

**State Preventative Medicine:
Public Health, Indian Removal, and the Growth of State Capacity, 1800-1850**

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“Contagious and fatal diseases have destroyed thousands of Indians, which, by the application of well known remedies, might have been checked on their first appearance, and their desolating effects prevented.”

— Rev. Jedidiah Morse to Secretary of War John C. Calhoun, 1822¹

“Drunk, sober, or sick, we will move them along.”

— Colonel J.J. Albert to George Gibson, 1832²

In 1832, Congress created a special vaccination program “to prevent...the spreading of... disease amongst the Indian tribes.”³ One of the federal government’s earliest efforts to assert responsibility over the public’s health, the Indian Vaccination Act was also the first medical program designed exclusively for the country’s indigenous population. Targeting smallpox, “the most lethal disease that traveled from Eurasia to the Western Hemisphere,” members of Congress appropriated \$17,000 to vaccinate Native Americans residing on the edge of the frontier, a tract of territory stretching from the northernmost reaches of the Mississippi River (in what is now Minnesota and Wisconsin) to its southern delta.⁴ Over the next decade, federal agents distributed

¹ Jedidiah Morse, *Report to the Secretary of War of the United States on Indian Affairs* (Washington, D.C.: Davis & Force, 1822), 92.

² J.J. Albert to George Gibson, November 17, 1832, *Correspondence on the Subject of the Emigration of Indians* Vol. IV (Washington DC: Duff Green, 1835), 512.

³ “Vaccination of the Indians,” April 4, 1832, *Gales and Seaton’s Register*, 22nd Congress, 1st Sess., 2834.

⁴ Eric Hinderaker and Peter C. Mancall, *At the Edge of Empire: The Backcountry in British North America* (Baltimore: Johns Hopkins University Press, 2003), 16. Congress initially appropriated \$12,000 to the fund and, in 1839, lawmakers set aside an additional \$5,000 for the program. *Congressional Record*, 25th Congress, 3rd Sess., 1839, 828.

vaccine matter to indigenous communities scattered across that territory, inoculating over 30,000 individuals by 1841 — more than a quarter of the population ultimately removed to designated lands west of the Mississippi.⁵

Despite a number of recent studies documenting the active and expanding role of the United States government in the early nineteenth century, a period long held to be “stateless,” the passage and implementation of the Indian Vaccination Act has received scant attention. Given our cramped, settler-oriented view of antebellum social provision and a similarly superficial understanding of the early republic’s public health apparatus, this is unfortunate, but not surprising. Indeed, in stark contrast to the wealth of scholarship exploring the development and retrenchment of social insurance programs in the post-New Deal era, few studies have examined the country’s first “health laws” in any detail.⁶ These statutes, passed by Congress in the decades after the nation’s founding, established procedures for civilian and maritime quarantines, created a hospital system for injured sailors, and improved the distribution of smallpox vaccine by permitting local physicians to order it through the mail, free of charge.⁷ Although wide-ranging in scope, these laws were explicitly intended to benefit the country’s white citizenry, ostensibly in exchange for their economic and political contributions to the developing nation.⁸ The Indian Vaccination Act presents precisely the opposite case. At a time when governing elites were

⁵ Federal records indicate that at least 21,036 American Indians were vaccinated by 1839 and an additional 9,471 vaccinations were reported by 1841. However, scholars have estimated (as a lower bound) that closer to 38,745 individuals were inoculated, based on census data and expenditures by Indian Affairs’ physicians.

⁶ *Gibbons v. Ogden*, 9 U.S. (9 Wheat.) 1 (1824).

⁷ The first congressional public health statute was the National Quarantine Act of 1796, which limited the federal government’s authority to impose quarantines without the support of the states affected by the epidemic in question. Two years later, in 1798, lawmakers established the United States Marine Hospital Service to care for sick and disabled seamen, laying the groundwork for what would eventually become the Public Health Service (formally established in 1899). In 1813, Congress passed an Act to Encourage Vaccination, which provided for the distribution of smallpox vaccines to states and private physicians through the U.S. mail free of charge. But the Act was repealed a decade later after a smallpox outbreak was traced to contaminated vaccine matter that had been delivered through the postal service.

⁸ Scholars have long argued that American welfare programs are explicitly designed to benefit “deserving” citizens, individuals perceived to have “contributed” to their political community. See Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States* (Cambridge: Harvard University Press, 1992), 217; Christopher Howard, *The Hidden Welfare State: Tax Expenditures and Social Policy in the United States* (Princeton: Princeton University Press, 2001).

seeking to “marginalize the ‘other’ and to articulate the political attributes of good citizenship,” lawmakers nevertheless saw fit to provide what was widely perceived to be a social benefit to a nonwhite, disenfranchised population.⁹

The administration of the Indian Vaccination Act is equally intriguing. Consistent with Stephen Skowronek’s canonical description of nineteenth-century America as “a state of courts and parties,” the sprawling literatures on American state-building and the development of social services have tended to characterize the early state as “antibureaucratic,” “hidden,” and “submerged.”¹⁰ More recent studies have complicated, but largely confirmed, this minimalist view of the antebellum state, finding that nineteenth-century policymakers frequently turned to public-private partnerships to promote state development, rather than amass sufficient bureaucratic capacity to mobilize resources or implement legislative directives at the national level. Here again, Indian vaccination presents a puzzle. Rejecting an implementation design whereby the health of Native Americans would be administered by — or perhaps more accurately, policed in partnership with — private entities, federal officials deemed Indian vaccination an affirmative responsibility of the state.¹¹ The fact that federal officials’ opted to build capacity “in-house,” rather than outsource responsibility, is especially curious insofar as a system of delegated governance through private actors would seem well suited to the task of coordinating medical services across a vast and treacherous frontier.

⁹ Barry Wright, “Migration, Radicalism, and State Security: Legislative Initiatives in the Canadas and the United States c. 1794-1804,” *Studies in American Political Development* 16 (2002): 49. Indian health laws are all the more interesting because Article 1, Section 2 of the Constitution explicitly excludes Native Americans from being counted in the representative system. Coupled with the fact that Native Americans were unable to vote in federal elections until 1924, the provision of health care to indigenous communities suggests that existing theories of representation, at least as concern the United States, may require some modification.

¹⁰ Howard, *The Hidden Welfare State*; Suzanne Mettler, *The Submerged State: How Invisible Government Policies Undermine American Democracy* (Chicago: University of Chicago Press, 2011); Theda Skocpol and Kenneth Finegold, “State Capacity and Economic Intervention in the Early New Deal,” *Political Science Quarterly* 97 (1982): 255-78; Stephen Skowronek, *Building a New American State: The Expansion of National Administrative Capacities, 1877-1920* (New York: Cambridge University Press, 1982).

¹¹ Edward Everett Ayer, *The Indian Question* (Albany, NY: Newberry Library, 1911), 1-7.

Against this backdrop, this paper seeks to answer two questions. First, what motivated members of Congress to provide medical care to Native Americans a full century before Native American enfranchisement? Second, how did the United States' nascent bureaucracy muster sufficient administrative capacity to implement the vaccination program?

In the early decades of the new republic, lawmakers viewed the provision of medical care to indigenous communities not as an affirmative state power, but as a substantive good to be parleyed in negotiations over disputed territory. Lacking sufficient cash reserves to acquire land rights from Indian nations outright, federal agents sought to trade medical supplies and the services of physicians, together with agricultural equipment and munitions, for title to unincorporated tracts of land. But, as westward expansion accelerated in the early 1800s, federal policymakers would come to embrace a more vigorous conception of "state preventative medicine."¹² By the 1820s, the Indian Office was receiving frequent reports from agents that smallpox and other communicable diseases were decimating the frontier's remaining indigenous inhabitants and endangering nearby military and settler communities. Shocked by the speed of contagion and rising mortality, Indian agents and War Department officials pressed Congress to take action.¹³

Lawmakers, however, were reluctant to devote resources to fight disease in Native American communities until it became clear that epidemics were slowing the pace and inflating the costs of Congress's newly formalized policy of Indian expropriation and removal. The Indian Vaccination Act would serve as a legislative "common carrier," bringing together the goals of a few progressive legislators — backed by abolitionist and missionary reformers — with those of a majority of members concerned that disease would undermine the forcible

¹² As quoted in William J. Novak, *The People's Welfare: Law and Regulation in Nineteenth-Century America* (Chapel Hill: University of North Carolina Press, 1996), 195.

¹³ During just one three-year period, between 1837 and 1840, it is estimated that 100,000 to 300,000 Indians died from smallpox. For more detailed estimates of native smallpox mortality, see Kristine B. Patterson and Thomas Runge, "Smallpox and the Native American," *The American Journal of the Medical Sciences* 323:4 (2002), 221.

removal of indigenous populations and the orderly acquisition of tribal lands.¹⁴ As we will see, this common carrier model would produce a stable and durable alliance — lasting throughout the Indian Vaccination Act’s implementation phase — between reformers within the bureaucracy who advocated vaccination as a means to improve Indian health, and those who saw vaccination merely as a means to speed the expropriation of Native American lands. This suggests that temporary coalitional arrangements in Congress, which may themselves be highly contingent or the result of expedience, can have lasting consequences for the administration and further evolution of policy outside the legislative branch.

Reinforcing the vaccination act’s link to state expansion, the Indian Office relied on existing relationships within the War Department to gradually construct an expansive bureaucratic network to regulate Indian health. Lacking a stable and feasible partnership with private parties, and absent legislative guidance, the Secretary of War and Superintendent of Indian Affairs merged the interests of Indian agents charged with providing a baseline level of disease control with those of soldiers enforcing Indian removal, tasking military surgeons with the work of vaccination. The War Department’s ability to borrow manpower in this way points to a feature often obscured by the enduring debate over state strength: the relative dexterity — a variant of what Ira Katznelson has termed “flexibility” — of early American institutions.¹⁵ As we will see, even if the American state was, at least in terms of its presence on the frontier, neither particularly “strong” nor especially “deep,” it was sufficiently nimble to take existing institutional capacity and redirect it to serve new ends. Assessing an agency’s relative dexterity may help researchers to identify the conditions — be they necessary or sufficient — for institutional conversion to occur, as well as to test more general hypotheses about why conversion is successful in some instances and not in others.¹⁶

¹⁴ Eric Schickler, *Disjointed Pluralism: Institutional Innovation and the Development of the U.S. Congress* (Princeton: Princeton University Press, 2001), 15.

¹⁵ Ira Katznelson, “Flexible Capacity: The Military and Early American Statebuilding,” in *Shaped by War and Trade: International Influences on American Political Development* (Princeton: Princeton University Press, 2002), 82-110.

¹⁶ Philip Rocco and Chloe Thurston, “From Metaphors to Measures: Observable Indicators of Gradual Institutional Change,” *Journal of Public Policy* 34 (2014): 35-62.

Before proceeding, however, two notes of caution are in order. As an initial matter, we cannot rely on the comprehensive records of legislative proceedings that students of Congress are typically privileged to draw on. The consideration and passage of the Indian Vaccination Act predates the formal publication of the *Congressional Record*, which documents the entirety of floor proceedings, roll call votes, and debates verbatim. Instead we must piece together an account of the Act's passage using the curated summaries of "leading debates and incidents" assembled in the *Register of Debates*, a commercial publication "intended to supply a deficiency" in the House and Senate *Journals*, which recorded motions, the outcome of floor votes, and brief descriptions of floor proceedings.¹⁷ I supplement these records further with the papers of members of the House and Senate Committees on Indian Affairs, messages from the president to Congress, official documents produced by the Bureau of Indian Affairs and War Department (which often include private correspondence between Indian agents and their superiors), and contemporaneous accounts in newspapers and periodicals. Moreover, save for petitions submitted to Congress and Indian agents, little in the archival record reflects the views of Native Americans themselves. Indeed, while accounts of contagion in indigenous communities abound, the majority of those that have been preserved were recorded by white missionaries, Indian agents, governors of Indian territory, and other state officials. Few accounts by Native Americans were written, and even fewer saved in archival collections. Consequently, the researcher — and reader — must exercise caution when assessing Native American attitudes toward vaccination, as well as the efficiency and efficacy of the program's implementation as experienced by indigenous communities.

Second, I want to be clear that the vaccination program was in no way an adequate response to American Indians' massive disease-induced depopulation in the decades after the founding of the republic. In 1837, alone, smallpox spread from government forts and trading posts in the upper Missouri River Valley, killing upwards of 10,000 Indians and nearly eradicating the Mandan nation. A witness to the aftermath of the outbreak, Henry Rowe Schoolcraft described "the scene of desolation, which the country now presents." "In whatever

¹⁷ "Preface," *Register of Debates in Congress*, 18th Congress, 2nd Sess., 1825, iv.

direction you turn nothing but the sad wrecks of mortality meet the eye,” he recalled, “it seems the very genius of desolation had...wreaked his vengeance.”¹⁸

With these caveats in mind, I proceed in six steps. First, I reflect on what the case of Indian vaccination can teach us about the linkages between public health, territorial expansion, and state-building in antebellum America. Next, I chronicle the origins of federal medical care for indigenous communities as a treaty or trust responsibility. A third section describes how bureaucrats within the War Department agitated for Congress to take responsibility for the health of frontier communities and to embrace a policy of state preventative medicine. Sections four and five chronicle the vaccination act’s passage and implementation. I conclude by drawing out some of the broader implications for our understanding of American state-building, antebellum representation, and the enduring legacies of common carrier coalitions.

