## Pil FMMAT1 By the Board of Health, to Railroad and Steamboat Corporations, \&c.

Whereas, Reliable information hav been received that goods have recently been shipped to this eity from Nemphis, Temno, where yelhow fever in mow prevailing as an epidemic;

Therefore be it orilered by the Bibard of IIealth, of the City of Aurora, Indiana, that from and after this date it thall be unlawfult for any owner, condactor, or persen in charge of a railroad car, steamboat, or other public conveyance, to discharge within the corporate limita of the City of Aurora uny goods, bagorage or articlew whatever, shipperd from a point south of Louisville, KYy., or aany diwtriet infected with yellow fever, nithout a writtem permit from the Board of Health.

It shall be unlawful for any oficer of a steaunboat, railroad car, ur any other conveyance to bring or cause to be brought amd lamed within the boumdary line of this eity any persom anwell with sympe toms of yeilon fever, or any perwon sick or unwell, coming from points infected with yellow fever, withont written permit from the Board of Health of the City of Aurora.

Any violation of these orders will be regarded as a violation of a City Drdimamee and remder the parties so violating liable to prowe ecution.

These orders are made in compliamee with the City Ordinamea adopted July ${ }^{\text {®iz, }} 18$ 88.

<br>E. C. EDNTD, N. Dos Seerctery.<br><br>Amrora Reard of Fienth

A mreran Hidin Juby is, $18 \%{ }^{\circ}$


Copyright 1972
American Public Health Association, Inc.
1015 Eighteenth Street, N.W.
Washington, D. C. 20036

Printed in U.S.A.

# the first one hundred years: 

essays on the history of the american public health association

by nancy r. bernstein



This series of essays in reportorial style chronicles both the successes and the failures of the American Public Health Association over the years. In this it is somewhat different from the usual centennial history. In highlighting the ferment that has often characterized the organization, Ms. Bernstein has, I believe, made a valuable contribution to our understanding of APHA.

Seldom content with the status quoeither inside or outside the Associa-tion-APHA has remained vital while other organizations, comparable in age, have stultified. The thread of creative discontent that runs throughout this history will undoubtedly continue in the second hundred years of the organization. It is this that will continue to be a strength of the movement which the Association represents.

James R. Kimmey, MD Executive Director

## preface



The following 12 essays do not pretend to be a scholarly record of the 100 years of the American Public Health Association. They are the very personal observations of one who knew very little about the Association before the task was begun, and came to grow very fond of it as each chapter unfolded.

The strength of the Association, of course, has been its members. It is unfortunate that so few of the people who have shaped the character of APHA have been mentioned in these essays. It is hoped that those who are mentioned will serve as representatives of all those who have contributed.

APHA's most impressive feature, to this author, is its ability to withstand dissidence within the organization and turn it into strength. APHA has to grow stronger; its history of flexibility and change will not let it do otherwise.

Nancy R. Bernstein

## chapter 1

"So let us on this most auspicious anniversary look backward and learn the lessons of experience which it teaches before we take a step into the uncharted future."
-Stephen Smith, 1921, on the 50th Anniversary of APHA.

If the miracles of modern science had allowed Stephen Smith to mark the 100th anniversary of the organization which he founded, what might be his observations on its progress?

No doubt he would be shocked at the concept of participatory democracy in formulating association policy, and furthermore, at the fact that it could work. Probably, he would applaud APHA's movement toward activism in the health field, for Smith was one of the earliest advocates of national health legislation. Finally, he would not be surprised to find himself alive at the age of 149 , since the tremendous advances in medicine made during his lifetime filled him with optimism that infirmity and disease could be completely conquered by the year 1971.

Stephen Smith was born Feb. 19, 1823, before the great strides in medical progress had begun. Public health in

## birth of an association

the seventeenth and eighteenth centuries was, for the public, largely a matter of ignorance and superstition; the best defense against an epidemic was believed to be fasting and prayer for deliverance. Concern for health meant little to people whose food supplies were precarious, and the lack of general education made communication of new advances in health difficult.

In 1850, a man who was lucky enough to survive past childhood could expect to live 41 years. His newborn child had a 75 per cent chance of reaching his fifth birthday. In New York City alone, the death rate was 38 per 1,000 , approximately 23,000 deaths each year from preventable disease. "Smallpox, scarlet fever, measles, diphtheria, were domestic pestilences with which the people were so familiar that they regarded them as necessary features of childhood," Smith wrote. "With the immigrant came typhus and typhoid fevers, which resistlessly swept through the tenement houses, decimating the pov-erty-stricken tenants." Consumption, malaria, cholera, and yellow fever struck poor and rich alike.

The growth of vital statistics-first developed through compulsory parish
registration in Europe-was the key to reform in public health. From the comparison of crude death rates grew the concept of preventable diseases, especially as related to the totality of disease, not just specific epidemics. Statistics showed that the highest death rates existed in the filthy, overcrowded, unventilated, and unsewered dwellings of the poor. Inevitably, the conclusion was drawn that "sanitation" could prevent disease.

Physicians of the period eagerly grasped the "filth" theory of disease production. Although Edward Jenner had demonstrated, in 1796, the prevention of smallpox by inoculation, the science of bacteriology had not yet been developed to destroy the beliefs that filth breeds disease rather than merely carrying it, that all kinds of dirt-not merely human wastes-are dangerous, and that infectious diseases are carried mysteriously through the air. Though physicians did much for human comfort and convenience and saved many lives, their adherence to the filth theory for many years obscured the validity and application of the germ theory.

The theory of spontaneous generation was laid to rest in the 1850's and 60's,
by Pasteur and others. Joseph Lister applied Pasteur's findings to antiseptic surgery in 1865; Robert Koch discovered and demonstrated the anthrax bacillus as the cause of anthrax in 1876. Later, in 1881, Koch developed the use of solid media for the isolation of pure cultures-laying the groundwork for modern laboratory technique ${ }^{\text {c }}$

These and many other scientific advances accompanied the impetus for a public health movement in the 1870's. The mid-point of the century had witnessed great social reforms in such movements as women's rights and the abolition of slavery. The demand for sanitary reform developed with a frequently religious intensity of moral feeling, particularly when diseases originating in squalor threatened the lives and health of rich and poor alike, and when the health of industrial workers was recognized as important to improving productivity.

Until this period, there was a general absence of recognition by authorities -and citizens-of an obligation to develop public health services. Health movements, lacking scientific evidence and public support, had begun and failed in the eighteenth and early nineteenth centuries. The Quarantine and Sanitary Convention, originated to reform U.S. quarantine laws, met annually from 1857 to 1860 , until it was interrupted by the Civil War. Though it never reconvened, the convention motivated the organization of new and existing health groups.

In 1872, only three states and the District of Columbia had established boards of health. Accurate registration of births, deaths, and marriages was claimed by only two states. The Ameri-
can Medical Association, organized in 1846, had moved into the public health field in 1871 with formation of a committee on public hygiene, but no organization solely devoted to public health existed at that time.

Such was the state of public health in 1872 when Stephen Smith invited a group of "refined gentlemen" to discuss informally the possibility of a national sanitary, association. Smith's reputation as a physician and sanitarian was already well established. Tributes to him, although colored by the effusive writing style of the period, characterize him as a man of innovation in his field of surgery, an early advocate of reform in health legislation, a humanitarian, and a charismatic leader.

He was "straight, erect, and selfdisciplined as an army officer," Fielding H. Garrison, MD, said, "keen and quick of perception, yet with the genial, humorous 'twinkle.' No one could clasp his hand and look into his face without feeling impressed with his astonishing vitality and virility."

Smith was born on a small farm in Onondaga County, N. Y., in 1823, a descendant of an American officer in the Revolutionary Army. Ninety-nine years after his birth, Smith told the fiftieth meeting of APHA, "I had selected medicine as my profession on the suggestion of my physicians as a preventive measure against the recurrence of a form of indigestion of which I had been a victim from childhood. To that advice I attribute my activities for middle life and the comparatively comfortable age to which I have attained."

Whatever his motivation, Smith attended Cortland Academy in Homer,
N. Y., and lectures at Geneva Medical College. In 1849-50, he was a resident medical student at the hospital of the Sisters of Charity, and then entered the College of Physicians and Surgeons of Columbia University. Following graduation in 1851, he "found himself in a strange city, with legalized power to practice and nobody to treat."

Successfully passing a highly competitive examination, Smith earned a place on the resident staff of Bellevue Hos-

pital. There, he was one of the few physicians to escape an epidemic of typhus fever and, apparently immune, was appointed visiting physician of the fever hospital established on Blackwell's Island.

Examining the admissions records of patients at the hospital, Smith found that more than 100 fever patients had been admitted from one tenement alone. He visited the house, a port of entry for many newly arrived Irish immigrants, and found a "veritable fever nest." Sewage was strewn about, doors and windows were broken, and the house's many occupants slept on straw scattered on the floor. Smith's attempts to close the house were unsuccessful, since no legal authority existed to "abate a public health nuisance." Outraged, Smith contacted the Citizen's Association, a civic group organized to fight Boss Tweed, then in control of Tammany Hall.

Under the association's sponsorship, a committee conducted a survey of New York City sanitary conditions and found that the previous failure of efforts to introduce health legislation was due to official denials of the unsanitary conditions in the city, and the incompetence and ignorance of local authorities. The Board of Health existed only when the city aldermen convened as such; "health wardens" were usually saloonkeepers.

In 1864, Smith and an attorney, Dorman B. Eaton, drafted a Metropolitan Health Law, a specific code which included a clause to prevent legal authorities from obstructing the efforts of public health officials. The bill encountered expected opposition, and was not passed until 1866, its final pas-
sage partly the result of a successful educational campaign among members of the medical profession.

Spurred by the threat of a cholera epidemic in New York, the legislature created a Metropolitan Health Board to enact the provisions of the law. Smith was appointed a commissioner, a post which he held until 1875, and later credited the achievements of the board to his "revolutionary law," particularly the "extreme power it gave health authorities in performance of their duties."

The American Public Health Association had its inception in the Metropolitan Board of Health. During the three-year struggle to secure the health law, wide-spread interest in civic sanitation had been created. The Board's success in controlling the cholera epidemic in New York prompted public support for organization of local boards of health, and Smith's correspondence as a commissioner indicated that there was great interest in establishing a nationwide chain of communications in public health.

Smith was determined to undertake a campaign of education through the medium of a national public health association. He believed that such an association, through annual meetings and publications, would "awaken and maintain the active and permanent interest of the people in sanitary administration," "greatly facilitate the enlightenment of the public," and "promote the appointment of more competent health authorities."

Smith's suggestion of an association composed of existing health officials and interested citizens was well re-
ceived by the six men who accepted his invitation to meet at the Mott

Street offices of the New York Board of Health on the afternoon of April 18, 1872. Although the passage of time has somewhat diminished the accomplishments of the meeting participants, the seven who gathered for the first informal meeting of the American Public Health Association were among the top health specialists of the era. Three of them would later head APHA.


Edwin M. Snow, superintendent of health in Providence, R. I. and a prominent health statistician, presided at the first meeting. The others were John H . Rauch, Chicago urban health specialist; Christopher C. Cox, president of the District of Columbia Board of Health and later, lieutenant governor of Maryland; Edward H. Janes, a New York physician; John Ordronaux, a specialist in military and legal aspects of medicine from Roslyn, N. Y.; Carl Pfeiffer, a New York architect who documented the relationship of good housing to good health; and Smith.

The seven men limited their discussion that afternoon to the formation of a "National Sanitary Association" and concluded that a larger, more formal meeting was necessary. Accordingly, they adjourned and reconvened later that evening at the New York Hotel. Snow was called home because of illness, and three others joined the company: Heber Smith, MD, of the Marine Hospital Service; Moreau Morris, MD, New York; and Elisha Harris, a New York physician and statistician.

At the evening meeting, those present agreed to form a Committee on Permanent Organization. Representation from the army and navy medical staffs was also suggested, possibly Smith's first step in securing alliances in his plan to press for a national health administration. The committee called for the first organizational meeting to be held at the Ocean Hotel, Long Branch, N. J., Sept. 12, 1872.

Elisha Harris, as committee chairman,
presided at the September meeting, attended by 15 members. A proposed plan of organization was presented and, after revision, adopted as the first constitution of the American Public Health Association. "The advancement of sanitary science and promotion of organizations and measures for practical application of public hygiene," was designated as the new association's objective.

Harris turned the gavel over to Smith,


New Yorker Hotel, site of first evening meeting of APHA founders in 1872.
elected first president of APHA. Snow was named first vice president; C. B. White, a Louisiana physician, second vice president; Rauch, treasurer; and Harris, secretary.

The first constitution provided the basis for much of today's Association structure. Dues were established; the annual fee for membership was $\$ 5.00$. Alterations in the constitution could be made at an annual meeting only after proposal at an earlier meeting, and could be adopted only by a vote of two-thirds of the members present.

An executive committee was named; its six elected members joined the officers in authorizing expenses and payments, and supervising Association interests. But in addition, the committee considered all applications for membership, and reviewed the titles and abstracts of all papers submitted for the annual meeting. Furthermore, although any member could propose a motion from the floor, all resolutions and actions were referred without debate to the committee.

The founders had purposely granted absolute control of all business affairs to shape and direct policy on all new questions. The autocratic powers delegated to the committee were considered an asset to the Association's, growth by Smith and the others. "Great care was taken to protect [the Association] from those internal dissensions which wreck so many societies," he wrote.

## In 1897, Smith recalled:

New members often chafed under a rule that prevented them from bringing before the body for open and general discussion, some sub-
ject which would have given rise to sharp antagonisms, so productive of mischief, and from which no possible good could come. Twice, during my own occupancy of the presidency, the Association was saved from rupture by a strict adherence to this feature of the constitution . . . Professor Gross remarked at [the first meeting's] close that he never attended a society which disposed of so much scientific and so little secular matter in the same length of time.

On the other hand, records of early meetings show that several members were not happy with the lack of general participation in policy-making, and occasionally resigned in protest.

At the first annual meeting, held May 1-3, 1873, in Cincinnati, 70 new members, mostly physicians, were elected. Membership in the Association continued to grow at a steady pace for many years, but a large membership in itself was never the objective of the founders. "We were very careful to select the best men that could be found," Smith said. "We did not aim so much at a large membership as at its quality."

Early meetings were planned with a view towards creating the greatest possible effect on the local citizenry, and indeed, the first three annual meetings of the Association generated wide public and press interest. Daytime sessions were devoted to reading and discussing papers, but evenings were turned over to popular speakers.

Smith learned early the value of psychology and publicity in planning the annual meetings. The committee on arrangements always scheduled a
"town meeting" in the host city, conducted by local citizens and addressed by local speakers. Not accidentally, the mayor of the town was usually the presiding officer at the meeting, and prominent townspeople were invited to address the meeting-and the press. Flattery evidently produced results, for the meetings did much to interest peo-ple-town by town-in health reform.

Because of the structure of the Asso-ciation-and its concentration of deci-sion-making authority in the hands of a few men-the focus at the early meetings was on the scientific papers rather than on Association business. Most of the sessions were occupied with oral presentation of the papers, followed by discussion.

What was lacking in statistical and scientific evidence was compensated for in personal observation. "I had a patient who . . ." or "I once knew a man who . . ." often launched a lengthy exposition on a health problem of the day. While the dack of sophistication of the scientific data was in keeping with the state of medical knowledge at the time, these early meetings represented the first opportunity for health officials to share experiences on a nationwide basis.

Communication of these ideas on an even wider scale was essential to Smith's objective of a truly national chain of information and education. Following Rauch's report of $\$ 131$ in dues collected at the first meeting, Smith appointed a committee to investigate the publication of the transactions of the meeting. Though the first volume of "Public Health Reports and Papers" was not published until 1875, the mechanisms for publication were in progress at the first meeting.

## A Map SHOWING WHERE XTXXEW EXVER has appeared in the WNITETD S'LATRES From 1668 to 1874.

 Prepared to accompany the PAPER on the Natural Historyand Distribution of YELLOW FEVER in the UNITED STATES Read before theAmertean Pubxie Meakin Assocxation in NEW YORK, NOV.12'1873, BY eJo MM. TTOMNIETR, MM. ITD)


In the first few years, the Association was too small to raise sufficient funds for publication of the papers in the volume needed to meet the demand, and "in the style which the secretary, Dr. Harris, approved," according to Smith. "The fastidious taste of the secretary" determined that the two men publish the first journal at their own expense, a cost of over $\$ 1,000$.

Papers of that day were presented on many of the topics which are still of concern 100 years later. Subjects included alcoholism, sanitary systems, influence of hereditary defects on health, reports on death rates and infant mortality, housing, syphilis hospitals, and state public health systems. However, the papers were heavy on personal observation and quoted as liberally from the Bible as they did from scientific sources.

The information contained in these papers, if not directly contradictory, must have on occasion served to confuse the readers as much as to educate them. In the early years, physicians presented reports such as "Sewer Gas as the Cause of Scarlet Fever" and "Does Smallpox Become Epidemic or Is It Spread Only By Its Own Contagion?" Other papers, however, were ahead of their time in their presentation of scientific theories. F. A. P. Barnard of Columbia College, for example, reported on "The Germ Theory of Disease and Its Relation to Hygiene" in 1873, long before his colleagues took the theory seriously.

The second meeting of the Association, held in New York at the Union League Club, Nov. 11-14, 1873, found the organization in predictable difficulties. Despite the founders' expectations of a
growing membership, no constitutional quorum of 25 members had ever been present at an APHA business meeting. Therefore, the Association was dissolved, and the members reconvened to form a new organization. The name and basic structure were retained, but the constitution was amended to allow a quorum of nine and provide for annual election of officers (except the secretary, elected for three years).

By this time, the fledgling organization had developed a respected reputation among health and medical experts in and out of the country. Florence Nightingale wrote from England that she could not gather "sanitary publications" to send in return that would compensate for the valuable reports of the Association. At the third meeting, Smith instructed the secretary to open correspondence with local health authorities all over the country, requesting information and offering to reply on similar subjects. In addition, resolutions were passed instructing the executive committee to communicate with each state governor, urging efficient sanitary organization, and securing a representative from each state for a committee to prepare a proposal for a national health department.

Smith's fondest dream was to see a national health agency established, preferably on the cabinet level. While European countries tended to centralize their health services under state officials, American public health was based on local government, with the role of the national government confined primarily to advice and financial aid. By the 1870's, more than 200 local boards of health had been established, but Smith and the Association aimed for active, vigorous, well-funded boards
in every city and state. They did not believe that this could be achieved without a central governmental agency.

In other areas, meanwhile, the Association increased its pressure on the government to secure needed legislation. Though no control of the sale and distribution of food products existed in the 1870's, the educational campaign conducted by APHA during that decade ultimately played a large part in the drafting of laws on adulteration. Another resolution passed was an appeal to study poisonous wallpapers.

The most ambitious project undertaken during Smith's tenure as president was undoubtedly a committee survey on sanitary conditions in major cities. Remarkably detailed, the report included statistics on water supplies, drainage and sewage, streets and public grounds, "habitations," garbage and excreta, slaughterhouses, and health laws.

Smith served as president of the Association for three terms, until 1874. At the third annual meeting, he was reelected president, but declined, preferring to retain his voice in Association policy through a seat on the Executive Committee. Though other strong men were to head the organization in his lifetime, Smith's influence on the Association in the first 50 years of its existence was immeasurable.

Whether urging a humane policy in resolutions on immigration quotas, or securing international cooperation in public health matters, Smith's voice was to be heard many times in the future as the "conscience of APHA."

## chapter 2

"I would suggest that in cities all licensed restaurants and bars should be required by law to close at ten o'clock, and that theatres, and other places of amusement, commence at seven o'clock, so as to close at ten, or eleven at the latest. If it were possible to add one hour each night to the sleep of the residents of cities, I feel persuaded it would do much to elevate morals and preserve health."

Joseph M. Toner, MD, APHA president 1875-76

Joseph Toner did not directly imply in his inaugural address that an extra hour of sleep would ward off yellow fever, but the suggestion would be no less seriously entertained than any other made in the next fifteen years of debate on the disease. The cause and prevention of yellow fever-and what to do about it-was the biggest single question to occupy the meetings of the American Public Health Association until Major Walter Reed settled the question finally at the 1900 APHA Annual Meeting.

Yellow fever could not help but be on everyone's mind in the 1870's. Epidemics arrived as annually as New Year's, attacking the country through

## yellow fever and the early years

its southern ports. Nearly 75,000 people were stricken with the disease at its peak in 1878; 15,000 of them did not survive.

Though researchers were no closer in 1895 than in 1875 to discovering the mosquito as the carrier of the disease, valuable work was conducted during these two decades. Most of it, however, was to have more political implications than scientific-a factor which would ultimately render abortive the attempt to establish a national health agency.

As early as the first APHA meeting in April, 1872, Christopher Cox, president of the District of Columbia Board of Health, introduced a bill that would place a "National Sanitary Bureau" within the Department of Interior. Encouraged by APHA President Stephen Smith and the others, Cox asked two legislators to introduce the bill in Congress. There it languished, possibly because health as an issue was subordinate to the problems of the Civil War aftermath.

APHA continued to press for a national board through a committee composed of representatives from each state,
working to prepare a new law for the organization of such an agency. The need for a federal board of health was not popularly recognized, however, until the great epidemic of 1878 made it obvious that local boards of health could not control a disease that ignored state boundaries.

In 1878, Congress passed the National Quarantine Act, giving the Surgeon General of the Marine Hospital Service the authority to enforce port quarantine. But as drafted, the bill was meaningless: the Surgeon General was given no appropriations, and could not interfere with existing state laws to enforce the quarantines.

Many Congressmen felt that quarantine was a matter for state and local governments to decide, and Congress had no powers to legislate on the subject. The debate on states' rights would occur over and over again, until it effectively stripped any national health legislation of its effectiveness.

With transportation and the end of regional isolation rapidly increasing, the Act was obviously useless in halting the spread of yellow fever.

Later that year Congress appropriated, with considerable grumbling over the amount, some $\$ 50,000$ for an investigation of ways to contain the epidemic. A Board of Experts, headed by Surgeon General John M: Woodworth, MD, was appointed to collect and assess the data and report back to Congressional committees.

Simultaneously, APHA resumed its own drive for a national health agency. The Association had been focusing on the strengthening of local and state health boards, but the 1878 epidemic made it obvious that a national, unifying agency was needed to control the disease. In Nov. 1878, APHA set up an advisory committee to consider plans for a national public health law. This committee would report to the Executive Committee, which in turn would report to Congress.

The new advisory committee had not yet met when Sen. Lamar introduced a bill in Congress that would establish a department of public health under a director-general, who would simultaneously head the Marine Hospital Service. APHA members were instantly aroused. They believed that Woodworth would be named director, that in fact he may have drafted the bill to change the MHS into a public health service.

The animosity was both personal and professional. The Marine Hospital Service had lost much of its function when the steamship replaced sailing vessels, and many APHA members felt Woodworth lacked the expertise to head a public health agency. Though Smith called Woodworth "a man of culture, of polished manners, a good organizer, and an enthusiastic student
of sanitary science," John S. Billings, APHA vice president, was unimpressed. In a letter to a friend, Billings characterized Woodworth as "a pretty shrewd politician and wirepuller-very am-bitious-not at all of any scientific or professional reputation, a very agreeable and polished gentleman, but in no manner qualified to hold the power he seeks."

Ironically, Stephen Smith had drafted the Lamar bill, with Woodworth's ap-


## John Shaw Billings

proval, but the senator's final version was in a form neither could approve. By the time the true author was revealed, public health leaders had been alienated from Woodworth, and the resulting friction damaged the future relationship between the Marine Hospital Service and the National Board of Health.

The APHA Executive and Advisory Committees drew up a substitute pro-
posal empowering the National Academy of Sciences to organize a Provisional National Health Commission.

This commission would propose a permanent form of organization, one that Billings and others hoped would be independent rather than placed in an existing federal department, would employ experts to conduct investigation of diseases, and would collect information and give advice. Recognizing the overwhelming odds against securing national quarantine legislation during the current session, Billings
"Unfortunately . . . protection of the citizen from preventable diseases, which destroy thousands of lives annually, the cash value of which amounts to millions, seems to be no part of the national care or responsibility . . . The interests of the public health have not received a corresponding and sufficient share of national aid and encouragement."

James R. Reeves, MD
APHA president, 1885
hoped that the board could provide the scientific evidence needed for later passage of the legislation.

In March, 1879, after much debate, Congress finally passed an "act to prevent the introduction of infectious or contagious diseases into the United States, and to establish a National Board of Health." Seven members, including four past or future APHA presidents, were appointed, plus one representative each from the Marine Hospital Service, Army, Navy, and Justice Departments. The members received $\$ 10$ per diem plus expenses,
and their duties were to collect public health information, to advise federal and state governments on health, and to submit to Congress a plan for a permanent health organization with emphasis on quarantine. Its term of life was to be four years.

The National Board of Health was doomed before the ink was dry. Legislators, recognizing the need for some form of national health control, but unwilling to relinquish their states' rights to obtain it, stripped the bill, and subsequently the board, of its powers. Though one Michigan congressman had pointed out that "yellow fever has an immense contempt for states' rights," debate on the resulting act would not empower the board to legislate any meaningful national quarantine act.

Perhaps realizing the impossibility of securing such powers, the board itself did not advocate an omnipotent federal quarantine. Members of the board wanted to stimulate and aid scientific research; establish an emergency fund for epidemics; and assist state and local boards in administering quarantines. They hoped to skirt the issue of states' rights by stopping ships outside the line of state jurisdiction; the vessels would then have to pass the state exam as well. Hopefully, the states would eventually be satisfied with the federal inspection only.

Predictably, the bill met strong opposition in the Senate and was subsequently weakened so that it authorized the board to "cooperate and aid the state and local boards of health to prevent introduction and contagion of diseases." Undaunted, the board asked for $\$ 500,000$ in state aid funds, to be
given to the local boards in return for public health data. The appropriation was defeated; Congress felt it had no power to appropriate money for purely local sanitary measures.

The board was then put in the uncomfortable position of having to sit back and watch states attacked by bouts of yellow fever; unless the board was specifically asked to intervene, it could do nothing to control the epidemic. Applications, when made, had to go through an "absurd and very annoying system of red tape" and were often rejected because of lack of funds.

All of this did little to build public faith in the work of the board. When first created, the board was well received by both press and the public. Expectations of success were high, and the board was blamed when they were not fulfilled. Few people were aware of the wording of the law or the political maneuverings that created it, and could not understand why the board sat back while national epidemics raged. Among its other problems, the board had to suffer public and press censure for the remainder of its life.

Members of the board carried on with its work until 1883, when appropriations for it were terminated. During its four years of existence, the board undertook valuable investigations into the causes of yellow fever, sanitary surveys of the country, planning of a national public health agency, and aid to state and local boards-projects that had rarely been considered previously. Yet the board's administrative structure was unwieldy, its powers unduly restrictive, and its creation designed to arouse antagonisms.

If the National Board of Health did nothing else, it showed how a federal agency could encourage local health actions on a national basis, and dramatically pointed out the need to resolve the question of federal-state relations if a national public health system was to be effective.

APHA's relationship with the National Board of Health was encouraging but less than fully supportive in all aspects. Stephen Smith had served on the board, as did APHA presidents James L. Cabell, Hosmer A. Johnson, and Billings. The National Board regarded APHA as the leading source of respected public health officials, and called on the Association frequently for advice. Meetings were often held in conjunction with APHA meetings.

Even within APHA, voices had been raised early to protect the infringement of states' rights. At the seventh annual meeting, a resolution endorsing and supporting the work of the board was introduced, but was weakened by "states rights-conscious" members. In 1881, the Association passed a resolution viewing "with regret" the curtailment of the board's duties and funds, yet at the same meeting, could not wholeheartedly support a proposal to reorganize the badly crumbling board into a centralized coalition of state health representatives to be formed by APHA. The Association is "voluntary," a member chastened, and "does not speak for state boards."

The disagreements over the National Board of Health were only symbols of a deeper split among Association members. What had started out as an association of administrative officers was quickly attracting laboratory and bac-
teriology specialists, sanitary analysts, and chemists, and by 1885, the entire National Association of Master Plumbers. Medicine remained predominant, however, among APHA members, because, as Billings put it, few public health workers were paid well enough to make a living without a "sideline." By 1881, there were 700 members, the overwhelming majority having virtually no say in Association policy. Billings, like Stephen Smith before him, thought this was a good thing. He believed the Association was for scientific papers of discussion and not for consideration of local quarrels. "You must have somebody who will be responsible, and shut out the mass of matter that would otherwise be put upon you," he said. This did not stop one member from referring to the Advisory Committee as the "star chamber."

In 1881, the debate over the Association's structure broke into the open. There were objections at the Annual Meeting to "three or four men" electing members, deciding business, and in general representing the interests of the entire membership. A year later, the animosities sharpened over an amendment to divide the Association into active and associate members. Both would pay identical dues, but only active members would be able to vote or hold office.

Billings and the other "Old Guard" members favored the amendment as a means of keeping the Associationand its policy-professional in character, thereby giving greater weight to its positions on various issues. Some worried aloud that hygiene would become a "popular" subject, while the opposition countered that popularization and knowledge of hygiene and
health was the very objective of APHA.
The entire discussion sparked an examination of the purposes and goals of the organization. What was APHA to be-a force for legislative action, an educational society, or a private club?

