BOOK REVIEW

Quarantine! East European Jewish Immigrants and the New York City Epidemics of 1892. BY HOWARD MARKEL. Baltimore, Md: Johns Hopkins University Press, 1997. 262 pages. \$29.95.

The recent arrest of an HIV-positive New York State man accused of infecting perhaps dozens of girls and women with the virus reminds us of the powerful emotions associated with the spread of severe infections. A picture of the man, Nushawn Williams, appeared on the front page of the *New York Times* and other newspapers across the country. Commentators used the occasion to demand more stringent prosecution or the forcible isolation of HIV-infected individuals who engage in unprotected sex.

The extreme nature of Mr. Williams' behavior made the decision to prosecute him easy. What is less clear is the proper role of legal proceedings or other restrictive measures for the thousands of other HIV-positive persons who place uninfected partners at risk. How do officials decide which individuals constitute a public health threat? To what degree is society willing to restrict the activities of such people? Do efforts to isolate potentially infectious persons necessarily lead to the stigmatization of disadvantaged populations?

These questions are provocatively raised by Howard Markel in his carefully researched new book *Quarantine! East European Jewish Immigrants and the New York City Epidemics of 1892*. In telling the story of quarantines established in New York City in 1892 for outbreaks of typhus and cholera, Markel, a physician-historian at the University of Michigan, demonstrates how public health policies designed to protect the public often became conflated with issues such as class, race, and immigration. In an era of drug-resistant infections that can spread rapidly from continent to continent, the potential ramifications of aggressive public health measures are well worth remembering.

Quarantine, of course, has been the most commonly used strategy for separating the infected from the uninfected. The term itself is derived from the ancient practice of isolating for 40 days arriving ships thought to be harboring passengers with infections such as the plague. Although ostensibly implemented for public health purposes, the actual use of quarantine over time has reflected local politics, economic concerns, and, most notably, cultural beliefs about the groups or individuals quarantined.

These factors were most certainly operative in New York in 1892, particularly because of the presumed association between infectious disease and the city's growing population of Eastern European Jewish immigrants. The Jews were already viewed as "dirty maggots" whose crowded tenement dwellings on the Lower

East Side were "pestilential rookeries" (p. 31); the arrival of contagious infections only further cemented anti-immigrant tendencies. To be sure, both the typhus and the cholera outbreaks did have clear connections to the city's immigrant population. The first cases of typhus in New York were diagnosed among a group of Russian Jews who had recently immigrated aboard the S.S. *Massilia*. Similarly, those persons diagnosed with cholera were largely steerage passengers arriving from Eastern Europe through cholera-infested Hamburg.

Yet, as Markel reveals, quarantine policies often had more to do with nativist or anti-Semitic beliefs that Jews were vectors of disease than with the actual public health threat that they represented. Ignoring the growing bacteriologic knowledge that these infections spared no social groups, medical and lay commentators readily attributed the appearance of typhus and cholera to a lax immigration policy that welcomed "the scum of invalided Europe" (p. 88). Given such sentiments, it is not surprising that quarantine policies selectively targeted poor Jewish immigrants. In response to typhus, for example, officials quarantined both infected and uninfected Russian Jews on desolate North Brother Island in the East River; the miserable, unsanitary conditions there most likely caused many of the healthy immigrants to acquire the disease. Forcible isolation for cholera followed a similar pattern: upper-class immigrants at risk of infection were generally subjected to much less aggressive quarantine measures.

One of the exceptional aspects of Markel's book is his extensive scrutiny of the Yiddish-language newspapers that covered the events in 1892. These documents provide a unique view of the experience of quarantine from the perspective of those being quarantined. In one typical instance, a 40-year-old woman with typhus was dragged out of her lodging, "kicking and screaming," in full view of her husband, children, and neighbors (p. 61). Noting how such forcible isolation procedures singled out Russian Jews far beyond the actual threat they posed, one Yiddish journalist wrote: "Blaming these sick Russian Jews . . . for bringing the scourge is a patriotic lie, ragged and tattered to its very construction" (p. 72).

