THE POLITICS OF AN EPIDEMIC: SARS & CHINATOWN

by

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ABSTRACT

This thesis explores how the 2003 epidemic of Severe Acute Respiratory Syndrome, or SARS, threw into relief the myriad historical, political and economic factors that shape understandings of and responses to a new disease. The author traces how the historic “othering” of Chinese immigrants and their descendents in the United States was combined with dominant discourses of risk and blame to understand SARS and the potential for a domestic epidemic. Narratives from community members of Manhattan’s Chinatown are used to investigate the local impacts of the production of these discourses during the SARS epidemic. Finally, the author explores how these dominant discourses were applied locally within Chinatown understand local and personal risk.
CHAPTER I: INTRODUCTION

In the spring of 2003, news headlines announced that Americans were facing a new foreign threat that had already “terrorized three continents.” U.S. News and World Report warned of the imminent invasion of the SARS epidemic, proclaiming “SARS Hits Home,” before the CDC had confirmed any cases. Newsweek dubbed the present “The New Age of Epidemics.” Yet what the American public really experienced was an epidemic of fear, not of disease.

Severe Acute Respiratory Syndrome, or SARS, is a respiratory virus that was identified by the World Health Organization (WHO) in March 2003. The disease is characterized by a fever of over 100.4 degrees Fahrenheit, with some patients developing a dry cough and most eventually suffering from pneumonia. SARS is spread by “close contact” with another person, defined by the Centers for Disease Control and Prevention as direct contact with the body or secretions of someone infected by the virus and “talking to someone within three feet.”1

From the first known case in November, 2002 to the summer of 2003, the SARS epidemic wreaked havoc in mainland China, Hong Kong, and Taiwan, and spread to other countries including Canada. SARS first became of international concern when the then-unidentified and unnamed disease claimed the lives of several people in Hong Kong.

1 However, as late as January 13, 2004 the CDC noted that SARS might be spread via additional routes still unknown to doctors.
The epidemic was a real health threat in Asia and fears of the contagion paralyzed Hong Kong and the Chinese Province of Guangdong. Residents rushed to buy masks, herbal remedies, and vinegar which when boiled was believed to prevent infection. In China, people began killing pets after it was reported that cats could carry and spread the virus. Others began smoking after it was reported that a public health official had remarked that smokers were not contracting the virus. By the time SARS was contained in the summer of 2003, 8,098 people had become infected worldwide and 774 had died (CDC 2004). Yet while the virus primarily devastated Asia, fear of the contagion spread far beyond the actual infected areas.

Despite the facts that only eight people in the United States had laboratory evidence of SARS and that most of these people contracted the virus abroad (CDC 2004), media reports fixated on the possibility of a domestic epidemic. In mid-March 2003 American news agencies started reporting on a mysterious illness in China. By the beginning of April, daily headlines charted the progress of the virus that was by then widely known as SARS. Mainstream American coverage described SARS as the product of Chinese “culture,” and blamed the spread of the epidemic on the Chinese cover-up of cases.

A national survey conducted by the Harvard School of Public Health revealed that by mid-April, 93% of Americans had heard of SARS. Further, the survey showed that fourteen percent of Americans nationally avoided Asian businesses (Blendon, et al. 2003). While the latter is not an overwhelming statistic, many Asian communities began
reporting losses in business and tourism, indicating that a larger percentage of people in areas near Asian communities might have avoided Asian businesses.

New York City’s Chinatown was particularly hard hit, as rumors of local infections circulated fear around the community and many Asian Americans felt stigmatized in the general public. Even without a local epidemic, SARS caused economic damage to Chinatown’s economy that was already struggling from the nearby terrorist attacks of 9/11. Tourism plummeted as the public avoided what they perceived as an infected space and people. Restaurants in particular suffered losses after one particular rumor reported that a local restaurant owner had spread SARS to his employees before dying. According to many of my informants, tourism and business were still lagging in the summer of 2004, one year after SARS had been contained. Although there was never a single infection in Chinatown, the community was quickly identified as a site of contagion and risk.

**Description of Study**

This project was initiated because of the general public’s association of Chinatown with SARS infection, despite the lack of cases throughout the epidemic. Although many Chinese- and Asian American communities were affected by stigmatization surrounding SARS, I chose to interview people in New York City’s Chinatown because of my familiarity with the city and because the SARS epidemic caused devastating economic impacts on a community that was still reeling from the 2001 terrorist attacks on the World Trade Center just a few blocks away. The association of Chinatown with SARS caused a plummet in tourism and restaurant business, two of
the mainstays of the Chinatown economy. According to the Asian American Business Development Center, Chinatown businesses experienced 30-70% losses, many on top of the losses they experienced from 9/11. In my interviews, community members frequently referred to the economic impact of the epidemic as the latter part of a “double-whammy,” further devastating the already struggling economy since September 2001. In addition, a Charles B. Wang Community Health Center survey revealed that community members suffered from increased anxiety during this period (Chen and Tsang 2003). According to one Chinese health educator at the Center, community members were fearful of both the health and economic risks of the SARS epidemic.

My research was guided by an interest in how community members responded to the epidemic and to being identified as a source of contagion. I wanted to explore how they became aware of and explained the distant epidemic, as well as how they perceived their own and the community’s risk. Chinatown community members were in a unique position of being connected to the place of infection through family and friends in places such as China, Hong Kong, and Taiwan. Indeed, many people learned of the epidemic from people they knew in Asia before the infection was named, and before it was a central item of daily news reports.

During the summer of 2004, I conducted thirty-seven semi-structured, open-ended interviews with individuals selected from different sectors of New York City’s Chinatown and from health institutions. In order to explore a wide variety of perspectives on SARS and the events during the 2003 epidemic, I conducted in-depth interviews with health professionals (a doctor and a health educator from a community health center, 3
pharmacists, 2 acupuncturists), a priest, several leaders of local social and economic organizations, two school administrators, three restaurant owners, one travel agent, an employee of a cultural institution, two college students and two professionals who grew up in Chinatown, and one professional who immigrated to the United States less than 10 years ago from Fujian. Most of my informants had at least some college education. All of my informants spent much of their time, living and/or working, in Chinatown during the 2003 epidemic.

Interviews were conducted in English and revolved around personal descriptions of Chinatown and concerns respondents had specific to the community. Interviewees were asked to recall the events in Chinatown during the epidemic and their personal and professional responses. In addition, questions were asked regarding respondents’ assessments of individual and community risk. Interviews were taped and specific narratives were transcribed once dominant themes were identified. In analyzing the narratives that emerged from these interviews, special attention was paid to discourses of risk and blame, and the connections people made to social, political and economic issues when talking about SARS. In addition, I have maintained email contact with several interviewees, who have been kind enough to answer questions that arose throughout the analysis process.

Language barriers and my status as an outsider limited my ability to recruit informants from a wide socio-cultural background. The majority of community members whom I interviewed were professionals who either immigrated from or were born to immigrant parents from Guangdong Province, Taiwan, or Hong Kong. These populations
make up the more established Chinatown residents (Kwong 1996). This narrow sampling limits my ability to generalize about community perceptions of risk and perspectives on the impact SARS had on the community. I have tried to compensate for these limitations by seeking diversity in geographic location and occupation among my informants.

Despite these limitations, informants’ observations of events and discourses in Chinatown during the distant epidemic have been crucial to gaining a better sense of what SARS represented to the community. In particular, they illustrate the pressures put on Chinatown and Chinese Americans to conform to the idea of the “model minority” community. Further, informants’ narratives illustrate the multitude of factors that contribute to how people understand an epidemic, including personal risk.

Defining the Chinatown “community” was a difficult task. Rising rents in Manhattan have compelled many Chinese to move to Queens and Brooklyn, where two newer “Chinatowns” have emerged. However, many Chinese and Chinese Americans continue to come to Manhattan’s Chinatown to shop, eat out, and to attend church. I therefore broadly define “community member” as the residents, business owners, employees and frequent patrons of Chinatown, many of whom are Chinese and Chinese American.

**Argument**

I argue that discourses of risk and responsibility during the 2003 SARS epidemic illustrate the myriad historical, political and economic factors that shape understandings of and responses to a new disease. Specifically, the impact this distant epidemic had on New York’s Chinatown demonstrates that dominant
society continues to define Chinese Americans as the dangerous “other.” Further, responses within Chinatown reveal the pressures on the community to conform to the “model minority” ideal, which contribute to intra-community fissures between established residents and recent immigrants. The impacts of the epidemic additionally reveal Chinatown’s interconnectedness to the surrounding community as well as the world. In particular, responses to SARS throw into relief Chinatown’s role in the global economy as a site of production and destination for movement of bodies resulting from globalization. Taken together, my argument directly contradicts the widely-held belief that Chinatown is an isolated, self-sufficient ethnic enclave of the “model minority.”

Historic and current associations of Chinatown with danger and the exotic formed the basis for the public’s fear of the community as a site of contagion during the 2003 SARS epidemic. Rumors of community infections and depictions of Chinese inferiority were readily believed by the American public because they corresponded with an entrenched belief that Chinatown is a dangerous, filthy and exotic place isolated from the broader society (Lin 1998). Further, this image is perpetuated by popular media constructions of Chinatown, as well as policy discourses related to the “model minority/ethnic enclave” paradigm. The construction of Chinese Americans as the diseased “other” during SARS illustrates their tenuous status as the “model minority.”

Chinatown in the public imagination continues to be constructed by forces outside of Chinatown in a dialectic relationship with Chinatown economic and political strategies that depend on the notion of the exotic and the relative isolation of the community. The
primary ways the American public experiences and learns about Chinatown and Chinese Americans are through the media (Lin 1998) and the tourist industry that rely on these images. Achieving the demands of the “model minority” ideal, therefore, are impossible because this same discourse perpetuates the idea of Chinese Americans as exotic and foreign, two characterizations with informed their association with SARS infection.

Chinatown community members have historically responded to their economic and political marginalization in myriad ways. One of the primary strategies has been to assert a united Chinese identity, particularly in moments of community action or protest (Lin 1998). The notions of community solidarity and the “model minority” are employed by state officials to justify the State’s lack of attention to community concerns (Kwong 1996). The prevalent idea that Chinatown community members are taking care of themselves has led to its characterization as an “ethnic enclave” of the “model minority.” (Kwong 1996; Lin 1998)

However, the stigmatization of Chinatown during the 2003 SARS epidemic reveals that constructions of Chinese Americans as the “model minority” have not negated their historic association with disease, danger, and foreignness. Further, discourses of risk and responsibility that blamed SARS on Chinese “culture” were not universally rejected by community members. Indeed, local responses to these discourses and strategies to distance oneself from the social risk of SARS reveal many fissures within the Chinatown community. Although community organizations protested the association of Chinatown with risk of infection by projecting a united Chinese community, many informants differentiated between their risk and those of others. Many
used the same dominant discourses of risk and blame that labeled Chinese Americans as the diseased “other” to explain why recent immigrants represented community risk to infection.

In response to community stigmatization, therefore, community members’ strategies included both asserting and challenging the notion of Chinatown’s unity. Further, the ability of community members to negate Chinatown’s association with infection was ultimately limited by the entrenched history of portrayals of Chinatown as dangerous, exotic, and self-isolated. These imaginings of Chinatown continue to be perpetuated by the media, the tourism industry, and community challenges resulting from the cheap labor upon which much of Chinatown’s development is based.