The Political Lessons of Indian Vaccination

Political scientists may be justifiably wary of theorizing on the basis of one case. But the Indian Vaccination Act should not be dismissed as a stray or unrepresentative entry in the long and troubled history between the U.S. government and the “First American Citizens.”¹⁹ Indeed, as Stephen Rockwell reminds us, “since the early nineteenth century, the United States has obligated itself to provide health care, physicians, and medical supplies to Indians through treaties, laws, and the trust responsibility.”²⁰ As I hope to persuade readers, examining the ways in which antebellum federal policymakers approached the problem of infectious disease among Native Americans can help to augment — and complicate — our understanding of the linkages between public health, geographic expansion, and the administrative pathways of state development in the Jacksonian era. Specifically, I argue that training our analytical focus on federal efforts to curb contagion in indigenous communities can help us to better appraise the

¹⁸ Henry Rowe Schoolcraft, *Information Respecting the History, Conditions and Prospects of the Indian Tribes of the United States* Vol. I (Philadelphia: Lippincott, Grambo and Co., 1851), 258.

¹⁹ Kevin Bruyneel, “Challenging American Boundaries: Indigenous People and the ‘Gift’ of U.S. Citizenship,” *Studies in American Political Development* 18 (2004): 40.

²⁰ Stephen J. Rockwell, *Indian Affairs and the Administrative State in the Nineteenth Century* (New York: Cambridge University Press, 2010), 30.

what of state-building — that is, the range of policy areas in which the early American state was active; the *who* of state-building — the target populations of federal intervention; and the *how* of state-building — the ways in which administrative actors sought to implement congressional directives.

The quest to define the *what* of American state-building has long captivated students of American political development (APD), but it has largely excluded from its empirical and theoretical core the politics of social-good provision to Native Americans in the antebellum period, with important consequences for our collective understanding of the processes undergirding state development. Indeed, the first generation of APD scholarship tended to describe the early American state as a hodgepodge of weak institutions dedicated to three goals: stimulating economic growth, managing race relations, and securing the western frontier.²¹ Preoccupied by these endeavors, the early republic was naturally laggard in developing a vigorous program of disease control and public health provision.

A growing body of more recent APD scholarship has sought to challenge this minimalist view, arguing instead that the early republic was far more capable and active in promoting a range of policies characteristic of a modern state than previously supposed.²² Examining the dynamics of land policy from different vantages, Laura Jensen and Paul Frymer detail how Congress used land warrants, territorial bounties, and homesteading laws to transfer wealth in the

²¹ Typical of this approach, Daniel Carpenter writes: “Nineteenth-century politics commissioned a state equipped to perform little more than the delivery of mail, the routine taxing of imported goods, and the rote distribution of pensions and public lands.” Daniel Carpenter, *The Forging Bureaucratic Autonomy: Reputations, Networks, and Policy Innovation in Executive Agencies, 1862-1928* (Princeton: Princeton University Press, 2001), 60. See also Matthew A. Crenson, *The Federal Machine: Beginnings of Bureaucracy in Jacksonian America* (Baltimore: Johns Hopkins University Press, 1975); Skowronek, *Building a New American State*; Skocpol, *Protecting Soldiers and Mothers*, 105-151; Richard Franklin Bense, *Yankee Leviathan: The Origins of Central State Authority in America, 1859-1877* (New York: Cambridge University Press, 1990).

²² Richard R. John, *Spreading the News: The American Postal System from Franklin to Morse* (Cambridge: Harvard University Press, 1995); Laura S. Jensen, “The Early American Origins of Entitlements,” *Studies in American Political Development* 10 (1996): 360-404. Richard R. John, “Governmental Institutions as Agents of Change: Rethinking American Political Development in the Early Republic, 1787-1835,” *Studies in American Political Development* 11 (1997): 347-80; Brian Balogh, *A Government Out of Sight: The Mystery of National Authority in Nineteenth-Century America* (New York: Cambridge University Press, 2009).

form of property to constituents as entitlements, often with the aim of bolstering white migration and entrenching slavery.²³ Drawing our attention to a different antebellum institution, Katznelson and David Ericson point to the diverse array of state-building activities facilitated by the U.S. military.²⁴ Together, these findings offer an important corrective to Walter Dean Burnham's assertion that "the chief distinguishing characteristic of the American political system before 1861 is that there was no state."²⁵

Despite their abundant strengths, however, these same studies — along with their predecessors — downplay the state's involvement in regulating public health and overlook entirely patterns of social provision to Native Americans, including efforts to combat infectious disease.²⁶ Deepening the lacuna, political scientists and historians who do analyze the politics and provision of public health tend to eschew the antebellum period in favor of critical junctures in the twentieth century. In what is now a thriving literature, students of health policy have amassed an eclectic mix of scholarship exploring, for example, the rise of modern public health administration and national public health capacity, the provision and retrenchment of

²³ Laura S. Jensen, *Patriots, Settlers, and the Origins of American Social Policy* (New York: Cambridge University Press, 2003); Paul Frymer, *Building an American Empire: The Era of Territorial and Political Expansion* (Princeton: Princeton University Press, 2016).

²⁴ David Ericson, "The United States Military, State Development, and Slavery in the Early Republic," *Studies in American Political Development* 31 (2017): 105-116; Ira Katznelson and Martin Shefter, *Shaped by War and Trade: International Influences on American Political Development* (Princeton: Princeton University Press, 2002). See also Paul Frymer, "'A Rush and a Push and the Land is Ours': Territorial Expansion, Land Policy, and U.S. State Formation," *Perspectives on Politics* 12 (2014): 119-144. To be fair, both Bensek and Skowronek devote considerable attention to the military and its role as a modernizing agent in the later half of the nineteenth century. On Bensek's account, the army provided congressional Republicans the necessary "central state authority" to repress southern separatism and impose economic policies advantageous to northern interests in the decades after the Civil War. For Skowronek, the War Department was emblematic of nineteenth-century America's patchwork model of state development: limited in its administrative capacity prior to Reconstruction, and later shaped by party politics, as much as by geographic and imperial exigencies. See Bensek's *Yankee Leviathan* and Skowronek's *Building a New American State*.

²⁵ As quoted in Peter J. Katzenstein, "The Small European States in the International Economy: Economic Dependence and Corporatist Politics," in *The Antinomies of Interdependence: National Welfare and the International Division of Labor*, ed. John Gerard Ruggie (New York: Columbia University Press, 1983), 84.

²⁶ But see Rockwell, *Indian Affairs and the Administrative State*, 31; David H. DeJong, *'If You Knew The Conditions': A Chronicle of the Indian Medical Service and American Indian Health Care, 1908-1955* (Lanham MD, Lexington Books, 2008) and *Plagues, Politics, and Policy: A Chronicle of the Indian Health Service, 1955-2008* (Lanham MD, Lexington Books, 2011).

programmatic health services, the growth and politicization of medical professional associations, and fluctuations in public support for health care entitlements.²⁷ Although methodologically diverse and empirically wide-ranging, the majority of these studies share a common periodization scheme, beginning in the decades immediately preceding or directly following the New Deal. Linking up to the literature on American state development more broadly, this choice is often justified on the ground that prior to World War I, public efforts to regulate health were “feeble, episodic, and administratively immature,” a view that “meshes well” with the assumption that nineteenth-century statecraft was weak, limited, and unsophisticated.²⁸

The handful of studies that do acknowledge government efforts to regulate health in the nineteenth century uniformly limit their analyses to local — that is, “commonwealth” — interventions. William Novak, for example, offers abundant evidence that, from the first decades of the republic’s founding, local boards of health and state-level officials imposed an array of regulations intended to promote the public’s health and hygiene.²⁹ But Novak’s account is marred by his thin description of *federal* efforts to deliver medical care and guard against contagion. Michael Willrich, too, gives short shrift to federal action in his study of American vaccination programs. While arguing that “since the dawn of the American Republic, state and local governments have wielded powers both plenary and plentiful to protect the people against smallpox...and other pestilences,” he spares little attention for “the state’s power — indeed its inherent legal duty — to protect the population from peril.”³⁰

²⁷ See for example: Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982); Jacob Hacker, *The Divided Welfare State: The Battle over Public and Private Social Benefits in the United States* (New York: Cambridge University Press, 2002); Jonathan Oberlander, *The Political Life of Medicare* (Chicago: University of Chicago Press, 2003); Jill Quadagno, *One Nation, Uninsured: Why the U.S. Has No National Health Insurance* (New York: Oxford University Press, 2005); James Morone and Lawrence Jacobs, *Healthy, Wealthy, and Fair: Health Care and the Good Society* (New York: Oxford University Press, 2007); Daniel Sledge, “War, Tropical Disease, and the Emergence of National Public Health Capacity in the United States,” *Studies in American Political Development* 26 (2012): 125-162.

²⁸ Novak, *The People’s Welfare*, 194.

²⁹ *Ibid.*, 191-234.

³⁰ Michael Willrich, “‘The Least Vaccinated of Any Civilized Country’: Personal Liberty and Public Health in the Progressive Era,” *The Journal of Policy History* 20 (2008), 76. See also Willrich, *Pox: An American History* (New York: Penguin Press, 2011).

But, as we will see in the empirical sections to follow, the federal government was, from the very beginning, deeply involved in regulating the health of the settler public as well as that of indigenous communities. In the early decades of the new republic, medical supplies and the services of physicians were considered goods to be traded to Native Americans in exchange for title to their territory. As westward expansion accelerated, federal policymakers embraced a more vigorous conception of state preventative medicine to protect both indigenous and neighboring settler communities, and more importantly, to reduce the escalating costs of Indian removal. This pattern suggests that the nineteenth-century state was both capable and far-reaching, assuming responsibility for a wider range of tasks than previously appreciated. Perhaps more important, public health, which is so often excluded from the bundle of constitutive functions of the federal government in the decades before the Civil War, is, in fact, essential to the developmental arc of antebellum state institutions and frontier policies. Indeed, I will show that the provision of medical services to Native Americans was fundamentally intertwined with expansion and settlement from the republic's inception, as Rockwell argues was true for other antebellum social policies.³¹ In fact, the Indian Vaccination Act suggests that, far from an indicator of modernization — marking the maturation of state institutions into their elaborated Bismarckian forms — a program of disease control can be central to emerging governments. For their part, indigenous communities came to view the state's provision of health care as a right enumerated in treaty law and owed “as part of the . . . government's payment for Indian land.”³²

Regardless of whether nineteenth-century health laws were primarily local or federal, *who* within the polity did policymakers seek to protect? Here, existing accounts of antebellum public health administration — and patterns of social welfare provision, more generally — tend to consider the disparate impact of state policies on different classes of mainly white citizens,

³¹ Rockwell, *Indian Affairs and the Administrative State*, 30.

³² Emery A. Johnson and Everett R. Rhoades, “The History and Organization of Indian Health Services and Systems,” *American Indian Health: Innovations in Health Care, Promotion, and Policy* ed., Everett R. Rhoades (Baltimore, MD: Johns Hopkins University Press, 2001), 75.

excluding Native Americans altogether.³³ Distinguishing between soldiers and settlers, Anglo-Americans and immigrants, indentured servants and enslaved blacks, scholars suggest that the benefits of public health programs accrued to the nation's privileged classes, while the burdens were disproportionately felt by the underclass.³⁴ Little to no attention is paid to Congress's efforts to police the health of, and provide medical services to, indigenous communities beyond the country's borders.³⁵ In fact, scholars often assume that lawmakers had little incentive to legislate on behalf of those beyond their settler citizenry (and, in some cases, their slaves); only the courts, insulated from the electoral connection, proved even remotely sympathetic to the rights and physical welfare of Native Americans.

The Indian Vaccination Act complicates this view of *who* received antebellum social services and entitlements. Pressed by missionary and abolitionist reformers, a small group of

³³ Willrich, "The Least Vaccinated," 85; Jensen, *Patriots, Settlers and the Origins of American Social Policy*, 36-43; Skocpol, *Social Policy in the United States: Future Possibilities in Historical Perspective* (Princeton: Princeton University Press, 1995); John Resch, *Suffering Soldiers: Revolutionary War Veterans, Moral Sentiment, and Political Culture in the Early Republic* (Boston: University of Massachusetts Press, 1999); Desmond S. King and Rogers M. Smith, "Racial Orders in American Political Development," *American Political Science Review* 99 (2005), 85-86. See also Suzanne Mettler, *Dividing Citizens: Gender and Federalism in New Deal Public Policy* (Ithaca, NY: Cornell University Press, 1998).

³⁴ See for example, Gaines M. Foster, "The Limitations of Federal Health Care for Freedmen," *The Journal of Southern History* 48 (1982): 349-372; Alan M. Kraut, *Silent Travelers: Germs, Genes, and the Immigrant Menace* (New York: Basic Books, 1994); Dayle B. DeLancey, "Vaccinating Freedom: Smallpox Prevention and the Discourses of African American Citizenship in Antebellum Philadelphia," *The Journal of African American History* 95 (2010): 296-321. Only in the decades after the Civil War did federal and state policymakers begin to provide social welfare programs for distressed women, orphans, the aged, and the sick. But these programs typically relied on partnerships with private institutions, both charities and for-profit organizations, to deliver the relief. During this same period, Willrich observes that "race stymied smallpox control, as white taxpayers, particularly in the South, balked at paying for vaccine to protect blacks; meanwhile, African Americans rightly mistrusted government vaccinators whose chief aim was to protect the white community." See Willrich, *Pox: An American History*, 12.