Most of the members felt the public belonged in the Association, but not necessarily in the management of its affairs. The strongest objection to the amendment came from those who op-
posed giving the Executive Committee the authority to decide in which class of membership an applicant belonged -a rather "clubby" aspect the general membership did not like. Those on the Executive Committee, on the other hand, believed that open election of members would become a "town meeting" at which professional and private character would be discussed, and possibly ruined.

The final amendment was a compro-

mise of sorts. The Executive Committee retained the right to select the members and place them in the "appropriate" category, but the constitution specifically stated the qualifications of each of these categories. Associate members were not allowed to vote, however, and paid the same dues as active members. Opposition to this policy remained high, however.

Despite the dissensions within the membership, the work of the Association continued at a high pace. Numerous committees were established on such matters as communicable diseases of animals, water supply, disposal of the dead, and venereal disease. Their reports were extensive, and more often than not, laid the groundwork for statements of Association policy. Resolutions of the period were frequently repetitious: for years, a resolution was offered at every meeting on establishment of boards of health and/or the National Board of Health; yellow fever; and a national census. One resolution

[^0]might be offered at the same meeting in several versions, perhaps because there was no formal rewording of resolutions as introduced. If someone wished to add a point to a resolution, he merely waited to introduce one of his own on the subject.

Stream pollution was one of the earliest target areas of the Association. In 1878, C. F. Folsom, secretary of the Massachusetts Board of Health, proposed a detailed law to prevent stream pollution, including strict penalties for individuals and corporations knowingly discharging refuse into public waters. Folsom suggested an Association committee study the matter, though one or two members wished to act on it immediately.

Toner was enthusiastic about the law, stating, "The principle must be recognized by persons living among water-courses, that while they have a right to use the water, they must do so in a manner not to destroy the right of their neighbors." Others were more cautious, however. The differences in state laws and sanitary development would have made enforcement difficult at best, and, as one member said, "We had better not be in too much haste to say we have hatched the egg . . . there are various States still incubating." A committee was appointed to study the matter, but no records exist of any meeting or report on the law.

There were resolutions, in 1875 , to petition Congress for a uniform system of registry of deaths, marriages, and births; in 1877, to establish a chair of medicine and public hygiene in every medical school in the country; and in the same year, "to investigate the causes of disabilities which lead to
pauperism and result from the neglect and incompetence of medical care received by needy poor." Some of the resolutions were followed by specific actions, such as an 1878 suggestion that an Index Catalogue be prepared for the National Medical Library. APHA members petitioned Congress on the idea, and a year later, funds were appropriated for the catalogue.

The resolutions that evoked the greatest controversy, however, were those concerned with yellow fever, particularly as it related to quarantine, venereal disease, and immigration laws.

Debate over the yellow fever question centered around two opposing principles: was the disease caused by contagion or miasma? Prevented by quarantine or cleanliness? The proponents' arguments grew so hot that at annual meetings, speakers would often publicly repudiate each other, questioning their evidence and sometimes, their professionalism. Some unusual theories of the cause were presented, such as the belief that yellow fever came from uncleaned privy vaults; and such prevention measures as the application of cold air or dry super-heated steam to destroy yellow fever germs on ships were seriously considered by the Association. Recognizing the absence of the disease in cold and dry climates, some members thought yellow fever could be eliminated by refrigerating the entire southern United States. What they didn't realize, however, was that the cold air killed the source of the disease, and not the disease itself.

In 1880, another topic took the forefront of the proceedings at Association meetings. The previous year, George Sternberg had proposed a plan to pun-
ish as criminals any persons knowingly inflicting venereal disease. A committee of five was appointed to study the issue and reported to the Association at the following meeting. To counter the spread of VD, which they said was
"The very objective of this resolution is to defend the sanctity of the mar-riage-bed. As a father, 1 would infinitely prefer my daughter to live and die unmarried and pure, than wed a young man of a community in which one in every five, ten or fifteen is affected with syphilis."

Albert Gihon, MD
APHA president, 1883
communicated by "the hired bathingdresses at the seaside resort, and the costumes rented for the fancy ball, toys, barber utensils, playing cards, loaned pipes, canes and gloves," the committee recommended a draft of a law incorporating Sternberg's suggestion, and giving municipal and state health officers the same powers to prevent, detect, suppress, and treat VD as they possessed for smallpox.

The proposal elicited enormous response. Questions were raised on the propriety of attempting to legislate on a moral issue and of introducing a delicate subject matter into the public arena and the courts. One member stated, "The more you familiarize the public with vice, the greater will be its spread." An Illinois clergyman accused the Association of "striking a blow against the sanctity of the mar-riage-bed," and castigated APHA for hinting at legalization of prostitution.

Others opposed the proposal for diferent reasons. Ezra Hunt bristled, "I could no more ask for legislation to
punish a man for communicating venereal disease than for getting drunk." Some cautioned the committee to move more slowly on the matter. In response, Albert Gihon protested, "I have been four years trying to get this Association to do something. Now that is slow enough certainly." To support his plea, Gihon presented as evidence pictures of "innocent children who are the offspring of syphilitic husbands and fathers." Finally the resolution was passed after the reference to state and municipal boards was eliminated, to the dismay of many members, including one who commented, "All you will ever see or hear of the matter now will be in our own proceedings."
Racial and ethnic prejudices did not bypass the Association discussions at meetings. Some members, particularly those from southern states, frequently aired racial misconceptions in a scientific context, but they were virtually ignored by everyone but the stenographer. In 1883, however, a resolution was introduced asking Congress to prevent the "coming of these foreign defective and criminal people to burden our resources." Member after member rose to support this resolution.

It was left to Stephen Smith, by then one of the country's leading experts in care of the mentally ill, to refute the charges that the country's asylums were filled with insane immigrants. "It would seem to me impracticable that we should study the heredity of the emigrant," Smith said. "If he has an insane relative I do not know why he should not land even then as well as though his father had a leg broken." The resolution was eventually passed, but somewhat modified by the removal of what Smith called "absurd and crude" ideas.

By the $1880^{\prime}$ 's, the annual meetings had grown considerably in size and scope. Discussion on papers had to be limited to 10 minutes, and speakers had to sign up in advance. Members were quite outspoken in their criticism of papers, often maintaining the difficult combination of courtesy and insult in the same tone of voice. Prior to the 1881 meeting, Executive and Advisory Committee members submitted suggestions for topics, including that of one cynic who remarked, "The time

> "Our safety depends upon official vigilance." Engraving shows angel with shield of cleanliness at Port of New York. Harper's Weekly, 1885.

of the Association could best be occupied in correcting the false theories announced at former meetings."

Papers were introduced on such topics as cattle disease, sanitary systems, and
the evils of school life (citing ill-fitting schoolroom chairs, inadequate sanitary facilities, and mental arithmetic-"a new way of torturing children"). The quality of the papers was upgraded considerably when Henry Lomb of Rochester, N.Y., offered prizes for essays on subjects selected by himself. Association committees reviewed the entries, and in 1885, the first APHA awards were announced. Explaining his decision to fund the competition, Lomb said, "I see what you want. You


## "Westward Bound." Harper's Weekly cover, 1883, shows doctor vaccinating for smallpox aboard immigrant train.

have an abundance of light, but your light must be hidden under a bushel because you have no means to disseminate it."
The meetings were not all business, however. In 1884, an evening session
was interspersed with musical selections, and members later visited a local gentleman's wine cellar. The following year, members took Congressional representatives to an oyster roast, not purely a social occasion. In 1887, the Association voted to admit ladies to the meetings, more for the purpose of decoration than for any attempt to win the feminist vote.

These addresses in the 1880's were still, by tradition, lofty discourses on health and knowledge. The early leaders felt they had a messianic duty to guide and educate men in the care of their health, and quoted poetry, the Bible, and Greek mythology to prove it. Though they were frequently wrong in their judgments, though they sometimes elevated earlier, undeserving members to APHA sainthood, their dedication to their mission was unquestioned.

## chapter 3

"As science advances, woman gradually acquires her true position in the scale of social life, the object of universal regard, the inimitable type of the artist's skill, the theme of the poet's happiest inspirations."

James E. Reeves<br>APHA President, 1885

Elisha Harris had thought the physician to be "the natural teacher of hygiene," but he hoped that woman also "may become a missionary of health and of most permanently useful instruction to the ignorant poor." Though prior to 1890 women were most often seen at APHA meetings solely to accompany their husbands, they soon began taking a more active role in Association business and scientific sessions, perhaps in defiance of chauvinistic sentiments such as those voiced by Reeves and Harris. By 1893, women were joining the discussions on APHA policy and addressing the annual meetings on a variety of hygiene topics.
"Any one is welcome to our ranks who takes any practical and living interest in the grand objects of the prevention of disease and the raising of the standard of the people's health," said Frederick Montizambert, MD, of Quebec, in his

## walter reed and internationalism

presidential address before the 1891 Annual Meeting. Montizambert's election as the first non-U.S. president of APHA, and the growing number of applications for membership each year, were evidence that the Association was expanding rapidly in influence outside the United States and in size within it.

By 1897, the twenty-fifth anniversary of the Association, there were 869 members in active service, and the following year, nearly 1,000 . A number of these members were public health workers from other countries on the North American continent.

International health conferences had been held in Paris in 1851 and 1859, Constantinople in 1866, and Vienna in 1874. None of the meetings had tangible results, but they kept the idea of international collaboration alive in the minds of such men as Stephen Smith, and laid the basis for later cooperative work among the nations. Much more had to be learned about infectious diseases before any significant work could be undertaken through international cooperation.

In 1878, the Association adopted a
resolution "That it is the duty of the General Government to invite foreign nations to co-operate with it in the establishment of uniform and effective international quarantine regulations." The following year, Elisha Harris introduced a set of proposed rules for international quarantine, first submitted to the International Conference for Re form of the Law of Nations.

The newly created National Board of Health did not ignore the expressed wishes of the Association. Recognizing the futility of seeking international cooperation on the touchy issue of quarantine, the National Board, together with a National Academy of Sciences committee, called for a conference to consider sanitary matters other than quarantine. Congress approved the resolution, and President Rutherford B. Hayes issued invitations for a Washington conference. Twenty-two foreign nations accepted the invitation, and the meeting was held in January, 1881.

The Association passed a resolution that year urging an International Sanitary Congress to give the force of international law to the conclusions of the conference at Washington, but such a worthy end was to be obstructed, iron-


#### Abstract

"The influence of the Association in securing international cooperation, at least on this continent, will be very great. I heartily commend this enlargement of the Association, and trust that the day is not far distant when you will include other neighboring states, with a view to restricting, if not wiping out, the most widely-spread epidemic diseases. If Cuba, with all its interest, were represented here, is it not probable that means would be devised by which the germ of yellow fever would be eradicated from the few foci where they perennially germinate?"

Stephen Smith, 1896


ically enough, by the conference's American delegates. James Cabell later reported that the American representatives at the Washington meeting found themselves in the equivocal position of opposing measures of sanitary regulation which they approved in the abstract, simply because Congress had expressly refused to sign any treaty binding the government to enforce international quarantine regulations.

By this time, Association members were impatient with the lack of progress in securing some form of international co-operation in health matters. Turning to its closest neighbor, APHA invited Canada to join the Association in 1884, and in 1891, elected Montizambert president.

The active participation of Canadian members in the Association could not halt the appearance of yellow fever along the southern borders of the United States, however. In 1889, a resolution was adopted asking Mexico, Cuba, and Colombia to send delegates to the next Annual Meeting. "The

Association feels that in the restriction and prevention of contagious and infectious diseases in particular there should be a closer cooperation between the health authorities of the U.S. and Canada and the countries lying south of the U.S., and that by such cooperation the sanitary interests of all would be greatly enhanced," the invitation said. Only Mexico responded, sending two delegates to the 1890 meeting in Kansas City; that year, all physicians of the Mexican republic were officially added to the list of active members.

Mexican participation in the Association was quite valuable as long as it lasted. In 1891, delegates from Mexico described health systems in their country, which prompted APHA members to call for a similarly well-constructed public health program in the U.S., though they acknowledged the difficulties inherent in drawing up a unified plan for the independent states.

The following year, the annual meeting was held in Mexico City, and Domingo Orvañanos was nominated for first vicepresident. The height of the internationalist feelings in the Association was reached in 1897, when Eduardo Liceaga, MD, president of the Supreme Board of Health of Mexico, was elected APHA president. Unable to speak a word of English, Liceaga served as Association president for a year without once presiding over the proceedings.

APHA members continued to pressure Congress for some affirmative action on international health matters. In 1889, the Association considered a resolution urging President Benjamin Harrison to open negotiations with Spain for the
acquisition of Cuba, in view of the "constant menace to the health of the United States from the uninterrupted presence of the most serious known contagious diseases in the island of Cuba, a dependency of a country 3,000 miles distant." Though the resolution was deemed "inexpedient" and "beyond the scope and general object of the Association" by the Executive Committee, the concept was prophetic and would be realized before too many years elapsed.

There were resolutions passed in 1892 to appoint an international commission, with Felix Fomento as chairman, to investigate yellow fever; and to alter the immigration laws of the U.S., Canada, and Mexico to provide greater safety and welfare to passengers and crews aboard ships, and to protect the countries against the importation of diseases.

At the 1893 Annual Meeting, held in conjunction with the World's Congress Auxiliary, an International Congress of Public Health met to discuss issues of concern. A resolution was passed that year asking the International Congress to urge the represented countries to study conditions of healthy living in home and community, to form voluntary public health associations, and to afford efficient and persistent support to the work of public health officials.

Stephen Smith, still active in Association business, had long been an ardent supporter of a formal cooperative agreement among countries on health matters. In 1894, he was appointed by President Cleveland as a delegate to the ninth International Sanitary Conference, which adopted a code of rules to supervise the immigration of infected persons. Smith urged Cleveland to call
a similar conference with the same objective in the U.S., but though the President agreed with the idea, he told Smith he could not take any action on it.

By the 1890's, the stage was set for significant cooperation among nations
"No community can be healthy that has communication with a community which, by its filthy habits, affords opportunity for the cultivation and spread of contagious diseases. Our own security against epidemics depends not only upon the cleanliness of our towns, villages, and even individual families, but even more upon the cleanliness of our neighbors, especially in such a place as Cuba, where we have yellow fever germinating and liable to be transferred to us. By means of international cooperation with contiguous nations, we might render the nations on this continent the healthiest in the world."

Stephen Smith, 1896
in the advancement of public health. Still to come were a few important achievements in the field of bacteriology, which was to the Association's first twenty-five years what vital statistics had been to the era of sanitary reform which prompted APHA's founding.

There had been solid advances in bacteriology in the 1870's, with the sophisticated development of technical methods for the cultivation and study of bacteria. Pasteur focused his attention on the prevention and treatment of contagious diseases, and in the 1880's, the golden era of bacteriologyemerged. The development of vaccines and the study of immunology soon followed the
rapid discovery of the causative organisms of various diseases such as tuberculosis, leprosy, malaria, and diphtheria.

Most significant contributions to the development of bacteriology were made by Europeans, but Americans such as APHA President George M. Sternberg (1885) were quick to implement them for practical purposes. Bacteriological laboratories were set up in the United States as early as 1887, and a year later, in Providence, R.I., by

Charles V. Chapin, later an APHA president, and in Michigan, by Victor C. Vaughan, an Association member. The units' main function was the analysis of water and food.

Many, if not most, of these early bacteriologists were members of the Association, and quickly brought their interests and influence to bear on its structure. In 1884, APHA's sanitary analysts and chemists notified the Association of their intention to remain


Sternberg
members, but asked for a "section or committee on sanitary analysis for food, water, etc.," perhaps a warning that more representation of bacteriologists was needed.

In 1895, the APHA Executive Committee approved a suggestion of the committee on pollution of water supplies that a cooperative investigation into the bacteriology of water be launched. A subcommittee met to determine the organization and methods of laboratory procedures to be adopted, but found a standard could not be established until certain questions were answered.

To answer these questions, a convention of bacteriologists was called in New York in 1895. Most of the prominent bacteriologists in the country were present, including Professors William T. Sedgwick and Theobald Smith, and Professor William H. Welch of Johns Hopkins University, who was chairman, proclaimed it the first convocation of bacteriologists. As outstanding as the members might have been, the size of the group was simply too unwieldly to formulate a definitive program for the study of bacteriology. It was voted that a committee of nine undertake the final draft of a manual on laboratory standards, and the other members agreed to modify their own procedures in accordance.

The committee had a mammoth task to accomplish. The proceedings of the New York convention, which were published in the annual report of the Association, were used to shape the standards adopted by the committee, and as expected, the methods were widely in variance with each other.

Committee members were unsuccessful in soliciting funds for their op-eration- the insurance companies they approached were sympathetic but close-fisted-and the final report was largely the result of the members'contributions of their own time and effort.

The work of the committee was all the more remarkable because it represented a compendium of the best methods then in use. To gain uniformity and exactness of information, committee members refrained from insisting that a particular method be inserted in the report, though they may have used that method exclusively in the past.

The final report, which was presented to the Association in 1896 and approved for publication (with amendments) the following year, contained detailed information and tests necessary for the study of bacteria, including the preparation of cultures and other criteria needed by the bacteriologists.

Never did the committee demand that only its recommended methods be used. It did ask, however, that where new species were being studied for publication, the procedures it outlined be tried. Encouraged by the widespread acceptance of the report-the forerunner of the "Standard Methods" publi-cations-the bacteriologists pressed for an APHA committee on laboratory work and methods. In 1899 a subcommittee proposed formation of a section "for the consideration of bio-chemical topics." It would be called the Bacteriological and Chemical Section of APHA and its members would be APHA members engaged in bacteriology or chemical laboratory work.

The Association Executive Committee approved the Section's formation, and
changed the constitution accordingly. New members had to be sponsored by at least three section members, approved by a two-thirds vote of the section's governing committee, and elected by a majority of the section members present. The officers-a chairman, vice-chairman, secretary, and local secretary-and four others elected by the section comprised the governing committee, together with the retiring chairman ex officio. Meetings of the section were deliberately scheduled for the day before the first session of the annual meeting, to open them to all members of the Association and to avoid conflicts with the general meeting.

The first meeting of the first APHA section was held in the Pathological Laboratory of the Central Insane Hospital in Indianapolis in 1899. Theobald Smith was elected chairman by the 38 members attending, and committees were appointed on standard methods of water analysis; bacteriology of milk in its sanitary relations; variations of the colon bacillus in relation to public health; and exhibition of laboratory apparatus and appliances for teaching of hygiene. Wyatt G. Johnston, a prime leader in the movement for the section, was elected secretary and later, chairman.

Formation of the bacteriologists' section was a symbol of the tremendous advances made in the last decades of the nineteenth century. Nearly every one of the bacteria known in 1897 had been found and described in the twenty-five years since the Association was founded. Still to be discovered was the causative agent of yellow fever.

Although yellow fever had ceased to dominate the Association meetings in the 1890's, it continued to absorb the attention of many of the members. In 1897, an APHA committee was appointed to seek a government commission of expert bacteriologists to be sent to Havana and other cities for an investigation of the disease. The committee members, including Sternberg, met with President McKinley in November of that year. Less than a month later, McKinley asked Congress


## Theobald Smith

for such a commission, and a bill was introduced in the house to appoint four bacteriologists-one each from the Army, Navy, Marine Hospital Service, and civilian life. Before Congress could act on the proposed legislation, the Spanish-American War was declared and ended, and Cuba became a U.S. protectorate, occupied by American troops.

Under written instructions from Sternberg, the Surgeon General of the Army, a medical commission was dispatched to Cuba "to give special at-
tention to questions relating to the etiology and prevention of yellow fever." The medical officers included Major Walter Reed, James Carroll, A. Agramonte, and Jesse W. Lazear. The subjects of the experiments were Army volunteers and the commission members themselves; Lazear died during the first year from an accidental mosquito bite.

The mosquito had been suggested as a possible transmittal agent of yellow


Major Walter Reed
fever as early as 1853 by Beauperthy, and given classic formulation by Carlos Finlay in 1881, but the evidence was inconclusive. In 1898, the cause of yellow fever was widely suspected to be the "bacillus icterodes," though Sternberg doubted it and Reed and Carroll thought it to be only a secondary cause of the disease. The same year, a Marine Hospital Service investigatory team reported "bacillus icterodes is the cause of yellow fever."

In a report on "The Etiology of Yellow Fever," given at the 28th Annual Meet-
ing of the Association in 1900, Reed and Carroll proved conclusively that the suspected germ was not the sole cause of yellow fever, and concluded, "The mosquito serves as the intermediate host for the parasite of yellow fever." There was no discussion of the report, and shortly afterward, APHA president Henry Horlbeck said, "There have been no other claimants that we are cognizant with during the year 1900, as to the discovery of the specific cause of yellow fever."

It was not until after the meeting that the full significance of the discovery was realized. Reed's team had proved that while yellow fever was transmissable, it was not contagious, and a course of action became clear: eliminate mosquitoes and protect the sick from their bites. The Yellow Fever Commission accepted their conclusions, and put the proposed measures into action in Havana in February, 1901. Eight months later, yellow fever was eliminated completely from the city.

With this important discovery, the twentieth century began. Significant advances in bacteriology had changed the practice of public health, and the Association itself was beginning to feel pressures from within and without on its structure. The early founders - Harris, Snow, Rauch, Hunt, Cabell, and Toner -were dead, and Stephen Smith, addressing the 1901 Association Annual Meeting, said, "I only am escaped alone to tell thee."

> In 1894, the APHA Executive Committee adopted new regulations for presentation of papers:


Finlay

- All papers on topics within the province of a committee would be referred to the chairman and then to the Executive Committee;
- No papers would be considered for presentation unless abstracts were submitted 20 days before the Annual Meeting;
- Papers were restricted to "strictly sanitary, climatologic, and preventive questions, all clinical, pathological, therapeutic or other strictly medical statements being excluded; nor shall any paper tending to the advertisement of special or local interests or establishments be accepted."
Since 1871, APHA had published annually a volume of "Public Health Reports and Papers of the American Public Health Association." In view of the more cohesive structure established for the presentation of papers, a new format for the annual publication was suggested. A quarterly journal, it was thought, would make the work of the Association more timely and more widely known, would be cheaper to produce, and would increase the circulation through subscriptions.

From 1895 to 1899, the quarterly Journal of the American Public Health Association replaced the annual volume of transactions. A publications committee, consisting of three active Association members, directed the production of the journal. The committee had to publish those papers selected by the Executive Committee, but could exercise some discretion in selection of the others. Changes in the format included insertion of discussion of the papers following the pertinent report, a series of short, unsigned editorials, and ex-
cerpts from foreign public health reports.

In 1899, the Association reverted to the annual volume format, but retained a standing committee on publications. This committee, consisting of a chairman, the secretary and treasurer of APHA, a member of each section, and the president, ex-officio, was instructed to "make summaries of addresses not of permanent scientific value," and to formulate a scheme for establishment of a public health journal.

## chapter 4

"Doubtless all will admit that the patent medicine man, through his friends and staunch allies, the yellow journal, the farmer's stable, the public toilets, the street cars and even the parks and highways, has been more successful in commanding public attention to his wares, than has the American Public Health Association in getting its proceedings before the general public."

John A. Kingsbury,<br>APHA member, 1909

Association members had good reason to be disappointed in their failure to communicate their findings to the public. The years between 1900 and 1910 were important ones-years in which significant work was accomplished by the Association's new sections and committees and a more responsive structure was developed for the entire organization. Yet the Association's membership was small, its annual report was limited in distribution, and its work was known by few people outside APHA.

Membership growth had been slow, though some preferred to term it "stagnant." But the important bacteriological discoveries reaching the U.S. shores

## the new young leaders

from Europe were having a significant impact on the quality of the membership. The old leaders were gone, and taking their places were young men eager to apply the new discoveries to practical methods of health and sanitation. In the first decade of the twentieth century, three of these young men, later to become internationally known public health leaders, conducted and reported to the Association some of their most valuable works in bacteriology.

William Thompson Sedgwick (18551921) was professor of biology and public health at the Massachusetts Institute of Technology for 38 years, and one of the founders of the School of Public Health of Harvard and MIT. An exciting and magnetic teacher, his influence on sanitary engineering was tremendous. As the first teacher to give a bacteriology course to civil engineers, he was providing them with principles that could be previously learned only in medical schools, and doing so in a way that could not be easily forgotten.
"He would hold up a glass of water and talk for an hour about what it contained. He would excite us by say-
ing that it contained enough germs of typhoid fever to give the disease to a thousand people, and then go on to show how sanitary engineers could make the water safe to drink," said one of his former students, George $C$. Whipple.

Many of the methods Sedgwick de-vised-such as the aërobioscope to strain bacteria from the air, and the Sedgwick-Rafter method are still valid today. He was president of the Society of American Bacteriologists, which he helped found, and of the American Society of Naturalists, and was a leader in development of the first scientifically designed municipal water filter in America, at Lawrence, Mass. Later, he became internationally known for his accomplishments and principles of public health, prompting a London newspaper to tag him the "Ambassador of Health."
Though he cared more for general principles than mathematical details, Sedgwick knew how to use statistics to draw logical conclusions. A prolific writer, the professor published more than 100 important papers between 1883 and 1921, many of them in the Association journal, and most of them in cooperation with his students.


William T. Sedgwick

Charles-Edward Amory Winslow (18771957) was one of "Sedgwick's boys." In 1902, the year he was elected to membership in the Association, he presented a paper with Sedgwick on "The Relative Importance of Public Water Supplies in the Causation of Typhoid Fever," based on their experimental studies in Massachusetts. Like Sedgwick, he published a number of important works in bacteriology during that decade, among them "The Conveyance of Bacteria by Sewer Air," and the first textbook on the elements of water bacteriology.

If Sedgwick was the ambassador of health, Winslow was its statesman. As a member of APHA, he held virtually every important office, including the presidency, editorship of the journal, and chairmanship of two sections and numerous committees. His wide variety of interests-community health and housing, health education, history, mental health, voluntary agencies, public health nursing, and occupational health were a few-led him to make distinguished contributions in each.

Charles Value Chapin (1856-1941) was a different sort of man than his two contemporaries. Quiet and unassuming, he was more at home in the laboratory than on the public platform, accepting reluctantly the honors and offices urged upon him.

Where Sedgwick had sought the general, Chapin sought the specific. He took scrupulous care in the collection of information, making painstaking tabulations, asking penetrating questions, and drawing careful conclusions, as evidenced in his annual reports as
head of the Providence, R.I. health department. His reports to the Association were frequent and valuable, and in 1910 he published his classic work on "The Sources and Modes of Infection," firmly establishing the role of the human carrier in disease.

The influence of these three men was strongly felt in the infant Section of Bacteriology and Chemistry. The Section's Committee on Standard Methods of Water Analysis gave a summary


## Charles Chapin

in 1900 of contemporary methods, based on replies of 125 analysts to letters of inquiry. The following year, the committee made definite recommendations for the methods to be pursued in physical, microscopical, and quantitative bacteriological examinations, and published its final report in 1905 as a supplement to the "Reports and Papers of the Association."

In the report, the first of the "Standard Methods" publications, the committee said that many of the old techniques of analysis used in the last ten years
were outmoded and not universally applicable. As sanitary investigation grew more sophisticated new methods of application were required to keep up with new inventions, such as the rapid biological filter, and new lines of bacteriological investigation. "Standard Methods," with its detailed descriptions of techniques, "was not intended to stifle research," the committee pointed out, "but to improve the technique of water analysis and to compare current methods with those recommended in the report." Within three years, the committee began preparation of a new edition to reflect changes in the field.

Encouraged by the acceptance of the water analysis report and a similar one on bacterial milk analysis, the Section voted in 1907 to establish technical committees in other areas. Each Section member received a list of proposed committees and checked off those he was willing to work on. Committees on chemical milk analysis, bacteriological diagnosis of typhoid, diphtheria, tuberculosis, rabies, and syphilis, preparation of antitoxins and vaccine, and analysis of air were established by this method. "The attempt was made to provide, in this Section, an organization as complete for its purely scientific side as for its administration," B. R. Rickards, the Section's secretary reported.

In yet another area-that of statisticsthe organization of a section proved vital to the development of the field nationwide. The formation of the Statistics Section in 1908 was symptomatic of the growing interest in the science of vital statistics, paralleled by the establishment of the American

Statistical Association and a committee on statistics of the American Medical Association.

The first meeting of the new section marked thirty years since Elisha Harris urged all states to have "a good system of vital statistics organized and in harmonious operation contributing comparable and numerically complete results." Fulfilling Harris' charge, the Association, in 1898, had passed a resolution urging that the Bertillion classi-
fication of causes of death be adopted by registrars of vital statistics in the U.S., Canada, and Mexico. As revised in 1900 in Paris, the international classification system was adopted by those countries, and carried out immediately in some states. Further efforts of the APHA Committee on Demography and Statistics, in conjunction with the U.S. Census Office, resulted in extension of the country's registration area through enactment of suitable laws and enforcement procedures.

The standard certificate of death was born in the Association in 1901. It was immediately endorsed by the U.S. Census Bureau and adopted, along with a uniform certificate of birth, as the standard in the country. Not satisfied with these initial steps toward uniform registration, APHA statisticians tirelessly continued to press for greater uniformity among the state systems, and stronger penalties for failure to comply with the registration laws.

