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Syphilis from 1880 to 1920: A Public Health Nightmare and the First Challenge to Medical Ethics

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Introduction

Around the turn of the twentieth century, syphilis was a public health disaster in the United States of America. Because of the lack of official reporting of cases to public authorities, estimates of its incidence are difficult to obtain; however, the figure has been estimated conservatively at ten percent[1] to fifteen percent[2] of the general population from about 1900 to 1920, although its occurrence was presumed to be higher among men than women. Furthermore, since it is transmitted primarily through sexual contact, syphilis was a huge stigma that all individuals wanted to avoid. When people did contract the disease, they were therefore inclined to hide it from the public so as to avoid being permanently branded by their communities. Because of the disgrace associated with syphilis, the topic was generally avoided by the public and the media, such that a veil of secrecy came to conceal it. As one author wrote in 1920,

> The third great plague is syphilis, a disease which, in these times of public enlightenment, is still shrouded in obscurity, entrenched behind a barrier of silence, and armed, by our own ignorance and false shame, with a thousand times its actual power to destroy. . . . It is one of the ironies, the paradoxes, of fate that the disease against which the most tremendous advances have been made, the most brilliant victories won, is the third great plague, syphilis the disease that still destroys us through our ignorance or our refusal to know the truth.[3]

Indeed, discussion of the disease only took place in specialized books and in medical journals, not in publications that most people would have read. Viewed as a subject beyond the "boundaries of decency," syphilis was thought to be a disorder that affected only the immoral. In fact, the American press, yielding to the desires of the common people, was so unwilling to deal with the matter that the *Reader's Guide to Periodical*

Literature did not include "syphilis" as a heading until 1907, and the *New York Times Index* avoided the term until late 1917.[4]

This taboo did nothing to help reduce the spread of the disease, as physicians were forced to tackle a problem about which few people knew. To complicate matters, the medical establishment was still new, in its earliest stages as an organized profession. American practice had still been unregulated in the mid-nineteenth century; it was not until the beginning of the twentieth century that state licensing and certification of physicians became widespread such that American doctors began to have a distinct legal standing[5]. These circumstances allowed frauds and quacks to persist throughout the early twentieth century. Physicians were left on shaky ground to confront the array of problems associated with the onslaught of syphilis beginning around 1880.

Syphilis challenged physicians in numerous areas. Just how privileged should communications between a doctor and his patient, when that patient has syphilis, be? What if a patient wants to get married and not tell his or her spouse of this condition prior to marriage? What if a diagnosis of syphilis is uncertain should the doctor air on the side of caution by telling the patient and likely causing him great emotional suffering, or should the doctor not unnecessarily burden the patient with such concerns? How extensive should public education efforts be, since increasing awareness might lead some people with the disease to avoid telling anyone due to fears of stigmatization? Should those with syphilis be segregated into separate facilities in order to reduce further transmission? Should a cure even be sought, since such an action might encourage vice? These were but a portion of the questions that the medical profession had to settle in its dealings with syphilis.

Recognizing the gravity of the situation, the American Medical Association (AMA) adopted "Principles of Medical Ethics" in May 1903 to replace its "Code of Ethics" from 1847. This new set of principles did not expressly deal with venereal diseases but did set explicit guidelines for patient confidentiality. By June 1912, these principles had been revised again, with two sections added dealing with various aspects of communicable diseases. The revisions and additions show an immature practice attempting to professionalize in the face of tough ethical issues raised by syphilis.

A close examination of physicians' writings from the period shows that the medical establishment acted with great tactfulness, choosing to respect confidentiality and ensure a patient's rights. They took great care to follow ethical guidelines in order to make certain that physicians were perceived as professionals. This caution was

paramount, especially before the discovery of effective treatments since a diagnosis of syphilis, being both incurable and communicable, would cause the patient great mental turmoil. It was not until about 1910, following the discovery of salvarsan by Dr. Paul Ehrlich, that some physicians increasingly called for stricter control measures and for some form of reporting of cases, and the AMA's "Principles of Ethics" of 1912 reflected this trend. Hence, overall, medical conduct from about 1880 to 1920, when the incidence of syphilis was probably at its height, was determined and shaped by medical ethics, with doctors always seeking to act in accordance with ethical guidelines.

A History of Medical Ethics

Writing in 1882, medical doctor Daniel W. Cathell explained the importance of medical ethics to physicians as follows:

> It is your duty to familiarize yourself with the Code of Ethics at the very threshold of your professional career, and never to violate either its letter or spirit. . . . [I]t is founded upon the broad basis of equal rights and equal privileges to every member of the profession, and stands like a lighthouse to all who wish to sail an honorable course. This code of ethics is the oracle to which you can resort and learn what things justice allows and what it prohibits; and it is to a very great extent these lofty ethics that elevate the medical profession in our land so far above common avocations.[6]

Dr. Thomas Percival proposed the first code of ethics in 1807, and numerous state medical societies were quick to adopt some form of ethical guidelines. With only minor changes, the code was adopted in its entirety by the AMA at its first meeting in 1847, and local medical groups seeking representation in the AMA had to require that their members follow this code.

