M.D.
Executive Officer, Mississippi State Board of Health

BENNO E. KUECHLE
Vice-President
Employers Mutual of Wausau, Wisconsin

T. LEFOY RICHMAN
Project Coordinator, National Commission on Community Health Services, Bethesda, Md. (Previously on the staff of the American Social Hygiene Association, and prior to that on the staff of the Venereal Diseases Control Program, U.S. Public Health Service.)

The Task Force reported to Surgeon-General Terry three months later on December 29, 1961.[18] In her letter of transmittal, Dr. Baumgartner wrote:

> The report emphasizes use of the skills, knowledge, and equipment already available. It does not concern itself greatly with research, though obviously the control of any disease may be enhanced by new, original discoveries. Nevertheless, I am sure I speak for every member of the Task Force when I say that effective action to eliminate syphilis as a public health hazard need not want for further studies. It can proceed immediately—the basic ingredients for an effective

[17] Dr. Terry succeeded Dr. Leroy Burney, who replaced Dr. Leonard Scheele when he retired in 1956. Dr. Burney left the Service concurrently with the change in administration in 1961.

[18] U.S. Public Health Service, Publication No. 918, *The Eradication of Syphilis: A Task Force Report to the Surgeon-General, Public Health Service, on Syphilis Control in the United States* (Washington, D.C.: Government Printing Office, 1962).

program are available. Scientific knowledge of how to deal with the disease, and hundreds of trained, dedicated people in State and local health departments and on your own staff have shown how the job can be done. They have been hampered by slim budgets and apathy, both public and professional.

The report of the Task Force contains a brief and good statistical and descriptive overview of the syphilis control program followed by recommendations for action.[19] The burden of the recommendation rests on proper coordination between the private physicians and the health departments. During World War II and into the Fifties, the rapid treatment centers were the chief instruments of control for the armed services and the health departments. As the rapid treatment centers were cut back in favor of out-patient treatment with penicillin in public clinics and physicians' offices, and the Armed Forces were reduced from 12 million men to 3 million peacetime force, the built-in controls applicable in wartime were no longer operative.

It was now clear to the Task Force that "stopping the spread of syphilis was not possible without the private physician."[20] It was estimated that he was probably treating more cases than were public clinics, and that he was reporting to health authorities only about one-fourth of the cases he treated. Although many physicians might be excellent interviewers, few had the time to interview, and none had the time to investigate for contacts. The main recommendation was to help the private physician assume his responsibility fully in syphilis control. Since case-finding was central to control, case-finding, the very activity which the Federal appropriations helped to support, had to be increased.

To implement this recommendation it was suggested that the program provide for at least two visits per year to 100,000 general practitioners and one visit per year to the remaining 130,000 physicians. A continuing assessment of these visits should be maintained until the "core group of physicians that treat venereal disease is discovered." Careful and efficient service to this core group, as well as assistance in interviewing and case-finding, should be continued until there is evidence that syphilis is no longer being spread.

The Task Force staked out two areas of activity: (1) epidemiology and (2) education of the professionals involved, the public and its leaders.

[19] Inasmuch as the present study is not a statistical report of the incidence of venereal disease, I have not attempted to go beyond the usually published trend data. These are included in the appendix. A detailed treatment of statistical trends, however, can be found in Monroe Lerner and Odin W. Anderson, Chap. 18, "Control of Venereal Disease," *Health Progress in the United States, 1900–1960* (Chicago: University of Chicago Press, 1963), p. 177.

[20] *Task Force Report*, p. 11.

