Oral History Center

Epidemics and American History

US History Grade 11

September 2020

For more information on curriculum, see the Oral History Center website.

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Introduction

This set of lesson plans was created in 2020 at the height of the COVID-19 pandemic. If you are using this lesson plan within recent memory of this epidemic, you or your students may be more curious about the history of epidemics than before. The entire world is currently affected by a single organism, a little strand of RNA wrapped in a few molecules of proteins and fat. People are afraid, fighting with each other about what to do, and losing time against a dangerous threat. People are mistrustful and doubt the information they receive from experts about what to do, as the recommended or mandated responses involve tremendous sacrifices of time, resources, money, and in some cases, livelihoods and personal health. Furthermore, people are mistrustful of experts, full stop. They question scientific evidence and science-based recommendations if they seem to run against what people believe and are familiar with. And this is a particular pattern in US history.

If this unit is used long after this danger has passed, students may wonder why the history of epidemics should matter. This history matters because the periodic emergence and recurrence of epidemic disease is the normal pattern of recorded history. These diseases are so devastating that they restructure the societies that face them in ways that offer some protection from future harm. These structures—public health, military, medical, scientific, and community institutions—remain for the most part out of the public eye, until they become the object of accusations of government bloat and unnecessary expenditures. Since other daily problems command our attention, these systems are often subject to cuts in funding and public support. With the passage of time and the emergence of new challenges, these institutions and their plans become outdated. However, it is our recent complacency about epidemic disease that is out of step with the broad patterns of history. We place enormous value on individual initiative and freedom of choice, and the story we tell ourselves about our government is that it is committed in theory to taking a minimal role in the lives of its citizens. Epidemic diseases do not operate on us as individuals alone; they depend on us to be connected. And we are connected, more than ever before, making epidemics and the threat of pandemics more and more deadly and costly to our interconnected global economy.

A Brief History Lesson

The history of epidemics is characterized by deep, recurring patterns of thought and behavior. Epidemic diseases very often sprang up in port cities, which gave rise to two explanations. One is that the disease agent, whatever it was, came on board the ships bringing goods and people from somewhere else. The other was a more environmental or place-based explanation for disease. Port cities were in lowland areas, often nestled in the deltas of great rivers which would carry goods down to waiting ships or up to towns and cities in the interior of the country. Though unknown at the time, some diseases, such as Yellow Fever and malaria, for example, are spread by mosquitoes, which flourish in swampy areas and in certain times of the year. This lent support to the idea that disease was the result of breathing foul-smelling "bad air," or *mal aria* in Italian, the name given to another mosquito-borne illness.

Blaming the victim: poor people and foreigners thought to spread disease

A practice common to both theories of the spread of disease was to blame some group as its cause. Even if some people believed that it was the swamp that made people sick, they tended to think it was those "bad" people who lived nearest the swamps who got sick. Sinful behavior, in a common view, would lead to illness. The poor—with their perceived vices of alcohol, prostitution, and lack of self-regard—also congregated in port cities. They were therefore to blame for their own sickness. And since the port city was the connection point to the rest of the world, people also blamed foreigners from other countries, even those who had been living in the port cities for a long time.

Interestingly, historians who studied epidemics that occurred in the nineteenth century concluded that those who most often proclaimed that disease was based on place or the seasons were overwhelmingly from the merchant class, those who faced bankruptcy if the port responded by shutting down trade. For others who believed that disease was a contagion that spread from person to person, the solution was to keep ships that wanted to dock out to sea for a period of up to 40 days, or what the French called *quarantaine* and what we still call "quarantine" today. Closing ports disrupted trade. Those who had the means could flee the ports for homes in the country, escaping both the "bad air" of the swamps or whatever contagion might pass from the infected to the healthy. Just as often, however, they brought the disease with them and infected people in the countryside.

