Mismanaging Mayhem: How Washington Responds to Crisis

Edited by
James Jay Carafano
Richard Weitz

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Mismanaging Mayhem

How Washington Responds to Crisis

Edited by James Jay Carafano
and Richard Weitz

The Changing Face of War
For the men and women who serve the nation—past, present, and future
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Between the unshakable ideas that government is the root of all evil and the answer to all problems stands the reality of governing. Governing is hard. When life and liberty stand at risk, applying everything official Washington can do to keep the nation safe, free, and prosperous can be even more perilous.

The United States government has more than 2 million civilian employees. Five out of six work out of sight of the national capital. They are joined by almost 3 million in uniform around the world and a Congress backed by a staff of over twenty thousand on Capitol Hill. Counting them all together makes Washington a bigger employer than any corporation. The men and women that serve in the executive and legislative branches comprise a vast enterprise—carrying out mundane duties, responding to crises, forging new visions, correcting past mistakes. Over the course of history, sometimes they have made America a better place—sometimes their efforts have gone horribly wrong.

Coordinating the work of departments, agencies, staffs, and Congress—and then harmonizing action with state and local governments, the private sector (including everything from commercial companies to the Red Cross), and foreign partners ranging from other countries to international organizations like the United Nations and European Union—is often called “interagency operations.” Conducting them well is a challenge. The Departments of Defense, State, Homeland Security, and Treasury, as well as the FBI, CIA, and other government agencies, have different capabilities, budgets, cultures, operational styles, and congressional oversight committees. They even operate under different laws. Getting multiple agencies and departments organized on battlefields, after disasters, and during times of crisis can be as frustrating as “herding cats.” As a result, the history of getting government agencies to cooperate is replete with stories of courage, heartbreaking tragedy, and blundering incompetence. The purpose of the book is
to shed light on why managing interagency operations has proven especially difficult for the U.S. government.

To meet the dangers of the twenty-first century, interagency operations will be more important than ever, yet few Americans understand the troubling history of Washington’s failures and the pressing needs for reform. *Mismanaging Mayhem* is an unprecedented effort at crafting a sober history of government’s most pressing problem: working together when lives are on the line.

The stories told here examine some of the nation’s darkest moments and most exhilarating victories, from dealing with the great flu epidemic of 1918, to responding to natural disasters at home and abroad, to fighting wars and rebuilding countries. They document how government bureaucracies have tried to work together over time to keep Americans safe and secure. These histories are remarkable not only for the lessons they offer on the difficulties of improving interagency operations but also for suggesting some surprising insights on the tumultuous legacy of when Washington took charge.

- Government policies contributed to the influenza pandemic of 1918.
- During World War II, winning political battles mattered more than winning the war of ideas.
- In the course of the Cold War, some agencies thought their most important job was to criticize the United States.
- If the president had not acted with dispatch after the 1964 Alaskan earthquake, the whole state might have been evacuated.
- America largely won the battle for “hearts and minds” in Vietnam.
- Congress and the White House helped create the “energy crisis.”
- Iran-Contra operations cut through bureaucratic red tape, but they undermined the presidency in the process.
- Suffering from the “Somalia Syndrome,” interagency squabbling worsened humanitarian suffering in Bosnia and Kosovo.
- Washington’s initial response exacerbated the Asian financial crisis.
- Although a UN official criticized American tsunami relief as “too little, too late,” the U.S. response was, in fact, an exemplary success.
- Contrary to media reporting, the Federal Emergency Management Agency led an effective response immediately after hurricane Katrina in the most devastated areas.

*Mismanaging Mayhem* tells the untold stories of how and why government agencies worked together to make things better—or worse.

Although many of the revelations in the case studies are surprising, the collective lessons of interagency history are even more insightful. Perhaps the most fundamental truism they suggest is that there is nothing wrong with the underlying principles of American governance. Some contend that interagency operations can never work effectively because our form of government values competing centers of power over unified purpose and effort. These studies suggest the opposite. Constitutional “checks and balances” that divide federal power between the executive, legislative, and judicial branches are essential for good governance. This
division entails not only sharing responsibility within and among the branches of
government but also ensuring accountability and transparency in the act of
governing. Shortcutting, circumventing, centralizing, undermining, or obfuscating
constitutional responsibilities is not an effective means for making interagency
operations or democratic government work better.

Respecting the principle of federalism is also vital. Embodied in the U.S.
Constitution, the imperatives of limited government and federalism give citizens
and local communities the greatest role in shaping their lives. The Tenth Amend-
ment declares that “powers not delegated to the United States by the Constitution,
nor prohibited by it to the States, are reserved to the States respectively, or to the
people.” In matters relating to their communities, local jurisdictions and individu-
als have the preponderance of authority and autonomy. This just makes sense: the
people closest to the problem are the ones best equipped to find the best solution.

Nevertheless, Washington can do much better. The U.S. government has a
long-standing problem integrating the elements of national power. The case
studies, covering a span of nine decades of American history, offer examples of
interagency successes and failures. Despite the differences, some themes appear
again and again.

• Government undervalues individuals. Human capital refers to the stock of skills,
knowledge, and attributes resident in the workforce. Throughout its history
Washington has paid scant attention to recruiting, training, exercising, and
educating people to conduct interagency operations. Thus, at crucial moments,
success or failure often turned on the happenstance of whether the right people
with the right talents happened to be in the right job. Rather than investing in
human capital before a crisis, Washington plays Russian roulette.

• Washington lacks the lifeline of a guiding idea. Doctrine is a body of knowledge
for guiding joint action. Good doctrine does not tell individuals what to think,
but it guides them in how to think—particularly, how to address complex,
ambiguous, and unanticipated challenges when time and resources are both in
short supply. The greater the scale of an operation, the more decentralized execu-
tion matters, the more essential sound doctrine becomes. Throughout its history,
government has had very little that merits the label of “interagency doctrine.”
When its doctrine was taught and practiced, it made a difference. When not,
chaos won.

