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FACULTY RESEARCH

Epidemics in America: The Good, the Bad, and the Immigrant

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In his work No Star Is Lost, James T. Farrell creates a telling episode of epidemic disease in Chicago in the early 20th century. The children of the O'Neill family all have come down with diphtheria, the public health officials have been called and the children are taken away to the Municipal Contagious Disease Hospital. As Jim O'Neill, the father of the children, arrives home, he is disturbed by two things. First, his children are transported to the hospital in a police wagon and, second, a large quarantine sign is nailed to his door. He feels shame and guilt.

Jim looked at the red sign tacked to his front door, and read the large black lettering: DIPHTHERIA They were quarantined as if they were lepers. The whole world was told by that red sign to stay away from them. (624)

Jim's eldest son, Bill, delirious from fever, tries to run away, fearing that he will be punished although, as he puts it, "I ain't done nothing" (623).

With these passages, Farrell captures the social construction of epidemic disease in America, characterized as it is by a curious combination of illness, blame, and guilt. As early as 1794 Dr. Benjamin Rush observed, "Loathsome and dangerous diseases have been considered by all nations as of foreign extraction." Certainly this was the case in America where, by the late 18th century, colonists had internalized the notion that the American continent was a virginal territory, free of corruption and disease.

Thus, when illness struck, people looked elsewhere for a cause and found it in the immigrant populations. Historian Alan Kraut, in his work, Silent Travelers, confirms that, in the United States, "There is a fear of contamination from the foreign-born"(3). This fear is heightened in the instance of epidemic disease when such medicalized nativism can result in the stigmatization of entire ethnic groups. Haitian, French, German, Asian, Italian, and Irish immigrants have each in their turn been blamed for outbreaks of deadly epidemics, ranging from yellow fever to cholera, bubonic plague, polio, diphtheria, influenza, and AIDS.

An epidemic is, after all, not merely a medical occurrence; it is a truly frightful experience, which challenges people's sense of well-being. The essential arbitrariness of an epidemic forces people to explain the occurrence in order to quell their panic. Consequently, outbreaks of epidemic disease are usually characterized first, by denial, an unwillingness to recognize the disease, and second, by assigning blame. Blame makes the disease appear less random and its victims more identifiable and culpable. People, for one reason or another, "deserve" the disease: they have done something wrong; they have brought it on themselves; they are being punished by God.

By the time the cholera epidemic of 1832 swept across the United States, inhabitants had no difficulty in pointing out that the Irish, who were the primary sufferers, deserved their fate. Alan Kraut explains,

"Living in run-down shanties and tenements, Irish Immigrants felled during the 1832 cholera epidemics were believed by many of the native-born to have died of individual vices typical of their group, a divinely determined punishment ..." (33)

The vices, in this particular instance, were intemperance, lack of cleanliness, and Catholicism. Even those who did not adhere to the direct association of vice with disease, often felt that the lifestyle of the Irish was an inadvertent violation of natural law and, hence, punishable by God.

Charles Rosenberg, in his study, The Cholera Years, agrees. The link between cholera and the Irish was an immediate and immutable one. It became the subject of church sermons, newspaper diatribes, and public sentiment. Anti-Irish biases hardened amid cries for immigration restriction and quarantine. Such local, state, and federal actions complete the pattern of social reaction to epidemics. A society's response to an epidemic usually is itself characterized by moral and social prejudice and often results in regulations aimed at increased surveillance and control of the "offending" victims. These "other" people, who are, after all, "contagious," are thus dehumanized and segregated further from the larger community.

The Irish were not the only immigrant group labeled as carriers of epidemic disease, however. Beginning in the 1870s the Chinese population in California was blamed for the presence of various diseases culminating in 1900 when Chinese immigrants were considered the cause of an outbreak of bubonic plague. Later, in 1916, Italian immigrants in New York and other east coast cities were identified as the source of a polio epidemic. As was the case with the Irish, societal reaction was harsh. This time they included exclusion laws, a Naturalization Act which made Chinese immigrants ineligible for citizenship, and calls for far more restrictive immigration laws and deportations of Italians and other eastern Europeans. Clearly, Americans had come to equate disease with foreigners and, in an

attempt to eradicate the first, they sought to blame, restrict, and exclude the second. But, as historian Alan Kraut argues, "formalizing exclusion and restriction served as a self-fulfilling prophecy, codifying the connection between immigrant and illness" (30).