**Background**

This project builds upon the work of several anthropologists and other social scientists who have focused on epidemics, each exploring disease from important distinct perspectives. It is useful to start with the idea of epidemic psychology (Strong 1990), which identifies many, though not all, of the myriad patterns of behavior following the emergence of an infectious epidemic. In searching for a universal model of how people respond to a new epidemic, Philip Strong outlines several characteristics of psychosocial responses to a new disease. These responses are most evident during the initial recognition of a new epidemic, particularly in situations where there is no established social response. Strong divides his analysis into three separate psychosocial “epidemics,” which he argues can occur simultaneously: the epidemic of fear, the epidemic of
explanation and moralization, and the epidemic of action or proposed action. Each of these reactions, according to Strong, has the potential to “infect” everyone in society.

An epidemic of fear is characterized by suspicion and stigmatization. Particularly before the causes of a disease and routes of infection are identified, people fear multiple route infection. The entire environment and some populations may be perceived as contaminated and potentially infectious (Strong 1990). For example, one study in Sweden during the initial period of the HIV/AIDS epidemic revealed that both the general public and nurses were found to share the fear that HIV could be contracted from public toilets and kissing. 30% of police officers and 15% of nurses in the study revealed that they would avoid helping a stranger for fear of contracting the disease, particularly if the person was bleeding (Herlitz and Brorsson 1990).

These fears and suspicions of others and places may be unrelated to the reality of disease (Strong 1990). People who have not been exposed to a disease may fear that they suffer from it, as happened during the HIV/AIDS epidemic (Strong 1990) and the 1994 plague epidemic in India (Shah 1997). The public may be aware of these contradictions as well. In the Swedish study (Herlitz and Brorsson 1990), only one fifth of the respondents believed that HIV could spread via toilet seats, yet over one third said that they would demand a separate toilet for an infected colleague. Those infected and groups associated with an epidemic, for example homosexuals during the initial emergence of HIV/AIDS or the Chinese immigrants during the late 19th Century San Francisco smallpox outbreaks (Craddock 1995), are stigmatized and sometimes avoided or isolated (Strong 1990).
Epidemics of explanation, moralization, and action can be responses not only to the disease, but also to the panic fueled by the epidemic of fear. During the initial stages of an epidemic, the public is searching for meaning and explanation. In the absence of established responses to the disease, different actions and interpretations are proposed by separate individuals and groups, which then compete in public discourse for legitimacy. Many of these explanations have a moral character to them, and some may even tie a new epidemic to breaches of religious doctrine (Strong 1990). Strong calls this phase an “epidemic of interpretation,” which may lead to the questioning of fundamentals underlying social order. Moral debates may lead to commentaries and criticisms of social order or the state, which may in turn lead to social change (Strong 1990).

For example, during the initial years of the HIV/AIDS epidemic in Sweden, India’s small pneumonic plague epidemic in 1994, and in China during the emergence of SARS, the public believed that the government and medical authorities were withholding information (Garrett 2000; Herlitz and Brorsson 1990; Shah 1997; Shih 2002). It has been noted that such distrust may pave the way for future political reforms (Elliot 2003). Further, the 2003 SARS epidemic drew world attention to China’s rural health crisis, where residents lack healthcare and communicable diseases such as tuberculosis and hepatitis are on the rise (The Lancet 2004). Criticisms over the Chinese government’s handling of the SARS epidemic has led to the State finally addressing the ever-growing problem of HIV/AIDS and the virtually non-existant public health system in rural China (Lei 2005).
According to Strong, language plays an enormous role in the proliferation of epidemic psychology. Through discourses of science, technology, and religion people make sense of their world and attempt to cope with threats to health and social order, such as an epidemic. Language can rapidly disseminate an epidemic of fear and stigmatization, particularly through television, by shaping the means and possible responses possible to an epidemic. Further, language shapes one’s perception of risk and the disease itself (Strong 1990).

Although Strong’s conceptualization is a useful beginning, in many ways it is unsatisfactory for critically looking at social responses to an epidemic. His model focuses on psychosocial responses that occur only at the local level where the epidemic occurs. Yet in a world where people are connected by rapid transportation and mass media such as the internet, both disease and the responses attached to them have the potential to become pandemic. Further, Strong doesn’t consider historical, local or global political and economic influences that determine discourses and actions taken in response to an epidemic. How are responses and the language surrounding an epidemic produced? Who benefits and who suffers from responses to an epidemic? Finally, Strong’s model lacks an examination of stigmatization and strategies of “othering” that occur during an epidemic. Answering these questions is crucial to understanding the social construction of an epidemic.

**Anthropology and Contagious Epidemics**

Several anthropologists have examined epidemics through the lens of power in order to investigate the production of knowledge, illness narratives, and the construction
of an epidemic as a social event. Medical anthropologist Stacey Leigh Pigg (2001) looks at how knowledge of the HIV/AIDS epidemic was produced and communicated in Nepal at a time when very few Nepalese were familiar with the disease. She examines how internationally standardized knowledge about HIV/AIDS played out in Nepalese production of awareness and emphasizes that epidemics are social events. “[R]eactions to AIDS are very much a part of what AIDS is…We never encounter AIDS in the abstract, apart from some matrix of knowledge about it.” (2001:488) Pigg asks whose knowledge counts, and draws attention to the privileged position that externally produced (and often initially incorrect) biomedical models have in HIV/AIDS awareness programs. Despite the hegemony of biomedical models, however, Pigg’s research also highlights the processes of negotiation that occur in the production of knowledge. Pigg argues that it is important to situate knowledge of a disease within specific social and historical processes by which the same is produced and recognized. Further, we should “see positioned people…negotiating knowledges in different ways” (Pigg 2001:525).

Anthropologist and physician Paul Farmer (1994) explores a similar theme, asking how a cultural model of HIV/AIDS was produced in Do Kay, Haiti and how illness narratives fit into narratives of broader experience. He credits radio with shaping the contours of the cultural model of HIV/AIDS by disseminating a “vague grid of associations” (1994:807) with blood and homosexuality. However, Farmer argues that preexisting meaning structures, for example references to blood disorders and tuberculosis with which the Do Kay people were already familiar, were even more important to their understanding HIV/AIDS. Farmer also identifies the important
elements of illness narratives: the advent of the illness, its emplotment that renders it human, and the prototypical case many people can recall. The prototypical case is the story of an infected individual who becomes symbolic of the infection’s spread. Similar stories appeared in my interviewees’ accounts of the SARS epidemic of a doctor who traveled from Guangdong to a Hong Kong hotel where he transmitted SARS to travelers who transported it across the world.

In their ethnography of a Venezuelan cholera epidemic, Charles Briggs and Clara Mantini-Briggs (2003) discuss the role narratives play in the construction of cultural memory of an event and their function as a coping mechanism. They define cultural memory as the “field of contested meanings” that lies between personal memory and history, and as the product of a continual struggle to construct and understand the identities, actions, and relationships of history. They argue that narratives are a crucial part of the construction of cultural memory because they can be taken from their original contexts and recontextualized to fit other settings, becoming “floating icons of the events they describe.” (2003:78) In the process, these narratives become objectified as authentic and authoritative representations of an event. In addition, illness narratives may help people cope with the search for order during and after an epidemic.

Briggs and Mantini-Briggs (2003) are careful to pay attention to the variegated and sometimes contradictory cholera narratives in their fieldwork. They argue that different narratives originating from different sources compete for legitimacy and characterize the same events differently. In their study, everyone was telling and spreading their own and others’ stories about the cholera epidemic throughout the
affected delta and beyond. These cholera narratives had real effects on how people lived and died during the epidemic. The media’s stories on the unfolding epidemic forced public health officials to respond by drawing public attention to the crisis. These accounts also shaped the language that eventually characterized the epidemic. In addition, the media coverage established public health officials as the only authorities on the epidemic, and in the process excluded alternative accounts. Officials’ narratives were an institutional survival strategy that displaced blame for the epidemic on the communities that were suffering the most by attributing cholera to indigenous culture. This directly contributed to the racialization of the epidemic. Finally, local narratives were constructed by people according to their own concerns and the modes of explanation they had at their disposal. Social position affected how people told their story and their personal reactions.

Briggs and Mantini-Briggs’ (2003) ethnography illustrates that the construction of epidemic narratives is a collective process that involves many people who contribute their own experiences and perspectives. Further, the authors show that it is wrong to assume that groups stick to either dominant narratives or counter narratives, nor to assume that these narratives are localized and aren’t shared widely. Their work therefore offers important methodological lessons for the anthropologist, particularly to pay close attention to the issues individuals raise and to the way people position themselves in their narratives.

**Blame and Disease**

Many anthropologists have noted the assignment of blame during a deadly epidemic. In 1966, Mary Douglas drew attention to the relationship between pollution
rules, morals, and social order. In her seminal book, *Purity and Danger: An Analysis of the Concepts of Pollution and Taboo*, Douglas (1966) argues that the body is the original scheme for symbolism, upon which the rules of purity and pollution are projected and embodied. Discourses regarding pollution are intimately tied to moral standards. Dirt symbolizes something outside of the desired order, matter out of place, while pollution reflects a breach of morals. People who are considered marginal or out of place are seen as threats to the social and moral order.

Even though Douglas wrote *Purity and Danger* in 1966, her insights are relevant because the tendency to connect ideas of pollution with morals continues to be evident in contemporary perceptions and representations of disease. Disease continues to be both an imagined and real phenomenon projected upon the “other.” Several anthropologists have echoed Douglas’ concept of pollution in their examinations of the production of responses to contagious epidemics.

In his research on othering and HIV/AIDS, Crawford (1994) asks why disease is associated with the “other” in American discourses. He identifies the resurgent emphasis on the pursuit of a healthy body since the mid-1970’s as the means by which the middle class displays and practices their social identity. The pursuit of health is the primary means of middle class boundary maintenance. According to Crawford, the boundaries of the healthy self are never secure, and therefore the maintenance of a healthy identity necessitates a diseased “other”. Fear of HIV/AIDS is therefore not only a fear of contagion, but of the vulnerability of this social identity of the healthy self. Crawford further argues that othering is a strategy to deal with the sense of loss of control
experienced during a deadly epidemic. Othering is a coping mechanism undertaken to
distance one’s personal risk of infection and death by projecting it onto an “other”.

Nations and Monte’s research during a cholera epidemic in Brazil looks at
responses to such boundary maintenance among those stigmatized. They illustrate that
stigmatized populations do not silently accept discourses of risk and blame that label
them as the dangerous “other”. In their fieldwork, they found that so-called patient non-
compliance was undertaken by those associated with cholera in order to avoid the social
risk of a positive diagnosis. They argue that the stigmatizing metaphors of cholera,
extant in official and popular discourse, caused people to reject medical instructions.
People feared the social risk of the morally polluting infection more than they were afraid
of the disease itself.