Forty-four members attended the first provisional meeting of the section in 1907, electing J. N. Hurty as chairman, and Cressy L. Wilbur as secretary. The formal name of the section remained in doubt, however, while Association members debated the entire question of section function.

Arguments were raised by Association members that sections should be made distinct organizations, such as "The American Association of Registrars of Vital Statistics, organized as a Section of the American Public Health Association." Despite the title's unwieldiness, proponents felt the name would carry more weight and dignity than would the simple "Section on Vital Statistics." Besides, it was believed, something was needed to distinguish the specialist from other members of the Association in the eyes of the public, and full recognition and distinction of the specialty might entice neophyte organizations to join the Association.

Others, however, believed, "We are all public health men, no matter in what department, and all branches should be united and work together. It would be well for the members of sections
"Free schools exist in every State, orderly government prevails, the courts everywhere are pure, literature, art, and science flourish, and honor and righteousness control; yet, at this time, only fifteen States comprise the registration area . . . The vital statistics of the National Government, as collected decennially, are a failure . . ."
J. N. Hurty, MD

Statistics Section Chairman, 1908
to come to Association meetings and discuss all questions pertaining to all aspects of public health work." The question of section name was put before the Association and decided in favor of "Section on Vital Statistics." Those who feared loss of influence for the Section were evidently quieted when, in 1909, Congress recognized the Section for its promotion of the international classification system.

Within a few years, two other sections were well on their way to formation. At the 1907 meeting, a committee reported on the feasibility of establishing a section of municipal health officers. Such a section, it was reported, would consider such subjects as the relationship of municipal health departments to the general city government, the organization of a health department, scope of operations and budgets, needed legislation, and rec-ord-keeping. "Health officers need, not an abstract knowledge of sanitary science, but the ability, through such knowledge, to correct conditions endangering the community's health," the committee said. The Section was established in 1908, and by 1911, a section on sanitary engineering had also been established, along with a short-lived Sociology Section.

Accompanying the growth of specialization was a general feeling that the Association's structure was too inflexible to accommodate the varying interests of its members. President F. F. Wesbrook appointed a committee in 1905 to consider changes in the Association. The following year, the committee submitted its suggestions, saying, "[We] believe that with the adoption of a more representative form of government of the Association through a satisfactorily appointed body of delegates from the various sections of the countries represented . . . and with the business management of the financial and publication affairs of the Association in the hands of a small body of long-term trustees, that the interest of all persons in the work of the Association will be greatly stimulated."

Acceptance of the revised Constitution took two years to accomplish, at the insistence of Association leaders who wanted to make a thorough study of the changes. The final document, adopted in 1908, detailed the qualifications for each type of membership more fully than ever before. Professional, recognized credentials were necessary for active membership, though anyone with a general interest in health could become a non-voting associate member. Honorary membership was reserved as a reward for "unusual and highly meritorious service or achievements." Though the by-laws failed to mention it, honorary membership was also used as a political tool, and frequently awarded to congressmen and U.S. presidents.

The new Constitution also spelled out the duties of the officers, including that of the president to deliver an
address, not to exceed thirty minutes, on the evening of the first day of the Annual Meeting. Officers were to be elected by a vote of the Association and nominated by the Advisory Council, which was composed of representatives from the public health services of the U.S., Canada, and Mexico, each state and province in these countries and Cuba, the U.S. Army and Navy, each section, the general officers, and the five-member board of trustees.

As scientific knowledge continued to be amassed, discussion on relevant topics at Association meetings became increasingly sophisticated, particularly on bacteriological topics. Though the discussion on yellow fever did not end with Walter Reed's report (some thought the influence of fomites in the spread of the disease could not be discounted), it gradually shifted to how best to destroy mosquitoes. By the time Eduardo Liceaga reported in 1910 that "yellow fever has disappeared from the Mexican Republic," control of tuberculosis and other diseases absorbed the attention of the members.

In 1893, the Committee on Tuberculosis had recommended adoption of registration for tuberculosis cases, disinfection, establishment of special treatment hospitals, organization of societies for prevention of TB, government inspection of dairies, and legislation against spitting in public. By 1904, the committee was able to report significant acceptance of its recommendations. In 1897, New York City had adopted the system of full notification of tuberculosis cases, helping to break down the opposition to the system in other cities and states. More health authorities were insisting
on full disinfection, and 67 sanitoria and 38 TB societies had been established. Unfortunately, reported committee chairman Lawrence F. Flick, "Legislation against spitting . . . has missed the mark."

APHA committees were instrumental in focusing attention on other aspects of the newly burgeoning health field. A committee on school hygiene was appointed in 1900 to report on the progress of measures designed for early detection of communicable diseases among school children, recording their physical development and improving sanitary conditions on school premises.

The teaching of hygiene in high schools, colleges, and universities was also considered crucial by Association members. Upgrading of the profession was needed to command the respect of the public, and more status and better pay for public health workers would not be undesirable by-products of this goal.

In 1903, a resolution was passed approving the recommendation of the Committee on Teaching of Hygiene that a diploma of "Doctor of Public Health" be awarded in universities, and that the government provide a professorship in hygiene at Annapolis and West Point. The committee continued its work for several years, later devising a detailed scheme for hygiene education in schools. The Association also protested, in 1909, the practice of appointing public health officers and employes on the basis of political expediency.

Another popular topic of the day was the rise in anti-vaccination sentiment.

Its growth, William A. Evans reported to the Association in 1908, was "founded on the prevailing principles of American law . . . which is that every man has control over his own body, and that he alone shall decide what shall be done for that body." Many people were fearful that the vaccines and sera were unpure, and would do more harm than the disease itself. To counteract this sentiment, APHA members worked to secure regulation of vaccines so as to give the country "absolutely pure and reliable products, and . . . establish the confidence of the public, thus removing the great objection that may have existed against their use."

Other APHA individuals and committees pressed, in the 1900's, for adoption of standard milk examinations by the state boards of health, for a sex education program for children and adults based on medical as well as moral principles, and for a two-year course in hygiene instruction for veterinary students. In 1908, still another area of interest for the Association developed when APHA President Richard $H$. Lewis was invited to a conference called by President Roosevelt to consider "the vital question of the conservation of the natural resources of the country, which are being wasted with such lavish prodigality as to make the judicious grieve and the wise to take alarm."

APHA's relations with the President were not always that smooth during the decade. The old battle over a national bureau of health continued without interruption into the twentieth century, but things became more complex. APHA had always been vocal in its wishes for a federal health depart-
ment, but other organizations were having their own thoughts on it, and the differences in opinion were not always easily mended.

In 1900, the Spooner bill was introduced in the Senate, authorizing a National Commission of Public Health, under the supervision of a commissioner appointed by the President or the commission's Advisory Council. Symbolic of the times, the commission would be placed under the Treasury Department because health (as demonstrated by the yellow fever epidemics) was important to the economic interests of the nation.

The Marine Hospital Service was obviously miffed over the bill, which would give central authority over health matters to another, as-yet-uncreated agency. Supporters of the bill, including APHA, were stronger, however, and its passage seemed assured, when, in 1901, another bill was introduced "to increase the efficiency and change the name of the Marine Hospital Service." The immediate effect was to split professional support given to the Spooner bill.

Representatives of APHA and the AMA, which had been working together for establishment of a national commission, met in an emergency session with Spooner and decided the only hope was a compromise bill, providing for a public health service and marine hospital service, but not a department. The bill was passed, amid the health groups' hopes that a national department would soon follow.

Both APHA and AMA seemed resigned to acknowledging that the time was not yet ripe for a separate department


Lewis
of health. Then, in 1905, members of the American Association for the Advancement of Science formed a militant "Committee of One Hundred," to inform the public and influence national legislation on public health. For some time, AMA also had been exerting pressure for a national department, but with the specific ultimatum that it be headed by a Cabinet officer. Some APHA members felt the AMA's stand was unrealistic, since President Roosevelt had favored creation of a
department but was expressly opposed to adding another officer to his already crowded Cabinet.

Though the American Health League, an outgrowth of the Committee of One Hundred, eventually received credit for the insertion of a health plank into the platforms of the two political parties, pressure created by growing public opinion and the mounting campaign of the health organizations undoubtedly helped. By 1909, APHA
had established a formal structure for continuing cooperation, with the AMA, the American Health League, and other groups, clearly aware of the greater results available through coalitions.

Finally, in 1910, a bill was introduced by Sen. Robert L. Owen of Oklahoma, containing provisions similar to those of the Spooner bill. All health agencies in the government, except military offices, would be transferred to a department of public health under a


Administration of first typhoid vaccination, 1909.
cabinet officer. The bill was immediately supported by APHA, AMA, and others, but opposition was strong.

Owen's bill eventually died in committee, and when the senator reintroduced the bill the following year, the clause for a separate department of health was missing. Nevertheless, the well-oiled machinery necessary to create the department appeared to be assembling rapidly.
The accomplishments of APHA during this decade were many and valuable in establishing a scientific basis for the Association's policies. Yet it was obvious that the "Reports and Papers," with its limited audience, was insufficient as a means of communicating these accomplishments.

In 1906, the committee appointed to consider changes in the Constitution also recommended the establishment of a monthly journal of public hygiene to be the official organ of the Association. It should contain papers of interest from other journals, the committee said, and a record of sanitary progress, editorials, information on health legislation, announcements, and reviews, as well as abstracts of papers presented at APHA meetings.

The Laboratory Section took the first step towards establishment of a journal by adopting as its own, in 1908, the "American Journal of Public Hygiene," official organ of the Massachusetts Association of Boards of Health. In 1909, the journal became the official publication of the entire Association, which contracted for 400 pages from the publishers. Simultaneously, publication of the annual "Transac-
tions" was suspended because of high publishing and distribution costs.

For two years, this arrangement attempted to serve the Association's need to provide "interchange of thought and knowledge and new developments . . . which has long been open to other professions . . . [and] is lacking to the professional public hygienist." But the quarterly journal was obviously insufficient to record the increased activities of the Association, particularly those of the Laboratory and Statistics Sections.

The high costs of the publication in relation to its value were worrisome to the Association leaders. B. R. Rickards suggested various ways to increase the membership, such as lowering the dues, increasing the direct contact of the membership committee with prospective members, and establishing a central headquarters with an executive secretary. Rickards was convinced that members simply had to be given more for their money, and the new Constitution was seen as one way to do this. Beyond the changes in Association structure, a monthly journal was deemed necessary. In January, 1911, the Association established the monthly "American Journal of Public Health."

In the last year of the decade, the Association was well on its way to becoming a highly structured, self-sustaining organization. Some were suggesting branch associations in every state, a massive public health education campaign, and a regular channel of communications between the Association and the press.

Moreover, it was felt, if the Association were incorporated, it would be
easier to obtain trust fund contributions. Philanthropists might hesitate to give funds to an association which could change its objectives overnight, it was explained, but under the laws of incorporation, APHA's stability would be unquestioned. Accordingly, a committee was appointed to seek articles of incorporation from Congress, marking the beginning of a new era for APHA.

## chapter 5

"It is true that our calomel ointment and silver salts will probably prevent this disease in men, but so certainly as we offer it to a man, just so certainly will he go on and contract bad habits, because the root of this disease is love. Love and the cosmic urge work hand in hand. When love leads down, it is disease; when it leads up, it is begetting the best of your kind."

Dr. William Singer, 1913

Begetting the "best of your kind" was very much on the mind of APHA and the American public-in the pre-war years. Medical science had done so much to promote the survival of the weakest in the past forty years that a frequent concern raised privately and publicly was the eventual domination of the human race by the handicapped and feeble-minded. To avoid that end, some suggested, it was necessary to improve the working and living conditions, as well as the health, of the increasingly large number of survivors.

Despite the difficulty of that task, APHA members had great optimism in the future, and faith in their ability to spread the doctrine of good health. Reflected in the pages of their proceed-

## preparing for battle

ings are the concerns of a multitude of crusaders for an array of causes: women's suffrage, the temperance movement, maternal and child care, drug and tobacco abuse, industrial hygiene, medicinal fraud, and venereal disease. The impact of industrialization on the life and health of Americans was no less a matter of importance to the Association than it was to the myriad social health organizations raising their banners in the early twentieth century.

Symbolic of the influence of the reformists on APHA was the first meeting, in 1912, of the Sociological Section, organized "to increase the social workers' knowledge of health problems and their interest in them, to bring social worker and health officer into closer touch with each other..." It was obvious that the nation's medical and health resources, so preoccupied in the past with the mere survival of the individual over disease, must now be applied to the occupational and social diseases accompanying industrialization and urban expansion.

As early as 1910, the Association had adopted a pamphlet on sex hygiene, a topic not often discussed until, in 1914, thousands of soldiers were discovered to have a disease unmentioned-and
therefore untreated-among polite society for almost two centuries. The 1910 APHA report emphasized five factors in a campaign against venereal disease: recognition, study and control of syphilis and gonorrhea as communicable diseases; an educational campaign for parents of all social classes and children of all ages and sexes; advocacy of temperance because of the "relationship between alcoholism, venereal disease, and insanity; advocacy of personal cleanliness and venereal prophylaxis for those whose carnal appetites cannot be controlled by the agencies of moral prophylaxis; and promotion of early marriage."

A 1914 resolution called on the government for a system of confidential notification of these diseases, an educational campaign, and proper provision for diagnosis and treatment of all cases. In 1916, an APHA Committee on Venereal Diseases recommended that the diseases be made a community responsibility, accepted and reported without moral stigma to the individual victim. The committee looked to the day when the public would maintain the same attitudes toward syphilis and gonorrhea as it held toward typhoid fever.

Fewer facts were known about the widening reach of another old problem: drug abuse. Health officers and physicians related personal experiences in treating "opium-eaters" and morphine addicts, and uniformly condemned patent medicines with high narcotic content. Concern for "this pitiful array of wrecks waiting, as in a breadline, for the free dope prescription . . young men and women asking in a whisper for a fifty-cent prescription for 'coke,'" motivated APHA members to appoint a drug abuse committee and draw a resolution that state authorities establish custodial institutions for noncriminal drug users.

Anti-narcotic sentiment in the nation triggered passage of the Harrison Act in 1915, which placed restrictions upon importers, manufacturers, and wholesale and retail druggists. However, a Journal editorial called the act "mutilated," with weak and indefinite clauses that exempted private physicians, even though, the Journal noted, "It has been shown repeatedly that the physician is the greatest single factor in drug addiction formation," by his casual prescribing of narcotic drugs.

The Association "show-and-tell" drug abuse discussions laid the groundwork for some ahead-of-their-time suggestions. One member presented the new angle of continuing to restrict the supply of drugs, but also treating the users. Another asked whether "habit-forming drugs" included nicotine, caffeine, and alcohol, and though his question was greeted with laughter, a motion was later made-but not seconded-to limit smoking during the proceedings of the annual meeting. "I do think that in public health conventions smoking might well be confined to the corridors
of the Hotel and to an especial part of them where the public in general does not go," said Harvey Wiley, MD.

Most of the members agreed that alcohol, too, was dangerous to health but were opposed to its prohibition. "Those who have been interested in recent years in psychiatry from the psychological viewpoint all agree that there is no such thing as a normal person who drinks to excess ... no absolute prohibition will ever put an end to the alcoholic problem, because it is not a problem of the drug alone, but a problem of psychic pathology," said Sidney MacCurdy. In 1916, Haven Emerson cited evidence to prove that alcohol lowered the body's resistance to disease, but stressed that he did not seek legislative interference for prohibition. Instead, he thought, public health workers could teach consumers "not to use their liquor," particularly through exemplary abstinence.
By 1914, there was no doubt that APHA had a role to play in promoting safer, healthier working conditions. Many papers had been submitted on industrial lead poisoning, prevention of accidents, and protection of women and children from hazardous job conditions. Support for a section on industrial hygiene was wide, and Association Secretary Selskar M. Gunn noted that such a section would appeal to large companies being sought by APHA for corporate membership. The by-laws were amended to allow companies to join the Association for a fee of $\$ 25$ $\$ 100$, a limit set because "it might seem inadvisable that we should permit any one organization to contribute too large a sum to our funds. It might be made a point of criticism and might, conceivably, at some time, diminish our influence."

Industrial concerns were beginning to become interested in improving their employes' welfare, an interest criticized as profit-motivated by many observers. It may have been to the profit of the factory owner to protect his workers from injury and sickness, a Journal editorial countered, but it could not help but profit society as well, regardless of the underlying motive. For the first time in APHA history, formation of a section was approved before the members were secured. In 1915, the


Pioneer industrial health worker Alice Hamilton, MD, in a 1947 portrait outside her Connecticut home.

Industrial Hygiene Section elected a woman, Alice Hamilton, MD, as its first vice-chairman, and the following year, elected her chairman.

Hamilton's election was symbolic of the growing influence of women in
health and welfare matters and in the Association. Though women had joined APHA since 1873, most of them either took no active part in the meetings or represented voluntary organizations. Few were actually members of the health-related professions.

By 1916, changes in attitudes toward women were definitely reflected in the proceedings. "As a matter of public health, we must see to it that women are paid equal wages for equal work," Josephine Goldmark, of the National Consumers League, told the Industrial Hygiene Section in 1917. "If a woman is properly selected through physical examination and is allowed to work under medical supervision and the occupation is conducted subject to the standards set for hygiene, sanitation, and accident prevention, women can do any sort of work which men can do," E. R. Hayhurst told APHA members. And a Journal editorial asked: Why shouldn't young women trained or available for training be used to fill positions left open by men joining the army?

One woman, at least, demanded less talk and more action from APHA members on the subject of equal rights for women. In 1915, Allie Clement drafted a resolution that "mothers should be allowed equal power with men in controlling the public health conditions surrounding their children, and that the wage earning women should have the power of the ballot to improve working conditions which affect not only their own health, but that of posterity . . ." "Until the wage earning women have something to say about the working conditions," Clement said, "they are going to be exploited and the next generation is going to suffer."

Adoption of the resolution was immediately urged by Surgeon General William Gorgas and others. Reminded by President Sedgwick that the motion must go through the "usual machinery," Clement, undaunted, asked for an immediate vote of the assemblage on the resolution. Again told the action was in violation of the constitution, Clement persisted until the resolution was passed-as she wrote it-by the Executive Committee.

Perhaps because of the growing number of women professionals in the organization, women's medical problems were introduced for the first time. A 1916 resolution called for a committee to study the inequities of the nation's laws "which permitted duly qualified physicians to perform abortions under certain conditions but made it a criminal offense to give contraceptive advice." Discussions on birth control centered on strengthening the human race through fewer, not more, children, and on the idea that healthier mothers and babies resulted from fewer pregnancies.

These concerns were a reflection of a general interest in improving child and maternal health, and lowering infant mortality through better prenatal care, disease prevention, cleaner milk (and emphasis on breast feeding), and dietary improvement. A Section on Food and Drugs was formed in 1917, spurred by the problems of food shortages caused by the war.

Other subjects were confronted for the first time during these years. With increased life expectancies came the problems of old age, discussed for the first time at an APHA meeting in 1915. The trend toward specialization in pub-
lic health nursing and the close relationship of good roads to good health were also noted.

In Sedgwick's presidential address in 1915, he pointed to the significant progress made in school hygiene, heating and ventilation, and preservation of foods, but criticized the lack of public toilets and neglect of personal hygiene. A committee to submit standard methods for plumbing and house drainage was approved in 1914, but

work on a standard plumbing code by a joint committee of APHA, the National Municipal League, and the American Society of Sanitary Engineering did not begin until 1918. Following Sedgwick's call for privies, Cressy L. Wilbur formed "A National League for Insistence on Proper Provision for the Common Decencies of Life," with Sedgwick as honorary chairman.

Throughout the discussion of these issues, one theme was clear. Advanced medical research would do nothing to raise the individual's level of health if he did not know about it. The early leaders of APHA had underestimated the importance of popular health edu-
cation, and lost the National Board of Health as a result. Thirty years later, their successors were not about to make the same mistake.

Alarmed at popular press reports of miraculous elixirs and remarkable operations, members suggested a committee on newspaper promotion of public health work, a popular health magazine containing scientifically-based information, and an Association health bulletin service. A resolution typical of many passed during those years opposed the sale of patent medicines and nostrums whose contents were unknown to the health authorities, and recommended laws requiring manufacturers to file a statement of the drugs' ingredients and therapeutic claims.

## "After the war there is to be a new heaven and new earth; a new democracy, and a new Public Health Association." <br> Charles J. Hastings <br> APHA president, 1918

"To enact a health insurance law simply as a relief measure without adequate prevention features would be a serious mistake, but with a comprehensive plan for disease prevention there is every reason to believe that it would prove to be a measure of extraordinary value in improving the health and efficiency of the wageearning population."

As quoted by John F. Anderson APHA president, 1916

The fight against medical quackery received unanimous support from the members, every one of whom could recount a story of an illegal practitioner earning his living by "curing" epilepsy with sound waves from the piano, deaf-
ness and blindness with the reading of "pleasant literature," or some other miraculous remedy. "How-to" Journal articles appeared regularly, on developing programs of health "propaganda" to counter the widely-advertised "health experts."

In 1916, the Association established a Health Information Bureau to issue weekly bulletins of advice and instructions for health officers, prepare standardized literature and records, prepare special bulletins for use in industry, and undertake the organization of correspondence schools for health workers. Use of this unofficial clearinghouse was free of charge to all health workers, and queries were welcomed. The following year, Metropolitan Life Insurance Company offered a $\$ 25,000$ grant to publish health education pamphlets and forms prepared by the Association. Executive Committee members decided to use the money to create an Institute of Health, and their detailed plans-including development of employment services, an information service for health officials of smaller communities, and bulletins for inexperienced health workers-were interrupted only by the entrance of the United States into the war.

By this time, APHA was only one of many professional and voluntary health organizations, their proliferation sometimes causing as much confusion among the public as good works. Woodward suggested that the numerous health agencies "lay aside selfinterest" and consolidate to achieve maximum effectiveness. Who better than APHA, said some members, could coordinate the activities of the various groups, avoiding waste of resources and duplication of efforts?

This idea partly prompted APHA's participation in the National Committee on Health Organizations, but no real cooperative health council was established until 1920.

The fear, expressed by Lee Frankel in 1916, however, that other organizations were "trespassing upon our preserves," was partially responsible for a gradual reorganization of the Association's structure.

In the first subtle change, arrangers of the 1914 Annual Meeting heeded President William C. Woodward's suggestion that the meetings be planned so that other organizations could meet simultaneously and jointly with APHA. That year, a joint session was held with the National Mouth Hygiene Association, and papers included "Kissing as a Fine Art-the Best Methods of Preventing Unpleasant After Effects"-a toothbrush saga. In 1915, the Annual Meeting in Buffalo was the site of "a clinic in public health legislation and administration," co-sponsored with the New York State Sanitary Officers' Conference.

The Executive Committee recommended that small societies be urged to join APHA as sections devoted to a particular interest. When the National Association for Preventing the Pollution of Rivers and Waterways asked to become identified with the Association, possibly as a section, the group was invited to hold its next annual meeting jointly with APHA. "That would secure one meeting jointly without committing ourselves to their proposition that they make a section, and give us an opportunity for considering it and hearing their arguments perhaps a little more fully," one member advised.

Though that particular group disbanded soon after the discussion, the mechanism for section formation was established.

Like other associations before it, APHA needed a more facile method of communicating its message nationally. District or state branches, Secretary Gunn said, holding occasional meetings throughout the year, would increase the appeal of membership in the Association, since many people did not join APHA because their chances of attending an Annual Meeting were so remote. Gunn was authorized in 1916 to communicate with state health association officers regarding affiliation with APHA, and amendment of the constitution to provide for such affiliates was begun the next year. In 1918, the Kansas Public Health Association petitioned to affiliate with APHA-one of three state associations to formally affiliate the following year.
". . . there is one thing about the American Public Health Association which differs from most of the ' 57 varieties' . . . It is not tied down by any institutional limits; it is not encompassed by four walls. It is a fluid, mobile organization that changes its policy and plans as such change is required. We have changed the Constitution and By-Laws twice in approximately six years, and I assume we would change them again next year if the requirement appeared. We have no axe to grind. We are not interested in any particular diseases. We as health officers and as representatives of the public are interested in one thing only, that is, in public health."

Lee K. Frankel
APHA president, 1919

In 1911, Woodward contended that the Association was of little significance between meetings, a theme he amplified in his presidential address of 1914. His address was one of several important events of that year's meeting, generated by the members' consciousness of a new mission. After several years of dormancy, the Association seemed ready to undertake attainment of a leadership position in the suddenly burgeoning health field. The first step was to restructure its internal organization.

After a series of changes, the new Constitution provided for a Board of Directors to administer Association business. Sections and affiliates were represented, as well as thirty members-atlarge, and each director served for three years. Though the membership defeated a proposal to allow the Board of Directors to amend the by-laws between meetings, other Association business was conducted by the board in quarterly meetings.
"The idea of appeals to the laity, the idea of a large non-expert membership, did not appeal to the imagination or the mind of [the founders] and the result is that we have a bit of machinery in the Constitution and By-laws that . . . is utterly unsuited for effective work with the public," Woodward commented in 1914. Within a few years, the requirement for endorsement of proposed members was dropped, the membership campaign became year-round and full-time, and the Journal headlined an editorial "Wanted: Five Thousand Members."

Each member was urged to recruit one new member, and by 1916, the membership of 1,647 was double the 1910 figure. Yet the Association was strug-
gling to support its young, steadily improving Journal as well as its ambitious plans for the future, and money was scarce. A 1915 campaign among members netted $\$ 1,200$, and Sedgwick himself tapped Boston businessmen for a grand total of $\$ 2,850$, though Gunn said they gave "really to Professor Sedgwick and not to the Association or the Journal."

The Journal, more than any other operation of the Association during this decade, was expected to accomplish the dual objectives of increasing membership and educating the public and the profession. No longer was the Journal merely to record for posterity the abstracts, papers, and proceedings of the Annual Meetings. Featured in the Journal during this decade were book reviews, editorials on current topics, notes on public health work, personals and Association news, and reports on other health organizations. For the thousands of poorly trained health officers and the public bewildered by the large number of health organizations and literature, the Association, through the Journal, would assume its duty "to take its place prominently and firmly as a guide to the people in placing before them trustworthy information on health matters."

The problem of incorporating technical papers for the members with popularized articles for the public was only one of many confronting the Journal editor, who was also Association secretary, administrative head, the membership solicitor, the publicity manager, and advertising man. Not surprisingly, the Journal had four editors in the eight years before 1924. "The Journal was practically insolvent," re-
ported Arthur W. Hedrich, editor from 1917 to 1922. "Most of the work was done at night, and the principal worries, as I remember them, were to get the editorials written, and to erase enough author's corrections from the proofs to keep the printer's bill within bounds."
The scientific work of the Association continued at a high pace during these years. "General addresses giving nothing new were to a large extent absent, being replaced by real contributions to public health science," an editorial commented on the 1917 Annual Meeting. Achievements in such areas as statistics, bacteriology, and sociology, and the increase in communication among health workers, paved the way for the development of public health as a science. Not only were schools of public health opening their doors (Harvard-MIT in 1913, Johns Hopkins in 1916), but municipal health departments were increasingly the beneficiaries of valuable insights into the organization of public health practice, such as those offered by George C. Whipple and Charles Chapin.

Though Chapin had been one of the earliest advocates of terminal disinfection, he was the first to prove its ineffectiveness through highly scientific research. Discontinuing this practice saved his Providence health department thousands of dollars, which he immediately applied to other areas. In 1915, Chapin issued his classic dissertation on "Effective Lines of Health Work," based on his determination of relative values in public health practices. "There is probably not a single large municipal health department in the country which is operated along strictly logical lines," his report said. "They are mostly ill-balanced. Much is
done that counts little for health and much is left undone which would save many lives." For the first time, a logical, scientific plan of organization was formulated for a health program.

The same year, an APHA committee was appointed to prepare specimen forms and a complete system of uniform administrative accounting adapted to health department work. Meetings of the public health officers' section became increasingly sophisticated, although some members from smaller cities felt the sessions were dominated by the reports of larger towns, information of little use to them in their work. Thinly veiling their threat to secede from the section, these members were rewarded with a full session on public health problems of small municipalities. Several years later, Sedgwick suggested the consolidation of several communities into one health district, along the lines of school district plans.
Public recognition of health work was inadvertently spurred by the advent of the Great War. Literature on military hygiene began to emerge in great volume; Majors Haven Emerson and Victor C. Vaughan, Livingston Farrand, Gunn, and W. A. Evans were among those who "did their bit" as civilian and military medical men. To alleviate the health labor shortage, the Journal ran free "help wanted" announcements.

Because of the drain on available medical resources at home, there was great fear of hitherto "undreamed-of sanitary problems," as well as recognition of the toll that venereal disease, alcohol, tuberculosis, and typhoid would have on the fighting forces. "The thing which will win this war, so far as the United States is concerned, is the
health of the American people," a Journal editorial stated. Conserving the health of the American civilians became a patriotic duty.

