Which Face? Whose Nation?

Immigration, Public Health, and the Construction of Disease at America's Ports and Borders, 1891-1928

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This article examines medical inspections of immigrants arriving to U.S. ports and borders from the period 1891 to 1928. Comparing the activities of the U.S. Public Health Service at four immigration stations, the authors emphasize the importance of regional differences in the history of immigration and public heath. In addition, they argue that categories of medical exclusion emerged in conjunction with early-20th-century attitudes toward skin color and nationality, increasing stringent citizenship laws, and immigrant groups' varying relationships to the labor market. Finally, the authors argue that medical labels became more flexible over time, moving from clearly infectious and quarantinable diseases to more chronic conditions of physical and/or mental disability.

Since the early days of the republic, anti-immigrant sentiment has played a part in the forging, expansion, and consolidation of America. Drawing from an extensive array of metaphors and explanations, nativist rhetoric has, at different times, been based on claims of religious incompatibility, cultural backwardness, or economic dependency. What all of these objections have shared is a general belief that certain immigrants are inassimilable and potentially destructive to American society. One of the most insidious and powerful rationales for restricting immigration has been based on the need to safeguard the national public health against contagious or infectious diseases, deleterious genetic traits, and even chronic conditions or disabilities. Current concerns about immigrants introducing drug-resistant tuberculosis into American cities and the relatively recent quarantine of Haitians suspected of HIV seropositivity on Guantánamo Bay, Cuba, demonstrate that associations between outsiders and disease are very much with us today.

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It was during the late 19th century, however, that the immigrant experience—of leaving one's homeland, traveling by land or sea, and being appraised on arrival to America—began to be increasingly mediated through the language and practice of public health. With the promulgation of the Immigration Act of 1891 that mandated the exclusion of persons suffering from a "loathsome or dangerous contagious disease" and, additionally, that required steamship companies to disinfect passengers before transit and bear the costs of possible deportation, a new era of inspection began. This and subsequent laws—which rearranged and expanded the criteria of exclusion—turned entry into the United States into a passage partially defined by a medical vocabulary of pathology and health. Moreover, as the U.S. Public Health Service (USPHS) began to play an important role at ports of entry throughout the country, the mediation of immigration through a new set of medical criteria became quite real for those migrating during this period. From Ellis Island to Angel Island, the hands, eyes, and instruments of public health officials assayed and scrutinized the physical condition of the nation's future citizens. After what was frequently a frightening examination, the majority of newcomers were admitted; some, however, were deported or hospitalized for weeks or months as they underwent treatment for a number of illnesses ranging from ringworm to trachoma.

In this article, we explore the complicated nexus of American immigration and public health during the Progressive Era. During these decades, the first great wave of immigration brought more than 25 million individuals from Europe, Asia, and the Western Hemisphere to the ports and borders of America. At the same time that rapid urbanization, industrialization, and the settlement of diverse ethnic groups in most major cities were reshaping the country, medical practice and knowledge were also being swiftly transformed. A watershed period in modern medicine, the Progressive Era saw the elaboration of germ theory and bacteriology, which revolutionized understanding of the etiologies of many infectious or contagious scourges and contributed to significantly improved means of sanitation and disease prevention. Within the clinic and hospital, as well, new technologies were being developed—such as the X ray and the electrocardiogram—that enabled physicians to extend their external gaze on the patient inward to assess the workings of the human body. Finally, the Progressive Era was also characterized by the emergence of a series of novel theories about heredity and human capacity. The leitmotivs of the Progressive Era—science, efficiency, and order—cannot be understood without considering the popularity of a national eugenics movement that promoted, and helped to secure, laws to regulate the reproduction of the "unfit."

Although many facets of American immigration have been studied by historians, the dimensions of medicine and public health have only recently received close attention. In 1955, John Higham (1955/1995) authored the first major study of the development of nativism, nationalism, and antiforeign sentiment that included health and disease within its rubric. The role of public health in the triumph of scientific racism in the 1920s, the passage of the Johnson-Reed Act

of 1924, and the immigrant experience in general, however, have only begun to be more closely analyzed. In his excellent monograph, *Silent Travelers: Germs, Genes, and the "Immigrant Menace,"* Alan Kraut (1994) explores the role of the USPHS and other agencies in the construction of foreigners as dangerous, diseased, and contagious. Along with several other scholarly articles (Birn, 1997; Dwork, 1981; Fairchild & Tynan, 1994; Yew, 1980), this book provides a picture of medical inspection at ports of entry—above all, Ellis Island—and describes the methods used by public health authorities to gauge the physical and mental constitution of the newly arrived. In spite of the ground broken by these works, there has been little attempt to analyze the intersections between immigration and public health from a synthetic perspective that considers regional differences. The preponderance of attention devoted to Ellis Island and the Atlantic seaboard, which received more than 75% of all immigrants during this period, obscures striking variations in the medical inspection process at the country's many immigration stations. As we shall demonstrate in this article, from coast to coast and border to border, immigrants were subjected to divergent public health practices and were distinctly perceived depending on skin color, nationality, citizenship status, and relationship to the labor market.[1] Taking these regional disparities into account is especially important given that during the Progressive Era public health responsibilities were gradually transferred from local or state authorities to the domain of the federal government (see Marcus, 1979). Highlighting and analyzing the nuances of these processes of nationalization and standardization also shed light on the ways in which earlier patterns may be culturally embedded in the dynamics of contemporary immigrant health care.