By the 1880s, however, it became obvious that this code was outdated. In fact, four states had adopted codes different from that of the AMA, and two more states ignored the idea of codes and focused on lobbying for laws to govern medical practice. Further, only 20 percent of medical professionals had even accepted the code by becoming members of their local medical societies. Many societies had even been accepting members practicing sectarian medicine or members who engaged in consultations, both of which were explicitly banned in the code. "It thus happened that the Code of Ethics, in its attempted application to diverse conditions, physical, educational, political, social, and professional, became in many instances a most unethical document".[7]

Finally, in 1903, at the New Orleans meeting of the AMA, the problems with the code were discussed in order to reach a compromise. A set of "Principles of Ethics of the American Medical Association" resulted, replacing the old code, which had become outdated and which had declined in utility. The new guidelines reflected various changes desired by some state societies and allowed individual medical organizations to interpret the principles as necessary.[8]

Although accounts of the revision of the AMA's ethical code typically end at this point and conclude by stating that the principles "were again revised" in June 1912,[9] it is useful to examine the changes made between 1903 and 1912 more closely[10]. Although most of the changes were stylistic, two important additions were made. First, in the section on "Patience, Delicacy, and Secrecy," the italicized portions below had been added:

> Patience and delicacy should characterize all the acts of a physician. The confidences concerning individual or domestic life entrusted by a patient to a physician and the defects of disposition or flaws of character observed in patients during medical attendance should be held as a trust and should never be revealed except when imperatively required by the laws of the state. *There are occasions, however, when a physician must determine whether or not his duty to society requires him to take definite action to protect a healthy individual from becoming infected because the physician has knowledge, obtained through the confidences entrusted to him as a physician, of a communicable disease to which the healthy individual is about to be exposed. In such a case, the physician should act as he would desire another to act toward one of his own family under like circumstances. Before he determines his course, the physician should know the civil law of his commonwealth concerning privileged communications*.[11]

Second, in the section entitled "Physicians Should Enlighten Public Duties in Epidemics" the following portion in italics had been added:

> Physicians, especially those engaged in public health work, should enlighten the public regarding quarantine regulations; on the location, arrangement, and dietaries of hospitals, asylums, schools, prisons, and similar institutions; and concerning measures for the prevention of epidemic and contagious diseases. When an epidemic prevails, a physician must continue his labors for the alleviation of suffering people, without regard to the risk to his own health or life or to financial return. *At all times, it is the duty of the physician to notify the properly constituted public health authorities of every case of communicable disease under his care, in accordance with the laws, rules, and regulations* of *the health authorities of the locality in which the patient is.[12]*

Indeed, it is likely that the medical challenges posed by syphilis forced physicians to reexamine the principles that were to guide them in their practices.

Some Medical Aspects of Syphilis

The course of untreated venereal syphilis includes three stages. The primary stage begins one to ten weeks following infection and is marked by the appearance of a chancre or hard sore at the site of infection. The chancre may be so slight in color as to go unnoticed and heals within ten to forty days without leaving a scar.

The secondary stage produces clinical manifestations in about half of all cases and is characterized by lesions, a rash, or other generalized symptoms. This stage may begin four to eight weeks after the appearance of the chancre, or it can be delayed for many months. It can last several months, with the skin lesions disappearing spontaneously, usually without scarring.

Following the secondary stage, a latent period ensues, ranging in length from a few months to a lifetime, during which no outward sign of syphilis is recognizable and the patient is not infectious. Serological tests, however, remain positive for a long period of time.

About one in four patients may be expected to develop tertiary syphilis after this latency period. In half of these patients showing tertiary-stage symptoms, the disease is crippling or fatal. In the remaining half, the disease is benign and is characterized by ulcerated lesions, which are noninfectious and not fatal.

Between 1880 and 1920, there were two major medical advancements regarding syphilis. First, in 1906, the German bacteriologist August von Wassermann, working in conjunction with Albert Neisser, discovered the Wassermann reaction, a blood-serum test that could be used to determined if a person had syphilis. Additionally, as previously mentioned, in 1909, the German scientist Paul Ehrlich discovered arsphenamine, a drug that was marketed under the name of salvarsan. Released in 1910, salvarsan marked a major milestone in trying to control the spread of syphilis and was the most effective drug for treating syphilis until the discovery of penicillin in 1928.