• Process cannot replace people. At the highest levels of government, no
organizational design, institutional procedures, or legislative remedy proved ade-
quate to overcome poor leadership and combative personalities. Presidential lead-
ership is particularly crucial to the conduct of interagency operations. Over the
course of history, presidents have had significant flexibility in organizing the
White House to suit their personal styles. That is all for the best. After all, the pur-
pose of the presidential staff is to help presidents lead, not to tell them how to
lead. Likewise, congressional leadership, especially from the chairs of congressional
committees, is equally vital. There is no way to gerrymander the authorities of the
committees to eliminate the necessity for competent, bipartisan leadership that
puts the needs of the nation over politics and personal interest. In the end, no
government reform can replace the responsibility of the people to elect officials who can build trust and confidence in government; the responsibility of officials to select qualified leaders to run the government; and the responsibility of elected and appointed leaders to demonstrate courage, character, and competence in time of crisis.

In the case of interagency operational failures, history does often repeat itself, most especially when the issues of investing in human capital, establishing inter-agency doctrine, and focusing on strategic leadership remain unaddressed.

The fact that in some instances interagency collaboration works better than in others suggest the possibility for effective systematic reforms. Mismanaging Mayhem is also instructive for framing the challenge of implementing reforms. The case studies suggest that it is a mistake to think of the interagency processes as a uniform, one-size-fits-all activity that requires uniform, one-size-fits-all changes. Rather, the interagency process can be divided into three distinct components.

At the highest level stands the process of making interagency policy and strategy. These are the tasks largely accomplished in government office buildings inside the Washington beltway by the White House and heads of federal agencies, in cooperation and consultation with the Congress. They are largely responsible for deciding how all the elements of national power (including military force, diplomacy, economic might, and power of information) will be used to get things done. They decide the ends (what must be done), the means (what will be used), and the ways (how it will be done) for achieving national objectives. History suggests that over the course of modern history this has, in fact, become the strongest component of the interagency process. When results fall short, as for example in the case studies of the Iran-Contra scandal and the interventions in Bosnia and Kosovo, failure can often be traced to people and personalities more than process. Improving performance at the highest level of interagency activities should properly focus on the qualities and competencies of executive leadership, as well as getting leaders the quality information they need to make informed decisions.

Operational activities stand on the second rung of the interagency process. These activities comprise the overarching guidance, management, and allocation of resources for implementing the decisions made in Washington. Managing the response to the pandemic of 1918 and rebuilding after the Alaskan earthquake both offer examples of organizing government campaigns to implement government policy. Arguably, it is at this level of government where Washington’s record is most mixed. Outside the Pentagon’s combat command structure (which has staffs to oversee military operations in different parts of the world), the U.S. government has few established mechanisms with the capability to oversee complex contingences over a wide geographical area. Processes and organizations are usually established ad hoc. Some are successful; some are dismal failures.

The third component of interagency activities is in the field where the actual work gets done: rescuing people stranded on rooftops, handing out emergency supplies, administering vaccines, supervising a contractor. Here, success and failure usually turn on whether government has correctly scaled the solution to fit
the problem. Most overseas interagency activities are usually conducted by a “country team” supervised by ambassadors and their professional staffs. Likewise, inside the United States, state and local governments largely take care of their own affairs. When the problems are manageable, as in the case of coordinating tsunami relief within individual countries, these approaches work well. On the other hand, when the challenges swell beyond the capacity of local leaders to cope, as the case studies of pacification programs in Vietnam and the response to hurricane Katrina illustrate, more robust support mechanisms are required. Arguably, what is most required at the level of field activities is better doctrine and more substantial investments in human capital (preparing people to do the job before the crisis).

In addition to the insights provided by the historical case studies, Mismanaging Mayhem includes a review of contemporary research and literature relevant to interagency operations. An extended essay addressing everything from emergency response to intelligence operations summarizes the recommendations of over a hundred papers, books, and studies. This chapter offers a one-stop shop for an introduction into the plethora of issues and proposals made by scholars on how to master the challenge of herding cats. The case studies provide a context for judging the value of their insights. Taken together, the history of interagency operations and the many proposals made to guide the way forward offer the foundation for a national discussion on the next steps for interagency reform.

The editors and authors of Mismanaging Mayhem brought a depth of experience and expertise to the task of writing the unwritten history of interagency operations. Many have both extensive academic credentials and a wealth of real-life operational experience. All freely contributed their time and talents, recognizing that their only reward would be advancing the cause of making government serve its citizens better.
End of Days: Responding to the Great Pandemic of 1918

John Shortal

From 1918 to 1919, an influenza pandemic struck the United States in three successive waves. This pandemic was the most destructive in the history of the world. The United States suffered six hundred seventy-five thousand deaths out of a population of 105 million. The American government not only failed to mount an effective, coordinated response to the crisis, but Washington’s policies exacerbated the outbreak and undermined the war effort.

In 1918, the United States was a nation at war. The president and his principal advisors were preoccupied with the battle for France. Government censorship prevented the press from unreservedly covering the influenza pandemic. No one was appointed to deal with the emergency. Washington never developed a strategy to coordinate the national, state, and local response to the pandemic. No surveillance and tracking system was developed to identify trends and movement patterns of the pandemic. No quarantine or containment procedures were planned, developed or implemented at the direction of the central government. The volume of sick and dying overwhelmed the health care system.

Despite the social disruption and economic loss caused by the disease, Washington failed to learn and implement effective responses and countermeasures between the successive influenza waves. The federal government never developed a communications and outreach plan to educate the public and the health care community regarding the nature of the disease and the actions required to protect citizens. If a pandemic similar to that of 1918–19 were to strike the United States today, and the U.S. government responded in a similar manner, 90 million people would fall ill, 45 million would receive out patient care, 10 million would be hospitalized, and 2 million would die.
FIRST WAVE

The first known cases of influenza were reported in rural Haskell County, Kansas in late January and early February 1918 by Dr. Loring Minier, a country doctor, whose practice covered hundreds of square miles. Dr. Minier began to notice that several patients, in small towns and isolated farms, exhibited common symptoms usually associated with influenza. The patients all had chills, high fevers, dry coughs, body aches, headaches, sore throats, and stuffy noses. However, he noticed that this strain of the influenza virus was different. It was especially virulent and lethal.

As cases mounted, the nature of the outbreak disturbed Minier most. This virus killed young adults, the strongest and healthiest members of society. Normally, this group had the best chance of surviving a disease. Minier was so concerned that he took the extraordinary step of reporting the virus to the U.S. Public Health Service. These officials neither offered advice nor assistance nor acted on the information.1

Throughout February 1918, the volume of influenza patients overwhelmed Minier’s small practice. By mid-March, however, the disease seemed to have run its course. There were no new cases. People returned to school and work. The disease had burned itself out in rural Haskell County—at least that was what Minier thought.