Some readers are surprised to learn that contagious and infectious diseases actually played a relatively small role in excluding immigrants; justifications were more frequently based on evidence—or suspicion—of extreme poverty, criminal or immoral behavior, being a contract laborer, or subversive political beliefs. At a time when epidemics were on the decline, many public health officials became concerned less with diseases such as cholera, typhoid, and plague and more interested in identifying more ambiguous conditions and syndromes such as feeblemindedness, constitutional psychopathic inferiority, and poor physique. The three physicians who occupied the position of surgeon general during the Progressive Era reflected this trend and often voiced their anxieties and opinions about what "face" the nation should have and who should comprise the body politic. Between the ubiquitous racializing and "othering" discourses of the Progressive Era, and the great ability of germs to level all differences of class, race, or gender, a fluid terminology of disease and pathology developed. Immigrants, public health officials, politicians, and social activists all fought over the definitions of such terms and, as such, helped change the landscape and limits of identity and ethnicity in early-20th-century America.

In this article, we take a first step toward exploring this complex history. We begin by mapping out the activities of the various health agencies (federal, state, and local) assigned to Ellis Island, New York; Angel Island, San Francisco; Port

Huron and Detroit, Michigan; and El Paso and Laredo along the Texas-Mexico border. In the concluding section, we address several of the implications of these regional variations and suggest that although medical criteria were often used opportunistically to stigmatize specific immigrant groups in moments of perceived social crisis, the associations and metaphors generated by such incidents often created more durable stereotypes. Such associations of disease and disability not only affected the ways in which native-born Americans perceived immigrants during the Progressive Era but also had an impact on how various immigrant communities related to and worked with the American medical and public health establishment.

THE VIEW FROM NEW YORK

During the Progressive Era, when a premium was placed on efficiency and expertise, the immigration reception center at Ellis Island, in New York Harbor, was lauded by government officials, physicians, and journalists as a paragon of what Frederick Taylor (1911) characterized as "scientific management." As a result of the Immigration Act of 1891, which placed the administration of immigration issues under the control of the federal government, the Ellis Island immigration facility opened its doors in January of 1892. A fire in 1897 destroyed the original wooden structure, and the beaux-art, red-brick structure that now houses the U.S. Immigration Museum at Ellis Island opened in 1901.

Built to process approximately 5,000 immigrants per day as well as to inspect them for physical, economic, mental, and moral fitness, by 1907 it was not uncommon for the facility to receive more than 10,000 immigrants on any given day and more than 500,000 annually. The overwhelming majority of these immigrants were from northern, eastern, and southern Europe, the Mediterranean, and, to a much lesser extent, Asia and Latin America. Nonetheless, despite the large quantity of immigrants requiring physical examinations, there was only a handful of physicians to conduct them. In 1892, only 6 USPHS physicians were assigned to staff the inspection line in the Great Hall, the Contagious Disease Hospital, and to check first- and second-class passengers on board incoming ships. This number increased to 8 physicians in 1902, 16 in 1905, and during the decade before World War I when immigration reached its peak, there were 25 physicians stationed at Ellis Island and four queues processed simultaneously. Referred to as "the Line," the medical inspection was stridently defended by its practitioners and, just as often, derided by a number of medical observers. The psychiatrist and superintendent of the Johns Hopkins Hospital, Henry M. Hurd, for example, viewed the mass inspection of thousands of immigrants in such a short period as superficial and clinically unsound. In 1892, he wondered aloud to a newspaper reporter: "How can a physician inspect two thousand persons as they should be in a couple of hours, when it sometimes takes a doctor twice as long to diagnose one patient?" ("Awake to the Danger," 1892, p. 6).

The separation of state and federal powers over public health administration was a hotly contested issue in New York Harbor. To accommodate these concerns, incoming ships were first inspected at the New York State Quarantine Station, off Staten Island, by state health officers, for evidence of the "quarantinable" diseases including cholera, typhus fever, small pox, bubonic and pneumonic plague, yellow fever, and leprosy. These diseases were believed to be extremely dangerous and easily spread to others either by direct or indirect contact. As a result of improved communication between seaports (via telegraph), sanitation on board the ships themselves, and rigorous medical inspections of immigrants before leaving for America, these epidemic diseases were a relative rarity and easily controllable during the early decades of the 20th century, especially when compared to their international spread during the 18th and 19th centuries.