Briggs and Mantini-Briggs (2003) use Douglas’ concept of matter out of place to
discuss the language of citizenship that emerged in discourses surrounding a Venezuelan
cholera epidemic. According to the authors, this language of citizenship provides a
framework of inclusion in and exclusion from membership in the community in which
one lives. Their research is interested in the use of sanitary citizenship embedded in
discourses of risk and responsibility during the epidemic. The authors define sanitary
citizens as those who have “modern” medical knowledge of the body, illness, healing and
hygiene and who depend on biomedical professionals when ill. Unsanitary subjects are
“premodern”, marginal people who are deemed incapable or resistant to modern medical
explanations and techniques. Unsanitary subjects need to be protected from their own
dangerous practices for their own good and the health of sanitary citizens. This group is
identified by one characteristic, such as race or class, which can be used to extend the unsanitary label to others who share the characteristic. Briggs and Mantini-Briggs characterize this as racial profiling in a medical context. Further, whole nation-states may be blamed for not transforming their subjects into sanitary citizens, thus labeling the whole country as premodern. During the 2003 SARS epidemic, the language of sanitary citizenship characterizing dominant discourses of risk and blame defined the Chinese as unsanitary subjects.

Briggs and Mantini-Briggs cite Farmer’s concept of the “geography of blame” (1992) that occurs when nationalistic discourse places responsibility for a disease on the “other”. They identify the racialization of space and spatialization of race that occurs in such discourses. In their research they identified how indígenas and criollos were associated with specific areas, and vice versa. Indigenous geographic spaces were labeled unhealthy, while those of criollos were labeled healthy. The use of words like “invasion” in reference to indígenas entering areas perceived to be non-indigenous further racialized space, transforming the so-called invader into matter out of place.

The authors further argue that the language of blame encourages sanitary citizens to position themselves outside of risk and to associate the disease and the infected with foreigners and indígenas. This undermined the Venezuelan health education campaign that targeted the middle classes who, as sanitary citizens, didn’t perceive themselves to be at risk (Briggs and Mantini-Briggs 2003).

Along with Paul Farmer (1992), Briggs and Mantini-Briggs (2003) argue that blaming the poor draws attention away from larger questions of social inequality, thereby
excusing the institutions responsible for their misery. It blames the most powerless for the conditions they are forced to live in, conditions which make them more vulnerable to infectious disease epidemics. It also contradicts nationalistic and globalism discourses of unity.

Farmer (1992) documents how during the initial emergence of the HIV/AIDS epidemic, discourses in the American press and public echoed preexisting ideas about the people and geography of Haiti. In particular, references to voodoo practices and Haitian inferiority were utilized to construct explanations and social meaning of the virus. This resulted in widespread discrimination of Haitian immigrants and Haitian Americans in the United States. Farmer’s research (1992), like that of Briggs and Mantini Briggs (2003) shows how such stigmatization was rooted in scientific discourses of the CDC that placed Haitians in their own so-called HIV/AIDS risk group. Briggs and Mantini-Briggs place much of the responsibility for the legitimization of stigmatizing discourses on anthropology’s cultural reasoning. Such reasoning was used to naturalize the intractability of Venezuelan indigenous, thus legitimizing the perception that as unsanitary subjects they rejected the adoption of modern health practices. Further, the language of culture was used to support the matter out of places thesis: the spaces to which the Venezuelan indigenous fled from their cholera-stricken villages were deemed culturally inappropriate by state authorities (with the help of an anthropologist) who incarcerated and then removed them from the town. Finally, the emergence of cholera, a disease associated with the past, was traced to the so-called indigenous cultural practice of eating crabs. The indigenous diet was identified as the source of epidemic and a risk
factor for this generalized population. The ceremonial eating of crabs by one indigenous population was mapped onto other indígenas in the region, enabling the state to ignore their role in fostering the conditions for the epidemic.

Both ethnographies illustrate that stigmatizing discourses are disseminated and naturalized by the media, thus contributing to the production of risk and social meaning of a particular epidemic (Briggs and Mantini-Briggs 2003; Farmer 1992). Further, the state through policy implementation legitimizes such discourses by putting them into practice (Briggs and Mantini-Briggs 2003; Ghosh and Coutinho 2000).

Briggs and Mantini-Briggs’ research (2003) emphasizes the importance of news media images in this process. Discourses of risk and blame targeting the poor and indigenous were naturalized by the press who juxtaposed text with images that illustrated the cultural reasoning behind indigenous inferiority and risk. Indígenas were depicted through these images as diseased, tired victims. They came across as irrational, ahistorical, and decontextualized. In contrast, public health officials and politicians were portrayed as ordered, healthy, and modern. In this way, the use of pictures helped shape cultural memory and hide government responsibility and global forces that helped create the conditions that fostered high mortality during the cholera epidemic. These images were de- and re-contextualized as they circulated and became “immutable mobiles,” images that were able to represent (and thus imagine) entire races and classes of people (2003:323).
Media and Contagious Epidemics

Other social scientists have documented how media representations of diseases figure prominently in shaping awareness and understanding of a distant epidemic. In their study on the affects of media images on British residents’ perceptions of the Ebola virus, Joffe and Haarhoff (2002) argue that images may enter one’s consciousness in an uncritical manner, conjuring feelings that may be resistant to challenge. Indeed, images have the potential to convey more than simple words and can shape public perceptions of personal danger, rates of infection, geographic and ethnic associations with a disease.

However, Joffe and Haarhoff (2002) argue that risk signals, including images and symbols, portray a risk event and shape, but do not dictate, the public’s conceptualization of the risk. They argue, following Sheldon Ungar (1998), that the messages produced by the media were not just ones of fear and suspicion, but also of reassurance. Joffe and Haarhoff (2002) found that the British press emphasizes the potential global spread of Ebola before placating its readers with information about containment procedures. The media thus heightened the fear of a health crisis for readers who have no personal experience or relationship to Ebola, and then asserted solutions for the epidemic and fear. Although British newspapers attempted to portray Ebola as a “real” threat to Britons, Joffe and Haarhoff found that many people conceptualized the disease as if it were science fiction. The tendency to other the disease and perceive it as isolated among black African populations characterized public responses in their study. It is also clear from their study, although they do not directly state so, that although the media might not
dictate how the public conceptualizes personal risk of infection, it does lay the parameters for how such risk is judged.

**My Contribution**

My research follows the lead of Joffe and Haarhoff (2002) in looking at responses to a distant disease event, the 2003 epidemic of Severe Acute Respiratory Syndrome (SARS). However, unlike these authors, I examine the construction of risk discourses from a historical, political and economic perspective, taking into account how inequalities of power shape the meaning and responses to an epidemic. Further, I investigate how those who are “othered” in this process respond to the discourses that stigmatize them.

In this ethnography I investigate what happened in New York City’s Chinatown where there were no infections, but community members were nevertheless associated with the disease. Throughout American history, Chinese Americans and Chinese immigrants have been associated with disease, but in the last thirty-five years they have also become the celebrated “model minority” praised for their economic success. This popular imagining of the Chinese community, however, quickly gave way to the historical association of Chinatown with danger and disease. Tourism plummeted as the public avoided the neighborhood and feared contagion, particularly via Chinese restaurants.

However, community members weren’t powerless in the face of such discrimination. Unlike many of the stigmatized populations in the aforementioned ethnographies, who had little access to media and other information production centers,
the variegated socioeconomic positions of New York City’s Chinatown community members made it possible for some to refute their stigmatization on behalf of the entire community. Several community groups organized a rally to protest Chinatown’s association with SARS and to proclaim the neighborhood safe for tourism and businesses.

At the same time that some community members were proclaiming the safety and health of Chinatown, others felt that the community could be at risk for infection and differentially assigned risk and responsibility for a potential epidemic within Chinatown. In addition to being a strategy to distance self from risk and manage social risk, the specific location of blame by community members is a reflection of local concerns, Western and Chinese discourses of modernity, and of the demands the “model minority” rhetoric places on all Chinese in the United States. Community members’ responses to the epidemic and to the discourse that associated Chinatown with SARS were shaped by numerous factors including, but not limited to, discourses of modernity, personal and professional positions in the community, concerns about friends and family in Asia and Chinatown, and strategies of mitigating social risk and risk of infection.

In this thesis I will explore the factors that shaped how Chinatown became associated with the epidemic and responses of community members. I will begin by recalling the history of Chinatown as an immigrant community produced by discrimination and historically associated with disease and danger. I will then explore how SARS was represented in the news media and the dominant discourses that associated the disease with the primitive, and visually represented the epidemic with
pictures of Asians in masks. Finally, I will discuss community responses to the epidemic based on interviews I conducted in Chinatown one year after the epidemic ended.
CHAPTER II:

CHINATOWN AND CHINESE AMERICANS IN THE PUBLIC IMAGINATION –
THE HISTORIC CONSTRUCTION OF AN OTHERED SPACE AND PEOPLE

In order to begin exploring the events and discourses within Chinatown during the 2003 SARS epidemic, it is necessary to first investigate why Chinatown and Chinese Americans became associated with SARS by the general American public. I am particularly interested in how historical ideas regarding Chinese American communities played into understandings of a potential SARS epidemic in the United States.

In his book *AIDS and Accusation*, Paul Farmer (1992) illustrates how the American public, health officials, and the media used pre-existing imaginings of Haitians and Haiti in order to explain the then-emerging epidemic of HIV/AIDS. The media and public health officials portrayed Haitians as highly vulnerable to infection and as probable carriers of the disease using references to dangerous cultural practices and moral inferiority. These discourses were rooted in existing perceptions of Haitians as inferior people with backwards voodoo traditions. A similar, although less vitriolic with the containment of SARS, discourse emerged with the SARS epidemic. An examination of public imaginings of Chinese Americans is necessary to understand how SARS became a racialized epidemic.

The association of Chinese immigrants and their communities with danger and disease has a historical precedent that has persisted despite Chinatown’s relatively recent characterization as a successful ethnic enclave of the “model minority.” Part of this image is that Chinatown is somehow separate and isolated from the rest of the United States. In
this chapter, I will trace historical associations of Chinatown with disease, danger, and isolation and examine how these associations have persisted today. I will also investigate the ramifications of the resulting social, political, and economic isolation on the community. First, I will briefly recount the history of Chinatown and Chinese immigration to the United States.

**Chinese Immigration and the Emergence of Chinatown**

Chinese immigration to the United States dates back to the 1840’s, after China’s defeat to the British in the Opium War (1838-1842) forced open several ports in China for trade, including Guangzhou (Canton). Chinese immigrants during this time came to the United States for many reasons. Territorial conflicts and peasant uprisings made China economically and socially unstable, causing people to look overseas for ways to support their families. Many of the Chinese who came to the United States were lured by the promise of fortune in gold mining, and most intended to return to China with the money they earned (Zhou 1992).

The majority of these immigrant workers, or “coolies,” were peasants from the Pearl River Delta, near Guangzhou, who paid more for their passage than they made in a year. Under the coolie system of contract labor (translated into “the selling of pigs” in Chinese), fees for passage were often fronted by the coolie broker to the immigrant, who would then have to repay his debt out of his earnings. The often illiterate coolies signed contracts before the details were filled in, enabling exploitation by their employers and brokers (Zhou 1992). Current illegal immigration to New York from China mirrors this pattern.
Many Chinese immigrants settled in California and other parts of the West where they worked as agricultural laborers and miners. After the gold rush, they pursued employment in surrounding states, working on the transcontinental railroad, and other industries including fishing, seasonal agriculture, urban factories, and domestic work (Lin 1998).