Ethical Dimensions of the Diagnosis of Syphilis

Physicians always urged people to seek medical attention if they suspected they had syphilis, for as historian Claude Quetel writes, "[I]f an accident were to befall you all

the same, the worst attitude to adopt would be silence, which renders the medical art ineffective."[13] However, doctor-patient relationships involving syphilis had complex implications.

First, the diagnosis of syphilis could often be difficult, especially since there was frequently a long period of latency. In all situations, the carefulness of doctors in making diagnoses was critical, for one did not want to mistakenly diagnose with syphilis a patient who did not actually have the disease, nor did one want to find the patient to be healthy when he had actually contracted syphilis. Since a misdiagnosis of syphilis brought great mental suffering to the patient, the physician's duty to be skillful and attentive to his patients took on an added significance.

Further, it was not always clear if a doctor should even tell a patient that he had syphilis. In 1882, Cathell admonished fellow physicians

> Even when you are positive that a person has syphilis, it is not always best to say so. Prudence will sometimes require you to reserve your opinion, but at the same time give the proper medicine. Indeed, in practising medicine, you will see and understand many sins and blemishes of which you must appear oblivious.[14]

The 1903 "Principles of Ethics" contain a clause entitled "Encouragement of Patients," which seemed to permit this policy by stating,

> The physician should be a minister of hope and comfort to the sick, since life may be lengthened or shortened not only by the acts, but by the words or manner of the physician, whose solemn duty is to avoid all utterances and actions having a tendency to discourage and depress the patient[15].

However, it seems that doctors came to disagree with this position, especially those writing years later as syphilis had become more of a problem. As Mapes wrote in 1898, syphilis is transmitted between people, and, by not informing the patient of the disease and its dangers, the physician would essentially be responsible for that person infecting others. However, with a disease such as cancer, in which infecting others was not possible, telling the patient of his condition was not advised since it would only cause severe mental anguish[16]. The aforementioned clause of the 1903 "Principles of Ethics" was absent from the 1912 version. Its removal may have may have served to eliminate the possibility that a doctor would not tell a patient he had syphilis due to the depression that the diagnosis would cause, since considerations of infectiousness were more important.

Finally, there were those cases in which the patient refused to believe that he had syphilis, often because chancres and sores had not yet appeared, or because he had been misdiagnosed by a quack. Then it was imperative that the doctor establish his credibility with the patient in order to persuade him that the diagnosis was correct. Cathall advised doctors, "If you can show such a patient a fac-simile of his case in your illustrated works on venereal diseases, or read to him a description from a text-book, it will generally convince him fully."[17] Often times, the patient was reluctant to simply accept the long-term consequences of a disease such as syphilis, and he wanted to make sure that the physician was indeed making a correct judgment.

Marriage and Syphilis[18]

Many of the ethical issues surrounding syphilis centered around the subject of marriage. Since syphilis is a venereal and congenital disease, it can be transmitted between partners during sexual contact and from mother to child during pregnancy. Thus, many questions arose regarding marriage, infidelity, and conception in relationships in which one or both of the partners had syphilis. At the heart of the dilemma was the physician, whose advice regarding these key issues would not only influence his patients, but also that patient's sexual partners, spouse, and potential children. In order to prevent innocent people from contracting the horrible disease, the physician had to walk a tight line between protecting the rights of his patients and endangering the health of the public. As Quetel writes in his book *History of Syphilis*,

> [The physician] cannot escape the role of mediator, or arbiter, which is forced on him when a former syphilitic comes to his surgery and asks: Doctor, is it safe for me to marry? . . . [A] conflict arises, in which the interests of the patient and the public interest are opposed, "for beyond this client stands a young girl, unborn children, a family, and society, and your prohibition will protect them all. What importance the doctor's mission assumes when he becomes the arbiter of so many common interests in this way![19]

Instead of categorically forbidding marriage or allowing it as soon as the primosecondary symptoms had disappeared, doctors around 1900 charted a middle course of suggesting a waiting period after the symptoms were no longer apparent. Some doctors pursued this option because they believed syphilis was indeed curable; others, however, were much more doubtful of any prospects of complete recovery but felt that it was important not to deny individuals the ability to marry and have children, especially when the symptoms did not reappear after some time.[20]

The exact waiting period recommended following the absence of symptoms varied from doctor to doctor and depended on the severity of the case. Contemporary physicians disagreed: Fournier believed that six months to three years was sufficient;[21] Thomas Shannon recommended one year;[22] and John Stokes suggested two years of waiting after three years of treatment: "the five-year rule."[23] Most thought that these periods should be longer for women because of the added risk of them passing the disease to their children during pregnancy[24]. Following the development of the Wassermann test, some doctors changed the standard to state that a syphilitic should not marry until one or two years after the test is no longer positive, although others doubted the accuracy of this indicator[25]. Based on his records, one doctor estimated that a man with untreated syphilis who married and took no special precautions to protect his wife had a ninety-two percent chance of infecting his wife in the first year, a seventy-one percent chance in the second year, a twenty percent chance in the third year, and a negligible possibility every year thereafter.[26]