Medical inspections in New York Harbor were structured by the hierarchies of class and socioeconomic standing. After the inspection at the quarantine station, USPHS physicians boarded transatlantic steamships for a brief and cursory examination of the first- and second-class passengers. Indeed, some immigrants were encouraged to spend the extra capital for a second-class ticket to avoid the more rigorous medical examinations carried out at Ellis Island and other ports. If a cabin-class passenger was suspected of having a dangerous or loathsome contagious disease or some physical condition that would interfere with his or her ability to earn a living, he or she was transferred by barge, along with those in steerage, for a more complete physical at Ellis Island. Despite repeated warnings from prominent bacteriologists that germs did not respect the boundaries of class, the focal point of these inspections was the most destitute—above all, impoverished Europeans—traveling in the dank, squalid quarters of the steerage.

Public health officials searched for a number of physical and mental conditions as immigrants passed through the labyrinthine, cordoned-off areas that contained the Line. At several checkpoints, individuals were scrutinized for specific problems. As they climbed, baggage in tow, up the stairs to the Great Hall, for example, inspectors looked for shortness of breath and signs of cardiac weakness. Public health officers also checked for goiter by observing neck size and shape and looked for rashes on the skin, nails, and scalp that might indicate ringworm, favus, or other fungal infections. Most vividly remembered by immigrants who passed through Ellis Island, however, was the dreaded eye examination for trachoma (for examples, see Brownstone, Franck, & Brownstone, 1979; Ellis Island Oral History Project, 1985). Known to be endemic in eastern Europe, the Mediterranean, and Asia, trachoma left three out of four of its victims blind. Because its etiology was not yet well understood, physicians found trachoma extremely difficult to diagnose; this situation of uncertainty made eye diseases a source of great anxiety for many public health officials and also helped to make the label of trachoma especially fluid and ambiguous. Instruments commonly used as part of the inspection process were stethoscopes, and after 1910, X rays, which were employed in order to detect pulmonary tubercu-

losis. The tools of the bacteriology laboratory, such as microscopes, slides, and stains were also part of the public health officer's repertoire. These were especially important in the diagnosis of sexually transmitted diseases such as syphilis and gonorrhea, which although identifiable by genital examinations, by the mid-1910s could be much more readily determined using culture methods. Other conditions that USPHS officials searched immigrants for included feeblemindedness, chronic psychopathic inferiority, insanity, hernias, rheumatism, malignancies, senility, varicose veins, blindness, and poor eyesight.

In any given year between 1891 and 1928, less than 3% of the total amount of those seeking entry to the United States were actually rejected for reasons of a contagious, infectious, or loathsome disease; mental disorder; or physical disability. In fact, the average annual amount of those rejected for medical reasons at Ellis Island during this period was less than 1%. What changed as the Progressive Era unfolded, however, as demonstrated by Yew (1980) and Kraut (1994), was the percentage of those debarred for medical reasons as a fraction of the total number of those debarred for any reason, including evidence of criminal behavior, prostitution, being a contract laborer, untoward political beliefs, and insufficient financial resources. For example, in 1898, of the total number of immigrants excluded, only 2% were rejected based on medical criteria. In 1913, this figure rose to 57%, and 2 years later, to 69% (Kraut, 1994, p. 66; Yew, 1980, p. 492; data also drawn from U.S. Treasury, 1891-1901, 1902-1911; U.S. Treasury, USPHS, 1912-1930, for the years 1898 to 1924). More significant than the proportional increase, however, is the fact that these exclusions were not due to an increase in the incidence or detection of infectious or contagious diseases such as trachoma or favus. It was related, instead, to expanded scrutiny for, and identification of, chronic disabilities that were deemed likely to make an immigrant dependent on the state or a "public charge," as codified in the Immigration Act of 1907.

Between 1897 and 1928, Ellis Island doctors moved further and further away from their original charge to discern and prevent the entry of contagion that posed an immediate threat to the nation to the identification of more chronic syndromelike conditions that seemingly placed the country's economic and productive strength in jeopardy. In the 1910s, for example, public health officers diagnosed higher numbers of cases of poor physique—a favorite "wastebasket" label of nativist groups such as the Immigration Restriction League—arguing that such debilitated individuals should not be allowed to become part of the body politic.[2] This was especially pronounced in the case of eastern European Jews fleeing programs in the Pale of Settlement; USPHS officials often observed their poor posture, rounded shoulders, and malnourished cast—beyond living in poverty, these conditions were often traceable to occupations that required them to work hunched over at sewing machines in the needle or garment trades or at desks as religious scholars. Even with this trend, however, the number of immigrants excluded for medical reasons on Ellis Island remained low. There are several explanations for this. First, despite the

