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The Perennial Fear of Foreign Bodies

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The old, oft-quoted immigrant saying, "America beckons, but Americans repel," points to a paradox at the heart of U.S. immigration history. Newcomers have been most welcome when their labor, talents, and skills contribute to the nation's prosperity, but that welcome has been simultaneously undercut by distrust and resistance.

It was no accident, for example, that between 1880 and the 1920s over 23.5 million newcomers were admitted to the United States when surging industrial growth required plentiful supplies of low-cost unskilled and semi-skilled labor. At the same time, however, suspicion of newcomers soared. Native-born Americans of northern and western European stock—descendants of immigrants of an earlier era—warned against swarthy Catholic arrivals from Mexico and Italy and unassimilable Jews from Eastern Europe. They branded Asian migration the "yellow peril." In more recent eras, some Americans have viewed the foreign-born as assets while others perceived them to be detrimental to the United States, draining the energy and resources of the society, or undermining its cultural vitality.

Certain moments are notable for their especially acute expressions of nativist sentiments, restrictive legislation, and pervasive insecurities. At times, popular opposition to immigration has been driven by economic anxieties that newcomers are competing successfully with the native-born for jobs. At other times, anxieties arise from perceived threats to the nation's security, either from external enemies or from internal subversion planned and executed by homegrown fascists, anarchists, communists, or other radicals. Current fears of terrorism by radical Islamists, especially devotees of al-Qaeda or ISIS, have epitomized such national security concerns since the World Trade Center attacks of 1993 and 2001, and prompt some Americans' beliefs that the nation has overly generous immigration policies and/or insufficiently careful admissions procedures.

An intense, recurring insecurity, often neglected by scholars, has been medicalized prejudice, or the "double helix of health and fear."[1] Anxieties about foreign bodies and contagion have been widespread throughout American history, often spiking at moments when new medical discoveries or medical crises have coincided with escalations in the numbers of immigrants or refugees, or a shift in the origins and identities of those at the nation's doorstep.

During the urbanization, industrialization, and geographic expansion of the United States in the nineteenth century, immigrant laborers built the railroads that carried produce and people across the American landscape. Sturdy migrants, laboring in factories and mines, fueled the great surge in American economic development. But many native-born people suspected that these newcomers might lack the health and physical vitality to thrive and be productive in the American environment. Some nativists feared that immigrant bodies posed a threat to the health and well-being of the native born. They blamed newcomers for bringing specific diseases that sickened and endangered the lives of their hosts. Others sought to arouse apprehensions that immigrants' vulnerability to disease and lack of robust physiques might render the newly arrived weak, sick, and incapable of supporting themselves. In an era when care of the sick and disabled received only minimal support from state and municipal governments,

[1]Alan M. Kraut, *Silent Travelers, Germs , Genes, and the "Immigrant Menace"* (New York, 1994), 256.

this was no small concern. Society's sick and vulnerable, native and newcomer, often found assistance only in poor houses, asylums, or municipal hospitals never designed to care for large numbers of individuals over extended periods of time. Roman Catholics and Jews often established hospitals and clinics to care for their own and avoid charges that they posed a burden to their new neighbors.[2]

Apprehensions over threats posed by immigrant bodies led Americans to turn to their government for protection. As early as 1882 federal legislation excluding any person "unable to take care of himself or herself without becoming a public charge" often led to the rejection of newcomers who were too ill or disabled to support themselves.[3] The Secretary of the Treasury, charged with enforcement, contracted with state officers to execute the provisions of the law. In 1890, federal authorities assumed from the states most of the responsibilities for the interrogation, medical inspection, and, if needed, quarantine of newcomers. At federal immigration depots, such as New York's Ellis Island and San Francisco's Angel Island, uniformed U.S. immigration officials armed with the diagnoses of United States Marine Hospital Service physicians excluded newcomers weakened by disease, suffering from physical disability, or who otherwise deemed incapable of supporting themselves and contributing their labor to the nation's economic growth. Between 1892 and the 1920s, rejection rates at Ellis Island on medical grounds soared. From less than 2 percent in 1898, the percentage increased to 57 percent in 1913 and 69 percent by 1916. Only 2–3 percent of immigrants who arrived were actually rejected, but of that small percentage, an increasing proportion was turned away for reasons of ill health, while a decreasing percentage was excluded for other causes such as being political subversives, criminals, contract laborers, or members of "immoral classes" (prostitutes).[4] The development of germ theory, which transformed understandings of many diseases, along with improved medical technologies such as x-ray machines and more precise laboratory techniques for identification of tuberculosis, syphilis, and gonorrhea, permitted physicians to better assess the health and vitality of immigrant bodies, reinforcing this growing tendency to understand immigration in medicalized terms.