Between late February and early March, three young men from Haskell County left home for Camp Funston, Kansas.

In March 1918, Camp Funston was the second-largest training facility for the United States Army with fifty-six thousand new recruits. The facility was growing so rapidly that a hospital had not yet been built. There were not enough barracks for all the soldiers. Many were quartered in tents. They lacked heating fuel and warm clothes. Nature did not help. The especially harsh winter of 1917–18 was a perfect breeding ground for disease.2

The army camps proved to be particularly effective incubators for the flu virus. Influenza is caused by a virus that attacks the upper respiratory tract—nose, throat, and, in some cases, the lungs. The influenza virus spreads from one person to another through airborne particles, which are expelled from the lungs when the infected person coughs or sneezes. The virus enters the body through the nose or mouth. Influenza can also be picked up simply by touching a surface that has been contaminated by someone with the disease. It takes between one and four days for a person to develop symptoms of influenza. However, a person can be contagious before they start to show symptoms. The disease spreads very quickly through the masses in a crowded environment and cold weather enables the virus to exist for longer periods outside the body.

On March 4, 1918, a few days after the soldiers from Haskell County arrived at Camp Funston, the first case of influenza was reported. Within three weeks, more than 1,100 soldiers were admitted to the hospital and thousands more received treatment at the numerous infirmaries at the camp. The symptoms lasted two to three days. Then the men recovered.
The army did not consider notifying the U.S. Public Health Service nor did they quarantine the post. The soldiers, sick and healthy, were loaded onto trains and shipped to other camps. In a few short weeks, the movement of soldiers on railroads and rivers spread the influenza virus across the country. The influenza interrupted the training and preparation for combat at twenty-four of the army’s thirty-six major installations.  

A World at War

In the last week of March 1918, the United States entered its second year of the war. That month, the German army launched a great offensive. In a desperate search for a decisive victory on the Western Front, the high command planned to drive a wedge between the British and French armies and defeat them before American forces could reach the battlefield in large numbers. Attacking on a fifty-mile front, the German army advanced forty miles in eight days, took seventy thousand prisoners, and inflicted two hundred thousand casualties. By the first week of April, German artillery shelled Paris.  

The allies, exhausted by four years of war, clamored for the arrival of American soldiers. The United States government, trying to be a good ally, mobilized the nation. Civilians poured into the cities in search of work in the defense industry. Ports swelled with sailors and merchant seamen. Soldiers packed railroad cars headed for the overseas embarkation docks on the East Coast. There, they transferred to troopships and shipped for France. The influenza went with them.  

Urban centers along the eastern seaboard proved especially fertile breeding locations for the disease. The influenza virus struck the large urban centers as swiftly and as aggressively as it had the military installations. From March to April, the plague decimated thirty of the largest fifty cities and nearby military camps, disrupting commerce in its wake. In Detroit, in March 1918, a total of 1,066 employees of the Ford Motor Company contracted the influenza virus and were sent home from work.  

The pattern at the Ford plant was illustrative of the outbreak’s course. On March 1, ten people reported sick with influenza. On March 27, the number of cases increased to fifty-four. On March 28, the number jumped to 145. From March 29 to April 8, the Ford Plant averaged 168 sick people per day. On April 9, the number decreased to sixty-five and continued to decline everyday until May 8, when the epidemic ended. Again, as on the military installations, many fell ill, but few died.  

As the wave of influenza appeared suddenly and dissipated quickly, it received little notice. In fact, one historian noted, “The spring epidemic is not even mentioned in the index of the 1918 volumes of The Journal of the American Medical Association.” Influenza was not a reportable disease; only influenza-related deaths were registered with the various public health departments, which most doctors ascribed to uncomplicated cases of pneumonia. The U.S. government, myopically focused on the war effort, paid scant attention.  

While the outbreak waned, the Allies’ desperation for American reinforcements swelled. The British prime minister, Lloyd George, sent a telegram to the
American secretary of war, Newton Baker, on March 29. In the telegram he wrote, “I have cabled to President Wilson asking him to . . . send men over to France with the utmost speed to make good losses . . . before this fighting is over, every man may count.” In April 1918, one hundred twenty thousand soldiers were shipped from ports on the U.S. East Coast to France. That was just the beginning. In the next seven months, the strength of the American army in France increased to 1,878,714 men. Unfortunately, as recorded in a popular song of the time, these American replacements brought the influenza “over there.”

The first reported cases of the virus in France occurred at the port of Brest, during the first week of April. Almost 40 percent of the American army disembarked at the French port. From Brest, influenza quickly spread to the French army. It struck Paris by the end of the month. The British army was hit particularly hard in mid-April. In the British First Army alone, tens of thousands got sick and thirty-six thousand were hospitalized. The British Second and Third Armies were similarly affected. By the middle of June, the civilian population of England was also suffering from influenza.

Flu did not take sides in the war. The German army was also hit hard by the disease. In fact, after the war, General Erich Ludendorff, commander in chief on the Western Front, blamed influenza for the failure of the spring offensive. The pattern was identical in all countries and in all armies in the spring of 1918; few died, but many got deathly ill.

Europe was not alone. The U.S. Navy helped spread the disease around the world. In April, the USS North Carolina in Norfolk, Virginia reported one hundred cases. In Rochefort, France, the USS May had 25 percent of the crew sick with influenza. The USS Oregon at Mare Island, California recorded two-thirds of its crew, amounting to 450 men, ill. In Santiago, Chile, the Seventh Regiment of the Marines reported a mild epidemic. In May, the pandemic picked up speed. The USS Birmingham at Gibraltar had seventy-eight cases. The USS Chester at Plymouth, England, reported 20 percent of the crew ill. The USS Nashville at Bizerti, Africa, reported that 47 percent of its crew fell ill while traveling from Gibraltar. Influenza traveled with the fleet to China, Russia, Hawaii, and the Azores.

On land, the pandemic quickly spread through Europe from England, France, and Germany to Portugal, Greece, Denmark, Norway, Holland, Spain, and beyond. It also jumped to Bombay and New Zealand. In the spring, despite its ability to spread like wildfire, the first wave of influenza remained relatively mild. It moved rapidly, incapacitating large numbers, but did not result in a high mortality rate. The number of worldwide deaths in the first wave was estimated to be in the tens of thousands.