At the 1917 Annual Meeting in Washington, known as "the war meeting," each section held a conference on health problems of the war. The central theme was the welfare of the soldier, sailor, and civilian; a year later, as the war appeared to be winding down, it shifted to conservation


Hedrich
of the health of the civilian population. Most members were optimistic in their belief that "preventive medicine is justifying itself," since military men, trained in personal hygiene, would be returning to private life after the war. It was thought that the war had focused attention on health problems as never before, and that at its end, the spotlight might turn towards such neglected areas as national health insurance.

No sooner had the war ended when the nation was plunged into a severe epidemic of influenza, which was said to have "prostrated the East Coast" and caused a three-month postponement of the 1918 Annual Meeting. Health officers flocked to the Chicago meeting
"demanding that this Association furnish them information as to what to do when it does recur," according to W. A. Evans. A hurriedly formed committee on influenza delineated rules of guidance for local health officials in the event of another outbreak, and members were cautioned against using crude statistics to draw conclusions.

The dependence of the health officials on the Association for professional advice on controlling the epidemic
of this standard guide, containing descriptions of diseases and the methods of control, were compiled under the chairmanship of Haven Emerson, with the help of, among others, Winslow, Chapin, William H. Park, E. C. Levy, and Theobald Smith.

Together with the newly progressive Journal, these publications and committee reports formed the basis for much of the later organizational work of the Association.


Medical Advisory Board and staff of Department of Health, League of Red Cross Societies, 1921. C.-E. A. Winslow, "statesman of health" during the early years of the twentieth century, is center figure, back row.
greatly pointed up the growth of APHA as a respected scientific body, since it first served as a forum for discussion of yellow fever and cholera. Its publications on examination of water and milk were already standards in the field, and in 1917, the Public Health Service published the report of the Committee for the Control of Communicable Diseases. The early editions

[^1]Whereas it is evident at the present time that there exists no widely efficient control of this evil, Federal, State, municipal or otherwise, therefore
Be It Resolved that the President be empowered to appoint a standing committee of five members which shall be known as the Committee on Habit Forming Drugs and whose duty shall be as follows:

1. The collection of all available accurate data relative to narcotism in the United States.
2. A summary of existing anti-narcotic legislation in this country.
3. The preparation of a full report to be presented at the next annual meeting of the Association which shall have as its object the presentation of existing facts, recommendations for the control of the present alarming situation as the Committee may deem advisable and the outlining of such law as shall control the importation, production, manufacture, sale and distribution of habit forming drugs.

Resolution, 1914

## chapter 6

"I well remember his entry into the ballroom of the Hotel Astor on the arm of John D. Rockefeller, Jr. He received a standing ovation from a large assembly of men who but for his pioneering effort half a century earlier would, in all probability, have had little if any association with the public health movement."

Louis I. Dublin, "After Eighty Years"
"He said the older men who will probably speak at the banquet will probably deal with the past; '1,' he said, 'am going to speak of the future.' "

Lee K. Frankel
Ninety-nine-year-old Stephen Smith did indeed speak of the future at the SemiCentennial Annual Meeting of the American Public Health Association. His mind alert, his voice bright, Smith strolled through the exhibits at the meeting, cracking jokes with his escorts. Alone at the podium at the banquet in his honor, Smith stood erect and delivered his proposal for a campaign to lengthen the average span of human life from 45 years to 100 .

Within ten months, Smith was dead. The organization he had founded fifty years before as a small, elite group of sanitarians was about to come of age,

## public health and the jazz age

developing public health services and organization for the first time as a modern science. There were now more than 3,000 members, and the Association's nine-employe headquarters was permanently installed in offices in the Penn Terminal Building in New York, along with other member agencies of the new National Health Council.

The Association, partly because of the general diversity of its members' interests, had been working more and more closely with other health groups. Affiliation with the American Association for the Advancement of Science had been accepted, and joint reports were made with the American Hospital Association and the American Child Health Association. A proposal to coordinate all the health agencies through one organization had been well received, but a plan to bring together the leaders of the groups resulted in the National Health Council, with Livingston Farrand, and then Lee Frankel, as chairman.

Frankel, who was director of welfare services of the Metropolitan Life Insurance Company, "put the Association on its feet for the first time," according to his associate Louis I. Dublin. Both as APHA president in 1919 and as
one of the most cheerfully positive members in the Association's history, Frankel was largely responsible for its growth in income and membership.

Frankel and Dublin were convinced that the general level of health in the U.S. could be raised substantially if public health officers had access to "the most approved practices as demonstrated in the leading communities." They arranged for their company's district managers to undertake a survey of the services, organization, and needs of community health departments. Finding the information to be piecemeal and lacking standards for comparison, they decided to turn the job over to APHA.

In 1920, Metropolitan gave APHA $\$ 5,000$ to conduct a survey of health departments. A committee was appointed, consisting of Winslow, Chapin, and Wade Frost, with Dublin as secretary. "It was very clear that the committee must have Professor Winslow of Yale as its chairman," recalled Dublin. "He had shown great interest in the project, was widely acclaimed for his understanding of health problems, and would be most acceptable to the rank and file of health officers. He very
graciously accepted that responsibility and associated himself with a group of leaders in public health."

The survey, which was conducted by 22 public health students in 83 cities, represented the first attempt ever made to examine health practices on a common basis. Ira V. Hiscock and Thurber Fales, two young proteges of Winslow and Frost respectively, tabulated the results.

In 1921, the committee reported on
what it had found. Investigation of health practices in cities with populations of more than 100,000 revealed that the average annual expenditure per capita was only 52 cents; that large disbursements in sanitary inspection were based on complaints and not on periodic review of environmental quality; that there existed a "great diversity in control of communicable diseases"; and that-Chapin's reports notwithstanding--two-thirds of the cities still practiced terminal fumi-


Farrand
gation. It was evident that safeguarding the public health was as much a matter of happenstance as of scientific method, and that variance in health techniques was the rule and not the exception.

The Association committee had shown great promise as an informationgatherer, but it was obvious that more money was needed before it could make headway on the solutions. The insurance company's original gift was a financial shot-in-the-arm for APHA, which had been hard-hit by the conversion to a peace-time economy and, later, by the expense of the semicentennial meeting. Too, "specialism in public health, which is much in evidence, is also a menace to our membership, since new societies are constantly being formed," said Mazyck P. Ravenel. With membership promotion more difficult, other sources of funding were welcome.

But the Metropolitan gift was a cause for concern among some members. Murmurs of discontent surfaced in 1921 through charges by the Public Health Administration Section. "Direction and control of APHA has tended to pass from those government and public health administrators to individuals and more particularly to corporate agencies . . . thousands of members have no voice in selection of governing officers or changes in constitution . . . [and the Association has] no clearly defined objectives," while it neglects its responsibilities in the areas of venereal disease control, health officer education, and activity in the legislative arena, Section spokesmen stated. Furthermore, others charged, unwise establishment of sections had been promulgated, the Association was "a nonentity in public
affairs," and its "chief value was as a social gathering."
> "I belong to the old school of health officers who had to learn by experience. There were no schools of hygiene in my day. If it had been left to my own experience, I am afraid I would have made a sorry job of it, but fortunately, Providence is almost at the back door of Boston and I could run down here frequently and associate with such men as Walcott and Sedgwick, Theobald Smith, Harrington, Richards, and scores of others."

> Charles V. Chapin, 1923

Partly true, acknowledged Ravenel, Frankel, and Vaughan. Since incorporation, it was apparent that the Constitution was not well adapted to the needs of an association, and that the governing mechanism was too unwieldy to function as an administrative body. But many of the shortcomings were met in a new constitution proposed by Peter Bryce, Haven Emerson, and Arthur Hedrich, they said, and the charges of corporate intervention were not justified.

The Public Health Administration Section's members may not have liked the way Metropolitan's gift was given to the Association, hinting that they would have preferred to control its use themselves. Partly because of the Section's fears of being shunted aside, and partly because of a general feeling that professionalism was slipping from the Association, a reorganization was effected in 1922. Its basic objective was to create a profession of public health, and its basic tool for achieving this was the creation of fellowship for those
who had attained a certain degree of eminence in the field.

Yet the Committee on Reorganization, headed by Vaughan, felt the fellowship class should be neither exclusive nor small. By electing fellows, Committee members said, "We will be able to create eventually a consciousness on the part of the public" in the promotion of public health. Though only fellows would be able to vote, hold office, or chair committees, more democratic control over policy would be insured by increasing section representation on the Governing Council. Dues were graded, with fellows paying more than either members or associate members, who were the "nucleus of the future."

The by-laws outlining fellowship were explicit-too explicit for some who were insulted that they had been left off the first list of fellows. Others objected to the requirement that an applicant be sponsored by two existing APHA fellows. "My published writings and my work will have to act as my sponsors. Count me out if these will not do," said one member. Still others, commented Hedrich, sent "very caustic comments on the question of the additional payment." One wrote, "I regret that those in charge . . . have deemed it advisable to commercialize an Association which has such a potent influence in health activity, by selling fellowships at \$10 per year."

Most, however, thought fellowship was a good idea. "It is necessary to restrict the voting membership to the strictly professional and technical groups, [but] at the same time, instead of counting our members by hundreds we wish to count them by thousands, and it is nec-
essary to have this lay membership," said the president, A. J. McLaughlin, MD, in defending the Committee on Reorganization's fellowship proposal. Under the new plan, APHA would now be a national parent organization, with state and county societies in close affiliation, bound together by the objective of "the conservation of human life," and a public health magazine, the American Journal of Public Health.

The development of the Journal during this period mirrored the intensified efforts of the Association to professionalize public health. Arthur Hedrich served as Association secretary and editor of the Journal until the reorganization plan of 1922 established a new administration for the publication. Henry Vaughan became editor, Mazyck P. Ravenel associate editor, and Hedrich managing editor. In 1925, Homer P. Calver, already acting as secretary, became managing editor when Hedrich "begged the Executive Board to let him resign." Under the leadership of this editorial committee, the Journal achieved its first measure of stability. Though contributed papers were a rarity in the early 1920's, the journal's published articles represented a golden era in public health science. Reports by Chapin, Winslow, and Emerson frequently appeared, and Wesley W. Peter reported on public health in China.

The list of specialized publications of the Association was also growing steadily. "Standard Methods for the Bacteriological Examination of Shellfish" was adopted in 1920 and revised five years later after a typhoid outbreak scare. In 1923, the Executive Board voted to cooperate with the American Water Works Association in revision of "Standard Methods for the Examination
of Water and Sewage," and "Standard Methods of Milk Analysis" received its first foreign language translation when the French edition was published.

An important adjunct to the reorganization goal of improved professional status was the specification of affiliated societies in the bylaws. APHA leaders suggested that affiliates be organized along the lines of the national associa-tion-that is, the nucleus of the state society should be the professional men of the state. Only one affiliated society was allowed from each state, and the dues were fixed at between $\$ 10$ and $\$ 100$, based on income. Some of the affiliates were already working on their own to upgrade the profession: the Montana state society's second annual meeting was addressed by 24 noted health officials, including the Surgeon General, and featured six section meetings; the Ohio Public Health Association proclaimed a "militant" campaign to convince communities that health protection required trained health officers; and the Maine affiliate published its own health journal.
APHA's sections continued to reflect the changing interests and needs of health workers. The Industrial Hygiene Section was faltering, because much of its official membership was leaving to join the Association of Industrial Physicians and Surgeons. Members of the Sociological Section conceded in 1921 that "the Section has not justified itself," a fact that was blamed on the lack of a specific professional group to fill the Section's membership ranks.
But other sections were taking their places. In 1921, Lee Frankel was elected the first chairman of the Health Education and Publicity Section, which was expected to fill the void left when the Sociological Section folded. That same
year, a Section on Public Health Nursing was requested. Both became permanent sections in 1923, while the Child Hygiene Section was organized in 1921. In 1924, a petition was presented for the formation of a Mouth Hygiene Section, because the "public [was] in need of protection of its oral health by a central public health agency."
The sections on nursing and health education were received enthusiastically from the beginning. Both had goodsized memberships and active programs. Public health nurses carried out their own study of qualifications required for nursing supervisors in health departments, and the public health educators claimed they had the most exciting sessions at annual meetings, as members debated the merits of various techniques in health education. There was little dispute over the content of the message to the public, but a tremendous variance in recommended ways to get that message across.
It was a matter of agreement that the Association's most valuable work was contained in the reports of its committees, many of which were standardizing public health procedures for the first time. At one point, so many committees had been appointed that a Committee on Committees was named. But to be effective, the committees needed money, especially to transport their far-flung members to a common meeting place.
With the grant from Metropolitan Life, the Committee on Municipal Health Department Practice, as it was known, had been assured of continuance. In 1922, Winslow presented his report on "The Ideal Health Department," containing a city-by-city review of the Committee's findings, and a suggested
"ideal health department" based on the results of the survey.

The report was enthusiastically received. Surgeon General Hugh S. Cumming offered to establish an Office of Administrative Health Practice, where the records of the Committee would be made available for use by all health officers. W. S. Rankin, who was subsequently named field director of the project, called the report the "Dun and Bradstreet of public health practice," and said that for the first time health officers of the country would be aware of what their associates were doing. It was felt that here at last was a scientifically based, workable system that might stimulate self-inspection among health departments.

Winslow also announced that a series of awards would be presented at the 1924 meeting in recognition of attainment and advancement of community health services. Some members were hesitant about awarding medals, feeling it might induce smugness among the winners and hinder the progress of health services rather than help it. It was also felt the work should be extended to smaller cities, a project made feasible by Ira Hiscock's publication of "Public Health Practice of Small Cities in Connecticut." Based on the same outline as that used by Winslow, the Hiscock report provided a tool with which any municipality could measure its progress.

At the 1924 meeting, Winslow presented the Committee's fourth report. He outlined the functions of the Committee as threefold: the collection and filing of current information on public health practice; the critical analysis and interpretation of the data; and the reporting of the results to the local health
officer in a way that could help him. The formulation of such a reporting method was begun in 1923 when Chapin was asked to draft an appraisal form by ranking the various lines of public health activity by relative importance, based on his 1913 report on relative values.
At the same time, George Palmer and his associates at the American Child Health Association were ranking health activities in U.S. cities ranging in size from 40,000 to 70,000 residents,
and other agencies were testing the appraisal form in various parts of the country. In August, 1924, the various groups met to determine the final release of the appraisal form. The next month, following Winslow's discussion of the Committee's plan of operation, it was decided to enlarge the group to include public health administrators and representatives of interested agencies. Deciding that the appraisal form should serve county and rural health organizations as well as city depart-
ments, the name of the committee was changed to the Committee on Administrative Practice.
It was hoped that this score card would do much to upgrade the profession. "The work of the [Committee], if successful, will establish professional standards of administrative public health work, and these professional standards will do much to eliminate the obstructive influence of politics [and] raise the status of public health work in general," said Calver.


Gathering for a portrait in the late 1930's are Association leaders (back row from left) Kendall Emerson, J. D. Dunshee, Carl Buck, J. L. Pomeroy, (front from left) Mazyck P. Ravenel, E. L. Bishop, Haven Emerson, Thomas Parran, Jr., and Louis I. Dublin.

Lamenting over the forced "retirement" of Richmond health officer and former APHA president Ernest C. Levy, the Journal expressed hope that, when perfected, the score card would weigh the accomplishments of a health officer and translate the measure into an easily understood and compared figure. Previously, "the competent and incompetent alike have had . . . to back their claims for recognition largely on their own statements and those of their sympathetic friends." In Kansas too, Samuel J. Crumbine was removed as health officer through "political maneuvers," later going to the American Child Health Association.

But politics in health was not the same thing as health in politics. Though political control of the health official's chair was condemned by APHA members, it was thought that health workers might do well to learn something about the political process, and perhaps increase their influence on legislation. Though Senator Owen was still introducing his annual health bill without success, New York City Health Commissioner Royal S. Copeland had been elected to the Senate, and others, such as John Hurty, were making their mark in state assemblies.

During his presidential campaign, Warren G. Harding's pledge to create a new department for the welfare of the people had raised the hopes of Association members. Harding carried out his promise by recommending such a department to Congress, but then proceeded to install his family physician as head of the proposed operation. To add to the insult, he named the physi-cian-a civilian-a brigadier general.
The subsequent bill was opposed by APHA because it not only combined
departments of health, education, and social welfare into one, but also added to it the Veterans Bureau, "riddled with politics and marked by gross inefficiency." Ravenel commented that the Bureau's inclusion in the proposed department had been likened to "the implantation of a cancer into the abdomen of a new born baby."

Harding's bill failed, but the Association grudgingly gave him credit for "trying". When Calvin Coolidge suc-

ceeded Harding, a rare critical Journal editorial called the presidential message "distinctly disappointing to every physician and health worker in the United States" because it had failed to mention any appropriations for health. Federal health activities remained as fragmented-more so, in fact-than ever.

Association leaders turned instead to upgrading the profession from within. A 1920 investigating committee had found that 20 different public health degrees were awarded by 22 educational institutions. One Missouri school was awarding a doctorate in public health to students who had attended
a series of 40-minute lectures on public health, given by a city water works employe who had a degree in medicine from the school in which he taught.

In 1923, the APHA Committee on Standardization of Public Health Training, chaired by Winslow, reported on Hiscock's study of health courses given to medical undergraduates, and a study of courses offered in public health schools. The conclusion was that more emphasis on preventive medicine was

needed in medical schools. What was needed in the schools of public health, it was found, was not more courses but more students. Too few trained health officers were being produced by the schools. The report commented further, "The Committee might profitably give further consideration, if facilities could be provided, to a study of minimum and fundamental essentials in the recognized public health degrees and assist . . . individual schools regarding the prevailing practice and the desirable minimum requirements."

Public health organization as a science was still crystallizing. Problems were now being discussed after the facts
were presented and before the solutions were suggested. The scientific method was being applied to areas outside the laboratory. Drug addiction was fading as a topic of interest, while chronic diseases and personal health services were coming into the limelight.

There was talk, in 1920, about the high cost of health care. A critical Journal editorial cited the growing complexity and expense of modern medicine and


Crumbine
spoke of the "failure of the present organization of medicine to bring the advantages of medical science within the reach of the people." The New York State Health Department's rural clinic experiment, and diagnostic clinics such as the Mayo brothers', were being noticed, and some members thought socialized medicine was worth an investigation. "Health is not the monopoly of any group or class," Mazyck P. Ravenel told the 1921 APHA meeting. "It is the common heritage, and should be the common property of all, and one of the objects most dear to the heart of our Association is to give to everyone the store of knowledge we now possess."

Birth control was becoming an issue among the members. Ravenel and others opposed the concept, saying, "Wherever we make immorality easy and safe, vice has increased." The Journal cautioned against the prevalence of fraudulent cures for cancer, which was becoming more common as the life span increased, but it added that "ill-fitting dental plates, lacerations of childbirth, and ulcers should be given attention since chronic irritation often, if not always, is the exciting factor in

the causation of cancer."
In other areas, the Journal and the annual meetings were providing a forum for definite scientific advancement. R. L. Kahn demonstrated his precipitation test for syphilis at the 52nd Annual Meeting. "The Dick test for the diagnosis of susceptibility to scarlet fever and the immunization of susceptible persons by means of streptococcus toxin was the outstanding feature from the scientific standpoint," reported a Journal editorial on the meeting. Many of the members had the test performed on themselves by George Dick.

The Journal and the Public Health

Education Section were fighting "faddism and divine healers" in medicine; the possible harmful relationship between tobacco and health was noted; and, as the year drew to a close, members described their shock when "Mr. Scopes of Tennessee" was convicted for teaching evolution.

Although a version of an APHA seal appeared in the Journal as early as 1916, dissatisfaction with it led to a design contest for a new one in 1919. A number of designs were submitted, but were considered unsuitable because they were "inadequately indicative of public health at the time, being concerned more with medicine or physical culture," according to the recollections of Arthur Hedrich, then secretary.
"Public health had not yet emerged clearly as a separate specific professional entity," recalled Homer N. Calver years later. "How then could one design a seal which reflected [its] diverse, sometimes opposing and seldom integrated interests? The idea of a tree with many leaves therefore appealed to me."

In 1923, the Executive Board accepted a suggestion that the APHA seal picture a tree, with the motto taken from Revelation 22:2-"And the leaves of the tree were for the healing of the nations." The final design, prepared by a Yale student, was approved in 1925.

## chapter ${ }^{7}$

"Whether we like it or not, however, the tendency of the times makes it clear that some form, or forms, of organized community medical service are coming, as surely as the sun will rise to-morrow. While we hestitate and consider, the thing is happening all about us. . . . It is only through the leadership of the health officer as an agent of the public solemnly charged with the duty of preventing disease and promoting health in every form, and through the thoughtful and broadminded cooperation of the medical profession, that the legitimate demand for an organized preventive medical service can be wisely met."

Charles-Edward A. Winslow, 1926
Giving the health officer the tools he needed to promote and protect health was the first order of business for the Committee on Adminstrative Practice in the years 1926-32. Newly reorganized and made a permanent committee, it came to constitute the technical service division of APHA, sponsoring some of the most valuable work ever conducted by the Association.

Its subcommittees-there were ten by 1928-collected survey material, shaped it into model forms and pro-

## struggling through the depression

grams, and made the results available through its information service. Much of the material collected was utilized by numerous subcommittees, each approaching the same data from a different viewpoint.

CAP's work on community health services was gaining much attention throughout the nation. At the American Health Congress, held in 1926 under the auspices of the National Health Council, there was much favorable talk of the Committee's recent findings in various sized cities and its plans for new organization of health services in these towns.

The following year, a book on community health organization-written by Hiscock and others-was issued by CAP, and became a manual for health departments across the country. Revised several times in later years, the book dealt with the need for health legislation, and planning and action in health administration.

The Committee's fears that its appraisal form might cause standardization and stagnation among cities using it led to the planned revision of the form every three years. In its first revision, in 1928,
individual items were modified to eliminate unfair comparisons or to raise or lower quantitative standards in accordance with new developments in health services. Two new activities, indicative of longer life spans, were included: cancer and heart disease control.
"It has been said, and, we believe, with some justice, that no single factor has ever done more than has the use of the appraisal form to develop city health department practice in the U.S.," the Journal editorialized in 1928. Use of the form was revolutionizing rural as well as city health practices. Other organizations, such as the American Social Hygiene Association and the $\mathrm{Na}-$ tional Tuberculosis Association, picked up relevant items from the form, and the American Child Health Association voted to turn over all its survey activities to APHA.

In 1926, Winslow presented to the Association what was believed to be the first survey of the community from the point of view of public health nursing. Further recognition of this service's importance came when a member of the nursing section was named as an advisor to the surveys and appraisals, and later, with the ap-
pointment of a subcommittee on public health nursing.

Other activities of CAP during these years included issuance of a monthly "Health Officers Newsletter," a survey schedule for industrial hygiene, model local health ordinances, annual health department reports, and record forms. The latter were developed after five years of study, and included forms for communicable disease services, laboratories, school medical inspections, public health nursing, and later, tuberculosis and venereal disease control programs. These, of course, were in addition to investigations of rural health practices, and to the regular survey work being conducted in such places as Hawaii and Los Angeles County by Hiscock, field directors Carl E. Buck and W. Frank Walker, and James W. Wallace.

News of the Committee's work spread more rapidly when the U.S. Chamber of Commerce invited CAP to act as technical advisor in a planned Health Conservation Contest. The nation's businessmen outlined the contest's objective as the reduction of U.S. economic losses due to unnecessary illness and premature deaths. Though members of the Committee would not have put it quite that way, they agreed to undertake the advisory role, believing that the competition would be good publicity for health work and might spur higher per capita appropriations for health.

Beginning in 1929, the contest was held annually, with several cities receiving honors for the high grades they had scored on the appraisal form. In 1930 alone, local health officers in 87 cities received technical aid from the Committee in connection with the contest.

Though the organization of community health services was proceeding at a good pace, the road was not unobstructed. Relationships between public health officials and private physicians had always been cordial and cooperative, but friction was noticeable by the 1920's. It had been generally believed that the state's function was to prevent disease and the private practitioner's was to cure it, but the growing complexity of medical practice was putting new strains on that system. Some public health workers felt that the line between preventive and curative medicine could not be neatly drawn, a feeling that was not echoed by "some older members of the medical profession who were resisting the encroachment on their territory."

In his presidential address, "Public Health at the Crossroads," Winslow noted that the voices critical of the present system of medical services were growing louder. He pointed to the lack of medical care in rural areas and said that the cost of care had risen so high that only the "very rich and the very poor" could obtain it. "We must soon come to a decision as to the point at which social responsibility for the care of individual health shall cease, if such a point exists," Winslow said.

No one knew for sure how many people lacked medical attention. In 1927, a meeting on medical care costs was called in Washington. Winslow and Haven Emerson were delegates to the conference, which set as its objective the determination of "how the best medical care can be secured for the whole people at a minimum cost." The committee, which included economists
as well as physicians and public health workers, confronted the question of the cost of medical services in relation to the family's budget under various social and geographic conditions, and the amount of capital invested in medical practice.

A preliminary survey showed that many people in the U.S. were not receiving adequate medical service at costs within their means. There was nothing in the findings to indicate that a report issued the previous year by the U.S. Children's Bureau was erroneous in estimating that half of all married mothers had no prenatal care at all, and only five per cent had "Grade A" care.

More than one million persons were found to be working full-time in health occupations, but maldistribution of these resources was rampant. Many physicians were not earning adequate incomes in relation to their years of training.

APHA leaders may have been critical of the current medical system, but they were anxious, at the same time, to maintain a smooth relationship with the medical profession. "Cooperation", "mutually satisfying solutions," and "better understanding of the problems" were the words and phrases of the day. The relationship between "preventive and curative medicine" was the subject of a conference of the American Medical Association, and Haven Emerson headed a subcommittee to invite AMA to create a joint standing committee on the problem. A special session on preventive medicine from the viewpoint of the practicing physician was held at the 1930 APHA meeting.

Hinting at the root of the problem, APHA members suggested that physi-
cians should be convinced that preventive medicine would not diminish their own incomes. A Journal editorial even pointed out that preventive medicine could be as profitable as curative medicine.

The Association's Committee on Administrative Practice soon expanded its studies of community health to include medical care and individual health services. A subcommittee on the relationship between health departments and local hospitals was retitled the Subcommittee on Organized Care of the Sick. It was directed to clearly avoid entanglement in the administrative affairs of primary interest groups such as the American College of Surgeons and American Hospital Association.

Instead, surveys were planned on the need for hospital beds, clinics, or other facilities in the community; social and economic groups for whom such facilities were required; and the geographic distribution of existing facilities. A list was drawn up of "Twenty-five Questions" for public health officials to ask themselves about their communities before they invested in new facilities.

Hospitals were a topic of general interest to health professionals, who were watching closely as the new Massachusetts General Hospital executed a plan to provide hospital care to middle-class patients. A preliminary report in 1928 of the subcommittee on care of the sick paved the way for a study two years later on the popular issue of confining patients with communicable diseases to general, rather than "contagious" hospitals. The subcommittee's survey of practices in the field showed that in every way-reduced costs, better train-
ing, and readily available emergency care-communicable disease patients were more economically and efficiently treated in isolation wards of general hospitals than in separate facilities.

The Committee on Administrative Practices was the most prominent of the Association's valuable components but it was not the only one. In a general reorganization-the result of still another self-examination in 1928-the Association centralized its activities into
four standing committees to replace the previous 80. The Committeeson Administrative Practice, Meetings and Publications, Research and Standards, and Fellowship and Membership -were provided with a salaried secretary and required to submit a program and budget to the Executive Board for the ensuing year.

On the administrative side, the Executive Board was directed by the new Constitution to elect its own chairman,


APHA President Dublin (left) and President-elect Ferrell flank President Hoover during White House reception for 1932 Annual Meeting attendees.
and the duties of the board and the officers were more firmly fixed in the by-laws. The office of President-elect was also established to assure "continuity of effort and increase [the] democratic character of representation and selection of officers."

One of the reorganization committee's chief criticisms had been that the Association lacked the financial resources to carry out its enterprises. Membership reached 4,000 in 1929, but nearly 30 per cent of the Association's income was obtained through grants, while other sources were decreasing. A life membership campaign established in 1928 did well, but support for the work of CAP and other committees came generally from Metropolitan Life, the W. K. Kellogg Foundation, the Commonwealth Fund, and other agencies. Sections were reorganized so that their councils retained more continuity, and section constitutions, generally considered ineffective, were eliminated.

A plan to divide the burgeoning Public Health Administration Section into two groups-one for small town health officers and one for large cities-was defeated on the grounds that "we are all working for the same general cause no matter what the size of the town." Instead, the section was renamed the "Health Officers Section" and membership was limited to the administrative head of the department of health and his immediate deputies. The rest of the members formed a new Section on Epidemiology, in 1928, "intended to meet a definite need for a group of earnest public health workers." Don M. Griswold was the first chairman, and Haven Emerson, secretary.

Other section events included changing the names of the Health Education and

Publicity Section (to Public Health Education) in 1926, and the Food and Drugs Section (to Food, Drugs, and Nutrition). The latter section was becoming particularly interested in the vitamin content of foods, and in the debate on pasteurization of milk, which -far from being universal in the United States in the 20 's-was looked upon with suspicion by some who found through tests that heating raw milk destroyed some of its nutritive value. The Industrial Hygiene Section


Homer N. Calver
approved reports on the definitions and standards for treatment and industrial control of lead poisoning and on occupational disease legislation.