In the area of epidemiology the main emphasis was placed, as described above, on increasing the available investigative manpower and the amount of funds necessary to keep that manpower operating at peak efficiency. This meant increasing the number of personal visits of field investigators to private physicians and laboratories, increasing the epidemiological service to privately treated cases of infectious syphilis, increasing re-interviewing of both clinic and private patients for sex contacts, extending cluster testing, (the extension of interview to include not only sex contacts of patients, but others who the patient thinks might benefit by an examination for syphilis) to all infectious syphilis cases, and intensifying efforts to interview for sex contacts all patients presenting cases of early latent syphilis.[21]

In the area of education there was a general recommendation to reach the obvious groups—physicians, nurses, social workers, family agencies, and similar bodies. It was further felt that a new generation had come into young adulthood which was quite unaware of the seriousness of syphilis infection. The Task Force recognized the long-range nature of the problem and the need to prepare for the long-haul within a voluntary framework. In evaluating the Task Force report at the Appropriations hearings held in 1962, Rep. Fogarty said: "I think it is a good report, as far as it goes, but I think it is a rather conservative report."[22]

The Task Force also gave a cost estimate: The provision of needed personnel to visit physicians, to follow up laboratory reports, and to intensify interview investigation would cost $3.5 million annually, in addition to funds then available (the 1961 budget being $5,814,500), plus $500,000 for research in studies of human behavior and to promote educational programs essential to the control effort. The budget, following this report, rose from $5,814,500 to $8 million.

The item for behavioral research is of interest because the American Social Health Association had granted over $100,000 to three researchers in behavioral science in various parts of the country, pioneering again in pointing to research as a sound basis for intelligent action. Virtually nothing came of these grants, however, because inadequate funds precluded adequate staffing for planning an overall research strategy. The ASHA was aware of this but it can be commended for recognizing the need for research at a time when little was being done.[23]

[21] *Task Force Report*, p. 29.

[22] *House Appropriations Committee Hearings on Appropriations Bill for 1963*, p. 299.

[23] One article was published of a conceptual nature: Martin B. Lock, "Sex Role and Identity in Adolescence," Reprint from: *Casework Papers, 1959, Family Service Association of America.*

An indication of the worldwide interest in venereal disease control because of the increasing incidence everywhere was the World Forum on Syphilis and Other Treponematoses held in Washington, D.C., September 4–8, 1962. The entire gamut of the problem was discussed. The sponsors were the American Social Health Association, American Venereal Disease Association, and the U.S. Public Health Service. Participating agencies were the World Health Organization and the International Union Against the Treponematoses.[24]

[24] U.S. Public Health Service, Publication No. 997. *Proceedings of the World Forum on Syphilis and Other Treponematoses* (Washington, D.C.: Government Printing Office, 1964).

V

OBSERVATIONS AND CONCLUSIONS

THE story of the attempts to control and hopefully to eradicate syphilis shows that under certain circumstances it is possible to reduce the incidence of syphilis to remarkably low levels. It also shows that unless vigilance is continued while the incidence is going down, syphilis will rise again as a new generation reaches the teen-age and early adult age groups. It will be recalled that in 1947 the number of new cases of syphilis stood at 106,500. During the period 1955–1957 approximately 6,500 new cases of primary and secondary syphilis were reported annually, the lowest number ever reported in this country. This reduction is made further remarkable by the reasonable assumption that reporting was probably more complete than previously. In 1963, the reported new cases were exceeding 22,000![1]

Cries of alarm are being sounded again, but now in a very different control situation than during the Forties when the venereal disease control program was being established. This was recognized by the *Task Force Report* of 1961 when it recommended that the chief check-points for control were the private medical practitioners working with case-finding and case-interviewing personnel from the State and local health departments. The drastic change in treatment methods make out-patient treatment possible but at the same time increase difficulty in holding the patient until care is assured.

In this connection it would seem that one plausible theory that can be put forth to explain the dramatic reduction in the number of new cases of syphilis within ten years after the end of World War II was the almost total control situation that war conditions permitted. Though war conditions

[1] Concurrently there is an increase in several European countries which previously had had very low rates ("Endemic Treponematoses and Venereal Infections—2", *WHO Chronicle*, December, 1964).

usually create greater risk of exposure to syphilis, even in the face of this it was possible to blunt the increase and eventually reduce the incidence. The vision that Parran and Vonderlehr had in 1936 of ridding this country of syphilis in twenty years was swallowed up by the gigantic war effort and the military machine reaching its peak in 1945.