As studies have indicated, the lower the socioeconomic status of a group within a community, the higher their morbidity and mortality rates. Marginal groups work and live in more hazardous environments than mainstream communities; they are less knowledgeable about disease, and have less access to medical care. In addition, the higher the degree of ethnic exclusivity, the greater the distrust of outside medical authority. In essence, as researcher Edward Suchman put it, "social isolation seems to breed 'medical' isolation" (330).

This pattern was confirmed by my own dissertation study of the 1918 influenza epidemic in the town of Norwood, Massachusetts. I chose this subject because my paternal grandmother died in the epidemic, at the age of 38, leaving a husband and five children. It was a piece of family history, in fact, the only family story ever told about her. As I began my research, I found that the 1918 pandemic was the worst epidemic in modern history, killing between 20 and 30 million world-wide within a year. Yet there was no extensive literature on this epidemic, no memorial to its scope and size, although conservative estimates place the number of deaths in the United States between 500 and 600 thousand. Here, for example, is a characteristic description of the pandemic:

"Despite being the largest epidemic in history, it had little long-term effect, because, ... the influenza epidemic was relatively short-lived and the population losses were rapidly replaced." (Swenson 1988:186)

Surely there was more to the story; mothers, fathers, brothers, sisters, children, and spouses are never "rapidly replaced." I was puzzled by this characterization until I continued my research and found that the populations within American society which were most severely affected during the 1918 epidemic were young adult, lower-class, and foreign-born; those groups most ostracized and isolated from the social mainstream.

Norwood's victims correlated perfectly with these general statistics: the vast majority were between 20 and 40 years of age, almost all were lower-class, and 75% were foreign born (This in a town where only 30% of the population was foreign born).

Further study indicated that once it became apparent it was Norwood's immigrant laborers who were dying, the official response was quick and sharp. The Committee on Public Safety, a group formed months earlier to monitor the activities of presumed political subversives, was placed in charge of the town's relief efforts. Such a step immediately equated illness with undesirable political activity. And, the response itself was far more military than medical.

"Old Corner House" - Norwood's first health care center

Immigrant neighborhoods, and only immigrant neighborhoods, were canvassed and searched. The sick were transported, sometimes against their will, to an emergency hospital where they were denied visitors. As a consequence, uncertainty and fear increased. Undoubtedly expecting official sanctions or retribution, many failed to report illness and even deaths. Newspaper reports suggested that unsanitary living conditions, personal hygiene, and lack of assimilation were the causes of the epidemic. New public health regulations and public assembly restrictions aimed at the immigrant populations were instituted. Even in death, the immigrants were ostracized, buried on the perimeter of the cemetery, often in unmarked graves. Under this onslaught, immigrants could only keep their silence and hope to remain invisible.

Seventy-five years later, however, some still remembered the sting of prejudice. One resident recollected her neighbor repeatedly tearing a quarantine sign off of his door until he was threatened with arrest. Another, a child at the time, recalled:

"I remember [they] came up to the house with a great big white sign and on the sign it said INFLUENZA in red letters. And they nailed it to the door. I'll never forget it. ...It was as if, I don't know, we'd done something wrong. We'd done something wrong and we were being punished."

Following the epidemic, political mistrust, ethnic prejudice, and the fear of disease combined to produce a xenophobic panic. Strong feelings led to the establishment of more encompassing public health guidelines and, in Norwood and across the United States, instigated calls for immediate assimilation or deportation. In effect, the medical epidemic helped to justify a political climate which culminated in the infamous Palmer Raids of January, 1920.

It is time to admit that pre-existing prejudice and inequality are far more important to the trajectory of epidemic disease than previously acknowledged. For groups that are already marginalized, the stigma of disease guarantees their continued ostracism from the cultural mainstream. "Different" becomes synonymous with "dangerous" and "diseased." These implications of blame did not go unheeded in the immigrant community of Norwood or in Farrell's Chicago. Illness was hidden, something to be ashamed of. And shame is central to sociologist Erving Goffman's concept of stigma. Victims of stigmatization often internalize the notion of "a spoiled identity." Such was the case with immigrants who came to recognize themselves as the "contagious other." In this context, illness, and epidemic disease in particular, foster guilt and shame on the part of the victims. They, too, come to blame themselves for their disease.

Finally, then, the combination of disease, blame, guilt and shame results in a scenario much like the one Farrell depicts. Social institutions of public health become judgemental and callous as sick children are carted off in a police wagon, equating illness with crime. And, within the immigrant family, blame is internalized as guilt, causing small boys to cry out in fear of punishment and grown men to feel shame when they read a quarantine sign.

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