Chapter 1

THE SANITATIONIST STATE

One of the most deeply engrained legends of American history is that the United States has consistently championed individual freedom over collective solidarity. But early American responses to epidemics exerted considerable state authority and substantially limited individual freedoms in order to achieve great public health victories. Sometimes those victories even became occasions for improving the lives of the poorest among us.

Illness, disease, and death were part of daily life both in the colonies and in the era of the early republic. Smallpox killed far more people during the War for Independence than were killed in battle, partly because the virus came home with soldiers and wreaked havoc in
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communities all across the new country.¹ Smallpox outbreaks in the Civil War and its aftermath devastated communities of formerly enslaved people.² Regular cycles of yellow fever coursed through Charleston, New Orleans, and Savannah. Refugees from revolution in Haiti brought the disease to Philadelphia in 1793, where it killed one in ten residents, and to New York two years later.³ Hot summers encouraged mosquitoes and led to regular recurrences of the disease in the Northeast for another decade. New Orleans seemed to hardly have a year without cases of yellow fever; outbreaks in the city in the 1850s cost tens of thousands of lives.⁴ Cholera reached the United States in 1832, then returned in 1849 and 1866, killing thousands of people in the most gruesome fashion: diarrhea, vomiting, and cramps caused dehydration so severe that sufferers’ skin tightened and turned blue from extreme loss of fluids.⁵ Many died within hours of their first symptom.

Under such circumstances, pursuing happiness meant promoting health. Early American lawmakers had little understanding of the science of disease—germ theory would not arrive until the United States’ second
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century—but physicians and jurists understood enough to know that infectious disease was a public problem that required collective solutions.

Robust legal authority for responding to public health crises existed from the earliest days of settler colonialism in North America. Scholars have long cited British philosopher John Locke as an originator of the modern tradition of individual freedoms in the liberal state. But Locke’s “Fundamental Constitutions,” written in 1669 for the colony of Carolina, established a broad power to take care of all “corruption or infection of the common air or water, and all things” necessary to protect “the public commerce and health.” Authorities could conscript private property and drain privately owned wetlands. Colonial legal codes regularly made provision to close the courts in the event of pestilence. Such shutdowns were a big deal in an era when court sessions functioned like fair days and served as occasions for auctions and public markets. The colony of Connecticut (like many other colonies) authorized the town officials to isolate and care for any person “visited with the Small Pox” or “suspected to be infected”—and to charge the person or their parents...
or master for the costs, if possible. In 1761, the colony prohibited smallpox inoculations for fear that they would accidentally spread the disease.

In the early republic, state legislatures and elected officials routinely enacted formidable measures to guard against disease. Six months after the end of the Revolutionary War, the New York legislature empowered the state’s governor to set up quarantines to prevent the arrival of yellow fever “or any other contagious Distemper.” Within a few years, state officials had built a detailed system of regulations with precise mandates for the loading and unloading of vessels and reporting obligations for boardinghouses, inns, and physicians who became aware of “pestilential or infectious disease” among their guests or patients. New York prohibited importation of cotton or hides between May and November and extended discretionary authority to mayors and to the governor so that they would be empowered to respond quickly to crises.

Early legal provisions against pestilence were state law, partly because the federal government under the weak Articles of Confederation utterly lacked the capacity
to act. But the ratification of the new federal Constitution in 1788 did not change matters much, at least with regard to the legal power to regulate the risk of infectious disease. State law remained primary. After a 1793 outbreak of yellow fever, for example, Pennsylvania established a state health office to protect Philadelphia “from the introduction of pestilential and contagious diseases.”11 (The prescient statute incorporating the city just a few years before had listed the “advancement of public health” second only to “the suppression of vice and immorality” among the purposes of the city government.)12 The city’s board of health was empowered to declare private lanes, courts, or alleys a nuisance and to require owners to pave them. Health officials on the Delaware River boasted vast authority over the inspection and quarantining of vessels. Officials themselves were regulated, too. Philadelphia Health Office inspectors were to be fined $20 if they refused to perform their office.

All across the country, states and cities prohibited the burial of bodies in urban settings, ruling out time-honored graveyards in churchyards and public squares and moving interments out to new cemeteries

Officials enacted innumerable public health mandates, typically without much fuss. In 1795, Virginia authorized quarantines at “any place within this commonwealth” that “shall become infected with a malignant distemper.” Mississippi (like a number of other states) made special provision for removing prisoners when disease broke out in jails. Michigan’s first enactments included the creation of local boards empowered to order the removal of “all nuisances, sources of filth, and causes of sickness,” including sick people themselves, “that may in their opinion be injurious to the health of the inhabitants within their township.” The local Michigan boards had broad authority to restrict the movement and activity of the families of people who had fallen ill. State law even imposed a general obligation on family members to report cases of smallpox among relatives. Failure to report a loved one to the authorities could result in a $100 fine.