³⁵ To the extent that we have any point of entry to understand the "intercurrence" of public health and marginalized communities, we must turn to more modern works, such as Evan Lieberman's prediction that "when the 'us-them' dynamic is absent from politics, political entrepreneurs are more likely to perceive and to frame the epidemic as a shared threat that demands the mobilization of public resources." Karen Orren and Stephen Skowronek, *The Search for American Political Development* (New York: Cambridge University Press, 2004), 118; Evan S. Lieberman, *Boundaries of Contagion: How Ethnic Politics Have Shaped Government Responses to AIDS* (Princeton: Princeton University Press, 2009), xiii. See also Cathy J. Cohen, *The Boundaries of Blackness: AIDS and the Breakdown of Black Politics* (Chicago: University of Chicago Press, 1999).

progressive lawmakers sought to justify on humanitarian grounds policies designed to combat the devastation wrought by smallpox in indigenous communities. However, the majority of lawmakers who supported Indian vaccination did so because they understood that contagious disease posed a threat to white settlers, and risked slowing the pace and inflating the costs of Indian removal. Thus, by fusing progressive and expansionist interests, Indian vaccination proved to be a successful “common carrier” proposal — a policy supported by opposing groups for different reasons. That a majority in Congress consented to fund a vaccination program for Native Americans out of a desire to expropriate their land reaffirms the idea that objective need is rarely sufficient to persuade Congress to act. The possibility that smallpox might eradicate the country’s indigenous population was not, in and of itself, reason for lawmakers to embrace a more vigorous model of state preventative medicine. As Justin Crowe has argued was true for the expansion of federal courts, the problem required legislative and bureaucratic entrepreneurs invested in state-based disease control and possessing sufficient political clout to spur action.³⁶

When it comes to *how* nineteenth-century bureaucrats developed the expertise and organizational capacity to govern a fractured polity, or to settle an already inhabited territory, there is little consensus. A growing chorus of scholars have argued that policymakers often relied on “collaborative relationships” with nongovernmental actors to perform the bundle of functions at the state’s core.³⁷ These hybrid or “associational” arrangements enabled state actors to “borrow” capacity rather than build it themselves.³⁸ As Colin Moore argues, these public-

³⁶ Justin Crowe, *Building the Judiciary: Law, Courts, and the Politics of Institutional Development* (Princeton: Princeton University Press, 2012). See also Eric Schickler, “Entrepreneurial Defenses of Congressional Power,” in *Formative Acts: American Politics in the Making* eds. Stephen Skowronek and Matthew Glassman (Philadelphia: University of Pennsylvania Press, 2007), 293-315.

³⁷ Colin Moore, *American Imperialism and the State, 1893-1921* (New York: Cambridge University Press, 2017), 22. See also Wayne E. Fuller, *Morality and the Mail in Nineteenth-Century America* (Urbana: University of Illinois Press, 2003); Robert C. Lieberman, *Shaping Race Policy: The United States in Comparative Perspective* (Princeton: Princeton University Press, 2007); Andrew S. Kelly, “The Political Development of Scientific Capacity in the United States,” *Studies in American Political Development* 28 (2014); Colin D. Moore, *American Imperialism and the State, 1893-1921* (Cambridge: Cambridge University Press, 2017).

³⁸ Brian Balogh, *The Associational State: American Governance in the Twentieth Century* (Philadelphia: University of Pennsylvania Press, 2015); Elisabeth Clemens, “Lineages of the Rube Goldberg State,” in *The Art of the State: Rethinking Political Institutions*, ed. Ian Shapiro et al. (New York: New York University Press, 2006), 191.

private partnerships are particularly valuable to bureaucrats engaged in territorial expansion. Because “spending state resources on people *outside* the boundaries of the nation...provides no electoral benefits to members of Congress,” federal legislators granted late nineteenth-century bureaucrats significant autonomy to create colonies overseas, but few resources to manage them. In turn, with low administrative capacity and weak public support, colonial officials turned to private financiers to fund and help direct America’s burgeoning overseas empire.³⁹

However, it is also the case that a variety of antebellum agencies, including the War Department and Indian Office — similarly charged with the task of colonization, albeit on the U.S. mainland — worked to cultivate their own administrative expertise and capacity without the aid of private partners. “The country’s military,” Katznelson writes, “developed considerable capacity in the antebellum era, serving a state without a fixed territory, settled neighbors, or, most of the time, large nearby land armies.”⁴⁰ In the absence of legislative and judicial capacity, Rockwell argues, the federal government’s core administrative agencies routinely sought to build rather than borrow capacity.⁴¹

The Indian Vaccination Act offers a new and important data point. Lacking a stable and cost-effective partnership with private physicians, the Secretary of War and Superintendent of Indian Affairs deployed military surgeons to administer vaccinations in cooperation with local Indian agents and the army officers charged with removal. Guided by Indian agents, War Department physicians traveled to Native American villages across the frontier carrying what they hoped was live vaccine material — typically pieces of thread or wisps of cotton contaminated by the non-fatal cowpox virus — which they then scratched into patients’ arms using needles or lancets.⁴² The procedure was deemed successful when the incision healed with

³⁹ On this account, “private actors are central players in the administration of policies and not merely supportive constituencies used to build support for public programs.” Moore, *American Imperialism*, 24.

⁴⁰ Katznelson, “Flexible Capacity,” 92.

⁴¹ Rockwell, *Indian Affairs and the Administrative State*, 31-35.

⁴² In the early 1700s the preferred method of “variolaion” or inoculation involved rubbing the dried pustules of mild cases of smallpox into the skin of healthy subjects to provide a lifetime immunity to the disease. The practice carried far more risk than the use of cowpox.

a pockmark scar.⁴³ That the Indian Office sought to convert existing government capacity to new ends, rather than borrow *or* build, suggests two refinements to theories of antebellum administrative capacity and public-private partnerships, more narrowly.

First, the War Department's capacity to shift its manpower and expertise to meet new logistical challenges suggests that scholars interested in the growth of federal administrative institutions should be as attentive to their relative *dexterity* as they are to the binary of weak and strong bureaucracies. To be sure, historical institutionalists have long appreciated the virtues of institutional conversion — the notion that old institutions can be redirected to serve new goals — but scholars of state development have been slower to recognize that states, and their component bureaucracies, vary in the degree to which they are capable of repurposing existing personnel and expertise to further different aims.⁴⁴ In the case of Native American vaccination, the antebellum republic's "expansible" War Department was nimble enough to adapt to the changing state of Indian affairs, all the while "the volatility of the frontier...left Congress and the courts lagging behind events and inexpert at addressing complicated circumstances."⁴⁵ Although an examination of how military surgeons were able to incorporate vaccine administration into their existing obligations is beyond the scope of this paper, we will see that it is crucial that they were able to do so.

⁴³ Elizabeth A. Fenn, *Pox Americana: The Great Smallpox Epidemic of 1775-82* (New York: Hill and Wang, 2001).

⁴⁴ The idea of administrative dexterity is related but not synonymous with Katznelson's concept of "flexibility" or Secretary of War John C. Calhoun's ambition to create an "expansible army." While Katznelson points to the military's ability to successfully operate as a highly mobile, "lean" fighting force, and then rapidly expand at relatively low cost when prodded by international threat, the focus here is on the War Department's capacity to redirect personnel from one policy objective to another. Put another way, *flexibility* connotes a military "constantly in motion, its forts often fixed for only short periods, its navy always on the move, searching for pressure points," whereas *dexterity* refers to the movement or conversion of military expertise and manpower internal to the War Department to manage new administrative tasks. It is also distinct from the relative "malleability" — operationalized as variation in the number and clarity of institutional rules — that Philip Rocco and Chloe Thurston identify as predictive of conversion. See Katznelson, "Flexible Capacity," 98-101; Rocco and Thurston, "From Metaphors to Measures," 38.

⁴⁵ Rockwell, *Indian Affairs and the Administrative State*, 33.

Second, the administration of the vaccination program suggests that public-private partnerships may be less likely to form when the primary state actors charged with administering a congressional directive are collectively invested in achieving the program's goals efficiently and effectively. Just as vaccination was a common carrier for lawmakers, Indian agents, military physicians, and rank-and-file soldiers all shared an interest in limiting the spread of the disease on the frontier, even if their ultimate goals and responsibilities varied considerably. While legislators and bureaucrats may opt to administer certain kinds of colonial endeavors — particularly those centered around resource extraction — through public-private partnerships, where settlement is the end goal, the state may prefer to centralize administrative authority in government agencies.⁴⁶

Medical Care as Currency

The early American state, Katznelson observes, “had two main purposes: the management of a sectionally heterogenous polity and the extension of its sovereignty.”⁴⁷ These twin goals, however, were often in tension. In the late 1700s and early 1800s, federal officials struggled to balance their desire for an orderly and defensible plan for frontier settlement with settlers' expansionist impulses. Although it would take several decades for legislators to embrace disease control as an affirmative state power, they were quick to recognize that providing even rudimentary medical care to indigenous communities helped to further both objectives.

In the aftermath of the American revolution, the leaders of the new republic were eager to monetize “the riches...and natural funds of the continent” to discharge the former colonies' wartime debts.⁴⁸ With limited authority to raise taxes, the sale of British land cessions — signed over by the Treaty of Paris in 1783 — represented the federal government's primary means of

⁴⁶ This is in keeping with Moore's prediction that state-building through collaborative relationships is most likely when administrators must overcome “weak congressional and public support” and fractured (and consequently “incapable”) agencies to make policy. Moore, *American Imperialism*, 22.

⁴⁷ Katznelson, “Flexible Capacity,” 104.

⁴⁸ Thomas Paine, “On Government of Western Territory,” *Ohio in the Time of the Confederation* ed. Archer Butler Hulbert (Marietta, Ohio: Marietta Historical Commission, 1918), 8.

revenue.⁴⁹ Even prior to Britain’s transfer of territory by treaty, delegates to the Continental Congress discussed the possibility of using “the western lands, if ceded to the United States... towards a fund for paying the debt of these states.”⁵⁰ But to convert the “immense tracts of land” into a “national fund,” the legislature would need to turn the territory, gained and then governed by British colonial and treaty law, into titled parcels suitable for private sale and settlement.⁵¹

This would prove a formidable task, as lawmakers struggled to assert federal preeminence over Indian territory and trade. In 1787, the Continental Congress issued an ordinance declaring that “the United States in Congress assembled... have the sole and exclusive right and power of regulating trade, and managing all affairs of the Indians.”⁵² But citing the ordinance’s proviso that “the legislative right of any state within its own limits [shall] not be infringed or violated,” many of the states that held claim to portions of the western frontier under their colonial charters continued the pre-revolutionary practice of negotiating directly with local tribes over territory and the boundaries of settlement.⁵³ As Rockwell recounts, state officials in Georgia, North Carolina, and New York — citing constituent pressure — sought to “treat[] directly with Indian tribes and assign[] lands independently.”⁵⁴ In some instances, state governments were aided by federal treaty commissioners, who argued that Britain’s defeat

⁴⁹ Frymer, *Building an American Empire*, 47.

⁵⁰ “September 5, 1782,” *Journals of the Continental Congress*, Vol. 23, 550. See also Michael Klarman, *The Framers Coup: The Making of the United States Constitution* (New York: Oxford University Press, 2016), 30 and 66.

⁵¹ David Howell to Jonathan Arnold, February 21, 1784, *Letters of Delegates to Congress*, Vol. 21, 381-384.

⁵² “Ordinance for the Regulation of Indian Affairs,” August 7, 1786, *Journals of the Continental Congress*, Vol. 31, 490-93.

⁵³ Seven states’ colonial charters laid claim to tracts of western wilderness: Massachusetts, Connecticut, New York, Virginia, North Carolina, South Carolina, and Georgia. This created an early sectional cleavage between “landed” and “landless” states that the Articles of Confederation would struggle to resolve. See Jensen, *Patriots, Settlers, and the Origins of American Social Policy* 126-127 and Klarman, *The Framers Coup*, 14, 26, and 44-45.

⁵⁴ Rockwell, *Indian Affairs and the Administrative State*, 52.

rendered the Crown's Indian allies "conquered nations" and their lands the spoils of war.⁵⁵ While state officials saw little reason to compensate Native Americans for their ceded territory and had few resources to do so, federal lawmakers feared that abrogating British treaty agreements would "produce all the evils of a general Indian war on the frontiers" — a war the new republic could ill-afford.⁵⁶

Administratively, however, federal lawmakers lacked sufficient authority or oversight capacity to ensure that local elected officials and settlers respected existing political borders and treaty agreements. Believing it impossible to forestall westward expansion, Congress instead sought to regulate it. In the hopes of managing the pace, if not the fact, of settler migration, members agreed to require treaty commissioners to purchase the "right of soil" to territory before it was opened to settlement.⁵⁷ As Secretary of War Henry Knox advised lawmakers: "The Indians are greatly tenacious of their lands, and generally do not relinquish their right, excepting on the principle of a specific consideration, expressly given for their purchase of the same...It cannot be violated but with difficulty, and at an expense greatly exceeding the value of the object."⁵⁸

But if gaining title to Indian territory required payment, how would the federal government secure the necessary funds? Indeed, the Committee on Indian Affairs reported: "The public finances do not admit of any considerable expenditure to extinguish the Indian claims."⁵⁹ Without sufficient revenue to purchase title to frontier lands outright, the Committee

⁵⁵ As Rockwell recounts, this method of land acquisition structured the treaty agreements of Fort Stanwix (1784), Fort McIntosh (1785), and Fort Finney (1786). See Rockwell, *Indian Affairs and the Administrative State*, 54.