Doctors generally raised no objections if two syphilitics desired to marry each other. They were, however, careful to warn the couple that serious damage could be done if the woman became pregnant and to recommend that both husband and wife be free of symptoms for at least two years before attempting to conceive.[27]

Marital syphilis usually was passed from husband to wife and rarely from wife to husband. Most women were believed to have refrained from sex before marriage and to be faithful to their husbands during marriage. A man who claimed to be loyal to his wife and to have nonetheless contracted syphilis during marriage was generally not believed. Syphilis was much more common in married women than in those who were single (except prostitutes), since married women were often infected by their husbands. Men who developed syphilis during marriage were also noted to infect their wives much more than those who developed it before marriage.[28]

Even when all precautions were followed and a syphilitic married well after the period of infectiousness was over, doctors still recommended that every member of the family regularly have a Wassermann test to account for the small possibility that they still may have contracted the disease[29]. If either spouse was syphilitic during conception, the thorough treatment of the woman, including the administration of salvarsan throughout the pregnancy, was strongly advised in order to prevent congenital syphilis.[30]

However, the doctor's recommendations to his patients were, as one might suspect, not always followed. Although some patients heeded the doctor's advice and were willing to wait to get married, many other syphilitics insisted on hiding the disease and getting married immediately, raising ethical dilemmas in the area of patient confidentiality. Nonetheless, whatever the patient decided was final, and most laws prior to 1910 forbade breaching medical confidentiality without the patient's consent[31]. Thus, the physician would usually plead with his patient not to proceed with the marriage, as depicted in the famous French play *Les Avari,s*, in which a doctor exhorts a man against marriage: "To get married without saying anything is to enter society failing to disclose crucial information. . . . In the name of those innocents, I beseech you, it is the future, the race I am defending!"[32]

Doctors, in their quest to prevent infection, demanded that innocent people be safeguarded in marital cases involving syphilis. They called for syphilis to be recognized as a reason that an innocent party may seek a divorce, regardless of whether the partner contracted syphilis before or after the marriage occurred. Although this move was seen as an attack on the institution of marriage, it was felt to be justified by the dangers associated with syphilis. Further, physicians believed that such a law would not lead to many divorces, but, more significantly, would instead prevent marriages in which a partner did not inform his spouse of his syphilis or in which a partner was prone to adultery.[33]

Various states also attempted to prevent this problem and curtail the spread of syphilis, especially after the discovery of salvarsan as a treatment. By 1916, nine states had enacted laws making syphilis a bar to marriage. These laws made annulment and divorce significantly easier in cases where a spouse was found to have had syphilis prior to the marriage without informing the partner. However, they accomplished very little in terms of public health because their specific requirements made enforcement very difficult. Indeed, requiring a negative Wassermann and providing the test free of charge at a public facility would likely have been a better option than those pursued by these states, but this response was considered too expensive to implement[34]. Shortly before 1920, Ohio became the first state to allow physicians to inform all involved parties if a person to be married had a venereal disease.

Thus, marriage truly tested the limits of doctor-patient confidentiality, since some patients with syphilis did not heed the advice to postpone marriage or at least to inform their future spouses. However, many physicians felt as though they were accomplices in a crime by not informing innocent women of the medical condition of their future

husbands. After all, the Hippocratic oath, considered the foundation of all systems of medical ethics, states, "My tongue shall be silent as to the secrets which are confided to me and I will not use my profession to corrupt manners or *aid crime*."[35] Many saw this opening as a possible justification for violating the sacred concept of the medical secret, since breaching confidentiality would prevent a crime.

Medical doctors remained very divided over how absolute the standard really was. The classic example was a case in which an innocent young woman was about to make a grave error by unknowingly marrying a syphilitic without a moral conscience. The arguments on both sides are fascinating to explore. Among those who favored breaching confidentiality, one doctor argued, "[S]hall we respond with a silence which may be misunderstood and thus render ourselves accomplices of the fruits of which will be so deplorable? Never would I have the courage to obey the law under such circumstances. My conscience would speak higher than it." The language used by those favoring preservation of an absolute standard is just as colorful. One commented on the idea that a doctor would not remain silent for his patients: "It [is] treason, perpetrated with the 'best intentions,' but still a treason, for [the patients are] no longer masters of the secret which no doubt would not have been revealed if they had known what use was going to be made of it."[36] Ultimately, each doctor decided these difficult cases by applying his own reasoning and judgment; since physicians on both sides had worthy intentions, none were truly deserving of condemnation.