increased role of medical terminology and inspections during this period, USPHS officers were never granted expanded powers by the Congress to actually reject any immigrant. More referees than judges, Ellis Island doctors were ultimately consultants and advisors to immigration officials rather than gendarmes with categorical powers to debar the newly arrived. Second, aid societies, such as the Hebrew Immigrant Aid Society, assisted immigrants in the appeal process and actively contested categories of exclusion such as poor physique and feeblemindedness. Once an immigrant was certified by a physician, his or her case was reviewed by a special board of inquiry and the final determination depended on the vagaries of the moment as well as the immigrant's negotiating skills and resources. Third, the citizenship status of Europeans arriving to Ellis Island was more secure than that of Asian immigrants. Usually considered White by law (Haney López, 1996), although not according to popular stereotypes, Europeans—at least on paper—were eligible for naturalization and possessed political and legal rights. Freedom to migrate to America was not severely hampered until the enactment of strict quotas in 1921 and 1924. Based on a mixture of nativist thought, arguments about the potentially devastating economic effects of open immigration and sensational eugenic "evidence" of the effects of immigrants on the national "germ plasm," these immigration restriction acts effectively slammed the gates shut to European and Asian immigrants for more than 40 years.

AT THE EDGE OF THE PACIFIC: ANGEL ISLAND, SAN FRANCISCO BAY

Between 1910 and 1940, 3,000 miles away from New York Harbor, a federal port of entry was maintained at Angel Island in the San Francisco Bay. Before 1910, Angel Island served as a detention center for Chinese immigrants awaiting medical examination and processing by immigration authorities at the Embarcadero. Historian Daniels (1997) contrasts, perhaps too starkly, Ellis Island—literally under the shadow of the Statue of Liberty—as an icon of "welcome and acceptance," to the smaller and more removed center at Angel Island, which was instead, he writes, a site of "suspicion and rejection." Indeed, the history of Asian immigration to the United States encompasses a very different story than the one that characterizes the eastern and southern European exodus during the years 1880 to 1924. As a result of several anti-Chinese congressional debates in the late 1870s and the passage of the Chinese Exclusion Act in 1882, which was extended for another 10 years in 1892 and then made more permanent at the approval of President Theodore Roosevelt, harsh numerical restrictions were placed on Chinese immigrants. Within an economy of racial perception that revolved around fears of cultural and biological difference, Asians were viewed as distinct "others." While they disparaged the "new" European

immigrants as swarthy and sickly, many Americans viewed Asians as totally foreign and inassimilable, evincing that "racial separateness between whites and Asians could never be blurred no matter how many coats of Americanization were painted on them" (Markel, 1997, p. 85).

Although San Francisco authorities had long overseen an immigration reception center at the city's waterfront, they agreed to relinquish control in the early 1900s after a poorly managed epidemic of bubonic plague struck the Chinatown district and exposed the fissures between municipal, state, and federal powers with regard to public health.[3] The federally operated Angel Island facility, about a 45-minute boat ride from the San Francisco waterfront, opened in 1910 and was composed of a series of wooden structures that included a hospital, a small administration building, detention quarters, and a wharf. Eventually, a laundry facility and extra barracks and power-plant buildings were added. Like most immigration or quarantine stations in the United States at the turn of the century, the Angel Island facility was inadequate in terms of space, cleanliness, and staffing. Unlike the other stations, however, Angel Island was almost exclusively dedicated to the inspection, disinfection, and at times, detention of Chinese, Japanese, and other Asian immigrants who sailed in steamships across the Pacific Ocean.

Exact numbers of those who were processed at Angel Island are difficult to ascertain. Best estimates range between 60,000 and 100,000 during the port's decades of operation, a mere fraction of the more than 10 million who passed through Ellis Island during this same period. The majority of those who came through Angel Island were Chinese merchants and their families, students, tourists, and those who could claim American citizenship. Chinese and Japanese diplomats and Europeans and Asians traveling first class were not required to stop at Angel Island. Sizable numbers of Japanese immigrants also passed through Angel Island. This group included roughly 10,000 "picture brides" and Japanese Americans who had been educated in Japan and were permitted to enter America as a result of the "Gentleman's agreement" signed by Theodore Roosevelt and the prime minister of Japan in 1907. There were also several thousand immigrants from India, Korea, other Asian countries, a small number of Europeans, and fewer still from the Caribbean and West Indies (numbers taken from Daniels, 1997).

Beyond the standard medical examination, Asian immigrants were inspected for several diseases that had been identified by surveillance studies of the most prevalent infectious and parasitic diseases in Asia at the time. These included trachoma, bubonic and pneumonic plague, hookworm (*uncinariasis*), threadworm (*filiariasis*), and liver fluke (*chlonoraisis*). The search for hookworm and other intestinal parasitic infections was especially embarrassing for Asian immigrants because it required then to submit a stool specimen, often on demand. Immigrants coming through Angel Island were also scrutinized for sexually transmitted diseases, tuberculosis, and more chronic physical disorders

