

REED UEDA: Welcome, I'm reading away. I'm the host and moderator for today. I have been on the steering committee for the Inter-University Committee on International Migration for many, many years. And I have some distinguished colleagues also on the steering committee. I think some of them are joining us, John Tirman. And if there's anyone else, maybe you can wait until the question and answer session to identify yourself.

Oh, Noora Lori is also on. I'm going to mention her actually before I finish my remarks. She will be doing a presentation next time we meet. Our next event, next Thursday, November 5th, also starting at noon, is with Noora Lori, who will speak on off-shore citizens permanent temporary status in the Gulf.

But for today, I should, first of all, introduce our speaker, Alan Kraut, who's distinguished work and prolific work I have been following since I started as an assistant professor in the 1980s. And I was just telling him that one of the first things I used was a textbook he had written called *The Huddled Masses*. And I used to assign it to my undergraduate class on immigration. It was a very fine book.

But that was only the beginning. I followed his work. He's written on so many different things. But the relevant work is *Silent Travelers*, which is a very thoughtful and well-researched work on the fear of immigrants as bearers of disease. Today, he's going to be talking-- his title of his talk is *Immigration and Epidemics, an Historical Perspective*.

And if I could just quote a little bit from the abstract, the Chinese virus or Wuhan flu are some of the names coined by President Donald Trump to identify COVID-19. The resulting stigmatization of Asian Americans is just the latest example of the double helix of health and fear that is a perennial in American immigration history and which has inspired calls for immigration restriction.

COVID-19 has offered today's restrictionist policymakers a rationale for easing legislation designed to protect public health as justification for reducing immigration and refugee admissions, as well as delaying asylum hearings. Professor Kraut's presentation places in historical perspective the link between public health

crises, especially epidemics, and American immigration policy and the American public's xenophobic fears.

I can just say briefly, Allen's biography is very full and impressive. He's distinguished professor at American University in Washington, DC. He holds a faculty appointment at the Uniformed University of the Health Sciences, the armed services medical school. And he is a non-resident Fellow at the Migration Policy Institute in Washington, DC.

Dr. Kraut is a past president of the Organization of American Historians, the largest professional organization of those who study US history and current president of the National History Coalition. Dr. Kraut is a specialist in US immigration and ethnic history and the history of medicine and public health in the United States. He is the author or editor of nine books and over 100 articles and book reviews.

Dr. Kraut's scholarly projects have been supported by the Rockefeller Foundation, the National Endowment for the Humanities, the Smithsonian Institution, the American Philosophical Society, the National Institutes of Health, and the Healthcare Foundation of New Jersey. In the autumn of 1996, he was a DeWitt Stetten, Jr. Senior Fellow at NIH with support from the National Institute of Diabetes and Digestive and Kidney Diseases, NIDDK, and the National Cancer Institute.

Dr. Kraut now chairs the Statue of Liberty-Ellis Island History Advisory Committee for the Statue of Liberty-Ellis Island Foundation. He has also served as a consultant to the National Park Service and as an advisor to the Lower East Side Tenement Museum. He's been a historical consultant on documentaries treating issues in immigration history and the history of medicine and public health for PBS and the History Channel.

In 2017, Dr. Kraut received the Lifetime Achievement Award of the Immigration and Ethnic History Society for his contribution to scholarship on immigration history. And he is an elected Fellow of the Society of American Historians. As I said, I'm indebted to Dr. Alan Kraut for his scholarship. And as I said, I think his impact has gone into my classroom as well.

So let me turn it over to Alan Kraut. And he will begin his presentation. After he concludes, he will take questions or comments from you. And I have told him he

should probably just go ahead and call on you as you raise your questions. So I will bow out now and turn it over to Dr. Kraut. Alan, go ahead.

ALAN KRAUT: Thank you so much, Reed. Thank you for that kind introduction. And thank you for the invitation to be here. It's truly a pleasure to be with you this afternoon. I think you can see me now as well as hear me. I hope you can. If not, Reed, let me know, OK.

REED UEDA: Yep, you're on. Yep.

ALAN KRAUT: I'll apologize in advance for any clumsinesses with my PowerPoints. This is all, of course, a new world. And many of us, myself included, are really just learning how to navigate it. In past months, in recent months, we heard the President of the United States refer to the novel coronavirus or COVID-19 as the Chinese virus or the Wuhan flu.

Shocked, many of us have watched TV news footage of an Asian woman wearing a surgical mask being brutally beaten in the New York City subway by somebody who clearly seems to be punishing her personally for the coronavirus. On a Los Angeles subway, a man claims Chinese people are filthy and says every disease comes from China.

Rampant ignorance and misinformation about the coronavirus has led to these xenophobic attacks against fellow Americans or anyone in the US who looks Asian. Whether or not the president's characterization of COVID-19 contributed to the violent anti-Asian outbursts, I think there can be little doubt that the Trump administration has found in the pandemic an opportunity to further its agenda of immigration restriction and the reduction of refugee admissions.

And this afternoon, what I'd really like to do is to explore with you an historical perspective on the intersection of public health crises, the American public's xenophobic anxieties, and US immigration policy. Before we dive into the past though, let's begin with the current situation and the policies that need to be placed in historical perspective.

