

“The Eyes Have It”: Trachoma, the Perception of Disease, the United States Public Health Service, and the American Jewish Immigration Experience, 1897–1924

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Introduction

On the morning of 23 September 1916, the Sicula-Americana steamship *San Guglielmo* made its way into New York Harbor after a storm-tossed, fifteen-day voyage from Naples. Among the many immigrants on board the vessel was a thirty-seven-year-old East European rabbi named Chaim Goldenbaum. He was completing a long journey of escape from the Pale of Settlement to America, by way of Turkey, Palestine, Egypt, and Italy.¹ Unlike most of the 298,825 immigrants who were streaming into the

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1. Ship's Manifest of the S.S. *San Guglielmo*, in *Passenger and Crew List of Vessels Arriving at New York, 1887–1942*, 19–25 September 1916, vols. 5785–87, microcopy T-715, reel 2490, National Archives Records Administration, Washington, D.C. (henceforth NARA).

United States that year, however, the rabbi was brought to an abrupt halt shortly after he was discovered to have trachoma, a contagious disease of the eye that, if untreated, leads to inflammation, scarring, and, for many victims, blindness. Rabbi Goldenbaum was one of approximately 920 immigrants coming to America in 1916 diagnosed with trachoma.

Between 1897 and 1925, the average annual number of trachoma cases diagnosed at American ports and borders was about 1,500—far less than 1 percent of the annual number of immigrants seeking entry during this period. Yet, for most Americans living during the Progressive Era, the newly arrived immigrant personified the threat of trachoma. Indeed, it was a topic widely discussed in best-selling books and popular magazines,² and even at school board meetings where local outbreaks of trachoma were often blamed on immigrant children and their families.³ More pragmatically, the U.S. Public Health Service (USPHS) burnished its reputation, domain, and resources as a federal agency that protected the nation against imported germs such as trachoma, far out of propor-

2. See, for example, Broughton Brandenburg, *Imported Americans: The Story of the Experiences of a Distinguished American and His Wife Studying the Immigration Question* (New York: Stokes, 1904), pp. 138–39, 166–70, 200–201, 216–17; Edward A. Steiner, *From Alien to Citizen* (New York: Revell, 1914), pp. 27–44; idem, *On the Trail of the Immigrant* (New York: Revell, 1906), pp. 64–77, 82–87; idem, *The Immigrant Tide: Its Ebb and Flow* (New York: Revell, 1909); Howard B. Grose, *The Incoming Millions* (New York: Revell, 1906), pp. 13, 46–49; Frank Julian Warne, *The Tide of Immigration* (New York: Appleton, 1916), p. 100; Arthur Henry, “Among the Immigrants,” *Scribner’s Mag.*, 1901, 29: 301–11; Allan McLaughlin, “Immigration and the Public Health,” *Pop. Sci. Monthly*, 1903, 64: 232–38; idem, “The Problem of Immigration,” *ibid.*, 1905, 65: 531–37; idem, “How Immigrants Are Inspected,” *ibid.*, pp. 357–61; Alfred C. Reed, “Immigration and the Public Health,” *ibid.*, 1913, 83: 320–38; idem, “Going Through Ellis Island,” *ibid.*, 1913, 82: 5–18.

3. “Health Specialists Find Children’s Eyes Diseased,” *New York Times*, 31 July 1902, p. 9, col. 6; “Emergency Hospital Treatment of Trachoma,” *ibid.*, 25 January 1903, part 3, p. 25, cols. 1–2; Robert DeCoursey Ward, “The Restriction of Immigration,” *North Amer. Rev.*, 1904, 179: 226–37; A. C. Bardes, “Trachoma,” *Med. Rec.*, 1904, 66: 1052–55; C. C. Bradley, “Trachoma in Children,” *ibid.*, 1906, 69: 176–78; H. W. Wooton, “The Treatment of Trachoma in School Children and the Clinical Features of the Disease,” *Monthly Bull. Dept. Health City New York*, 1911, 1: 79–81; S. J. Baker, “The Control of Trachoma in School Children,” *ibid.*, pp. 82–84; idem, *Fighting for Life* (New York: Macmillan, 1939); Department of Health of the City of New York, *Instructions to Parents Regarding Trachoma* (Pamphlet, 1911), Collections of the New York Academy of Medicine; idem, “Teachers Should Watch for Sore Eyes Among Pupils,” *School Health News*, 1918, 4 (5): 1–3, 6; idem, “The Sight Conservation and Eye Clinics for Children Maintained by the Bureau of Hygiene,” *ibid.*, 1922, 8 (10): 1–4; idem, “Observation of Immigrant School Children to Detect Typhus and Other Epidemic Diseases,” *ibid.*, 1921, 7 (3): 1; Luther H. Gullick and Leonard P. Ayers, *Medical Inspection of Schools* (New York: Russell Sage Foundation/Survey Associates, 1913), pp. 21–61.

tion to its other, more domestic, public health activities. Indeed, more than 80 percent of its financial and human resources during this period were devoted to medical inspections at the seaports and borders that marked the trail of the immigrant.⁴

The immigrant groups stigmatized by trachoma during the Progressive Era included Greeks, Syrians, Italians, Mediterraneans, and Asians; for example, between 1904 and 1909, more than a third of all Chinese and Japanese immigrants who were denied entry into the United States were excluded because of a diagnosis of trachoma.⁵ One immigrant group that was particularly affected by the threat of trachoma was East European Jews, who will be the focus of this essay. The association of East European Jewish immigrants and trachoma, however, was not a one-sided diagnosis imposed by native-born Americans upon ignorant newcomers: it quickly found its way into the popular discourse and psyches of prospective immigrants in the “old country,” as well as those who came to the “new world,” regardless of their ocular health. The East European Jewish American community—represented by immigrant aid societies, the Yiddish press, the Yiddish theater, social agencies, and many concerned individuals—spent considerable time and effort discussing trachoma’s epidemiologic characteristics, the medical inspection of immigrants, the politics of American immigration law, how to work with the local and federal public health officials in developing immigrant-friendly programs to recognize and prevent trachoma, and, most urgently, how to handle the social stigma that often results when a so-called “undesirable” social group becomes strongly associated with a particular contagious disease.⁶

And so we are confronted with an intriguing paradox to untangle, between the perception of the great threat of trachoma and the relatively small numerical reality of that threat as measured by the incidence of the disease diagnosed at our ports and borders. With each telling and retelling, of course, the story of trachoma and the American immigration experience has acquired the status of legend, making historical docu-

4. For allocation of financial and human resources by the USPHS during this period, see *Annual Reports of the Surgeon General of the Public Health and Marine Hospital Service of the United States, 1897–1924* (Washington, D.C.: Government Printing Office, 1897–1924).

5. Letter from Surgeon General Walter Wyman to Secretary of State Philander C. Knox, 15 December 1909, box 117, file 52495/49A, RG 85, NARA.

6. For a discussion of how marginalized groups use scientific language to refute biological substantiations of racism, see Nancy L. Stepan and Sander L. Gilman, “Appropriating the Idioms of Science: The Rejection of Scientific Racism,” in *The Bounds of Race: Perspectives on Hegemony and Resistance*, ed. Dominick LaCapra (Ithaca: Cornell University Press, 1991), pp. 72–103.

mentation of the disease more difficult than it might seem at first glance. Interviews with settled immigrants several decades after their passage range from horrific recollections of the dreaded eye examination to no clear memories at all.⁷ Some historians have characterized the inspection process for trachoma as a successful example of the efficient and scientifically based operations of the United States Public Health Service, while others have concluded that the medical inspections at Ellis Island and similar centers were a “marked failure.”⁸ There exists, I shall argue, much documentation to establish that neither end of this historical spectrum is entirely accurate. Moreover, despite the frequent mention of trachoma in the American immigration experience, no comprehensive historical analysis of the disease has been produced. The essential question to posit is: why did trachoma inspire such fear and strong responses from both native-born Americans and the immigrant communities? For native-born Americans, alarmed by both the numbers and the types of immigrants then seeking entry, the disease briefly came to represent the embodiment of germs that traveled. For those immigrating, trachoma permeated the experience at almost *every* point along the journey. It was widely recognized as a disease that was often distasteful in its appearance, difficult to treat, contagious, and a leading cause of acquired blindness. If discovered, it often meant the end of that journey.

In this essay I will describe and analyze the factors that transformed trachoma from a bit player on the national stage of infectious diseases and immigration into a central character. In order to approach the complex social and biological construction of trachoma, it is essential to look beyond the snapshot generated at Ellis Island and other American immigration reception centers. Indeed, we must explore how physicians and the American lay public understood trachoma as a disease and a judgment on one’s fitness to enter the United States. More important, we must explore how immigrants themselves understood the disease by means of tracing their specific migration patterns and medical examinations,

7. See, for example, David M. Brownstone, Irene M. Franck, and Douglass L. Brownstone, *Island of Hopes, Island of Tears* (New York: Rawson Wade, 1979); Interviews from the Ellis Island Oral History Project (New York: AKRF, 1985); Thomas M. Pitkin, *Keepers of the Gate: A History of Ellis Island* (New York: New York University Press, 1975); Harlan Unrau, *Ellis Island, Statue of Liberty National Monument, New York–New Jersey*, 3 vols. (Washington, D.C.: U.S. Department of the Interior/National Park Service, 1984), 2: 575–732.

8. Anne-Emanuelle Birn, “Six Seconds Per Eyelid: The Medical Inspection of Immigrants at Ellis Island, 1892–1914,” *Dynamis*, 1997, 17: 281–316, quotation on p. 316. See also Alan M. Kraut, *Silent Travelers: Germs, Genes, and the Immigrant Menace* (New York: Basic Books, 1994), pp. 50–77; Elizabeth Yew, “Medical Inspection of Immigrants at Ellis Island, 1891–1924,” *Bull. N.Y. Acad. Med.*, 1980, 56: 488–510.

and, for those like Rabbi Goldenbaum who were unfortunate enough actually to contract the eye infection, we must reconstruct the experience and cultural context of being an immigrant with trachoma during this era.⁹

How American Physicians Defined the Disease

One of the most frustrating aspects of the attempt to develop sound public health measures against the ingress of trachoma was that physicians had a rather sketchy understanding of the infection's etiology, especially when compared to other germ diseases prevalent during this era. Current understanding of the disease links it to a microorganism known as *Chlamydia trachomatis*, an obligate intracellular microbe with discrete cell walls similar to gram-negative bacteria. But because the microorganism is quite fastidious and particular in its growth pattern, it is extremely difficult to grow in artificial culture media; indeed, it was not until well into the 1950s that such study was possible—making matters of investigation extremely difficult for bacteriologists of the early twentieth century. What was clearly understood during this period, however, was that it was extremely contagious through touch and direct contact and was likely to spread in regions where the weather was hot and personal hygiene was poor.