such as cardiac abnormalities, hernias, varicose veins, and various mental disorders. As on Ellis Island, the severity of the medical examination was dictated by class distinctions. At Angel Island, however, these differences were compounded by contemporary racial prejudices. For example, when examining first-class passengers who came through San Francisco Bay—for the most part White Europeans and other American citizens returning home after overseas travel—USPHS officers were far more conscientious about taking sanitary precautions, such as routine hand washing and the sterilization of clinical instruments, than when they handled the steerage class, made up principally of Chinese.[4] As on the eastern seaboard, those traveling first class were only subjected to a visual examination for trachoma and were spared the uncomfortable and startling eyelid eversion that was mandatory for Asian steerage passengers arriving to the San Francisco Bay. This conscious policy was communicated by a physician stationed at Yokahama, Japan, in a 1903 letter addressed to the surgeon general. This physician asserted that—on either side of the Pacific Ocean—manual inspections for trachoma were only to be carried out on "steerage aliens" because "the eversion of eyelids, essential for the diagnosis of trachoma, would, if practiced upon cabin passengers, be likely to embarrass the work of the Service here" (U.S. Immigration and Naturalization Service, 1994b).

The racial dimension of these differences in treatment become more striking when the relatively high number of Chinese immigrants rejected is taken into account. For example, although trachoma was typically associated with eastern and southern European immigrants during the first decade of the 20th century, at least one third of all Chinese debarred from entry into the United States were also certified with this diagnosis. Even more telling, however, is that of the approximately 60,000 Chinese who passed through Angel Island during this period, close to 10,000 were deported. This rate, roughly 17%, is at least five times as great as the 1% to 3% noted at Ellis Island. Moreover, although the Chinese never made up more than 1% of the nation's immigrant population during these years, they did comprise more than 4% of the number of immigrants deported each year (Daniels, 1997, pp. 6-7; Salyer, 1995, pp. 59-60; also see figures in U.S. Treasury, 1891-1901, 1902-1911; U.S. Treasury, USPHS, 1912-1930, for the years 1910 to 1930). A combination of factors—a general climate of Sinophobia supported by a wide spectrum of American society, associations of Asian immigrants with the debilitating diseases of trachoma and hookworm, and Asians' legal status as noncitizens—often translated into insensitive treatment on Angel Island. While detained in the barracks or hospital, many Chinese expressed their anger and sense of isolation by inscribing poems on the walls. In 1970, these traces of the past were discovered by a park ranger, and they have since been preserved. In one verse, an anonymous voice wrote, "I cannot bear to describe the harsh treatment by the doctors, Being stabbed for blood samples and examined for hookworms, was even more pitiful" (Lai, Lim, & Yung, 1980, p. 100).

THE TEXAS-MEXICO BORDER: LABORERS FROM A NEARBY LAND

Unlike Asians, who were subjected to the most exclusionary laws of any ethnic group from the late 19th to the mid-20th century, Mexicans—desired as laborers throughout the Southwest and in American cities and industries—were continually waived from the requirements of restrictive immigration laws. When the 1917 Immigration Act was passed, for example, growers and industrialists were able to convince President Wilson to exonerate Mexicans from the literacy test, head tax, and contract labor clause (Reisler, 1976). Nonetheless, a variety of intertwined factors—including high demands for Mexican labor until the Great Depression, the porosity of the 2,000-mile boundary line that divides the two countries, and the outbreak of the Mexican Revolution in 1910—turned the border into a region marked by tension and complex migratory patterns.

USPHS physicians were stationed at different points along the border as early as the 1890s; standardized procedures of medical inspection, however, were not put in force until the early 20th century. During this period—before arrivals were grouped into nonstatistical locals and statistical immigrants with the intent of settling in the United States—between 10,000 and 100,000 immigrants were inspected annually at ports extending along the Rio Grande from Brownsville to El Paso. Carried out both in buildings next to the international bridges that spanned from Mexico to America and in bustling train stations, these examinations included checking for trachoma, favus, tuberculosis, syphilis, evidence of smallpox vaccination, and on rare occasion, hookworm. Unlike New York Harbor, on the Texas-Mexico border, where immigrants arrived by foot, the quarantine inspection and the general clinical examination were collapsed into a continuous and often assaulting process of entry.

Until the 1910s, the lack of epidemics and a fluid border economy of peoples, industries, and culture allowed for a relatively lax inspection procedure and easy passage through the El Paso and Laredo stations. During this early period, in fact, immigration and public health officials were not primarily interested with Mexicans but with the Chinese, Syrians, and Greeks who were apparently avoiding Ellis Island and using the border as a back door into America.[5] Local oral histories of border residents and the records of the Immigration and Naturalization Service reveal that until the first decade of this century, Mexicans commonly came into the United States unquestioned; for this reason, Greeks and Syrians often sought to learn enough basic Spanish to enter America as *mexicanos*.[6]