The AMA seemingly understood the nature of this conflict, as reflected in the changes it made to its "Principles of Ethics" from 1903 to 1912. The new guidelines established in 1912 still stated that confidences "should never be revealed" but added that there were instances in which a doctor had to be mindful of protecting healthy individuals from infection by a person with a communicable disease[37]. This new standard virtually acknowledged the challenges that doctors were facing in the area of patient confidentiality as a result of marital cases involving syphilis.

Legislators sometimes obliged physicians to speak or remain silent on this issue. By 1904 the laws of twenty-three states made all communication between physicians and patients privileged, while in nineteen states doctors were obliged to reveal secrets in court when required by the nature of the case. One author recommended that all communication be privileged, except in three instances: with the consent of the patient, to defend himself when accused, or to expose crime[38]. This position was one with which many others agreed. By this standard, doctors would be allowed to divulge

information if a syphilitic was ruthlessly going to marry without telling his partner of the condition, for such an act was considered a crime.

Quacks and Frauds

Syphilis was a devastating ailment that had the ability to ruin lives and families. In the face of this burden, syphilitics often sought the advice of quacks, who offered baths, rubs, and hot springs as remedies for pain. However, the legitimate medical profession made all attempts to inform the public that quacks and frauds did not offer viable solutions to their problems. Physicians heavily stressed the need to consult with them in a suspected case of syphilis or after exposure to the disease, so that a correct diagnosis could be made, proper treatment options could be explored, and sound medical advice could be given. As one doctor wrote, "For a patient to falsify the facts or to ignore or conceal them is simply to work against his own interests and to hinder his physician in his efforts to benefit him."[39]

Clearly, among the reasons syphilitics felt the need to consult a quack, primary was the desire not to be discovered and branded. Prior to the 1920s, popular magazines and newspapers made no mention of syphilis, and "ninety-eight persons in a hundred who know that there is such a disease as syphilis are alive to the fact that it is considered a disgrace to have it, and to little else."[40] People simply viewed the disease as punishment for sexual wrongdoing. Some even thought that, if a cure were found, it would encourage sexual promiscuity and lead to moral disintegration because people would no longer have to fear the possibility of contracting a disease.

However, the calls for action against any sort of quackery were heard often, and the medical profession was seen as playing a vital role in the effort to get rid of frauds in order to safeguard the integrity of the medical practice. Physicians, fearing that people saw medicine mostly as a matter of "guess-work," led efforts to encourage the states to adopt measures against quackery. One doctor proposed a board of examiners that would determine if candidates were "well grounded in the structures and functions of the human body, the remedies for poisons, the rules for action in emergencies and the principles of diagnosis," with the members of this board being appointed on the basis of qualifications alone."[41]

It was not until about the mid-1910s, following word of the discovery of salvarsan, that the veil of secrecy that had obscured any informed public knowledge of syphilis was finally beginning to be lifted. Physicians, who viewed it as their ethical duty to help

educate people about diseases, helped in this effort. Articles, pamphlets, magazines, novels, lectures, and posters all addressed the subject directly and emphasized prophylaxis and treatment. Doctors in particular began to succeed in revealing some of the contradictions inherent in the view that syphilis was a form of punishment. They pointed out that syphilis does not punish fairly, especially since some of the most promiscuous people are spared while some of the innocent are not. Further, they stated,

> The very ones whose punishment it should be are the most indifferent to it, and the least influenced by fear of it in their pursuit of sexual gratification. . . . Sexual self-control is a habit, not a reasoned-out affair, and its foundation must rest on the rock bottom of character and not in the muck of venereal disease.[42]

They also sought to dispel the idea that cures and treatments would encourage vice and should not be found, both by explaining that fear of infection had already failed to deter sexual immorality and by citing the many innocent people who deserved protection from a disease so devastating[43]. Hence physicians, in their effort to combat syphilis, urged people to cast aside the mistaken attitudes that had, for so long, hampered eradication efforts and driven people to quacks, and instead to view the disease as a common enemy that destroys people's happiness and welfare.

The aim of these educational efforts was obviously to promote greater awareness of syphilis as a communicable disease, but in doing so, doctors and health associations also hoped to arouse enough sentiment such that people would begin to support stricter legislation[44]. In 1916, at a time when many hospitals still did not have provisions for the treatment of syphilis, one doctor reported, "It is easy to argue for special hospitals for syphilis, but the public is not educated enough to see this necessity."[45] In marriage as well, the barriers constructed by confidentiality between a doctor and his patient had to be countered by public arousal.