The military became the prime force in venereal disease control. Civilian efforts through the health departments became ancillary to the military effort, and the division of labor between the two permitted the health departments to concentrate control near military installations and defense plants. It can be said without facetiousness that the civilian sector—prostitutes, pickups, casuals, etc.—infected the military personnel and the military cured them. Further, the military reported the sources of infection from civilians to the health departments, thereby facilitating control in the civilian sector. The rapid treatment centers created total control situations in the civilian sector, because once admitted, or more accurately, committed, patients were not released until cured.

Total war created the conditions for near-total social control of individuals. The niceties of rights of privacy, the patient initiating the search for care and so on, became quite irrelevant in a wartime society where the motivating force for syphilis control was manpower efficiency rather than humanitarianism. Recall that 70 per cent of the men between 18 and 30 were in a total social-control situation. They were exposed to barrages of venereal disease health education films of gruesome realism probably not possible for presentation in a civilian and peacetime society, and they carried the impress of these films back into civilian society. Also, the armed forces did not discharge known cases of syphilis until after they were cured.

The break in the upward trend of cases of primary and secondary syphilis came in 1948 after eight years or so of as concentrated an attack on a single disease as has probably ever been undertaken, particularly a disease for which there is no immunization. Further, the break was quite dramatic, dropping from 106,500 new cases in 1947 to 80,500 in 1948; then 54,000 in 1949; 32,000 in 1950, continuing on a headlong drop until 1955, when the number was 6,500.

It would seem that because of the rate at which syphilis cases were reported and treated, the reservoir of infectious cases was being so rapidly depleted that the probability of new cases was reduced, thereby resulting in a further drop in cases. The disease was "disintegrating."[2] At almost precisely this point the civilian control apparatus was being dismantled, resulting in a reduction in case-finding and case-interviewing staff (the armed

[2] The term used by the *Task Force Report.*

forces were out of the control picture at this time). The rapid treatment centers were closed by July 1953 and dependence was placed on outpatient clinics and private practitioners because penicillin facilitated outpatient treatment. Private practitioners were active, but venereal disease clinics were not being reactivated rapidly if at all. Grants from the U.S. Public Health Service were being reduced and the states were not taking up the slack.

During World War II and for a few years thereafter, venereal disease control was regarded as a national problem because of its association with the military efforts and defense plants. The very nature of syphilis and the age-group most affected makes for easy transmission of syphilis and accounts for its wide-ranging mobility. The state jurisdictions were simply not equipped to cope with a disease which moves across geographic boundaries so easily. By viewing syphilis as a nationwide problem, the armed forces and the U.S. Public Health Service could operate smoothly over wide areas without the administrative problems of state and local jurisdictions.

Another plausible theory for the reduction and the subsequent increase, thoughtfully presented by Dr. Ira L. Schamberg, is the possibility that with the post-1945 increase in the general use of penicillin in non-syphilitic cases, many patients with undiagnosed syphilis were cured while being treated for other infectious diseases.[3] Schamberg theorizes further that the increase in syphilis after ten years of rather widespread use of penicillin might be explained by either the decrease in sensitivity of treponeme pallidum to penicillin or by the apparent decrease in non-specific use of penicillin. He prefers the latter because the evidence for it is good.

Both the theory I propose as a sociologist, and the one Schamberg proposes as a syphilologist point directly to the need for careful case-finding and certainty of treatment after cases are found. I indicated that this was easier in a total control situation made possible by wartime conditions than in peacetime civilian society—although not automatic unless the military is really concerned with this problem.[4]

Interesting as it is to speculate about the dominant reasons for the fall and subsequent rise in the syphilis rate, it is now necessary to settle down for the long haul in peacetime society with only a relatively small, but still

[3] Ira L. Schamberg, M.D., "Syphilis and Sisyphus," *British Journal of Venereal Disease:* 39:87–97, 1963.

[4] Other reasons for the resurgence in syphilis which are seriously proposed by observers of the social scene are (1) increased promiscuity of the teenager and (2) increased numbers of overt male homosexuals and an increase in their sexual activity. In my estimation Dr. Schamberg demolishes these reasons for lack of evidence, and I would concur. It is of interest to note in this regard that the syphilis rate, even though sketchily reported, was much higher 40 to 45 years ago than it is now.

important, proportion of young men in the armed forces. The basic structure of the operating framework of the U.S. Public Health Service and the State and local health departments, coupled with the widely-scattered medical practitioners making the first contact, and, hopefully, an increasingly more knowledgeable general public, particularly those in early adulthood, provide the current and generally accepted framework for syphilis control.