Germ theory of disease

From the last third of the nineteenth century to the beginning of the twentieth, scientists such as Edward Koch and Louis Pasteur discovered that small, invisible germs infected people, as well as food and water supplies, in ways that caused disease. Many cities were also reorganized to supply clean water to their citizens and to provide sewer systems to bring human and animal waste away from the population. In the twentieth century, scientists also developed vaccines and medicines against common epidemic diseases. People grew complacent, believing that science could conquer new diseases quickly and efficiently, so they came to believe there was nothing to worry about.

Public health services

The national public health service in the United States emerged from these first responses to epidemics in port cities. In fact, the first public health service was called the US Marine Hospital, founded in 1798 to deal with the quarantining of ships and to find and to care for sick sailors, which would later be known as contact-tracing.

The germ of fear

What's important to remember here is that the beginning of an epidemic is when scientists, doctors, and health officials know the least about a new disease, and when the public is most likely to be at risk of succumbing to fear. When people are afraid, they rush to protect the world they inhabit and often fall back on stereotypes about how they think the world works. This can involve scapegoating, blaming the first victims of the disease, or even just blaming groups they already dislike. Others resist the deployment of public health measures, as they fear that the proposed solution to the outbreak—some abridgement of their freedoms and an increase in the size and scope of government authority and expenditures—would be worse than the disease itself. They distrust experts and are more likely to believe that the disease will either not affect them or that its impact will be very temporary. This last tendency is especially true of the people of the United States, who have long had an ambivalent relationship to government. But in a panic situation, the tendency to blame outsiders and the first victims remains a key feature of epidemics in general, throughout history.

Additional Resources

In this unit, the focus will be on the oral history resources related to the AIDS epidemic as it struck San Francisco in the early 1980s. However, there are many resources out there which offer material for the study of epidemics in history. John Barry's *The Great Influenza* is one place to look.

The United States Centers for Disease Control and Prevention (CDC) has put together some helpful information about pandemics in history.
https://www.cdc.gov/flu/pandemic-resources/basics/past-pandemics.html

This online archive below is the product of extensive research by historians of medicine Howard Markel and Alexandra Stern, who were supported by the Pentagon, the CDC, and the Robert Wood Johnson Foundation to study the past in order to provide guidance on how to slow the spread of an epidemic without effective treatments in place. This research is the origin of the insight about "flattening the curve."
http://www.influenzaarchive.org/

2007 CDC/University of Michigan study

Historians, journalists, and the public at large have long been interested in the 1918 "Spanish flu" epidemic, a dramatic chapter in American life that has spawned an impressive body of books, articles, and multimedia. The memory of the 1918 epidemic also has left a lasting mark on public health policy, planning, and practice. Indeed, for each influenza epidemic that followed in its wake—in 1957, 1968, and most recently 2009—the events of 1918 have served both as a reference point and a severe, if not "worst case" scenario.

It was within this context that, in 2006 to 2007, the Center for the History of Medicine (University of Michigan) collaborated with the CDC on a study of the use of non-pharmaceutical interventions (NPI) in American cities during the 1918-1919 influenza epidemic. Unlike in 1918, today we have the ability to develop vaccines against specific strains of influenza in circulation. The process is a lengthy one, however, requiring numerous steps and many months before a vaccine can be produced and distributed in bulk. Realizing that it would take approximately five to six months for the first supplies of vaccine to become available in the event of a new influenza pandemic, and with the

possibility of an H5N1 "avian" influenza epidemic looming, public health officials at the CDC were interested to know what lessons could be gleaned from 1918. How did American cities respond in the fall of 1918? Were their efforts successful? Could these methods be used effectively today?

After an intense, year-long examination of the public health response of 43 American cities during the 1918–1919 epidemic, researchers at the Center for the History of Medicine and the CDC concluded that those cities that used social distancing measures and other non-pharmaceutical interventions in 1918 fared better than those that did not. More specifically, they found a strong association between early, sustained, and layered use of NPI and mitigating the consequences of the epidemic.

The results of this research were published in *Journal of the American Medical* Association in August 2007 and subsequently became the basis for the Department of Health and Human Services' community mitigation guidelines for pandemic influenza, and, ultimately, COVID-19.