As the 20th century progressed, however, and Mexicans began to settle in the United States—often making a temporary stay into permanent residence—the situation along the border began to shift. Partly for these demographic reasons and also because the USPHS was in a general phase of expansion, in 1910 a disinfection plant was built alongside the El Paso immigration station in order to bathe "every arrival from Mexico" with "soap and warm water" ("All immi-

grants," 1910, p. 9). Nonetheless, contagious diseases were few and far between, and U.S.-Mexican relations were relatively harmonious during this period. In 1910, for example, fewer than 1% of all immigrants were debarred for medical reasons; of 46,385 individuals inspected, only 328 were found to be suffering from a disease, mental defect, or condition that rendered them likely to become a "public charge" (U.S. Treasury, 1902-1911, for the fiscal year 1910, p. 163). The available annual reports from 1900 to 1930 reveal that, for Mexicans, these numbers remained consistently low; only rarely were Mexican immigrants diagnosed with diseases such as trachoma and favus, which were seen with much more regularity on the two coasts.

This situation changed drastically in 1917, however. After the Mexican Revolution erupted in 1911, USPHS and immigration officials became increasingly preoccupied with the openness of the border and the growing circulation of insurgents, refugees, and temporary laborers in the twin cities of El Paso–Juárez and Laredo–Nuevo Laredo. With news of a typhus epidemic in Mexico's interior beginning in 1915 and the discovery of several cases of the fever in El Paso in 1916, this concern became even more heightened and prompted the USPHS to send several high-ranking surgeons to the border to assess the threat of disease. In a climate of military tension, as General John J. Pershing futilely attempted to hunt down the revolutionary Pancho Villa in northern Mexico and after a spate of several deaths that took the life of El Paso's city physician, the USPHS decided in January 1917 that the moment for a full-scale quarantine had arrived. This unilateral decision on the part of U.S. officials did little to pacify or control augmenting tensions. On the morning the quarantine was put into effect, a group of 200 Mexican women, most likely working at domestics in homes of the El Paso Anglo elite, stormed the immigration bridge and station. Led by what one local paper called the "auburn-haired amazon," these protesters attacked the public health and immigration officials, declaring they would not be subjected to degrading medical inspections ("Auburn-Haired Amazon," 1917, p. 1).

The purpose of the quarantine, according to the USPHS physician in charge at the time, was to disinfect and delouse "all persons coming to El Paso from Mexico, considered as likely to be vermin infested" (Pierce, 1917, p. 427). Under the constant gaze of attendants, immigrants were stripped naked, showered with kerosene, examined for lice and nits, and vaccinated for smallpox if deemed necessary. At the end of this process, freshly sterilized clothing was returned to its owners who also received a USPHS certificate verifying that the bearer had "been deloused, bathed, vaccinated, clothing and baggage disinfected" (Pierce, 1917, p. 428). Several months after the quarantine had been in effect, officials reported that the threat of typhus had all but disappeared. Despite this fact, however, the border quarantine remained in effect until the late 1920s; a public health response to an apparently impending epidemic had been transformed into an extended quarantine along the Texas-Mexico border (Stern, 1999).

During the 1920s, disinfection plants were expanded and further outfitted at several Texas immigration stations. Delousing and fumigation were compulsory

for daily laborers and immigrants; Mexican workers who lived in Juárez or Nuevo Laredo and commuted to El Paso or Laredo to work each day had to undergo sterilization on a weekly basis (U.S. Immigration and Naturalization Service, 1994a). These requirements for entry into the United States were enforced both in the larger cities and in smaller towns with ports of entry, such as Terlingua, Roma, and Rio Grande City. In 1926, John W. Tappan, a local physician affiliated with the USPHS, published an article in the *Journal of the American Medical Association* that placed the quarantine in a national perspective. Justifying the ongoing disinfections on the basis of typhus outbreaks in the mid-1910s, Tappan wrote, "Conditions differ from those on the Canadian border. We have here to contend with an alien race: one with a different language, different customs, different moral standards and different diseases" (p. 1022). For their part, many Mexicans attempted to avoid passage through the border plants. In Laredo, the increasing number of Mexicans crossing into the United States at undesignated and illegal point of entry in order to evade delousing, vaccination, and other immigration requirements caused sufficient alarm for the USPHS to create a mounted quarantine guard. This service, which should be seen as a precursor to the Border Patrol, began monitoring the Rio Grande for "aliens" in 1921, and their daily journals record activities ranging from apprehension to vaccination.[7]

On the Texas-Mexico border, the discrepancies between the constant demand of Southwestern growers and industrialists for cheap labor and the mandate of the USPHS to protect the public health brought about a sui generis situation of protracted quarantine. Desired as laborers, Mexicans were only allowed to enter the United States after they had been cleansed and disinfected. This process, on one hand, was pivotal to the construction of the border as a solid boundary line between the two nations and, on the other, worked to associate Mexicans, especially from the working classes, with filth and disease. During the late 1920s, when eugenicists and legislators sought to severely restrict Mexican immigration to a quota, stereotypes of the louse-ridden Mexican peon were common. Although Mexicans were not numerically restricted nor denied rights of naturalization based on "race," within the racist climate of the Progressive Era and the 1920s, the inclusion of Mexicans and Mexican Americans within the body politic came at a high cost of humiliating disinfections, economic disenfranchisement, and frequently, the limits of de facto social segregation (see Gutiérrez, 1995).