On October 11th, *The New York Times* editorialists reminded their readers that when President Trump campaigned for his office in 2016 he promised to bar rapists

from Mexico, create a total and complete shutdown of Muslims entering the United States, and save Americans from what he called homicidal, undocumented immigrants.

After his election, the president sought to use the instrument of executive orders to accomplish his goals, as Stephen Miller and others in the West Wing pondered new strategies to slam the door in the face of immigrants and refugees and those seeking asylum. The novel coronavirus pandemic offered these restrictionists in the White House fresh opportunity to close the borders. And a clear, compelling rationale, the public's health, became the concern that could nicely fit on the rubric of national security.

So why did you want to close the door? Because the newcomers were public health menaces. And the public health is an issue of national security. Well, the technique deployed in the development of this rationale was to conflate legislation from an earlier era intended to protect public health with contemporary public health concerns and the White House's desire for restriction. So that folks in the West Wing went on a hunt really to find past legislation that might support their argument to close the borders.

In the early 1890s, cholera epidemics swept across Europe and reached America's shores. And here we go to the PowerPoint. Hang on. In 1892, President Benjamin Harrison suspended immigration to the United States for 20 days to protect Americans from cholera. However, he did not extend the period beyond that in an effort to assert broader immigration control.

And in 1893, Congress passed the National Quarantine Act. The act was never intended to restrict immigration as a cholera preventive. Instead, it specified national regulations of medical inspection and disinfection for ships and immigrants to be administered by the US Marine Hospital Service, which was later renamed the US Public Health Service that we're so familiar with today.

The regulations that supported the act established acceptable protocols for medical inspection and ship sanitation and required more specific medical documentation by the shipping lines before ships departed for the United States. In the event of a pending epidemic, the act authorized the president to halt immigration temporarily.

Now Benjamin Harrison was no friend of immigration. And he was especially no friend of Russian Jewish emigration to the United States.

And he signed the bill on February 15, 1893. But perhaps to his credit, he did not attempt to use the legislation to curb immigration. He did not see it as legislation that was intended to be restrictive immigration legislation. As historian Howard Markel at the University of Michigan has observed, the National Quarantine Act of 1893 might be best seen as a vital brick among many along the road the federal government continued to build during the 20th century and its assumption of public health responsibilities, end quote.

It certainly increased the power of public health experts. And that was a good thing but not immigration restrictionists. That act became one of the arguments for current policies. But the next mention of restricting immigration in the name of public health, and the law cited by many more contemporary restrictionists as justification for suspending immigration, is the Public Health Service Act of 1944.

Section 362 of that act authorizes the Surgeon General Thomas Perron, or did in 1944, to suspend the introduction of persons or goods into the United States on public health grounds. Based on what one critic from the American Civil Liberties Union has called an unprecedented interpretation of that 1944 act, the CDC, at the direction of the White House, invoked COVID-19 pandemic issues to redefine what constitutes the introduction of persons and introduction of communicable diseases into the US.

You see, the intent of that 1944 law was to prevent arrivals already diagnosed with the disease, or cargo believed to be contaminated from entering the country. And those are public health priorities. The law was never intended to be an instrument of immigration restriction. But the current White House referred to the 1944 law in claiming public health necessity for suspending hearings on asylum claims and in other ways of stalling the arrival of immigrants and refugees and aslyees.

Court cases brought as recently as this summer by the ACLU have sought to challenge this delay or denial of hearings in a timely manner. Even more recently, the administration announced its intention to reduce the number of refugees admitted each year from the 18,000 cap set for 2020 to 15,000 in fiscal 2021. In

fact, since taking office, the administration has slashed the number of refugees allowed into this country by more than 18%.

And once again, the rationale has been public health emergency. The social media contributes to spreading these vile stereotypes, no question about that. However, what is striking to those with historical perspectives is that the pattern of rationalizing xenophobia and justifying restrictionism by pointing to a health threat is hardly new or novel. The hunt for public health justification to immigration restriction is old wine in new bottles.

Throughout American history, xenophobes, nativists have argued that the physical well-being of Americans, especially their safety from epidemic disease, is dependent upon immigration restriction or what I have called in my work, *Silent Travelers* that Reed referred to before as a double helix of health and fear that has resulted in the stigmatizing of the foreign-born as carriers of disease to America's shores and justification for discrimination and, at times, even persecution.

So disease is deployed to stigmatize. Some of us here this afternoon I'm sure can recall that in 1963 sociologist Erving Goffman observed that the most essential version of stigma is the abomination of the body. Bodies associated with disease appear especially threatening. Because the disease-causing contagion cannot always be detected with the naked eye or easily avoided.

It lends an air of mystery to the process. Throughout human history, groups defined by race or religion have been persecuted because of their association with disease. The Black Death of the Middle Ages, for example, was blamed on Jews in various European communities. Ferocious physical persecution resulted in tens of thousands of deaths and sometimes torture prior to the deaths.

It was a horrible situation. And the justification for it was that the Jews had brought Black Death to European communities. Well, in recent memory, the foreign-born have been the targets of stigmatization. Many of us will recall that in the early days of HIV/AIDS in the 1980s, the disease was known as the disease of the four Hs, Haitians, homosexuals, hemophiliacs, and heroin users.