> The thousands of virtuous wives who suffer in ignorance disease, sterility and mutilation of their bodies, and in whom the holy office of maternity is desecrated by the production of abortions, tainted and diseased children, should know that the standard of morality they now tolerate in the men they marry is the responsible cause. This knowledge should come through general enlighteninent of the public. [46]

By informing the public of the scope of the problem with syphilis and the societal ills it was causing, people would come to demand more male responsibility in sex and marriage and measures providing for the free diagnosis and treatment of syphilis.

Doctors understood that they had an ethical responsibility to educate people and to prevent quackery so that lives could be saved by preventing the spread of infectious diseases. They knew that the burden of teaching people to protect themselves fell squarely on doctors, for without an enlightened public, "general laws and sweeping public measures are ... insufficient to prevent the spread" of diseases."[47] Common people had to be taught the aims and goals of medicine, for a true community effort was imperative to medical success in fighting syphilis.[48]

Reporting Cases of Syphilis

A major point of contention in the physician-patient relationship concerned the reporting of cases of venereal disease to a central public authority[49]. Physician Henry H. Hazen, writing in 1919, summed the debate well when he explained, "The majority of hygienists are in favor of it, and the majority of men who treat such cases are bitterly opposed to it, feeling that it will drive the patients into the hands of the quacks."[50] Many doctors simply felt that it would lead their patients to be uncooperative and to conceal their cases. As evidence, they pointed to the city of Christiania, with a population of 250,000, which had tried notification of venereal diseases for a decade, with very poor results. Their annual notification rate averaged less than 1 percent, even though the actual rate of infection for the general population was around 10 percent. Hospital admission rates for syphilis also declined significantly with the introduction of notification procedures[51]. As one physician quipped, "What are you going to do with your patient when you have got him reported?"[52]

Doctors rightly pointed out that any legislation that would be successful had to benefit the patient, and proposals for reporting could not be advantageous for syphilitics. Particularly prior to 1910, most doctors opposed reporting because nothing could be done to help the people being reported, especially since no effective treatment existed. Further, they knew that if they complied with such regulations, they would develop bad reputations that would lead patients to seek quacks or to avoid assistance altogether.[53]

Thus, numerous doctors came to the conclusion that reporting alone was woefully inadequate and that a legitimate plan would provide for an incentive to patients. With the discovery of salvarsan in 1909, that incentive was in sight. Many physicians began to advocate plans for reporting that included measures for free diagnosis and treatment, along with prohibitions against quacks and frauds. Since syphilis was no longer incurable, it seemed as though reporting might be an option, especially given that

public support was increasing for control measures such as notification[54]. Accordingly, the 1912 version of the AMA's "Principles of Ethics" called for physicians "to notify the properly constituted public health authorities of every case of communicable disease under his care,"[55] a clause which was not in the 1903 version.

Still, many doctors made it clear that to eradicate syphilis a more extensive plan than mere notification was needed. For example, Hazen advocated taking actions a step further. He pointed out that most patients with syphilis attended free clinics, often only making one visit and not seeking treatment for either themselves or their children. Thus, we could not worry about a patient's cooperation when most syphilitics would not even commit to any help without notification. He recommended a law similar to that passed in Western Australia, which required a patient to seek assistance immediately after developing a venereal disease, the doctor to notify authorities of the case, and the patient to receive treatment every month, with strict measures such as fines and imprisonment if any part was violated. It also allowed officials to force any person to submit to a medical examination. Thus, instead of simple notification, this law compelled treatment for all cases and refused to allow people to neglect their duties to be cured.[56]

Because of the lengthy period of contagiousness involved in syphilis, quarantining patients was simply not an option, as it would have been for scarlet fever or measles.

> We cannot deprive a patient of his power to earn a living, to say nothing of his liberty, without providing for his support and for that of those who are dependent on him. To do this in so common a disease as syphilis would involve an expenditure of money and an amount of machinery that is unthinkable. Accordingly, as a practical scheme for preventing its spread, the quarantine of syphilis throughout the infectious period is out of the question.[57]

Furthermore, since infections occurred by sexual contact, syphilis was very different from other disorders, and "a direct medical attack on the source of the infection [was] out of the question."[58]

By the mid-1910s, however, as salvarsan was being more widely used, some physicians did feel that short periods of quarantine were necessary, although this opinion was still unpopular. Stokes noted his frequent contact with patients, some of whom were so irresponsible that they did not care about a physician's pleas and were content to pursue their selfish interests, even if the likelihood of infecting others was still very great. He proposed quarantine "at least until the germs are killed off for the time being."[59] Most,

however, realized that, even for short time periods, segregating syphilitics would be rejected by the public and would be impossible to enforce given the number of patients. [60]

Clearly, reporting cases was a controversial issue with syphilis, since doctors wanted to protect their patients' medical secrets, while also serving the interests of society. After the discovery of salvarsan, however, the need to provide for some sort of reporting and treatment mechanism of patients was generally acknowledged by physicians and the public, despite its implications for the doctor- patient relationship.