Given the equation of poor Jewish immigrants with the spread of typhus and cholera in the city, it is not surprising that the outbreaks promoted calls for immigration restriction. "Such immigrants are not wanted in this city or any other part of the United States," editorialized the *New York Times*. "They should be excluded" (p. 67). Markel concludes his book by examining how such sentiments led to the passage of the National Quarantine Act of 1893. Yet, as Markel notes, by the time the act passed, Congress had replaced most of the bill's provisions limiting immigration with programs designed to improve the medical inspections of arriving foreigners. One prominent strategy was to increase the role of the federal government in overseeing public health policies at Ellis Island and other immigration stations.

This type of measured approach generally characterizes modern quarantine policies. Given the rise of civil liberties concerns after 1970, those with communicable diseases such as tuberculosis are now quarantined only as a last resort and when "medically indicated." Despite such policies, however, the tendency to blame poor, disadvantaged populations for the spread of tuberculosis, AIDS, and hepatitis remains all too prevalent. And

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because such diseases are so prominent in the Third World, such blame is most often directed at newly arrived immigrants from Asia, Africa, and South America.

By cautioning us against such tendencies, Markel's well-written narrative demonstrates the value of historical research to both clinical practice and the drafting of public health policies.

Even as officials proceed with the prosecution of Mr. Williams and devise strategies for preventing similar tragedies, such measures "must be applied equally and fairly to all who are ill with a . . . contagious disease" (p. 193).—**BARRON H. LERNER, MD, PhD**, *Division of General Medicine, Columbia University College of Physicians and Surgeons, New York, NY*.

REFLECTIONS

The Death Certificate

As I hastily left for the airport on the way to a long-awaited medical conference, my pager beeped. It was the emergency room of a local hospital. Holding for the doctor, I chastised myself, "I should've ignored this page and let my partner take the call — it's probably a patient needing to be transferred from a private hospital, which I don't have time for right now." I was stunned when the emergency room physician informed me that my patient, Mrs. A., had been brought in by EMS, and, despite their efforts, had expired. He wondered if I could help him complete the death certificate.

Mrs. A. was an 83-year-old Mexican-American woman I had followed for years with diabetes, coronary disease, and congestive heart failure. A tiny *mujercita* who emigrated to the United States in 1940, she had endured the death of her husband, withstood two radical mastectomies, and even had survived cardiac surgery in her late seventies. She proudly stood 4 feet 10 inches tall, wore brightly-colored nylon dresses, and always carried her Rosary beads. The beloved mother of seven children, she took the bus every day to the senior center, never missing the weekly square dances.

I recalled our monthly ritual. We would talk for several minutes about how she was doing and briefly review her home glucose monitoring. I would boost her onto the examining table, assess her neck veins, and carefully auscultate her lung bases. We joked as I quickly proceeded through inspection and palpation of her precordium. As I lay my stethoscope on her chest, we would both close our eyes and listen — sometimes for a minute, sometimes longer. The rushing river of mitral insufficiency would invariably flow forth, yet occasionally I discovered a new note or undertone to this waterfall. "It's still beating in there — sounds good to me" I proclaimed. Finally I would reinforce the importance of taking ACE-inhibitors, even though I knew they were probably causing her incessant cough.

I remembered agonizing over whether she should undergo heart surgery at such an advanced age, and how she barely made it through the complicated operation. I remembered how she graciously allowed countless medical students to examine her scalloped chest and feel, with utter amazement, her enlarged displaced PMI, and hear a holosystolic murmur for the very first time. I remembered her prodding me for a picture of my "new baby" every month for the last 2 years, a request I never honored. I remembered scolding her when she developed pulmonary edema after stopping her diuretics (not to mention the hypoglycemia after she starved herself to lose the "extra" weight). I remembered her smile and her gleaming brown eyes and her warm hugs at the end of every visit.

I instructed the ER physician to record "acute myocardial infarction" on her death certificate and boarded the airplane. As I stared over the endless, inviting white blanket outside my airplane window, I could feel her waiting nearby, bidding me farewell. I miss her already, even though it has been only a few hours.

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