Although the Naturalization Law of 1790 excluded the Chinese from American citizenship, they were generally welcomed in the United States because they fulfilled the demand for cheap labor left vacant after the end of the Atlantic slave trade (Lin 1998). After the completion of the transcontinental railroad, however, the Chinese were despised for competing with whites for jobs (Craddock 1995; Kwong 1987; Zhou 1992). The press, politicians, doctors and anti-Chinese associations increasingly depicted the Chinese as a threat to American health, morals, and the nation’s technological superiority (Ahmad 2000; Lin 1998). An active anti-Chinese Movement developed in the latter half of the 19th century, which led to the passage of the 1882 Chinese Exclusion Act, the first immigration law to exclude a single ethnic group from immigration. In the following decades, Congress passed subsequent acts that solidified the exclusion of Chinese from immigration and naturalization (Lin 1998).

During this period, known as the exclusion era, Chinese immigrants were physically intimidated in an effort to drive them from the country. They were forced out of their jobs, targeted by armed mobs who threw stones at them in the streets and looted their stores (Zhou 1992), and driven out of small towns into urban areas (Kwong 1987). While some immigrants returned to China, others fled east looking for work. They took
low wage jobs in industries Americans didn’t want to work in, such as restaurants and laundry (Lin 1998).

In response to this severe discrimination and adversity, the Chinese clustered together in urban areas as a protection strategy (Kwong 1987; Lin 1998; Zhou 1992). These areas eventually developed into Chinatowns. The Chinatown in New York City was the second, and largest of these communities. Over half of the immigrants arriving from China still settle in either California or New York (Zhou 1992).

According to Min Zhou (1992), Chinatown served three functions at its inception. It sheltered the Chinese from an American society hostile to their immigration. It served as an economic base where Chinese could find employment that barely satisfied their survival needs, but where they could participate in marginal employment markets without competing with the White working class. Finally, it served as a social center of support that reminded Chinese immigrants of home.

**Constructing a Racialized Space and People**

Chinatown is not only a geographic space, it is also an imagined one that is integral how the American public imagines Chinese Americans. Americans encounter Chinatown through media depictions, policy discourses, and the tourism industry, all of which tell alternating stories of who Chinese Americans are and what Chinatown represents. These representations serve to “other” Chinese Americans and their communities in a process that rationalizes internal inequalities and pits Chinese Americans against other minorities.
To understand the material significance of the social construction of Chinatown and Chinese Americans, it is useful to begin with Eric Wolf’s conceptualizations of tactical or organizational power and structural power (Wolf 2002). Wolf defines tactical or organizational power as that which “controls the settings in which people may show forth their potentialities and interact with others” (Wolf 2002:222). Structural power “organizes and orchestrates” these settings. It structures the choices people have by making certain behaviors possible and others less possible or impossible.

Using this political economic perspective to understand the social construction of Chinatown keeps us from falling into treating Chinatown as an isolated, independent community, a characterization prevalent in academic literature and public policy discourses. As Wolf (2002) himself argues, defining these modes of power allow the anthropologist to consider the global forces shaping the lives of Chinatown’s community members.

Further, the process of social construction (or “signification”) necessarily involves power (Wolf 2002). Metaphors involving dichotomies have multiple meanings which must be restricted to be applied. Power is involved in this process of signification by establishing what is “true” to the exclusion of other perspectives (Wolf 2002).

Finally, Wolf’s essay (Wolf 2002) explains society’s need to “other” people, to categorize and create a hierarchy of human beings. He argues that each mode of power requires the conceptualization and categorization to organize and deploy labor. The division of people into racial categories is one example.
Jan Lin (1998) and Peter Kwong’s work (Kwong 1996) demonstrates Wolf’s conceptualization of the power of significication. They illustrate how the social constructions of Chinese Americans and Chinatown have helped to structure and maintain the political economy of Chinatown by shaping the State’s interactions (or lack thereof) with the community.

Jan Lin (1998) argues that Chinatown is a “site through which American concepts about immigrating Chinese as a racial and ethnic category were constructed and reproduced” (Lin 1998:3) through official policy discourses. Lin (1998) argues that the public encounters and re-encounters these constructions through government policy discourses and the media, much the same way that Edward Said (1978) argued that notions of the “Orient” and “Oriental” were constructed through the cumulative writings of European scholars. Public knowledge of Chinatown is created through an imaginative discourse that both demonizes and exoticizes the neighborhood and Chinese Americans. Lin points to federal, state and local government policies that help create and perpetuate negative stereotypes of Chinatown and Chinese Americans through discourses that treat Chinese Americans as clannish and self-isolated and Chinatown as laden with social problems (Lin 1998).

There are many different, sometimes conflicting, constructions of Chinatown and Chinese Americans in the public imagination. Often Chinatown is negatively depicted as overcrowded and isolated, plagued with social problems, crime, and disease. However, recently Chinatown has become heralded as an economically successful enclave, and Chinese Americans are praised for being the “model minority” (Lin 1998). These
constructions are tapped at different points by various parties, both internal and external to Chinatown, to impose meaning on this space and the people within it. Later I will argue that negative depictions of Chinatown played a seminal role in how the public made sense of the SARS epidemic and risk of contagion.

**Medical Scapegoating**

Chinatown has often been perceived as a threat to American health and safety, a notion that finds its roots in the history of the Anti-Chinese Movement. Indeed the historic construction of American Chinatowns as centers of disease, as Susan Craddock (1995) argues in reference to San Francisco’s Chinatown, is one of the most enduring ideas that continues to define the community as foreign in the public imagination.

Medical scapegoating of Chinese communities has occurred since immigrants first started arriving from China in the 1840’s. Before the passage of the Chinese Exclusion Act of 1882, participants in the Anti-Chinese movement, which included many physicians, warned that allowing Chinese immigration would spread opium addiction throughout the White population and would lead to a decline in morals (Ahmad 2000). In 1876 one San Francisco physician described the Chinese as being the focus of any and all adversities experienced by the Caucasian population, including earthquakes (Barde 2003). These anti-Chinese sentiments reflected White Americans’ concerns over employment opportunities they saw threatened by Chinese labor, and over definitions of the American national identity. The Chinese were perceived as perpetually foreign, physically and linguistically different, and resistant to assimilation into the broader American society (Craddock 1995). This characterization continues today.
San Francisco’s Chinatown, the first in the nation, was the focus of much of the intense anti-Chinese rhetoric and action, particularly during several smallpox and plague epidemics of the late nineteenth- and early twentieth centuries. Although the first of these smallpox epidemics (1868) did not incur anti-Chinese rhetoric in official descriptions, the following years yielded increasing criticism of the Chinese for their disease-spreading culture. When the second epidemic hit in 1876, during the same period that people were arguing for the exclusion of Chinese from the United States, conventional wisdom had shifted away from viewing the disease as one of general origin and infection. After several years of characterizing the Chinese as hygienically inferior, the construction of infection and contagion was targeted onto the Chinese and the space associated with them: Chinatown. Although the epidemic was probably spread by European and American immigrants arriving from areas already experiencing an epidemic that started in 1871, San Francisco’s Chinese were quickly associated with smallpox. The further epidemics in 1881 and 1887 only made that association stronger until Chinatown was known as a center of disease (Craddock 1995). The events following the arrival of the worldwide bubonic plague pandemic in San Francisco, and indeed those of SARS epidemic as well, illustrate the resiliency of this association.

In the 1890’s a world bubonic plague pandemic began that was believed to have spread from China via trade routes originating from Guangdong and Hong Kong (Hirst 1953; Simpson 1905). The pandemic may have actually originated in Burma (Simpson 1905), but in Western medical discourses it became associated with the Chinese, their food and the way they were believed to live. Already associated with filth, the plague
became conflated with what was considered the Chinese lifestyle: crowded, dilapidated housing and what were described as unsanitary living conditions. One doctor attributed the plague to the Chinese “promiscuous manner in which the cattle, fowls, and domestic animals are permitted to live in close association with human beings” (Simpson 1905:177). Some doctors theorized that people became infected through food of the poorer classes, such as rice that was of poor quality or had been contaminated by rat feces (Hirst 1953; Simpson 1905). Further, “Asiatics” and “Orientals” were believed to be more susceptible to plague (McClain 1988), perhaps because of their diet that centered around rice (Edelson 2003). Such a view was disseminated to the public through daily newspaper reports of the plague, which helped shape public opinion of the Chinese and of the epidemic (Barde 2003). These same discourses would resurface in 2003 to explain why SARS emerged in China.

San Francisco, whose mayor would spearhead the Chinese Exclusion Convention of 1901 and would later run for the U.S. Senate using the anti-Chinese immigration slogan “Stop the Silent Invasion” (Lee 2002), immediately took action. The city applied a quarantine on Chinatown, which was believed to be the source of the bubonic plague epidemic of 1900. The quarantine, however, applied only to the Chinese, not to Chinatown’s white residents (McClain 1988). Following on the heels of over a half a century of anti-Chinese legislation and the recent razing of Honolulu’s Chinatown, San Francisco’s Chinese were rightfully skeptical of the public health measures purported to be taken on their behalf, and they challenged the quarantine in the courts (McClain 1988). After three days the quarantine was lifted, but over the next two months more cases of
bubonic plague were identified in San Francisco, causing fear that the disease would spread to other cities. In response to these fears and to the conventional wisdom that Asians were more susceptible to the plague, President McKinley ordered a quarantine on all Chinese and Japanese (Edelson 2003).

San Francisco’s Chinatown became indelibly associated with disease, contagion, and inferiority after these series epidemics. However, such associations were not limited to San Francisco’s Chinese population. The national attention surrounding San Francisco’s plague epidemics during the first decade of the twentieth century undoubtedly shaped national perceptions of Chinese immigrants and their communities, and contributed to the permanency of the association between Chinese communities and disease.

Crime and “Ethnic Vice”

Chinatown is frequently depicted as a center of “ethnic vice” (Lin 1998): an overcrowded and isolated community plagued with social problems and illegal activities. This perception relies on beliefs that Chinatown is predominated by organized criminal smuggling rings that hold illegal immigrants in slave-like labor, and that the community is beyond the control of the American state.

Jan Lin (1998) traces the historical association of Chinatown with crime to the development of its alternative economy during the exclusion era, which included prostitution and gambling. He attributes the emergence of these marginal activities to the fact that Chinatown was predominately male prior to the repeal of the Chinese Exclusion Act in 1943. Zhou (1992), on the other hand, explains their rise as the result of the
isolation of the Chinese by a hostile American public. The seclusion of community members in Chinatown enabled the immigrants to conduct marginal economic activities in order to fulfill their survival needs (Zhou 1992).

Whatever the explanation, these activities contributed to Chinatown’s already-prevalent depiction as a center of vice. This stereotype has sustained its place in the public’s imagination through popular media’s disproportionate focus on crime in Chinatown. Lin (1998) points to sensationalizing news exposés on brothels, sweatshops, illegal immigration, international smuggling rings, and violence that reduce the social reality of Chinatown and emphasize only the problems of a complex community. In the fall of 2003, the popular television show Third Watch featured an episode in which a ship of illegal Chinese immigrants infected with the plague runs aground on a New York City shore. The plot revolved around the escape of one Chinese man who fled all over New York City, potentially spreading infection in his wake. This plot undoubtedly played upon public concern over illegal immigration and foreign health threats. The episode recalled the real events of the Golden Venture ship of undocumented Chinese that grounded in Queens in the summer of 1993, and combined it with the SARS epidemic of 2003 during which many New Yorkers feared contagion from Chinese people.