Conclusion

Syphilis represented a unique public health challenge because it carried with it a huge stigma and because it was transmitted by sexual contact. It was a disease that no one wanted to have or discuss. Yet it probably afflicted 10 percent of the population, with a greater incidence in males than in females, and some methods of prevention, control, and treatment were imperative if the disease was ever to be eradicated.

The medical profession was faced with this weighty challenge. It was a profession that was still in its early stages of development and whose relations with the state and the public had been tenuous, especially prior to 1900. Doctors were battling fundamental questions of their role in a society that was being ravaged by a terrible disease being perpetuated by vast public ignorance. At the same time, within the profession itself, physicians were trying to formulate some coherent set of fundamental ethical principles to guide doctors and to provide them with a framework for dealing with the decisions that would confront them in their various duties.

The primary issue that lay at the heart of any discussion of medical ethics and any plan for controlling the spread of syphilis was patient confidentiality. To what extent could doctors be expected to conceal everything that occurred in their contact with patients? The most common conflict between ethics and a doctor's conscience arose when a man was diagnosed with syphilis and, despite warnings to wait, was intent on getting married without telling his partner of the condition. The tremendous debate on this subject that took place in the medical literature signals that doctors truly understood their ethical duties and recognized that any hasty action would impede their efforts to establish credibility with the public. The AMA, seemingly as an acknowledgment of this difficulty, revised its "Principles of Ethics" in 1912 to allow a doctor to breach confidentiality if he thought that the situation necessitated such action. Since there was

clearly no ultimate standard, the care that physicians took in addressing the problem was a significant step forward for the profession.

In addition, doctors also found it to be their ethical duty to educate the public on matters related to syphilis. They recognized that the veil of secrecy that shrouded the disease would continue to cost more lives. If people were not educated, they could not protect themselves against the potential dangers. Physicians also understood that public support was crucial to any legislation attempting to curtail the spread of syphilis. Any measures, including marriage restrictions, reporting of cases, more hospital beds for syphilitics, or even quarantines, were doomed to failure if the public did not understand their significance.

In the 1900s, the role of the public took on even greater importance. The literature reflects that, following the development of the Wassermann test in 1906 and Dr. Ehrlich's magic bullet (salvarsan) in 1909, physicians began to view the issues in a different light. Syphilis became easier to diagnose and treat, and thus it became more appropriate to advocate measures such as reporting, mandatory treatment, and isolation for patients. Prior to this time, there were fewer references to these legislative techniques since it was unrealistic to expect that syphilitics would allow such paternal measures when there was no hope for a cure. It was widely accepted that adopting such laws would simply serve to drive patients to quacks. However, in the 1910s, as salvarsan became widely available, the public began to demand that syphilitics be reported, diagnosed, and treated. Now that there was a cure, the reasons for doctors to hide cases were no longer as compelling.

Thus, the period between 1880 and 1920 saw syphilis and medical ethics combine to form a unique challenge. From about 1880 to 1910, doctors used ethical guidelines to establish patient trust and develop a framework for controlling syphilis through education. They understood that the public would play a dominant role in any efforts for eradication. By 1912, however, even the AMA came to recognize that patient confidentiality could not be absolute, and with the advent of salvarsan, the AMA also recognized the importance of reporting cases of syphilis. Additionally, many doctors advocated some form of notification and treatment of syphilis cases to stop the spread of the disease, and the public largely supported their efforts. Syphilis was a devastating ailment, and doctors, as well as the public, had committed themselves to eliminating it from the population, once and for all.

Notes

[1] John H. Stokes, *The Third Great Plague: A Discussion of Syphilis for Everyday People* (Philadelphia: W.B. Saunders Company, 1920), 26.

[2] Elie Metchnikoff, *The New Hygiene: Three Lectures on the Prevention of Infectious Disease* (Chicago: W.T. Keener and Company, 1907), 77.

[3] Stokes, 7.

[4] Terra Ziporyn, *Disease in the American Popular Press: The Case of Diphtheria, Typhoid Fever, and Syphylis* (New York: Greenwood, 1988), 115.

[5] J. N. Hays, *The Burdens of Disease: Epidemics and Human Response in Western History* (New Brunswick: Rutgers University Press, 1998), 216.

[6] Daniel W. Cathell, *The Physician Himself and What He Should Add to His Scientific Requirements* (Baltimore: Cushings & Bailey, 1882), 41-2.

[7] Charles A. D. Reed, "Medical Organization and the Present Status of the code of Ethics of the American Medical Association," *New York Medical Journal* 77 (1903): 371-2.

[8] Chauncey Leake, ed., *Percival's Medical Ethics* (Baltimore: Williams & Wilkins, 1927), 49-56.