⁵⁶ "Committee Report on the Southern Department," August 3, 1787, *Journals of the Continental Congress*, Vol. 33, 456-59.

⁵⁷ James Manning to Jabez Brown, *Letters to Delegates of Congress, 1774-1789* (Washington D.C.: Library of Congress, 1995), 344; Henry Knox to George Washington, June 15, 1789, *American State Papers: Indian Affairs* (Washington D.C.: Library of Congress, 1995), 13.

⁵⁸ "Report of the Secretary at War: Indian Affairs," *Territorial Papers of the United States* ed. Clarence E. Carter (Washington, D.C.: GPO, 1934), 103-105.

⁵⁹ "A Report on Indian Affairs," October 15, 1783, *Journals of the Continental Congress*, Vol. 25, 680-684.

recommended that settlement be slowed in the hopes that, in time, the government would accumulate the resources to obtain title lawfully.⁶⁰ In light of the administrative difficulty of controlling the pace of settlement, and the likely unpopularity of doing so, the War Department offered lawmakers another, more politically palatable, solution. Federal dollars would still be required to “procure a permanent peace with the Indian tribes...and to further extinguish[] by purchase Indian titles.” But when agents “found it necessary to engage any...additional sum,” they would offer “useful goods and services” that could be provided at less expense.⁶¹ Thus, title to Indian territory could be acquired at lower cost, and the “public creditors [who] have been led to believe...that those territories will be speedily improved into a fund towards the security and payment of the national debt” would be reassured.⁶²

Promises to supply medical care quickly proved to be an important asset in negotiations with the representatives, or purported representatives, of indigenous communities. Indeed, changes in treaty language and more informal agreements suggest that Indian agents routinely offered up the services of physicians and the provision of medicines — often curatives for venereal diseases — alongside instruction in animal husbandry and farming practice, in place of additional or more generous annuities. Beginning in the late 1780s, government officials regularly made pledges to provide a “myriad” of domestic, agricultural, and medical “commodities...[and] services...which commonly took the place of cash” as payment for ceded

⁶⁰ The treaty-making process required a substantial legislative appropriation to cover administrative expenses, payments for territory in the form of cash and goods and services, and diplomatic gifts. In 1776, for example, the Continental Congress allocated \$10,000 to purchase gifts for a single treaty council; lawmakers appropriated another \$10,000 for a different council two years later. See Francis Paul Prucha, *American Indian Treaties: The History of a Political Anomaly* (Berkeley: University of California Press, 1997), 30-31.

⁶¹ Charles Thomson to the Governor of the Territory of the United States Northwest of the River Ohio, July 2, 1788, *American State Papers: Indian Affairs*, 9.

⁶² In a letter to William Henry Harrison, then Governor of Indiana Territory, Thomas Jefferson proposed an alternative strategy to gain control of native lands by dint of goods, rather than cash. “We shall push our trading houses, and be glad to see the good and influential individuals run into debt, because we observe that when these debts get beyond what individuals can pay, they become willing to lop them off with a cession of lands.” Thomas Jefferson to William Henry Harrison, February 27, 1803, *Documents of United States Indian Policy* ed. Francis Paul Prucha (Lincoln, NE: University of Nebraska Press, 1975), 22-23.

territory.⁶³ Two decades later, a majority of treaty agreements included goods and services as partial payment for surrendered lands and by the end of the War of 1812, Native Americans had “in effect, parleyed their claims to land into claims for services from the new American government.”⁶⁴ While many Native American leaders expressed bewilderment that these goods and services were intended as compensation for ceding their “right of soil,” federal policymakers claimed their receipt extinguished Indian claims. As the Sauk war chief Black Hawk later recalled: “I touched the goose quill to the treaty, not knowing, however, that by that act, I consented to give away my village... [for] my reason teaches me that land cannot be sold.”⁶⁵

By the early nineteenth century, the federal government had secured title to millions of acres of formerly Indian country, assuming in return “obligations to provide health care, usually a physician and medications, to tribes.”⁶⁶ With physicians in short supply on the frontier, federal officials turned to the War Department’s military surgeons, already posted in western forts, to satisfy the government’s treaty commitments. In what would become common practice for the Bureau of Indian Affairs, Indian agents worked in tandem with army physicians to provide medical care directly to tribes located within their zones of authority.

Relying on salaried military physicians offered policymakers several advantages.⁶⁷ First, as nodes of economic development on the frontier, forts served as important trading hubs for Indian-settler commerce, and as such, ensured military surgeons ready access to the populations they endeavored to treat.⁶⁸ Indeed, War Department records suggest that fort surgeons were already in the habit of treating indigenous women who frequented military outposts for venereal

⁶³ Felix S. Cohen, “Original Indian Title,” *The Legal Conscience: Selected Papers of Felix S. Cohen*, ed. Lucy Kramer Cohen (New Haven, CT: Yale University Press, 1960), 281.

⁶⁴ Prucha, *American Indian Treaties*, 230-231.

⁶⁵ Black Hawk, *Black Hawk: An Autobiography* ed. Donald Jackson (Urbana, IL: University of Illinois Press, 1955), 87-101.

⁶⁶ Johnson and Rhoades, “The History and Organization of Indian Health Services and Systems,” 74.

⁶⁷ “H.R. 526,” April 3, 1832, *House Bills and Resolutions*, 22nd Congress, 1st Sess., 2.

⁶⁸ Herman J. Viola, *Thomas L. McKenney: Architect of America’s Early Indian Policy, 1816-1830* (Chicago: Sage Books, 1974), 48-50.

diseases that were contracted from garrisoned troops.⁶⁹ Second, military surgeons were, for the most part, experienced and competent, given the prevailing professional standards of the time and the realities of frontier medical practice. Third, and perhaps most important for the government's fiscal health, as salaried officials, military physicians did not require federal lawmakers to appropriate additional funds to meet their treaty obligations.⁷⁰

In these early decades of frontier settlement, Native Americans regularly reciprocated the exchange of medical care. Indian shamans, conjurers, and healers — often referred to in settler and military records as “medicine men” — were routinely solicited for their medical expertise and assistance when settlers lacked physicians of their own or suffered from illnesses and ailments familiar to indigenous healers.⁷¹ Paul Starr suggests that they were, in fact, far more knowledgeable about local pathogens and medicinal curatives than their white counterparts. “In early pioneer communities, Indian doctors... were held in quite as high repute as white doctors.” Even in more settled regions of the country, where formally trained physicians were in greater supply, indigenous medical expertise and “cures” were hailed by the medical establishment as “truly stupendous.”⁷² But, when their methods failed to halt the spread of Old World contagions, esteem for indigenous medical expertise declined. As the Superintendent of Indian Affairs would later opine: “We have all heard a great deal about the skill of Indian doctors. No doubt some of them are acquainted with the virtues of many plants, and know how to cure flesh wounds.” “As a body,” though, “they are utterly ignorant of our *Materia Medica*.”⁷³ Confronted by smallpox, which many Native Americans believed “the Great Spirit sent... to punish us for listening to the false promises of white men,” indigenous healers sought to relieve the symptoms of the disease

⁶⁹ DeJong, *If You Knew the Conditions*, 2-3.

⁷⁰ “Representative James M. Wayne, Removal of the Indians,” May 24, 1830, *Register of Debates in Congress*, 6: 1130-1131.

⁷¹ Sarah M. Broadhead to Cousin in Reynoldsville, September 3, 1813, Folder “M-4170.1,” Box 2, Native American Collection, University of Michigan William L. Clements Library, Ann Arbor, Michigan (WLCL).

⁷² Paul Starr, *The Social Transformation of American Medicine*, 48-49. See also: Benjamin Franklin, “Afterward to Every Man His Own Doctor” and “Poor Richard,” *The Papers of Benjamin Franklin Vol. II*, ed. Leonard W. Labaree (New Haven: Yale University Press, 1961), 155-158, 162-172.

⁷³ As quoted in Viola, *Thomas L. McKenney*, 144.

— fever, delirium, and rashes — but could do little to eradicate the virus or prevent it from spreading. Coupled with settlers’ newfound derision for Native American medical expertise was the common view that, in the words of one missionary, “Indians are not less, rather more, subject to disease than Europeans, their rough manner of life and the hardships of travel and the chase being contributing causes.” “The disorders to which the Indians are most commonly subjected... all proceed[] probably from the kind of life they lead, the hardships they undergo.”⁷⁴

It would soon become clear to federal policymakers that treaty-based care was fundamentally inadequate to combat the spread of infectious disease. As settlers pushed westward in increasing numbers, communicable diseases traveled with them. Trade and conflict brought indigenous communities on the periphery of the American empire into more frequent contact with white settlers — and in southern territories, their black slaves — exposing ever greater numbers of Native Americans to devastating pathogens. The effects of exposure to foreign diseases were exacerbated by the pressures of settler expansion, which reduced the land available for traditional methods of food production, contaminated drinking water, and eroded indigenous governing and cultural institutions.⁷⁵ Absent federal intervention, military physicians wrote their superiors, these so-called “virgin soil epidemics” would rapidly outpace the state’s capacity “to stay [the Indians’] downward course.”⁷⁶

⁷⁴ As quoted in David S. Jones, *Rationalizing Epidemics: Meanings and Uses of American Indian Mortality since 1600* (Cambridge: Harvard University Press, 2004), 78-79.

⁷⁵ Paul Kelton, “Avoiding the Smallpox Spirits: Colonial Epidemics and Southeastern Indian Survival,” *Ethnohistory* 51:1 (2004), 46.

⁷⁶ Richard White, *The Middle Ground: Indians, Empires, and Republics in the Great Lakes Region, 1650-1815* (New York: Cambridge University Press,), 41; T. Hartley Crawford to J.R. Poinsett, November 28, 1840, *Annual Report of the Commissioner of Indian Affairs* (Washington: Jacob Gideon, 1840), 7. Some military officials viewed smallpox as an ally in managing native affairs, insofar as it “naturally” eliminated Indian communities. As Lieutenant Richard Coytmore, a commander in Fort Prince George in South Carolina, wrote: “I cant [*sic*] help being so unhuman [*sic*] as to wish it may spread through the whole nation.” As quoted in Daniel J. Tortora, *Carolina in Crisis: Cherokees, Colonists, and Slaves in the American Southwest, 1756-1763* (Chapel Hill: University of North Carolina Press, 2015), 83.

Vaccination and Diplomacy

Policymakers in Washington were slow to heed these warnings. Eager to survey and settle the territory secured by the Louisiana Purchase, and preoccupied by international affairs, lawmakers spared little attention for the plight of indigenous communities. Advances in hygiene and the increasing availability of vaccine matter made it possible for enterprising military physicians to suppress localized bacterial and viral outbreaks on an ad hoc basis, but they lacked the resources or authority to provide more comprehensive care.⁷⁷ It would take repeated reports from seasoned frontier physicians describing the devastation wrought by disease to persuade then-Secretary of War John C. Calhoun to press lawmakers for authorization to intervene. But Calhoun's political rivals in Congress saw little reason to facilitate what they perceived to be a power grab. It would take another decade, two massive smallpox epidemics, and significant pressure from abolitionists and other social reformers opposed to Indian removal to spur the passage of a vaccination law.

The earliest calls for action were made by mezzo-level bureaucrats within the War Department. From 1802 to 1824, Indian agents and military officials posted at frontier forts repeatedly wrote their superiors, urging the Department to take steps to contain the spread of disease, especially smallpox, in Indian territory.⁷⁸ Their letters described scenes of abject horror and desolation — entire communities stricken by “the pox,” with hundreds of bodies left exposed for lack of survivors to care for them — and exhorted the Department to send supplies for vaccination. According to one account: “In 1802...the small pox...when once communicated...raged with great violence, and of a large band, scarcely one of those then at the

⁷⁷ In 1802, for example, army surgeons at several forts in Ohio territory vaccinated neighboring Indian tribes against smallpox, out of concern that an epidemic would endanger soldiers stationed at the military outposts. See Jones, *Rationalizing Epidemics*, 112. A year later, in June 1803, then-President Thomas Jefferson instructed the explorers Meriwether Lewis and William Clark to “carry with you some matter of the kinpox. Inform those of them with whom you may be of its efficacy as a preservative from the smallpox; and instruct and encourage them (i.e., the Indians) in the use of it.” But, it was not to be. As Lewis reported several months later, “I have reason to believe from several experiments made with what [vaccine matter] I have, that it has lost its virtue.” As quoted in E. Wagner Stearn and Allen E. Stearn, *The Effect of Smallpox on the Amerindian* (Boston: Bruce Humphries, 1945), 57.