Why Haitians? Because in 1983, an arithmetic error that occurred at the Centers for Disease Control caused Haitians to be classified as a high risk group for HIV/AIDS, a

designation that was later withdrawn in 1985 but not before Haitian families were prevented from renting apartments, and children were shunned on school playgrounds in Miami and Brooklyn and other places of Haitian settlement.

And so, again, disease was used to stigmatize, to smear a particular group. The menace of disease from afar is, of course, not a mythology. It's real. Hundreds of thousands of Native Americans died after their first contact with European settlers, sometimes called the Colombian exchange. They died of smallpox, measles, and a variety of other diseases to which their bodies lacked immunity.

These were what epidemiologists call virgin soil epidemics. Because those who are the hosts, those who got the disease had no ability, no immunities to throw off the disease. And therefore, the result was devastating to the populations. The Europeans interpreted the decimation as an act of God, destroying heathens to the advantage of Christians settling in the Americas.

Well, among the European colonists, there were quarantine regulations established to separate the sick from the well. Those quarantine regulations were passed fairly early in the American colonial experience. And after the American Revolution, those regulations were re-passed by now state legislatures, not colonial assemblies anymore. And sometimes the language was kept the same. The only word that was stricken was the word colony. And in place of the word colony was the word state.

And so there was a body of legislation that was intended to protect the community from ships that might be bringing disease to America's shores. Well, epidemics have often been the occasion for a spike in this kind of xenophobia in our country. And as historian Charles Rosenberg reminds us, a true epidemic is an event, not a trend. An event, not a trend.

And as a social phenomenon, it has a kind of dramaturgic form Professor Rosenberg tells us. There is a beginning, a middle, and an end. In xenophobia, hatred of the foreign-born has been framed as a kind of social ritual that reaffirms a social cohesiveness in the native born, in the face of an epidemic. One that, of course, justifies pre-existing racial and religious prejudices directed at those defined as other.

Because to distance the other is to protect your community from the epidemic

disease. It is truly an example of the medicalization of prejudice. There are a lot of examples of this medicalization of prejudice. This is the Archer Street Port in Philadelphia. In 1793, yellow fever epidemics ravaged the East coast of the United States, especially Philadelphia.

And those who hated German immigrants often called the illness German fever. Federalists who were pro-British and anti-French blamed the French departing Haiti, both white and black individuals in flight from the slave revolt, as being responsible for bringing illness, yellow fever, to Philadelphia and to other places.

And so right from the get go, as early as 1793, we see that these epidemics are like switches, which are turning on patterns of pre-existing prejudice, lighting them up, and resulting in acts of discrimination against those considered to be the others who are bringing this horror upon the community. By 1832, cholera epidemic starting again sweeping the east coast and, in 1832, was very largely blamed on Irish Catholic immigrants who were coming by the tens of thousands to the United States.

The charge reinforced the anti-Catholic sentiments that were fueled by the Protestant evangelists of the Second Great Awakening. And it happened again during a second cholera epidemic in 1849, a little less so in 1866 when the society that had been modernized by the Civil War experience turned from blame to a more constructive approach.

And what was that constructive approach? The formation of new governmental bodies to handle the public health threat. It was then that New York City, for example, formed the first Metropolitan Board of Health, a permanent fixture of urban government. Other localities did a similar kind of thing. And so now government was being marshaled to respond to epidemics.

Government response to illness from abroad in antebellum America was largely a state not a federal responsibility. Coastal states all had immigration bureaus. In New York, a call would go out to physicians in the spring at the start of migration season to come and volunteer their time at quarantine stations, like this one located on Staten Island, or to inspect newcomers at Castle Garden, which became the New York State Immigration Depot opening in 1855.

And of course, those of you who have been out to visit the Statue of Liberty or Ellis Island before the pandemic began may remember that you bought your ticket for the boat in a big round stone structure. Well, that big round stone structure is what is left of Castle Garden. It exists, of course, in what is today Battery Park. But in the 1850s was landfill that jutted out from the tip of Manhattan.

And so along with epidemics came these waves of prejudice that associated the epidemics with all bad things that the immigrants might represent. Well, there was, of course, a new great wave of immigration between the 1880s and the 1920s when 23 and 1/2 million newcomers arrive in the United States, mostly from southern and eastern Europe but also from China and Japan and parts of Latin America.

And fearing that the states were not up to either the quarantine or the inspection and interrogation responsibilities, the federal government gradually assumed quarantine responsibilities after 1878 from the states and then, in 1890, assumed health inspections as well. And the flagship immigration depot was Ellis Island, which was opened in 1892, where physicians of the US Marine Hospital Service conducted inspections.

And these inspections were about preventing disease from coming into the United States by halting those who might be bringing disease from coming into the United States. People would be gathered in the Great Hall at Ellis Island and one by one inspected by physicians who were at the perimeter of the Great Hall.

Here an inspector from the US Marine Hospital Service is applying the clinical gaze to an immigrant who is coming with her children through the line inspection. The US Marine Hospital Service and now the US Public Health Service observes the naval protocol and uniforms, whites in the summer, blues in the winter. So this is winter time when this lady is passing through the process.

Women examined women. The lady with the telescope is Dr. Rose Bebb, the first physician in the US Marine Hospital Service. And just as an aside here, for a long time, those of us involved with the Ellis Island Museum were really puzzled. We couldn't tell whether this was a nurse, was this a doctor, were there women doctors in the public health service?

