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HISTORY OF MEDICINE

Medical Examination of Immigrants at Ellis Island

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SARS, avian flu, bioterrorism: such threats to national security at the dawn of the 21st century have renewed anxieties about controlling disease at the nation's borders. Control of infectious agents also provided the impetus for immigrant medical inspections along the U.S. coasts in the late 19th century, but, in practice, it was the weeding out of chronic disease and disability that actually motivated public health officers on "the line" at Ellis Island and other U.S. immigration stations during the first 30 years of federal control of the nation's borders.

From the colonial era to the end of the 19th century, each state had borne responsibility for regulating immigration. But with the swelling numbers of immigrants in the 1880s and 1890s, an increasingly complex industrial economy, and mounting concern about the international spread of infectious diseases, the federal government took control of the nation's borders in 1891.

While admission decisions were made by the Immigration Service (IS), the law required medical inspection of immigrants by the United States Public Health Service (PHS). When a PHS medical officer formally diagnosed an immigrant with a disease or defect, throwing his or her admissibility into question, that individual was considered "medically certified." The law required the PHS to issue a medical certificate to those who suffered from a "loathsome or a dangerous contagious disease" [1]. Exclusion of those diagnosed with infectious diseases such as tuberculosis, venereal disease, trachoma, and favus was mandatory [2].

The PHS defined its mission rather narrowly—preventing the entrance of disease to the nation—but PHS officers interpreted their job more broadly. In their eyes, the goal was to prevent the entrance of undesirable people—those "who would not make good citizens" [3]. In the context of industrial-era America, immigrants who would wear out prematurely, requiring care and maintenance rather than supplying manpower, would not make "good" citizens. By 1903 the PHS had elaborated two major categories: "Class A" loathsome or dangerous contagious diseases and "Class B" diseases and conditions that would render an immigrant "likely to become a public charge." A subset of Class A conditions included mental conditions such as insanity and epilepsy.

Inspection on the "Line"

Medical examination centered on the “line,” which became shorthand for the set of techniques and procedures that medical officers used to examine thousands of immigrants quickly. Ellis Island—where roughly 70 percent of immigrants entered the United States—set the standard. After an arriving ship passed the quarantine inspection in New York Harbor, IS and PHS examiners boarded and examined all first- and second-class passengers as the ship proceeded up the harbor [4]. Upon docking, PHS officers transferred steerage or third-class passengers to Ellis Island by barge. Proceeding one after the other and lugging heavy baggage, prospective immigrants entered the station and moved slowly through a series of gated passageways resembling cattle pens. As they reached the end of the line, they slowly filed past one or more PHS officers who, at a glance, surveyed them for a variety of serious and minor diseases and conditions, finally turning back their eyelids with their fingers or a buttonhook to check for trachoma.

The diagnostic protocol emphasized the physician’s “gaze,” demonstrating the conviction that disease was written on the body. Dr. Albert Nute, while stationed in Boston, argued that “almost no grave organic disease can have a hold on an individual without stamping some evidence of its presence upon the appearance of the patient evident to the eye or hand of the trained observer” [5]. Exemplifying this notion, PHS regulations encouraged officers to place a chalk mark indicating the suspected disease or defect on the clothing of immigrants as they passed through the line: the letters “EX” on the lapel of a coat indicated that the individual should merely be further examined; the letter “C,” that the PHS officer suspected an eye condition; “S” indicated senility; and “X,” insanity [6].

In practice the PHS focused on those diseases and conditions that were transparent not only to highly experienced medical examiners but also to ordinary immigrants. Everyone could see that the elderly were turned aside for further inspection. Everyone could see a stooped back or a pregnant women traveling alone. Everyone could see the attention that was given to eyes and could thus gauge the importance of vision. And everyone could see that the young (except those too young to work), the muscular, and the robust were not turned aside.

Among the immigrants’ many apprehensions, the fear of rejection loomed foremost as they undertook passage from abroad. Prospective immigrants were forewarned of the medical examination through immigrant aid guides, steamship brochures, and the initial steamship company medical and quarantine examinations needed to secure passage to America. The PHS faced the immigrant as an adversary of sorts, for the PHS officers encountered “the shrewdest evasion and concealment” [7]. Aware of some of the conditions for which PHS officers searched, immigrants attempted to hide deformities of the arms and hands and to mask disease either physically or pharmacologically. They may not have been able to decipher the code that the PHS officers inscribed on their clothing, but the meaning of the writing was clear, as each marked individual was turned off the line, separated from friends, family, and fellow passengers, and directed into cage-like areas.

PHS officers immediately transferred those bearing chalk marks—typically 15 to 20 percent of arrivals—to either the physical or mental examination rooms. In the semi-private, single-sex physical examination rooms, immigrants partially disrobed and were examined with stethoscopes, thermometers, and eye charts. Sometimes height and weight were measured. Those suspected of having mental defects met with a PHS officer who asked them simple questions, such as their name or age, and gave them tests that required manipulation of cubes or puzzles or interpretation of events depicted in photographs. At the conclusion of the medical or mental examination, the immigrant would receive an OK card or a medical certificate.