THE THIRD COAST: PORT HURON AND DETROIT, MICHIGAN

The severity of the standardized quarantine along the Texas-Mexico border and the inspection procedures for immigrants coming through Ellis and Angel Islands is thrown into relief by examining the activities of the USPHS stationed

along the Canadian border at Detroit and Port Huron, Michigan. While more that a dozen officers rotated between Texas ports of entry, only a few physicians were stationed in Michigan. Overburdened with a demanding schedule of inspections at railway and ferry stations, until the 1920s USPHS officers along the "third coast" lacked many medical instruments, hospital facilities, and central headquarters. Although heavily trafficked, processing between 2,000 and 20,000 immigrants a year, the lack of activity at Detroit and Port Huron is striking.

The absence of activity at Michigan immigration stations can be explained by several factors (Stern & Markel, 1999). First, most immigrants arriving to Detroit and Port Huron had already undergone quarantine inspections when the transoceanic steamships they had boarded in Europe landed in cities along the eastern seaboard. Insulated by public health controls in cities such as New York, Boston, and Baltimore, Michigan was largely untouched by epidemics such as cholera, typhus, or plague. Second, an amicable relationship with Canadian immigration officials—which included an arrangement allowing USPHS officials to board trains and maintain stations in several provinces—obviated the kind of political strife that characterized U.S.-Mexican border relations. Finally, during an era of racial prejudices that deeply influenced medical inspections at Ellis Island, at Angel Island, and in Texas cities, the immigrants who passed through Michigan's gates were classified, in the words of the USPHS physician who worked at Port Huron for more than 20 years, as principally "the more desirable northern or western European" (*Annual Report. Medical Inspection. Aliens. Port Huron, Mich.*, 1928).

Working conditions at Michigan's immigration stations, however, were less than optimal. Both the Port Huron and Detroit stations lacked instruments such as microscopes, stethoscopes, and other laboratory materials until the 1920s. Nor did the USPHS establish detention areas, hospitals, or even a room for basic medical consultations during the Progressive Era. For these reasons, public health officers were required to travel long distances from train depots to ferry stations and, with the advent of the automobile, to the terminus of car tunnels to examine immigrants. A 1914 report by a surgeon who had been directed to Port Huron to take stock of immigration station, wrote to the surgeon general that "the physical facilities are poor, the officer being located in a small wooden building which has been condemned by the local health officer as unsanitary. It is poorly equipped. There is an unserviceable stethoscope and no microscope" (Williams, 1914).

Even at the largely neglected Michigan ports of entry, however, immigrants were excluded on the basis of medical criteria that drew directly from contemporary ethnic stereotypes. This was particularly true for the ambiguous diagnoses of feeblemindedness and poor physique. In the early 1920s, for example, after a young Jewish boy was certified as feebleminded, local public health authorities urged that he nevertheless be allowed to remain in the United States based on his ability "to take care of himself and manage money like others of his race" (Kilroy,

1921). Despite such pleas on the boy's behalf, however, the surgeon general, Hugh S. Cumming (1921), replied that the Immigration Act of 1917 mandated the deportation of the mentally defective, "not so much for the purpose of preventing the admission of alien paupers as it is for the protection of the race: the prevention of the propagation of feeble minded strains in our population." Beyond demonstrating the potential power of medical labels to deport immigrants, this incident also reflects the kinds of frictions between federal and local authorities that typified many immigration stations. Nonetheless, the inspection process at Port Huron and Detroit, Michigan—as with similar checkpoints along the Canadian border—was mainly one of an attentive guard on a quiet watch. Training and protocol dictated the same level of vigilance employed at other American ports and borders, but the fact remains that the enemy was nowhere near.

CONCLUSION

At the core of the many unsuccessful attempts to exclude immigrants for reasons of illness or disability are a series of interconnected questions: What were the categories of exclusion, and how were they employed? Who was eligible to become an American citizen? and literally, What face should the nation have? Although broad patterns of exclusion characterized the country during the Progressive Era, it is important to recognize how local and regional social, physical, and cultural forces shaped immigrant inspections and the construction of disease at America's ports and borders. In this brief article, we have shown that medical examinations differed according to variations in geography, commercial activity, demography, local-state-federal relations, and institutional capacities. Dominant national perceptions about specific immigrant groups—in terms of skin color, facial features, and associations with a particular illness or condition (whether real, exaggerated, or perceived)—were also significant factors. Finally, the outcome of medical diagnoses was also structured by immigrants' citizenship status, available social support mechanisms, level of education, and relationship to the labor market.