Topics of discussion and committee reports of the period were definitely a reflection of problems brought about by the Jazz Age. The effects of the automobile on public health, the spread of yellow fever by air travel, and noise abatement and smoke nuisance were discussed by APHA members at meetings and in the Journal.

Upset at the sight of "movie stars and singers endorsing their favorite cigarette," members passed a resolution recommending the inclusion of tobacco and tobacco products under the food and drug act and the amendment of the act so that their advertising claims would be subject to the same rules and regulations as their labels.

Since the Volstead Act had gone into effect in 1919, the statistics on the effect of prohibition depended on whom you asked. While one faction of the country said prohibition had improved the public health, another said, "We are becoming a nation of liars and of petty lawbreakers . . . the flood of bad liquor is undermining morals and the health of youth."

Between the two sides, APHA attempted to focus on the facts. Emerson showed that prohibition had succeeded in achieving a decrease in the death rate, mental hospital admissions (of alcoholics), and drug addiction, and an increase in school attendance and milk consumption. Dublin used the death rate and economic conditions in his analysis and concluded that the effect on health of actual prohibition -when effectively enforced-was fa-
vorable. But he would not embrace the 18 th Amendment, believing that other factors must be weighed in determining its value.

Public attention was also focusing more and more on problems of the environment. A symposium on domestic and industrial wastes in relation to public water supplies was cosponsored by APHA's Public Health Engineering and Administration Sections at the American Health Congress. "The industries procrastinate and await the solving of pollution problems by the nearby city, which in turn awaits action by other cities located upon a given stream," said George Fuller, APHA president in 1928. The biggest question was: who would exercise jurisdiction over stream pollution programs, particularly interstate waterways? Those knowledgeable in the field were hoping that local controls would prove adequate so that "further centralization of the government would be avoided."

An APHA Committee succeeded in restoring the commissioning of sanitary engineers to the budget of the U.S. Public Health Service. Working in conjunction with the Conference of State Sanitary Engineers, the Public Health Engineering Section adopted standards governing construction, equipment, and operation of pools and other bathing places. "Early in its history, the committee met the challenge that swimming pool sanitation was not a public health problem by collecting and presenting statistics to show that a considerable number of epidemics of different diseases had been caused by improperly operated swimming pools or by the indiscriminate use of incompletely sterilized bathing suits and towels," a Journal editorial said.

Committees of the Association also continued to work for public health professionalism. In October, 1926, the Journal published a supplement on a survey of the requirements for public health degrees in the U.S. and Canada. That same year, the "cream" of the APHA crop formed Delta Omega, a fraternity to honor public health achievements, much like the smaller American Public Health Association of years before. A member of the nursing section, reporting on the qualifications for public health nurses said, "She should have manifested wisdom, imagination, vision, judgment, loyalty, and other traits of personality."
"Most of us entered the field of public health in a more or less accidental fashion, without preliminary preparation or training," said Samuel Crumbine. But times were changing, and rapidly growing health departments were requiring new techniques of administration. Winslow denied that APHA favored replacing physician health officers with "laymen", who held "only" doctor of public health degrees.

Voicing an opinion popular with APHA leaders, Winslow, who held an MD degree, said, "The layman now serving as president of the American Public Health Association is strongly of the opinion that the city and state health officer should, wherever possible, be a physician with additional training in public health."

A year later, the Association recommended that health officers be licensed by the state upon the basis of their professional qualifications. The candidates would be required to pass examinations in various topics such as
communicable disease control, epidemiology, statistics, and laboratory procedures, and some credit would be given for previous public health experience. Defending its recommendation for licensing, a committee on personnel and training said, "There is no more reason why the degree of Doctor of Public Health should be sufficient to turn a person loose on the public than there is for the degree of Doctor of Medicine to give the right to practice."


Certain basic requirements for public health professionals were set out by the committee, along with a recommendation that a comprehensive study be undertaken of current educational practices in public health. A report was given on university degrees in health granted in the 1920's, and the schools of public health, which had been continuously running advertisements in the Journal, began to list summer school courses.

In 1928, a committee conducted a survey and found that only one out of five health officers in the country was ap-
pointed by a board of health, that the average annual salary was $\$ 4,420$ (though many held medical degrees), and that only 11 per cent of the cities required their health officers to be college graduates. The concern of the members about permanency of tenure was increased when APHA President Herman Bundesen was fired from his position as health commissioner of Chicago by newly elected Mayor "Big Bill" Thompson. Bundesen, well-known and respected for his campaign for


Tobey
pure milk and child and maternal health, had been replaced by the mayor's personal physician.

APHA members were shocked. Protests were received against holding the next Annual Meeting in Chicago as planned, but the Executive Board went ahead, while saying, "It is an affront to the public as well as a potential danger when the health officials are selected solely by the whim of political favoritism."

Several years later, a committee on training and personnel adopted a plan for the registration of full-time execu-
tive officers of health departments. Though the registration did not carry the force of law, the directory of health officers that resulted was a step toward upgrading the profession. In other moves to build a profession where there had recently been none, the Association voted to discontinue the membership of anyone who allowed himself to be quoted or used for illustration in the advertising of a commercial product, and decided also to refuse to endorse any products itself. In 1929, the Association established the Sedgwick Memorial Award for distinguished service in public health. The first one was awarded, unanimously, to Charles Chapin, for his contributions to the development of public health practices.
"The Association is in a better financial condition than at any time in its history, and there is every prospect that it will continue in this favorable position," an editorial in the November, 1929 Journal reported optimistically. There was no mention of the stock market crash the month before, and only a brief lament that attendance at the Minneapolis Annual Meeting was less than expected.

By 1931, the nation was in the grip of the Depression, but the Association was feeling it only peripherally. Addressing the ' 31 Annual Meeting, President Hugh S. Cumming noted that "our Association, in common with all of the social clubs, voluntary and scientific organizations, has suffered both in membership and in the collection of dues as the result of the worldwide economic depression," but he saw no reason for undue pessimism. The Association's yearbook, issued as a review of activities for the first time that year,
reported an actual gain in income and that the financial condition of APHA was "sound".
The Depression may have been the reason for a new part-time executive secretary. Homer N. Calver, who had directed the membership growth and strengthening of affiliates during his seven years as Executive Secretary, resigned in December 1930, and was replaced by Kendall Emerson, who acted simultaneously as director of the Na tional Tuberculosis Society. Some expenses were cut, and APHA employes accepted "serious salary cuts without murmur," according to one APHA official.

In 1930, 150 public health workers attended the first Western Branch regional meeting of the Association in Salt Lake City. Topics included undulant fever, tropical medicine, the recent CAP survey of Honolulu, Rocky Mountain spotted fever, and the public health aspects of Boulder Dam. William C. Hassler, MD, of San Francisco, was elected the first president of the Western Branch and proceeded to quadruple its membership. A prime organizer of the group, Hassler was voted president-elect of the Association in 1931, but died before he could assume the office.

Though APHA was surviving in the lean years, the Depression had a greater effect on public health than on the public health association. Health departments all over the country were suffering from budget cuts, reduction in personnel, and curtailment of projects such as preventive campaigns against diphtheria and typhoid fever. There was a general feeling among the membership that health was not being given the priority it deserved in the hard-hit
government budgets. Widespread malnutrition was feared by health officers and a critical Journal editorial noted, "The depression has caused municipalities to cast frantically about in search of those services which can stand deep appropriation cuts without producing loud protests from the taxpayers. Sewage treatment has somehow filled these specifications ideally."

Doctors, too, were having a hard time of it. Payment of fees was slower, and many physicians were carrying free patients as the number of indigent ill increased. Except for a few, doctors were not enjoying huge incomes, and there was growing unrest in the profession. Some were saying, "State medicine has already gone too far . . . becoming too paternalistic in health matters," referring to the welfare work being performed by the health departments.

Association members continued to press in the political arena for federal correlation of health activities, although APHA President Fuller said the Association "is comparatively weak as a professional society of official health administrators; relatively strong as an association of technical health workers; and practically inactive as a force in molding public opinıon." An APHA committee visited Coolidge in 1926, urging him to lead the move for coordination of health work. Though Coolidge encouraged the group to gather the necessary facts, he vetoed the resulting "Parker" bill because he said it would militarize the U.S. Public Health Service.

With Herbert Hoover in the White House, however, the Association had for the first time a friend and colleague
as president. Hoover had been closely associated with the American Child Health Association, and as Secretary of Commerce under Harding and Coolidge, had been extremely interested in health and child welfare. In 1930, he finally signed the Parker Bill, which improved the internal administration and scope of the Public Health Service.

The same year, the National institute of Health was created by a Senate bill. Continuing his close ties with the As-
sociation, Hoover convened a White House Conference on Child Health and Protection, in which APHA participated, and addressed the Association's 1932 Annual Meeting, receiving members in the White House that afternoon. On the steps of the President's house, sixty years of pressure resulted finally in Presidential recognition of the need for federal responsibility for the health of the people.


## chapter 8

"The major problem before us at the moment is, of course, the damage that has been done to the health machinery of the country by reduction in appropriations, sometimes necessary, more often the result of thoughtless panic and lack of intelligent planning. In many states and cities, the work of a decade has been undone."

## Report of the

APHA Executive Board, 1933

The economic Depression was finally weighing on the Association. "The bare essentials of existence" described APHA's activities in 1932-33, as travel expenses were cut to a minimum, and many of the committees met only at the Annual Meeting. Some office staff members were released, the headquarters space was rearranged and some of it rented out. The next year, as an economy move, the Association moved, with the National Health Council, into Rockefeller Center. Secretary Louis I. Dublin suggested, with Board approval, that some of the more "comfortable" members might wish to pay the year's dues for some who were unemployed and had let their membership lapse.

When the Annual Meeting Program Committee met early in 1932 to make

## rebuilding the health organization

plans for the convention, the outlook, according to a Governing Council report, was decidedly gloomy. Telegrams and letters were being received in the Association office daily announcing the retirement of old friends from official life as a result of political changes and budget reductions. "Everyone responsible," said the report, "felt that the real strength of the Association would be tested this year as it never had been before."

APHA managed to withstand the severe economic hardships. The 1932 Annual Meeting attendance was comparable to past years; the sessions and exhibits were hailed as outstanding. Late in 1932, formation of an APHA Southern Branch was authorized, and an organization meeting was held in Birmingham, Ala., with the Southern Medical Association. Membership was open to residents of the states of the confederacy and of Maryland, Missouri, Oklahoma, West Virginia, District of Columbia, Mexico, Cuba, and Puerto Rico. Purposes of the new branch were to strengthen Southern membership in APHA and to exchange experience and information relative to public health problems peculiar to the South. Later, the Association published the transac-
tions of that first organizational meeting, calling the work "a real contribution to the literature on public health progress in the South."

In 1933, the Western Branch had a balance of $\$ 113.24$. It had no paid employees and its budget represented the single dollar it collected from each person not under the jurisdiction of a western state affiliate. Though all affiliates received a refund of a dollar per member from APHA, and met in a Conference of Affiliated State Societies at the Annual Meeting, their relationships to APHA and to each other were not well defined. Financial restrictions and the relative newness of the affiliates made strengthening them during this time difficult.

Several years later, however, the Executive Board decided to try a plan whereby APHA would provide more affiliate services, such as newsletters, publicity, and programs, in return for the affiliates' promotion of APHA membership. But a requirement that an applicant for Association membership belong to his local affiliate was dropped. "It is evident," said one member, "that affiliated societies have not added considerably to the membership of the
parent Association; in fact, it is difficult to point to any recent increase as a result of state society effort."

In 1935, the Conference of Affiliated Societies debated whether the affiliates should take an active part in shaping city and state health activities. An opinion was expressed that such activities should center on such "impersonal" issues as vaccination, antivivisection, and standard-setting, but should stay out of the internal policies of the health department. Frictions between state and local health departments were noted and "meddling," it was thought, could only make things worse. "Aid when requested" summed up the relationship between the voluntary health organization and official health authorities, it was suggested.

Even the Committee on Administrative Practice, still the Association's "star," was curtailing its activities and staff. The committee reluctantly transferred its field work in connection with the Health Conservation Contest to state health departments.

Lack of money forced George T. Palmer to carry on his work on the revised Appraisal Form for City Health Work by mail. In 1933, the Commonwealth Fund published Allen W. Freeman's work on "A Study of Rural Health Services."

An Executive Board report called for CAP to take a position of leadership in the struggle to restore health machinery. "We are living through a unique period of purposeful social and economic planning and one of the leading features of such a period should be a program providing adequate health protection for the whole American people," it said.

At the 1933 Annual Meeting, the Association approved an "Official Declaration of Attitude of APHA on Desirable Standard Minimum Functions and Suitable Organization of Health Activities." The report behind the unwieldy title called for a full-time trained health officer in each official health organization, and an annual appropriation for official health work of $\$ 1.00$ per capita of the population served. Minimum activities in communicable disease control, child health, public education, laboratory, statistics, and environmental sanitation, were spelled out in an attempt to affirm the importance of health protection in times of economic crisis.

Work was going ahead, despite the hardships, in other areas as well. A Committee on Professional Education was established in 1932 to replace the subcommittee on training and personnel of the Committee on Research and Standards. An Association book, "What to Tell the Public About Health," containing short health talks, cartoons, and illustrations was a surprise best-seller in 1932. The public was evidently receptive to health information, and Dublin, John Ferrell, and both Haven and Kendall Emerson worked on the preparation of 15 weekly five-minute radio broadcasts on health, heard over NBC radio. Later, a radio program was co-sponsored with the Public Health Service. Throughout the 30's, an Association Committee on American Museum of Hygiene saw two health museums (in N. Y. and Cleveland) emanate from its work.
The Association was now in its tenth year as a book seller, maintaining references, and bibliographies for the membership. The Syndicated Public Health Bulletin was dropped from the
publications list, as was the Health Officers Directory, for its "incompleteness," but the sixth edition of Standard Methods of Milk Analysis and the fourth edition of the city health appraisal form were published in 1934, as was a report of the Committee on Sewage Disposal of the Public Health Engineering Section.

As the Association was growing larger, there was greater dissension over the control of its policy and funds, especially as available money grew scarcer. Rivalry between committees over disbursement was present to some extent, but it was the sections that did the most bickering.

Some of the sections were doing highly sophisticated work, while others were struggling to get a quorum of members. Sections were now grading papers presented at the Annual Meetings, and were urged, by the Committee on Publications and Meetings, to grade them more critically, "putting the stamp of approval upon scientific value rather than upon an author's name."

Most of the sections emphasized action and standard setting, taking time out occasionally for events such as the Public Health Engineering Section stag dinner and spelling bee, with the words drawn from "Standard Methods" publications. The Laboratory Section was very active, even asking for a full-time secretary. Standard Methods of Milk Analysis was broadened to include dairy products; studies were conducted on the sanitation of eating and drinking places, dishwashing devices, and typhoid vaccine; and a section resolution requested a central agency to conduct and correlate the results of research into standards of water cleanliness.

The Food and Nutrition Section was becoming interested in more technical subjects, such as dishwashing sterilization, staphylococcus, food poisoning, and metals in foods. Statistics Section members voted to recommend the amendment of the model law for birth reporting so as to omit on the birth record the statement of a child's illegitimacy, while an Engineering Section resolution asked for federal funds to permit the USPHS Office of Stream Pollution Investigation to do what its title implied.

By mid-decade, the Association had to limit, for the first time, the number of sessions and papers for each section at the Annual Meeting. Mazyck P. Ravenel's suggestion that "very few non-members should be invited to present papers" was turned down by Laboratory Section members who felt that the best papers should be secured regardless of the source. After all, some of the most interesting papers in recent years had been those of nonmembers, many of whom had joined after attending the Annual Meetings.

By 1934, the Association was recording its first growth, although slight, in several years. The following year, the Executive Board decided a full-time executive secretary was essential to the Association's permanent growth and appointed Reginald Atwater to replace Kendall Emerson.

This small growth in membership had a definite impact on the sections. Most were prospering, but Child Hygiene Section members seriously debated in 1936 whether or not to fold. So many professions were represented in the section, that it was feared that no Annual Meeting program could capture the diversity of interests. More and
more specialization was occurring in the field, new organizations had been formed, and child health had been absorbed into community health programs. What need was there for a section devoted solely to the health of the child?

Yet, the American Child Health Association had disbanded, a victim of the Depression, and increased federal activity underscored the need for a common forum to exchange ideas about child health. Instead of discontinuing the section, three committees were appointed on adolescence, premature infants, and school health education. In 1939, the name was changed to Maternal and Child Health Section.

New movements were also underway for the creation of mental hygiene and dental health sections. Haven Emerson reported that a Section on Mental Hygiene was justified, but there was some division over whether a sufficient number of people would join it, and it was decided to include the subject in other section sessions. "To segregate dental health professionals in a section of their own," said Emerson, "would defeat to a large extent the purposes which they have in mind."

With the sections prospering and competition growing for members, it was inevitable that they would chafe at the hold of the health officers on the Association. The Laboratory Section led a movement in the mid-thirties to bring about greater proportional representation on the Governing Council and Association committees. In 1935, the Lab Section had 12 per cent of the membership, but only meager representation on most committees and none at all on the Executive Board and Committee on Professional Education.

By 1936, the Laboratory Section reported that representation on the Governing Council and selection of the Sedgwick Award winner had become more equitable. In addition, Executive Board members had agreed that "the affairs of the Association are revolved around a few personalities," and that many younger men should be given a chance to show what they could do.

When the sections were not struggling for more control of the Association,


Victor C. Vaughan
they were frequently squabbling among themselves. It was in the area of standard setting that the greatest rivalries appeared.
Since its formation, the Committee on Research and Standards had stimulated no original research, acting instead as technical advisor and clearing house for the sections. Not only was this a supremely difficult diplomatic task, but the Committee soon announced its intention to place more emphasis on the work of its own subcommittees in formulating standards.

The first inter-section dispute grew out of a quarrel between the Food and

Nutrition and Laboratory Sections over who should prepare Standard Methods publications. As the Association's oldest section, Laboratory had acquired a certain prestige in the field and maintained control over the research committees. Yet, said F. C. Blanck, secretary of the Food and Nutrition Section, "(We are) more truly a Laboratory Section in the food field than is the Laboratory Section of the Association."

Speaking on behalf of his section,

Blanck said it should have more representation on the committees. "Standard Methods," he said, "are not vested in the Laboratory Section (although) this is a point which they have rather widely disseminated." Food and Nutrition Section members rejected a Laboratory proposal that the Nutrition spokesmen report to Standard Methods Committees, to be continued under the jurisdiction of the Laboratory Section. Instead, they said, Food and Nutrition Section should appoint its own stand-
ards committees, and no Association action on standards would be taken until this committee was consulted.

Now the Committee on Research and Standards was forced to act as arbiter in the dispute. APHA's Coordinating Committee on Standard Methods was reorganized, with the proviso that research on food problems other than milk be made the major responsibility of the Food and Nutrition Section. Additionally, fellows on the $\operatorname{CCSM}$


APHA members left cares behind as they set sail in October, 1937, on the MS Pilsudski for a post meeting cruise.
from other sections would be appointed by their own section councils, and not by the Laboratory Section. Though the latter complained, the arrangement apparently satisfied the other parties, and the CCSM reported the following year that jurisdictional disputes between the sections had finally been ironed out.

The Executive Board also voted to insert more flexibility into its proceedings, specifying at the suggestion of Wade Frost that committees, particularly those dealing with standards, be urged to record dissension or file minority reports. The Committee on Research and Standards would be asked to view critically and from the total Association viewpoint, the reports presented to it.

Though all the committees had ambitious plans, they were hampered in the thirties by a serious lack of funds. The Committee on Research and Standards continued to publish a bibliography and abstracts on lead poisoning, and began work on the standardization of the complement-fixation test for syphilis and a cooperative investigation of various types of selected culture media for use in bacteriological tests of water and sewage. But a volume on diagnostic procedures and reagents lay unpublished for years before funds could be found for it, and the committee was unable to perform needed coordination in research problems to follow up on a survey it had taken among the sections and committees.
One of its new subcommittees, however, was able to make its mark under the leadership of Winslow. The Subcommittee on the Hygiene of Housing had in mind a long-range scheme for promoting its objectives. Specialists
were gathered for the subcommittee in such areas as air conditioning, home economics, sanitary engineering, lighting, plumbing, and architecture. Its preliminary findings were presented in "Basic Principles of Healthful Housing" in 1938 under a Milbank Memorial Fund grant.
By 1940, ten subgroups had been appointed on physical engineering aspects, social and human use, and assistance to administrators of public health and housing programs. One of the subgroups, on Effects of Rehousing, completed a study of family morale and other attitudes associated with the rehousing of low-income families under the public housing program.

By 1935, the two-year old Committee on Professional Education was organized well enough to begin to fulfill its mandate of revising the standards of qualifications of public health workers upwards. It published reports the following year on qualifications of public health nurses, engineers, and sanitarians, and, several years later, was instrumental in stimulating a USPHS study, under the direction of Joseph Mountin, on the educational background and experience of health personnel.

At the 1938 meeting, the Governing Council asked CPE to undertake a study of the requirements for public health degrees. The resulting report on "The Educational Qualifications of Health Officers" put the committee on "the threshold of a new opportunity," according to an Executive Board report. "It seems possible that within the next few years the establishment of a list of approved schools of public health would be required by the demands of this rapidly developing situation."

The encouraging outlook for professional health education reflected the impetus given the health movement as a whole by the legislation passed during the first "100 days" of Franklin D. Roosevelt's administration. Coupled with the expanded health and welfare services for the nation was a demand for more health workers. The Association tried to keep up with the need by registering and recommending potential candidates for positions now opening up. Later, CPE was asked to help implement merit system plans authorized by the Social Security Act.

Millions of dollars were now being spent, through local welfare departments, by the Federal Emergency Relief Administration, though APHA would have preferred the money to come through the USPHS and state health departments. A resolution passed in 1934 recommended that one dollar per capita for each unemployed person be made available to local health organizations to meet the emergency situations caused by drastic cuts in city budgets.

The Committee on Administrative Practice saw as its function during this time the restoration of the health officer's budget. Studies on infant welfare and neonatal rates, pasteurization of milk, and laboratory studies on toxoid, scarlet fever, and diphtheria were conducted to point up the importance of these things for the public welfare. Keeping the health promotional activities in the spotlight through the City Health and a new Rural Health Conservation Contest, both sponsored in cooperation with the Chamber of Commerce, were also important to CAP.
What it did not know how to do, however, was confront the question of
medical care and public health.* In 1937, the Executive Board warned that "Those specially concerned with the problem of medical care as a public health function and who are naturally inclined toward the Association as a professional body, find no ready outlet in existing Sections." A resolution passed that year asked that a special committee, subsequently headed by Abel Wolman, be appointed to study public health aspects of medical care and to cooperate with the USPHS and others on the President's Interdepartmental Committee to coordinate Health and Welfare Activities in "extending public health work to meet modern needs, especially those occasioned by increasing importance of chronic diseases as causes of death."

This resolution was the public face of an issue that had been dividing the CAP and the Association for some years-the old question of the relationship of public health to medical care. The essence of the medical care question was brought into the public arena by passage of the Social Security Act.

To insure that the Act's provisions reached the American people, President Roosevelt had appointed the Interdepartmental Committee, assisted by a Technical Committee on Medical Care. Under the chairmanship of Martha Eliot, MD, assistant chief of the Children's Bureau and a moving force in APHA's Section on Maternal and Child Health, the committee depicted a shocking picture of the health conditions of the country.

[^2]Health workers had been guilty of a near-sighted look at the health of the population the committee found. Ravenel, for example, had wondered why the health of the people was as good as it seemed, given the economic conditions of the nation. Indeed, the committee report showed that unemployment, starvation wages, indecent housing, and shocking malnutrition were rampant-far worse than anyone had thought. Its statistics on the number of ill persons in the U.S. showed that the issue of medical care was not and could not be a side issue for health workers.

Though the Technical Committee gave only recommendations for discussion, its suggested program of maternal and child welfare, hospitals, and medical care and disability compensation was met with hostility by established practitioners. At the National Health Conference in 1938, Morris Fishbein, representing the AMA, said the American people were truly healthy and that the U.S. mortality and morbidity rates compared favorably with those of any nation in the world. He and others raised questions of political domination and federalization, which were answered by Drs. Alice Hamilton and Winslow, who said the federal government was not a strange, foreign body inserting itself into the U.S.
APHA's 1938 resolution endorsed the recommendations of the Technical Committee providing federal aid to the states, construction of facilities, and extension of public health services, and further pledged its professional expertise to the government to achieve its objectives.

In 1939, the Wagner bill, amending the Social Security Act to extend medical
services, was introduced in Congress. Several APHA leaders were asked to testify, and did so with varying viewpoints, indicating the division within APHA regarding medical care.

Haven Emerson, like Fishbein, doubted the validity of the Technical Committee's reports. He saw no emergency of ill health and said, "I do not believe it is the function of the state or national government to take care of women in confinement or to take care of babies


Abel Wolman-1936 President
or to take care of other things which are the functions of the practice of medicine and which can be better handled by local communities than by aid from Washington. I believe the most intelligent expenditure of what you might call stimulating money for the
health of the nation would be in the field of prevention rather than in the field of care of the sick."

Abel Wolman, speaking for APHA as its president, said that the Wagner Act was in accordance with the APHA recommendations in "practically all respects," though he agreed with Emerson that the program should be primarily in the hands of the local people, and that the federal government should give financial and technical aid only.
should handle diagnosis and treatment of individuals; to add that role to the health officers' present job would divert them from their true object of "health protection and health creation."
Joseph Mountin, a member of both CAP and the Technical Committee, viewed an expanded role for the health worker far differently. Giving the health officer the techniques for serving indi-viduals--from prevention to cure-was necessary, he felt, to cover the full range of health promotional activities.


Conquest of tuberculosis was a dream of the 40 's and the main goal of this New York committee. APHA members of the coordinating committee included Dr. Edward S. Godfrey (front row, center) and Marion Sheahan (fourth from left).

At an APHA General Session on Medical Care in October, 1939, Emerson reiterated his belief that public health was designed to serve social needs and not personal ones, therefore excluding the care of the sick. Only clinicians

Mountin and Emerson, on opposite sides of the ideological viewpoint, represented a common split among health workers and others, over the far-reaching implications of the entire New Deal legislation.

When, in 1940, the CAP met to discuss charges that it was ineffective and racked by differences of opinion, it could no longer ignore the issue of medical care. A program outlined by Mountin for Michael Davis' Subcommittee on Organized Care for the Sick gave full responsibility to the Subcommittee for further study on the problems of medical care and the role of the health department in administering medical programs. In the next years, the emergence of this committee and its effect on the health administrators was to cause one of the deepest rifts in the history of the Association.

It was 1939, and APHA once again found itself watching as the world went to war. A resolution passed that year said, "We who earnestly seek to eradicate recurring pestilence would now solemnly dedicate ourselves just as aggressively to the abolition of mankind's most devastating plague-war."

APHA, keeping a close watch on the world stage, recognized the impending health dangers much earlier than it had in World War I. In 1940, a committee on public health and the national defense was authorized to periodically review the potential problem areas.

A resolution passed that year endorsed the principle of the selective draft to maintain the flow of necessary personnel into medical and nursing professions, and there was no question that the health of the civilian population was an essential element in the national defense. Government agencies keeping a close eye on developments overseas requested that APHA revise its report on Control of Communicable Diseases in Man, "just in case."

## chapter 9

"Our one first aim is a victory for the United Nations, and to this end, we, as a body of public servants, pledge all the resources of our professional and technical capacities. Any neglect or curtailment of the essential protection of civilian health, whether at home or in the factory or other work place, is inconsistent with maximum efficiency of the military forces."

Declaration of the APHA
Executive Board, 1941

Twelve days after bombs devastated Pearl Harbor, the APHA Executive Board issued a declaration containing a war-time platform for the public health profession. Its greatest concern was the possible neglect of the civilian population, and the drain on an already overburdened public health work force.

Executive Secretary Reginald Atwater noted that the national emergency had become acute and asked for the guidance of the Executive Board: Should the Association be aggressive in response to the situation or should it wait to be called upon?

John L. Rice, chairman of the APHA Committee on Public Health and the National Defense reported that month

## medical care and the war years

that the manpower situation had been canvassed and public health priorities were being well administered. The Committee was asked to stand by, in answer to Atwater's query. The Executive Secretary, commenting on the role of the Association in the war effort, said that it was now obvious "that the design of the Association has become that of a technical society working in and for a liberal scientific movement."

By 1942, the Association could no longer "stand by." Rice reported at the 1942 Annual Meeting that "an acute problem during the year has been the establishment of criteria for those in essential services who should be protected against demands of armed forces for personnel." Further, there was a need for technical information in the supporting war efforts against communicable diseases and environmental pollution.

At that meeting, APHA was completely immersed in the war. Few activities or topics related to anything but the national defense. Like their predecessors 25 years earlier, APHA members were now answering to their military titles as often as to medical ones. But unlike them, Association members were well prepared for the U.S. entrance into the
war and far better equipped to cope with the health problems.