After World War II, the traditional Federal-State relationship between the U.S. Public Health Service and the State health departments was quite quickly re-established. The U.S. Public Health Service began to resume, vis-à-vis venereal disease control, its traditional role of stimulator, consultant, and catalyst.

The U.S. Public Health Service, unless specifically designated by law (e.g., Indian medical services, Maritime hospitals, etc.) is not supposed to assume major responsibility for service programs in the States. Title VI of the Social Security Act did not so intend. Consequently, after the War was over, the Service turned to other fields such as the National Institutes of Health. The States were in general quite derelict in not following through on the successes of the venereal disease control program. The States have difficulty in coping with syphilis without coordination from the U.S. Public Health Service because of jurisdictional limitations and the Service cannot adequately provide this leadership unless given adequate funds for consultation, education, and grants to state programs along classic patterns.[5]

In the peacetime context there are other problems in controlling syphilis in addition to those of Federal-State relationships. In a society with values such as ours there must be dependence on voluntary reporting by the physicians. Because case-finding and treatment have shifted to the private physician, he is now in the uncomfortable position of being the center of attention.[6] He occupies a key position as custodian of the health of the public where individuals are concerned. He is asked to function in part in a quasi-official capacity for the health department, and this puts him in a dilemma not usually present in relation to other communicable diseases.

[5] I am tempted here to comment on the untenable position in which professional and technical personnel of the U.S. Public Health Service are frequently placed during Congressional hearings on appropriations. Professional and technical personnel are required by an administration to defend the *policies* of the administration as reflected in the *priorities* set by the budget. When questions are raised which are clearly policy and priority matters they should be directed to upper-echelon personnel who are responsible for them. It is unprofessional for a professional to defend what he feels he cannot defend and it is unreasonable of policy-making personnel to put professionals in that position. Certainly, there must be better ways for Congressmen to obtain professional judgment, and I would assume many use them.

[6] "M.D.'s scored on apathy to V.D.; world experts say private physicians must report cases to stem the rising incidence of syphilis" (*Medical World News*, p. 98, September 28, 1962).

There are various estimates as to the proportion of cases of syphilis actually reported by private physicians, but it is estimated to be as low as 10 per cent of the cases actually treated, leaving a rather vast reservoir of unreported syphilis cases. The out-patient clinics, because of their institutional setting, presumably report all cases. The military also reports, of course, but they account for only three per cent or so of all cases reported. There must of necessity also be dependence on the afflicted patient to seek care voluntarily and if questioned reveal his (or her) contacts. As a result, the burden of current recommendations from eminent authorities is complete reporting and intensive case-finding.

In attempting to localize the main target areas of the syphilis problem, note first that the incidence of syphilis among the Negro race is extremely high compared with the white. This has always been so, both in the armed forces and in civilian society. Presumably it is associated with the usual melancholy syndrome of poverty, low education, crowding, and so forth. In 1963, for example, the number of cases of primary and secondary syphilis reported among whites was 4 per 100,000 population. Among nonwhites the rate was 74 per 100,000! Even if one could correct for the greater likelihood of reporting syphilis among Negroes because of their greater frequency of clinic visits, and the proclivity of whites to visit private physicians who often fail to report, it seems clear that the syphilis case rates among Negroes would still be much higher. There may also be a racial reason for the higher rate among Negroes in that they have not been exposed to syphilis for as many generations as those of European descent who have had time to develop some immunity. There are therefore tremendous problems in urban areas which have relatively high concentrations of Negro population.

Another aspect of the incidence of syphilis contributing to the difficulty of control is the increase in reported cases among teen-agers. In 1962 they constituted 17 per cent of all reported cases of primary and secondary syphilis, an increase of more than 200 per cent between 1956 and 1962.