One nosological feature of trachoma often considered to be a part of the social response associated with it was its highly visible nature: trachoma victims wore their stigma on the most prominent part of the face—the eyes. At first glance, one is tempted to construct an elegant thesis that, like the pox of variola or the lesions of leprosy—both highly visible symptoms—trachoma was almost biologically preordained to inspire fear among the medical inspectors and lay public alike. Such a hypothesis seems especially compelling when the public's reaction to trachoma is compared with less dramatic responses to other more common but not necessarily obvious infections, such as tuberculosis. There are a variety of disgusting signs and symptoms associated with trachoma, to be sure, but like many infectious diseases, it was understood by physicians of the early twentieth century to have several distinct stages and,

9. The experiences of Rabbi Goldenbaum are drawn from his case file in the Hebrew Immigrant Aid Society Collection, Ellis Island Bureau, 1905–23, microfilm reel MK10.8, YIVO Institute for Jewish Studies, New York, N.Y. (henceforth Goldenbaum File). Other immigrant experiences with trachoma were drawn from the YIVO-HIAS Collections, as well as the Immigration and Naturalization Service Special Boards of Inquiry Files housed at NARA.

depending on which stage the patient was experiencing, was not always easily recognizable by even the most experienced physician.

A short time after initial contact with the trachoma germ, perhaps five to twelve days, most trachoma patients develop a mild sensitivity to light (photophobia), tearing, and inflammation or redness of the inner eyelids (conjunctivae). Many of these early cases, about one-third, show relatively few signs of inflammation; in another third, the most severe, one finds the pus-exuding, granular, beefy-red eyelids that conjure up one of the most familiar clinical descriptions of trachoma. After this acute phase, which may last for days or weeks, the patient enters a more indolent phase where, as a result of chronic inflammation, granulation tissue develops—the so-called mixed phases of trachoma. Finally, after months or years without treatment, the inflammation sets in motion a destructive scarring and ulcerating mechanism—the cicatricial stage. When the ulceration involves the eyeball itself, or there is simply a closing over of the eye with a curtain of scar tissue, blindness develops in ten percent of all victims. Another factor affecting the ultimate damage to a trachoma patient's eyes is the number of times one is reinfected with the etiologic organism. In other patients, scar tissue supersedes the normal epithelial tissue of the conjunctiva and often invades deeper layers of tissues, but there is an arrest of further spread and different degrees of scarring are observed. But even with this clinical schematic, which was well understood by physicians of this era, one is wise to recall the protean nature of the disease. As the American ophthalmologist and textbook author Charles H. May noted in 1909, "trachoma does not always progress uninterruptedly, there are often intermissions and exacerbations."¹⁰

Indeed, private practitioners and federal government physicians often disagreed over individual patients detained for trachoma at Ellis Island and similar facilities. These medical debates reflect far more than the tension between the private and public spheres of medical practice: they also depict how much actual confusion existed among members of the medical profession over the diagnosis and treatment of trachoma during the late nineteenth and early twentieth centuries. Several prominent ophthalmologists, such as Charles May and Harry Freidenwald, asserted that patients were infectious to others only when the trachomatous follicles on the eyelids were "weeping" or secreting fluid. Moreover, these eye specialists held that patients with evidence of old scar tissue alone,

10. Charles H. May, *Manual of the Diseases of the Eye for Students and General Practitioners*, 6th ed. (New York: William Wood, 1909), pp. 97–100; quotation on p. 97. See also Louis A. Julianelle, *The Etiology of Trachoma* (New York: Commonwealth Fund, Oxford University Press, 1938).

without signs of inflammation or acute infection, should be considered cured.¹¹ Such an assertion was no mere esoteric point of the diagnostic process. The assessment of who was or who was not contagious to others was critical in regard to a particular immigrant's acceptance or rejection at American ports of entry. In fact, both of these issues—contagiousness and “cure”—were heatedly contested by USPHS medical officers, who insisted that as long as inflammatory granulations, including questionable areas of scar tissue, were present, the patient should be considered to be actively infectious and in jeopardy of a relapse.¹² And while the hearings of the special boards of inquiry that decided the fate of trachoma-certified immigrants often became quite protracted (heavily dependent on the financial and negotiating resources that an immigrant had at his or her disposal), the USPHS physicians who took a hard line on *all* cases of trachoma as being potentially contagious tended to prevail. Approximately nine out of every ten immigrants diagnosed with trachoma at American ports or borders were, in fact, returned to their port of origin.¹³ Ellis Island Commissioner William Williams put the matter even more bluntly in 1910: “It has been demonstrated (what, of course, we already knew) that when our surgeons say that a trachoma case is incurable, they know what they are talking about.”¹⁴

Largely as a result of the medical inspections that immigrants underwent at several points *before* leaving Europe, and the relatively quick passage time of most transatlantic steamers during this period (about seven to ten days), it was extremely rare for anyone suffering from recognizable mixed trachoma, cicatrization, or blindness to make it out of the European ports. This left only those with acute trachoma (often contracted en route), a phase that actually can mimic many other forms of conjunctivitis and eye irritation, or may be asymptomatic without careful examination of the eyelids. Conse-

11. Conference to Consider Medical Examination of Immigrants Convened by Oscar Straus, Secretary of Commerce and Labor, 8 February 1907, Records of the Immigration and Naturalization Service (INS), Subject Correspondence, 1906–32, file 51490/19, RG 85, NARA; Minutes of the National Jewish Immigration Committee, 13 March 1912, Collections of the American Jewish Historical Society, Waltham, Mass. (henceforth AJHS).

12. Special Board of Inquiry pertaining to Sara Kupferman, Case 98542/205, INS 60A/600 Collection, box 398, file 53370/143, RG 85, NARA.

13. Exact statistics from the Public Health and Immigration Services are difficult to come by because of the frequent change of categories from year to year, and the different numbers used for the same issue in the same reports; this figure was reached by surveying the *Annual Report of the Commissioner General of Immigration to the Secretary of Labor* (Washington, D.C.: Government Printing Office, 1900–1905).

14. William Williams to the Commissioner General of Immigration, 29 April 1910, Special Board of Inquiry pertaining to Ruth Selkridge, INS Collection 60A/600, box 76, file 2, RG 85, NARA.

quently, the definitive diagnosis of trachoma at Ellis Island and other American immigration reception centers was not always a simple matter; the disease could often be distinguished from milder eye conditions only with the help of the physician's best friend, "a tincture of time."

Despite trachoma's well-known association with immigrants, it was hardly an exclusively foreign visitor to American shores during this period: it was a common cause of blindness known to be especially endemic among poor whites living in the Appalachians, a social group whom the USPHS trachoma expert Dr. John McMullan distinguished from the "new immigrants" as "good and honest Anglo Saxon people of the mountains."¹⁵ In one 1911 survey of people living in the highland regions of Kentucky, more than 13 percent of those surveyed were victims of trachoma, and many were already partially or totally blind. The Native American population was also profoundly affected by the uncontrollable spread of trachoma—particularly those living on reservations, where 65 to 95 percent of the residents were found to be afflicted with some stage of the disease.¹⁶ Despite the fact that these groups made up the overwhelming majority of trachoma cases in the United States during this period and had little, if any, contact with immigrants, the broad consensus of American opinion that insinuated itself into official governmental policy characterized trachoma as the result of unrestricted immigration then coming from the impoverished sectors of Europe and Asia.

Trachoma began to be seriously discussed among public health workers, physicians, and others concerned with immigration issues as a potential problem in the mid-1890s, soon after the federal government assumed control of immigration from local and state governments. It is truly a contagious disease in that it is easily transmitted by touch; in other words, when someone infected with trachoma rubs his eyes (something most humans do many times a day) and then touches or shakes hands with another person, the infected person places the uninfected person at risk for contracting trachoma when the latter rubs his or her eyes.¹⁷ More-

15. John A. McMullan, "A Report on an Investigation of the Prevalence of Trachoma in the Mountains of Eastern Kentucky," *Pub. Health Rep.*, 1912, 27: 1815–22; quotation on p. 1818.

16. For studies of the trachoma problem among American Indians, see William H. Harrison, *Trachoma: Its Cause, Prevention and Treatment* (Washington, D.C.: Government Printing Office, 1915); J. W. Schereschewsky, "Trachoma among the Indians," *JAMA*, 1913, 61 (1): 1113–16; "Trachoma in Certain Indian Schools," Senate Rep. 1025, 60th Cong., 2d sess., 18 February 1909; Joseph J. Kindred, *Trachoma: A Dangerous Contagious Prevalent Preventable Disease of the Eye*, House Doc. 1405, 62d Cong., 3d sess., 1913. Native Americans living in Oklahoma, Wyoming, Nebraska, Utah, Arizona, and New Mexico suffered the highest rates of trachoma.

17. For a discussion of the concepts of infection and contagion, see Owsei Temkin, "An Historical Analysis of the Concept of Infection," in idem, *The Double Face of Janus and Other*

over, trachoma was a disease of the poor insofar as it luxuriated under conditions of poor hygiene and lack of running water. Such an easy mode of transmission was of particular concern to those charged with the medical inspection of immigrants, given the major means of transportation of the day: steerage steamships, crowded from stem to stern with poor immigrants originating from areas where trachoma was known to be a problem. If one immigrant infected with trachoma was mistakenly allowed to travel in the crowded steerage section of a steamship, that person, without adequate sanitary measures, provided a real health risk to the other immigrants in the same compartment.

The pervasive role this disease played in the American immigration experience officially began in 1897 when the supervising surgeon general of the U.S. Marine Hospital Service, Walter S. Wyman, designated trachoma as a “dangerous, contagious disease” that was “seldom seen except among recent immigrants from the eastern end of the Mediterranean, Polish and Russian Jews, Armenians and others from that locality.”¹⁸ Asked in October 1897 by the acting commissioner-general of immigration, Frank H. Larned, to render his medical opinion, Wyman concluded that a diagnosis of trachoma in an immigrant seeking entry to the United States demanded immediate return to the port of origin.

As a result of the surgeon general’s 1897 circular and the national immigration acts that followed in the first decade of the twentieth century, an elaborate and effective international system of medical surveillance of transmigrants was developed, particularly with respect to trachoma and a handful of other contagious diseases—from the deadly cholera to the chronic and annoying favus, ringworm, and other fungal infestations that mandated deportation.¹⁹ Perhaps the most essential aspect of the medical inspection process, however, was that it began long before the immigrant sailed into New York Harbor or any other American

Essays in the History of Medicine (Baltimore: Johns Hopkins University Press, 1977), pp. 456–71. See also Nancy Tomes, *The Gospel of Germs: Men, Women and the Microbe in American Life* (Cambridge: Harvard University Press, 1998).