As a technical society, APHA was proving its worth to the world. The whole breadth of its interests was reflected in the titles of Annual Meeting papers, ranging from "Contributions of the Medical Corps of the Army to the Public Health Laboratory," to "Food Handlers in the Army and their Relationship to Salmonella Food Poisoning Outbreaks" (a topic that thousands of Army veterans undoubtedly felt qualified to speak on). Venereal disease was again a huge problem to be confronted, but this time, discussion was on its treatment with the recently discovered (in 1928) drug, penicillin.
The 1942 meeting, attended by many members in uniform, was dominated by talk of the war. The nutrition of a country embarking on war-time rations, the health of young boys found unfit for military service, the well-being of mothers needed suddenly for industrial work-these were typical of the problems faced by the Association.
APHA publications were soon found in the far corners of the world. Both the Army and Navy used "Standard Methods for the Examination of Water and Sewage" and "Dairy Products,"
and "Diagnostic Procedures and Reagents" had been microfilmed and flown to China for use in war areas. The American Red Cross designated "Control of Communicable Diseases in Man" as "an essential item in the equipment of its instructors in first aid. Later in the war, the manual was published by USPHS in Arabic, French, Italian, and Chinese.
In 1943 and 1944, the Annual Meetings were denoted "wartime conferences," but 1945 was the first year in which no APHA meeting was held. An emergency had been declared in regard to the nation's transportation and hotel facilities, and it was suggested that cancellation of large group meetings would relieve it. Though the Governing Council did not meet and elected officers held their positions until 1946, some in the Association met with the Public Health Association of New York City in a 1945 Victory Meeting. To maintain the chronology, the 1946 meeting was designated as the 74th. One area receiving increased public attention because of the war was child health. A 1942 resolution of the Maternal and Child Health Section recommended that attention be focused on the health of children and mothers affected by the drastic changes in American life. As more women were called to work in vital industry, it became apparent that provision for day care centers and personnel were inadequate. In 1943, four APHA sections met in a joint session to develop health standards for such centers.
The study of child care in general was becoming more all-encompassing. A session on a public health program for the care of children with cerebral palsy was well attended. Nineteen forty-two meeting participants were "standing in the aisles" at a demonstra-
tion of the Kenny Method of treatment of poliomyelitis. Work on a survey of state standards-then practically non-existent-for children's camps was begun the following year.

The Maternal and Child Health Section was thriving, but in 1941, it voted against the formation of a proposed Section on School Health, perhaps feeling that the scope of the subject more properly belonged within the existing Section. But a committee ap-
with many of these problems. "The time has come when APHA should properly assume its responsibilities toward the school child," reported the committee. Though competition with the American School Health Association was feared, "the interests of these two groups . . . are so closely allied that the school child will be the gainer," the report said.

Formation of the Section was approved in 1942, with Leona Baumgartner, MD,


Winner of the 1946 Lasker Award, Dr. J. F. Mahoney, in his laboratory. Mahoney is known for his research in the penicillin treatment of syphilis.
pointed to investigate formation of a School Health Section reported that the subject was of interest to many professional people represented in APHA, and that there was no room for specific consideration of the problems of the school-age child.

The expansion of maternal and child health programs in the country was noted, along with the feeling that the MCH Section would be preoccupied
as first chairman. Symbolic of the interest in child health sparked by the war was Martha Eliot's proposal that year that in view of the results of selective service and other surveys, provision be made for health services and medical care to children and youth of secondary school age. As a supplement to the creation of the new Section, a 1942 resolution asked for a special committee to review the medical and dental needs of children.

The following year, a Section on Dental Health was created, culminating a long struggle for recognition. Perhaps prompted by the revelation that the greatest single reason for rejection of selectees at the beginning of World War II was dental disease, the Association not only approved the Section's formation but also issued resolutions calling for a national dental health program, and support for increased dental research and education in health agencies at all levels.

W. S. Leathers

Still another resolution was offered to formulate a program of education of undergraduate dental students in preventive medicine. Later, recommendations were made that the APHA Committee on Professional Education set standards for dental hygienists who would be employed by public health agencies, and a book was written on dental health administration.

Other sections of the Association were
changing their areas of concentration as war-related problems came into focus. Food and Nutrition Section members lobbied for continued enrichment of white breads (as made compulsory by the War Food Administration) and a resolution was sponsored favoring aid to schools to enable them to serve nutritious meals without discrimination between those children who could pay and those who could not. A recommendation was also made by the Section that physicians be given adequate nutrition education.

Laboratory Section members were concerned, in 1943, about the increasingly difficult task of procuring supplies and equipment for their labs. Tropical and other diseases were drifting into the country with returning veterans, and most laboratories were not prepared to cope with them. Section members asked that the Public Health Service be given the authority by the War Production Board to ensure continued supplies, but Section Council members deemed the request "controversial".

The long internal struggle over control of standard-setting continued in this period. Representatives of the Engineering Section spoke up in 1944 for representation in all matters pertaining to "Standard Methods for Examination of Water and Sewage," and representation on the coordinating committee. The same year, the Committee on Research and Standards unofficially adopted the premise that every procedure which it developed as a standard should be accompanied by a mechanism for review, noting Abel Wolman's words that "standards may make for rigidity where there should be flexibility; standards may make permanent that which should be transient."

It was not until 1947, however, that a Coordinating Committee on Laboratory Standards was proposed as a subcommittee of CRS, rather than as a continuing subcommittee of the Laboratory Section, long a sore point with the other sections. The new structure would assure representation of all the interested fields, and decrease the time needed for review and approval.

Not unexpectedly, the Laboratory Section felt there was a potential disadvantage inherent in removing the direction of research and the development of methods from the hands of the Section. The request was made that the Lab Council approve the selection of the chairman of the new committee, a request that was denied by CRS with the assurance that the Section would be consulted on "all suitable occasions."

With the entrance of the United States into the war, still another expert source of APHA was tapped. Under Professor Winslow, in 1942, the Subcommittee on the Hygiene of Housing was working in two areas: completion of the technique for appraisal of housing deficiencies in low-grade urban areas, and the study of principles and practices in the field of housing regulations under the law. Soon, government agencies responsible for the war housing program requested the subcommittee's advice on a revision of standards for war housing, and the development of standards for dormitory types of temporary housing.

Two years later, a successful survey of a 30 -block slum area of Portland, Me., placed the subcommittee under considerable pressure to publish its manual of housing survey instructions. Without a published manual, the sub-
committee could only employ its method where it could personally supervise the survey, a distinctly impractical technique. By the end of the war, widespread acceptance of the subcommittee's methods of appraisal prevailed throughout the nation.

Officials in cities throughout the country were using the survey. The first report on the physical environment of the home was published and the sub-. committee was delving into more spe-
shortages of such personnel at the height of the war and such resulting effects as inadequate maternity care, increased gastroenteritis, weakened supervision of water and sewage treatment, and neglect of industrial hygiene, the Committee said, "A defeatist attitude in the face of these situations is intolerable."

The solution, Committee members said, was to find persons who could be trained to perform public health


The APHA "Western Team" stops in Albuquerque, N. M. Standing (from left) are James H. Steele, W. T. Ingram, C. B. Frasher. Seated (from left) are Allan A. Twichell, Dorothy I. Rusley, and R. M. Atwater.
cific aspects of housing.
A big concern of all the committees, but particularly of the Committee on Professional Education, was the drain on health manpower effected by the military draft. Noting the excessive
functions, while upholding the standards of the profession. It was feared that there would be a tendency to lower educational qualifications because of the personnel shortages, but the Committee decided to "continue to aim at high standards rather than
risk the effects of incompetence if standards were lowered."

Accordingly, CPE continued to publish its reports of educational qualifications of various kinds of health workers. Such reports were issued for industrial hygienists, public health nursing personnel, medical administrators, and school physicians. By 1944, thirteen reports had been issued when CAP chairman Wilton L. Halverson, MD, recalled "the timid approach with which the first report was presented to the Governing Council in 1935 and the controversy which attended its appearance." Halverson noted, as a mark of progress, that the reports were continually reflected in the caliber of health personnel nationwide. By 1947, a total of 20 reports on 15 different professional specialties were in circulation.

CPE-and the Association in generalhad long been interested in improving the quality of public health schools. In 1942, a statement was published in the Journal on "Minimum Educational Facilities Necessary for Postgraduate Education of Those Seeking Careers in Public Health." The report, sent to the deans of every medical college and school of public health in the U.S. and Canada, precipitated a request by the Surgeon General and the Association of Schools of Public Health that CPE undertake a plan for certification of public health courses.

In 1945, the Governing Council authorized the Committee to develop such a plan for accreditation of curricula leading to public health degrees. Winslow agreed to be the consultant on the project, and began mapping out his visits to institutions requesting accreditation. During the following year, ten
schools of public health were accredited to bestow the degree of master of public health, and five to award the doctorate.

In 1944, there were 700 public health trainees in 41 different schools, with at least one offering a degree by correspondence. The majority of practitioners were apprentice-trained. Scarcely three years later, only ten schools were accredited by APHA, and "the next developmental phase," said William P. Shepard, MD, CPE chairman, "if the profession is to grow, is the attempt to distinguish between more competent and less competent members."
Post-war comments by members on the accreditation project included, "university or medical schools now have a yardstick for use in planning these new facilities," and "another debt of gratitude to Professor Winslow." Shepard felt that for the first time, the Committee could "surround the task of professionalizing public health," rather than just confront it. Such activities as disapproving the granting of honorary public health degrees, a report on veterans returning to public health work, and a post-war vocational counselling and placement service were performed by CPE at its peak.

The Executive Board took one of its most radical steps in 1947, when a resolution was passed endorsing equal opportunity for everyone in the field of public health and recommending a program of equal opportunity for employment, professional advancement and salaries in all activities of public health profession regardless of race, color, or creed. Salaries were a particular concern, as they had been for many years, and CPE began work on a
schedule of recommended compensation for public health personnel.

In 1945, the Governing Council approved a plan for the Lasker Awards (endowed by the Albert and Mary Lasker Foundation) "to recognize achievement and stimulate medical research with special reference to those diseases which are the major causes of death." The recipients were described by Wolman as "along the road" rather than at the "end of the road" in their
the Veterans Administration Department of Medicine and Surgery, and the American Academy of Pediatrics.

Another area of concentration for CPE was the state merit systems and development of exams for evaluation of civil service employes. $\mathrm{By}^{\prime}$ 1947, the committee had supplied 295 examinations for such fields as nursing, laboratory workers, and sanitarians. Three-quarters of all the states used the examinations in hiring personnel, and the Pub-

C.-E. A. Winslow and R. M. Aiwater (from left)
careers, and included, in the late forties, Surgeon General Thomas Parran, industrial health pioneer Alice Hamilton, Martha May Eliot, Rene J. Dubos, Haven Emerson, and Marion Sheahan, RN. Groups cited for the award included the National Institute of Health,
lic Health Service adapted it for its own candidates.

The steps toward strengthened professionalism, however, conflicted somewhat with a growing movement toward democratic participation in the affairs
of the Association-not unlike those movements that had appeared during the previous 75 years. Nowhere were these attitudes more crystalized than in the concept of fellowship.

Don W. Gudakunst, MD, the chairman of the Committee on Eligibility in 1941, reported that many civil service agencies inquired of applicants for public health positions "whether they had established their professional standing by becoming fellows of APHA." Commenting on the history of the Association, Wolman said, "Each step has borne a certain similarity to every other in its propulsion of the Association away from public participation in its intimate affairs and into channels where professional thought and action are essential." He said that the layman's great potential contribution was acknowledged by the ease of his acquisition of membership, but "the process of selection which the bylaws provide with respect to fellowship assures the scientific direction of the Association."

It was this process of selection-or more precisely, who was to be selected -that came under fire. While the Health Officers sought to limit fellowship to administrative heads, the Engineering Section, reflecting a general trend of most sections, sought to make itself more inclusive, not more restrictive.

The Maternal and Child Health Section sponsored a proposal in 1943 to remove the fee differential between members and fellows, contending that the higher fee represented a tax for the privilege of becoming a fellow. The proposal was defeated, however, and the matter lay dormant. Dues were finally raised in 1948, from $\$ 5$ to $\$ 7$ for members, $\$ 10$ to $\$ 12$ for fellows, and from $\$ 100$ to $\$ 200$ for life members.

The democratic principles engendered by the war emerged in another area. "It was recognized that public health of the future needed democratic planning and participation rather than the autocratic dictation by government or vested interests of fortified minorities," wrote CAP chairman Henry Vaughan years later. He said that this attitude implied the need for better health departments, medical and dental services -all within the reach of every citizen. "It was suggested," said Vaughan, "that the health officer of yesterday must unshackle himself from the dogmas and heritage of his predecessor and become a leader of the new public health of tomorrow."

In line with this thinking, the National Health Honor Roll was terminated in 1943, and the transition was made to a new program of local appraisals conducted in cooperation with state departments of health. The change was seen as a step forward, as the competitive factor had begun to lose its usefulness as soon as the leaders in each class were definitely established. The new goal was a national reporting area for health practices. Winslow's dream was to establish an area-like that existing for birth registrationwhereby communities could report regularly.

The National Reporting Area for Health Practices was created in 1944, with the data obtained from two years of evaluation schedules compiled by CAP. The resulting "Health Practice Indices" was a collection of 60 charts showing the details of health practices in 134 communities. Both the Indices, largely credited to George T. Palmer, DrPH, and the evaluation schedules were frequently used in the schools of public health.

CAP was determined to establish statistical and scientific justification for the standards they had encouraged. A few areas-scarlet fever isolation, pasteurization of milk, and three otherswere selected for study in an effort to fortify the principles earlier agreed upon by group and empirical judgment.

In 1942, CAP created a Subcommittee on Local Health Units, chaired by Haven Emerson. The subcommittee's


James Stevens Simmons
thesis was that neither federal nor state health services could function optimally unless local government accepted the primary responsibility for vital statistics registration, control of communicable diseases, public health laboratory service, environmental sanitation, maternity and child hygiene, and public health education.

What would be a suitable unit to undertake these functions as minimum
services? Emerson's subcommittee came up with an ideal unit serving no less than 50,000 people, each with a full time medical officer and two environmentalists, and a public health nurse for each 5,000 people. A total of 1,127 units would be needed for the continental U.S., it was determined.
"Local Health Units for the Nation," the report of the subcommittee, was a best-seller after it was published by the Commonwealth Fund in 1945, and had

Territorial Health Officers. Though personnel shortages were a big obstacle, plans were developed to establish minimum basic full-time, medically directed local health services for communities across the nation.

By 1948, CAP noted a more liberal administrative attitude toward consolidation of government units for effective health services. In 1947, representatives of 65 national organizations met at Princeton in a meeting


Abel Wolman and Edward S. Godfrey discuss Association business during an
Annual Meeting.
far-reaching influence. Some states used the report to develop public support for plans to extend health services. Following issuance of the report and Carl Buck's survey of health services in Colorado, for example, Florence Sabin (a later Lasker Award winner) led the movement within the state for reorganization. A conference on local health units was held at the University of Michigan in 1946, co-sponsored by APHA and the Association of State and
whose purpose was to share with the public the APHA effort to blanket the nation with these units. As a result, the National Advisory and Coordinating Committee was established under the National Health Council, and the National Congress of Parents and Teachers ultimately sponsored a federal bill for grants-in-aid to encourage creation of local health services, while other voluntary agencies made the objective part of their programs.

In addition to this major effort, CAP had developed a program for prevention of home accidents-neglected until then-and other areas such as nursing, environmental sanitation, and communicable diseases. When Field Director Carl Buck resigned in 1947, concluding 17 years of service to CAP, he and his associates had made unprecedented progress in upgrading the health departments of the nation. But the full measure of what was yet to be done in far-ranging programs of medical care, epidemiology, and other areas weighed heavily upon the Committee, limited severely by finances, staff, and facilities.

The issue of medical care continued to be a hotly debated one. Michael Davis, chairman of CAP's Subcommittee on the Organized Care of the Sick, had charged the parent Committee in 1941 with the inability to confront or conquer the issue. In 1941, Joseph Mountin outlined a proposal for a reorganized subcommittee, which would be primarily concerned with the problems of public medical service as exemplified by the supervision of care to the medically needy and recipients of public assistance. Other matters to be considered were studies of programs for rehabilitation work, supervision of satisfactory military medical services, and development of an appraisal form of organized medical care.

Many of these objectives were fulfilled between 1941 and 1943, but the small band of medical care advocates were dissatisfied with the scope of the subcommittee. In a move to acknowledge the growing awareness of the issue and of APHA's obligation to meet it, the group was renamed the Subcommittee on Medical Care.

In September, 1944, the subcommittee prepared a preliminary report on the national program for medical care. The report was a comprehensive, longrange and yet immediate plan for the delivery of high quality care to everyone, regardless of financial ability. Recommendations for implementation of the plan were specific, and the services were to be financed through "social insurance supplemented by general taxation, or taxation alone, and the federal government was "to
equalize the burdens of cost in accordance with the ability to pay."

Criticism of the report, one of three presented that year, was, as expected, vociferous. Haven Emerson and Wilson Smillie were strongly critical of the implied federal intervention in the plan, and some feared publicly that medical care was not a legitimate concern of the Association, but after much debate at the 1944 meeting, the Governing Council passed the report as an
official statement of the Association. Atwater noted later that many new applications for membership were received as against two resignations following the distribution of the report, indicating to him "constituted proof that the declaration accurately mirrored the attitude of the great majority of the public health profession."

Under Mountin, the subcommittee continued its activities and tackled new ones. Milton Terris, MD, was ap-


Sir Edward and Lady Daly (at left) and Dr. and Mrs. Harry Mustard at 1947 Annual Meeting in Atlantic City, New Jersey.
pointed medical associate to the subcommittee, and new activities included review of pending health legislation, development of a questionnaire for determining the extent of medical services in local health agencies, and preparation of an addendum statement of policy on medical care. CAP felt the latter was unnecessary, recommending instead that SCMC concentrate on defining the elements of its earlier plan.
Four special study groups were con-
sidering a study of chronic diseases (with AMA and AHA), hospital and health department relationships, the role of voluntary health agencies in a national medical care program, and the intergovernmental relationships in such a program.

In 1948, a committee on the creation of a Medical Care Section was formed, and with the support of such Association leaders as Martha Eliot, Atwater, and Hugh Leavell, the formation of the


Robert F. Shea, Ira V. Hiscock, John L. Snook, and Dr. Floyd Beelman (from left) at the 1949 Red Cross National Convention.
section was approved that year. Those who sought a meeting ground for discussion of common problems in the fields of medical care were successful.

In the post-war era, APHA helped to generate a tremendous new interest in public health. In 1944, a committee was appointed to investigate the development of an international public health organization, and in 1946, many APHA leaders were among the delegates to conferences preparatory to the proposed World Health Organization.

Though the new organization would provide the U.S. with established channels of communication to world health officials, APHA sought to renew its own contacts with Latin American counterparts. Dublin headed a committee to encourage professional relations with these officials, and a new edition of "Communicable Diseases in Man" was issued, with special reference to diseases prevalent in Central and South America.

In the aftermath of Hiroshima, the Association confronted health problems unimagined twenty-five years before. Full support was pledged to measures to bring relief to countries stricken by hunger and disease. A resolution was presented that child health stations be established because of the booming birth rate, and a paper was presented at the 1946 meeting on "The Benefits and Hazards of Nuclear Energy," (retitled at the last moment, "Safe and Beneficial Utilization of Nuclear Energy.") There was no doubt that the Association was firmly in the Atomic Age.

## chapter 10

". . . (T)hose who lie awake at night in fear of federal domination have at the bottom of their minds a different concept of government, which assumes that domination by someone is essential and that such domination can best be exercised by themselves. In a democracy as we conceive it, the government is Our Government. It cannot tyrannize over us because we control it; and we accept the underlying faith of the founding fathers in the ultimate soundness of the democratic process."

Editorial,<br>American Journal of Public Health October, 1949

This editorial, most probably authored by C.-E. A. Winslow, reflected the indisputable fact that federal aid to health was here to stay, and the conviction that it should be increased when possible. It was how to live with that fact that caused concern among some of APHA's members.

The editorial went on to note that since the first substantial federal grants in 1937 for development and support of state and local public health serv-

## entering the atomic age

ices, the increase in state and local funds exceeded the federal expenditures in the field. "Federal grants have not resulted in a decreased sense of local responsibility, but exactly the reverse. They have primed the pump for more and more fruitful drafts on state and county resources."

Attacking the need for health services from another angle, Congress passed the Hospital Survey and Construction Act (known then and now as HillBurton) in 1946, recognizing hospitals as a basic necessity in the public health structure.

What was APHA's role in the newly burgeoning area of public health legislation? It was not going to be a passive one, determined leaders of the Association. Since 1944, the chairman of the Executive Board had been appearing before House and Senate committees on health bills such as Hill-Burton, coverage of the nation with full-time local health units, support of graduate education in public health, and even proposals for national health insurance, although APHA would not endorse any particular bill.

This is not to say that the views expressed by APHA spokesmen repre-
sented unanimity on the part of the members. In June, 1950, Hugh R. Leavell told a House committee that APHA supported President Harry S Truman's plan to create a Department of Health, Education, and Security from the structure of the Federal Security Agency, as indicated in previous Association policy and testimony. However, some Governing Council members felt the plan was unwise, and the Committee on Administrative Practice introduced a motion at the 1951 Governing Council meeting opposing the combined department.

There were clearly two schools of thought on the matter. One segment thought a combined department was better than none, "that in this realistic world half a loaf is better than none and that the half a loaf would be of distinct help in nurturing public health," according to the Association newsletter of 1952. "An equally sizeable segment stood its ground, maintaining that the Association has an obligation to declare its highest hopes regardless of temporary and specific problems and a single federal department of health would do more for the people than one of which health was only a part."

Though a special committee of CAP had recommended the combined agency as more expedient, the parent Committee disagreed, saying, "Public health belongs in the highest echelon of government organization and should have departmental status." Leavell felt it was extremely important that the disagreement within APHA be resolved before an official position was taken, and the motion to oppose the combined department was carried in the Governing Council. In a bittersweet


Hugh R. Leavell
victory for the APHA minority, Congress established the Department of Health, Education, and Welfare on April 11, 1953, 70 years after the Na tional Board of Health was established.

Later that year, the Association of State and Territorial Health Officers issued a statement supporting federal grants-inaid for health, and deploring their current reduction. This led some APHA members to wonder if the Association should not also take a stand on this issue. If so, how? Was it the place of a volunteer agency to play a role in these matters? How could APHA's interests and those of like-minded organizations be advanced, especially in Washington?

As a first step, an ad hoc committee on public health legislation was formed with ASTHO. The following year, Herman E. Hilleboe, MD, reported that as a result of stepped-up activity by the committee, federal funds for grants had been restored to the states, as had some funds for venereal disease control. APHA members expressed their support during this period for a stronger voice for APHA in the health legislation process, and for Hilleboe's suggestion, as recommended by ASTHO, that a part-time representative - "someone officially recognized by both Associations as a Washington watchdog"-be appointed to act jointly for both groups.

By 1956, APHA components were reviewing in depth such pending legislation as the Hill-Burton Expansion Act, Vocational Rehabilitation Amendments, and Social Security Amendments of 1954. Roy Morton, Executive Board chairman, noted in 1956 that Congress had appropriated $\$ 3$ million for training public health personnel-a milestone for the profession. But the need still existed, Morton said, to make public health careers attractive to young people.

This had been a problem for some time. At the 1948 meeting, the Governing Council passed a resolution that APHA plan and establish an intensive national program of recruitment, anticipating a serious shortage of personnel as federal programs expanded. The following year, vocational pamphlets on opportunities for engineers, sanitarians, laboratory workers, industrial hygienists, and other professionals were distributed to students by the APHA offices. The Committee on Professional Education proposed a program of research and planning and active recruit-
ment to be conducted with ASTHO and other agencies and groups. The plan was approved by the groups, but some state health officers objected to the costs involved and it was never really implemented. A clearinghouse for job openings and candidates operated by the Association, however, continued to be the source for public health personnel.
The concern about acute shortages of personnel led to discussions on the role of non-medical administrators in the public health field. CPE spent considerable time discussing whether health officers should be required to have a medical degree. The ultimate decision was to continue the APHA standwhich concurred with that view-while adding a statement that the medical administrator's time could be better utilized by employment of trained administrative assistants.

The Committee continued to accredit the schools of public health, but flushed with its success, began to formulate a more definite philosophy. The Committee's role, said its chairman in 1953, was not to set rigidly uniform standards, but to serve as a stimulus for improved teaching, research, and experimentation in finding how best to integrate the various health disciplines into a whole. Two years later, the committee acknowledged that some felt the accreditation program was merely a policing function, but quoted the Association of Schools of Public Health as saying, "APHA has brought full statesmanship to bear on the evolution, growth, and development of graduate education in public health-far more than minimum standards of curriculum and admissions."

One of CPE's greatest areas of activity
was its Merit System Service, which had been set up in 1941 in response to requests from federal agencies as they sought to implement the 1939 Social Security Amendments. In 1951, the project's name was changed to Professional Examination Service, reflecting its expansion from the narrow area of merit systems in government to all health disciplines and employers. By 1951, the PES budget was the largest of any single project in the Association, and by 1955, PES was wholly feesupported. Exams had been provided for, among others, the American College of Hospital Administrators, Na tional Board of Veterinary Medical Examiners, and, on an experimental basis, some state boards of physician examiners. The 1953 Executive Board report to the Governing Council credited PES with changing the picture of health by taking personnel selection out of the political arena, as well as out of the area of subjective judgments, and by helping to set objective personnel policies.
Now that the mechanisms for accrediting personnel were well-established, all that was needed were the people for the jobs. CPE proposed a three-year study to determine why people choose public health careers. The study, headed by John Venable, MD, was to make full use of the then-current fascination with the behavioral sciences.

This fascination was reflected in virtually every aspect of the Association's activities. "A major public health goal is directed towards influencing people to change their behavior in order to reduce the probability that they will contract disease or spread it," Roy Morton wrote in 1955. A new committee was formed with the American Anthropological Association, the Amer-
ican Psychiatrists Association, and the American Sociological Society to provide an interdisciplinary channel of communication between public health and the behavioral sciences.

Mental health activities were becoming an increasingly large part of government budgets, with costs running into the millions of dollars. Both CAP and CRS were looking into evaluation and research, and Thomas R. Hood, MD, secretary of the Kansas State Board of Health, suggested that APHA define who should be responsible for mental health programs in state governments. Atwater said the Association should be a spokesman for the trained public health worker trying to enter the mental health field.

This interest in mental health gave impetus to the movement within APHA for a Section on Mental Health. John D. Porterfield, MD, chairman of a committee investigating formation of such a section, told the Governing Council in 1955 that, as yet, no major professional organization based on a multidisciplinary membership had undertaken an attack on the public health problems involved in mental health. There were still relatively few mental health workers with public health training and those members interested in the field felt there was no recognized home for them within the Association. The motion to create the Section was approved unanimously, and Porterfield was named its first chairman.

The new Section was the first one created since Medical Care was established in 1948. Never in the Association's history had a section grown so quickly, with Medical Care members totalling 1,000 within a few years. Recalling the early years of the Section,

Milton Roemer, MD, pointed out that the common view in public health circles then was to regard medical care as a political matter only. This view, he said, was soon dissipated by the quantity and quality of scientific papers on medical care problems. Roemer felt, as did others, that creation and growth of the Section helped legitimize the field, though the issue was still a controversial one in the conservative early Fifties. That it was also a strong force in the re-evaluation process that character-


Martha May Eliot
ized APHA during this same period is undeniable.

Members of the Section were bringing their talents to in-depth studies of various aspects of the field. As early as 1949, Richard Weinerman, MD, suggested that the Public Health Service take steps necessary to convene conferences for discussion of regionalization of medical services.

While the Section was seeking to establish its reputation in the field, its pred-ecessor-the Subcommittee on Medical Care of CAP-continued to conduct research and issue statements. A 1949 Statement on the Quality of Medical Care, published in the Journal, showed
evidence of a stronger concern for the quality of care than for its costs.

Though the subcommittee may have seemed conservative to its offspringthe Section-it viewed the whole issue of medical care quite differently than did other organized health groups. In 1949, APHA proposed a National Conference on Medical Care to be sponsored by itself and AMA, AHA, and the American Public Welfare Association. Such matters as planning for the care of the chronically ill would be discussed, with the purpose of determining areas of agreement and clarifying disagreements. "It would seem highly unfortunate if controversies based on differences of opinion over a few aspects of the overall problem of the nation's health should be allowed to overshadow the many points on which these groups are in basic agreement," said Leavell, who was then chairman of the Executive Board.

The following year, Wilton L. Halverson, MD, on behalf of CAP, proposed that a statement be adopted by APHA reaffirming a 1944 statement on "Medical Care in a National Health Program." The resolution, approved unanimously by the Governing Council, left no doubt that medical care was an integral part of a health program and the health association. Contained in that statement was APHA's conviction that its primary interest was in the ready availability of high quality, adequate quantity medical care for the people and that the Association did not advocate any one method of financing.

The National Conference on Medical Care eventually became a permanent Commission on Chronic Illness, which, though it lasted less than ten years, was extremely influential. Though the

Subcommittee on Medical Care issued statements with other organizations, and conducted research, its stimulus of the Commission was probably its single most important contribution before its demise in 1957.