Perhaps the most compelling conclusion that may be drawn to the fluid nature of the exclusionary labels themselves. If one label failed to work in rejecting the most objectionable, a new one (albeit typically just as unsuccessful) was soon created, whether of contagion, mental disorder, chronic disability, or physique. Although some medical categories of exclusion were more popular in certain regions of the country, almost all were somehow tainted with the underlying idea that the immigrant group in question threatened the nation in a particular way.

The fluidity of medical labels is nowhere clearer than in terms of the way exclusionary language often worked in tandem with the demands of the labor market and capitalist enterprises. Eastern European Jews on the Atlantic

seaboard, for example, were seen as a threat both to the economic and public health of America. As early as 1893, one immigration official equated the propensity of eastern European Jews to form labor unions and espouse socialistic beliefs with disease and ruin (Schulteis, 1893, p. 25). Some 15 years later, the secretary of the Immigration Restriction League, Prescott Hall (1908), blamed the "poor physique of Hebrews" on their inability to find jobs in farming or other forms of "hard manual labor" and their inability "to succeed in the struggle for economic independence" (p. 50). This kind of logic correlated disease with subversion and emasculation and bolstered arguments for the debarment of Jews from the American body politic. Conversely, along the Texas-Mexico border where cheap labor was in constant demand, Mexicans—who for various reasons were less likely to be part of socialist or anarchist unions—might have been labeled as dirty and filthy, but their physique was rarely a cause for debarment. In 1910, for example, before the outbreak of the Mexican Revolution, USPHS authorities at El Paso stated that "the majority of applicants for admission are healthy Mexican laborers from the interior, who, as a rule, are of fair physique" (U.S. Treasury, 1902-1911, for the fiscal year 1910, p. 164). After the implementation of the quarantine, moreover, when Mexicans were increasingly associated with typhus and other ailments, their weakened bodily constitution was seen as an asset to agricultural toil. In the 1920s, many farmers and industrialists in favor of continued waivers on immigration laws for Mexicans began to assert that the "physical attributes" of the Mexican "allowed him to be a perfect stoop laborer. Because the Mexican was small in size, agile, and wiry, growers explained, his ability in the fruit, vegetable, sugar beet, and cotton fields far exceeded that of the white man" (quoted in Reisler, 1976, p. 138).

In an era in which differences in skin color and physical characteristics were becoming increasingly medicalized, it is not surprising that exclusionary labels of disease and disability became an essential aspect of repeated attempts to legislate immigration restriction. Although medical labels never became the predominant reason for debarring specific immigrant groups, their use helped to inspire more durable biological metaphors for describing the potential risks of open immigration to the physical, economic, and social health of the nation. Such metaphors only became more resilient as the language of eugenics gained ubiquity in medical and popular circles during the Progressive Era. Diseased newcomers, eugenicists effectively argued, not only jeopardized the present with their propensity toward contagion, poverty, and alien beliefs; their admission also endangered the future of American society. Long after the arrival of the neurasthenic Jew, the criminally minded Italian, the dirty and lousy Mexican, or the trachomatous or parasite-infested Asian to American ports and borders, their defective genes would multiply and contaminate the national body. Fears of a country beset with chronic diseases and disabilities was central to the economic, social, and cultural arguments articulated by nativists during the 1920s and helped ensure passage of the Immigration Restriction Acts of 1921, 1924, and

1928 that reduced the flow of immigrants from Europe and Asia to a mere trickle.

NOTES

1. Gender and marital/familial status also played an important role in determining an immigrant's experience at both the hands of the U.S. Public Health Service (USPHS) and the Immigration and Naturalization Service. For an excellent introduction to the history of immigrant women during the Progressive Era, see Gabaccia (1994). Also see Ewen (1985).

2. For a description of the conditions scrutinized by USPHS officers at immigration centers during this period, see *Book of Instructions for the Medical Inspection of Immigrants* (U.S. Treasury, USPHS, 1917); for a description of the work of the Immigration Restriction League to apply medical diagnoses to policies of immigration restriction, see their papers at the Houghton Library, Harvard University Rare Book and Manuscript Collection (Immigration Restriction League, n.d.); also see Solomon (1956).

3. The best social history of the San Francisco bubonic plague epidemic of 1900-1901 is McClain (1994); also see Risse (1992).

4. See U.S. Immigration and Naturalization Service (1994c), which detail procedures and tensions over trachoma examinations of Chinese and Japanese immigrants on the Pacific Coast.

5. In 1906, A. A. Seraphic was commissioned to carry out undercover investigations of Syrian immigration from Mexico into the United States and consistently associated Syrians with trachoma and other contagious diseases. See U.S Immigration and Naturalization Service (1994d).

6. For an incisive reconstruction of the voices of Mexican immigrants with respect to the solidification of the border, see Sánchez (1993, chap. 2).

7. USPHS records from Laredo contain numerous such journals. See *Copy of Reported of Mounted Guards Heston B. Martin and Alvis C. Taylor* (1923).

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