18. Letter from Dr. Walter S. Wyman to Frank H. Larned, Acting Commissioner-General of Immigration, 30 October 1897, in *Copies of Letters Sent by the Office of the Surgeon General, 1872–1918*, vol. 137, 13 October–10 November 1897, pp. 303–4, RG 90, National Archives, College Park, Md. See also Myles Standish, “Contagious Conjunctivitis,” *Boston Med. Surg. J.*, 5 August 1897, 137 (6): 129–31. Standish, a descendant of the Mayflower immigrant bearing the same name, was a Boston ophthalmologist and provided the expert testimony upon which Wyman based his trachoma circular of 1897.

19. Regulations pertaining to the inspection for and handling of immigrants with trachoma became especially more rigid and standardized with the passage of the Immigration Act of 1907, which specified that the Public Health Service must certify all immigrants with mental and/or physical defects “which may affect the ability of such an alien to earn a

port. Implemented at several points along the immigration pathways, health regulations prohibited the travel of those infected with trachoma and assessed stiff economic fines against steamship companies found to be in violation of the law. The potential implementation of additional restriction laws also posed a threat to steamship profits in that it would reduce immigrant traffic.

Between 1898 and 1905, all immigrants with watery, red, or inflamed eyes were examined at American immigration reception centers along both seacoasts. Beginning in 1905, at the urging of several prominent immigration restrictionists, physicians, public officials, and, ultimately, congressional legislation, *all* immigrants seeking entry into the United States were examined for trachoma. And while it is difficult to measure the effect of the more stringent inspection regulations, it must be recalled that the influx of trachoma in the persons of immigrants was a mere trickle during this period (see Table 1).²⁰

The perception of trachoma as a disease of foreigners was articulated by a number of USPHS physicians, including Dr. Taliaferro Clark—who is best remembered today for his role in planning what ultimately became the Tuskegee Syphilis Study.²¹ Attributing the nation's trachoma problem to "undesirable" Russian and Polish Jews, southern Italians, and other "new immigrants," Dr. Clark warned that the "unrestricted importation of trachoma is fraught with grave dangers."²² In a manner that the historian is tempted to label as self-serving, Clark cautioned against the huge social and financial costs that would be incurred by minimizing our nation's elaborate public health defenses at her ports and borders, as suggested by proimmigration advocates. Not only did trachoma often render the

living" (*Act to Regulate the Immigration of Aliens into the United States* [59th Congress, Second Session], 20 February 1907, Chap. 1134, 34 Stat. 898. *U.S. Statutes at Large* 34 [1907]: 898–911). See also Edward P. Hutchison, *Legislative History of American Immigration Policy, 1798–1965* (Philadelphia: University of Pennsylvania Press, 1981), pp. 85–196; United States Immigration Commission, Reports of the U.S. Immigration Commission, *Emigration Conditions in Europe*, Senate Doc. 748, 61st Cong., 3d sess., 1911.

20. These numbers were arrived at by reviewing the data of immigrants debarred for trachoma as compiled by the USPHS, 1897–1924. There are problems and holes in these data. For a synthesis of the statistics of immigration and health in the United States during the great wave of immigration, see Amy L. Fairchild, "Science at the Borders: Immigrant Medical Inspection in Defense of the Nation, 1891–1930" (Ph.D. diss., Columbia University, 1997).

21. James H. Jones, *Bad Blood: The Tuskegee Syphilis Experiment*, rev. ed. (New York: Free Press, 1993), pp. 54, 113–32.

22. T. Clark and J. W. Schereschewsky, *Trachoma: Its Character and Effects*, prepared by the direction of the Surgeon General (Washington, D.C.: Government Printing Office, 1914), p. 12.

Table 1. Summary of the medical inspection of immigrants for trachoma at all ports and borders of the United States, 1897–1924

Year	Immigrants debarred for trachoma ^a	Immigrants debarred for dangerous or loathsome, conta- gious diseases	Total debarred (all reasons)	Total number of immigrants examined for physical/mental defects
1897	1	1	1,617	232,147
1898	206	258	3,030	242,365
1899	300	348	3,798	297,862
1900	275	393	4,246	78,218
1901	265	309	3,516	427,111
1902	567	709	4,974	694,624
1903	107	1,773	8,769	857,046
1904	961	1,560	7,994	824,415
1905	987	2,198	11,879	892,843
1906	1,600	2,273	12,432	1,175,000
1907	2,832	3,822	13,064	1,285,349
1908	1,993	2,900	10,902	935,597
1909	2,586	2,800	10,411	966,124
1910	3,220	3,937	24,270	1,280,957
1911	2,504	3,614	22,349	1,093,809
1912	1,906	3,834	16,057	1,143,234
1913	2,704	5,397	19,938	1,574,371
1914	3,051	5,618	33,041	1,485,957
1915	1,842	3,137	24,111	562,263
1916	920	2,593	18,867	481,270
1917	1,116	3,799	16,028	528,648
1918	1,319	3,556	7,297	278,736
1919	1,166	5,057	8,626	339,375
1920	1,028	5,216	11,795	762,217
1921	1,331	7,165	14,522	1,137,682
1922	425	1,243	13,731	551,454
1923	669	1,710	20,619	745,515
1924	154	2,372	30,284	874,962

Source: United States Treasury Department, *Annual Report of the Surgeon General of the Marine Hospital Service and the Public Health Service of the United States* (Washington, D.C.: Government Printing Office, 1897–1924); and *Annual Reports of the Commissioner General of Immigration* (Washington, D.C.: Government Printing Office, 1897–1924).

^aFrom 1897 to 1902, complete trachoma data were not recorded by the USMHS and USPHS. The incidence of trachoma cases for these years, therefore, is estimated at 80 percent of the cases classified as dangerous or loathsome contagious disease.

immigrant blind and a burden to society, the immigrant's germs, which were rather egalitarian in their mode of attack, had potential to spread the disease to native-born Americans, leaving more havoc in their wake.

Clark was not the only federal official charged with the inspection of immigrants who mixed his professional opinions with nativist sentiments. For example, Dr. John McMullan, who was stationed at Baltimore's Locust Point Immigration Center from 1911 to 1913, advocated a strict policy against the importation of trachoma in 1913:

Deportation is unquestionably a hardship, and so is isolation in smallpox, but who would say that the latter should mingle with others because of the dread of the pest house? One had better have smallpox than severe trachoma. . . . [changes in the immigration laws] would mean the addition to our population of these thousands of trachomatous aliens whose emigration to this country is now prohibited.²³

Equally bilious was the chief medical inspector of the Boston Quarantine Station, Dr. Victor Safford, an articulate critic of unrestricted immigration.²⁴ From 1904 to 1913, Safford was the resident trachoma expert at the Boston Quarantine Station and was often called up and down the Atlantic seaboard to confirm or deny a difficult diagnosis. He frequently complained about the unacceptable quality of immigrants seeking entry to the United States in his official correspondence and writings. For example, in a letter of 21 January 1905 to his commanding officer, Safford described a typical boatload of East European Jewish immigrants he was called upon to examine: "a minority of the steerage passengers were a clean, healthy lot of people, but the majority were as miserable and filthy a crowd as can be collected from Eastern Europe and Western Asia."²⁵

23. John McMullan, "Trachoma: Its Prevalence and Control among Immigrants," *J. Am. Med. Assoc.*, 1913, 1: 1110–13; quotation on p. 113. Interestingly, the running title for this article was "Keep Trachoma Out."

24. Victor Safford, *Immigration Problems: Personal Experiences of an Official* (New York: Dodd, Mead, 1925). Safford was also a volunteer medical consultant for the Immigration Restriction League, which actively agitated for more stringent medical regulations of immigrant exclusion in the first decades of the twentieth century; Barbara M. Solomon, *Ancestors and Immigrants: A Changing New England Tradition* (Cambridge: Harvard University, 1956).

25. V. Safford to Surgeon R. M. Woodward, Boston Immigration Station, 21 January 1905, Papers of the Boston Immigration Station, 1897–1924, file 409, box 58, RG 90, NARA, College Park, Md.

The Journey out of the Pale

By 1897, approximately 4,900,000 Jews lived in the Pale of Settlement, a collection of twenty-five Russian and Polish provinces. This population comprised more than 94 percent of all Jews living in the Russian Empire during this period. Beginning with the infamous May edict of 1881 and subsequent czarist anti-Semitic persecutions, hundreds of thousands of Jews emigrated each year—mostly bound for the *Goldene Medene* (the Golden Land) of America, and in smaller numbers for Palestine, Argentina, Canada, and other parts of Europe. After the barbaric Kishinev pogrom in 1903 and its successors over the next few years—not to mention famine, epidemics, revolution, and war—the Jewish exodus from Russia only increased in magnitude.²⁶

It is also important to note that the Pale of Settlement had long been recognized by medical experts to have a high incidence of trachoma, particularly among Russian peasants, Jews, and soldiers. For example, in Lodz and Kiev, two major urban centers in the Pale heavily populated by Jews, approximately 100 to 250 per thousand patients with eye diseases had trachoma. In other regions of the Pale, approximately 100 to 150 per thousand patients with eye diseases suffered from trachoma (see Table 2).²⁷ One anecdotal account by a Long Island physician named Allen S. Busby estimated that one-half of all the cases of blindness in Poland were caused by trachoma.²⁸ And while exact estimates of the incidence of trachoma are difficult to come by, it is safe to state that in this particular environment of poverty, overcrowding, and poor personal hygiene, such a public health crisis was hardly surprising. From time to time, especially during the first decade of the twentieth century, Russian medical journals and newspapers tried to scapegoat the Jews as the source of trachoma. Such stigmatization was not lost on Russian Jewish physicians, who had a great deal of experience in treating and diagnosing the disease. Their arguments are an excellent example of how each side of the debate, often using the same inadequate data, arrived at markedly different conclusions. For example, the *Evtetskii Medtinskii Golos* (*Jewish Medical*

26. Irving Howe, *World of Our Fathers: The Journey of the East European Jews to America, and the Life They Found and Made* (New York: Harcourt, Brace, Jovanovich, 1976), p. 5. See also Howard Markel, *Quarantine! East European Jewish Immigrants and the New York City Epidemics of 1892* (Baltimore: Johns Hopkins University Press, 1997), pp. 16–21.

27. Julius Boldt, *Trachoma*, trans. J. Herbert Parsons and Thomas Snowball (London: Hodder and Stoughton, 1904), pp. 42–43, 50; G. E. de Schweinitz, “Trachoma and Common Forms of Conjunctivitis,” in *Military Ophthalmic Surgery*, ed. Allen Greenwood (Philadelphia: Lea and Febiger, 1918), p. 64.