Another committee which had succeeded in achieving its objectives by narrowing its scope to very specific problems was the Association Committee on Child Health. Composed of representatives of more than half of the
grams for handicapped children, with a subcommittee headed by Mayhew Derryberry preparing reports on cerebral palsy, cleft palate, and hearing and vision defects. In 1954, Samuel I. Wishik, MD, chairman of the Committee, reported that seven years of work were finally bearing fruit with the impending publication of 12 books; the first, "Health Supervision of Young Children," was already in production, and the eleven others, on handicapping conditions, were soon to follow.


Mary Lasker presents 1952 Lasker Award to C.-E. A. Winslow.
sections, the committee collected statements on recommended practices in public health for children. One of its main areas of concentration was pro-

APHA's established forums for presentation and discussion of ideas-the Journal and the Annual Meeting-were the vehicles for communication of one
of the most important scientific discoveries of the 1950's. In November, 1953, an article by Jonas Salk appeared in the Journal on "Principles of Immunization as Applied to Poliomyelitis and Influenza," followed by further articles in 1954 and '55. The National Foundation for Infantile Paralysis "scoured APHA offices for stray copies [of reprints] to meet the demand of medical students." In May, 1955, Salk summarized the performance of his vaccine, and later that year, he appeared at an Annual Meeting sympo-sium-moderated by Malcolm Merrill -on the practical experiences with the vaccine. The following year, the Association's new newsletter "This is the News" looked forward to a year "in which not a single case of polio is reported."

In these years, the committee chairmen's reports could barely touch on all the activities being conducted throughout the year. The weight of administrative responsibilities-for staff and mem-bers-bore heavily upon the Executive Board, which occupied itself more and more with the "business" of running an Association.

There were new publications appearing and old ones being revised. The Committee on Research and Standards prepared a "Glossary of Water and Sewage Control Engineering" with three other organizations in 1949-the same year that friends of Haven Emerson celebrated his 75th birthday with the presentation of the seventh edition of "Communicable Diseases in Man," which had been under his direction for 32 years.

A new Subcommittee on Air Sanitation was interested in the use of glycols as air disinfectants, and the new edition of
"Standard Methods for Water and Sewage" contained techniques for the determination of and isolation from water of "nuisance" organisms. Other activities of the Coordinating Committee on Laboratory Methods included consolidation of previous reports on shellfish, and publication in 1948 of "Diagnostic Procedures for Virus and Rickettsial Diseases," one of the first books to be published on laboratory methods in virology.

Though CRS was less than fully successful in stimulating research on the part of the sections-one of its original purposes-Leavell noted its accomplishments for the outside world. "Standard Methods" publications, he said, had provided a mechanism for unifying laboratory and health department practice among the states, and created a strikingly similar routine despite the absence of any national plan for compelling uniformity.

Other activities included a new Subcommittee on Chemical Poisons, which was working for establishment of poison control centers throughout the nation, and the continuing work of the Subcommittee on Hygiene of Housing. Several of the latter's publications were issued during those years, including a monograph on "Housing for an Aging Population," and in 1952, the subcommittee published a guide for cities to formulate a model code "with the force of law" for health officers to regulate housing. "It has become obvious," wrote the chairman of the Executive Board in 1953, "that health officers have responsible administrative roles to play in the elimination of the more serious health hazards associated with sub-standard dwellings."

This was one of many roles being con-
sidered for the health officer to play by the Committee on Administrative Practice. A major project in 1949 was the study of health administration in state departments, to define basic needs for personnel, funds, organizations, and functions. Under its new chairman, Ira V. Hiscock, CAP began setting up closer ties with the Committee on Professional Education to discuss manpower and recruitment, and planned new studies on chronic disease and rehabilitation.
The Subcommittee on Public Health Nursing cosponsored a statement on "Public Health Nursing Responsibilities in a Community Health Program" in 1949, and a Task Force on Radiological Health was established under Daniel Bergsma as chairman in 1956. The whole environmental sanitation horizon of the health department was expanding. Not only were water, sewage, and communicable disease control among the functions of the health department, but city planning, accident prevention, illumination, air pollution, and industrial hygiene had also become departmental responsibilities. Nutrition, a relatively new function for the health officer, was recognized with the appointment in 1952 of a Subcommittee on Nutrition Practices, which published a manual of "Nutrition Practices" as a guide for other members of the public health team.

In 1952, a serious rift among the health officers appeared, reflecting the impact of the new directions APHA was taking toward expanded roles for health workers. A new organization, the American Association of Public Health Physicians, was proposed by some medical officers, who said they did not wish to hurt the Association, but felt the need for a new group "because of the nature of

APHA." What they meant by this was not clear, but the wish was expressed for a closer relationship between private practitioners of medicine and practitioners of public health. Leavell, strongly expressing his thoughts, said the Executive Board was quite concerned that it would lose the health officers' leadership. "Public health work is teamwork," he said, "and the leader of the team should not just go home if the game is not played to his satisfaction."

The Health Officers Section issued a statement that it was "not in a position to support or oppose" formation of AAPHP, and in 1955, the Section opened its membership to any applicant expressing a "particular interest in public health administration."

The Section's action was another in the trend toward more participation in and democratization of the Association's rule-making bodies. Amendments were introduced in 1949 to allow mem-bers-not just fellows-to vote for elective officers to the Governing Council. Proponents said the adoption of the amendments would give members a greater sense of participation, and was in accord with the democratic principles the U.S. had fought for in the last war. The opposition said the move would reduce the desirability of becoming fellows, and the lack of any professional requirements for members might "impair the quality of fellows elected to the Governing Council."

The Governing Council approved the changes in 1949, but the fellows voting on the amendments at the meeting turned them down. That year, however, a mail vote was extended for the first time to all fellows, to take effect in 1950. The amendments were sub-
mitted for a vote again that year, and with the blessing of Vlado A. Getting, MD, and his Committee of Eligibility, the amendments passed. Though members still could not hold office or a seat on the Council or vote on amendments, they at last had the opportunity to vote for the one-third of the Governing Council which was elected.

But there were soon more changes to come. The year the vote was extended, 61.9 per cent of the membership worked in government, with 11.4 per cent in university positions. More than one-third were physicians by profession, and one-sixth nurses. Total membership topped 12,000 , with approximately one thousand members estimated to be active in Association positions or committees. By 1953, there were 60 staff members, and 4,137 con-vention-goers attended the Annual Meeting. As the organization grew larger, procedures became more formalized and there was increased concern with the mechanisms by which the Association functioned.

Writing several years later, Leavell said the Executive Board was unable, in 1949, to state to its own satisfaction the objectives of the Association in a rapidly changing and expanding public health world. A critical look at APHA was again needed, as it had been many times before in the Association's history.
A special committee was established in 1951 under Lowell J. Reed, MD, to review the structure, operation, and goals of the Association. The committee reported that year on a variety of recommendations, but as the Executive Board commented, "To date there is unanimity on the idea of the Association being primarily a professional
association. Beyond this there are wide differences of opinion."

Questionnaires were issued to the members, most of whom felt the issues should be narrowed. When the replies were analyzed, it seemed that the great majority did indeed want the Association to remain a professional society with its core activities continued. "No one would change its basic character to an organization with a membership preponderantly non-professional, [though] some see the participation of non-professional persons as essential in advancing public health, accenting the word 'public,'" reported the Executive Board. Ninety per cent professional to ten per cent non-professional would be a good ratio, most thought, with control in professional hands essential. Uniform dues-for fellows and mem-bers-were also favored.

An informal group within the Association thought the Board's attempt to find out the members' views was commendable, and that satisfaction with the character of APHA as a professional society was fairly general. But, they pointed out, studies did expose large areas of dissatisfaction, and the Board should involve the maximum number of members in evaluation activities, by other means than "shot-gun questionnaires." Though there was primary agreement on continuing core activi-ties-the meeting, the Journal, review of standards, and liaison with other organizations-there were two major problem areas. One was the differential between fellows' and members' dues, and the other was the whole matter of affiliates.

An ad hoc committee on fellowship, membership, and dues, headed by George T. Palmer, was appointed to
study the philosophy of the system. In 1953 the group's report was adopted, recommending that student membership be established (without vote); fellowship be retained as a recognition of professional status; membership be opened to those merely interested in public health work, if not engaged in it professionally; members vote on constitutional amendments if passed by the Governing Council first; and the dues differential be dropped, beginning in 1956.

The other major problem was the Association's relationship with its affiliates. Though the mechanisms for their establishment were well-defined, the provision of services for and by them were not. In 1951, Myron Wegman, MD, as chairman of a reference committee on affiliated societies, noted the feeling that the rebates given to affiliates should be used instead to provide services directly to the state societies. It would be easier to give assistance on meetings, publications, membership recruitment, and other services, it was felt, from a strong central office already in existence, rather than trying to build up these services in each affiliate. In any case, the strengthening of the state societies was of highest priority.

The Wegman Report, as it was known, was considered controversial by some because it was thought to imply that regional branches were not essential to the Association structure. "While there was no disagreement in the call for strengthening and creating new affiliates," Wegman recalled, "and little disagreement about modification of relationships of public health associations of neighboring countries, there was sharp controversy over that implication."

Western Branch had repeatedly asked for funds to increase their services, and the request had been repeatedly denied by the Executive Board, though it concurred in the need for the expenditures. In 1955, another committee was appointed to study the relationships between the parent organization and its affiliates, and staff and officers began to travel more to the states in an attempt to improve the lines of communication. The first real strengthening of the affiliates did not appear until the
of strategic character that will give direction and orientation."

Atwater went on to present some provocative questions on the role of the voluntary health movement, the role of the government in a democracy in meeting the health needs of its people, and the role of the health department regarding medical care. He thought the country needed a forecast "as pregnant for the next 100 years as was the Shattuck Report in 1850."


President-elect John W. Knutson and President Ira V. Hiscock chat during the 1956 Annual Meeting.

Association began one of its most serious and historic evaluations in 1955, though some said the process began in 1949.

At the 1954 Annual Meeting, Executive Secretary Atwater presented a preliminary outline of a long-range project he dubbed, "Where Are We Going in Public Health?" "There is lacking in the U.S. a well-accepted sense of direction among those responsible for planning in public health," he said. He noted a tremendous expansion of public health activities in the past 40 years --"yet there is missing an over-all plan

A group of leaders within the Association took up the challenge. Ruth Freeman, RN, called for a large planning group, with materials prepared and returns analyzed by experts in the same manner as for White House Conferences. Long-range planning and a short period of implementation were foreseen, with a minimum of two years of study and several hundred thousand dollars needed. At the 1955 meeting, the theme of "Where Are We Going in Public Health?" was greeted enthusiastically, and a task force was appointed to answer the question.

## chapter 11

"Health agencies must find ways of drawing the public closer in the process of determining issues that affect the whole community. . . . More extensive employment of citizen advisory groups would contribute immeasurably to currently operating programs."

> Report of the APHA Task Force Arden House Conference Oct. 12-15, 1956

These words, written years after Association leaders first battled over how large a role the public should play in determination of its health care, were symbolic of how much the health care scene had changed in just a few years.

The 1950's had witnessed great social and economic changes which could not help but affect the way the public viewed medical and health issues. A 1958 statement on "Balanced Activities for APHA" noted these changes and their impact, particularly on personality development and family life. Americans were caught in a "total changing environment," with its situations of stress and anxiety arising from international tensions, from increased automation in business, and from the threat of the nuclear bomb. No health care

## building new foundations

system of the 1930's could cope with such developments as the first com-mercial-scale operation of a nuclear energy power plant and the first successful launching into outer space of "a series of man-made contrivances now traveling in orbits about this planet," as John D. Porterfield noted.

There were great changes in the living habits of the population-changes that occurred much faster than health departments and services could adapt. Rural populations declined, as masses of the young fled to the cities and created the new phenomenon known as "urban sprawl." In general, there was increased emphasis on attaining health in full measure rather than mere control of certain diseases. Herman Hilleboe had noted in 1956 that with the threat of communicable diseases lowered and tremendous achievements made in child care, the public health work of the future must deal more and more with mature persons. "Our public health programs must encompass the degenerative diseases and the longterm illness," he said. "We cannot delay longer, or we will be hopelessly overwhelmed."

It had been apparent to many that the dizzying speed with which changes
had occurred in the health field was also rendering the Association's structure to deal with them outdated. When an overhaul was contemplated publicly at the 1955 meeting, the membership had been enthusiastic. An Association task force, headed by President-elect John Knutson, was appointed to formulate a statement on new directions in public health. Its charge was to recommend a program through which the Association could expand its leadership and service functions, to recommend a financial structure to support this program, and to involve all Association components in its development.

Meeting at Arden House in Harriman, N. Y., in 1956, the task force utilized many of the reviews and studies conducted in the previous five years. Hammering out the details in that short period, the task force emerged with a three-part report. In general, the report urged the Association to be more active in improving the supply of public health manpower, including the encouragement of more imaginative utilization of personnel of all kinds; to provide leadership and consultation in the fields of public health administration, environmental protection, chronic diseases, and mental health and medi-
cal care; to assume a more aggressive role with regard to public health legislation; to improve its professional and public relations; and to strengthen its components, such as sections and affiliates. To finance this increased program, a dues increase would be necessary and a new category of member-ship-agency members-should be established, the report noted.

At the top of the proposed new structure was a Technical Development Board, composed of the chairmen of committees and six fellows from six different sections. It was TDB's function to review and coordinate activities and prevent duplication, overlap, and fragmentation among the work of the committees. Six standing committees were named on evaluation and standards, professional education, research policy, public policy and legislation, and affiliated societies and branches.

Though the task force was cautioned by the Executive Board to consider the implications of the elimination of the Committee on Administrative Practice - "the name having become in 30 years a virtual trademark"-the death knell for CAP was sounded with its functional replacement by TDB. Martha May Eliot was named the first chairman of TDB, and immediately made clear her feelings that "the new board must act as a board and not as chairmen of committees, each supporting his own area; it must act as a unit responsible for overall planning in program areas."

These program areas were to encompass the problems health workers considered to be most pressing. In 1959, the Association queried 100 state and local health department directors, and discovered additional mental health services to be on their "most wanted list," with radiological health seen as
the most important problem on the immediate horizon. The directors felt the most important achievement of 1958 was the progress made toward eradicating poliomyelitis, with the extension of state and federal support for training health personnel a close second. Recent progress made in the investigation of cancer, heart disease, and other chronic diseases was hailed, but the public health movement was chided for its failure to address itself fully to the problems of aging, accident
prevention, "urban sprawl," and comprehensive medical care for the indigent.
At about the same time, eight program areas were assigned-on accident prevention, chronic disease and rehabilitation, public health administration, medical care administration, mental about the new deal in the Association," he said. After the flurry of the task force report, then what?

In its first year of operation, the Tech-


APHA President Malcolm Merrill (left) greets California Governor Pat Brown and President-elect Marion Sheahan during the 1960 Annual Meeting.
nical Development Board had established work parties in the fields of chronic alcoholism, health services in case of community disaster, and control of staphylococcal infections, with the sole purpose of working out recommendations for Association action. By 1959, the program area committees were planning publications on accident prevention, child health, chronic disease and rehabilitation, radiological health, a medical care study prospectus, and a mental health guide.
These were some of the byproducts of the task force's plans, but they were not achieved without tremendous struggle. Substantial changes had been recommended and implemented, many of them immediately, but a number of questions had yet to be answered. What, for example, did the titles of the committees represent? What were the jurisdictions of PACs? Some of their functions overlapped those sections, and there was concern that new talent in the sections was not being given the opportunity to express itself.
It was clear during this "shakedown" period that many specifics needed to be worked out. Some components of the Association not directly changed by the Arden House Conference were nevertheless affected by the structural changes, and new ways had to be found to deal with nearly every phase of Association business.

Affiliates, for example, had barely been mentioned in the Arden House Report, with the explanation that an Association committee already existed to deal with changes in their structure. Not completely satisfied with the report, an ad hoc committee on affiliates recommended a system of a fully elective Governing Council, with representatives from affiliates on a proportionate
basis, thus reducing the number of councilors at large. The affiliate committee, possibly anticipating the requirement that 75 per cent of the APHA membership residing in a state belong to its affiliate, suggested that an additional class of associate membership be established at a reduced fee for public health workers in low income brackets. The committee also recommended that the basic function of the regional branch be the convening of periodic scientific or professional assemblies and the review of regional problems. There was little feeling that the branch should serve as an administrative arm of APHA or duplicate its services in any way.
In 1957, Malcolm Merrill, as chairman of the Committee on Affiliated Societies and Regional Branches, noted the reversal of the concept of affiliates looking to the Association for services and leadership. Now a reverse structure was sought, with the state association helping its parent: providing grass roots leadership and initiating rather than just receiving. Merrill also spoke of reversing the "present truncated cone pattern so that a solid base is obtained."

Meeting the commitment of strengthening affiliates and branches seemed in large part to mean that APHA staff and officers attend numerous affiliate meetings. But in 1958, a Western Regional Office opened in San Francisco, and there were plans to develop the Washington, D. C., office into a southern regional branch office. In 1959, the Western Office initiated its program of continuing education for its members, in connection with the University of California School of Public Health. The program was billed as a variety of courses for professional and technical
personnel who had received previous academic preparation for a public health career. In addition, an Institute on Association Management-a forerunner of presidents-elect meetingswas begun in the Western affiliates and extended to the south to give new officers a working knowledge of the parent organization and its policies.

The Arden House task force report also had its critics in the sections, though there the criticism was more oblique. The Executive Board had rejected a task force recommendation that sections be reoriented into program areas rather than professions. Instead, the program area committees were established, but the question of their jurisdiction in relation to the sections was a sore point for several years. For example, a TDB report on medical care was criticized by section leaders for its clinical and re-search-oriented approach, rather than its consideration of administrative aspects which, it was felt, was APHA's strength. The problem was one of emphasis, and Milt Terris, for one, was concerned that the program area committees were not studying specificenough areas, and therefore were ineffective in providing leadership.

As to the composition of the committees, there was fear that appointment to committees solely on the basis of section representation without regard for technical competence would eventually "weaken" Association publications and committee work as a whole. The unspoken concern seemed to hover over the standard-setting committees. In 1958, a Committee on Committees was appointed to broaden the base of information from which members could be selected for work groups. This committee was expected to have at its fingertips a pool of ex-
perts, particularly new talent heretofore underutilized in the sections.

If the Technical Development Board knew where it wanted to go, but was having trouble getting there, it shared a great deal of bewilderment with the health movement in general. It had been 12 years since Haven Emerson had published his book on local health units, and the enthusiasm that had greeted the concept of a powerful health unit had subsided considerably
by 1957. It was thought that perhaps too much emphasis had been placed on the structure of such a unit rather than on the services it would or should provide. The 1957 Annual Meeting was devoted largely to a discussion of what community health services were needed and desired, and then finding the best structure to provide them.

Community surveys were still being undertaken by an Association staff of consultants, with more requests made
than could be filled. But a Journal editorial in 1957 noted a "groundswell of unease" and dissatisfaction with the current health structure-or lack thereof-and its inability to cope with the pressures of economic and social change. Association leaders were urging health administrators to welcome new programs and ways of doing things.

Michael Davis, writing in the Journal in 1957, warned that, "to meet the


Legislative liaison Noble Swearingen discusses health legislation with (left) Rep. Melvin Laird (R-Wisc.) and (right) Rep. John Fogarty (D-R.I.).
demand of Americans for access to the full benefits of modern medicine, our society must have administrative as well as professional agencies." These would be public health agencies, provided that "public health officers seize opportunity and responsibilities and do not shun them. If many do shun them, then our society will set up new agencies to do the work required. Under those conditions, health departments could be bypassed and perhaps become bureaus within state and local
departments of welfare."

The 1956 task force report had reaffirmed the belief in the responsibility of the community for health services, with one of the essential ingredients in a successful program deemed to be "community wide organization and planning of health resources which take into account the importance to health of the social and economic aspects of daily living." APHA members watched carefully and supported the

1961 Health Services and Facilities Bill which authorized funds for community health departments, home health care, nursing home construction, hospital grants, and, most interestingly, "pioneering health agencies."

Under this act, the largest single grant was awarded to APHA in 1961 for establishment of a National Commission on Community Health Services. The commission, cosponsored by the $\mathrm{Na}-$ tional Health Council, conducted a sur-


Edgar Bronfman (far left), president of the Samuel Bronfman Foundation, congratulates winners of the first Bronfman PrizesDrs. Marcolino Candau, James Perkins, and James Watt-during APHA's 89th Annual Meeting.
vey of community health services in which attention was directed to improving planning and delivery of health services, with full regard for the impact on health of increased population, differences in the make-up of the labor force, and redistribution of population.

Studies were conducted on both the national and community levels over a period of four years, by its Community Action Studies Project and National Task Forces Project. Its series of reports, such as "Health is a Community Affair" and "A Self-Study Guide for Community Health Action-Planning," were notable for their emphasis on what needed to be done rather than on how much the federal government should spend, and are still in wide use today.
In 1959, an APHA policy statement declared that the public health department was the logical agency to administer medical care. Four years later, another statement stressed that traditional public health services were generally available for communities rather than for individuals on a personal basis. These services were still needed, the statement said, but were no longer sufficient to deal with major national health problems. An increase in individual medical services was proposed through the establishment of community health service centers to coordinate preventive, treatment, and rehabilitative resources. Ideally, the health department, in cooperation with hospitals and private practitioners, would coordinate these centers, and the health officer would be the unifying influence for the overall community effort as "the personal physician is the unifying influence in relation to the individual patient." A major emphasis throughout this statement and two accompanying
ones was the need for health departments to assume the leadership role in community planning, and the importance of local groups having a voice in the determination of policies.
There were other things on the collective APHA mind. The task force report had opened somewhat the procedures for Governing Council meetings, but at the same time had tightened the resolutions process. There were definite guidelines to follow now, with recommendations for action requested, and public hearings held, before Governing Council deliberations on the resolutions took place.
In 1958, as a fairly representative year, there were resolutions supporting nursing homes, calling for public regulation of the health insurance industry, urging a five-year U.S. census and behind-thewheel driver education, seeking comprehensive vector control programs, and endorsing federal grants for day care for children.
A 1959 policy statement recognized the emerging problem of population increase, and called for "freedom for all to use such methods of family size regulation as are consistent with their creed and mores." Planned Parenthood Association, Inc. awarded APHA a grant in 1963 for a study to determine the extent and content of birth control services and counseling available in hospitals and clinics, for those who could not readily secure them privately. Methods of reporting such services were also to be developed and tested. About the same time, Milbank Fund gave a supporting grant for the family and population-planning activities of the Maternal and Child Health Section.
In 1959, Food and Nutrition Section members were congratulating them-
selves on passage of the Food Additives Amendment Act, which carried out the intent of a Section resolution of 1949. A statement issued in 1957 on poultry inspection noted that over 30 per cent of cases of food-borne diseases were associated with the consumption of poultry, some because of salmonella, and urged stricter and more uniform inspection procedures.
APHA was also becoming more active in the planning and implementation of White House Conferences, both on children and on problems of the aged, sending more members officially and as representatives of other groups. In 1963, the Department of HEW awarded the Association a "substantial" grant to produce "A Guide to Public Health Control of Alcoholism," undertaken by a program area committee which noted that the level of public health services for alcoholism was far below that of other chronic disease services. And in 1964, APHA became a charter member of the National Interagency Council on Smoking and Health.

The Association began to take stronger stands on discrimination, reaffirming and expanding on earlier positions. In 1959, the Mental Health, Maternal and Child Health, and Medical Care Sections urged that an ad hoc committee be formed to implement APHA policy on racial integration in health services. The resulting statement urged that the Association request from its affiliates an analysis of the current situation in their states. A note of caution was injected with the statement that many other interrelated fields would come into focus in such a survey, but that any attempt by APHA to exercise the dominant role on the integration issue in those fields would be ineffective and inappropriate. Prior to the 1962
meeting, held for the first time in 25 years in the South, the Association newsletter reported, "We are happy that all our listed hotels in Miami Beach assure us of the same courtesy in the same facilities for all delegates and their families regardless of race."

The 1950 's also saw a resurgence of interest by APHA members in international health. Martha Eliot, for example, had resigned as associate chief of the U.S. Children's Bureau to become assistant director of the World Health Organization in Geneva, and had been among those responsible for the organization's planning. Interest in the health conditions of other countries had been stimulated, of course, by the war and the increased mobility of persons from country to country. Under a plan shared by APHA and the International Cooperation Administration, public health workers from other countries joined the Association, and a few attended the meetings.

Charles G. King had recommended strengthening APHA's international relations with other organizations, though Merrill said his committee should "get its own show on the road before taking a stand on the foreign problem." By 1959, however, the Program Area Committee on International Health thought it desirable to establish liaison with foreign public health associations as a preliminary step towards formation of an international union.
"Public Health is One World" was the theme of the 1959 Annual Meeting, a conception of Leona Baumgartner's that was greeted enthusiastically by the members and the 87 international visitors, many of whom "looked as American in dress and manner as their hosts for the meeting," commented
"This is the News." Panel discussions were held on inter-country adoptions, and Eleanor Roosevelt addressed the Lasker presentations.

The following year the theme was "Man in His Changing Environment," and Adlai Stevenson II urged top priority be given to sharing American health skills with other nations beset by disease and poverty. Stevenson also decried the shortage of medical schools in the U.S., the fact that many Americans die of curable diseases, and that "the economics of medical care deny it to many who need it the most."
APHA by this time was also a publishing house of major proportions. Not only were some of the "standards" still best-sellers, but there were new works on "Public Exposure to Radiation," "Chronic Disease and Rehabilitation," and "Control of Malnutrition in Man."

The Committee on Vital and Health Statistics Monographs of the Statistics Section, chaired by Morton Spiegelman, began work on data accumulated in the decennial census. The publications which emerged from this committee over more than a decade represented the first comprehensive analysis of vital and health statistics characteristics on such subjects as diabetes, diseases of the digestive system, and venereal disease. In 1958, the Journal appeared in a "new dress and in the company of a new editor, George Rosen, MD," and in 1964 a new quarterly publication of the Laboratory Section, "Health Laboratory Science," was issued for the first time.

In the field of professional education, the most pressing problem was still the shortage of qualified personnel. An extension was granted for the joint research project of APHA and the Uni-
versity of North Carolina School of Public Health on the factors that bring physicians into the public health field, with the hope that it would facilitate future recruitment. The Committee on Professional Education's accreditation project, now an international model, no longer had the minimum standards of public health schools as its compelling reason for existence, but rather a concern that the accreditation process would stimulate increased manpower resources.

There were also new prizes administered by APHA for recognition of service to the public health. In 1957, the Executive Board established the Presidential Citation for persons who rendered distinguished service to public health but who were not thus professionally engaged. The first Citation was awarded to John E. Fogarty, congressman from Rhode Island, for his leadership in health legislation.
In 1959, George W. Beadle became the 11th person to receive the Nobel prize as well as the Lasker Award, ten of those persons receiving that Associationadministered award first. In 1960, the Lasker awards were presented for the last time, and the following year, the Samuel Bronfman Foundation established its prizes for "exceptionally meritorious achievement leading directly to improved health for considerable numbers of people."

## chapter 12

"Because we believe this is a primary tenet of our public health code, we have embarked on a program of study and persuasion to see that this principle of equality in health services-for the providers and the recipients-shall become universal. We are not our brother's keeper. We are our brother's brother."

## John D. Porterfield, MD APHA President, 1965

In the last ten years, public health and the American Public Health Association have probably changed more than in the first 90 years of the Association's history. The "principle of equality in health services"-not new to APHA but accepted as a basic tenet in a policy statement-was evidence of an evolution in thinking that rendered APHA almost unrecognizable to many. Yet much of the character of the Association remained-and remains today -greatly similar in its 100 year history.

Who among the founders could have foreseen the advent of "the pill," the technology and information explosions and their effects on the health field, the War on Poverty signifying a solid role for the government in relieving the misery of Michael Harrington's

## the uncharted future

"Other America"? These changes and a general awakening of a collective social conscience evoked an Association commitment to become a force for action-not the first such commitment, but the first with teeth in it. No longer would APHA merely support the programs of others; change and innovation in providing health care would be primary goals.
The 1956 Arden House Conference took place at a time when the first great rumbles were felt in the health field. With the passage of a decade, it was clear that the recommendations of the Task Force had been invaluable in building a base for the Association's professional programs. Committees preparing "Standard Methods" and other publications now had staff support, and professional staff members were carrying out innovative programs with outside funding. Steps were taken to strengthen the Association's relationships with other organizationsnot just for a "good neighbor policy," but also in the hopes of forming liaisons for the purpose of effecting legislative changes.

The first Arden House Conference failed, however, to provide mecha-
nisms for participation by a wide number of members or resolve satisfactorily the relationships between Association components. But significant events in the health field made reevaluation and change compulsory, if the Association were to maintain any sort of leadership position in its own field.

1964-the year the Johnson Administration's War on Poverty was launchedwas an important year for health. The Hill-Burton Act, the Air Pollution Control Act, maternal and child health programs, and public health trainee programs were continued and expanded. Even more exciting to public health workers was the new legislation creating the Health Professions Educational Assistance Act, the Mental Health and Mental Retardation Act, the Nurse Training Act, and support for research programs in housing hygiene and dental public health.