In the summer of 1919, as influenza traveled around the world, America remained virtually flu free. Then, across the globe as it had in the United States, the outbreak subsided. In France, the British military authorities were so sure that the influenza attack was over that they officially declared an end on August 10. The pandemic, however, was far from over.
Understanding Influenza

In order for the influenza virus to become a pandemic strain, it must accomplish three tasks. It must first enter the human body and germinate. Second, it must be harmful to humans and third, be easily transmittable among populations. In the fall of 1918, the influenza virus accomplished all three tasks. The result for the United States, and the entire world, was the worst pandemic in history.

The influenza virus, like any virus, is constantly mutating. However, unlike other viruses, when the influenza virus mutates, it usually causes only slight changes in hemagglutinin and neuraminidase. Hemagglutinin is a protein that is adept at binding the virus to the cell that is being infected. Hemagglutinin is most likely to bind to the respiratory tract. Once the virus docks with a cell, it invades the cell and dumps virus RNA into the cell’s reproductive system, producing millions of new viruses. Neuraminidase spreads the new viruses from cell to cell. It takes approximately ten hours from the time the virus docks with the cell, until the new viruses (between one thousand and ten thousand) exit and begin invading new cells.\textsuperscript{12}

This mutation of hemagglutinin and neuraminidase happens just often enough to help the virus avoid detection by the body’s immune system. The immune system can only fight a virus if it can see it. This is a critical characteristic of the influenza virus; its shape-shifting confuses the immune system. Changes to the surface of the virus, deter the human body from producing antibodies which could attack it. This minor mutation of the hemagglutinin and neuraminidase is called antigen-drift. This antigen-drift is slow and recurrent. It was the major cause of new influenza outbreaks each year.\textsuperscript{13}

The influenza virus alters much faster than other viruses. That is why vaccines for influenza are different from those for other diseases. Unlike polio, smallpox, measles, and the mumps, scientists must constantly update the vaccination serum to protect against the current strain of the influenza virus.\textsuperscript{14}

Periodically, the influenza virus makes a transformation that is so drastic and sudden that the human immune system cannot identify the new virus. Dr. Anthony S. Fauci, director of the National Institute of Allergy and Infectious Diseases at the National Institutes of Health, explains, “Antigen shift is the reason that we must update influenza vaccines annually.”\textsuperscript{15} The antigen-shift that occurred in 1918 caused the pandemic.

SECOND WAVE

In the late summer of 1918, after traveling the globe, the influenza virus returned to the United States. The influenza outbreak in August and September bore no resemblance to the virus from the previous spring. This influenza virus had changed. As it had passed from person to person around the world, the virus had become a much more deadly and efficient killer.

In the second wave of the 1918–19 influenza pandemic, the United States government continued to focus on the war effort and ignored the health crisis.
posed by the pandemic. No one stepped forward to take charge, and the government in Washington left state and local officials to deal with the pandemic on their own. This wave of influenza killed tens of millions around the world.

They called the 1918 influenza, the “Spanish sickness.” In the spring of 1918, only neutral nations admitted the existence of an influenza pandemic. Stories of the disease's path, particularly in the Spanish press, were the only reports the public received on the existence of influenza pandemic. Meanwhile, censorship in France, Britain, Germany, and the United States masked the real facts about the course of the disease. Neither side wanted the enemy to have an advantage or to know their secrets and plans. This reticence also prevented citizens from knowing the truth.\(^\text{16}\)

The second wave of the influenza pandemic first manifested itself in three distant locations: the port cities of Freeport, Sierra Leone; Brest, France; and Boston, United States. The spread of the pandemic's second wave through the United States coincided with the U.S. Army’s commencement of major offensives in France. On September 10, 1918, the United States Army attacked the Germans at St. Mihiel. That same month the Americans launched the Meuse-Argonne offensive. One historian called the Meuse-Argonne offensive “the most ambitious military effort in history.” Six hundred thousand soldiers and four thousand artillery pieces participated in the attack. Many of the soldiers moved sixty miles to reach their attack positions.\(^\text{17}\)

In cable after cable in September 1918, General Pershing, the American commander in France, wired the army chief of staff, General Peyton C. March, for more troops. At one point General Pershing said, “We do not have the troops necessary to replace even our ordinary casualties . . . I cannot plan future operations intelligently without knowing that I will have at hand the means necessary to carry them out. If our calls cannot be met because of insurmountable difficulties, I ask that I be so informed.” Press censorship was so pervasive that even General Pershing did not fully grasp the effect of the influenza on the American army’s ability to provide reinforcements.

One week later General March telegrammed General Pershing to tell him the truth about the situation in the United States. The American government did not want the Germans to know that tens of thousands of soldiers were sick.\(^\text{18}\)

More than General Pershing’s planning was hampered by the secrecy which resulted from censorship. The rigid control of the press, and the way the United States government organized for World War I, had a highly deleterious effect on the country’s response to the influenza pandemic.

President Woodrow Wilson set the tone for the American government. In March 1917 he told a newspaper editor that “to fight you must be brutal and ruthless, and the spirit of ruthless brutality will enter into every fiber of our national life, infecting congress, the courts, the policeman on the beat, the man on the street.”\(^\text{19}\) With the plague now undermining the war effort, Washington started to pay attention.
**Organized for Disaster**

President Wilson selected extraordinary men to help him mobilize the nation for war, such as Secretary of Treasury William Gibbs MacAdoo, a man of unusual energy and ingenuity. MacAdoo developed a plan to finance the war by selling war bonds, raising half of the $33 billion required to fund American participation in the war. Wilson also established the War Industries Board in 1917, with Bernard Baruch, a wealthy New York stockbroker, as director. In a few short months, Baruch, wielding little more authority than his charisma, drive, and influence, increased industrial production by 20 percent. The president appointed Herbert Hoover as the director of the National Food Administration. Hoover also proved innovative and inspirational. He was so successful in persuading farmers to increase production that the United States not only fed its own civilian and military population, but supplied much of the food consumed by the allies as well. Hoover also ran the Fuel Board, responsible for conserving oil and coal for the war effort. Together with the secretary of war, Newton Baker, and the secretary of the navy, Josephus Daniels, Wilson had enlisted the best and the brightest to rapidly and successfully mobilize for war.