⁷⁸ Rockwell, *Indian Affairs and the Administrative State*, 78-80.

village, survived; and the unburied bones still remain, marking the situation they occupied.”⁷⁹ The agent concluded that smallpox “has been one of the greatest scourges that has overtaken [the Indians] since their first communication with the whites.”⁸⁰

While settlers and local officials often saw value in the rapid disease-induced depopulation of indigenous communities for the government’s pursuit of land acquisition, Indian agents and army officers argued that repeated epidemics would destabilize frontier trade and the network of treaties undergirding it. For settlers and local political elites in southern states, in particular, epidemics were as much a boon as a risk to white interests. Disease reduced the native population, weakened tribes’ resolve to defend their land rights, and undermined the authority of indigenous leaders — circumstances settlers could exploit with the help of local authorities to obtain territory at lower expense.⁸¹ But for Indian agents, these same circumstances threatened to undermine the profitable trade the federal government had cultivated with native communities. Following another epidemic that raged across the southern Mississippi Valley, Colonel W.A. Trimble wrote Calhoun directly. “The small pox has made dreadful ravages among the Indians...The Comanches compute the loss which they sustained in 1816, from this horrible disease, at four thousand souls.” With few resources on hand to stem the tide of contagion, Trimble urged the Secretary of War to secure additional funds for vaccination. “The

⁷⁹ As quoted in Elbert Herring to Office of Indian Affairs, December 1, 1832, *Message from the President of United States to the Two Houses of Congress* (Washington D.C.: Duff Green, 1832), 175.

⁸⁰ *Ibid.*, 176. The accounts of Indian agents and army officials were corroborated by the journals and letters of Lewis and Clark. After traveling through the Missouri Valley in 1805, Clark reported that “the Smallpox destroyed the greater part of the [Mandan] nation and reduced them to one large Village and Some Small ones.” Three decades later, another smallpox epidemic would destroy the Mandans entirely. See William Clark, *The Journals of the Lewis and Clark Expedition* ed. Gary E. Moulton (Lincoln, NE: University of Nebraska Press, 1983), 402-405.

⁸¹ South Carolina, for example, had a long tradition of capitalizing on disease to gain the upper hand in territorial negotiations with the Cherokee. See Tortora, *Carolina in Crisis*, 82-83,

vaccine inoculation might be introduced among them at a trifling expense; such a course is dictated by humanity.⁸²

The objective need of indigenous communities aside, Calhoun recognized the central role Native Americans played in the economics of the western territories. To determine “the actual state of the Indian tribes” and whether federal intervention was warranted, the Secretary commissioned a “narrative tour” of Indian territory in 1820.⁸³ The commission, led by Reverend Jedidiah Morse, confirmed the reports of disease-wrought devastation from the field.⁸⁴ Finding that “the smallpox particularly, has frequently, and in many tribes, made awful havoc,” Morse advised Calhoun to “attach” a “skillful physician...to every...[tribal] family.” Medical care, he wrote the Secretary, would further two aims of the federal government. First, it would preserve frontier trade, and second, it would — in Jefferson’s words — “lead [the Indians] to... civilization.”⁸⁵ As Morse concluded in the Commission’s final report:

To secure success in civilizing the Indians, it is necessary, by all acts of kindness for their welfare, to gain their confidence and their affections...One effectual way of doing this is, to make them feel the benefits of our medical knowledge...It is

⁸² W.A. Trimble to John C. Calhoun, August 7, 1818, in *A Report to the Secretary of War of the United States, on Indian Affairs* (New Haven, CT: S. Converse, 1822), 259-260. The cost of providing aid and diplomatic goods to native communities was of serious importance to the federal government, as it had been for the British. Indeed, in 1764, General Thomas Gage wrote to a fellow officer: “I would be glad of your opinion, on what...sort of presents should be given to [the Indians]...we must curtail all our expenses as much as its possible, which I must earnestly recommend to you; for they grow very uneasy at Home about it. I have very strong Letters from the Treasury on that subject.” Thomas Gage to William Johnson, December 16, 1764, Folder “Indian Affairs in the Aftermath of Peace,” Box 2, Native American History Collection, WCL.

⁸³ Jedidiah Morse to John C. Calhoun, June 6, 1822, in *A Report to the Secretary of War of the United States, on Indian Affairs* (New Haven, CT: S. Converse, 1822), 9-10.

⁸⁴ Letters from abolitionists and self-identified reformers echoed the sentiments expressed in War Department accounts. Corresponding with his cousin, Thomas Dean noted with particular sadness the death of Indian children from whooping cough and dysentery, as well as smallpox. Thomas Dean to Philaner Hunt, August 12, 1824, Folder “M-4320.1,” Box 2, Native American Collection, WLCL.

⁸⁵ “President Jefferson on Indian Trading Houses: A Special Message to Congress,” January 18, 1803, in *Documents of United States Indian Policy* ed. Francis Paul Prucha (Lincoln, NE: University of Nebraska Press, 2000), 21-22.

very desirable, therefore, that vaccination, should be, by all means, introduced as extensively as possible among the Indians.⁸⁶

Sympathetic to the commission's findings, and eager to deepen his authority over the western frontier, Calhoun proposed that Congress create a new War Department bureau — separate from the Office of Indian Trade — to oversee Indian affairs and, more immediately, to stabilize the health of indigenous communities.⁸⁷

But Calhoun's request aroused the suspicion of rival factions within the Republican party. Believing the Secretary of War intended to use the new office as a platform to run for president, Calhoun's many legislative rivals — including orthodox Jeffersonians, allies of Treasury Secretary William Crawford, and supporters of Henry Clay — refused to consider the proposal and collectively embraced a policy of “radical retrenchment” instead.⁸⁸ A presidential hopeful himself, House Speaker Clay denied Calhoun's request on the grounds that “private enterprise” was superior to “government involvement in Indian affairs.”⁸⁹ Undaunted, Calhoun dismissed his rivals' intransigence as the “murmurs [*sic*] of factions” and established a Bureau of Indian Affairs within the War Department under his own auspices in 1824.⁹⁰

Lacking congressional authorization and thus a budget appropriation of its own, Calhoun's new bureau had few resources to rationalize the administration of Indian affairs, let

⁸⁶ Jedidiah Morse, *A Report to the Secretary of War of the United States, on Indian Affairs* (New Haven, CT: S. Converse, 1822), 91-92.

⁸⁷ John C. Calhoun to Henry Clay, December 5, 1818, *The Papers of John C. Calhoun*, ed. W. Edwin Hemphill (Columbia, SC: University of South Carolina Press, 1959), 3: 345. See also Viola, *Thomas L. McKenney*, 92-93.

⁸⁸ C. Edward Skeen, “Calhoun, Crawford, and the Politics of Retrenchment,” *The South Carolina Historical Magazine* 73 (1972), 147. See also Richard W. Barsness, “John C. Calhoun and the Military Establishment, 1817-1825,” *The Wisconsin Magazine of History* 50 (1966): 45-53.

⁸⁹ William S. Belko, “John C. Calhoun and the Creation of the Bureau of Indian Affairs: An Essay on Political Rivalry, Ideology, and Policymaking in the Early Republic,” *The South Carolina Historical Magazine* 105:3 (2004), 171.

⁹⁰ As quoted in Skeen, “Calhoun, Crawford, and the Politics of Retrenchment,” 144; Rockwell, *Indian Affairs and the Administrative State*, 78.

alone to initiate a program of frontier disease control.⁹¹ With only treaty-based efforts to regulate Indian health, contagion remained a threat to both indigenous and settler communities. It also increased the costs of tribes' "voluntary emigration" westward. As the Superintendent of Indian Affairs, Thomas McKenney, would remind Calhoun's successor, Secretary of War James Barbour four years later: "Starving Indians must be fed and naked ones clothed, and sick ones physicked and nursed." "If it be the pleasure of the Congress to allow the Indians to go west of the Mississippi," McKenney concluded, "substantial provision" would need to be made "to cover the cost."⁹² To be sure, the Superintendent acknowledged, providing medical care to Indian communities would require additional resources, but, he argued, "this mode of conquering these people is merciful and it is cheap, in comparison to what a war with them would cost, to say nothing of the loss of human life."⁹³ As westward expansion accelerated in the later of half the 1820s, lawmakers would come to share McKenney's view that a program of state preventive medicine was critical to an efficient and orderly program of land acquisition.

Vaccination as a "Coercive Instrument"

In December 1829, President Andrew Jackson requested that Congress abrogate existing treaty agreements and empower the executive to remove individual Indian nations from their lands east of the Mississippi to reservations west of the river, and to appropriate federal funds to carry out their resettlement. While Jackson's Democratic party hailed Indian removal "as one of the great measures of national policy, which will distinguish the administration," congressional Whigs and Republicans condemned the proposal as a gross expansion of executive authority and repudiation of property rights.⁹⁴ After a long and divisive debate, Congress passed the Indian

⁹¹ Calhoun's first superintendent, Thomas McKenney, used that title during his time at the Bureau. He would also refer to agency as the Indian Office or Office of Indian Affairs. McKenney's replacements often preferred the title of "Commissioner." Viola, *Thomas L. McKenney*, 93-95.

⁹² Thomas L. McKenney to James Barbour, January 4, 1828, "Letter from the Secretary of War Transmitting Information of the Inadequacy of the Fund for Defraying the Expenses Attending the Emigration of the Creek Indians," House Doc. No. 44 (January 7, 1828), 5-6.

⁹³ As quoted in Viola, *Thomas L. McKenney*, 118.

⁹⁴ As quoted in Fred S. Rolater, "The American Indian and the Origin of the Second American Party System," *The Wisconsin Magazine of History*, 76 (1993): 180-203. See also Ronald Satz, *American Indian Policy in the Jacksonian Era* (Norman: University of Oklahoma Press, 1975), 20-30, 39-56.

Removal Act of 1830 by a narrow margin, granting the president the authority he desired to remove and resettle indigenous communities and to seize for private sale the territory they were forced to abdicate.⁹⁵ The War Department would direct the removal program and manage Congress's half-a-million-dollar appropriation — a gargantuan task that strained the federal government's central administrative capacities, even if it was, as Rockwell argues, "horribly effective."⁹⁶

Within a year of the Indian Removal Act's passage, army commanders charged with overseeing the removal program reported to their superiors in Washington that epidemics — both viral and bacterial — were slowing the pace and inflating the costs of the Indians' transport and resettlement. In a letter to the Secretary of the War, the Superintendent responsible for the Choctaws' emigration wrote: "What is worse, we learn that the small-pox is among the six-towns; if so, and the contagion spreads, it may, for a time, be an insurmountable difficulty."⁹⁷ In another account he wrote: "No man but one who was present can form any idea of the difficulties that we have encountered....It is true, we have been obliged to...browbeat the idea of the disease, although death was hourly among us, and the road lined with the sick. The extra wagons hired to haul the sick are about five to the 1,000."⁹⁸ Six months after removal commenced, Lewis Cass — then the territorial Governor of Michigan — estimated that disease-related delays and expenses were likely to increase the total cost of the removal program by "an enormous amount."⁹⁹

Under public pressure to abandon Indian removal on both humanitarian and budgetary grounds, lawmakers embraced vaccination. The Indian Vaccination Act of 1832 brought together

⁹⁵ Rockwell, *Indian Affairs and the Administrative State*, 156-157; Robert Remini, *Andrew Jackson and his Indian Wars* (New York: Viking, 2001), 231-239.

⁹⁶ Balogh, *Government Out of Sight*, 210; Rockwell, *Indian Affairs and the Administrative State*, 158.

⁹⁷ F.W. Armstrong to John H. Eaton, June 29, 1831, *Correspondence on the Subject of the Emigration of the Indians* Vol. II, 496.

⁹⁸ F.W. Armstrong to George Gibson, December 2, 1832, *Correspondence on the Subject of the Emigration of the Indians* Vol. I, 401.

⁹⁹ Lewis Cass to Samuel S. Hamilton, December 20, 1830, *Correspondence on the Subject of the Emigration of the Indians* Vol. II, 201.

a cross-sectional and bipartisan coalition of northerners and westerners supportive of state preventative medicine for alternately progressive and instrumental reasons.¹⁰⁰ Although a handful of progressive lawmakers hoped to prevent the “extinction” of Native American communities, the majority of lawmakers who advocated on behalf of Indian vaccination did so because they understood that contagious disease posed a threat to white settlers and undermined political and popular support for Indian removal. Debate over the legislation would expose a now-familiar sectional fissure. While a majority of northern and western lawmakers sought to assert greater federal control over frontier settlement, albeit for different reasons, southern lawmakers vigorously opposed the expansion of federal jurisdiction over Indian affairs, preferring instead that states be permitted to negotiate and trade with — and ultimately evict — Native Americans on their own terms.

While Indian agents and military surgeons had been the first to call for a program of state preventative medicine on the frontier, they were soon joined by prominent abolitionists and missionary reformers who mobilized against removal and demanded that lawmakers attend to Native American health. Newly-formed benevolent societies and women’s charitable organizations petitioned federal officials to “overcome that stern indifference which has too long been entertained towards the sons of the forest, by a nation which covered their glory” and to offer succor on behalf of “our aborigines.”¹⁰¹ As settlers flooded the frontier, abolitionist and

¹⁰⁰ Party identity is difficult to track during this period. Following the War of 1812, the first party system dissolved and it was not until the election of President Andrew Jackson in 1828 that a stable two-party system would begin to reemerge. In the intervening years, partisan identities fluctuated. As a result, scholars of the period have had difficulty pinpointing lawmakers’ party affiliation across multiple congresses. In keeping with the literature, I defer to members’ own self-described party identity at any given time. Members alternately described themselves as Jacksonians, Anti-Jacksonians, Democratic-Republicans, and Whigs. Adding to the confusion, it is not unusual to find members calling themselves Jacksonians in one Congress, and Anti-Jacksonians in the next. As Aldrich writes, confusion reigned until 1840, when “both parties had come close to being fully organized national, mass-based parties.” For this reason, party identification provides limited analytical traction in explaining legislators’ policy positions during the period I discuss in this paper. John H. Aldrich, *Why Parties? The Origin and Transformation of Political Parties in America* (Chicago: University of Chicago Press, 1995), 104.