APHA members were also quick to recognize the implications for health in the Economic Opportunity Act, "which recognizes the need to reduce or eliminate disease and disability as a prerequisite to amelioration of poverty," as a 1964 Journal editorial noted.
"While focusing attention on those aspects of poverty which are obstacles to health progress-considering poverty both as a cause and as a consequence of illness and disability-one must also be concerned with poverty as a barrier to the availability of financial resources needed for health services," wrote I. S. Falk the same year. A resolution was passed urging those responsible for implementing the War on Poverty to give high priority to all of its health aspects, and an Annual Meeting General Session focused on the topic. "The great change that has taken place in our thinking about this kind of poverty is that we are beginning to believe it can be abolished. The existence of poverty is finally becoming unacceptable," wrote George James, MD, in 1965.

With the subsequent passage of Medicare, there were hopes for improved access to medical care for a sizable segment of the nation's aged poor. But the administration of the program was not quite to the liking of some in the Association. In 1965, APHA directed an inquiry to all state health officers ragarding the designated responsibility for elements of the new program among the states. The results of the inquiry indicated that the status was far from uniform in the states, and in some cases ultimate responsibility was unclear. APHA urged that the public health position be made as strongly as possible where the decision as to administrative location had yet to be made, citing the Association's earlier statement urging the designation of the health department to carry out Medicare responsibilities.

Four years later, in 1969, the Association issued a policy statement on "So-
cial Policy and Medical Care," urging revision of Medicaid and strengthening of Medicare. Citing deficiencies in both programs, the Association made specific recommendations for overhaul of administrative and service aspects of the programs. Lacking the mechanisms for fundamental changes in the basic system of delivering health care, the APHA conclusion was that "the health care of the American people still falls tragically short of its true potential."

Medical care-its quality and provision -was most firmly a staple in the programs of the Association. A 1965 Journal editorial, commenting on Ray E. Trussel's Bronfman lecture, stated, "Today as we witness the expansion of public health to encompass the area of medical care, it becomes increasingly evident that public health must confront the challenge of the quality of the care provided."

The body of literature on medical care and public health swelled with publication of "A Guide to Medical Care Administration" and establishment in 1963 of the new Journal, "Medical Care." The two-volume work on "Medical Care in Transition," reflected the change in attitude toward the subject that had occurred: "Where once it was regarded as the province of the individual, it is rapidly coming to be regarded as a matter of social responsibility."

Ruth Freeman urged more research in patient care-"all aspects of the individual's health and well-being, not just medical care"-as a new facet of public health. The commitment to explore these other aspects coincided roughly with the 50th anniversary of the publication of "Control of Com-
municable Diseases in Man." The classic public health measures of sanitation and widespread immunization were now accepted tenets, and attention was turned by an increasingly socially-conscious Association to insuring a total healthy environment.

The environmental movement itself began to take its place as a cornerstone of the new social trend. A Radiological Health Section was established, and the Engineering and Sanitation Section changed its name to "Environment."

Because many people not in the Environment Section began to take an interest in the subject, the Executive Board foresaw a need to create a new structure for the study of environmental health within the Association. A task force recommended that all sections be grouped in four or five departments along lines of common, but less specialized, interests. This proposal drew mixed reactions, many of them fearing weakened sections, and instead, an Association committee on environment, with membership drawn from several sections, was established as a demonstration project. By 1969, the experiment was apparently successful, and became the basis for the reorganization into councils, with sections retained as the basic unit of the Association.

Accompanying the interest in ecology was strong support for environmental legislation. In 1964, the Committee on Public Policy and Legislation recommended support of a proposed Environmental Health Center in the Public Health Service, though Congress could not agree on a location. Later, the Association would provide testi-
mony on many water and air quality standards bills, and join forces with other groups to fight the grip of the Highway Trust Fund on allocations for transportation.
Another area characterized by a resurgence of interest was maternal and child health. Geographic redistribution, slum formation, and deterioration were correlated to an increase in infant mortality and morbidity. Federal aid was welcomed in a new drive to regain the nation's low infant mortality rates. Characteristic of the new interest was the award established by Ross Laboratories in honor of Martha May Eliot to recognize achievement in the field of maternal and child health.

Family planning became a part of APHA's programs. Ads for "the pill" appeared in the Journal, and a statement was issued reaffirming an earlier, pioneering stand urging governments in the United States at all levels to include family planning as an integral part of health programs, and that the U.S. expand its technical assistance in population programs to nations requesting it.

International health programs soon became an integral part of APHA's professional division, with much of its content based on a statement of desirable activities prepared by Ernest Stebbin's Committee on International Health. Despite periods of isolationism, APHA had always pressed for world-wide health organizations, and was instrumental in formation of the World Federation of Public Health Associations, with APHA executive directors serving as heads of the organization at one time or another.
One of APHA's most important contributions to expanding the boundaries
of the definition of public health was in the field of comprehensive health planning for communities. In April, 1966, Marion B. Folsom, chairman of the National Commission on Community Health Services, presented "Health Is a Community Affair," to President Johnson. Among its conclusions was a recommendation that health service boundaries be established by an area in which problems can be defined, dealt with and solved, rather than by the traditional method of political


Cornely
jurisdictions.
The report also insisted that communities provide comprehensive health services to all of its citizens; that personal physicians have broader knowledge of the elements of comprehensive health services; and that man learn to manage his environment "even though he is presently contaminating it at a rate approaching saturation." The report spawned a new activity, "Community Health, Inc.," to implement its recommendations. Meanwhile, there were other signs of the Association's interest in the field: establishment of a new section on Community Health Planning, and a unit called Community Health Action Planning Service-a direct descendant of the on-site appraisal method.

The volume of new health legislation and programs drastically increased the need for health workers, a need that had never really been met. In the early 60 's a series of National Conferences on Public Health Training were held at APHA meetings, one of the number of multidisciplinary groups preparing recommendations to the Surgeon General regarding strengthening the supply of health personnel. Not surprisingly, the Conference recommended increased funds for recruitment and training, and


Mattison
APHA successfully testified in support of bills for construction of health education institutions and student loans. Professional Examination Service became a separate entity in 1970, but the Association continues its accreditation and educational qualifications activities, and initiated a Committee and later, Council on Health Manpower. The institutions training the new public health personnel were changing, too. W. Fred Mayes, Dean of the University of North Carolina School of Public Health, noted in a Journal article that the early schools had begun with the "Health Officers School idea," expanding to health administration and practice, and then maximizing attention to the public health team. "Today there is much more emphasis on
education of the scientist and researcher," he said. He also noted "our overwhelming absorption with the new and emerging health hazards and the new health programs and techniques to deal with them."

Protecting the consumer from the hazards of an increasingly complex technological society was reflected in resolutions such as those on cigarette smoking, fad diets, and water quality. But the age of protecting the consumer, of planning his community health services or his environment without his participation was over. More and more, public health programs were decided with the advice and consent of citizen advisory boards or consumer representatives. Yet, how could you involve the community leader in the determination of his community health services if you could not involve him in your national organization?

There were other considerations, too. In a 1965 Journal editorial, George Rosen, MD, noted the tendency toward isolation among scientists, and warned of the need for perspective by scientists and education of the public. "We in APHA can undoubtedly contribute to education of the lay public in health matters by encouraging appropriate lay membership," he said. More strongly, Lorin Kerr, MD, approached the same idea: "Is it possible that the local and national legislative impact of APHA could be increased if the membership significantly represented the consumer of health services?"

APHA's structure, with its requirement that officers and committee chairmen be fellows, was not suited to this philosophy. There were also new
voices speaking up. At the 1968 meeting, a statement of the Concerned Black Members of APHA urged the Association to apply its talents and energies to the solution of the urban crisis and offered "as a resource the combined efforts of black health professionals all over the nation." At the same meeting, a Caucus for Peace and Human Rights, composed of a number of young health officers, reacted to a speech on "The Biological Warfare Problem" and a session on "Health Problems in Vietnam" with a petition repudiating participation by health professionals in the "development and production of offensive biological weapons."

Clearly the voices of protest reflected nationwide unrest on the campuses and in the cities. APHA leaders were careful to heed them. For two years, a second evaluation conference had been in the planning. Dissident groups at the 1968 meeting criticized the composition of the planned Conference on Association Functions, Organization and Relationships (CAFOR). Accordingly, additional persons were appointed to represent youth, consumer interest, and work experience at the point of delivery of health services.

In presenting the issues to be considered by CAFOR, the Association newsletter noted that most of the changes evolving from the first Arden House Conference had strengthened APHA's programs. But in addition, membership increased in those years almost two-fold; a Southern Branch office was established in Birmingham, and the number of interested lay representatives and nongovernmental health workers in APHA had increased. Noting that membership had always been
open to anyone with an interest in health, it was nevertheless also recognized that there was no real home for the layman in APHA's present structure. It was also questioned, "If APHA is to involve community leadership in dynamic areas of public health, this raises some questions as to whether APHA's internal organization at present is best adapted for responding to needs in program and problem areas involving such things as the environment, medical care, and ecology."


There were four themes dominant during CAFOR: social action, democratization, specialization, and strengthening relationships with affiliates and governing components. Probably its most basic statement was "Health professionals, other career workers in the health field, students of the health professions, and interested laymen-particularly consumer representatives such as on health planning agenciesshould all be encouraged to join APHA. The programs and influence of APHA should continue to be based upon strong professional membership." Accordingly, members were permitted to hold offices and committee seats, although fellowship was retained as an honorary recognization of achievement in public health.

There were many complex organizational changes-an Action Board was established to implement APHA policies; TDB was expanded into a Program Development Board as a basis for professional programs; Councils were set up with responsibility for technological recommendations and social actions within areas of common interest to several sections. Sections were retained as the basic organization structure, with other areas of "association business" to be run by Associa-

tion-wide committees.
Several other ideas were "floated," though not immediately implemented. Mixed reaction greeted the proposed sliding dues scale based on income, and when it was finally implemented in 1971, several members resigned, lamenting the "loss of professionalism in the organization." Another concept, that of strengthening relationships between APHA and its affiliates, through a change in status to "chapters" has not yet been implemented.

It is too early to evaluate the effects the CAFOR changes have had on APHA in the 1970's, but one can only chronicle highlights of the record. Three new sections were established: Social Work, Veterinary Public Health, and

New Professionals. With the establishment of the latter section in 1971, the role of the allied health professional in health planning was firmly established. There have not, in the last years, been a great number of consumers joining the Association, nor it is expected that there will be.

There have been, however, stronger liaisons sought with coalitions of consumer and other health professional organizations. Law suits and other legal actions have been initiated to secure legislation and enforcement of health protection laws, and successfully won in the areas of drug efficacy and equal access to health care under Hill-Burton regulations. In 1969, APHA President Lester Breslow, and Presi-dent-Elect Paul Cornely led a private citizens panel on a nationwide tour of consumer health problems, creating nationwide attention and subsequent publication of the report "Health Crisis in America."

In 1970, Berwyn Mattison announced his decision to retire as Executive Director of APHA and "open the way for new leadership." James R. Kimmey, MD, was appointed to succeed him, and charged by the search committee to "move the organization into consumer protection, increase its influence on national health policies and expenditures, and involve new health professionals in its activities."

Many of the resolutions passed in the last few years-on lead poisoning, drug abuse, and a single federal department of health, for example-are remarkably similar to those passed on prior occasions in the 100 year history of APHA. That they have to be reintroduced time and again is evidence that
a health crisis of major proportions still exists in this country.

But the difference between 1872 and 1972 is that at this time members are firmly committed to a policy of social action based on a solid foundation of scientific technology. Standards continue to be set in examination of water, air, and food-but they are also being set in new areas such as health maintenance organizations. Resolutions on drugs and population are being implemented by task forces of nationally known experts. And in the year of its Centennial, APHA sets as its goal the formulation of a national health policy.
What APHA is today, it did not become overnight or even ten years ago. It is very different from its ancestor in 1872, yet very much what Stephen Smith envisioned as a society of public health professionals engaged in protecting and preserving the health of the nation. The voices of dissidence that have characterized 100 years of the Association's history give it the strength and flexibility to endure the next one hundred.

We have taken the position that APHA is uniquely qualified to complement our broad scientific and professional competence in a wide variety of health fields with forceful action to see that technical accomplishments are extensively applied for the benefit of all people. We believe that our unique capability for effective action resides precisely in the variety of our mem-bership-in the combination of science and social action which we represent.

Myron E. Wegman, MD
APHA President, 1971-72

| appendix |  |  | $\begin{aligned} & \text { 18th } \\ & \text { 19th } \end{aligned}$ |
| :---: | :---: | :---: | :---: |
| SECTIONS OF THE AMERICAN PUBLIC HEALTH ASSOCIATION |  |  | 20th |
|  |  |  | 21 st |
| Laboratory . . . . . . . . . . . . . . . . 1899 |  |  | 23rd |
| Health Administration . . . . . . . . 1908 |  |  | 24th |
| Statistics ................. . . . . . 1908 |  |  | 25th |
| Environment . . . . . . . . . . . . . . . 1911 |  |  | 26th |
| Occupational Health |  |  | 27th |
| Food and Nutrition . . . . . . . . . . 1917 |  |  | 28th |
| Maternal and Child Health .... 1921 |  |  | 29th |
| Public Health Education . . . . . . 1922 |  |  | 30th |
| Public Health Nursing . . . . . . . . 1923 |  |  | 31st |
| Epidemiology . . . . . . . . . . . . . . 1929 |  |  | 32nd |
| School Health ............... 1942 |  |  | 33 rd |
| Dental Health |  | 1943 | 34th |
| Medical Care |  | 1948 | 35th |
| Mental Health |  | 1955 | 36th |
| Radiological Health |  | 1964 | 37th |
| Community Health Planning |  | 1969 | 38th |
| Social Work |  | 1970 | 39th |
| Veterinary Public Health |  | 1970 | 40th |
| New Professionals . . . . . . . . . . 1971 |  |  | 41st |
| ANNUAL MEETINGS OF THE |  |  | 43rd |
|  |  |  | 44th |
| AMERICAN PUBLIC HEALTH ASSOCIATION |  |  | 45th |
|  |  |  | 46th |
| Preliminary | Long Branch, N. J. | 1872 | 48th |
| 1st | Cincinnati, Ohio | 1873 | 49th |
| 2nd | New York, N. Y. | 1873 | 50th |
| 3rd | Philadelphia, Pa. | 1874 | 51st |
| 4th | Baltimore, Md. | 1875 | 52 nd |
| 5th | Boston, Mass. | 1876 | 53rd |
| 6th | Chicago, III. | 1877 | 54th |
| 7 th | Richmond, Va. | 1878 | 55th |
| 8th | Nashville, Tenn. | . 1879 | 56th |
| 9th | New Orleans, La. | 1880 | 57th |
| 10th | Savannah, Ga. | 1881 | 58th |
| 11th | Indianapolis, Ind. | 1882 | 59th |
| 12th | Detroit, Mich. | 1883 | 60th |
| 13th | St. Louis, Mo. | 1884 | 61st |
| 14th | Washington, D. C. | 1885 | 62 nd |
| 15th | Toronto, Canada | 1886 | 63 rd |
| 16th | Memphis, Tenn. | 1887 | 64th |
| 17th | Milwaukee, Wisc. | 1888 | 65th |

18th
19th
20th
21st
22nd 23rd
24th
25th
26th
27th
28th
29th
30th
路
33rd
34th
35th
36th
37th
38th
39th
40th
41st
42nd
43rd
44th
45th
46th
47th
48th
49th
50th
51st
nd

54th
55th
56th
57th
58th
59th
60th
62 nd
63 rd
64th
65th
Brooklyn, N. Y. 1889
Charleston, S. C. 1890

Kansas City, Mo. 1891
Mexico City, Mexico
1892
1893
1894
1895
1896
1897
Ottawa, Canada 1898
Minneapolis, Minn. 1899
Indianapolis, Ind. 1900
Buffalo, N. Y. 1901
New Orleans, La. 1902
Washington, D. C. 1903
Havana, Cuba 1904
Boston, Mass.
1905
Mexico City, Mexico
1906
Atlantic City, N. J. 1907
Winnipeg, Canada 1908
Richmond, Va.
1909
Milwaukee, Wisc. 1910
Havana, Cuba 1911
Washington, D. C. 1912
Colorado Springs, Colo.
1913
Jacksonville, Fla.
1914
Rochester, N. Y.
1915
Cincinnati, Ohio 1916
Washington, D. C. 1917
Chicago, III.
1918
New Orleans, La. 1919
San Francisco, Calif.
1920
1921
1922

| Cleveland, Ohio | 1922 |
| :--- | :--- |
| 1923 |  |

Detroit, Mich.
1924
1925
1926
Buffalo, N. Y. 1926
Chicago, III.
1928
Minneapolis, Minn. 1929
Fort Worth, Tex. 1930
Montreal, Canada 1931
Washington, D. C. 1932
Indianapolis, Ind. 1933
Pasadena, Calif. 1934
Milwaukee, Wisc. 1935
New Orleans, La. 1936

| 66th | New York, N. Y. | 1937 |
| :---: | :---: | :---: |
| 67th | Kansas City, Mo. | 1938 |
| 68th | Pittsburgh, Pa. | 1939 |
| 69th | Detroit, Mich. | 1940 |
| 70th | Atlantic City, N. J. | 1941 |
| 71st | St. Louis, Mo. | 1942 |
| 72nd | (Wartime Conf.) | 1943 |
| 73rd | New York, N. Y. (Wartime Conf.) | 1944 |
|  | New York, N. Y. (No Meeting) | 1945 |
| 74th | Cleveland, Ohio | 1946 |
| 75th | Atlantic City, N. J. | 1947 |
| 76th | Boston, Mass. | 1948 |
| 77th | New York, N. Y. | 1949 |
| 78th | St. Louis, Mo. | 1950 |
| 79th | San Francisco, Calif. | 1951 |
| 80th | Cleveland, Ohio | 1952 |
| 81st | New York, N. Y. | 1953 |
| 82nd | Buffalo, N. Y. | 1954 |
| 83 rd | Kansas City, Mo. | 1955 |
| 84th | Atlantic City, N. J. | 1956 |
| 85th | Cleveland, Ohio | 1957 |
| 86th | St. Louis, Mo. | 1958 |
| 87th | Atlantic City, N. J. | 1959 |
| 88th | San Francisco, Calif. | 1960 |
| 89th | Detroit, Mich. | 1961 |
| 90th | Miami Beach, Fla. | 1962 |
| 91st | Kansas City, Mo. | 1963 |
| 92 nd | New York, N. Y. | 1964 |
| 93 rd | Chicago, 111. | 1965 |
| 94th | San Francisco, Calif. | 1966 |
| 95th | Miami Beach, Fla. | 1967 |
| 96th | Detroit, Mich. | 1968 |
| 97th | Philadelphia, Pa. | 1969 |
| 98th | Houston, Tex. | 1970 |
| 99th | Minneapolis, Minn. | 1971 |
| 100th | Atlantic City, N. J. | 1972 |
|  | CIPIENTS OF THE |  |
| SEDGWICK MEMORIAL MEDAL |  |  |
| Established in honor of the late Professor William Thompson Sedgwick, the Sedgwick Memorial Medal is the highest honor presented by the Association, commemorating distinguished service in public health. There is no restriction on the area of service to |  |  |

Kansas City, Mo. 1938
Pittsburgh, Pa. 1939 1940
1941
St. Louis, Mo.1943New York, N. Y.(No Meeting)1945Athan City, N.1947
Boston, Mass.1949
St. Louis, Mo. ..... 1950
Cleveland Ohio1952
New York, N. Y1954
Atlantic City, N .1956
leveland Ohio1958San Francisco, Calif1960
it Mich19621963
New York, N. Y.1965
San Francisco, Calif.19671968
Philadelphia, Pa.1970Atlantic City, N. J.1972

## RECIPIENTS OF THE

 SEDGWICK MEMORIAL MEDALEstablished in honor of the late Proessor William Thompson Sedgwick, highest honor presented by the Association, commemorating distinguished restriction on the area of service to
be honored, and contributions in the fields of administration, research, education, technical service, and all specialties of public health practice receive equal consideration.

1929 Charles V. Chapin, MD
1930 Theobald Smith, MD
1931 George W. McCoy, MD
1932 William H. Park, MD
1933 Milton J. Rosenau, MD
1934 Prof. Edwin O. Jordan
1935
1936 Frederick F. Russell, MD
1938
1939
1940
1941
1942
1943
1944
1946
1947
1948
1949
1950
1951
1952
1953
1954
1955
1956
1957
1958
1959
1960
1961
1962
1963
1964
1965
1966
1967
1968
1969
1970
1971
1972

## RECIPIENTS OF THE PRESIDENTIAL CITATION OF the american public HEALTH ASSOCIATION

APHA's Presidential Citation is presented to persons not professionally engaged in public health practice, in recognition of outstanding contributions to the advancement of public health or the public health profession. The citation is not presented every year, but only on occasions of unusual merit. Candidates for the Presidential Citation are nominated by the president of the Association, and their choice is confirmed by the Executive Board.

1957 Rep. John E. Fogarty (D-R.I.), active in health legislation for 11 years
1959 Mary Woodward Lasker, president, Albert and Mary Lasker Foundation
1961 Anne F. Rogers Winslow (Mrs. C.-E. A. Winslow), member, Citizen Board of Directors, New Haven (Conn.) Visiting Nurse Association
1962 J. George Harrar, president, Rockefeller Foundation
1963 Rep. Oren Harris (D-Ark.), author or co-author of many public health and medical program bills
1964 The families of public health workers everywhere--accepted by Barbara James, daughter of Health Commissioner George James of New York City
1965 John Charles Daly, reporter and television personality active in water pollution control activities Emory W. Morris, DDS, president, W. K. Kellogg Foundation
1967 Robert M. Nash, director, Office of Equal Health Opportunity, Public Health Service

1968 Rep. Melvin R. Laird (R-Wisc.), member, House Appropriations Committee, Subcommittee on Labor, Health, Education, and Welfare
1969 Isidore E. Buff, MD, Donald L. Rasmussen, MD, Hawey A. Wells, Jr., MD, Lorin E. Kerr, MD, leaders in the fight against "black lung"
1971 William D. Ruckelshaus, administrator, Environmental Protection Agency
1972 Sen. Lister Hill (D-Ala.), sponsor or cosponsor of far-reaching health legislation, including the Hill-Burton hospital funding act

## PRESIDENTS OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

1872- Stephen Smith, MD
1874 New York, N. Y.
1875 Joseph M. Toner, MD Washington, D. C.
1876 Edwin M. Snow, MD Providence, R. I.
1877 John Henry Rauch, MD Springfield, III.
1878 Elisha Harris, MD New York, N. Y.
1879 James Lawrence Cabell, MD Charlottesville, Va.
1880 John Shaw Billings, MD Washington, D. C.
1881 Charles B. White, MD New Orleans, La.
1882 Robert C. Kedzie, MD Lansing, Mich.
1883 Ezra M. Hunt, MD Trenton, N. J.
1884 Albert L. Gihon, MD Washington, D. C.
1885 James E. Reeves, MD Wheeling, W. Va.
1886 Henry P. Walcott, MD Cambridge, Mass.
1887 George M. Sternberg, MD

Washington, D. C.
1888 Charles N. Hewitt, MD Red Wing, Minn.
1889 Hosmer A. Johnson, MD
Chicago, III.
1890 Henry B. Baker, MD Lansing, Mich.
1891 Frederick Montizambert, MD Quebec, Can.
1892 Felix Formento, MD New Orleans, La.
1893 Samuel H. Durgin, MD Boston, Mass.
1894 E. Persiller-Lachapelle, MD Montreal, Can.
1895 William Bailey, MD Louisville, Ky.
1896 Eduardo Liceaga, MD Mexico City, Mex.
1897 Henry B. Horlbeck, MD Charleston, S. C.
1898 Charles A. Lindsey, MD New Haven, Conn.
1899 Henry Mitchell, MD Trenton, N. J.
1900 Peter H. Bryce, MD Toronto, Can.
1901 Benjamin Lee, MD Philadelphia, Pa.
1902 Henry D. Holton, MD Brattleboro, Vt.
1903 Walter Wyman, MD Washington, D. C.
1904 Carlos J. Finlay, MD Havana, Cuba
1905 Frank F. Wesbrook, MD Minneapolis, Minn.
1906 Franklin C. Robinson, LLD Brunswick, Me.
1907 Domingo Orvananos, MD Mexico City, Mex.
1908 Richard H. Lewis, MD Raleigh, N. C.
1909 Gardner T. Swarts, MD Providence, R. I.
1910 Charles O. Probst, MD Columbus, Ohio
1911 Robert M. Simpson, MD Winnipeg, Can.

1912 J. N. Hurty, MD Indianapolis, Ind.
1913 Rudolph Hering, ScD New York, N. Y.
1914 W. C. Woodward, MD Washington, D. C.
1915 William T. Sedgwick, ScD Boston, Mass.
1916 John F. Anderson, MD Washington, D. C.
1917 W. A. Evans, MD Chicago, Ill.
1918 Charles J. Hastings, MD Toronto, Can.
1919 Lee K. Frankel, PhD New York, N. Y.
1920 W. S. Rankin, MD Raleigh, N. C.
1921 Mazyck P. Ravenel, MD Columbia, Mo.
1922 Allan J. McLaughlin, MD Washington, D. C.
1923 E. C. Levy, MD Richmond, Va.
1924 William H. Park, MD New York, N. Y.
1925 Henry F. Vaughan, DrPH Detroit, Mich.
1926 C.-E. A. Winslow, DrPH New Haven, Conn.
1927 Charles V. Chapin, MD Providence, R. I.
1928 Herman H. Bundesen, MD Chicago, III.
1929 George W. Fuller New York, N. Y.
1930 A. J. Chesley, MD St. Paul, Minn.
1931 Hugh S. Cumming, MD Washington, D. C.
1932 Louis I. Dublin, PhD New York, N. Y.
1933 John A. Ferrell, MD New York, N. Y.
1934 Haven Emerson, MD New York, N. Y.
1935 Eugene L. Bishop, MD Nashville, Tenn.
1936 Walter H. Brown, MD

Palo Alto, Calif.
1937 Thomas Parran, MD Albany, N. Y.
1938 Arthur T. McCormack, MD Louisville, Ky.
1939 Abel Wolman, DrEng Baltimore, Md.
1940 Edward S. Godfrey, Jr., MD Albany, N. Y.
1941 W. S. Leathers, MD Nashville, Tenn.
1942 John L. Rice, MD New York, N. Y.
1943 Allen W. Freeman, MD Baltimore, Md.
1944 Felix J. Underwood, MD Jackson, Miss.
1945- John J. Sippy, MD
1946 Stockton, Calif.
1947 Harry S. Mustard, MD New York, N. Y.
1948 Martha M. Eliot, MD Washington, D. C.
1949 Charles F. Wilinsky, MD Boston, Mass.
1950 Lowell J. Reed, PhD Baltimore, Md.
1951 William P. Shepard, MD San Francisco, Calif.
1952 Gaylord W. Anderson, MD Minneapolis, Minn.
1953 Wilton L. Halverson, MD San Francisco, Calif.
1954 Hugh R. Leavelt, MD Boston, Mass.
1955 Herman E. Hilleboe, MD Albany, N. Y.
1956 Ira V. Hiscock, ScD New Haven, Conn.
1957 John W. Knutson, DDS Washington, D. C.
1958 Roy J. Morton, CE Oak Ridge, Tenn.
1959 Leona Baumgartner, MD New York, N. Y.
1960 Malcolm H. Merrill, MD Berkeley, Calif.
1961 Marion Sheahan, RN Albany, N. Y.

[^3]
[^0]:    "Whenever a man or woman desires to be a permanent member of this Association the only qualification that should be required . . . is the primary qualification of professed and acknowledged interest in sanitary work. Beyond that we can grade as we please; but open wide the door, and let anyone that wants to be a permanent member come in and sit here . . . Now I am not afraid of submitting great sanitary questions to the people of this country. I do not think it is necessary to circumscribe those who are to sit here and express the opinion of this Association."

    Charles N. Hewitt, MD<br>APHA president, 1888

[^1]:    Whereas, the use of habit forming drugs in this country, is increasing with such appalling rapidity as to have assumed the proportions of a national evil, and
    Whereas, the effects of these drugs are admittedly prejudicial to health, community welfare, and race development, and

[^2]:    *I am indebted to Arthur J. Viseltear, PhD, MPH, for his interpretation of the emergence of medical care as an issue in his manuscript "Emergence of the Medical Care Section of the American Public Health Association, 1926-1948," accepted for publication by the American Journal of Public Health, 1973.

[^3]:    1962 Charles Glen King, PhD Bronx, N. Y.
    1963 J. W. R. Norton, MD
    Raleigh, N. C.
    1964 John D. Porterfield, MD Chicago, III.
    1965 Dwight F. Metzler, CE Albany, N. Y.
    1966 Ernest L. Stebbins, MD Baltimore, Md.
    1967 Milton Terris, MD New York, N. Y.
    1968 Lester J. Breslow, MD Los Angeles, Calif.
    1969 Paul B. Cornely, MD Washington, D. C.
    1970 P. Walton Purdom, PhD Radnor, Pa .
    1971 Myron E. Wegman, MD Ann Arbor, Mich.
    1972 Margaret B. Dolan, RN Chapel Hill, N. C.