Initial efforts by Wilson and his team served to hamstring, rather than enhance, the government’s pandemic response. At the height of the first influenza wave, at the administration’s request, Congress passed the Sedition Act of 1918. The Sedition Act made disloyalty a crime. This act, coupled with the Espionage Act of 1817, made it illegal to obstruct the draft or to oppose the Liberty loan plan introduced to fund the war. The law made disloyalty to the war effort a crime punishable by $10,000 and twenty years in jail. The U.S. courts interpreted this act very loosely. For example, Judge Van Valkenburgh defined freedom of speech as “criticism which is . . . friendly to the government, friendly to the war, and friendly to the policies of the government.”

The United States government also created several organizations to fight dissent and detect disloyalty, including the American Protective League, which boasted one hundred thousand volunteers.

The national Council of National Defense and its state chapters incorporated a vast network of volunteers and advisors, including one hundred eighty-four thousand people employed by local law enforcement agencies. Its two main local agencies were the Loyalty Bureau and the Public Safety Committee. Both these organizations also had a dark side. They encouraged Americans to spy on each other and report acts of disloyalty or pacifism. The resulting atmosphere of intolerance and distrust hampered rather than facilitated cooperation between the federal government, states, and local communities.

Local efforts to enforce patriotism sometimes devolved into acts of political revenge or outright lawlessness. In Arizona, members of a gun-toting vigilante group called the Citizens Protective League, arbitrarily rounded up twelve hundred local labor and antiwar activists and shipped them out of state with warnings never to return. Government officials did nothing. The *Los Angeles Times* declared the league’s initiative “a lesson that the whole of America would do well to copy.”
The federal government also created the Committee on Public Information, under the direction of George Creel, charged with generating support for the war. The committee had the power to punish anyone who published anything negative about the war. The committee told editors that if they had any doubt about an article to be published, they should submit it to the committee for review. Journalists could be punished by the Department of Justice for printing anything viewed as unpatriotic. The post office had the legal authority not to distribute any publication considered subversive. Editors remained wary of publishing reports that could be remotely viewed as disloyal or critical of the war effort.

An Unhealthy Response

Government worked at cross purposes. While most of Washington focused on harnessing the nation for war and suppressing any news that might distract Americans from that task, the few officials directly responsible for dealing with the health crisis did little. The Public Health Service, under the direction of Surgeon General Rupert Blue, was the government agency responsible for directing the response to the influenza pandemic in the fall of 1918. Unlike Wilson’s other war managers, Blue had been appointed by President Howard Taft. He was not part of the president’s inner circle. Additionally, although Blue had built a career as a “plague fighter,” battling malaria, typhoid fever, and bubonic plague, he proved incapable of leading an effective response to the public health disaster that was about to engulf the American landscape.

Before the war, the U.S. Public Health Service was a small organization that consisted of quarantine stations responsible for inspecting incoming ships, the Marine Hospital, and a small Hygienic Laboratory. Upon becoming president, Wilson expanded the authority of the service to pursue studies of the “diseases of man and the conditions affecting the propagation and spread thereof.” The president, however, did not greatly increase the funding or authority of the Public Health Service. When the war broke out, Blue commanded 180 public officials and 44 quarantine stations. This was the federal government’s entire force to combat the oncoming plague. The situation was similarly grim at the local level. State public health departments were neither efficient nor well funded. The commissioner of health in the state of Washington summed up the quality of the nation’s public health departments when he said that his subordinates were inadequately paid “and their policy is to do as much as the pay justifies.”

Blue did not possess the strength of character, energy, or ingenuity of either MacAdoo, Hoover, or Baruch. In the first week of September as influenza spread from Boston to the rest of the United States, the surgeon general did not direct the state public health departments to gather any data on the early cases of influenza. There was no method of tracking the movement of the virus. No early warning system existed, nor was a structure developed to identify and treat the populations that were most severely affected by the disease.
When the second wave came, the Public Health Service did nothing. The surgeon general did not attempt to quarantine ships transporting American soldiers and sailors. A strict maritime quarantine of any major U.S. port was out of the question. Quarantine would disrupt the flow of troops and supplies to the Western front. Colonel S. M. Kennedy, chief surgeon of the port of New York, said, “We can’t stop this war on account of Spanish or any other kind of influenza.”24 As a result, returning veterans spread the disease throughout the country.

The government’s greatest failure was deciding not to inform the American public about the true nature of the threat. The health service did nothing to prepare local communities for the pandemic. Service staff did not communicate a need for local preparedness, nor did it disseminate information to alert the public of the nature of the disease and the actions required to protect their health. Instead, they chose not to coordinate with other federal agencies and not hurt the war effort in any way. In fact, the service did more than remain silent; it suppressed the truth.

As one historian said, “In 1918, Departments of Public Health were often referred to as Departments of Public Assurance.” Leaders made statements like, “If normal precautions are taken, there is nothing to fear.” A Chicago public health official said, “Worry kills more people than the disease itself.” In Bronxville, New York, the Review Press and Reporter reported, “Fear kills more than the disease and the weak and the timid often succumb first.” In reality, the lack of public countermeasures, encouraged by indifferent government pronouncements, fueled the spread of the disease.25

On September 25, 1918, influenza was reported in twenty-six states. Senior medical officials from the army, navy, and Red Cross met in Washington to develop a strategy for the pandemic and to identify ways they could help individual states to cope with the disease. Neither Blue nor any other representative of the Public Health Service attended the meeting. Surgeon General Blue was afraid of disrupting the war effort and vacillated throughout the month of September.26

**Crucible of the Crisis**

Philadelphia was hit hardest by the flu. In the absence of a strategy or guidance from the federal government, local officials reacted slowly. Their lethargic response cost thousands of lives. In 1918, Philadelphia had a permanent population of 1.7 million, not including three hundred thousand workers who had migrated to the city in order to work in the defense establishment. The city was woefully unprepared for the pandemic’s arrival. Medical facilities were seriously understaffed because of the war. Twenty-six percent of doctors and an even higher percentage of nurses had gone to serve in the military. At the same time, 75 percent of the medical and surgical staffs were deployed overseas.27
On September 18, 1918, the first cases of flu appeared at the Philadelphia Navy Yard. Nevertheless, city public health officials did not even record incidents of the disease. Day by day, the number of sick and dying grew exponentially. On September 21, the Board of Health finally made influenza cases reportable. At the same time, however, the Philadelphia public health director, Wilmer Krusen, announced that “no epidemic prevails in the civilian population at the present time.” War bond marches even continued. Two hundred thousand people gathered along a two-mile route in downtown Philadelphia, as sailors, soldiers, marines, and Boy Scouts paraded by.