Periodic epidemics magnified concerns about migrants even further. As the historian Charles Rosenberg observes, an epidemic is a discrete period of time when a particular disease sweeps through a population in a particular area yielding very high rates of morbidity, is "an event, not a trend" and it can take on a dramaturgic form. Newcomers have often been blamed for such outbreaks.[5] In 1832, when a cholera epidemic swept the east coast of the United States, nativists targeted Irish Catholic newcomers and their impoverished living conditions as responsible for endangering the health of the native-born.[6] In 1910, the threat of typhus crossing the southern border with Mexican migrants caused American officials to ramp up medical inspections and screening procedures. Every immigrant was deloused, bathed, and vaccinated while their garments and baggage were disinfected, even before the medical inspection, to ensure that they did not bring disease. The process stigmatized Mexican bodies as racially inferior and unsanitary.[7] Italian immigrants, too, were stigmatized and accused of bringing polio to

[2]Kraut, *Silent Travelers*, 206–8. See also, Alan M. Kraut and Deborah A. Kraut, *Covenant of Care: Newark Beth Israel and the Jewish Hospital in America* (New Brunswick, NJ, 2007), 1–6.

[3]22 Stat. 214; 8 United States Code.

[4]Kraut, *Silent Travelers*, 66. See also Amy L. Fairchild, *Science at the Borders, Immigrant Medical Inspection and the Shaping of the Modern Industrial Labor Force* (Baltimore, 2003). On disability rejections, see Douglas C. Baynton, *Defectives in the Land: Disability and Immigration in the Age of Eugenics* (Chicago, 2016).

[5]Charles E. Rosenberg, "What Is an Epidemic? AIDS in Historical Perspective" and "Explaining Epidemics" in *Explaining Epidemics and Other Studies in the History of Medicine*, ed. Charles E. Rosenberg (New York, 1992), 278–92 and 293–304.

[6]Charles E. Rosenberg, *The Cholera Years: The United States in 1832, 1849, and 1866* (Chicago, 1962), 137–8.

[7]Alexandra Minna Stern, "Buildings, Boundaries and Blood: Medicalization and Nation-Building on the U.S.-Mexico Border," *The Hispanic Historical Review* 79 (February 1999): 41–81. See also, John McKiernan-González, *Fevered Measures: Public Health and Race at the Texas-Mexico Border, 1848–1942* (Durham, NC, 2012), 165–97.

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the United States in 1916.[8] Newcomers of many backgrounds were suspected of being responsible for the influenza epidemic in 1918, even though the total number of immigrants entering the U.S. had dropped from 1,218,480 in 1914 to 110,618 in 1918 because of wartime travel disruptions.[9]

Early twentieth-century nativist literature also fanned fears about immigrant bodies. In *Old World in the New* (1914), sociologist Edward Alsworth Ross warned that intermarriage between natives and newcomers would result in "race suicide." He criticized the immigrants headed to the turn-of-the-century United States as physically inferior to the pioneering breed from which he was descended and incapable of coping with the rigors of the American environment.[10] He thought it "fair to say that the blood now being injected into the veins of our people is 'subcommon.'"[11] He freely expressed his hatred of other races as biological liabilities in strong and crude language, going so far as to say that it would be better to fire on every vessel bringing Japanese to the United States rather than allow them to drop anchor. He similarly excoriated Jewish immigrants.[12] "On the physical side," he wrote, "the Hebrews are the polar opposite of our pioneer breed. Not only are they undersized and weak muscled, but they shun bodily activity and are exceedingly sensitive to pain."[13] Ross was fired from a Stanford University faculty position at the insistence of Jane Stanford, Leland Stanford's widow. It was not that the Stanfords were racial egalitarians, but their railroad interests depended on Asian labor, which they welcomed.[14]

Ross was hardly an outlier. In *The Passing of the Great Race* (1916), Madison Grant—the American patrician, attorney, world traveler, founder of the New York Zoological Society, trustee of the American Museum of Natural History, and co-creator with Theodore Roosevelt of the National Park System—wrote that just as a Syrian or Egyptian freedman could not be transformed into a Roman by "wearing a toga and applauding his favorite gladiator in the amphitheater," so, too, it would be impossible to transform into an American "the Polish Jew, whose dwarf stature, peculiar mentality, and ruthless concentration on self-interest are being engrafted upon the stock of the nation."[15]

Nativists such as Ross and Grant were progressives, adherents to the political philosophy that rational advancement in science, medicine, and technology, social organization, economic development, and government reform were crucial to improving the human condition. Highly educated men and women committed to such principles might be expected to abhor bigotry and discrimination, but many progressives, although not all, joined conservatives in calling for greater limits on immigration by those believed to be biologically inferior or medically suspect. Following World War I, the highly restrictive national origins quota system established by the 1924 Johnson-Reed Act, passed Congress with bipartisan support.