Treatment for the Medically Certified

The PHS encouraged its officers to spend as much time as necessary to make accurate diagnoses of those “turned off the line” [8]. Some were confined, often for many months and sometimes years, in the isolation units in the southernmost wing of Ellis Island. Over time, the IS granted medical treatment to more and more immigrants, often justifying it on humanitarian grounds. Of those who applied for hospitalization after 1907—which included not only the medically certified but also those in need of treatment for a condition not covered under the immigration law, such as diarrhea—only 13 percent were denied treatment. Most did not apply for treatment of Class A conditions because, if the request was granted, the immigrant was required to pay all medical expenses. Immigrants granted hospital treatment at Ellis Island and other ports were often deported for inability to pay hospital expenses associated with Class A conditions [9].

Each medically certified individual received a hearing before an IS Board of Special Inquiry (BSI). Here, a panel of three IS officers questioned the immigrant about his or her occupation, finances, and family residing in the United States. In most instances the BSI overruled the medical certificate and did not reject the immigrant. From approximately 1906 to 1930, only a handful (1.6 percent) of the medically certified ever appealed an excluding decision; the odds of success for those launching an appeal were, at best, even [10]. Deportation could split up families; husbands and wives were often separated, and children could be deported without their parents (though a parent might decide to go back with a child).

The procedure was intimidating, and, indeed, between 1891 and 1930 nearly 80,000 immigrants were barred at the nation’s doors for diseases or defects. Yet the vast majority were allowed to enter the country—on average, fewer than 1 percent were ever turned back for medical reasons [11]. Of those who were denied entry, most were certified, not with “loathsome and dangerous contagious diseases,” but with conditions that limited their capacity to perform unskilled labor. Senility (old age), varicose veins, hernias, poor vision, and deformities of the limbs or spine were among the primary causes for exclusion. That so few of the more than 25 million arriving immigrants inspected by the PHS were excluded sets into bold relief the country’s almost insatiable industrial demand for cheap labor.

Origin-Related Differences in Inspection Procedures

Yet the demand for labor conformed to racial ideology. Influenced by scientific racism, the medical examination procedures differed for European, Latin American, and Asian immigrants. On the East Coast, the medical exam served more of a processing than exclusionary function for European immigrants. Non-Europeans faced more considerable medical obstacles to entry at the nation's Pacific Coast and Mexican border immigration stations. At Texas border stations, PHS medical inspectors stripped, showered, disinfected, searched for lice, and physically examined large groups of immigrants. All second- and third-class Asians immigrants arriving in San Francisco endured a physical exam similar to that conducted along the Mexican border in addition to routine laboratory testing for parasitic infection, which required detention at Angel Island for one or more days. Disease, health officials argued, was not so easily "read" in the "inscrutable" Asians, particularly the Chinese [12].

But while the demand for labor had assured that the flow of European immigrants to the U.S. would continue relatively unrestricted, in the years after World War I political elites successfully argued that the immigration of "undesirable" southern and eastern Europeans had to be cut off at the source. The Immigration Act of 1924 restricted immigration numerically and made national origin the basis for admission into the U.S. On the European front, the 1924 Act transferred immigrant medical inspection abroad and established the visa system: immigrants could no longer depart for the United States until an American consular office abroad had granted them visas. Medical inspection, which was now conducted along the lines of private medical exams, became a prerequisite for consular approval. One of the consequences of this shift was an increase in the percentage of immigrants denied entry on the basis of disease. Between 1926 and 1930, nearly 5 percent of those examined abroad were ultimately refused visas for medical reasons—a significant increase over the medical exclusion rate of less than 1 percent that had prevailed in the United States since 1891 [13]. As a result, the medical exam came to be viewed as more "scientific" and "objective."

Medical Screening Today

Today guidelines for the medical screening of aliens seeking permanent residency or certain categories of temporary residency in the United States are set by the Centers for Disease Control and Prevention's Division of Global Migration and Quarantine (DGMQ). Health-related grounds for barring admission to the United States include having a "communicable disease of public health significance," including chancroid, gonorrhea, HIV infection, infectious leprosy, infectious stage syphilis, and active tuberculosis [14].

Tuberculosis (TB) provides a vivid example of the complexities that continue to bedevil immigrant medical screening. After decades of decreasing incidence, a TB epidemic occurred in the United States during the late 1980s and early 1990s, reawakening the nation to the presence of what had been considered a conquered disease. Not surprisingly, links between TB and the foreign-born spurred calls for

more screening of immigrants, both before and after their arrival in the United States [15]. By law, an applicant for a visa or permanent residency who has TB is inadmissible only if the disease is clinically active, and waivers for prospective immigrants with active disease are available. Individuals with latent TB infection (LTBI) are not barred; however, such infections lead to active disease in about 5 percent of cases, and reactivation of latent TB is believed to account for the majority of active cases in immigrants [16]. The possibility that latent cases will reactivate has led immigration policy to address LTBI. In 2000, the Institute of Medicine (IOM) called for an overhaul of TB screening procedures for prospective immigrants in order to enable more accurate detection of LTBI [17]. The IOM also proposed that aliens with LTBI complete treatment for the infection before receiving a permanent residency card [18].

In keeping with the IOM's recommendations, the DGMQ's updated Technical Instructions for Tuberculosis Screening and Treatment for Panel Physicians, released in 2007, includes a new classification (Class B2 TB) for applicants with suspected LTBI [19]. No such classification was in the previous Technical Instructions (1991). Prospective immigrants with Class B2 TB are cleared for travel to the United States but are to be evaluated for LTBI once in the country [20]. Contemporary screening for TB is thus following the historical trajectory of immigrant medical screening: expanding its scope from infectious agents to chronic ones, but, importantly, not strictly for the purposes of excluding immigrants with disease.

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