The ethnic vice depiction is further emphasized by guidebooks that introduce Chinatown to visitors. The books repeatedly use terms such as “cluttered,” “crowded,” “sinuous,” “sprawling,” and “smelly” to describe the area. Visitors are encouraged to visit “Bloody Angle” on Doyers Street where “notorious” gangs once vied to control local opium trafficking and gambling. Others describe cramped tenements and the
peddling of illegal fireworks. Furthermore, the guidebooks almost universally describe Chinatown as violating its boundaries by “invading” Little Italy north of Canal Street, the historical boundary of Chinatown. The Chinese are thus portrayed as matter out of place (Douglas 1966), moving beyond their culturally appropriate space south of Canal St. During my fieldwork in Chinatown, I saw many tourists wandering around carrying these same guidebooks.

Exotic Foreign Enclave and the “Model Minority”

Another Chinatown that exists in the public’s imagination is that of the exotic foreign enclave, full of cheap Asian goods and alimentary pleasures. Chinatown as a foreign space is fascinating, timeless, and sometimes backwards. This exotic depiction is central to Chinatown tourism, and, like the image of Chinatown’s ethnic vice, it can be found in tourist guidebooks:

*Ribs, whole chicken and Peking ducks glisten in the storefront windows nearby: the sight of them can put more than a vegetarian off his food. Perhaps even more fascinating are the Chinese herbalists. The roots and powders in their boxes, drawers and glass are century-old remedies, but, to those accustomed to Western medicine, may seem like voodoo potions.*

(The Mini Rough Guide to NYC 2002)

The ethnic enclave discourse is also found in academic literature that depicts Chinatown as an isolated space serving the economic and social needs of a unified Chinese population. This literature frames Chinatown as a semi-independent economy where English is not required for employment, and where the Chinese tend to their concerns and conflicts without outside interference. Zhou (1992) embraces the enclave model, and describes Chinatown as a stepping stone for Chinese immigrants into mainstream American society and social mobility. She argues that the Chinatown
economy offers Chinese immigrants employment in culturally and linguistically appropriate settings, enabling them to achieve success without losing their ethnic identity and solidarity.

Zhou acknowledges worker exploitation and the concentration of power among a few elites, but she skirts discussing intra-community economic and political inequalities. Instead, she emphasizes the positive aspects of Chinatown, such as the growing business sector and the geographic expansion of the community. Crucial to Zhou are the economic and employment opportunities Chinatown offers to Chinese immigrants, which she argues benefit both Chinatown’s entrepreneurs and its workers:

[Immigrant Chinese] depend on Chinatown not because they are willing to accept low wage jobs, poor working conditions, and exploitation but rather because they view it as a better option. In Chinatown they are provided with a familiar work environment in which they are effectively shielded from deficiencies in language, education, and general knowledge of the larger society. [...] Thus, social capital benefits both the enclave entrepreneurs and the workers. The “willing self-exploitation” of the enclave entrepreneurs apparently brings about profits for ethnic entrepreneurs, but the entrepreneurs are also obliged to help train the workers in occupational skills and to promote eventual transition to self-employment. (Zhou 1992:12-13)

Zhou believes Chinatown offers an alternative path to social mobility by providing employment opportunities to people whose economic success would otherwise be hindered by language and cultural barriers.

Zhou’s analysis centers on the idea of community ethnic solidarity, a gross misuse of cultural reasoning that Zhou uses to explain away exploitation and inequalities in Chinatown. By framing the exploitation of immigrant and poor Chinese as “a better option”, Zhou overlooks both the economic and political forces that limit their options.
Her characterization of Chinatown is wishful at best, and ignores the diversity and power struggles in the community.

In contrast to Zhou, Peter Kwong (1987) argues fiercely against what he calls the myth of the ethnic enclave. According to Kwong, who has worked in Chinatown labor organizations, the ethnic enclave discourse masks community inequalities behind an appearance of success. Kwong describes the reality of Chinatown, where people are primarily working class individuals without health benefits or job security, and many reside in poor living conditions. He argues that Chinatown is not advancing economically, and that in fact wages are falling. Further, Kwong describes the limited economic mobility in Chinatown, where fierce competition to offer the cheapest prices keeps wages low and the hours long in jobs where safety and employment regulations are routinely violated and rarely prosecuted.

Like Kwong, Lin (1998) describes duality of the ethnic enclave, where Chinese with limited skills can find work but are not protected by health, safety and working regulations. Chinatown’s unregulated economy feeds high productivity, but at a cost to workers. This illegal working environment is maintained by an informal political structure that operates independently but with the tacit support of the city (Kwong 1987; 1996; 1997).

The image of Chinatown as a successful enclave of ethnic solidarity is supported by the notion of Chinese Americans as the “model minority.” In 1970, Americans were surprised at Census results showing that Chinese Americans had higher levels of educational achievement and that more Chinese were in professional fields than the
national average. Particularly striking to the public and social scientists was how quickly the Chinese appeared to have achieved these levels of success. (This was most likely due to the fact that these were the first significant data made available about Chinese Americans (Kwong 1987). Chinese Americans were praised as the “model minority” for having achieved economic and educational success in a short period without public assistance. They were hailed as the prime example of the American dream for being “willing to start at the bottom and help one another to get ahead.” (Kwong 1987:5)

However, the 1970 Census ignored the vast economic differences between different Chinese American groups. In *The New Chinatown*, Peter Kwong (1987) describes a polarized Chinese population in New York City by differentiating between the economically successful “Uptown Chinese” and the economically depressed “Downtown Chinese” in Chinatown. Uptown Chinese include many Chinese elites who immigrated to the United States after the defeat of Chiang Kai-shek during the 1949 socialist revolution, as well as scholars who were stranded in the U.S. at that time. In addition, the provision in the Immigration Act of 1965 to admit professional and skilled individuals increased the numbers of Taiwanese students and professionals in the United States, many from elite and highly-educated classes.

In comparison, the Chinese of Chinatown have experienced much fewer educational and economic successes. According to the 1980 Census, these Chinese had much lower median household incomes. Only 27.6% held high school diplomas, and 24.7% lived below the poverty line, compared to 17.2% for all of New York City (Kwong 1987). Whereas many of the original Uptown Chinese immigrated with capital
and high education levels, many Chinese in Chinatown have had to work long hours under exploitative working conditions and wages, casting doubt on their ability to achieve economic mobility (Kwong 1987).

The model minority characterization overlooks the polarity of these data to portray Chinese Americans as a unified community whose hard-working immigrants have been able to rise to the top. However, the idea that Chinatown is an exemplary community has not negated its historic stigmatization. During the SARS epidemic, the images of ethnic vice and foreign enclave supplanted the more recent conception of the model minority community. Further, community member responses to this stigmatization problematize Chinatown’s image as a community of unified Chinese.

**Co-existence of the “Model Minority” and the “Dangerous Other”**

The ideas of the “model minority” and the “ethnic enclave” are able to co-exist alongside that of the “dangerous other” because they both emerge from and perpetuate agendas tied to the racialization of identity, space, and inequalities. These ideas are part of the historical process that has constructed Chinatown and Chinese Americans as different, thereby reinforcing the construction of the American (i.e. “white”) identity. This process of defining Chinatown and Chinese Americans as different from “us” racializes both the people and space of Chinatown, thereby making the geographic growth of Chinatown an inappropriate movement of bodies into places where they don’t belong. Chinatown’s expansion north of Canal Street, for example, is interpreted as an “invasion” of Chinese into Little Italy, rather than a reflection of the economic factors that compel Italian immigrants and business owners to inhabit other spaces.
Further, these discourses turn economic and social inequalities into questions of cultural superiority, creating a racial/ethnic hierarchy of American minorities. Asians are successful because they are hard-working and value education, unlike African Americans and others who are characterized as lazy and living off the government. Asian Americans are thus pitted against other minorities by policy makers who wish to characterize economic inequalities as the result of the cultural inferiority of other communities of color, rather than the result of historical and institutionalized racism. Anti-Korean violence during the Los Angeles Rodney King riots is a reflection of this tension legitimized by the “model minority” discourse. It is also a sad example of what Fanon called the “racial distribution of guilt” (Fanon 1967), as the violence was more likely to be interpreted as an ethnic conflict than as a result of the institutionalized racial scale of privilege and poverty, of which the “model minority” discourse is also a product.

I am not arguing here that the signification of Chinatown is a wholly external process. The residents of Chinatown are, in the words of Kay Anderson, “active agents in their own ‘place making’” (Anderson 1987:583). Chinatown is a community distinguished by its cultural traditions and the Asian heritages of its residents. Indeed, many of my informants are active participants in constructing what their community means to the public by emphasizing its cultural heritage, its rich history, and its contributions to New York’s cultural and business fabric.

What is important to recognize is that Chinatowns, not just the one in New York City, contribute to the possibilities of experience and identity in the United States, our American cultural diversity. The rhetoric that characterizes Chinatown as an “ethnic
enclave” and Chinese Americans as alternately the dangerous Chinese “other” or the “model minority” produces and reproduces their status as not part of the “general public,” meaning the white public. It explains away the reticence of the State to address New York Chinatown’s poverty, labor abuses, human smuggling and community crime, to say nothing of its post-9/11 economic needs, by characterizing these problems as the result of intractable “cultural” differences or inferiority or by characterizing the community as self-sufficient. Therefore, in the context of SARS, the ideas that Asians are more at-risk and that Chinatown is a likely site of contagion were believable because neither belong to the “general public” that, in dominant discourses, will be protected by the “superior” American public health system.

An Insular Community: Myth and Reality

All of these categorizations are predicated on the assumption that Chinatown is an insular community and that Chinese Americans prefer to take care of themselves. This notion is rooted to some degree in the historical clustering of Chinese immigrants as a response to discrimination. Indeed, the preference for self-isolation was pointed out by many of the people I interviewed. However, the construction of Chinatown’s isolation and independence belies its interconnectedness with New York City. It enables the State and outside community to marginalize Chinatown and ignore community concerns, while simultaneously benefiting the few Chinatown elites. Further, it conceives of Chinatown as a community of ethnic solidarity, overlooking the diverse population of both Chinese immigrants and American born Chinese who have variegated relationships with each other and with the larger American society. Finally, notions that Chinatown is a self-
sustaining, isolated ethnic community perpetuate its foreigness and marginalized position.

External conceptions of Chinese Americans as cloistered are rooted in historical anti-Chinese discrimination. As noted before, during the years of the Chinese Exclusion Act and Anti-Chinese Movement, Chinese immigrants were forced to cluster together in urban areas where they developed their own economic practices to compensate for fierce anti-Chinese discrimination in the larger society (Kwong 1987; Lin 1998; Zhou 1992). Most Chinese at this time intended to return to China when they had earned enough money to own small amounts of land. They were not interested in becoming part of an American society that despised them (Kwong 1987; Zhou 1992). With the repeal of the Chinese Exclusion Act in 1943, the passage War Brides Act in 1946 and the Hart-Cellar Immigration Act of 1965 that prioritized family reunification, the Chinese began to move from seeing themselves as sojourners toward being permanent residents in the United States (Zhou 1992).