As time went by, state and local governments asserted ever more public health powers, and even created
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new urban administration agencies with broad authority to support public health. In 1827, Boston required that any child attending school be vaccinated against smallpox. Six years later, a tiny new Illinois town called Chicago enacted sweeping sanitary provisions to fend off cholera, including street cleaning, removal of nuisances, banning animal carcass disposal in the river, and regulating the disposal of waste.16 Urban sanitary codes swelled, embodying a social philosophy of solidarity. “No family, no person liveth to himself alone,” declared Massachusetts’s 1850 Sanitary Commission. “Every person has a direct or indirect interest in every other person. We are social beings—bound together by indissoluble ties.” As the commissioners put it, their work reflected Cicero’s ancient legal dictum, “salus populi suprema lex, to protect one set of human beings from being the victims of disease and death through the selfish cupidity of others.”17

In early 1866, in anticipation of the coming summer cholera season, and in view of the worsening filth of the streets in the nation’s largest city, the New York State legislature established a new Metropolitan Board of Health for Manhattan and the immediate surround-
ing counties. The legislature endowed the board with the consolidated public health authority of all the local boards of health and the public officials of the city. The commissioners earned salaries, and were authorized to rent offices and to build a staff of attorneys and clerks. They could condemn buildings and machinery and direct the police to carry out their orders, including arresting those who refused to comply, and they could charge the costs of any enforcement proceedings to the property owners. In the event of “great and imminent peril to the public health,” the Metropolitan Board had the “extraordinary power” and indeed the duty to take what measures the commissioners believed were warranted, even if not expressly authorized by the legislature.

So vast was the power of the Metropolitan Board, at least by nineteenth-century standards, that the legislature in Albany added one last provision to the law in hopes of protecting the people of New York from an anticipated abuse. It would be a crime to impersonate an officer of the board, punishable by not less than one year in prison.

Of course, the fact that government has the power to do something in theory does not always mean that it
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can exercise such power effectively in practice. As lawyer-historian Hendrik Hartog shows in a classic study, early New York City struggled for decades to regulate the pigs that wandered in its streets. Enactment after enactment failed to accomplish the goal of clearing the streets of pigs and the refuse they left. Only in 1849, after thirty years of efforts, did city authorities finally remove thousands of pigs to fend off a renewed wave of cholera.20

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Courts in the early republic almost universally upheld the government’s authority to manage the spread of infectious disease. Federal courts upheld quarantines and the detention of vessels at the nation’s ports.21 State courts did, too: in Georgia, the Superior Court upheld a fine levied by Augusta when the owner of a vessel from smallpox-ridden Charleston refused to follow the city council’s quarantine rules.22 In Pennsylvania, the Supreme Court upheld new taxes to procure water supplies conducive to the public health.23 The North Carolina courts upheld a conviction for selling unwholesome meat on the ground that “the public health, whether affected
through the medium of unwholesome food, or poisoning the atmosphere, or introducing infectious diseases, is anxiously guarded by the common law.”

In the landmark 1824 case of Gibbons v. Ogden, Chief Justice John Marshall of the U.S. Supreme Court summed up the early American cases. Gibbons, which arose out of a dispute over ferry rights in New York Harbor, offered early support for broad federal authority to regulate interstate commerce. But Marshall, who served as chief justice for more than three decades and who built the Court as an institution in American life, nonetheless recognized the “acknowledged power of a State to provide for the health of its citizens.” The power of the state, Marshall asserted, encompassed an “immense mass of legislation,” including “inspection laws, quarantine laws,” and “health laws of every description.” Marshall observed simply that “the constitutionality of such laws has never, so far as we are informed, been denied.”

A quarter century later, Lemuel Shaw of Massachusetts’s Supreme Judicial Court affirmed and developed the same point: the state had the authority to intervene in epidemics. The police power, he asserted in 1851,
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included the authority “to prohibit buildings from being used for hospitals for contagious diseases, or for the carrying on of noxious or offensive trades; to prohibit the raising of a dam, and causing stagnant water to spread over meadows, near inhabited villages, thereby raising noxious exhalations, injurious to health and dangerous to life.” States, Shaw explained further, had no obligation to compensate property owners for such regulations; the state’s regulatory authority was part of the inherent sovereign power of the government, to which all private property was subject.