Finally, another problem compounding the difficulties of control is the reported emergence of the homosexual as a source of transmission of syphilis. This appears to be a relatively new factor in syphilis transmission, since such sources of infection were not reported in any significant number until a few years ago. In New York City, homosexuals are estimated as accounting for one-half of the reported cases of syphilis.[7] The extent to which the

[7] New York Academy of Medicine, Committee on Public Health, *Resurgence of Venereal Disease: A Report*. (New York: The Academy, March 2, 1964) (Mimeographed); and *Homosexuality: A Report* (New York: The Academy, n.d.).

apparent increase in the number of homosexuals with syphilis is due to an actual increase in homosexuality or to a real increase is not known.

After this discourse on the massive problems that must be overcome to deal effectively with the increasing syphilis case rate, it is difficult to be rosily optimistic about the possibilities of control and eradication. One undeniable fact pointing toward optimism, however, is the low incidence experienced during the period 1955–1957. Even though the combination of circumstances resulting in this low incidence cannot be elucidated, certainly the existence of an apparatus facilitating case-finding and treatment is a fundamental and simple necessity. A highly structured and authoritarian apparatus can presumably control syphilis in a relatively short time.[8] The decentralized, voluntary, and cooperative method now in operation will take a relatively longer time, but it is the only method Americans want to accept during peacetime.

Let us then examine critically the logical checkpoints for case-finding leading to effective treatment, and the practicality of using these checkpoints, within the particular conditions in this country and its value system:

1. *Routine serological testing in high schools.* Almost all teen-agers are in high school and annual or other periodic tests might be made on this captive audience. Almost 3,600 new cases of primary and secondary syphilis were reported in 1962. Further examination of this checkpoint reveals that the highest incidence is thought to be among high school dropouts and, further, there is a low yield of cases relative to the time and effort necessary. Therefore, this checkpoint may not be as good as it might seem at first glance.

2. *Routine serological tests in colleges, vocational and trade schools, etc.* Over 6,000 new cases of primary and secondary syphilis were reported in the age-group 20–24 in 1962. Again only a relatively small proportion of this age group is in an education and training situation and the amount of work involved is low in relation to the yield. Colleges and universities already give routine physical examinations on entrance.

3. *Routine serological tests as a condition of employment.* Conceivably, testing in such circumstances would yield a great many new cases, but the

[8] A report by an international medical group visiting the U.S.S.R. recently seems to accept at face value the official statistics of the Russian health service that the number of cases of active syphilis is down to 1.4 per 100,000 population. In the United States the case rate for all stages of active syphilis was 69 per 100,000. The report states: "All patients in whom syphilis is diagnosed for the first time *must* be admitted to a hospital within 24 hours. [Italics mine.] Treatment is then started, and the necessary investigation of contacts undertaken." The report was sponsored by 22 physicians from 19 countries under WHO auspices visiting a number of venereological and dermatological institutes in the U.S.S.R. and written by Dr. R. R. Wilcox (Great Britain), "Venereal and Skin Diseases in the U.S.S.R.," *WHO Chronicle* 18:48–60, February, 1964.

practical problem is one of assuring the prospective employee that his being hired is not jeopardized if a positive serology is found.

4. *Routine serological tests of those who apply for a marriage license.* Tests for syphilis are already mandatory at time of application for marriage licenses and many cases have been uncovered. The control problem does not really rest here, however, because syphilis is usually contracted extramaritally. The tests at this checkpoint, nevertheless, help to protect the marriage partner if syphilis is discovered before the marriage, even though the protection of the general public health may be minimal.

5. *Routine serological tests of those who are admitted to hospitals.* Even though only 12–15 per cent of the general population in this country are admitted to hospitals annually, public health personnel seem to feel that this is an important checkpoint. It has the advantage of routinization in an institutional setting and provides some assurance of ability to hold the patient if a positive serology is uncovered.[9]

Current U.S. Public Health Service policy, as well as that of State and local health departments, as expressed by the Task Force Report, is focussed mainly on the private medical practitioner as the first line of case-finding, reporting, and treatment assisted by case-finding and interviewing personnel provided by the health departments. It is realized that the medical practitioner does not have the time nor the personnel and facilities for intensive case-finding.