During the Cold War, the perception that the Chinese were a threat to American society gained further strength. In Chinatowns across the country, many Chinese immigrants were infuriated with the Chiang Kai-shek’s Chinese Nationalist Party (KMT) manipulating the exchange rates so that the money they sent home was severely devalued. While their families in China received little of the money American Chinese sent home, Chinese officials made millions (Kwong 1987). Many in Chinatown therefore had little sympathy for Chiang Kai-shek’s defeat. U.S. authorities assumed most residents
were pro-Communist and accused many of being Communist agents, resulting in their deportation (Kwong 1987).

1950’s American anti-Communism, furthermore, restored the hegemony of the traditional Chinatown elites whose influence had been declining. These elites, who have maintained close ties with Taiwan, were able to use American persecution of suspected Communists to silence political discourses contrary to their interests, particularly the growing labor movement. Community affairs were solved to the advantage of those in power, who simultaneously projected an image of ethnic unity (Kwong 1987). This “code of silence” reinforced external perceptions of Chinatown’s insular, clannish nature.

Hostility toward the Chinese as part of the supposed Communist threat began to die down in the 1970’s. President Nixon’s celebrated visit to China in 1972 marked an improvement in relations with the Chinese government and sparked American interest in Chinese culture. According to Kwong (1987), this resulted in greater ethnic pride among the Chinese. However, the belief Chinese immigrants do not wish to become permanent members of American society persists (Lin 1998). Further, the historical precedence of external hostility toward the Chinese has endured, thus sustaining the pattern of insular community focus and general independence from state intervention.

As Zhou notes, the self-isolation Chinese sought during exclusion “created a stereotype of unassimilability that in turn reinforced the community’s irrelevance to the larger society.” (Zhou 1992:40) This perception of irrelevance is borne out in government practice of non-intervention except in cases such as extreme gang violence or drug smuggling that threaten the larger society (Kwong 1987). By and large, authorities
stay out of Chinatown and community members are believed to be taking care of their concerns themselves.

Kwong (1987) argues that Chinatown’s elites disproportionately benefit from the community’s partial independence from State involvement. This semi-independence from government scrutiny allows Chinatown’s underground economy of low wage unregulated work to thrive, while also enabling the survival of an informal political structure established at Chinatown’s inception. Chinatown’s informal political structure consists of community associations established by the first Chinese immigrants based on family name, village of origin, and trade (Kwong 1987). These associations – referred to as traditional associations in the literature - served as a collective defense against the external hostilities experienced by early Chinese immigrants (Kwong 1987). They established territories of influence within Chinatown where only the businesses of association members could operate. Traditional associations were also highly exclusionary and during community conflicts, often around territorial competition, members rallied around their association. According to Kwong (1987), this is the root of Chinatown’s intense factionalism, which he notes is contrary to external impressions of ethnic solidarity.

The Chinese Consolidated Benevolent Association (CCBA) was established as an umbrella organization of these associations in order to avoid serious disputes between them. However, it also concentrated power in the hands of a few individuals, most of whom are from Guangdong province (Kwong 1987). Outside authorities often treat the CCBA as the informal mayors of Chinatown, although their officials are not elected. In
the past, Chinatown businesses and residents were forced to pay taxes to the organization. Kwong describes the CCBA as an organization that “exists to enable a self-appointed elite to maintain control of Chinatown.” (Kwong 1987:92) According to Kwong, the informal political structure in Chinatown, which centers on the CCBA and concentrates powering the hand of Chinatown’s wealthy elites, survives because of the unstated policy of non-intervention by outside authorities.

While government non-intervention perpetuates the informal political structure, Chinatown’s “code of silence” reinforces the government policy of non-intervention. Conflicts in Chinatown are resolved internally under proclamations of ethnic solidarity (part of the ethnic enclave rhetoric) in ways that often advantage those in power. Seeking outside help is considered a last resort. According to Kwong, elites are able intimidate those who break the code and seek help from the larger society because they monopolize access to the outside world and maintain ties to immigration authorities. This hegemony historically is further maintained by their control of information through the media, which shies away from controversial issues such as labor disputes (Kwong 1987; 1997).

However, the political climate of Chinatown began to change in the 1990’s. New community and labor based organizations, many of which are led by American born Chinese, began to emerge and challenge the traditional Chinatown hegemony. In 1993, the workers of a large Chinatown restaurant went on strike in part to draw the outside public’s attention to labor abuses in Chinatown and to counter outside perceptions that Chinese workers accept exploitation because of their culture. Such public demonstrations conflict with the image of ethnic solidarity projected by the traditional organizations,
particularly the CCBA, creating a competition between contemporary and traditional
associations (Lin 1998).

There is also factionalism among these new contemporary organizations,
however, who are competing for members and resources (Lin 1998). Jan Lin notes that
the recent influx of immigrants from Fujian added to this competition when they began
establishing their own associations (email to author, January 21, 2005). This factionalism
is occasionally counterbalanced by cooperation among groups to organize collective
actions around issues, such as labor rights (Lin 1998).

Despite the emergence of a public activist community, many community
members continue to avoid political activism for fear of being blacklisted from
employment (Lin 1998). Although the CCBA no long holds a monopoly on media access
and politics, many residents I spoke with continue to avoid political criticisms openly,
saying that Chinatown is a very political and small community.

Further, motivations for self-isolation persist. Many of the people I talked to
referred to a general distrust of outsiders, and noted that if I had not introduced by a well-
known community figure, they would not have talked to me. One man told me a story of
his friend who had helped a news reporter by giving him an interview on growing up in
Chinatown. The reporter twisted the story around to portray the man as a gang member
and Chinatown as a community riddled with crime. Another person helping me with my
research explained that the Chinese community keeps to itself because of their
experiences in China, where, according to this individual, the government pays neighbors
to rat each other out.
The sense that the larger society and government only pay attention to Chinatown when community issues threaten the safety of the larger society, a sentiment noted both by my respondents and Kwong (1987), reinforces community feelings that they are irrelevant to the larger society. That Chinatown’s irrelevance to and isolation from the rest of society is a myth was clearly illustrated by the devastating economic and psychological impacts of both the terrorist attacks of September 11, 2001 and the medical scapegoating that occurred during the 2003 SARS epidemic. During the latter, the historical constructions of Chinatown as a center of disease and danger, and of Chinese Americans as the foreign other were drawn upon to imagine Chinatown as the epicenter of a potential American epidemic.
CHAPTER III: THE CONSTRUCTION OF THE SARS EPIDEMIC

In this chapter, I will trace how the Epidemic was explained and visually represented to the general American public by mainstream media and illustrate that SARS was overwhelmingly associated with Asians and with “the primitive.” Drawing on studies of media influence on perceptions of risk, I argue that media discourses of risk and responsibility became the hegemonic framework by which the American public, including many people in Chinatown, understood the epidemic.

The stigmatization of Chinatown and Asians during SARS occurred in part because messages of risk and responsibility disseminated by the mass media corresponded to dominant imaginings of Chinatown and Chinese Americans, previously discussed in Chapter 2. Coverage of SARS-related risk relied on metaphors of filth and the primitive “other” that were combined with imagery depicting Asians as the both the infected and infector of SARS. These messages corresponded with pre-existing public imaginings of Chinese and Chinese Americans as a foreign, exotic, and often diseased “other”. This characterization is further mapped onto other Asians since, as was noted to me by several respondents, Americans don’t generally distinguish between different Asian groups.

In the previous chapter I argued that these imaginings are rooted in the historical discrimination against and medical scapegoating of Chinese immigrants since the mid-19th century. Since that time, Chinese communities such as Chinatown have come to be perceived as foreign exotic places simultaneously celebrated for their economic success but vilified as filthy and crime-ridden. The American public has little personal experience
or knowledge of Asia and Asians and a long history of associating Chinese immigrants with infectious disease (Barde 2003; Craddock 1995; Haas 1959; Kalisch 1972; McClain 1988). This fact contributed to the mapping of media discourses of Chinese filth and the primitive onto Asian Americans, particularly Chinese Americans.

**Media and Risk: Social Amplification?**

Since many factors shape how a person responds to risk discourses, the media’s influence on public perceptions of risk is unclear. Some social scientists have posited that in communicating about risk events to unaffected populations, the media plays a central role in the *social amplification of risk* (Kasperson, et al. 2001). That is, the generation of intense concern about a specific, and sometimes minor, hazard due to the wide communication about that risk (Kasperson, et al. 2001; Moeller 1999). Kasperson et al (2001) explain that this amplification occurs at “social stations,” such as mass media and personal communication, which communicate not only information about the risk, but also where it is, who is affected, and who is responsible.

Other authors argue that it is difficult to determine whether media coverage actually influences public perception of risk, since one cannot control for other factors that influence risk perceptions and responses, including social positioning and previous knowledge (Joffe and Haarhoff 2002; Lichtenberg and MacLean 1991). Joffe and Haarhoff’s research (2002) illustrates that one cannot assume a positive relationship between media coverage and heightened risk perception. Their study of British responses to an outbreak of Ebola in Zaire indicates that the media does influence how people understand an epidemic and how they talk about it. However, their research also indicates
that even sensationalistic media coverage does not necessarily heighten personal perceptions of risk, particularly when the disease is othered among a distant population. Their respondents felt detached from the threat of Ebola because they associated it with black Africans. Joffé and Haarhoff (2002) concluded that British readers responded more to othering discourses within the press coverage than they did to sensationalistic language of British risk because they interpreted Ebola as a disease contained among the “other”: black Africans.

**Mass Media and Mass Awareness**

What is important to this study is something that is recognized by all of the authors cited here: the media plays a crucial role in the awareness and interpretation of a risk event. The media plays a central role in disseminating awareness and dominant discourses around a risk event. It legitimizes some explanations to the exclusion of others, thereby structuring the option by which people explain an epidemic and evaluate risk. In the case of an epidemic of disease, the media makes distant, often unaffected, populations aware of the epidemic and provides the dominant framework by which a disease is interpreted: the cause, explanation, as well as the vocabulary of risk and responsibility.

For people not yet directly affected by an epidemic, the media is often the primary means by which they become aware of the event (Briggs and Mantini-Briggs 2003; Farmer 1992; Herzlich and Pierret 1989; Kasperson, et al. 2001). Herzlich and Pierret (1989) argue that HIV/AIDS initially would have remained a concern for only the few thousand infected people worldwide had not the media drawn attention to the disease and
disseminated explanations of the virus’ social meaning. Americans in particular are dependent on media coverage of distant diseases, since they have little knowledge of any foreign events independent of what is presented in the media (Moeller 1999). Further, the American public receives most of its information regarding risks from the media (Lichtenberg and MacLean 1991). Americans are thus dependent upon the press’ explanations and interpretations of foreign epidemics.

Since the media usually choose to cover rare and dramatic risks, to the extent that they often ignore more common and serious ones (Kasperson, et al. 2001; Moeller 1999), public awareness of these risks is likely to be higher. Indeed, Lichtenberg and MacLean (1991) argue that vivid press coverage of certain risks enables people to imagine and remember them. This results in the perception that such risks are more likely to occur than others that in reality are more common and more dangerous. Further, mainstream media’s tendency to focus on diseases only as a threat to wealthy populations, the “sanitary citizens” of the world, results in a dearth of coverage diseases such as tuberculosis and HIV/AIDS that threaten a larger portion of the world’s population (Farmer 2003).