State courts sustained broad authority to clean the streets and remove waste, to condemn and destroy dangerous buildings or infectious property, and to prohibit the slaughtering of animals in cities. Courts upheld mandatory vaccination and reasonable waiting times for commercial vessels at the ports. In Louisiana, the state Supreme Court affirmed the authority of New Orleans officials to prohibit private parties from erecting a private hospital within city limits, even if it would not be a nuisance per se, given the importance of upholding the city’s “extensive discretion” in fighting off recurring epi-
sodes of a “dreadful epidemic.” The Alabama Supreme Court captured the spirit of the law when it voiced Cicer-
ro’s dictum to uphold the condemnation of two filthy tenements: “Salus populi suprema lex.”

Two of the most important cases arose out of New York in the years when the new Erie Canal was caus-
ing the city to grow by leaps and bounds. Brick Presbyterian Church v. Mayor of New York (1826) arose out of a new regulation prohibiting the interment of bodies in Lower Manhattan. As the historian William Novak has observed, the law “summarily abolished the vested rights” of churches that had been granted permission to use their land for church houses and graveyards. Even more strikingly, the vested rights in question belonged to the leading churches of the city, long powerful brokers in the political marketplace. Yet the New York Supreme Court upheld the new regulation against the churches’ challenge, ruling that the cemetery regulation was a “salutary application of police powers,” not an unconstitutional taking of property. A year later the same court reaffirmed and extended the point, ruling that the city could prohibit “nuisances to public health”
like the church graveyards without paying compensation and without causing “an unconstitutional impairment of the obligation of contracts.” 31 Nine years after that, the New York courts upheld the destruction of unsanitary real property to slow a cholera outbreak that had already killed some five hundred people in the city. 32

In 1868, the early American cases culminated in a decision by the high court of New York State affirming the authority of the new Metropolitan Board of Health. “From the earliest organization of the government,” ruled Chief Judge Ward Hunt, states had vested local boards and their officers with “the absolute control over persons and property, so far as the public health was concerned.” Hunt, who would soon accept appointment to the U.S. Supreme Court, explained that boards had long “exercised a summary jurisdiction over the subject,” which had allowed them to act first and get the approval of the courts later. A dissenter objected that the new Metropolitan Board impermissibly mixed legislative, executive, and judicial power. His complaint anticipated future critiques of the administrative state in the twentieth century. But Hunt and the majority disagreed. The public health pow-
ers of the state, he ruled, “were not bound to wait the slow course of the law.”

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In the nineteenth century, public health law was so vital that a now mostly forgotten field of law grew up around the problem of disease. “The jurisprudence of hygiene” or “sanitary jurisprudence” took up questions of public health. As early as 1819, Americans were reprinting English authorities on the public health law of contagious diseases. Writers cited the precedent of quarantines from Leviticus. Some medical jurists advised cities to take forceful action to stop the spread of disease. Officials, they advised, should create quarantine lines “not to be transgressed by the infected, nor by the healthy.” Authorities were to separate ill family members from healthy ones, forcibly if necessary.

This seemingly arcane field of the law soon became a forum for political debate over the meaning of responsible citizenship. In one respect, the jurisprudence of hygiene contained the seeds of a deep and abiding social reform. When the Massachusetts sanitary commissioners
insisted that “no person liveth to himself alone,” and that “we are social beings,” they were giving voice to values of social interdependence and solidarity. If social conditions and poor urban environs were the determinants of disease, then improving the living conditions of the poor was the way to fight off illness.

John Billings, a U.S. Army surgeon and lecturer on the law of hygiene, embraced this model of sanitary jurisprudence, which we might call a progressive sanitationism. Billings observed in 1879 that people “can have but little power as individuals to avoid, prevent, or destroy” the causes of epidemics and disease. The causes of illness, he insisted, are established for us, not by us. Hygiene, for Billings, was the collective practice of protecting the health of every member of the community. Just as the state protected our liberty and property, so too the state protected our health. Indeed, Billings affirmed the view of Chief Justice John Marshall and Chief Judge Lemuel Shaw in Massachusetts. Liberty and property would sometimes have to give way to public health imperatives. The public’s health highlighted the value of collective action through the state, because our incapacity to
manage our own environments individually meant that in the domain of public health we are all dependent on government to act for us. In dense cities like New York and Philadelphia, those most at risk of illness posed a risk to everyone else. As Billings put it, the “dangerous classes” were “an ever-present menace.”