In line with recommendations of the Task Force Report, a national program called the Physician Visitation Program has been under way since the middle of 1963. Health departments send trained personnel to visit physicians, almost all in private practice, acquainting them with details of the local syphilis control program and encouraging them to report cases to the health department. Preliminary data from Kansas City, Missouri, suggest the type of result this program can have. During the six month period from January to June 1963, prior to the inauguration of the Visitation Program, 103 physicians reported 169 cases of venereal disease, almost all of them syphilis cases. After the inauguration of the Physician Visitation Program, July to December, 1963, the number of physicians reporting had increased to 181 and the cases reported to 367.[10] Thus, at this early stage, there is some indication of the value of this sort of activity.

It is hoped that with increasing awareness and cooperation on the part

[9] Another possible checkpoint is at the time of application for and renewal of drivers' licenses. Logical and complete as this checkpoint may be, it is very likely not politically feasible.

[10] Data obtained from the Venereal Disease Branch, Communicable Disease Center, U.S. Public Health Service.

of the private medical practitioner; emphasis on health education of the general public, with special attention to the young adult group, regarding syphilis symptoms, methods, and sources of treatment; and added emphasis on professional education in medical schools, incidence of syphilis will again turn downward and will be held at bay in a voluntary framework.[11]

This is a long-run view—possibly requiring ten years or more of concentrated effort. We must, therefore, prepare to cope with this problem indefinitely on all fronts. Within the voluntary framework we may have to consider that a certain minimum, but containable, incidence of early syphilis may be the price we pay for disliking a total social control situation. But we certainly cannot indulge in the generally commendable American characteristic of setting up targets to be shot down once and for all. In syphilis control we should have learned twice that this style of attack is not realistic.

[11] U.S. Public Health Service, Publication No. 1190, *Venereal Disease Education: A Report of the Special Subcommittee of the Public Health Advisory Committee on Venereal Disease Control* (Washington, D.C.: Government Printing Office, 1964).

APPENDIX TABLES

TABLE 1

FEDERAL APPROPRIATIONS FOR VENEREAL DISEASE CONTROL BY YEAR, 1938 TO 1964

Year	Appropriation	Year	Appropriation
1938.....	$ 80,000	1952.....	$11,653,360
1939.....	3,080,000	1953.....	9,800,000
1940.....	4,723,400	1954.....	5,000,000
1941.....	6,200,000	1955.....	3,000,000
1942.....	8,750,000	1956.....	3,626,000
1943.....	12,500,000	1957.....	4,195,000
1944.....	12,367,000	1958.....	4,415,000
1945.....	12,339,000	1959.....	5,400,000
1946.....	11,949,000	1960.....	5,400,000
1947.....	16,909,000*	1961.....	5,814,500
1948.....	17,324,500	1962.....	6,000,000
1949.....	17,370,000	1963.....	8,000,000
1950.....	16,000,000	1964.....	9,588,000
1951.....	12,863,500		

SOURCES: From 1938 to 1944 the House Appropriations Committee Hearings; from 1945 to 1963, correspondence with Mr. Edward F. Tuerk, Chief, Operations and Development Unit, Venereal Disease Branch, Communicable Disease Center, U.S. Public Health Service, March 24, 1964.

* This sudden increase represents adding the cost of operating the Rapid Treatment Centers authorized by the Lanham Act to the total venereal disease appropriation.

NOTE: Because of different methods that might be used to estimate costs, e.g., authorizations, appropriations, and actual expenditures, these figures may vary somewhat between different sources.