28. Allen S. Busby, “Trachoma,” *Long Island Med. J.*, 1907, 1 (8): 373–75.

Table 2. Cases of trachoma per thousand of all eye patients in the Pale of Settlement and the Russian Empire, ca. 1900

Cities/Regions	Cases of trachoma (per thousand)
Moscow	24–40
Rostow	60
St. Petersburg	96
Helsingfors	102
Saratow	114
Lodz	116
Libau	121
Warsaw	124
Reval	146
Dorpat	180–350
Riga	200
Kasan	180–220
Kiev	250
Bessarabia	250
Bohemia	40
East Silesia	40
West Silesia	< 10
West Galicia	110
East Galicia	> 110

Source: Adapted from Julius Boldt, *Trachoma*, trans. J. Herbert Parsons and Thomas Snowball (London: Hodder and Stoughton, 1904), pp. 42–46.

Voice) solicited the opinions of the world's leading eye specialists in 1908 in order to refute the scientific and medical fallacy of these claims.²⁹ One of the most pointed commentaries flowed from the pen of Kiev ophthalmologist Max Mandlestamm:

As always, Jews are serving as scapegoats for somebody else's faults. . . . we are alerted to the fact that during the early decades of mass Jewish immigration . . . from the places where trachoma was endemic, Jews had no problems entering the United States. We also have no scientific evidence supporting that after this first wave of immigration, if trachoma became a more significant problem

29. See Max Mandlestamm, "Trachoma and Emigration to America," *Jewish Medical Voice* (Odessa), 1908, 2–3: 90–96; G. M. Rabinovich, "Emigrants and Trachoma," *ibid.*, pp. 97–105; L. M. Rosenfeld, "Trachoma and Jewish Emigration," *ibid.*, pp. 106–17; "Questionnaire about Trachoma, Favus, and Herpes Tonsurans," *ibid.*, pp. 119–23. I am indebted to Dr. Lisa Epstein of the YIVO Institute for Jewish Studies for pointing these articles out to me, and to Natasha Rekhter of the University of Michigan for translating them from Russian into English.

in the United States. Neither have we any information that in New York City, where the Jewish population consists of 900,000 people, there were any trachoma epidemics. These facts make us question the origin of the current American government policy.³⁰

Pseudo-scientific claims that trachoma was a uniquely Jewish-borne disease were also refuted by prominent non-Jewish medical experts, such as the German ophthalmologist Julius Boldt, who asserted in his well-known 1904 textbook *Trachoma* that while no district in Russia was entirely free of trachoma, the disease was not dependent on nationality or race: “all nationalities and races acquire it if the opportunity presents itself. The Jews who are so severely affected in Galicia suffer extremely rarely in Hungary where civilization (and sanitary standards) is much more advanced.”³¹

The American Jewish community of the early twentieth century was extremely well organized in its relief efforts for the fleeing East European Jews. However, while anxious to help their co-religionists escape from the Pale, American Jews were at the same time fearful of appearing “soft” to their fellow Americans on the entry of diseased immigrants. Their approach, then, was to contribute funds and medical consultants to improve the quality of medical inspections of Jews leaving Russia, and to communicate frequently with those emigrants by way of publications and traveling agents to make sure that they understood the immigration regulations *before* leaving their homes. For example, the National Jewish Immigration Committee, which consisted of concerned Jewish lawyers, physicians, social activists, and journalists, worked assiduously to assist Jews out of Eastern Europe, to help those who did arrive in the United States to assimilate into American society, and to lobby government officials on the vital importance of facilitating this mass exodus. As early as 1912, the Committee held a series of meetings devoted to the topics of the medical inspection process on both sides of the Atlantic Ocean, the association of trachoma with East European Jews, the incidence of trachoma, treatment options, cure rates, and what messages to send their coreligionists in Eastern Europe that were both “direct and positive.”³²

Similarly, the American Jewish Committee, the Jewish Publication Society, and the Immigration Publication Society developed numerous pamphlets and circulars in Yiddish, as well as several other languages,

30. Mandelstamm, “Trachoma and Emigration to America” (n. 29), p. 90.

31. Boldt, *Trachoma* (n. 27), p. 50; see also pp. 42–43.

32. Minutes of the National Jewish Immigration Committee, 1 December 1912, AJHS. The Committee met regularly throughout the first three decades of the twentieth century in active support of these and similar causes.

explaining the medical examination process on both sides of the Atlantic Ocean and the futility of trying to “fool” the immigration officials.³³ Perhaps best known was an immigrant handbook that went through several printings and translations during this period entitled *What Every Emigrant Should Know*. The booklet was widely distributed in *shtetls* (villages) and towns across the Pale under the auspices of the United States–based National Council of Jewish Women. Welcoming the able-bodied, hard-working immigrant, the booklet’s author, Cecilia Razovsky, warned against the insane, the poor, the criminal, the ill, and especially the trachomatous, making the journey: “Before you decide to leave your own country and begin a new life in a strange land, Think Hard! Consider Long! Decide Slowly! . . . Be sure to be free of trachoma, because America will not let [the immigrant] enter if he shows a trace of it.”³⁴

There were also pictorial explanations of trachoma and the medical inspection, such as a vivid 1923 poster produced by the Fund for the Relief of Jewish Victims of the War in Eastern Europe and the London-based Federation of Ukrainian Jews (Fig. 1). This broadsheet provided information in exquisite pictorial detail on the many ways one could contract trachoma—ranging from communal use of a hand towel to close physical contact with someone who had the disease—and its myriad physical manifestations, in order to both prevent the spread of the disease and discourage those who did have it from attempting to emigrate.³⁵ Exactly what these American- or English-based organizations expected East European Jews to do, in terms of diagnosis or treatment for trachoma, is unclear. Indeed, there existed relatively few effective means of treatment for these unfortunate people that would ameliorate the disease and make them eligible to emigrate to the United States. Perhaps the only implicit message of action being delivered to potential immigrants was that if you *were* suffering from trachoma, you should *not* come to America.

In late 1913, when Rabbi Goldenbaum, his wife, and four children decided to leave their impoverished *shtetl*, there were several common pathways out of the Russian Pale, but these can be briefly summarized by

33. The American Jewish Committee also met regularly to discuss immigration issues, and their proceedings during this period have been formally preserved in the *American Jewish Yearbook* for the years 1900–1924 (Philadelphia: Jewish Publication Society, 1900–1924). See also Henry Cohen, “The Immigration Publication Society,” *Jewish Charities*, 1915, offprint in AJHS.

34. Cecilia Razovsky, *What Every Emigrant Should Know: A Simple Pamphlet for the Guidance and Benefit of Prospective Immigrants to the United States*, Yiddish and English editions (New York: National Council of Jewish Women, Department of Immigrant Aid, 1922), pp. 1, 18.

35. I am indebted to Jeffery Sharlett of the National Yiddish Book Center for pointing out this fascinating artifact of trachoma and East European Jewry to me.

two major routes: across the border to Germany or Austria-Hungary, and then leaving Europe at one of the northern seaports such as Hamburg, Antwerp, Le Havre, Rotterdam, or Liverpool; or south through Odessa and the Mediterranean. At many points along these immigration paths, particularly along the Russian border and at the large ports of embarkation, the steamship companies operated a chain of emigrant medical inspection centers, staffed by their own physicians but often working in concert with local authorities. The Goldenbaums, unlike most of their fellow emigrants who left through northern Europe for America, were bound for a new settlement in Palestine in an area that ultimately became Tel Aviv. They traveled by foot, carrying their possessions in a small cart, through the Pale, southward to the port of Odessa; after a brief stay in a cheap lodging house, they sailed to Constantinople and then traveled by foot and rail through what is today Turkey and Lebanon to the Jewish settlement in Palestine still called Ahuzzat Bayit. Along the way, each of them underwent at least three medical examinations (at the Russian border, at the port of Odessa, and again in Constantinople) and all were given clean bills of health. Such was not the case for about 2 to 5 percent of the Russian Jews attempting to emigrate out of the Pale during this era; most of these medical rejections, about 85 percent, were for diagnoses of trachoma or eye problems resembling it.³⁶

As noted, most Russian Jews living in the Pale had woefully inadequate access to medical care of any kind, let alone consultation with a physician well versed in diseases of the eye.³⁷ Indeed, for most of these impoverished Jews, eye care meant an occasional visit by an itinerant oculist who traveled from *shtetl* to *shtetl* fitting those in need with eyeglasses. Consequently, trachoma examinations mandated by the immigration regulations were often the first time most of these people had their eyes scrutinized by a physician for any reason, and many were shocked and frightened by the abrupt and “rigid” inspections.³⁸

The examination for trachoma entailed everting (flipping up) the eyelid, visually inspecting it, and, if necessary, running one’s finger across the inner surface of the eyelid to check for the tell-tale granulations (inflammatory tissue). There are a variety of ways a physician might evert

36. United States Immigration Commission, Reports of the Immigration Commission, *Emigration Conditions in Europe* (n. 19), pp. 93–124.

37. Lisa R. Epstein, “Caring for the Soul’s House: The Jews of Russia and Health Care, 1860–1914” (Ph.D. diss., Yale University, 1995); Nancy M. Frieden, *Russian Physicians in an Era of Reform and Revolution, 1856–1905* (Princeton: Princeton University Press, 1981); Susan G. Solomon and John F. Hutchinson, eds., *Health and Society in Revolutionary Russia* (Bloomington: Indiana University Press, 1990).

38. Rosenfeld, “Trachoma and Jewish Emigration” (n. 29), pp. 2–3.

the eyelids: a dexterous use of the thumb and forefingers, a flat, thin piece of metal such as a buttonhook (then used to lace up shoes), or specially designed eyelid-everting forceps, which were widely available from American and European surgical supply houses during this period. On both sides of the Atlantic, examining physicians used all three of these techniques, depending largely on personal preference.³⁹ The examination was a short one because it was based on visual and tactile inspection, maneuvers that can be easily accomplished in a matter of seconds. More pragmatically, physicians examining the eyes of patients—regardless of their age—rarely had more than a few seconds before patients simply shut their eyes and refused further manipulation. Moreover, the average control-station physician performed hundreds of these examinations per day on the seemingly endless line of those who wanted to leave Europe and Asia.