Since the 1924 Immigration Act's national origins quota system was replaced by the Hart-Celler Act of 1965, similar dynamics of beckoning and repelling immigrants have resurfaced, although with important new twists. If in the late nineteenth and early twentieth centuries Chinese, Japanese, and Southern and Eastern Europeans found themselves the special

[8]Haven Emerson, *A Monograph on the Epidemic of Poliomyelitis (Infantile Paralysis) in New York City in 1916* (New York, 1917). See also, Naomi Rogers, *Dirt and Disease: Polio Before FDR* (New Brunswick, NJ, 1992), 41–2, 47.

[9]Alan M. Kraut, "Immigration, Ethnicity, and the Pandemic," in "The 1918–1919 Influenza Pandemic in the United States," *Public Health Reports*, 125, Supplement 3 (Apr. 2010): 123–33, here 125–6.

[10]Edward Alsworth Ross, *The Old World in the New: The Significance of Past and Present Immigration to the American People* (New York, 1914).

[11]Ibid., 285–6.

[12]Sean H. McMahon, *Social Control & Public Intellect: The Legacy of Edward A. Ross* (New Brunswick, NJ, 1999), 13–25.

[13]Ross, *The Old World in the New*, 139.

[14]Ibid., 139; McMahon, *Social Control and Public Intellect*, 13–25.

[15]Madison Grant, *The Passing of the Great Race, or the Racial Basis of European History* (New York, 1916), 14–6.

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targets of nativists, more recently it has been Mexicans, Central Americans, Southeast Asians, and South Asians who have been scorned. Nativist rhetoric and prejudiced behavior, long characterized by racism and religious bigotry against Catholics and Jews, now also reflects a strident Islamaphobia.

Epidemics also continue to elicit nativist responses made even more acute by the fact that international air travel now allows harmful pathogens to move halfway around the world in a matter of hours. In the early 1980s nativists held Haitian immigrants responsible for the arrival of HIV-AIDS in the United States despite specific denials by the Centers for Disease Control in 1983.[16] Severe Acute Respiratory Syndrome (SARS), Ebola, and Zika outbreaks also spurred demands to close American borders to the foreign-born.[17]

Those who would bar the doors to immigrants and refugees seeking fresh starts draw more broadly on notions that their bodies are physically unsuited to the challenge. The current debate over refugees from Syria has included charges by opponents that newcomers threaten the health of the general population because they have been inadequately screened, allegations that have not been borne out in fact. Even so, when polled in 2015, more than half the nations' governors opposed allowing Syrian refugees into their states.[18]

Ironically, studies suggest some migrants may actually be more physically fit than the native born. Research done at the University of California at San Francisco found that Mexican immigrants, compared to those born and raised on this side of the border, have mortality rates 16 percent lower from heart disease, 19 percent lower from kidney disease, and 24 percent lower for liver cirrhosis. Given the stresses of migration and the adoption of American lifestyles, including inadequate exercise, poor diet, and increased alcohol consumption, it may be that, "Becoming an American can be bad for your health."[19]

And in a final, even greater irony, the United States, once fearful of the foreign-born as disease carriers, now depends upon immigrant healthcare providers who have been arriving in the United States in increasing numbers since 1965, often to the detriment of their countries of origin that are desperately in need of well-trained, experienced medical personnel. By 2010 the foreign born accounted for 16 percent of all civilians employed in health care occupations in the United States.[20] In some health care professions, this share was even larger. By 2012, more than one-quarter of the 853,000 physicians and surgeons in the United States were foreign born, and more than one out of every five persons working in health care support jobs such as nursing, psychiatric, and home health aides were too.[21]

[16]Kraut, *Silent Travelers*, 1–3, 260–1.