TABLE 2

FEDERAL APPROPRIATIONS FOR VENEREAL DISEASE CONTROL, 1945 TO 1964, AND V.D. APPROPRIATIONS AS A PER CENT OF TOTAL PUBLIC HEALTH SERVICE APPROPRIATIONS

Fiscal Year	Total V.D. Appropriation	Total Public Health Service Appropriation	% V.D. of Total
1945.....	$12,339,000	$ 127,725,073	9.66
1946.....	11,949,000	142,305,380	8.40
1947.....	16,909,000	103,797,686	16.29
1948.....	17,324,500	191,283,100	9.06
1949.....	17,370,000	237,053,500	7.33
1950.....	16,000,000	320,528,803	4.99
1951.....	12,863,500	225,069,280	5.72
1952.....	11,653,360	231,343,508	5.04
1953.....	9,800,000	221,607,250	4.42
1954.....	5,000,000	210,619,500	2.37
1955.....	3,000,000	251,310,000	1.19
1956.....	3,626,000	391,440,500	.93
1957.....	4,195,000	534,141,000	.79
1958.....	4,415,000	565,757,797	.78
1959.....	5,400,000	758,177,208	.71
1960.....	5,400,000	840,314,152	.64
1961.....	5,814,500	1,039,052,837	.56
1962.....	6,000,000	1,369,656,118	.44
1963.....	8,000,000	1,581,540,000	.51
1964.....	9,588,000	1,608,723,000	.59

SOURCES: V.D. Appropriations obtained from the Venereal Disease Branch, Communicable Disease Center, U.S. Public Health Service. Public Health Service Appropriations obtained from U.S. Public Health Service. Background material concerning the Mission and Organization of the Public Health Service, prepared for the Interstate and Foreign Commerce Committee, House of Representatives, April, 1963. Washington, D.C. Government Printing Office, 1963.

TABLE 3

CIVILIAN CASE RATES PER 100,000 POPULATION FOR ALL STAGES OF SYPHILIS BY RACE: UNITED STATES SUMMARY
(Known Military Cases Excluded)
Fiscal Years, 1941–1963

Fiscal Years	Total	White	Non-White
1941.....	368.2	160.9	2179.4
1942.....	363.4	153.8	2179.2
1943.....	447.0	186.2	2971.8
1944.....	367.9	151.2	2196.3
1945.....	282.3	118.9	1647.5
1946.....	271.7	119.1	1560.6
1947.....	264.6	118.4	1507.8
1948.....	234.7	98.7	1375.5
1949.....	197.3	81.2	1175.9
1950.....	154.2	62.9	926.1
1951.....	131.8	52.5	790.2
1952.....	110.8	45.9	646.4
1953.....	100.8	41.9	596.4
1954.....	87.5	36.8	510.8
1955.....	76.0	33.9	424.3
1956.....	77.1	33.2	437.9
1957.....	78.3	34.6	437.6
1958.....	68.5	29.5	383.0
1959.....	69.3	30.7	377.3
1960.....	68.0	32.3	352.0
1961.....	69.7	33.6	349.6
1962.....	68.1	32.9	340.4
1963.....	69.3	33.9	337.9

SOURCE: U.S. Public Health Service. V.D. Statistical Letter Supplement: Trends in Morbidity and Epidemiological Activity, December 1963. Table 1b.

TABLE 4

CIVILIAN CASE RATES PER 100,000 POPULATION FOR ALL EARLY SYPHILIS BY RACE: UNITED STATES SUMMARY
(Known Military Cases Excluded)
Fiscal Years, 1941–1963

Fiscal Years	Total	White	Non-White
1941.....	134.3	50.6	866.1
1942.....	145.0	52.2	948.7
1943.....	179.8	60.4	1198.0
1944.....	158.3	55.7	1024.9
1945.....	140.4	50.3	893.2
1946.....	151.5	60.7	918.9
1947.....	152.0	61.8	918.6
1948.....	123.8	46.5	772.0
1949.....	94.7	33.7	608.8
1950.....	65.1	22.6	419.5
1951.....	46.8	15.0	310.1
1952.....	33.1	10.7	216.8
1953.....	27.0	9.0	178.5
1954.....	20.8	7.0	135.2
1955.....	17.5	6.5	107.9
1956.....	16.3	5.7	103.6
1957.....	15.2	6.0	90.7
1958.....	13.7	5.0	84.5
1959.....	14.9	5.5	89.5
1960.....	16.6	6.5	96.6
1961.....	21.1	8.0	123.2
1962.....	21.9	8.0	129.8
1963.....	22.0	7.2	131.1

SOURCE: U.S. Public Health Service. V.D. Statistical Letter Supplement: Trends in Morbidity and Epidemiological Activity, December 1963. Table 2b.