Well, Rose Bebb was the first. And we were able to establish that she was a physician by the fact that she is using the stethoscope. And in those days, nurses were not permitted to use stethoscopes, only physicians. And so we were able to establish that Dr. Bebb was in fact a physician conducting an examination here. Go back one.

And so the stigmatization of newcomers now had at times with it the diagnoses that were conducted on Ellis Island. In 1882, even 10 years before Ellis Island opened, the Congress of the United States passed the Chinese Exclusion Act, dramatically curbing Chinese immigration to the United States not wiping it out completely. Scholars, business people were still able to enter but limiting the arrival of Chinese workers.

But in 1900, cases of bubonic plague surfaced in San Francisco and were blamed on the Chinese already living there. All of Chinatown was quarantined, roped off. And many citizens of San Francisco, white citizens of San Francisco, simply wanted to torch it, to burn it down, and scatter the people who lived there. This is another example where an epidemic initiated a wave of discrimination and hatred.

And there were other such episodes. The polio epidemic of 1916 that ravaged the east coast was blamed on southern Italian workers. The prevalence of tuberculosis, while not an epidemic in the formal sense, was blamed very largely on Eastern European Jews. TB was called the "tailor's disease," or the "Jewish disease." And anti-Semitic nativists often pointed to the inferiority of the Jewish body as an argument against assimilation.

One such nativist was E A Ross, a sociologist at the University of Wisconsin, who wrote a book *The Old World in The New* which was published in 1914. Ross writes, on the physical side, 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. In other places in his work and the work of other such xenophobes and anti-Semites, Jews are described as inherently tuberculant.

Well, that's a kind of overview of what has gone on in the 19th and earliest years of the 20th century. Of course, the most deadly epidemic of the early 20th century was the 1918 influenza pandemic. And there has been so much written lately about that pandemic and its possible similarities, at the very least uses in understanding our

current situation.

These are some Red Cross volunteers who are folding masks that are going to be distributed during the influenza pandemic. It was a horrible pandemic. It killed an estimated 20 million people and perhaps as many as 100 million people worldwide. In the United States, approximately 550,000 died. We are now, of course, in the COVID situation where close to a quarter of a million have died.

An estimated-- estimates are incomplete. And so it may have been even more. The 1918 pandemic took the lives of a lot of young adults between 29 and 34 years of age, not the very young and not the very old who had been typical victims of other pandemics and are certainly the typical victims in this pandemic. Though in this pandemic, like in earlier-- in the earlier case, there are cases in all age ranges.

In any case, in 1918, the US was also a nation at war. Many of the young men who died had been drafted into the armed services to fight in World War I. America's armed forces were hit very hard. This is an army camp where-- considered a makeshift hospital has been set up. 32,000 died in US military camps and another 18,136 in Europe, American soldiers fighting abroad.

Many of you have heard of this disease in 1918 as referred to as the Spanish flu. As the pandemic reached epic proportion in the fall of 1918, it came-- it was commonly known, if not the Spanish flu, the Spanish lady was the other name for it. Many assumed this was because the sickness had originated in the Iberian Peninsula. But the nickname was actually the result of a widespread misunderstanding.

Spain was one of only a few major European countries to remain neutral during World War I. Unlike in the allied and central powers nations, where wartime censors suppressed the news of the flu to avoid affecting morale, the Spanish media reported on it regularly. And they reported on it extensively in all of its, at times, gory detail.

News of the sickness first made headlines in Madrid in late May of 1918. And coverage only increased after the Spanish King Alfonso XIII came down with a nasty case himself a week later. Since nations undergoing a media blackout could only read in-depth accounts from Spanish news sources, they naturally assumed that the

country was the pandemic ground zero.

And so the Spanish, meanwhile, believed that the virus had spread to them from France. And so they called it the French flu. In short, the stigmatization was being passed around in the media of the day in 1918. In the US, the first known case was reported at a military base, Fort Riley, Kansas, on March 11th, 1918.

Researchers have conducted extensive studies of the remains of victims of that pandemic. But to this day, they have yet to discover why the strain that ravaged the world in 1918 was so lethal. Much research to be done not only on our own current pandemic but on an earlier pandemic as well. Because the influenza pandemic affected so many countries and affected our young men fighting in World War I of so many backgrounds, no immigrant group was singled out and stigmatized with responsibility for bringing this scourge to the United States.

In fact, 500,000 soldiers were foreign-born in our forces, representing 46 different nationalities were serving in the US military. And so there was not an attempt to really point the finger as there had been before and say, you know, this immigrant group, this is the group that did this to us. Well, the number of newcomers also had dropped. And that was another reason that newcomers were often not stigmatized. Immigration was way down.

It dropped from 110,000 in 1918, dropped to 110,000 from 1,200,000, which it had been in 1914. And Ellis Island was not very busy. It was now being used for prisoners of war and enemy aliens. And the two hospitals on Ellis Island were caring for military personnel. The stigmatization of newcomers for the influenza epidemic, though, was not completely absent but occasional and highly, highly localized.