Influenza spread like wildfire throughout the city. Three days after the parade 117 people died of influenza. On October 4, the University of Pennsylvania newspaper, the *Daily Pennsylvanian*, reported 636 new cases of influenza and 139 deaths. On that day, the Board of Health closed all public places including schools, churches, and theaters. By then, it was too late.

As the number of dead and dying increased, so did fear and anxiety. The people of Philadelphia had no information on what was happening. The censorship of the media, and lack of knowledge about influenza, resulted in a total inability to properly react to the pandemic. The population of the city simply did not know what to do and who to turn to for advice. The pharmacies were stripped of all medicine in the first days of the outbreak, forcing people to rely on home remedies—“goose-grease poultries, sulfur fumes, onion syrup, and chloride of lime.” The newspapers had advertisements from swindlers preying on people’s fears and needs. The ads promised relief: “Sick with influenza? Use Ely’s Cream Balm. No more snuffling. No struggling for breathing.”

What Philadelphia needed, in October 1918, to survive was strong leadership. The federal government did not provide it. Neither did the governor. The Board of Health did not have the staff, the leadership experience or economic and political influence necessary to control the spread of the pandemic. The mayor and City Hall should have stepped up and coordinated relief efforts, but they did not. As one historian said, “In Philadelphia, the City Hall was a source of favors more than of leadership.” Leadership for the city of Philadelphia came from an ad hoc arrangement of diverse organizations. In Pennsylvania, George Wharton Pepper headed the state chapter of the defense council. In Philadelphia, the council was directed by Judge J. Willis Martin. The Peppers and Martins were connected to the oldest and most distinguished families in the city. They both had significant political and economic clout. Judge Martin’s wife directed Emergency Aid, which was Philadelphia’s most important private social agency. On October 7, Pepper, Martin and the heads of dozens of private organizations met at the headquarters building of Emergency Aid. The meeting included many women from Philadelphia’s most prominent families, the principal informal leaders in the city. They formed an ad hoc committee that had ready access to money and was prepared to spend it to coordinate the fight against influenza. Almost every organization in Philadelphia, political, social,
economic, and religious, volunteered to partner with this committee to help in the crisis.32

The National Response

The situation in Philadelphia was not unique. Rather, it was indicative of a pattern that reoccurred in every major U.S. city. Local efforts to combat the outbreak occurred independently. The politicians, the media, and even the public health officials believed that the war was the priority. Therefore, financing the war through liberty bonds, work at shipyards and war industries, moving troops from smaller posts to larger posts and then on to ports of embarkation on the East Coast took precedence over battling the pandemic. President Wilson never made a public statement about influenza.33 Washington never made a serious effort to mount a nationally coordinated campaign to combat the pandemic.

The government never deviated from its single-minded focus on the war effort. As one historian noted, “The relief effort for influenza victims would find no assistance in the Food Administration or the Fuel Administration or the Railroad Administration. From neither the White House nor any other senior administration post would there come any leadership, any attempts to set priorities, any attempt to coordinate activities, any attempt to deliver resources.”34 Lack of coordination was not the result of indifference; it emanated from Wilson’s single-minded determination to prosecute the war in France.

Ironically, Washington policies exacerbated the greatest threat to the American war effort. In many large cities industries suffered from acute absenteeism due to influenza. Basic services—sanitation, law enforcement, fire fighting, and postal delivery—were greatly disrupted. Absenteeism also interrupted transportation, communication, health care, and food supplies.

In the fall of 1918, accurate information about influenza was critically necessary. Washington completely failed to meet that need. Neither civic leaders nor doctors knew vital facts about the disease, such as its spread patterns and the rate of infection. This information was needed by both the medical community, to fight the disease, and the public to ease panic. Despite the desperate need for authoritative information, Washington did very little. Initially, the Public Health Service was reluctant to make any statement about the disease for fear of being perceived as disloyal to the war effort. Public health officials waited almost a month before saying anything. In fact, the first public announcement made by the Public Health Service, on September 13, 1918, was to say that the “Bureau has no information on the nature of the disease.”35

Furthermore, the service did not have a system in place to track the disease nor to keep the medical community and public informed. There was no system of reporting new cases of the disease that connected the federal, state, and local governments. The surgeon general waited until the crisis was upon him to respond. He was slow to react even then. In October, he finally directed the states and municipal health departments to submit weekly reports on influenza. However, by
that time, doctors were so overworked that, in many cases, they identified preexisting conditions, rather than influenza, as the cause of death. The overworked health departments could not analyze the data because of the volume of deaths reported at the peak of the crisis.

Initially, the surgeon general did not direct any action that would isolate or quarantine the spread of the disease. In October, he finally directed public health officials to close all public places. Unfortunately, local public health officials did not have the power to implement this order. Some communities embraced the public health measures to control influenza. Others resisted because they were inconvenient, burdensome, or went against the community values, such as closing schools or churches.

The surgeon general published 6 million pamphlets to educate local health departments and the general public about the dangers of influenza. Unfortunately, they arrived too late to be of use. The Public Health Service also created a Volunteer Medical Service Corps, which maintained lists of doctors available to help with influenza. But again, the surgeon general waited to implement this until October 1918. By that time, the disease had already seized the country, and medical professionals were in short supply.36

Likewise, the Red Cross created a national committee to coordinate with the surgeon general and the armed forces. The Red Cross and the Public Health Service agreed to a division of labor. The service would locate, assign, and pay physicians. The Red Cross agreed to supply nurses and pay their salaries and expenses; provide emergency hospital supplies, resources, and personnel to state and local health departments; and distribute official statements by the Public Health Service on prevention and treatment.37