TABLE 5

CIVILIAN CASE RATES PER 100,000 POPULATION FOR PRIMARY AND SECONDARY SYPHILIS BY RACE
UNITED STATES SUMMARY
(Known Military Cases Excluded)
Fiscal Years, 1941–1963

Fiscal Year	Total	White	Non-White
1941.....	51.7	24.7	287.9
1942.....	57.0	26.0	325.3
1943.....	63.8	27.5	373.6
1944.....	61.6	27.7	348.5
1945.....	60.5	27.0	340.3
1946.....	70.9	34.7	376.9
1947.....	75.6	36.9	404.9
1948.....	55.9	25.8	308.5
1949.....	37.1	16.4	211.2
1950.....	21.6	9.4	123.4
1951.....	12.1	5.0	70.9
1952.....	7.9	3.3	45.5
1953.....	6.2	2.7	35.6
1954.....	4.9	2.1	28.0
1955.....	4.1	1.8	22.5
1956.....	4.1	1.6	25.0
1957.....	3.8	1.6	21.8
1958.....	3.9	1.6	22.6
1959.....	4.7	2.0	26.6
1960.....	7.1	3.1	38.7
1961.....	10.4	4.0	60.6
1962.....	11.0	3.8	66.7
1963.....	11.9	3.8	73.7

SOURCE: U.S. Public Health Service. V.D. Statistical Letleter Supplement: Trends in Morbidity and Epidemiological Activity, December 1963. Table 1b.

TABLE 6

PRIMARY AND SECONDARY SYPHILIS: AGE-SPECIFIC CASE RATES PER 100,000 POPULATION BY AGE GROUP AND RACE
UNITED STATES SUMMARY

Calendar Years 1956–1962

Age Group	Year	White	Non-White	Total
Under 14....	1956	.0	1.1	0.2
	1957	.1	1.2	0.2
	1958	.0	1.5	0.2
	1959	.1	1.4	0.3
	1960	.0	1.8	0.3
	1961	.0	2.9	0.4
	1962	.0	3.0	0.5
15–19.....	1956	2.6	60.9	10.1
	1957	2.6	64.5	10.5
	1958	2.6	64.0	10.2
	1959	3.2	85.1	13.3
	1960	4.2	130.5	19.8
	1961	5.2	158.9	24.2
	1962	4.7	169.5	24.8
20–24.....	1956	6.4	103.0	18.6
	1957	6.9	105.4	19.5
	1958	6.7	113.7	20.4
	1959	10.2	142.3	27.3
	1960	14.7	262.1	45.9
	1961	15.9	307.1	52.8
	1962	14.3	346.1	55.8
25–29.....	1956	5.2	61.2	11.5
	1957	5.2	62.9	11.8
	1958	5.5	72.7	13.3
	1959	8.5	92.2	18.4
	1960	14.2	162.1	32.1
	1961	14.7	215.2	39.0
	1962	13.0	235.7	40.2
30–39.....	1956	2.8	31.1	5.7
	1957	2.8	29.7	5.6
	1958	3.5	32.5	6.5
	1959	5.1	44.4	9.3
	1960	8.5	72.2	15.6
	1961	9.2	96.8	19.0
	1962	8.0	109.5	19.5

(continued on following page)

TABLE 6—*Continued*

40–49.....	1956	1.4	11.7	2.4
	1957	1.4	11.2	2.3
	1958	1.5	11.7	2.5
	1959	1.8	13.7	3.0
	1960	3.0	22.4	4.9
	1961	3.8	33.9	6.9
	1962	3.4	39.1	7.1
50 plus.....	1956	.5	4.0	.7
	1957	.5	3.4	.7
	1958	.5	2.9	.7
	1959	.6	4.4	.9
	1960	.7	5.4	1.1
	1961	.9	7.6	1.5
	1962	1.0	9.5	1.8

SOURCE: U.S. Public Health Service. V.D. Statistical Letter Supplement: Trends in Morbidity and Epidemiological Activity, December 1963. Table 5b.

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