For a critical assessment of the medical inspection of emigrants in Europe in the early twentieth century, one would do well to look to the experiences of the Jewish physician and medical author Maurice Fishberg, who was sent by the U.S. Immigration Bureau in 1905 to assess the trachoma problem among emigrants. Traveling to the farthest reaches of the Russian border and along both the southern and northern routes of migration, Dr. Fishberg observed thousands of Jewish emigrants flooding out of the Pale. Two of the largest emigrant ports he inspected that fall were Hamburg and Bremen.⁴⁰ German law prohibited East European emigrants from stopping over in any city of the Empire as a result of the cholera epidemic of 1892, which was largely blamed on migrating Russian Jews.⁴¹ Such regulations, of course, threatened the German steamship

39. Examination techniques are summarized in May, *Manual* (n. 10), pp. 97–100; Casey A. Wood, ed., *The American Encyclopedia and Dictionary of Ophthalmology*, vol. 17 (Chicago: Cleveland Press, 1913–21), pp. 12878–944; U.S. Treasury Department, *Book of Instructions for the Medical Inspection of Immigrants* (Washington, D.C.: Government Printing Office, 1903); U.S. Treasury Department, U.S. Public Health Service, *Regulations Governing the Medical Inspection of Aliens, August 1917*, Miscellaneous Publication no. 5 (Washington, D.C.: Government Printing Office, 1917). For the types of instruments used to evert the eyelids (other than the fingers and a buttonhook), see Charles Truax, *The Mechanics of Surgery Comprising Detailed Descriptions, Illustrations, and Lists of the Instruments, Appliances and Furniture Necessary in Modern Surgical Art* (Chicago: Hammond Press, 1899), Collections of the Historical Center for the Health Sciences, University of Michigan Medical School, Ann Arbor, Mich.

40. Maurice Fishberg, “Report to the Commissioner-General of Immigration, Frank P. Sargent,” in *Annual Report of the Commissioner-General of Immigration to the Secretary of Commerce and Labor for 1905* (Washington, D.C.: Government Printing Office, 1905), pp. 50–56.

41. For a description of the American responses to the 1892 cholera epidemic, see Markel, *Quarantine!* (n. 26). For a magisterial description of the 1892 epidemic in Germany

companies with great economic loss, since the East European migrants not admitted to Germany would flock to other ports for passage to America; the companies therefore circumvented the sanitary regulations by perfecting methods of isolating the majority (and the poorest) of the emigrants at “control stations” along the German borders. As soon as a Russian emigrant traveling by third- or fourth-class railway ticket—or, for those even poorer, on foot—crossed the border, he was, for all intents and purposes, placed under arrest by a gendarme and kept in custody or close observation until he embarked on the steamship bound for the country of his destination.

In his 1905 report, Fishberg described how emigrants hoping to leave through Hamburg or Bremen via a steerage steamship ticket were stripped, chemically disinfected, bathed, and, while still naked to make sure no condition was hidden, inspected by physicians. Emigrants discovered to have trachoma or favus were ordered to return to their native land; if necessary, a gendarme forcibly escorted the ill immigrant back to the border. While Fishberg pointed out several flaws and occasional acts of deception in the inspection process at the major European ports of immigrant traffic, his overall conclusion was that the inspection of immigrants at “control stations” along the Russo-German and Austro-Hungarian borders, and again before they left Europe, were, by and large, a success from a sanitary standpoint.⁴²

Mary Antin, the well-known writer and herself an immigrant to Boston by way of Hamburg in 1894, had a very different perspective on the German immigrant inspection process:

Our mysterious ride came to an end on the outskirts of the city, where we were once more lined up, cross questioned, disinfected, labeled, and pigeonholed. . . . This last place of detention turned out to be a prison. “Quarantine” they called it . . . two weeks within high brick walls, several hundred of us herded in half a dozen compartments—numbered—sleeping in rows, like sick people in a hospital; with roll-call morning and night, and short rations three times a day; with never a sign of the free world beyond our barred windows; with anxiety and longing and the sickness in our hearts, and in our ears the unfamiliar voice of the invisible ocean, which drew and repelled us at the same time. The fortnight in quarantine was not an episode; it was an epoch, divisible into eras, periods, events.⁴³

and throughout Europe, see Richard J. Evans, *Death in Hamburg: Society and Politics in the Cholera Years, 1830–1910* (Oxford: Clarendon Press, 1987).

42. Fishberg, “Report” (n. 40), pp. 52–53.

43. Mary Antin, *The Promised Land* (Boston: Houghton, Mifflin, 1912), p. 177.

Other contemporary descriptions of the medical inspection process were also less than complimentary. For example, Dr. Benjamin Croft, a physician in Springfield, Massachusetts, was so astounded by the stories he was hearing from his trachoma patients inspected at the Russo-German border that he was compelled to write about it for the *Boston Medical and Surgical Journal* in 1906:

The waiting emigrants were arranged in lines and made to pass a physician who examined eyes by everting the lids. My patient declares that the man in front of him was rejected because of sore eyes, and that his own and his companion's, who was next in line, were examined with the soiled fingers of the physician and that the latter was not provided with any means of cleansing his hands.⁴⁴

There existed a markedly different standard of care, however, for those with financial resources. One practice that American immigration and public health officials often complained about was “the second-class scam”: only those traveling in third or fourth class were subjected to disinfections and rigorous medical inspections, while those traveling in first or second class were afforded a much more cursory inspection experience, with the implicit message that only the poor harbored disease. As a result of these inspection protocols, all who could afford the price of a second-class ticket, did so.⁴⁵

In larger seaports, from Hamburg to Odessa and beyond, there were travelers' aids, legitimate eye specialists, and, in larger numbers, a host of outright quacks and charlatans called “runners” who preyed upon the anxious immigrants. The Yiddish press frequently derided those who specialized in matters of the eye as “*trachoma shleppern*”; they promised frightened victims false hopes of rapid cure or, at least, assistance in cosmetic attempts to “fool” the medical inspectors when reexamined.⁴⁶ In more cases than not, all but the wealthiest could afford no more than a few weeks to months of the quack treatments offered by the *shleppern*,

44. Benjamin P. Croft, “Trachoma,” *Boston Med. Surg. J.*, 1906, 155: 305–7; quotation on p. 306. Other contemporary accounts that cast suspicion both on the medical inspection process and on the validity of the diagnoses themselves appear in A. L. Benedict, “Trachoma and Immigration,” *New York Med. J.*, 1903, 78: 373–74; Ellice Alger, “The Epidemic of So-Called Trachoma,” *ibid.*, 1904, 80: 684–87; Howard F. Hansell, “Trachoma, Clinically and Socially Considered,” *ibid.*, 1907, 85: 486–88.

45. Fishberg, “Report” (n. 40), p. 54.

46. *Ibid.*, p. 56; Steiner, *From Alien to Citizen* (n. 2), p. 31; *Der Tog* (*The New York Yiddish Day*), 14 December 1908, p. 2. The term *shlepp* literally means “to drag,” but it was used in this case for “runner,” referring to those who promised to “run” immigrants across the border without hindrance from the immigration authorities.

not to mention the exorbitant rates charged for room and board in the port cities, before their money ran out. Given the resistance of trachoma to the treatments then available and the efficient medical inspections required before embarking on a ship for America, it is safe to assume that most of those diagnosed with trachoma at European control stations or ports were ultimately returned to their difficult lives in the Pale.

As a result of these inspections, one not infrequent tragedy was the separation of families just before embarkation because one member was discovered to have trachoma. Since most emigrants purchased their steamship tickets well in advance of their actual departure, a nonrefundable expenditure that represented a life's savings for most of them, it was not economically feasible for the entire family to return to the Pale and, as a result, the family member with trachoma was often left behind. In other cases, the entire family would return to the Pale of Settlement.⁴⁷

“Off for America”

Having succeeded in escaping from the Russian Empire, the Goldenbaums found life in Palestine both difficult and disappointing. Worried about how he was going to provide for his travel-weary family and also about the looming prospect that his eighteen-year-old son (his oldest) might soon be drafted into the Turkish Army, Rabbi Goldenbaum decided to travel once again—this time alone, and to the United States where, he heard from acquaintances, he might be able to eke out a living and, eventually, send for the rest of his family. But in order to obtain passage at the largest south European seaport, Naples, Goldenbaum had to travel through Egypt.⁴⁸ This leg of the journey, undoubtedly influenced by the events of World War I, took fourteen months.

As for contracting trachoma, unfortunately, one could not have found a worse spot to be living or traveling than Palestine and Egypt during this period. Indeed, one of the more antiquated names for trachoma, still in use during the early twentieth century, was “Egyptian ophthalmia.”⁴⁹ Exact rates of the incidence and prevalence of trachoma in the Middle

47. The INS Special Boards of Inquiry case collections are, unfortunately, replete with such tragic cases; see INS Collection 60A/600, RG 85, NARA. The separation of families was not restricted to East European Jews, of course; one finds similar tragedies among the other major immigrant groups during this period as well.

48. Goldenbaum File.

49. Mary C. Karasch, “Ophthalmia (Conjunctivitis and Trachoma),” in *The Cambridge World History of Human Disease*, ed. K. F. Kiple (New York: Cambridge University Press, 1993), pp. 897–906, quotation on p. 897. The disease continues to be a problem in the present-day Middle East, where it blinds millions.

East during the early decades of the twentieth century are difficult to ascertain, although contemporary studies strongly suggest that it was a major public health problem. British physician A. F. MacCallan reported in 1913 that “trachoma is generalized throughout Egypt affecting about 95 percent of the population.”⁵⁰

In the late summer of 1916, Rabbi Goldenbaum left Cairo for Port Said where he boarded a steamer to Naples, a major emigrant seaport that long relied on the advice of U.S. Public Health Service physicians in the administration of the medical inspection process. USPHS officers were stationed as consultants at several European and Asian ports, but in Naples they were granted permission to inspect departing emigrants using the criteria of U.S. immigration laws. They could not bar the passage of a particular emigrant, per se, but they could forward a descriptive list of diseased emigrants to both the steamship companies and the USPHS officers stationed at the receiving American port. Given the expense of returning an emigrant and the \$100 fine incurred for transporting a diseased passenger, the steamship companies were only too happy to bar the individual in question from making the crossing in their vessels. As a result, Naples enjoyed one of the highest rates of medical rejection when compared to other European ports during this period. For example, during the first decade of the twentieth century, approximately 4 to 6 percent of all emigrants attempting to leave Naples were rejected because of some type of contagious disease; between 75 and 85 percent of these rejections were because of trachoma and other inflammatory diseases of the eye.⁵¹

Somehow, Goldenbaum saved or raised the necessary capital to purchase a second-class ticket for his passage to America. Unlike the comfortable first-class cabins then available on transatlantic steamships, however, second-class accommodations were only slightly better than the squalid and cramped conditions of steerage. The steamship company provided bedding and dishes for those traveling in this compartment (as opposed to steerage, where passengers had to provide their own), and it was crudely furnished with a dining table and berths.⁵² Nevertheless, Rabbi

50. Arthur F. MacCallan, *Trachoma and Its Complications in Egypt* (Cambridge: Cambridge University Press, 1913), p. 3. See also *Report of the Trachoma Conference in the Jewish Colony of Palestine of 1914*, in Hebrew (Jerusalem: Jewish Health Bureau, 1915), Collections of the NYAM; Joseph Krinsky, “Trachoma in Palestine,” *Long Island Med. J.*, 1920, 14 (4): 171–76.