If the condition of the so-called dangerous classes could be improved, however, the menace of contagion could be managed and even reduced. As one European observer put it, “It is not quarantines, but the rule of law and a chicken in every pot that cholera will respect.” Public health was a product of the accumulated social relations and systems of the society. And so, for some, the law of public health turned attention to improving the lives of the poorest Americans. John Griscom, an early sanitarian in New York, observed that a disproportionate share of disease victims were poor immigrants, although the rich seemed to live in ways that were just as profligate and immoderate. Griscom concluded that the bad health and shorter life spans of the city’s immigrant populations were due to “the confined spaces in which they dwell, the unwholesome air they breathe, and their filth and degra-
dation.”42 In 1867, New York adopted a new tenement housing code that increased tenants’ standard of living by mandating a minimum of one privy per twenty tenement inhabitants; a few years later the state upped the minimum to one per fifteen.43

In the early twentieth century, Progressive reformers worked to further improve the conditions of poor urban dwellers. New York enacted a series of laws regulating tenements. Child health stations offered infants safe milk and vaccines for smallpox and diphtheria.44 Reformer Lillian Wald founded the Visiting Nurse Service at her Henry Street Settlement and led efforts to fight tuberculosis and other infectious diseases in immigrant communities.45 Wald’s colleague Florence Kelley headed the National Consumers League, which drew attention to the risks of unsanitary conditions for workers, in part by observing that such conditions posed dangers for middle-class consumers of the goods such workers produced.46 (Consumers, she warned, might be “buying smallpox.”)47 Some, like the American Medical Association, focused on the personal habits of the working poor, blaming them for spitting in the streets and on floors. But
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Progressives such as Kelley and Wald scoffed that such a focus obscured the real issues. “Everybody knows the true remedy,” wrote the novelist and political agitator Upton Sinclair, “which would be the paying of sufficient wages, and the tearing down of the filthy tenements into which the laborers are packed.”

At other times, and in other hands, however, the jurisprudence of hygiene could produce a politics that focused on individual rather than social responsibility. In London, public health reformer Edwin Chadwick epitomized the conservative version of sanitationism. Chadwick was a leading force behind the 1834 reforms to the British Poor Laws, which aimed to reduce the costs of poor relief by instituting draconian workhouses and pushing people back into the labor force. By the 1840s, he was, in one biographer’s estimation, “the most unpopular single individual in the whole kingdom,” and for good reason. Chadwick was a standoffish and prickly character. In his view, attention to the public health of the poor and the working classes would produce better habits of thrift, temperance, and hard work. Filth produced moral decay, Chadwick insisted, and his massive 1842
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Report on the Sanitary Condition of the Labouring Population of Great Britain advocated cleanliness—better sanitation, water, and sewage services—as a way of further reducing the costs of poor relief and improving the labor supply to British industry.\(^{51}\)

Here was a very different politics of sanitation, not a progressive view that might lead to bettering the conditions of the poor, but a conservative or reactionary view that saw sanitation as a path to maximizing the value of the laboring poor and protecting elites from the risks of contagions spilling out of poor neighborhoods. In the United States, mid-nineteenth-century sanitarians like Massachusetts’s Lemuel Shattuck carried Chadwick’s view forward, imagining that poor health and poor hygiene were signs of a lack of moral virtue. States like Michigan in 1899 made it a crime for people with venereal disease (along with epileptics and the supposedly feebleminded) to exercise the right to marry.\(^{52}\) In myriad ways, the poor and disadvantaged were blamed for their bad health—and not only for their own. In the 1916 polio epidemic, rates of the disease were higher in wealthy neighborhoods, at least in part because
improved sanitation in middle- and upper-class homes deprived young children of early exposure to the polio virus, leaving them without the usual levels of immunity. Yet public health authorities focused nonetheless on the supposed dangerous filth of poor neighborhoods. Quarantine requirements for polio epidemics, moreover, were often regressive, needlessly imposing impractical mandates for separate dining and toilet facilities. “No tenement dweller,” writes the polio historian Naomi Rogers, “could have complied.”

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Sanitationism’s two political valences—one progressive, the other conservative—competed with one another throughout the nineteenth and into the twentieth century. Still, the progressive and conservative variants of sanitationism typically shared a common aim. They took the welfare of the poor and the working class seriously, even if they arrived at different prescriptions. They were both, at their core, forms of liberal politics.

The structure of American government was relatively well suited to pursuing both forms of nineteenth-century
sanitationism. The federal government, with its limited constitutional authority, played virtually no role. But state and local governments were able to promote sanitationist strategies for disease control. Thanks to the slow speed of transportation relative to later eras, the scope of eighteenth- and nineteenth-century epidemics often more or less matched the capacity of state and local jurisdictions. Expensive local and state investments in public health would serve the interests of local taxpayers, who benefited in the form of reduced risks of disease. Public health problems, as John Billings had observed, could align the interests of middle- and upper-class taxpayers with the poor and the working class, at least to a degree. Yet the capacities of the American state were poorly designed to achieve the more ambitiously progressive sanitationist visions. State and local governments were informal and underfunded affairs, run by amateur statesmen. This was not all bad; amateur hour in the statehouse has made it harder for certain tyrannical forms of statecraft to emerge. But a different and more authoritarian story line developed when the interests of those with power and those without were no longer aligned.
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