[9] Leake, 56.

[10] Leake, 239-71.

[11] Leake, 258.

[12] Leake, 270.

[13] Claude Quetel, *History of Syphilis*, trans. Judith Braddock and Brian Pike (Baltimore: Johns Hopkins University Press), 144-5.

[14] Cathell, 71.

[15] Leake, 241-2.

[16] C. C. Mapes, "Shall Patients Be Informed that They Have Cancer or Syphilis?" *New York Medical Journal* 68 (1898): 560-1.

[17] Cathell, 187.

[18] For a discussion of seven cases demonstrating a range of situations dealing with syphilis and marriage, see Henry Lee, *Lectures on Syphilitic and Vaccino-Syphilitic Inoculations: Their Prevention, Diagnosis, and Treatment* (London: J. Churchill & Sons, 1863), 254-65.

[19] Quetel, 150.

[20] Quetel, 150.

[21] Quetel, 150.

[22] Thomas W. Shannon, *Nature's Secrets Revealed: The Laws of Sex Life and Heredity or Eugenics* (Marietta, Ohio: S.A. Mullikin, 1919), 274. The author adds, "It would be much better for the race if all who have in any way been tainted with this foul disease would refrain from having children. Never mind the appearance; take no chances, though you may seem well."

[23] Stokes, 127.

[24] Loyd Thompson, *Syphilis: Diagnosis and Treatment* (Philadelphia: Lea & Febiger, 1916), 181.

[25] Sigmund Pollitzer, "Syphilis in Relation to Some Social Problems," *American Journal of Obstetrics and Diseases of Women and Children* 73 (1916): 848.

[26] Stokes, 126.

[27] Abner Post, "Some Considerations Concerning Syphilis and Marriage," *Boston Medical and Surgical Journal* 121 (1889): 601-2.

[28] Edward B. Vedder, *Syphilis and Public Health* (Philadelphia: Lea & Febiger, 1918), 135-7.

[29] Quetel, 128.

[30] Thompson, 402.

[31] Quetel, 151. He also cites an 1886 case, in which a doctor was imprisoned for one year and fined 1000 francs for sending a request for payment to a bailiff. The request stated the name of a person who owed the doctor 300 francs "for having treated him for, and cured him of, two serious syphilitic diseases contracted at different times during the years 1862 and 1863."

[32] Quetel, 153.

[33] John V. Shoemaker, “Syphilis, Marriage, and Divorce,” *Journal of the American Medical Association* 9 (1887): 80.

[34] Vedder, 202-3.

[35] Prince A. Morrow, “Syphilis and the Medical Secret,” *Journal of Cutaneous Diseases Including Syphilis* 21 (1903), 271; italics in original.

[36] Morrow, “Syphilis and the Medical Secret,” 273-5.

[37] Leake, 257-8.

[38] David W. Cheever, “Privileged Medical Communications,” *Medical Communications of the Massachusetts Medical Society* 19 (1904): 684-6.

[39] Stokes, 140.

[40] Stokes, 142.

[41] D. B. St. John Roosa, “The Relations of the Medical Professional to the State,” *Samaritan* 7 (1879): 151-2.

[42] Stokes, 143-6.

[43] Metchnikoff, 102-3.

[44] Many of the education efforts were spearheaded by a group called the Society for Moral and Sanitary Prophylaxis, which managed to achieve sex education in schools. See Pollitzer, 855-6.

[45] Isadore Dyer, “The Control of Syphilis,” *Interstate Medical Journal* 23 (1916): 650-1.

[46] Prince A. Morrow, “The Control of Syphilis and Venereal Disease,” *Boston Medical and Surgical Journal* 156 (1907): 172.

[47] William Sydney Thayer, “On Some Relations of the Physician to the Public: Duties and Opportunities,” *Journal of the American Medical Association* 50 (1908): 1881.

[48] Alfred Worcester, “The Physician’s Extra-Professional Duties,” *Boston Medical and Surgical Journal* 132 (1895): 586.

[49] Interestingly, one of the groups who vociferously advocated a policy of notification and treatment was women, who found it abominable that people were free to spread venereal diseases. See Vedder, 237.

[50] Henry H. Hazen, *Syphilis: A Treatise on Etiology, Pathology, Diagnosis, Prognosis, Prophylaxis, and Treatment* (St. Louis: C.V. Mosby Company, 1919), 545.

[51] Vedder, 236.

[52] Vedder, 238.

[53] Vedder, 236.

[54] Vedder, 237-42.

[55] Leake, 270.

[56] Hazen, 545-7.

[57] Stokes, 121.

[58] Henry J. Nichols, “Syphilis as a Public Health Question,” *Journal of the American Medical Association* 62 (1914): 1526.

[59] Stokes, 153.

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