In addition, people are more likely to believe and remember information that supports or corresponds with their own prior beliefs and knowledge (Lichtenberg and MacLean 1991). This argument is similar to that made by Farmer (1992) that the public explains a new epidemic vis-à-vis the pre-existing popular knowledge regarding the infected and the place where the epidemic is thought to have emerged. Kasperson et al (2001) argue that the simplistic and reductionist nature of these “mental maps” of distant
and unfamiliar places are easily transformed into stereotypes that are resistant to corrective change. By relying on metaphors that draw on stereotypes of the “other”, many of which are predicated on the modern/pre-modern dichotomy, media coverage plays a central role in shaping the stigmatization of people and places during an emerging epidemic.

The framework of awareness by which people come to talk about and understand an emerging epidemic is largely determined by the “facts” presented by a media dominated by a small number of transnational corporations. As conglomerated media giants, they control not only news media, but often television, film, and book publishing. According to Robert McChesney, a media critic and research professor at the Institute of Communications Research at the University of Illinois, many of these corporations are based in the United States. Their coverage privileges issues pertaining to the concerns of American businesses and upper-middle classes (McChesney 1997). Yet their audience is global and their coverage reaches far beyond American and European media markets. For example, explanations and interpretations of a Latin American cholera epidemic were internationally produced and circulated by corporate media. These interpretations were even disseminated back to the suffering indigenous communities, whose culture was blamed for the epidemic (Briggs and Mantini-Briggs 2003).

The concentration of power within a few media corporations has only occurred over the past 15 years (McChesney 1997). Indeed when Herzlich and Pierret (1989) conducted an analysis of French newspaper coverage of the emerging HIV/AIDS epidemic they commented that it was impossible to control for all of the AIDS discourses
in the media. While in the 1980’s there was still a wide variety of media outlets with differing strategies and guiding ideologies, the international conglomeration of today’s news media means that the same messages are likely to be repeated by multiple news outlets to different audiences internationally.

**Mass Interpretation: Risk and Social meaning**

Briggs and Mantini-Briggs’ research (2003) illustrates how the discourses in dominant global media are repeated and have impacts on the local level. These authors trace the hegemonic discourses repeated by the media to international public health circles dominated by the World Health Organization (WHO) and the Centers of Disease Control (CDC). Briggs and Mantini-Briggs (2003) use Foucault’s concept of *biopower* to consider who determines how people think about their own bodies as well as those of others. They identify international biomedical professionals, such as members of the WHO and the CDC, as those who determine the hegemonic discourses of disease and risk because the press privileges their perspectives and explanations during the emergence of a new disease.

Expert and official explanations of risk events, such as an epidemic, are mediated through the media (Briggs and Mantini-Briggs 2003; Lichtenberg and MacLean 1991). Journalists turn to international medical experts and scientific publications to get the facts on the epidemiology and progression of an epidemic and for explanations regarding its emergence. Although local populations, especially those who are blamed for an epidemic in international discourses, do not necessarily embrace these hegemonic discourses, those
populations with little access to power and resources have a difficult – if not impossible –
time getting their narratives out into global medical discourse.

Further, as is evident in Briggs and Mantini-Briggs’ work (2003), global
hegemonic disease discourses shape public and institutional responses. In the case of the
Venezuelan cholera epidemic, although medical explanations had the appearance of
neutrality, they relied on popular discourses and historical imaginings of poverty, filth,
suffering and backwardness to describe the epidemic, thus separating Latin America from
the modern, healthy world. Further, US public health professionals relied on the
modernity/pre-modernity opposition in their comparison of the US to Latin America.
They related the cholera epidemic to the vulnerability of American borders, a discourse
which Briggs and Mantini-Briggs (2003) identify as part of racist beliefs that white
middle class bodies will be contaminated by poor, brown bodies. Indeed, the same
discourse of porous borders was evident in American media speculation over a domestic
SARS epidemic. Briggs and Mantini-Briggs argue that in this way, international public
health is complicit in the stigmatization of poor and racialized populations (2003). By
privileging and establishing the public health perspectives as the truth, corporate media
are likewise complicit in the construction of stigmatization surrounding a disease.

By using scientific information and relying on scientific experts to relate and
explain the events of a disease epidemic, media coverage has the appearance of
objectivity. However, scientific discourses mask the motivations and subjective opinions
of researchers and research institutes whose perspectives are privileged in media
coverage. Further, the media contributes to the subjective interpretation of the social
meaning of a disease by tying it to political, economic and other social issues. SARS, for example, was explained as a problem of globalization, the irresponsibility of the Chinese government, inferior and backwards Chinese culture, and uncontrolled progress. Interpretations of social meaning are often embedded in discussions of risk and responsibility that are inherently political, despite their basis in scientific and cultural reasoning. Many of these interpretations become part of the public discourses and debates surrounding an epidemic.

**Symbolisms of Disease and the “Other”**

Symbolism is the primary way the media embeds social meaning into their coverage of an emerging epidemic. Ulrich Beck argues that “cultural symbols are staged in the mass media” (1999:44) where they gain political significance. According to Beck, we rely on symbols to understand abstract risks.

> This is true especially in the abstractness and omnipresence of destruction that keep the world risk society going. Tangible, simplifying symbols, in which cultural nerve fibres are touched and alarmed, here acquire a key political significance. (Beck 1999:44)

In her seminal book, *Purity and Danger: An Analysis of the Concepts of Pollution and Taboo*, Mary Douglas (1966) argues that the body is the original scheme for symbolism, upon which the rules of purity and pollution are projected and embodied. Discourses regarding pollution are intimately tied to moral standards. Notions of dirt symbolize something outside of the desired order while pollution reflects a breach of morals. The tendency to connect pollution with morals continues to be evident in perceptions and representations of disease. Disease continues to be both an imagined and real phenomenon projected upon the “other”, particularly poor immigrants.
As discussed previously, the characterization of disease as a phenomenon of the “other” with external origins has a historical precedence. Yet blame not only falls on the shoulders of foreigners; it is largely directed at the poor, a practice that also finds its roots in history. In 1891, United States Surgeon General Dr. John Shaw Billings pointed to disease as evidence of the moral inferiority of the poor “who are structurally and almost necessarily idle, ignorant, intemperate and more or less vicious, who are failures or the descendents of failures” (Nelkin and Gilman 1991:48). In the antebellum south, high levels of syphilis among African Americans were blamed upon the abolishment of slavery that separated the slave from his benign protector (Nelkin and Gilman 1991). Such discourses are highly moral, laden with references to the unhygienic practices of the poor and their moral failings. They are also political. Yet the political agendas behind such statements are often invisible. Public health discourses couched in scientific terms and benevolent tones of protection that are seemingly objective and thus the perfect medium to advance political agendas (Briggs and Mantini-Briggs 2003).

Just as people are more likely to respond to information that corresponds with their existing knowledge and conceptualizations (Farmer 1992; Lichtenberg and MacLean 1991), so too will people embrace symbols with historical resonance (Roseberry [1985] 2002; Stephen 2002; Wolf 1999). As noted by Wolf (1999), the strength of symbolism depends on its historical meaning, its roots in shared historical memory.

The continued blaming of the poor and minorities for disease is yet another example of this truth. Such finger pointing continues today in a climate of individualism
that blames, for example, a person’s so-called “lifestyle” for their HIV/AIDS status. Paul Farmer (1992) notes that discourses such as these frequently serve to blame those who are predisposed to disease due to the conditions of structural violence in which they live. Although many preventable epidemics do occur in impoverished or otherwise marginalized communities, discourses of blame overlook external factors that perpetuate the poverty and violence predisposing certain populations to devastating epidemics.

These geographies of blame (Farmer 1992) are given further legitimacy in television entertainment. In recent years Ebola, West Nile virus, the plague, and now SARS have invaded the United States in American television dramas. Directly after the containment of SARS the television show Third Watch featured a plot wherein police officers searched all over New York City for an illegal Chinese immigrant who might have been spreading plague across the city.

Despite advanced medical and scientific knowledge, and technologies that can map the genetic structure of a virus or bacteria, diseases continue to be blamed on the “other”. The tendency to blame people for diseases despite advances in science is not new. As noted by Robert Barde in reference to Chinese immigrants, bacteriological discoveries of the 1880s that identified the organisms causing many feared diseases “changed only the language of the scapegoating, not the target” (Barde 2003:160).

Today these perceptions gain wider legitimacy more quickly through the media and entertainment such as television and film. These almost universally available mediums synthesize factual, scientific information with subjective opinion, dramatized
accounts, historical and political references to produce apparently objective accounts of disease.

**Visualizing the Epidemic**

Pictures are the most important tool the media has to symbolically represent the news. The use of images is especially important to consider, since pictures may enter one’s consciousness in an uncritical manner, conjuring feelings that may be resistant to challenge (Joffe and Haarhoff 2002). Indeed, images have the potential to convey more than simple words and may shape public perceptions of personal danger, rates of infection, geographic and ethnic associations with a disease. Images function as *risk signals*, conveying the seriousness and manageability of a risk (Kasperson, et al. 2001:22). In the case of a new disease, pictures of medical professionals in biohazard suits impart a message of extreme danger and contagion. Repeated images of a particular group of people in disease coverage, such as Asians during SARS, conveys their heightened risk and potential to spread infection. Further, by juxtaposing text with pictures, the press naturalizes its interpretations of the epidemic (Briggs and Mantini-Briggs 2003).

**The Disease Drama**

The symbolisms and discourses of risk and the “other” are played out in the dramatization of an emerging epidemic, creating memorable narratives that will be recalled and debated in the public. The disease drama is replete with a large cast of characters and subplots that convey the social meaning and moral of the event. Stories are populated with protagonists (doctors, epidemiologists, modernity, Western medicine...
and science) and antagonists (the disease, those responsible, “traditional lifestyles” or “cultural practices”) (Moeller 1999). This cast of characters includes the victims, who often double as the antagonists as risk discourses place blame for the disease on their shoulders. Victims are often those identified by the medical term “risk group,” a term whose ties to science naturalizes the stigmatization of certain groups and their association with the disease, such as homosexuals and Haitians with regard to HIV/AIDS (Farmer 1992). This stigmatization of already marginalized groups draws attention to their marginality and status as, to borrow Mary Douglas’ term, matter out of place (Douglas 1966). Herzlich and Pierret (1989) note that French newspaper readers “learned” about homosexuals through media coverage of HIV/AIDS that identified them as a risk group. In this way, the stigmatization of an entire group is legitimized using the language of science.

The characters in media coverage convey the otherness of a disease through their relationship to modernity. Journalists use a language of sanitary citizenship, predicated on the modern/pre-modern dichotomy, that provides a framework of inclusion in and exclusion from membership in the audience community (Briggs and Mantini-Briggs 2003). In this way, journalists portray Western medicine and doctors as superior, while denying the infected the agency to protect themselves.

Further, comparisons are made between the new disease and recognizable “vanished” diseases that are associated with the past (Herzlich and Pierret 1989). The SARS epidemic was repeatedly compared to the plague and the 1918 flu epidemic by both journalists and medical officials, a tribute to the position those epidemics hold in our
collective historical memory. By comparing the disease to the past, the media conveys
the premodern status of the infection, the place where it emerged and the people infected.
This language is ultimately one of responsibility: the sick are blamed for not participating
in the modern, sanitary society, thus putting others at risk for premodern diseases. In such
discourses, nation-states may be blamed for not transforming their subjects into sanitary
citizens, and the entire country is labeled premodern (Briggs and Mantini-Briggs).