51. See *Reports of the Immigration Commission: Emigration Conditions in Europe* (n. 36), pp. 93–124; *Annual Report of the Commissioner General of Immigration, 1905*, pp. 50–56; *Annual Report of the Supervising Surgeon General of the U.S. Marine Hospital Service, 1900*, p. 523; Allan McLaughlin, “Italian and Other Latin Immigrants,” *Pop. Sci. Monthly*, 1904, 65: 341–49.

52. John Malcolm Brinnin, *The Sway of the Grand Saloon* (London: Arlington Books, 1986), pp. 164, 261–62.

Goldenbaum's second-class passage is intriguing to the historian tracing his path of migration. It is doubtful that by 1916 the "second-class scam" was still in successful operation—particularly in Naples, which was uniformly regarded by USPHS officials as the best port in all of Europe for the prevention of diseased aliens boarding ships to the United States. Indeed, contemporary reports suggest that *all* emigrants leaving Naples, regardless of class, were examined for evidence of loathsome or dangerous, contagious diseases. Moreover, as codified by the 1907 Immigration Act, once a ship arrived in an American port, USPHS officers boarded that ship and examined all first- and second-class passengers, albeit rapidly, before final disembarkation. If a first- or second-class passenger *was* suspected of having a disease, he was included with the steerage passengers for a more detailed medical examination. Yet, it must be noted, even this method was not 100 percent foolproof. As the USPHS physician A. C. Reed reported in 1913, the chances for "a defective immigrant escaping in the first or second class cabin are far greater than [in] the steerage."⁵³ While it seems likely that Rabbi Goldenbaum was examined before boarding the *San Guglielmo* in Naples and found to be free of disease, it is difficult to confirm this with absolute certainty: he may have had trachoma before boarding the vessel, or he may not. However, given his travels through Palestine and Egypt, and the advice freely offered by other emigrants about the strict regulations against those with even a hint of trachoma, he probably considered the second-class ticket a wise investment to make in the event that he did have the disease.

Little is documented about the voyage of the Siculo-Americana Line's *San Guglielmo*. We do know that the ship was making her penultimate voyage to New York and left Naples on 9 September 1916. The fifteen-day passage was almost twice as long as the average transatlantic crossing, but we also know that the ship made brief stops in Messina and Palermo before setting her compass *en route* for New York.⁵⁴ Approximately 1,019 passengers, mostly Greek and Italian emigrants, were in steerage, and another 93 were in the second-class compartment. From contemporary descriptions of transatlantic immigrant steamship passage during this period, one can surmise that ocean travel was hardly beneficial to ocular health: wind, salt air, unhygienic living conditions, and sporadic access to clean water for washing often led to irritation of the sensitive tissues of

53. Reed, "Immigration and the Public Health" (n. 2), p. 323.

54. Eugene W. Smith, *Passenger Ships of the World, Past and Present* (Boston: George H. Dean, 1963), pp. 236–37; *Morton Allan Directory of European Passenger Steamship Arrivals for the Years 1890 to 1930 at the Port of New York* (Baltimore: Genealogical Publishing, 1980), p. 190.

the emigrants' eyes, making them prone to all types of eye infections ranging from the benign viral conjunctivitis to the more chronic and debilitating trachoma. One of the more common explanations for immigrants with red, teary eyes upon arrival in the United States, incidentally, was that many of them were crying—out of fear, excitement, or other emotions experienced during the voyage and just before medical inspection.⁵⁵

The *San Guglielmo* entered New York Harbor on the morning of 23 September. After a brief inspection at the New York State Quarantine Station, off Staten Island, to search for evidence of cholera, typhus, plague, yellow fever, and smallpox, the ship dropped her anchor in the Lower Bay. There, she was boarded by USPHS physicians to examine the second-class passengers. After conferring with the ship's surgeon, a physician named Parcelhuis Albino who had ten years' experience on the Sicula-Americana Line, the federal officials ordered all of the steerage passengers transferred by barge to Ellis Island. In addition, a total of 186 passengers, from both the steerage and the second-class compartment, were sent to Ellis Island for special inquiry inspections. One of these passengers was the 5'7", black-haired rabbi, Chaim Irwin Goldenbaum.⁵⁶

During the Progressive Era of self-proclaimed efficiency and expertise, government bureaucrats heralded Ellis Island as a paragon of the principles of "scientific management."⁵⁷ It had been developed to process approximately five thousand immigrants per day and inspect them for physical, economic, mental, and moral fitness, but by 1907 it was not uncommon for more than ten thousand to pass through the Ellis Island immigration center on any given day. Often during this period, they waited as long as forty-eight hours for their final inspection. Rabbi Goldenbaum's experience with the famous "inspection line" occurred late in the afternoon of his day of arrival in America. After a quick yet ingenious inspection of his heart function (the long stairway to the Great Hall served as a superb cardiac stress test), the rabbi was shepherded through a maze of fences and barriers while physicians inspected him for a variety of problems ranging from goiter to fungal infestations of the skin, nails, and scalp. Soon enough, however, he came to the point in "the Line" where his eyes were to be examined.

Several descriptions of the trachoma examinations published in official government reports as well as popular magazine and newspaper

55. Howe, *World of Our Fathers* (n. 26), pp. 39–42; Reports of the Immigration Commission, 1907–10, *Immigration Legislation: Steerage Legislation, 1819–1908*, Senate Doc. 758, 61st Cong., 3d sess., 1911, pp. 335–485.

56. Ship's Manifest, S.S. *San Guglielmo* (n. 1).

57. See, for example, Frederick W. Taylor, *The Principles of Scientific Management* (New York: Harper and Brothers, 1911).

articles during this period document scrupulous attention to diagnostic and sanitary techniques, and present the USPHS as practitioners of the most modern scientific methods of the day for preventing the incursion of disease.⁵⁸ Yet there were occasional eyewitness accounts that reveal a more distressing and decidedly unhygienic view of “the Line.”⁵⁹ Perhaps the most intriguing critic of the examinations conducted at Ellis Island was President Theodore Roosevelt. Long sensitive to the needs and, more acutely, the political clout of immigrants who became naturalized citizens, Roosevelt visited Ellis Island several times during his presidency. In 1906, he worriedly wrote his secretary of Labor and Commerce, Victor H. Metcalf, about the poor sterile technique employed by the Ellis Island physicians:

I would like a report from Ellis Island as to some scheme for improving the examination of the eyes of immigrants to discover whether they have trachoma. When I was at Ellis Island myself I was struck by the way in which the doctors made the examinations with dirty hands and with no pretense to clean their instruments, so that it would seem to me that these examinations as conducted would themselves be a fruitful source of carrying infection from diseased to healthy people.⁶⁰

Although public health reports often stressed the point that physicians sterilized their hands and instruments between immigrant examinations, very few of the extant archival photographs documenting the examination support such a claim. These lapses in sterile technique were not lost on the immigrants.⁶¹ By 1916, we can assume that the physicians routinely cleaned their hands and instruments, whether buttonhook or

58. See, e.g., Reed, “Going to Ellis Island”; idem, “Immigration and the Public Health”; McLaughlin, “How Immigrants Are Inspected”; Henry, “Among the Immigrants” (all in n. 2).

59. See, for example, the testimony of British Ambassador to the United States Geddes on a visit to Ellis Island in 1923, where he describes a physician doing serial inguinal-genital hernia examinations on young men without washing hands between patients: *Dispatch from Her Majesty’s Ambassador at Washington Reporting on Conditions at Ellis Island Immigration Station* (London, 1923).

60. Theodore Roosevelt to V. H. Metcalf, 22 February 1906, in *Letters of Theodore Roosevelt*, vol. 5, ed. Elting E. Morison (Cambridge: Harvard University Press, 1952), pp. 162–63, item 3828.

61. Disinfectant regulations are clearly codified by 1917: see U.S. Treasury Department, *Regulations* (n. 39), p. 19. Most of the extant photographs in the National Archives and Library of Congress Collections were taken between 1915 and 1924. Many are easily surmised to be staged photographs, with careful posing of the immigrants and the inspectors; the overwhelming majority (82 percent), however, also reveal a paucity of sanitary measures, such as an easy means of hand washing. This prompts the question, if the photographs were posed and sanitary technique was standard operational procedure as listed in the USPHS regulations, why did not all of the photographs have a staged portable sink or basin?

forceps, with disinfectant between patients; we also know that some USPHS physicians still used the thumb-and-forefinger technique to at least 1923.⁶² The more cogent point, however, is that immigrants worried and talked about the possibility of contracting trachoma, literally, at the hands of an inspecting physician at Ellis Island and other immigration reception centers, during this era.

The physician on duty everted Goldenbaum's eyelids as he must have done thousands of times per day, but slowed his tactile examination when his finger sensed a patch of tiny raised bumps—granulations—that represented the body's inflammatory response to the trachoma germ. The physician consulted a few of his colleagues working on the inspection line that day to confirm his tentative diagnosis, as was standard practice on Ellis Island. All agreed that while it was mild and recent in origin, the rabbi was, most likely, suffering from trachoma. The physician then picked up a broad, blue piece of chalk and scrawled the letter "T" (for trachoma) on the rabbi's overcoat. No harmless graffitto, the chalk mark relegated the rabbi to a five-day stay at the Contagious Disease hospital, where curable cases of viral conjunctivitis or simply inflamed eyes would be more easily distinguished from cases of actual trachoma. Of those who were more definitively diagnosed with trachoma after five to seven days of observation, about 95 percent were debarred from entry to the United States and sent back as soon as possible on the same steamship line on which they arrived. Depending on the situation, the health of the immigrant, and the schedule of the steamship lines, however, this could take another few days to weeks. But each year during the period studied, about one to two hundred immigrants were treated for trachoma at the Ellis Island facility.

Understandably, the U.S. government was hesitant to accept these chronic cases, as were the local hospitals of New York City, even those that catered to the needs of immigrants such as the Beth Israel Hospital.⁶³ The average time spent on the trachoma ward at the Ellis Island hospital was about six months—a striking contrast to all other medical problems,

62. See, for example, E. H. Mullan photograph ca. 1923, inspecting Chinese immigrants for trachoma using his thumb and forefingers: National Library of Medicine Collections, Bethesda, Md.