For example, in Denver where policeman Frank Potesto had succumbed to the flu and been honored by his fellow Italians, there was a great deal of anti-Italian feeling. Denver, the home of many TB sanatoria, had a large number of immigrant patients in its institutions. Now only 2,800 of Denver's 250,000 residents were Italian. Still, there was anti-Italian sentiment. Some of it was generated by the nativists in the American Protective Association, others by nativists in the Ku Klux Klan.

Italians in Denver were stereotyped as poor, slovenly, violent, and given to heavy

drinking. Their Catholicism and inability to speak English well all seemed to many native Americans as marks against them in a city that was predominantly white, Anglo-Saxon, Protestant at this time. What did public health officials say to all of this?

One unnamed health department official, quoted in the *Denver Post*, cited the newcomers social customs as the root cause. So it wasn't that the Italians were inherently disease, but they had bad habits. The quotation reads, when an Italian is taken sick, a physician is seldom called. But all the relatives and friends immediately flock into the house to call on the sick person, end quote.

So poverty, cultural preferences for folk healers, in some cases, the desire to be close not distant from the sick, friends and relatives one might have was the basis for immigrant behavior. But to health officials, it was clear evidence that these newcomers not only suffered but spread the disease because of their behavior, which the journalists of the Denver newspapers regarded as primitive and willfully non-compliant with what health authorities were suggesting, including isolating the sick from the well or what we would call social distancing.

The victims seemed to be contributing to the spread of the disease. Another public health official was even more explicit. Quote, the foreign element gives us much trouble when an epidemic occurs. They pay no attention to the rules or orders issued by the health department in its efforts to check the disease, end quote. And this guy, too, saw visits to influenza patients as detrimental to confining the pandemic.

They weren't social distancing. How many visitors swirled around the victim's bed? Well, according to this newspaper reporter, two or three dozen or more, thus disrupting any effort to isolate the patient. That's probably an exaggeration. But it was one that served the journalist's purpose, which was to demonstrate how irresponsible these immigrants were behaving and, therefore, what a detriment they were to the public's health.

As you can imagine on the other end of things, ethnic communities with a lot of new arrivals responded to the fear that the pandemic would spark additional prejudice by contributing to the struggle against the disease in a lot of ways. Activists within

the immigrant medical community wrote and spoke about their community's struggle to provide new arrivals with a healthy environment.

In the Italian immigrant community of New York, for example, one physician Dr. Antonio Stella himself an immigrant, encouraged newcomers to embrace modern medicine, denounce-- he denounced the persistence of superstition and pagan beliefs, such as the idea that the disease was called-- was caused by the result of the evil eye.

Stella also made the case that the prevalence of disease, including influenza, in the Italian immigrant community was the result of conditions beyond the control of newcomers. And in a very, very poignant essay called "The Effects of Urban Congestion on Italian Women and Children" Dr. Stella wrote, and this is Dr. Stella, when we shall have given the people clean, healthy homes, full of light and sunshine, we will have accomplished the physical and moral regeneration of the masses.

We shall have given them that to which every human being is entitled, health and happiness. There was in the midst of epidemics not that much health and happiness in congested immigrant neighborhoods. Immigrant communities also resisted the prejudices resulting from their identification with the pandemic by supporting medical institutions.

In the midst of the Jewish immigrant community, hospitals and clinics arose that cared for everybody who came through the door, regardless of their faith or their ethnicity. At Boston's Beth Israel Hospital, 250 patients with influenza were admitted in the fall of 1918 when many hospitals were turning away patients with influenza. The mortality rate was 25%, similar to other hospitals across the city.

Several of the nurses in the hospital contracted influenza and one died. After the pandemic ended, Boston's mayor Andrew Peters wrote, I write to thank you and to convey to the superintendent of the hospital my gratitude for the services the hospital has rendered to the city during the influenza epidemic. I assure you that this is no small measure appreciated by all.

The physicians and nurses of Baltimore's Hebrew Hospital made home visits in the surrounding neighborhood to treat flu victims. And one nurse social worker even

borrowed an automobile so she could go beyond the vicinity where the hospital was located to see patients. Other hospitals, Catholic hospitals did often the same thing in cities like Boston and Baltimore.

And so while accusations against immigrants as the cause of the influenza outbreak were rare in 1918, there was an acute awareness that the fears generated by the pandemic could turn very quickly to anti-immigrant behavior if public health officials and ethnic community leaders did not use their influence to persuade the native born that newcomers were obeying the directives of public health officials. Often, these directives were filtered through the Foreign Language Press.

And I'm in the debt of some of the students who helped me decipher some of the material in the Foreign Language Press. Officials depended upon these newspaper editors to encourage best health practices during the pandemic. And they are invaluable-- these papers are an invaluable source engaging how at least some opinion leaders in the immigrant communities were urging their readers to respond to the crisis.

For example, the editors of the Italian newspaper, *Il Progresso Italo-Americano*, urged its readers to obey public authorities, including the police, who were being deployed to enforce regulations, to practice good sanitary habits by not drinking from communal cups at fountains and not spitting on the sidewalks. And the police were told to issue summonses and to stop people who were engaged in what the law regarded as unhealthy behavior that could spread the influenza.

Similarly, the largest selling Yiddish language daily in New York, *The Forward* or *Forverts* in Yiddish, edited by Abraham Cahan, encouraged cooperation and respect for all edicts of the New York Health Department and for the words of the New York Health Commissioner Royal Copeland.