¹⁰¹ Lydia H. Sigourney, *Traits of the Aborigines of Boston* (Cambridge: The University Press, 1822), 284. Abolitionists, both white and black, were also strong proponents of vaccination for African Americans. In antebellum pamphlets and periodicals they lauded “vaccination in order to encourage behaviors consistent with citizenship, including intellectual advancement and civic responsibility.” See DeLancey, “Vaccinating Freedom,” 297.

progressive religious periodicals circulated accounts of indigenous dispossession and extermination by disease, explicitly linking Indian land rights to the health of Native American communities. Accusing federal actors of prioritizing commercial gain over human life, the young Reverend George Barrell Cheever wrote: “How long shall it be that a Christian people... shall stand balancing the consideration of profit and loss on a national question of justice and benevolence?”¹⁰² Framing their critiques in broader terms, William Lloyd Garrison, editor of the antislavery newspaper *The Liberator*, and Lydia Maria Child, editor of the *The National Anti-Slavery Standard*, likened Congress’s “total depravity” in its dealings with American Indians to lawmakers’ often brutal treatment of and contempt for enslaved blacks.¹⁰³ Child, in particular, spared little sympathy for northern pietism, writing: “To those who would assert the lenity of the northern settlers, and would compare the slow inroads of these [in Indian territory]...with the bloody acts and wanton cruelties of their precedents of southern America...they may boast for the former a record less black with iniquity; but their means...have still terminated in the same end.”¹⁰⁴

Public pressure to intervene in Indian health intensified in the wake of two devastating smallpox epidemics in 1830 and the winter of 1832 that left tens of thousands of Native Americans dead. Petitioners from Indian nations slated for removal, missionary societies, and abolitionist organizations inundated Congress with letters and articles protesting removal and the government’s callous regard for Indian life.¹⁰⁵ Indeed, the *Journal of Commerce* reported that

¹⁰² George B. Cheever, “The Removal of the Indians: An Examination of an Article in the North American Review and an Exhibition of the Advancement of the Southern Tribes in Civilization and Christianity,” *American Monthly Review*, 10 (1830), 704.

¹⁰³ As quoted in Robert W. Mardock, *The Reformers and the American Indian* (Columbia: University of Missouri Press, 1971), 8-9. The link between abolitionists and Indian reformers was sufficiently strong that Garrison designed the *Liberator*’s engraved heading to depict a slave block with slave auctioneers trampling copies of Indian treaties into dust at their feet.

¹⁰⁴ Lydia Maria Child, *The Christian Indian: or, Times of the First Settlers* (New York: Collins and Hannay, 1825), 6.

¹⁰⁵ Frymer, *Building an American Empire*, 123-125. See also Mary Hershberger, “Mobilizing Women, Anticipating Abolition: The Struggle against Indian Removal in the 1830s,” *The Journal of American History*, 86 (1999), 15-40.

“the tables of the members [of Congress] are covered with pamphlets devoted to the discussions of the Indian question,” concluding “there is a mighty movement in the land on this subject.”¹⁰⁶

In April 1832, Representative John Bell of Tennessee, Chairman of the Committee on Indian Affairs, bowed to public outcry and internal lobbying from the War Department to report a bill “to prevent the spreading of the smallpox along the Indian frontiers” to the House floor in April 1832.¹⁰⁷ The proposed resolution authorized the Secretary of War to appoint “as many special agents as he shall think proper” to “visit the Indian tribes on the Upper Missouri river and its branches and on the Upper Mississippi river, and between it and the [Great] lakes...to arrest the progress of small pox among the several tribes, by the application of vaccination.” Each agent would “be attended by one physician or surgeon, to be detached from the army, or not, as the Secretary of War shall find expedient.” Twelve thousand dollars would be appropriated to supply the agents with “genuine vaccine matter” and to pay the physicians a per diem for their services.¹⁰⁸ Citing the devastation wrought by “contagion” in Indian territory, Bell urged the House to “provide the means of extending the benefits of vaccination as a preventative of the smallpox, to the Indian tribes, and thereby, as far as possible, save them from the destructive ravages of that disease.”¹⁰⁹

Bell’s support for Indian vaccination is, at first glance, surprising. For not two years earlier, the congressman had championed Jackson’s Indian removal bill in the House.¹¹⁰ Arguing that northerners’ “tenderness” toward Indian nations slated for removal was hypocritical, as indigenous communities in northern states had long since been forced to abandon their “ancient lands,” Bell labored to overcome what he perceived to be “violent sectional” opposition to pass

¹⁰⁶ As quoted in Hershberger, “Mobilizing Women, Anticipating Abolition,” 24.

¹⁰⁷ “Vaccination of the Indians,” April 4, 1832, *Gales and Seaton’s Register*, 22nd Congress, 1st Sess., 2384.

¹⁰⁸ “H.R. 526,” April 3, 1832, *House Bills and Resolutions*, 22nd Congress, 1st Sess., 2.

¹⁰⁹ “Representative John Bell, Vaccination of the Indians,” April 4, 1832, *Journal of the House of Representatives of the United States*, 25: 567.

¹¹⁰ “Removal of the Indians,” May 15, 1830, *Register of Debates in Congress*, 21st Congress, 1st Sess., 994-998.

the president's legislation.¹¹¹ In addition, as a candidate for the House, the congressman had campaigned for Jackson and opposed the proliferation of federal programs "outside the pale of congressional authority." But, as a self-identified "frontiersman," Bell was familiar with the "chaotic conditions attending the removal of the Indians," and no stranger to the realities of "contagion" in Indian territory.¹¹² As he explained to colleagues: "Motives of humanity, as well as of interest, influenced the committee to...enable [the Department of War] to apply the most speedy and effectual remedy the nature of the case would permit."¹¹³

Owing, perhaps, to these "feelings of humanity," and the shared belief that reducing "contagion" was critical for the financial and security interests of white settlers, House debate over the proposal was limited. Fusing moral justifications with appeals to frontier security, the majority of members who supported Bell's resolution were Whigs and Anti-Jacksonians from northern and western states. Representative Tristram Burges of Rhode Island, a strident opponent of Jackson's policy of Indian removal, applauded Bell's plan, but emphasized the need for administrative proficiency to assure security and stability in Indian territory. Asking "whether it might not be advisable to double the number of surgeons and physicians, and give up the appointment of these special agents, who...could not be so well acquainted with the [tribes] habits or haunts," Burges favored an amendment that would require the War Department to rely on experienced agents in an effort to speed the dispersal of vaccine matter. Seconding Burges'

¹¹¹ "Removal of the Indians," May 24, 1830, *Register of Debates in Congress*, 21st Congress, 1st Sess., 1133-1136. See also John Bell, *Speech of John Bell of Tennessee, on Slavery in the United States and the Causes of the Present Dissensions Between the North and the South* (Washington D.C.: Gideon and Co., 1850), 13.

¹¹² As quoted in Norman L. Parks, "The Career of John Bell as Congressman from Tennessee, 1827-1841," *Tennessee Historical Quarterly* 1:3 (1942), 229-249.

¹¹³ "Vaccination of the Indians," April 4, 1832, *Gales and Seaton's Register*, 22nd Congress, 1st Sess., 2384. Bell also read from a report submitted by the War Department in March 1832 describing the "frightful distemper" of "the monstrous disease." The account noted that the Indians "were dying so fast, and taken down in such large numbers that they had ceased to bury the dead," and described "their misery [as] so great and so general." It was the War Department's official recommendation to "have them vaccinated, in order to prevent the desolating ravages of this dreadful disorder." Lewis Cass, "Small Pox Among the Indians," March 30, 1832, *A Letter from the Secretary of War*, House Document No. 190, 22nd Congress, 1st Sess., 1-2.

call for competent and efficient administration, Representative William Irvin of Ohio urged his colleagues to refrain from delaying “a bill which was solely of a benevolent character.”¹¹⁴

Although opposition in the House was muted, southern congressmen — mostly staunch Jacksonians — voiced three concerns. First, opponents contended that the proposed appropriation was “too much” because “many of the tribes had the smallpox already,” and distributing vaccine matter to survivors served little purpose. Second, they argued the proposal created unnecessary redundancies. With “so many other persons stationed as agents amongst the Indian tribes, whose services could be called on,” there was no need for the “employment of ‘special agents.’” Finally, presaging a key concern of their Senate colleagues, they questioned whether “the Indians themselves would be the greatest obstacle to the disease being checked,” preferring their own medicines to those of the “white man.”¹¹⁵ Despite these concerns, the congressmen uniformly acknowledged the moral and public health imperatives to “give every necessary aid to prevent the ravages that were apprehended from the spreading of the disease” on the frontier.¹¹⁶ After limited debate, the bill was read for a final time and passed by a voice vote on April 10, 1832.¹¹⁷

The proposed vaccination program faced stronger sectional and partisan resistance in the Senate. As in the House, the bill was sponsored by the Chairman of the Committee on Indian Affairs, Senator Hugh White of Tennessee. Like Bell, White favored Jackson’s removal program, justifying the resettlement of eastern Indian nations on humanitarian and paternalistic grounds. Arguing that “the Indian population...residing where they now do, [await] certain misery and ruin,” the senator concluded that relocation was the only way to preserve tribal autonomy and culture. By emigrating “beyond the Mississippi,” he would later write, “they can,

¹¹⁴ Vaccination of the Indians,” April 4, 1832, *Gales and Seaton’s Register*, 22nd Congress, 1st Sess., 2386.

¹¹⁵ Vaccination of the Indians,” April 4, 1832, *Gales and Seaton’s Register*, 22nd Congress, 1st Sess., 2384-2385.

¹¹⁶ Vaccination of the Indians,” April 4, 1832, *Gales and Seaton’s Register*, 22nd Congress, 1st Sess., 2384.

¹¹⁷ “H.R. 526: Vaccination of the Indians,” April 10, 1832, *Journal of the House of Representatives of the United States*, 25: 578.

as freemen, have a government of their own choice, their interests can be promoted, and their rights protected, by the United States without collision with any State.”¹¹⁸ At the same time, White was well aware the War Department lacked the funds to successfully resettle indigenous communities — that is, both efficiently and with relative care for human life. Shortly after the passage of the removal bill, McKenney wrote the senator that without “suitable benefits” and attention to native welfare “[they] shall be neglected and become wretched, and finally disappear,” disappointing “those who seek, by this mode [of removal], to save them.”¹¹⁹ White reiterated this concern in his defense of the vaccination plan, appealing to the Senate’s interest in “humanity *and* expediency,” and describing “the miserable condition of the Indians...afflicted with the small pox, dying in such numbers that the dead lay unburied.”¹²⁰

Vehemently opposed to federal intervention and unpersuaded by White’s appeal to expediency, Senator Alexander Buckner of Missouri devoted the better part of three days to protest the vaccination plan. A committed Jacksonian and a strident defender of states’ and slaveholders’ rights, the senator “expressed himself entirely averse to conferring benefits on those who had done so much injury to our own citizens.” Reframing the budgetary concerns raised by southern representatives, Buckner attacked the plan to use federal dollars to promote Indian health when “a small appropriation was denied to his district to erect a hospital.” Disputing that the proposal served to secure the frontier from the threat of communicable disease, the senator argued instead that it was a surreptitious attempt to create new opportunities for patronage in an agency with strong ties to the president. “Who would gain the benefits of the bill?”¹²¹ Several anti-Jacksonian senators seconded this objection, arguing that the plan “gave to the President an unrestricted right to appoint agents, and to extend his patronage,” and that by granting overmuch discretion to bureaucratic actors “it opened the door to fraud on the Indians

¹¹⁸ Hugh Lawson White, “Cherokee Memorial,” February 4, 1835, *A Memoir of Hugh Lawson White: Judge of the Supreme Court of Tennessee, Member of the Senate of the United States* ed. Nancy N. Scott (Philadelphia, PA: J.B. Lippincott, 1856), 167.

¹¹⁹ As quoted in Viola, *Thomas L. McKenney*, 222.

¹²⁰ “Indian Vaccination,” April 17, 1832, *Gales and Seaton’s Register*, 22nd Congress, 1st Sess., 792.

¹²¹ *Ibid.*

and on the Government.”¹²² Buckner also took up the claim first raised in the House that “the superstitious notions of the Indian would prevent him from receiving them [the inoculations].”¹²³ Rejecting the notion that the vaccination program would hasten Indian removal or further diplomatic ends, the senator encouraged his colleagues to withhold “benefits on those...who were our natural enemy...[and] who had committed the most wanton cruelties.”¹²⁴

Despite Buckner’s impassioned protest, a bipartisan coalition of northern and western senators — as well as several southerners — passed the bill, 30-11, on April 24, 1832 with little fanfare (see Tables 1 and 2).¹²⁵ Merging progressive and expansionist goals, the Indian Vaccination Act succeeded precisely because it satisfied multiple, often conflicting, interests. Roused by the appeals of missionary and abolitionist reformers, lawmakers like Burges and Irvin saw vaccination as a means to guard against the destruction of indigenous communities. But humanitarian principles, alone, were insufficient to rally a Senate majority. For the majority of Senate body, what mattered was that smallpox posed a threat to the republic’s economic and geographic security. Both Bell and White cited these interests in their appeals to those senators who questioned the loyalty of Indian nations and doubted that vaccination would redound to their constituents’ benefit. Preventing the spread of disease, they argued, would stabilize frontier trade, secure the health of white communities, and speed Indian removal. Though their speeches failed to sway most southern senators and representatives, Bell and White did win over other staunch expansionists, like Buckner’s Missouri colleague, Senator Thomas Hart Benton, who had in the past warred against federal intervention in Indian affairs.¹²⁶

¹²² “Indian Vaccination,” April 18, 1832, *Gales and Seaton’s Register*, 22nd Congress, 1st Sess., 795.