63. Louis Frank to Samuel Littman, 24 April 1915, HIAS Ellis Island Bureau Cases (Miscellaneous Sick Cases), HIAS Collection, YIVO. This letter is typical of much of the correspondence between HIAS and the local hospitals with regard to accepting trachoma cases, which were well known to be chronic and expensive to treat. For a discussion of nineteenth- and early-twentieth-century American hospital admission procedures with respect to acute contagious and chronic diseases, see Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (Baltimore: Johns Hopkins University Press, 1995).

which had an average length of stay of about ten to fifteen days.⁶⁴ Consequently, the patients who were selected for treatment were those deemed most likely to recover by the USPHS physicians. This decision, however, was not in the final domain of the USPHS physicians; instead, immigrants facing debarment appeared before special boards of inquiry held to discuss the merits of each individual case.⁶⁵

The rabbi had three things in his favor when the Board of Inquiry met to discuss his fate on 26 September 1916. First and foremost was the early and treatable stage of his eye disease. Second, deportation had become less palatable on humanitarian grounds with the onset of the conflict we now call World War I. The third factor was the rather recent success achieved by the East European Jewish American community in establishing itself within the broader fabric of American society, and in providing assistance to fellow newcomers. By 1916—especially in New York City, where more than half of all East European Jewish immigrants settled—there were numerous synagogues, benevolent organizations, immigrant-run financial institutions and businesses, kosher butchers and restaurants, and Yiddish newspapers and magazines. There was also a burgeoning labor movement, particularly for the “needle trades” or garment industry, and there were entertainment venues ranging from the famed Yiddish theater to cross-over acts in American vaudeville and the legitimate theater—not to mention the social organizations developed by the German Jewish immigrants who were far better established in American society.⁶⁶ Although the New York City immigrant neighborhoods—composed of East European Jews, Poles, Italians, Chinese, Irish, Germans, and other newcomers—became a powerful symbol of the evils of immigration in the eyes of nativists, several immigrant aid societies, such as the Hebrew Immigrant Aid Society (HIAS), which was founded in 1902, were well poised to counter such sentiments. HIAS agents worked assiduously during this period for the improvement of conditions at Ellis Island and

64. Data compiled from *Annual Reports of the U.S. Commissioner-General of Immigration, 1900–1920*.

65. See “Annual Reports of the Commissioner of Ellis Island, 1902–09, 1909–13,” William Williams Papers, box 5, Rare Book and Manuscript Collections, New York Public Library, New York, N.Y. See also the autobiographies of two subsequent commissioners of Ellis Island: Frederic C. Howe, *Confessions of a Reformer* (New York: Scribner, 1925); Robert Watchorn, *Autobiography of Robert Watchorn*, ed. Herbert F. West (Oklahoma City: Robert Watchorn Charities, 1959), pp. 110–53.

66. For engaging accounts of the Lower East Side’s immigrant Jewish community during this period, see Ronald Sanders, *The Downtown Jews: Portraits of an Immigrant Generation* (New York: Harper and Row, 1969); Moses Rischin, *The Promised City: New York’s Jews, 1870–1914* (Cambridge: Harvard University Press, 1962).

other immigration reception centers, and for the care and comfort of those who were detained.⁶⁷

HIAS agent Samuel Frommer—who, like his other immigrant aid society colleagues stationed on the island, was multilingual and well versed in the international art of the *noodge*—ably represented Rabbi Goldenbaum.⁶⁸ Frommer pledged that HIAS was willing to underwrite all expenses related to the rabbi's treatment. HIAS, a dedicated group with only fledgling financial resources, was rarely so bold in its support efforts. Given the reverence that the Jewish American community still held for their religious leaders, and the cultural importance they placed on charitable acts, the agent must have been confident that HIAS would not be alone in the payment of the rabbi's hospital bills.

More commonly, for immigrants who required any form of extended medical treatment at Ellis Island, immigrant aid societies acted essentially as “middlemen” between the detained and their family members (if any existed) already settled in the United States, to make sure that all hospital costs were paid for, in advance. Health care for “public charges” and immigrants was sporadic in the early decades of the twentieth century, and what little was offered was largely underwritten by private citizens and groups.⁶⁹ Such an expense was often a financial drain on relatives, who may have been struggling themselves to earn a living, and the more distant the relationship, the more frequently a relative declined to come up with the necessary funds—resulting in the immigrant's being sent back to the port of origin.⁷⁰

The most common way for immigrant families to raise the funds to care for needy or ill relatives detained at Ellis Island was to organize parties, dinners, and benefit productions of Yiddish plays. In New York City alone, there were more than a dozen professional Yiddish acting

67. Although HIAS was founded in 1902, there did exist earlier organizations such as the Hebrew Sheltering and Immigrant Aid Society, which joined forces with HIAS in 1909, and the Hebrew Emigrant Aid Society, which had two incarnations in the late 1870s and early 1880s. The major difference between all of these organizations when compared to HIAS was that the latter was founded and operated by East European Jews (as opposed to German Jews), who looked on their clients as “brothers” rather than objects of charity. See Mark Wischnitzer, *Visas to Freedom: The History of HIAS* (Cleveland: World, 1956).

68. Goldenbaum File. The Yiddish word *noodge* might be translated as frequent needling, bothering, and advocating for a specific cause or goal.

69. Tina Levitan, *Islands of Compassion: A History of the Jewish Hospitals of New York* (New York: Twayne, 1965); David Rosner, *Once Charitable Enterprise: Hospitals and Health Care in Brooklyn and New York, 1885–1915* (Cambridge: Cambridge University Press, 1982).

70. See, for example, the Aron Genbarg File, HIAS Ellis Island Bureau, MKM 10.8, files 37–42, HIAS Collections, YIVO. Genbarg was sent back to Russia because his family could not afford to raise the funds, despite frequent requests from HIAS agents.

troupes, all of which relied upon the *landsmanshaftn* (immigrant social groups) to buy blocks of tickets for a meal and an evening of entertainment at reduced rates in order to raise money among the members.⁷¹ Not only were the Yiddish theater and *landsmanshaftn* useful means of raising money, on many occasions the plays themselves were about the travails of the East European Jewish immigrant.⁷²

At Ellis Island's Contagious Disease Hospital #2

The treatment for trachoma employed at Ellis Island during this period was, by today's standards of care, brutal. This was not, however, an issue of poor medical care or insensitive treatment; indeed, the physicians working at Ellis Island probably had as much experience with the diagnosis and treatment of trachoma as those at any other medical facility in the world—and perhaps more. At this point in history, however, there were still no definitive medications capable of vanquishing the infection. The treatment of choice, then, was to facilitate the body's attempt to cure itself of infection and, if necessary, remove the diseased tissue along with a wide margin of healthy tissue in order to prevent further spread and recurrence of the infection.

71. Ibid. The definition "social group" does not do justice to the Yiddish term *landsmanshaftn*; more broadly, they were immigrant benevolent societies whose members shared strong geographical, social, and cultural ties to their East European *shtetls*. Michael Weisser defines them as groups whose "social and benevolent activities were a crucial means of supplying the basic psychic and cultural stability that was largely absent from the American experience" (Michael R. Weisser, *A Brotherhood of Memory: Jewish Landsmanshaftn in the New World* [New York: Basic Books, 1985], p. 4). See also Daniel Soyer, *Jewish Immigrant Associations and American Identity in New York, 1880–1939* (Cambridge: Harvard University Press, 1997); Molly Picon and Jean Grillo, *Molly! An Autobiography* (New York: Simon and Schuster, 1980), p. 46.

72. For example, the first full-length Yiddish drama on an American subject, *Die Emigratsie kein Amerika* (Emigration to America) was written and produced by Joseph Latiner in New York in 1886. This trend only increased in the early decades of the twentieth century, before World War I, when East European immigration reached its peak. Some of the best-known productions of this genre included Allen Shomer's 1911 play, *At Sea and Ellis Island*; Jacob Adler's 1913 production of *The Immigrant*; and Jacob Gordin's 1914 productions, *The Russian Jew in America* and *Dementia Americana*. See Lulla Adler Rosenfeld, *The Yiddish Theater and Jacob P. Adler* (New York: Shapolsky, 1988), pp. 162, 260, 324, 339–40; Nahma Sandrow, *Vagabond Stars: A World History of Yiddish Theater* (New York: Limelight Editions, 1986), pp. 57, 172; Solomon Liptzin, *A History of Yiddish Literature* (Middle Village, N.Y.: Jonathan David, 1972), pp. 78–79. There were even popular Yiddish songs about the difficult experiences of immigration and Ellis Island, including "Shikt a Tiket" (Send a ticket), "Frayhayt Statue" (Statue of Liberty), "Kestl Gardn" (Castle Garden), and "Elis Ayland" (Ellis Island); the words and music can be found in Jerry Silverman, *The Yiddish Song Book* (New York: Stein and Day, 1983), pp. 152–53, 155–57, 161.

In order to facilitate the *vis mediatrix naturae* (the healing power of nature), the physicians initially avoided the harsher treatments commonly employed in the treatment of trachoma—ranging from the application of antiseptic and caustic chemical agents to surgical procedures. As a result, the rabbi was confined to a darkened room where cold compresses were applied to his eyes for an hour at a time, at two-hour intervals. This was accompanied by having his eyes irrigated with a 20 percent argyrol solution (a weak solution of an organic silver compound, which was an alternative to the more caustic, and common, 1–2 percent silver nitrate solution) three times a day, followed by an eye wash with a 4 percent solution of boric acid or “deci-normal” salt solution in order to remove any secretions.

Unfortunately, several weeks of this mild therapy failed to clear up the rabbi’s trachoma, and it was decided to perform a procedure called “follicular expression.” As a result, Goldenbaum was taken to the operating room where his eyelids were everted and painted with a solution of cocaine as an anesthetic; following this, the soft and prominent trachoma granules were “expressed” or ruptured with a specially designed roller forceps, in order to squeeze out the infectious contents to the point that a moderate hemorrhage or bruise was created on the eyelids. Scarification (the making of tiny, superficial incisions) was then performed on the eyelids after this squeezing procedure. Goldenbaum underwent several of these operations (about one per week) during his four-month stay at Ellis Island. As an adjunct to this surgical approach, the physicians treated him with the “blue-stone,” a form of copper sulfate that was rubbed onto the diseased eyelid tissue, in order to prevent new granulation tissue from forming. A final painful procedure that the rabbi endured on his road to recovery was called *grattage*, the vigorous rubbing of the inner eyelids with a steel, toothbrush-like instrument dipped in corrosive chemicals such as bichloride of mercury; again, the objective was to destroy the diseased tissue and limit the damage to the healthy tissue that remained.⁷³

These painful trachoma treatments were far from obscure to the immigrant community, and even formed the basis for one of the most graphic installments of Sholom Aleichem’s last novel, *Off for America*, which found a huge audience among Yiddish-speaking immigrants and American readers just at the time Rabbi Goldenbaum was detained at Ellis Island. The novel was translated into English and serialized in the famed Sunday magazine of Joseph Pulitzer’s *New York World* between

73. Goldenbaum’s treatment regimen is extracted from the Goldenbaum File. See also Clark and Schereschewsky, *Trachoma* (n. 22), pp. 30–32.