[17]Iris Chang, "Fear of SARS, Fear of Strangers," *New York Times*, May 1, 2003, http://www.nytimes.com/2003/05/21/opinion/fear-of-sars-fear-of-strangers.html (accessed June 1, 2018); Muzaffar Chisti, Faye Hipsman, and Sarah Pierce, "Ebola Outbreak Rekindles Debate on Restricting Admissions to the United States on Health Grounds," *Migration Information Source*, Migration Policy Institute, Oct. 23, 2014, https://www.migrationpolicy.org/article/ebola-outbreak-rekindles-debate-restricting-admissions-united-states-health-grounds; Eric D. Carter, "When Outbreaks Go Global: Migration and Public Health in a Time of Zika," *Migration Information Source*, Migration Policy Institute, July 7, 2016, https://www.migrationpolicy.org/article/when-outbreaks-go-global-migration-and-public health-time-zika (accessed June 1, 2018). See also, Donald G. McNeil, Jr., *ZIKA: The Emerging Epidemic* (New York, 2016).

[18]Ashley Fantz and Ben Brumfeld, "More Than Half the Nation's Governors Say Syrian Refugees Not Welcome," *CNN*, Nov.19, 2015, http://www.cnn.com/2015/11/16/world/paris-attacks-syrian-refugees-backlash/index.html (accessed June 1, 2018).

[19]Sabrina Tavernise, "The Health Toll of Immigration," *New York Times*, May 18, 2013, http://www.nytimes.com/2013/05/19/health/the-health-toll-of-immigration.html (accessed June 1, 2018). The use of public health to define Mexicans as unfit to be Americans is treated by Natalia Molina, *Fit to Be Citizens? Public Health and Race in Los Angeles, 1897–1939* (Berkeley, CA, 2006) and McKiernan-González, *Fevered Measures.*

[20]Kristen McCabe, "Foreign-Born Health Care Workers in the United States," *Migration Information Source*, June 27, 2012, http://www.migrationpolicy.org/article/foreign-born-health-care-workers-united-states (accessed June 1, 2018).

[21]Ibid.

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Foreign-born healthcare providers from less developed countries have made the United States an "Empire of Care."[22] By 1972, 90 percent of the physicians and surgeons coming to the United States emigrated from less developed countries. As one newspaper observed, "With one hand the United States is giving [foreign countries] millions to develop themselves. And with the other it is casually taking away the seed corn of future leaders in natural science, health, and technical knowledge."[23] It was a brain drain. By 1971, Asians accounted for two-thirds of the physicians admitted as immigrants into the United States. About 40 percent of all foreign-born healthcare workers residing in the United States in 2010 were born in Asia, especially India, the Philippines, and Pakistan. Asians are followed by Latin Americans (not including the Caribbean), at 18 percent, and those from the Caribbean, at 17 percent.[24]

The extensive roles immigrants play in American healthcare are even more notable as the future of United States immigration and refugee policies have been cast in doubt. In 2018, President Donald J. Trump's vigorous deportation initiative aimed at unauthorized newcomers and those who had been admitted as TPS (temporary protected status) migrants has had an unfortunate by-product, the diminution in the staff available to facilities that care for the aging baby-boomer population. The Paraprofessional Healthcare Institute estimates that as many as 34,600 non-U.S. citizens from Haiti, Nicaragua, El Salvador, and Honduras could be affected as well as others from Somalia and Iran, two countries listed in the president's travel ban.[25] Once again, the United States is beckoning newcomers to the land of opportunity even as some of the hosts are rolling up the welcome mat.

Alan M. Kraut is university professor of history at American University. He specializes in immigration and ethnic history and the history of medicine and public health in the United States. His books include *The Huddled Masses: The Immigrant in American Society, 1880–1921* (1982; rev. 2001), *American Refugee Policy and European Jewry, 1933–1945* (co-authored, 1987), *Silent Travelers: Germs, Genes, and the "Immigrant Menace"* (1994), *Goldberger's War: The Life and Work of a Public Health Crusader* (2003), *Covenant of Care: Newark Beth Israel and the Jewish Hospital in America* (co-authored, 2007), and *Ethnic Historians and the Mainstream: Shaping America's Immigration Story (*co-edited, 2013). He is a past president of the Immigration and Ethnic History Society and the Organization of American Historians. He is a fellow of the Society of American Historians.

[22]Catherine Ceniza Choy, *Empire of Care: Nursing and Migration in Filipino American History* (Durham, NC, 2003).

[23]*Christian Science Monitor* as quoted in Mae M. Ngai, *Impossible Subjects: Illegal Aliens and the Making of Modern America* (Princeton, NJ, 2004), 260.

[24]McCabe, "Foreign-Born Health Care Workers in the United States," 6.

[25]Melissa Bailey, "Immigrant Caregivers Face Uncertainty," *Washington Post*, Mar. 25, 2018, A3.

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