¹²³ “Indian Vaccination,” April 17, 1832, *Gales and Seaton’s Register*, 22nd Congress, 1st Sess., 792.

¹²⁴ *Ibid.*

¹²⁵ “Indian Vaccination,” April 24, 1832, *Journal of the Senate*, 21: 253.

¹²⁶ “Indian Vaccination,” April 24, 1832, *Journal of the Senate*, 21: 253. For more on Benton’s strategy for American expansion, see Jensen, *Patriots, Settlers, and the Origins of American Social Policy*, 181; Frymer, *Building an American Empire*, 130-137; Rockwell, *Indian Affairs and the Administrative State*, 127-131.

The factors motivating southern intransigence are more ambiguous. It is certainly plausible that a larger number of southern lawmakers might have favored the vaccination proposal than ultimately voted for it. After all, Jackson — a southerner, committed expansionist, and slaveholder — signed the bill without protest. Indeed, the South’s political elite regularly expressed concern that neighboring Native Americans, in collaboration with escaped slaves, would use infectious disease as an instrument of war or rebellion.¹²⁷ And with sizable indigenous populations remaining in many southern states, white traders and government officials often “return[ed] from the [Indian] country, bringing pestilence along with [them],” even if the resulting contagion was not intentional.¹²⁸ Southern state officials were also well aware that disease slowed the progress of Indian removal, and posed serious risk to the soldiers tasked with enforcing tribes’ resettlement. Perhaps most important, communicable disease imperiled the region’s chief property interest: slave chattel.¹²⁹ Epidemics had the potential to roil a state’s plantation economy, as slaveholders were compelled to pay the costs of medical treatment to protect their property or risk significant financial loss.¹³⁰ Consequently, when sectional divisions did emerge in debates over other aspects of Indian policy, it was often an east-west cleavage rather than a north-south divide. As was true for both Indian removal and vaccination, one camp “centered in New England, the Middle Atlantic states, and the Upper South — areas with little or no Indian population,” the other “came from the Lower South and Northwest, where whites were anxious to rid themselves of their Indian neighbors.”¹³¹

Nevertheless, the objections raised by southern legislators make clear that they were reluctant to expand federal authority over Indian affairs and saw little advantage in preventing

¹²⁷ Indeed, throughout the Revolution, southern officials warned their constituents that northern loyalists might send runaway slaves infected with smallpox home to cripple Patriot households. See Fenn, *Pox Americana*, 130-133; Philip Ranlet, “The British Slaves and Smallpox in Revolutionary Virginia,” *The Journal of Negro History* 64 (1999): 217-226.

¹²⁸ As quoted in Tortora, *Carolina in Crisis*, 81.

¹²⁹ Fenn, *Pox Americana*, 126-134; Tortura, *Carolina in Crisis*, 85-86.

¹³⁰ Stephen C. Kenny, “A Dictate of Both Interest and Mercy? Slave Hospitals in the Antebellum South,” *Journal of the History of Medicine and Allied Sciences* 65 (2010): 1-47.

¹³¹ Viola, *Thomas L. McKenney*, 212.

disease in indigenous communities from taking its natural course. Native American settlements often provided refuge for runaway slaves, which “set what...southerners could only regard as a very bad example.” In the Deep South, in particular, the Indian question was closely tied to the slavery question, as the political elite of Georgia, South Carolina, and Florida fought to police both indigenous and enslaved persons on their own terms, unbound by the strictures of treaty law.¹³² Moreover, the debate over Indian vaccination took place in a climate of intensifying sectionalism, as southern unease deepened that northern states sought to settle the west because they wished to erode southern influence in the national government and use federal power to the detriment of what they thought of broadly as the South’s unique economic and territorial interests.¹³³ These fears of federal aggression would be confirmed six months after the passage of the Indian Vaccination Act with the tariff nullification crisis of 1832. After South Carolina refused to implement the 1828 and 1832 tariffs, believing they favored northern industry at the expense of southern agricultural production, Jackson — backed by Congress — threatened to send federal troops into the state to enforce the protectionist taxes.¹³⁴

Ultimately, the archival record is sufficiently sparse that one cannot say for certain why a majority of the South’s senators and representatives saw little to gain from a program of state preventive medicine for American Indians. But, as the congressional sponsors of the Indian Vaccination Act attempted to persuade their colleagues, there can be little doubt that both indigenous and settler communities stood to benefit from state action to ward off contagion.

¹³² Kerber, “The Abolitionist Perception of the Indian,” 276.

¹³³ Frymer, *Building an American Empire*, 140-151. This was a concern that southern lawmakers had long harbored. As Klarman recounts, southern delegates to the Continental Congress “warned that the interest of the northern carrying states was ‘strikingly different from that of the [southern] productive states,’ and he predicted that ‘this government will operate as a faction of seven states to oppress the rest of the union.’” Klarman, *The Framers Coup*, 390-391.

¹³⁴ Andrew Jackson to Lewis Cass, December 17, 1832, Andrew Jackson Papers, Series 1, Vol. 82, Library of Congress Manuscript Division Digital Archive (LOCMD) <http://hdl.loc.gov/loc.mss/maj.01082_0244_0245> (accessed August 1, 2017); Andrew Jackson to U.S. Congress, January 16, 1833, Andrew Jackson Papers, Series 8, Vol. 178, LOCMD <http://hdl.loc.gov/loc.mss/maj.08178_0034_0041> (accessed August 1, 2017); Andrew Jackson, December 10, 1833, “Proclamation Concerning the Ordinance of South Carolina on the Subject of the Tariff,” *Elliot’s Debates*, Vol. 4 (Washington: 1836), 582-592.

Table 1: Senate support for the Indian Vaccination Act of 1832 by party affiliation.

Senator	Party	State			
Samuel Bell	Anti-Jacksonian	NH	Thomas Hart Benton	Jacksonian	MO
Ezekiel Chambers	Anti-Jacksonian	MD	George M. Dallas	Jacksonian	GA
Thomas Ewing	Anti-Jacksonian	OH	Charles E. Dudley	Jacksonian	NY
Samuel A. Foot	Anti-Jacksonian	CT	Powhatan Ellis	Jacksonian	MS
Theodore Frelinghuysen	Anti-Jacksonian	NJ	John Forsyth	Jacksonian	GA
Josiah S. Johnston	Anti-Jacksonian	LA	Felix Grundy	Jacksonian	TN
Samuel Prentiss	Anti-Jacksonian	VT	Isaac Hill	Jacksonian	NH
Asher Robbins	Anti-Jacksonian	RI	Elias K. Kane	Jacksonian	IL
Benjamin Ruggles	Anti-Jacksonian	OH	William Rufus King	Jacksonian	AL
Horatio Seymour	Anti-Jacksonian	VT	William L. Marcy	Jacksonian	NY
Nathaniel Silsbee	Anti-Jacksonian	MA	John M. Robinson	Jacksonian	IL
Peleg Sprague	Anti-Jacksonian	ME	Samuel Smith	Jacksonian	MD
Gideon Tomlinson	Anti-Jacksonian	CT	Hugh Lawson White	Jacksonian	TN
Daniel Webster	Anti-Jacksonian	MA	William Wilkins	Jacksonian	PA
Charles E. Dudley	Jacksonian	NY	Henry Clay	Republican	KY

Source: “Indian Vaccination,” April 24, 1832, *Journal of the Senate*, 21: 253.

Table 2: Senate opposition to the Indian Vaccination Act of 1832 by party affiliation.

Senator	Party	State			
George A. Waggaman	Anti-Jacksonian	LA	Stephen D. Miller	Jacksonian	SC
George M. Bibb	Jacksonian	KY	Gabriel Moore	Jacksonian	AL
Alexander Buckner	Jacksonian	MO	Littleton W. Tazewell	Jacksonian	VA
Mahlon Dickerson	Jacksonian	NJ	John Tipton	Jacksonian	IN
Robert Y. Hayne	Jacksonian	SC	John Tyler	Jacksonian	VA
William P. Mangum	Jacksonian	NC			

Source: “Indian Vaccination,” April 24, 1832, *Journal of the Senate*, 21: 253.

Implementation in the Absence of Private Partners

With Jackson's signature secured, the difficult task of administering the vaccination law fell to the War Department and its Bureau of Indian Affairs. Recognizing that a program of mass vaccination on a volatile frontier posed significant administrative challenges, Congress had granted the War Department wide discretion to assemble a group of capable physicians as it deemed "expedient." Indeed, the text of the law authorized the Secretary of War to determine whether to press military surgeons into service, or to hire civilian physicians already on the frontier.¹³⁵ Lewis Cass, now the newly appointed Secretary of War, instructed federal agents to recruit army personnel "to vaccinate such Indians as may be willing to submit to the process," rather than contract with civilian physicians to implement Congress's directive.¹³⁶ Believing disease control critical to Indian removal, but unable to entice qualified civilian physicians to work at government rates, Cass leveraged existing relationships within the War Department to construct an expansive bureaucratic network that would oversee native health for much of the nineteenth century.

In many ways, Jackson's new Secretary of War was well equipped to administer a program of frontier vaccination. As the longtime territorial governor of Michigan, Cass cultivated considerable expertise in the field of Indian affairs: supervising trade, appointing Indian agents, and overseeing diplomatic duties. By the time he assumed leadership of the War Department, Cass had spent nearly two decades overseeing of a dozen Indian agents, hundreds of troops, and nearly ten thousand Native Americans. Like many territorial governors, Cass took seriously the dangers infectious disease posed for military and settler populations. As a commander during the Indian wars of 1815, he witnessed "the terrible ravages" of disease, where "troops died in such numbers that panic and disease seemed likely to do much greater damage

¹³⁵ "H.R. 526," April 3, 1832, *House Bills and Resolutions*, 22nd Congress, 1st Sess., 2.

¹³⁶ Lewis Cass to Indian Agents in Illinois and Michigan, "Vaccination Circular," May 10, 1832, *Letter from the Secretary of War on Vaccination of Indians*, House Document No. 82, 22nd Congress, 2nd. Sess., 5-6.

than any human enemy.”¹³⁷ And, as was common for settler families on the frontier, Cass himself had lost several children to outbreaks of smallpox and cholera.¹³⁸

Despite his attention to frontier health, as territorial governor, Cass spared little sympathy for the plight of Native Americans. An early advocate for prohibition in Indian territory, Cass blamed “the general introduction of spirits into the Indian country” for “prostrating the mental and physical energies...of the Indians” and ultimately contributing to their “reduction in population.” Alcohol — not disease — drove “the circle of destruction” in indigenous communities, although he conceded “its operation has been aided...by the small pox whose ravages have been sometimes frightful.” As for Native American land claims, Cass dismissed them as “pretended fictions...probably invented to satisfy the inquiries of the white man.”¹³⁹ Deeply committed to Jackson’s policy of Indian removal, Cass devoted his tenure as territorial governor to eliminating threats to American expansion. Writing to his superiors in the War Department, he argued: “The natural progress of our settlements cannot be prevented, as no sound politician would seriously propose that the present Indian boundaries should be a barrier to our expanding population.”¹⁴⁰ Communicable disease, he would eventually conclude, was just such a threat. Indeed, after overseeing the removal of several Indian tribes from Michigan territory, Cass calculated that disease-related delays increased the cost of operations “two to three times the original estimate.”¹⁴¹

As Secretary of War, Cass would confront these costs on a larger scale. After the Indian Removal Act was passed, the War Department received dozens of reports from Indian agents expressing their charges’ desire for medical care. “The Indians have heard all about the

¹³⁷ Andrew C. McLaughlin, *American Statesman: Lewis Cass* (Boston: Houghton, Mifflin and Co., 1896), 138.

¹³⁸ Willard Carl Klunder, *Lewis Cass and the Politics of Moderation* (Kent, OH: Kent State University Press, 1996), 69.

¹³⁹ Lewis Cass, “Review of Published Works on Indians,” Folder 28, Box 6, Lewis Cass Papers, WLC.

¹⁴⁰ Lewis Cass, “Concerning a System for the Regulation of Indian Affairs,” November 29, 1816, Folder 27, Box 6, Lewis Cass Papers, WLC.

¹⁴¹ Andrew C. McLaughlin, *American Statesman: Lewis Cass* (Boston: Houghton, Mifflin and Co., 1896), 138.

prevalence of the small-pox west of the Mississippi, and they could not be induced to remove without guarding themselves against this terrible disease,” the agent supervising the emigration of Ohio tribes wrote his commanders. “We should all be highly gratified, and feel ourselves much more safe in the long and tedious journey before us, if you would grant us a physician to accompany the Ohio emigrants to the country of their destination.”¹⁴² Determined to carry out their removal orders as scheduled, agents sought out the services of local physicians and purchased additional wagons and supplies to transport the sick and sustain them on the journey.¹⁴³ But with expenses mounting, Indian removal threatened to exceed the War Department’s budget and risked jeopardizing the program’s political support. As McKenney complained to Cass: “The States clamour [*sic*] to get rid of the Indians — agreed: but it is not possible, much as I should be gratified if it could be so, to pay the cost of all this out of the pittance, at the disposition of the Department for Contingencies.” To Superintendent Clark he wrote: “The policy seems to have been removal — but the ways and means are not provided.”¹⁴⁴ Even when removal succeeded, and tribes were settled on their designated reservations, Cass recognized that disease left them in a “wretched condition, their wants increasing, their feelings dispensing and their prospects dreary.”¹⁴⁵ “Under these circumstances,” he concluded, “the Indians have a moral right to expect assistance from us.”¹⁴⁶

Cass acknowledged that providing even rudimentary care to Indian communities would not be easy. “We must convince them that we are laboring for their advantage before we can

¹⁴² George Gaines to George Gibson, June 3, 1832, *Correspondence on the Subject of the Emigration of Indians* Vol. I, 686. See also Henry C. Brish to William Clark, June 6, 1832, *Correspondence on the Subject of the Emigration of Indians* Vol. V, 118; Henry C. Brish to William Clark, July 16, 1832, *Correspondence on the Subject of the Emigration of Indians* Vol. V, 118-119.