January and June of 1916. With national syndication, approximately five million Americans, not to mention Sholom Aleichem's legion of Yiddish-speaking readers, read these poignant stories.⁷⁴

In one installment published in the *New York World Sunday Magazine* on 26 March 1916, Sholom Aleichem recounts the story of a family immigrating from Antwerp to America whose youngest daughter, Goldele, is diagnosed with trachoma and must remain behind. Nearly a year passes—which must have seemed like a lifetime for a child—and one observer, Mrs. Zeitshuk, blames Goldele's eye problems on the little girl's constant crying. Goldele, on the other hand, has a germ theory-informed explanation for her continued eye problems:

“[it's] on account of the blue-stone! Every time that I come to the doctor, he rubs my eyes with the same blue-stone he uses on the other patients. If I could afford to have a blue-stone of my own I would have been cured long ago. . . . Then perhaps I might be able to see my papa and mama.”⁷⁵

Such a statement is particularly intriguing, retrospectively, in that it is entirely possible that if a particular blue-stone was used on several people with trachoma in succession, additional trachoma germs might be unwittingly introduced into a patient's eyes. Current knowledge of the *Chlamydia* germ suggests that it is a rather hearty organism and could, theoretically, survive on a wet chunk of copper sulfate for several minutes after initial contact. But even if the blue-stone was washed and disinfected between uses on different patients, the comment by Goldele (and, by extension, Sholom Aleichem) is remarkable in the way it reveals both the immigrant's resistance to blue-stone treatment and the author's perceptions of germ theory during this period.⁷⁶

74. Sholom Aleichem, the pen name of Sholom Rabinowitz, was the most popular and beloved of Yiddish writers, in both Eastern Europe and the new world. The “Off to America” stories were translated by Marian Weinstein (of the New York Yiddish daily newspaper, *Der Tog* [The Day], where they were originally published in Yiddish under the supervision of Sholom Aleichem), in *New York World Magazine* beginning on 2 January 1916, and then, serially, in the following issues: 9 January, pp. 13, 17; 16 January, p. 13; 23 January, p. 12; 30 January, p. 12; 13 February, p. 13; 27 February, p. 13. The last few installments were published posthumously, for the writer died in New York City on 14 May 1916 and the novel's last, unfinished chapter represents his last written words; the next day he was buried in Brooklyn, but only after what was then considered one of the largest funeral processions ever held in New York City. For a memoir of this exciting conclusion to Sholom Aleichem's writing career, see Marie Waife-Goldberg, *My Father, Sholom Aleichem* (New York: Simon and Schuster, 1968), pp. 302–5; Ellen D. Kellman, “Sholom Aleichem's Funeral (New York 1916): The Making of a National Pageant,” *YIVO Annual*, 1991, 20: 277–304.

75. Sholom Aleichem, “Off for the Golden Land,” *Jewish Immigration Bull.*, 1917, 7 (1), 10–11; quotation on p. 10.

76. I am indebted to Professor Bert Hansen of Baruch College, CUNY, for his help in clarifying this point. Indeed, my rationale for describing in detail the various treatments for

Every day during his confinement, the rabbi recited the morning, afternoon, and evening prayers central to the orthodox practice of Judaism. Between his devotions and treatments, he convalesced in bed or, weather permitting, on the hospital's fenced-in porch with a poignantly tantalizing view of the Statue of Liberty and the skyscrapers of lower Manhattan. Apparently, his vision was good enough for writing a number of letters from the hospital's library during the winter of 1916–17 on stationery emblazoned with the message "This letter paper is furnished by the Government, free of charge, to immigrants detained at Ellis Island, New York Harbor, for use in communicating with their relatives or friends." In a tightly scripted Yiddish, Rabbi Goldenbaum detailed his travails. His letters record not only a difficult journey, but also a medical staff at Ellis Island who did not speak his language or fully respect his cultural and religious sensibilities.⁷⁷

Soon after the rabbi's admission to the hospital, his situation was championed by some of the Yiddish newspapers and, perhaps more important, by David de Sola Pool, the celebrated rabbi of New York City's oldest synagogue, Shearith Israel. Hoping to arrange Goldenbaum's transfer to a kosher hospital such as Beth Israel, de Sola Pool beseeched the HIAS agents: "Is there no way of hastening his release? The man is very orthodox and is eating little more than milk and dry bread, and unless some change is made, it is feared that discouragement, grief, and even hunger will have a very bad effect on him."⁷⁸

The request for transfer to Beth Israel, however, was never filed, because the physicians at Ellis Island felt that they were making some progress with Goldenbaum and did not want to disrupt his treatment. For several weeks, they argued over whether to perform a more extensive surgical procedure on the rabbi's eyes to remove the last vestige of scar tissue. By late January 1917 they decided that his condition was "very favorable,"⁷⁹ and he was finally released from Ellis Island under the bond of the HIAS on 29 January. Goldenbaum's first American address was the

trachoma is not to suggest that the USPHS physicians were providing needless or callous treatment, but instead to show that these treatments were known to the immigrant community, and were part of the fear that makes up the social construction of the disease during this era.

77. See undated letters from Rabbi Chaim Goldenbaum to Rabbi David de Sola Pool, ca. Winter 1916–17, Goldenbaum File.

78. *Ibid.*, De Sola Pool to HIAS, 22 January 1917. See also *The Jewish Communal Register of New York City, 1917–1918* (New York: Kehillah-Jewish Community of New York, 1918), p. 1401.

79. Letter from Irving Fain, Acting General Manager, HIAS, to Rabbi David de Sola Pool, 24 January 1917, Goldenbaum File.

HIAS boarding house at 229–231 East Broadway, in the heart of New York's Lower East Side.

Through the offices of HIAS and de Sola Pool, Goldenbaum secured a position as an assistant rabbi at a newly established synagogue in Atlanta, Georgia, Congregation Ahavath Achim. Atlanta must have been a strange place indeed for the Yiddish-speaking rabbi.⁸⁰ Two years earlier, the city had shamed itself internationally with the lynching of Leo Frank, an American Jewish factory manager accused of murdering a young woman in his employ.⁸¹ Only one week after Chaim Goldenbaum's arrival in Atlanta on 2 April 1917, President Wilson urged the U.S. Congress to declare war on Germany. On 4 April, the Congress was all too happy to comply. If Goldenbaum could have read the 8 April edition of the *Atlanta Constitution*, he most likely would have been alarmed by the front-page headline quoting local U.S. Attorney Hooper Alexander's warning to all immigrants living in Georgia: "Obey the Law! Keep Your Mouth Shut!"⁸² Alas, there the paper trail ends. No written record of Rabbi Goldenbaum's tenure at Ahavath Achim exists in that venerable institution's archives. It is probable that he returned to New York City, earning a living as a Hebrew school teacher or rabbi of a small congregation, with the hope of reuniting his family. And in many ways his story reflects the ambivalence engendered by the experience of trachoma: on the one hand, he endured great hardship and difficulty at Ellis Island; and on the other, unlike most immigrants who were diagnosed with trachoma, he was cured of a potentially blinding disease under the care of government physicians, allowing him to be considered for a rabbinical position in the United States. One can, at least, hope that things worked out for the rabbi with trachoma.

Conclusion

Expanding our view from the experiences of Chaim Goldenbaum and others like him to those of both the native-born American and the "new immigrant" communities, one cannot help but be struck by the intense response that trachoma engendered among all concerned. During this

80. Goldenbaum File, 29 January 1916; Doris H. Goldstein, *From Generation to Generation: A Centennial History of Congregation Ahavath Achim, 1887–1987* (Atlanta, Ga.: Ahavath Achim Synagogue, 1987); Steven Hertzberg, *Strangers Within the Gate City: The Jews of Atlanta* (Philadelphia: Jewish Publication Society of America, 1978).

81. Leonard Dinnerstein, *The Leo Frank Case* (New York: Columbia University Press, 1968); Nancy MacLean, "The Leo Frank Case Reconsidered: Gender and Sexual Politics in the Making of a Reactionary Populism," *J. Amer. Hist.*, 1991, 78: 917–48.

82. *Atlanta Constitution*, 8 April 1917, p. 1, col. 3.

period, a strong current of nativist thought that blended eugenic, economic, and social theories with laboratory discoveries of germ-caused diseases arose to explain scientifically the inferiority of new immigrants. Such explanations were simultaneously authoritative enough to gain political ground and loose enough to encircle all social groups deemed by the majority to be outcasts. One striking result of this mentality was that the U.S. Public Health Service focused its resources and staff primarily against “germs from other nations,” often at the expense of health problems that originated from within our borders. More broadly, trachoma became a powerful symbol of the threats of immigrant disease, dependency, and economic ruin against the body politic. Indeed, trachoma’s rise and fall in the American immigration experience was closely related to the swelling numbers and types of immigrants seeking entry during this period.

This nativist discourse was exquisitely frustrating and, at times, damaging to those toward whom it was directed. In point of fact, almost every new immigrant had firsthand experience with the trachoma examination itself; many knew, or had heard of, someone who was detained and ultimately sent back. The potential tragedy of a family member returned to Europe because of trachoma was a painful reality for almost of all of these immigrants. But it is important to note that the idioms of biology, bacteriology, and disease were not appropriated only by nativists desiring to erect barriers to the arrival of immigrants on American shores—immigrants and those who had a vested interest in their safe settlement in American society also eloquently appropriated these idioms and scientific or medical explanations. Their responses are a remarkable record of the ways in which so-called undesirable social groups attempted both rhetorically and politically to combat the stigma of disease.

Finally, in terms of the Jewish American immigration experience, trachoma reflects the newcomers’ understanding of human disease, identity, and the medicalization of the immigration experience. The work of the American Jewish immigrant community—a social group about which American society had much ambivalence—to fight against stigmatizing labels and policies is a superb example of how nonbiological factors can shape the experience of illness. Beyond the Yiddish press, literature, songs, and theater, their responses included the establishment of hospitals that catered to the unique needs of immigrants, and the forming of numerous social agencies dedicated to helping healthy Jews emigrate out of the Pale and assimilate into American society. With a sophisticated understanding of the American political and legal system as well as of human disease and its treatment, immigrant aid societies such as HIAS pioneered a form of ethnic politics that continues to play

an important role in our political rubric. And, perhaps more than any other label of exclusion raised at our nation's gates, the stigma of trachoma became an essential consideration in the East European Jewish immigrant's calculus of migration.