Copeland was a Tammany appointee. He was not held in high regard by many. But during the pandemic, he rose to the occasion and did some very important and controversial things. Just to give you an idea, one of them was to send the children to school rather than keep them at home. Why was this so controversial? Well, clearly you were exposing them to other children in the schools.

But the argument that was made to Copeland and that he accepted and acted on was that in the schools, in those days, there were full-time nurses in almost every school. And some of the schools had doctors as well, or doctors who rotated through the schools. Where better to keep the children under surveillance than in the schools?

If they were kept at home, the parents had to go out to work. The children would be roaming the streets. It would be unclear when a child was sick. There would be nobody to diagnose the situation and take appropriate action. So contrary to what others were doing, Royal Copeland said the safest place for the children of New York City during this pandemic is in school not out of school.

And so the newspapers, *The Forward* and others, rushed to support Copeland in his decision-making and also to try and calm the population and get them to be compliant. When it came to responsibility for the disease though, that was another matter. Now the *Jewish Daily Forward* was a socialist newspaper. I know that for a fact because my grandfather read it every day of his life. And he was an ardent socialist.

And so the editorialists, Cahan and others, at *The Forward*, when it came time to lay blame for the pandemic, of course, didn't blame the immigrant community. Who did they blame? Capitalists. And in the editorials of *The Forward*, greedy landlords were described who gave too little heat in the winter time, who charged exorbitant rents, and factory owners who exploited their workers. And so in effect what *The Forward* did was to politicize the pandemic.

They were not adverse at all to politicizing the pandemic. Interestingly enough, the government of the United States did not. Immigration restriction was high on Congress' agenda in the early 1920s, with permanent legislation passing in 1924 that established an immigration admissions quota system, a national origins quota system.

But of all the reasons mounted by immigration restrictionists in the congressional debates prior to that legislation being passed, the pandemic was not mentioned. Congressmen and senators did not turn to public health as justification for restriction or denial of appeal procedures. There is no record of appeals being

denied, as they are now, for reasons of public health.

As I said, not so in 2020. As I've already mentioned, the White House has linked the current pandemic to its restrictive immigration and refugee priorities. And both parties have made public response to the pandemic an issue in the 2020 presidential campaign. Once again, as has happened often in the past, there was a conflation of immigration and public health priorities.

So let me bring this to a conclusion. The saga of the COVID-19 pandemic is still in progress. We have pictures of the guilty party. You're seeing one from under a microscope. And how the disease will affect immigration and the integration of newcomers into American society is a chapter of the tale that's still being written. It is part of the larger issue of whether or not and how American society will be permanently changed by the pandemic.

We are now all wearing masks. Those who study 1918 often refer to that pandemic as the forgotten pandemic. Because in the many decades following the crisis, so little was said about its legacy. Some speculate that it was dwarfed by World War I or because major public figures, including President Woodrow Wilson who actually got the influenza while he was at Versailles, spoke so little of it.

But that is not the case now. We cannot use 1918 as a guide, a perfect guide, to understand what will happen in the years before us. In my own thinking about the matter, I doubt very much that this public health crisis will leave our society as it was last February. Some changes were already quite obvious, the increase in online classes at universities, the increase in online shopping and decline of traditional retail outlets, the increased dependence upon social media for business and politics, from everything from presidential races to organizing protests.

However, there is likely to be an increase in medical surveillance and attention to the exigencies of public health. Immigration and refugee admissions may be recast by public health priorities in ways they have not been since the 1890s, when immigration inspection procedures, like those on Ellis Island, were first established.

Whatever adjective future scholars use to describe the current pandemic and its intersection with immigration, I think I feel confident in saying that the word forgotten is unlikely to be among the words used to describe our current situation.

Thank you very much. So let me turn now and stop the screen share and turn on the Q&A.

REED UEDA: Alan, thank you for your fine presentation. I wanted to-- maybe I can start off the Q&A. Obviously, politicization of the pandemics in the form of immigration, anti-immigrant movements and policies, like the 1924 Quota Act that you describe, can happen. But I think you said it wasn't really mentioned, right, in the justification.

ALAN KRAUT: Right. That in and of itself is rather interesting.

REED UEDA: Yeah. That's what I was wondering--

ALAN KRAUT: Of all the reasons mounted--

REED UEDA: --what your thoughts are about that.

ALAN KRAUT: --to restrict immigration, this was not one of them.

REED UEDA: Yeah, right. Well, how about this-- this is my last chance to ask this question. So what about schools? I mean, you answered very-- in a very interesting way with a lot of research about the role of language, of the Foreign Language Press in informing immigrants about the dangers of diseases. This also-- and I was just thinking about how-- in my mind, I thought, could this have also added-- this concern with communicating with immigrants had the repercussion of perhaps overemphasizing sort of the Americanization aspect in public schools.

That is, you know, we have to force them to learn English, so they can be-- we can communicate with them, you know, about these various dangers. A kind of, well, there was also like I'm not sure to what extent this was as important as linguistic assimilation in the public schools. But there was a home economics movement, a kind of health cult that came into existence in the public schools.

Anyway, I just thought perhaps the schools were affected by this as well.