In less than two months, the Red Cross recruited almost fifteen thousand women to reinforce the overwhelmed medical communities. These women included trained nurses, practical nurses, nurse’s aides, and women who had taken the Red Cross home hygiene course. They assisted in military hospitals and camps, troop ships, civilian hospitals, and in private homes throughout the United States. The Red Cross also directed every local chapter to organize its own committee on influenza. Volunteers surveyed the local hospitals, identified personnel and supply requirements and then coordinated the allocation of nurses and the procurement of needed medical supplies. In many cases, they set up makeshift hospitals.38

Once efforts were fully under way, the ad hoc partnership between the Red Cross, the Public Health Service and the military proved effective. The Red Cross initially provided $575,000 to recruit nurses and other medical support personnel. Eventually, the Red Cross spent $2 million of its own budget to fight the influenza pandemic. In addition to much-needed funding, the Red Cross provided health care professional support and vital logistical support to local communities and hospitals in need.39

Red Cross funding proved critical in the fight against influenza in the fall of 1918. The money quickly found its way to local officials. The Public Health
Service, on the other hand, continued to have acute cash-flow problems. With an annual budget of only $3 million, the service had barely sufficient resources to pay for its annual operations.

Eventually, Congress appropriated $1 million for the Public Health Service’s fight against the influenza pandemic. Republican leader Henry Cabot Lodge captured the feeling prevalent in Congress when he said, “If the disease is not arrested, it may spread to every part of the country. Already it has affected our munitions plants. Its ravages may be more severe unless we grapple with it now, and we cannot do it without money.” Still, even with a flush of funds, the Public Health Service was not as successful as the Red Cross in securing doctors or nurses. The pay was insufficient and the service waited until the epidemic was in full force, and the available doctors committed, before trying to recruit them. After the service’s recruiting mission largely failed, the surgeon general had to return $115,000 of the appropriated funds.

The Military Response

The influenza pandemic had a critical impact on the war effort. The number of sick U.S. soldiers arriving in France overwhelmed the army medical staff. Pershing’s staff requested additional medical personnel and supplies and for soldiers to be quarantined for one week prior to embarkation. The acting surgeon general of the army, Charles Richard, noted in a message to the army chief of staff that “if infected troops continue to arrive in France it will add greatly to the burden already heavy of caring for sick and noneffectives with the present shortage of medical personnel and equipment.” General Richard was not overstating the case. On September 18, 1918, the hospitals and convalescent camps of the Allied Expeditionary Forces (AEF) held 66,738 men. Two weeks later the number was up to 84,856. By November 7, 1918, military personnel had fallen ill with influenza.

General Richard recommended “that all troop movements overseas be suspended for the present, except as demanded by urgent military necessity.” The army rejected the idea and the army’s Medical Department appealed directly to President Wilson. The army chief of staff, General Peyton March, told the president that troop shipments should not be stopped for any reason. He emphasized to the president the “psychological effect it would have on a weakening enemy to learn that the American divisions and replacements were no longer arriving.” The president deferred to General March.

In the United States, the volume of sick soldiers virtually halted all training at military installations. The man in charge of the Selective Service, Major General Enoch Crowder, realized that sending more soldiers into the camps would only exacerbate the situation. On his own authority, Crowder canceled the draft for the month of October. His decision prevented one hundred forty-two thousand men from reporting to military installations overwhelmed by influenza. This act and the million dollars appropriated by the Congress were among the very few positive decisions made by the federal government during the influenza pandemic.
Over the course of the outbreak, army medical officers and military scientists learned a good deal about how the virus was transmitted and how to treat the victims. They also discovered, however, that other than ruthless quarantine and isolation, there was little that could be done to stem the spread of infection.

Even within the military, some of the most effective responses to the disease originated not from the War Department but from decisions by individual officers in the field. The commander of Camp Colt, Pennsylvania, a young officer, Dwight Eisenhower, led one of the most successful efforts. The medical staff segregated the sick from the rest of the camp and Eisenhower ordered a daily round of inoculations against infectious diseases (such as smallpox and typhoid) and medical examinations for all personnel. After a week, the epidemic was contained. Only 150 people had died. Eisenhower’s response had so impressed the War Department that he was ordered to send members of his medical staff to other posts in order to train their medical personnel.46

By the end of November 1918, the second wave ended. This wave was much deadlier than the first. The most surprising aspect was who died. This wave struck the young and healthy. In most communicable disease outbreaks this group has the lowest mortality rate, since they generally have the most robust immune systems. This was not the case in the second wave. Fifty percent of those who died were in the twenty- to thirty-year age group.47

THIRD WAVE

The virus mutated again and returned in December 1918. This latest outbreak peeked in January and February of 1919, though it persisted until April. Although less lethal than the second wave, the flu that swept the country in 1919 remained deadly.

Again, the outbreak severely impacted both military and civilian communities. The United States Army, which had almost 4 million men at the peak of the war, quickly demobilized to two hundred thousand by 1920. The third wave arrived after the campaign in Europe had ended; thus it was not overshadowed by the need to maintain morale and secrecy. Neither the press nor Congress, however, took any interest in this wave of the pandemic. Few lessons learned from the second wave were applied to the latest outbreak.48

After the war, the United States maintained an army to occupy Europe, including a cadre of two hundred forty thousand to police parts of western Germany. In the first three months of 1919, almost thirteen thousand soldiers were sick from influenza. The postwar medical establishment proved only marginally effective in fighting the latest outbreak of the disease.

In February 1919, an Alabaman senator presented a resolution to Congress requesting that funds be appropriated so that the U.S. Public Health Service could study influenza. The senator wanted the U.S. Public Health Service to investigate the cause of the disease and find a way to eliminate it in the future. The secretary of war, Newton Baker, endorsed this resolution because he believed that studying
influenza and related diseases was the “most urgent [issue] confronting public health authorities today.” However, in 1920, the Congress only approved one-tenth of the money requested, five hundred thousand of the $5 million. Even when the war was over, the American government still had little interest in the Spanish flu.49

AFTER THE DISASTER

The impact of the influenza pandemic was immense. In the United States, six hundred seventy-five thousand people died out of a population of 105 million. Worldwide the loss has been estimated between 20 to 50 million. In raw numbers, the disease killed more people than any other in human history. Yet, despite the enormous loss of life, little attention was paid to reflecting on the federal government’s failure to launch a coordinated response. As historian Alfred Crosby noted, there are several reasons for this. First, the disease struck quickly, caused massive damage in a short period of time, and moved on. Second, it did not kill anyone famous or powerful. Its victims were predominantly in the prime of their lives, twenty to thirty years old, the same age as those who had died in the war. Third, when it dissipated, it did not leave anyone scarred or disfigured like polio, cancer or syphilis. Fourth, it impacted everyone equally, young and old, rich and poor, Germans and Americans. Fifth, no institution or organization (political, economic, or military) changed because of the disease. Most Americans viewed the three waves as a consequence of the war.50

In retrospect, it should have been clear that the requirement for effective interagency operations was axiomatic. The influenza outbreak demonstrated that, by their nature, public health crises adversely impact every aspect of life and can never be dealt with in isolation. Any public health crisis will likely demand a cooperative response from all elements of government. And any major activity, whether it be fighting a war or responding to a natural disaster, will require us to grapple with significant health issues.