¹⁴³ John Robb to William P. Duval, August 21, 1832, *Correspondence on the Subject of the Emigration of Indians* Vol. II, 904-905.

¹⁴⁴ As quoted in Viola, *Thomas L. McKenney*, 217-218.

¹⁴⁵ Lewis Cass, “Review of Published Works on Indians,” Folder 28, Box 6, Lewis Cass Papers, WLC.

¹⁴⁶ Lewis Cass, “Concerning a System for the Regulation of Indian Affairs,” November 29, 1816, Folder 27, Box 6, Lewis Cass Papers, WLC.

expect their confidence, and this conviction must be the result of a long course of experience.”¹⁴⁷ But to fulfill this duty — and to preserve Indian removal as a viable policy program — the federal government would need to establish a baseline level of disease control. As his own field agents implored: “could [they] not *speedily*...arrest this destroying plague by vaccination? Men could be found who would penetrate the forests in search of every horde of these despairing sufferers.”¹⁴⁸ With the passage of the Indian Vaccination Act, the War Department was empowered to do precisely that.

Immediately following the act’s passage, Cass issued two detailed directives to agents in the Bureau of Indian Affairs, ordering them to carry out the vaccination program with all haste. The Secretary instructed the agents to first “explain to the Indians the...nature and advantages of the process of vaccination” so that they might be “induced to submit to this preventative.” At that point, he wrote, “no further measures will be necessary than to make an arrangement with the army surgeon stationed [nearby]...to vaccinate such Indians as may be willing to submit to the process.” Vaccine matter would be procured by the Surgeon General and distributed to each agent and reservation superintendent. To track the program’s efficacy, Cass ordered vaccinating surgeons to maintain careful records, “enter[ing] the names and ages of the Indians vaccinated, the tribes to which they belong, and the time when the duty was performed,” as well as “the state of the prevalent diseases, and their mode of treatment.”¹⁴⁹ In both directives and in private letters to individual Indian agents, the Secretary emphasized the need for economy, “the appropriation made by Congress being small.”¹⁵⁰ “It is desirable,” Cass wrote his agents, “that

¹⁴⁷ Lewis Cass, “Concerning a System for the Regulation of Indian Affairs,” November 29, 1816, Folder 27, Box 6, Lewis Cass Papers, WLC.

¹⁴⁸ Isaac McCoy to Lewis Cass, March 23, 1832, *A Letter from the Secretary of War*, House Document No. 190, 22nd Congress, 1st Sess., 3.

¹⁴⁹ Lewis Cass to Indian Agents in Illinois and Michigan, May 10, 1832, *Letter from the Secretary of War*, House Document No. 82, 22nd Congress, 2nd Sess., 5.

¹⁵⁰ John Robb to William P. Duval, August 21, 1832, *Correspondence on the Subject of the Emigration of Indians* Vol. II, 905. Lewis Cass to James B. Gardiner, June 21, 1832, *Correspondence on the Subject of the Emigration of Indians* Vol. II, 847.

the expenditure should be kept as far within [the appropriation] as may be compatible with the object obtained.”¹⁵¹

By and large, the vaccination program was implemented according to the Secretary’s instruction. Overseen by Superintendent of Indian Affairs Elbert Herring, agents prepared native communities in their jurisdictions for vaccination, and within months of the act’s passage, vaccine matter was distributed across the frontier by military couriers. As Cass had originally directed, army surgeons administered a majority of the vaccinations and were compensated at six dollars per day for their services and expenses. However, in cases “where the Indians were sparsely settled, or scattered over a wide space,” and isolated from military posts, Herring authorized agents to employ “[civilian] physicians residing near the Indian country.”¹⁵² “You will employ an army surgeon, if he can conveniently attend to it, and if not, then any other physician of good standing, to vaccinate the [Indians].”¹⁵³ But Herring quickly learned that civilian physicians “of good standing” were often unwilling to work for the same pay as military surgeons, demanding additional compensation for “traveling expenses” and often the services of an assistant.¹⁵⁴ Unable to find qualified civilian physicians willing to work for government wages, in 1833 the Superintendent wrote Cass to ask if more of the vaccination appropriation “could be usefully expended” to increase compensation.¹⁵⁵

Overrun by similar requests for additional funds to speed Indian removal, Cass refused. Instead, the Secretary reiterated his instruction to rely on existing relationships within the War Department to administer the vaccination program. If civilian physicians wished to negotiate

¹⁵¹ Lewis Cass to William Marshall, May 15, 1832, *Letter from the Secretary of War on Vaccination*, House Doc. No. 82, 22nd Congress, 2nd Sess., 6.

¹⁵² Elbert Herring to Lewis Cass, January 31, 1833, *Letter from the Secretary of War*, House Doc. No. 82, 22nd Congress, 2nd Sess., 1-2.

¹⁵³ Elbert Herring to F.W. Armstrong, April 12, 1833, *Correspondence on the Subject of the Emigration of Indians*, Vol. III, 659.

¹⁵⁴ Elbert Herring to Lewis Cass, January 31, 1833, *Letter from the Secretary of War*, House Doc. No. 82, 22nd Congress, 2nd Sess., 2. See also *Letters Received by the Office of Indian Affairs, 1824-1881*, Roll 170, Microcopy No. 234, National Archives and Records Service, Washington D.C.

¹⁵⁵ Elbert Herring to Lewis Cass, January 31, 1833, *Letter from the Secretary of War*, House Doc. No. 82, 22nd Congress, 2nd Sess., 3.

better terms, Herring was ordered to replace them with military surgeons. To further control costs, Cass encouraged Herring to target communities in closer proximity to military forts, abandoning tribes in the uppermost Missouri River valley. Repeating his orders directly to Bureau agents, Cass wrote: “It is impossible for this department to give you specific instructions respecting the best and economical mode of affecting the object of the law...however, my general view [is that]...no effort will be made to send a Surgeon higher up the Missouri.”¹⁵⁶ Although he acknowledged that limiting vaccination would place northern tribes at greater risk of infection, the Secretary argued that because these tribes were not yet slated for removal, an epidemic would pose little risk to soldiers or settlers.¹⁵⁷ Moreover, should an epidemic occur, members of Congress might be more willing to appropriate additional funds for the management of Indian affairs. “While humanity shudders at the sight of more than three thousand human carcasses [*sic*], cast upon the open field in the space of a few days...it pleads with energy, that the desperate survivors should be brought into the wardship of the United States.”¹⁵⁸

Although woefully inadequate to stem the tide of indigenous depopulation, more than 30,000 Indians were vaccinated between 1832 and 1841.¹⁵⁹ The program’s appropriation now exhausted, federal lawmakers — increasingly determined to cut spending on Indian affairs — declined to earmark additional funds for native vaccination. With the majority of eastern tribes resettled onto lands west of the Mississippi, Congress would substantially change how the federal government organized the provision of medical care to indigenous communities. Over

¹⁵⁶ Lewis Cass to John Dougherty, 1833, *Letters Sent by the Office of Indian Affairs, 1824-1881*, Roll 8, Microcopy No. 465, National Archives and Records Service, Washington D.C.

¹⁵⁷ Some have argued that Cass failed to vaccinate tribes in the northern Missouri River valley because they had either refused to agree to treaty terms favorable to the United States or were of limited importance to native trade. See J. Diane Pearson, “Lewis Cass and the Politics of Disease: The Indian Vaccination Act of 1832,” *Wicazo Sa Review*, 18:2 (2003), 9-35.

¹⁵⁸ Lewis Cass to William P. Duval, March 1833, *Correspondence on the Subject of the Emigration of Indians* Vol. III, 512. In fact, the Secretary proved prescient in his assessment, but at great cost to the northern tribes of the Missouri River valley. After a devastating smallpox epidemic fully eradicated the unvaccinated tribes in 1837, federal lawmakers set aside \$5,000 to ensure the vaccination of all native communities scheduled for removal.

¹⁵⁹ Based on War Department estimates of the Indian population east of the Missouri River in the 1830s, vaccinations were administered to roughly a quarter of the population. See Lewis Cass, “Removal of the Indians,” *North American Review* 30 (1830), 62-64.

the next decade, the War Department revised removal procedures, directly assigning physicians to serve tribes slated for removal and to provide care once they were relocated onto reservations.

In light of the literature emphasizing nineteenth-century policymakers' reliance on public-private partnerships to promote state development, the War Department's continued dependence on state actors is puzzling. Indeed, with only a small corps of standing officers in the antebellum military, and half a continent to patrol, it is easy to imagine the Secretary delegating authority to civilian practitioners to oversee Indian medical care. It is perhaps harder to imagine the Secretary, with such limited resources, recruiting a separate corps of physicians whose sole and exclusive responsibility it would be to deliver care to indigenous communities — the Indian Medical Service would not be established until the twentieth century. But, of course, Cass did neither: choosing instead to shift, or convert, medical personnel and expertise within the War Department to satisfy Congress's directive.

What can we learn from the Secretary's decision to convert state capacity to new ends, rather than borrow *or* build? First, the War Department's capacity to shift its manpower and expertise to meet new logistical challenges suggests that an agency's relative dexterity — its ability to adapt to a changing policy portfolio and political environment — may help to determine whether bureaucratic actors invest in collaborative relationships with private parties or choose to build or repurpose state machinery. In the case of Indian vaccination, Calhoun's self-consciously “expansible” War Department had a sufficiently nimble personnel with broad-based knowledge of the frontier that it could, on its own, incorporate vaccination as a new administrative obligation.

Second, Cass's exclusive reliance on War Department personnel to implement the vaccination program suggests that collaborative partnerships with private actors may be less likely to form when the policy “taps into multiple bases of support” within an agency and when the potential bureaucratic administrators are collectively invested in achieving the program's goals efficiently and effectively.¹⁶⁰ In the case of the vaccination program, Indian agents,

¹⁶⁰ Schickler, *Disjointed Pluralism*, 13.

military physicians, and rank-and-file soldiers shared a common interest in limiting the spread of the disease on the frontier, albeit for different reasons. As in Congress, only a small cadre of officers in the Bureau of Indian Affairs believed that vaccination was a moral act necessitated by decades of treaty law. Far more Indian agents recognized that reducing contagion would facilitate westward expansion by lowering the human and financial costs associated with Indian removal. Military surgeons, too, understood the importance of disease control, as epidemics posed significant risk to frontier forts and the soldiers charged with resettling Indian nations west of the Mississippi. Consequently, we might posit that the political logics which hold common carrier coalitions together in Congress are likely to take on a life of their own, long past their origins at the hands of legislative entrepreneurs.

Conclusion

This study began with two questions: what motivated lawmakers to provide medical care to Native Americans a full century before Indian enfranchisement, and how did the state muster sufficient administrative capacity to implement the program? As we have seen, the passage of the Indian Vaccination Act was the product of a common carrier coalition. Bringing together lawmakers who sought to combat the devastation wrought by smallpox in Native American communities with those who believed that the spread of disease posed a threat to white settlers and threatened the viability of Indian removal, the vaccination bill satisfied multiple, potentially conflicting, interests. Seeking to implement the vaccination program without straining the War Department's limited resources, the Secretary of War converted the agency's existing manpower and expertise to new ends. Relying on military surgeons to administer vaccinations in cooperation with local Indian agents and the soldiers charged with enforcing eastern tribes' emigration ensured that the program was conducted both efficiently and relatively effectively. By the end of the decade, federal agents distributed vaccine to over 30,000 individuals, more than a quarter of the population ultimately removed west of the Mississippi River.

Conflicted though the program's origins may be, the case of Indian vaccination nevertheless has much to teach us about the *what*, *who*, and *how* of state-building. We have seen

that the federal government was, from the very beginning, deeply involved in regulating the health of indigenous communities to the benefit of the settler public. This suggests that far from having little incentive to legislate on behalf of those beyond their settler citizenry, members of Congress were very much interested in policing the health of, and providing medical services to, communities beyond the country's borders. Of course, legislators were not simply good-hearted samaritans. Regulating Indian health satisfied multiple goals, most importantly westward expansion, which the congressional entrepreneurs backing vaccination exploited to win passage. Contrary to subsequent patterns of colonial administration, the Indian vaccination act was implemented without the aid of private parties or nongovernmental associations, a plan made possible by the War Department's remarkable dexterity. Finally, taking a step back from the particulars of Indian vaccination, I hope to have persuaded readers that there is still much to learn about the intricacies of American state-building and social provision — subjects on which much ink has already been profitably (and not so profitably) spilled — when we widen our analytic gaze to include Native Americans.