ALAN KRAUT: I don't think there's any doubt about it that the schools had already been, long before the pandemic, sort of little microcosms where Americanism of all kinds was being preached. And part of that was, how do you live? What do you eat?

REED UEDA: Correct.

ALAN KRAUT: How do you take care of your body?

REED UEDA: That's right.

ALAN KRAUT: So that, you know, that was already part of it. What's so interesting about the public schools in the period we're talking about this afternoon, in the 1918, 1919 period, is that they bore a responsibility for the health of children that modern public schools don't assume. And I've always found that fascinating. I can remember a school nurse, you know, being present back in the early 1950s when I was in an elementary school.

But it was even more so in that there were-- in some cases, the only opportunity that a child had for real medical attention, including dental work and concern for the eyes, was in the public school, which is quite remarkable. Back in 1998, I was on a task force that was studying the health conditions of contemporary immigrant children. And somebody raised the issue at the table, well, how did they do it during previous waves of immigration?

And as the only historian present, I said, they did it through the public schools. That's something that could be done again if there was the commitment to funding that kind of service in public schools. And you would reach the children immediately.

REED UEDA: Very interesting. I think others should join in. I'm sure there are others with comments or questions.

ALAN KRAUT: The floor is open folks.

REED UEDA: Alan, go ahead and call on them when they--

ALAN KRAUT: Yeah, I don't see any right now.

REED UEDA: --start to speak.

ALAN KRAUT: Do you Reed?

REED UEDA: No, I don't.

ALAN KRAUT: OK.

REED UEDA: Let me start scrolling along here. I see some of our steering committee members, but their microphones are off.

AUDIENCE: Can I interrupt with a brief--

REED UEDA: Oh sure, Anna.

ALAN KRAUT: By all means.

AUDIENCE: I'm interested because you talked about how, in the 1920s, race was not a criterion for health. But health seems to have been a consideration. I'm thinking about my experience becoming, first, a permanent resident and then a citizen. And as far as I know, there's still a requirement for X-rays and a medical examination.

ALAN KRAUT: Oh, absolutely. It was always a concern.

AUDIENCE: Is that completely unrelated?

ALAN KRAUT: No, I think there was always the realization that health was important for two reasons. Number one, disease could be brought from abroad. And so there is good reason to take the precautions of health inspection, not necessarily to brand people of any particular country or identity as disease carriers but rather to acknowledge that sometimes disease was even acquired in the ships coming across the Atlantic or the Pacific. So there was good reason for inspection.

And we've changed our procedures. There's no Ellis Island any longer. But we do require medical inspection before the granting of immigration papers and before folks are permitted to come to our shores. As residents, there is absolutely medical inspection. And there are medical inspections in our refugee camps.

So that's an ongoing concern. One was the disease. The other was, would they be sufficiently robust to be able to support themselves? Or would they become a drain on the American economy? And that was certainly a second but very important concern in the minds of officials.

AUDIENCE: That raises for me a second, very secondary question. But given your expertise about Ellis Island, my recollection is, not personal recollection, that for a long time

at least for ships arriving from England in New York Harbor, people in the third, fourth steerage classes were taken to Ellis Island. But there were no such inspections but people in first, and I'm not sure about second class.

ALAN KRAUT: Yeah. Well, that's--

AUDIENCE: Is that correct?

ALAN KRAUT: --not completely correct.

AUDIENCE: And so was this a class as well as race discrimination?

ALAN KRAUT: It was not race discrimination at all. It was definitely class discrimination. And that is, to start with, it was that-- it wasn't that there was no inspection. Because in fact, by the later period, there were inspections conducted by the ship lines themselves before anybody was permitted to go onboard ship. But those who traveled first and second class were visited in their cabins by federal inspectors and interrogated in the privacy of their cabins.

The rest, those who were traveling third class and steerage, were required to go to Ellis Island. And so I think what you have is, yes, most definitely a class divide, dependant on the kind of ticket that you could afford that you purchased. And we know of many cases where those who were rejected for medical reasons went home, saved more money, and came back with a different kind of ticket, a first or second class ticket, in order to get into the United States. Because they knew that the inspection would be perfunctory, to say the least.

AUDIENCE: Thank you.

ALAN KRAUT: Sure. I see a question from Ronald Holt. Hello, I recently have seen an effort to blame the 1918 influenza pandemic on the Chinese. Is there any significant evidence that the 1918 flu originated in China? Certainly none that I know of. It's-- certainly I've heard this as well. And I think the bottle that's being used for the charge is, again, the virus jumping from an animal to human beings, which is the way influenza often begins.

So there might have been such a jump. But the spread to the United States came across Europe. And there was undoubtedly, as there is now, a change in the nature

of the virus before it reached the United States. Any other questions? Yes, from Dennis and Paula Porter, how will Americans be thwarted by other countries in the future versus Americans restricting movements of others coming to the USA? I think this might be an even stranger change.

Certainly, I mean, this is the first time in memory that Americans have been forbidden from entering other countries for health reasons. There's no question about that and a number of historians have pointed that out, that this is odd. What I think it's going to lead to though, in all seriousness, is a much greater degree of cooperation and emphasis on honesty in reporting internationally.

I think the conflicts between the United States and the World Health Organization, between the United States and China are really all about the issue of honesty and reporting, and how the data is disseminated, and tracking the diseases in a responsible and-- a responsible way with the interests of the larger human community in mind. I think that's terribly, terribly important.