The often synergistic relationship between large-scale activity and public health crises also illustrated that major interagency challenges frequently do not present themselves sequentially. Governments frequently find that they have to deal with crises simultaneously. Concentrating on one to the exclusion of others is unacceptable and can have disastrous consequences. In addition, the larger the scale and complexity of the operation, the less likely it is that leaders can rely on a “textbook response” to guide them on how to best organize and respond to the unknowns and ambiguities, competing demands, and multiplicity of factors that might complicate their efforts.

There is no question that the response of the Wilson administration was completely inadequate. Ironically, Wilson understood the value of integrating government activities to work toward a common goal. After all, he organized the war effort with singular determination, concentrating not only on diplomatic and military tasks but also on harnessing the home front for war. Indeed, raising,
organizing, and deploying the AEF was a remarkable achievement, considering that before 1918 the U.S. military was small, widely dispersed, and thoroughly ill-equipped to fight modern wars.

In responding to the pandemic of 1919, however, Wilson failed to recognize that an interagency response was required. Washington never mounted an integrated effort. The federal government lacked an overall policy to guide operations. Without the lifeline of a guiding idea, agencies often found themselves working at cross purposes, or worse striving for a common goal (i.e., winning the war) but ignoring one of the greatest threats to achieving the objective, a debilitating illness that sapped more manpower than the enemies' bombs and bullets.

Washington floundered because it lacked a clear policy or doctrine that provided an overall principle by which to manage the crisis. In 1918, Rupert Blue had the responsibility of ensuring public health, but he had neither the influence, nor the authority, nor the resources to carry out his mandate. He did not have access to the president that Hoover, Baruch, MacAdoo, or Baker enjoyed. Blue was incapable of impressing upon the president the seriousness of the pandemic. The president turned to other senior leaders for advice regarding the crisis, as illustrated by his deferral to the army chief of staff, in the pandemic’s second wave.

Outside dealing with the business of war, the White House lacked the capacity to conduct integrated policy planning and crisis decision making at the highest levels. The executive office of the president was small and there was no equivalent to today’s National Security Council.

Left to devise policy on his own, Blue did not make any decisions in the first wave. Between waves, he took no action to learn from the previous pandemic. In the second wave, he had the opportunity to quarantine the disease when it first erupted. He also could have attempted to stop the Fourth Liberty Loan drive, but again he vacillated. In fact, the surgeon general tried too hard not to disrupt the war effort, and acted only after the pandemic had spread.

The deeply flawed response to the pandemic also demonstrated the value of shared situational awareness in responding to a crisis, not only for informing top-level decision makers but also for distributing knowledge to empower decentralized coordination and execution at the local level. In short, what leaders responding to the pandemic lacked was a means to get the right information to the right person at the right time to do the right thing. This shortfall was particularly glaring with regard to the lack of surveillance and reporting, a form of situational awareness particularly vital to dealing with the spread of communicable disease.

In 1918, there was no system in place to track the movement of influenza. There was no method in place for the medical community to share information between countries. The lack of an established reporting and surveillance system combined with the paranoid desire to obscure the details of the disease to maintain support for the war destroyed any hope for cooperation between nations or communities. Without the free flow of information regarding the disease, the national leaders and medical community in the United States did not know where
or when the virus would strike. Additionally, there was no advance notice on the identity or nature of the illness.

The surgeon general did not require that the medical community report new cases of influenza in 1918. Even after the loss of life and disruption of industry in the first wave, the Public Health Service made no attempt to track or report on influenza. This action was only taken after the disease had erupted all along the East Coast in the second wave, when it was too late to save lives. The service did not have a system to coordinate information from local community leaders, physicians and nurses, hospital administrators and public health officials. Failure to classify influenza as reportable and the lack of a coordinating system across federal, state, and local levels meant that there was virtually no early warning system or initial response to the pandemic.

Public Health Service officials had no way to detect the introduction of new cases into the United States. Once the disease had erupted in America, they could not track its movement from one community to another. They could not monitor the pandemic’s impact on a community—number sick, hospitalized, or dead. They could not identify trends in the disease and target populations that were seriously affected and appropriately direct resources to help.

The response to the 1918 pandemic also demonstrated that the larger the scale and complexity of the operation, the greater the need for decentralized execution that relies heavily on the individuals closest to the crisis to identify problems and develop and implement solutions. War censorship, however, made effective information sharing impossible. Washington lacked all means to conduct open communication between the federal government and state and local officials, as well as the medical community and the general public. Censorship of the press and the loose interpretation of the Sedition Act led to reluctance on the part of key leaders to inform the medical community, and the general public, about the nature of the pandemic. Physicians in local communities had no information on influenza. The influenza they encountered in 1918–19 was unlike anything they had seen before. They were looking for answers about basic medical treatments, prioritization recommendations for the ill, medications to use and where to send people for care. Unfortunately, in 1918, the little information that was known was slow to arrive.

Open communication with the general public is essential to reduce anxiety and fear, and to enlist support for emergency measures. During the pandemic of 1918–19, with millions of people sick, the government and the media were silent on the disease. This silence did not engender trust in the decisions of public health officials. The public must be educated on any threat it faces. For example, in October 1918, when the surgeon general finally closed all public gathering places, the civic response to this measure was mixed. Some communities supported it and others felt the measure was oppressive and resisted. In some cities, churches were closed, but bars were kept open. There was disagreement in various communities on the necessity of closing schools or churches. In San Francisco, when public health officials tried to get people to wear gauze masks, they encountered