And if that's what comes out of all of this, that's a good thing. That's a very positive thing. Those of us who remember the SARS pandemic a number of years ago will recall that the Canadians, especially the mayor of Toronto, for the longest time denied the presence of the disease in its community. Because he thought it was bad for business.

Well yeah, you know, it's all bad for business. But most of all, it's bad for people and survival. And so there has to be adequate surveillance and adequate dissemination and openness, if about no other issues, certainly about this. And if there is not, if there is the failure to be open about it, I think in the future we might see our country but other countries as well shutting down inflow of population at particular times, trying to do what Benjamin Harrison did back in that period I mentioned at the beginning of my talk. And that is to close their borders for a certain number of days at the very, very first sign of illness.

So questions from Pamela McCarron, were animals ever blamed, foreign or domestic? No. Certainly not that I know of of blaming animals as, in this instance, in the case of influenza in 1918, as vectors of disease. For other diseases, of course, animals are blamed as vectors all the time. Think about the role of mosquitoes in

yellow fever for example in spreading disease.

So yes, animals are very important in this process as vectors. Follow-up question from Ronald Holt, thanks, do you expect border restrictions to be lifted soon? And the answer, my answer, is no. I don't think border restrictions are going to be lifted soon. I think right now there's a tremendous amount of fear, a tremendous amount of anxiety.

People are trying to latch on to anything that has the possibility of preventing disease from harming them and intruding upon their communities. And I really don't think we're going to see any kind of normal openness and human passing from country to country with great ease. There are some now, but I don't expect to see that expanded a great deal.

In fact, if you listen to the airlines and what they're saying about their passenger load and so on, it's very, very clear that people are not comfortable traveling by air from country to country unless they absolutely, absolutely have to. They're suspicious of the air exchange systems in the planes, just as they are in the case of trains in Amtrak and so on.

So I think this is definitely going to be the case until we achieve our herd immunity, which we won't achieve most likely until we have the vaccine. And the vaccine is a ways away in spite of what anybody else says. The words from the Centers for Disease Control and from the National Institutes of Health is that we are not about to have a vaccine by next week or the week after or the week after that.

And it's only when we have the vaccine, there's confidence in the vaccine, people are willing to take the vaccine, and it can be efficiently disseminated throughout the population are we really going to get to where we want to go and will people feel safe enough and communities feel safe enough to admit people and for people to travel around as they have prior to the onset of a pandemic.

From Dennis and Paula Porter, when were the sanatorium systems initiated in the 1850s or around 1900? Closer to the turn of the century, when you begin to see the rise of sanatoria, tuberculosis sanatoria, in places like Denver, Colorado, which a community that was called a place for respiratory refugees. And one of the things that we see happening around 1900 and in subsequent decades is labor unions and

voluntary organizations putting their money into various sanatoria so that their membership will have access to that form of care should they come down with the disease.

So we see this on a very, very large scale, not just in Denver but in parts of upstate New York and so on. Because a part of the problem was that the advocates of sanatoria were convinced that that kind of care and a change in climate was critical for caring for TB patients. The problem was that there wasn't agreement within the medical community about what kind of environment was best.

Was it best to have people on the shore? Was it best to have people in mountains, the clear mountain air, and clean wholesome food? One of the interesting things about TB, as compared to other diseases, is that there are long periods, long hiatus' before the disease becomes active again. So you can have TB. It goes into a kind of remission. And then something will spur it on again.

And until the advent of drugs to treat TB, people lived at the sanatoria hoping that their disease would remain in remission. Or if it spiked, they were at least in a place where they could be cared for, depending on the kinds of resources that they had to get that kind of care. From Ron Holt, I think one of the saddest things about this pandemic would be if it leads to worse relations between the US and China.

I share that concern. On the other hand, it's hard to imagine a worse relationship right now. Both candidates for the presidency see China as a major threat to the United States, less in terms of health going forward but certainly in terms of economic competition and military build-up and so on. So whatever contribution the pandemic makes, I think it's going to be relative minor-- relatively minor compared to the other concerns that the two countries have about each other right now.

OK. Anna, did you have a follow-up question? I see your image on the screen.

REED UEDA: Well, Anna, did you have another question? No. So I think it is time to draw to a close. And I'm sure I speak for everyone that we are very grateful to Alan Kraut, Professor Kraut, for providing us with this invaluable historical perspective on disease and immigration. It is a very complex subject. It leads into many areas.

You really have to be an interdisciplinary historian, which I think it's quite evident

that Alan really has the ability to bridge many areas of scholarly endeavor, not just history but medicine, health, institutions and organizations that deal with these issues as well as our politics. So with that, Alan--

ALAN KRAUT: Thank you very much.

REED UEDA: I want to thank you personally and look forward to following your work on this subject and other subjects.

ALAN KRAUT: Thanks very much. Thank you so much for having me. And thank you to everybody who attended this afternoon. And thank-- a special thanks for those of you who ask questions, always delighted to hear good questions. Thanks again, Reed.

REED UEDA: All right, Alan. I look forward to seeing you again. Thank you very much.

ALAN KRAUT: Same here. Bye-bye now.

REED UEDA: Bye-bye.

[MUSIC PLAYING]