The disease itself often becomes a character, imbued with malicious intent and
disregard for borders. The spread of the disease may be embodied by Patient 0 or a
character unique to the contagion, such as the “healthy carriers” of HIV/AIDS (Herzlich
and Pierret 1989) or the “super-spreaders” of SARS. This further personifies the
epidemic and creates a profile of those supposedly spreading the disease.

In sum, by assigning motives and responsibility to the disease and those infected,
the media contributes to the construction of blame that unfairly targets already
marginalized populations. Often, they are immigrants, the poor, racial minorities, or all of
the above.

**Context and Media Coverage of the SARS Epidemic**

Sensationalization of risk was common as the American media pursued its story
of “the world war against SARS”² and painted a grim picture of a deadly disease that
threatened our borders. A brief examination of the context in which SARS emerged,
evidenced in the main news coverage before the identification of the epidemic, is useful

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for understanding the significance of the disease and how it was made relevant for American news audiences.

When the SARS epidemic was identified in mid-March 2003, Americans were in the midst of debates and fears over Iraq’s weapons of mass destruction. Uncertainties about Iraqi threats of bio-weapons and the American government’s ability to protect its citizens were readily apparent in the press. Prevalent in the news were stories regarding “Dr. Germ’s” bio-weapons, and smallpox vaccines for military and medical personnel. Renewed inoculations against smallpox reflected fears of fatal epidemics originating from outside the country, namely from a bio-weapon.

Compounded with the ambiguously defined “War on Terrorism,” Americans are repeatedly reminded that foreigners are a risk to their health and safety. Indeed, Fairchild (2004) notes that since the 9/11 attacks, metaphors against immigrants as diseased others have had renewed prominence.³ The public, whether or not SARS was interpreted as a weapon of terrorism, was primed for a frightening epidemic of foreign origin. Indeed, since the terrorist attacks of September 11th, 2001 the public had been warned to expect a possible biological attack using the dreaded smallpox virus. Despite the actual threats of nuclear proliferation in Iran and North Korea, the potential threat of bio-terrorism continued to be highlighted by the state as a justification for war and as a reminder of American vulnerability. By framing health crises as the product of foreign bodies, bodies which are often imbued with malicious intent, both the government and the media draw attention away from home-grown threats to health. Indeed, if more Americans had

³ Although I agree with this point by Fairchild, I disagree with her overall premise that American attitudes toward immigration continue to emphasize inclusion.
access to healthcare, national epidemics and potential bio-weapons such as anthrax might not be as looming a threat.\(^4\)

**Identifying the Threat**

As Farmer’s research (1992) indicates, social constructions of an immigrant minority group’s country of origin contribute to the social and moral identity the larger society assigns them. These identities come to the fore during an epidemic when people are looking for a party to blame. While popular imaginings of a people have a historical basis, they also reflect and are strengthened by current events that give further meaning to these representations. In dominant discourses of SARS popular conceptions of China and Chinese were mapped onto Chinese Americans. The distinction between China and Chinatown became blurred as blaming China and Chinese people for the crisis influenced the characterization of Chinatown and Chinese Americans as potential carriers.

Political and economic tensions with China were readily visible in the press and entertainment before and after the epidemic. China emerged in the 1990’s as a formidable economic competitor, much to the surprise of many economists. Since 2000, there have been increased tensions over the United States’ position on the status of Taiwan as an independent or Chinese state, and whether American forces would be used to defend Taiwan in the case of a Chinese military movement to retain this contested area (Sutter 2004). In autumn before the SARS epidemic, China was the focus of U.S. efforts to negotiate the abatement of North Korea’s nuclear program. Combined with these specific

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\(^4\) Peter Kwong argues as much with regard to illegal immigrants. Recent anti-immigration laws such as California’s Prop. .187 and Arizona’s Prop. 200 decrease undocumented migrants’ ability to access health services including vaccinations, which Kwong argues puts all Americans at risk (Kwong 1997).
events, there is a historic underlying distrust and fear of China as a communist nation and of Chinese immigrants as her loyal servants. Wen Ho Lee, a Los Alamos physicist accused of spying for China, is one recent example of this enduring suspicion of Chinese in the United States.

**Placing Blame for SARS**

In its coverage of the SARS epidemic, the media sought to paint a picture of how the disease emerged, where it came from, and why it spread across the world. In addition, American journalists assessed the risk of infection for their audience. Time Magazine’s headline promised to answer the question: “How Scared Should You Be?” These risk assessments and explanations of the virus’ origins relied on metaphors that othered the disease.

The majority of blame for the disease in media discourse is centered on China. In press accounts, Chinese officials share responsibility for the epidemic with overcrowded markets and communities. SARS was used as an example of why the Chinese government needs to be more transparent, particularly in light of the many cases they covered up during the initial outbreak.

However, while the Chinese government may have been blamed for the spread of the epidemic, Chinese “culture” and people were identified as those responsible for the emergence of SARS. Indeed, with the containment of SARS in the summer of 2003, the WHO and press began to praise the Chinese government for its eventual determined response to the crisis. Blame for the virus then shifted to the shoulders of the Chinese

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5 Time May 5, 2003
people, particularly the poor, whose agricultural practices and diet and indifference to
health were said to have caused the disease.

In following explanation, the risk of SARS infection is globalized because an
imagined homogenous Chinese population refuses to recognize its global responsibility
and give up a “tradition” for the good of world health:

*One thing China hasn’t learned from its SARS experience is that its eating habits –
particularly the taste for freshly killed meat – might have to change. Scientists found
that civets, a cat-size creature and a local delicacy, can harbor the SARS virus...This
winter the battle will be shaping up between China’s tradition and the world’s safety.
(Newsweek, 12/8/2003, pg 79)*

Indeed, in both discussions that blamed the Chinese state and ones that blamed the
people themselves, China is said to need to learn lessons. The Chinese must conform to
internationally-determined standards in order to be considered a modern, sanitary state.
Although it is true that China has significant health problems it has yet to adequately
address, such as access to adequate healthcare and an ever-growing epidemic of
HIV/AIDS, these discourses necessarily portray China as inferior in relation to the United
States whose health system is praised for its superiority. Chinese doctors are further
portrayed as inferior when “*top virologists*” of several other countries are praised for
working on a vaccine.6 Such characterizations overlook the vast inequalities of
healthcare in the United States.

Discussions of risk and responsibility regarding SARS were often steeped in
references to modern/pre-modern dichotomy, using language of sanitary citizenship that
defined China as a diseased threat to the modern healthy world. Some journalists called

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6 Time: 5/5/2003, pg. 52, emphasis added
China “backward,” while others simply described the country in terms that conjure images of filth and squalor. Guangdong, the southern province where the virus was first identified, is described as a disease factory, as if the Chinese marketed the flu with its exports each year.

The novel coronavirus that causes the syndrome emerged from Guangdong, the same Chinese province that delivers new flu viruses to the world most years. Pigs, ducks, chickens and people live cheek-by-jowl on the district’s primitive farms, exchanging flu and cold germs so rapidly that a single pig can easily incubate human and avian viruses simultaneously... The clincher is that these farms sit just a few miles from Guangzhou, a teeming city that mixes people, animals and microbes from the countryside with travelers from around the world. You could hardly design a better system for turning small outbreaks into big ones.7

It is worth noting that Hong Kong, a bastion of successful capitalist development, is not maligned as Communist mainland China is, although at the height of the press coverage SARS deaths in Hong Kong numbered almost as many as all of China. Instead, infections in Hong Kong are a tribute to the virus’ virulence and ability to outsmart modern medicine.

China might be relatively backward, but Hong Kong, with a modern medical system, has experienced about as many deaths as have been reported in the rest of China put together. (Time May 5, 2003: page 50)

The same logic that portrayed China as inferior were used to pin heightened susceptibility to plague, cholera and other infectious diseases onto the Chinese in the late nineteenth- and early twentieth centuries (Edelson 2003; Hirst 1953; McClain 1988; Simpson 1905) was utilized during the SARS epidemic. Media coverage is rife with numerous discussions of crowded Chinese poultry markets, and “primitive” farms as the

7 Newsweek: 5/5/2003, pg. 35
origin of the SARS species jump from fowl to human. Southeastern Chinese are blamed for living in close proximity to birds and other animals, which may contribute to disease. Several months after SARS’ containment, southern China was still described as “the world’s most efficient virus factory and ground zero for most of the globe’s influenza epidemics”.8

Indeed, this logic has the same function: to blame those who are more at risk for infection because of their political and economic marginalization. In the 19th and early 20th century, culpability for smallpox and plague epidemics was placed on Chinese immigrants as a justification for excluding them from American citizenship, rights, and labor. With SARS, Chinese diet, rural farmers, and a so-called cultural indifference to world health were identified as the factors that led to the epidemic. These discourses ignore the fact that the Chinese government had abandoned the rural health system. Believing that economic growth would naturally lead to improved healthcare, the Chinese state’s neglect of rural health created a grossly unequal situation in healthcare access. Large companies in urban areas provide coverage for their employees in company-owned hospitals. In rural China where there are few companies, residents must rely on doctors who don’t even have enough resources to protect themselves from communicable diseases. This is particularly a problem in the poorest regions (The Lancet 2004). As I will discuss later, discourses of risk and blame in Chinatown identified rural Chinese immigrants as those most likely to bring infection into the community.

8 Newsweek: 12/8/2003. pg. 76
Ironically, while China was blamed for the SARS epidemic as a technologically and politically inferior nation, fault was placed on progress as well. Indeed, progress is the named culprit in the spread of not only SARS but all modern, threatening diseases. One journalist declared that “modern technology has made our lives more dangerous.”9

Urbanization, poverty, globalization and rapid travel were all implicated in the spread of infection, drawing attention to concerns over development and capitalism.

One final category of culprits worth mentioning in the epidemic is that of the “super-spreader.” The media honed in on the SARS super-spreader theory, which posited that there are individuals who are able to infect many more people than others. Some media accounts attributed the SARS epidemic in Canada to a super-spreader. Viewed from a perspective of risk and blame, the super-spreader designation places responsibility on an individual for infecting many people. It is the ultimate global citizen in a world of individualistic medicine: not only is a person responsible for his or her own illness, he or she is also responsible for the illnesses of the world.

**Luck and Vulnerability**

Although coverage identified “primitive” and “backward” Chinese practices as the source of the disease, and deception by the Chinese government as the source of the epidemic, the superiority of the United States was not absolute. The media widely quoted Julie Gerberding of the CDC saying that the U.S. was simply lucky to have seen a very low incidence of infection. International travelers were of particular concern, and several people returning from Asia were interviewed by the media for having voluntarily or been

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9 Newsweek: 5/5/2003, pg. 34
asked to self-quarantine themselves at home. The border, already a symbol of Americans’
fears of foreign threats, became a site of vulnerability. Television coverage emphasized
the risk of a microbial invasion from Canada into the United States over “the world’s
longest undefended border.”

Other Discourses of Risk and Responsibility
Although I have highlighted the media’s othering discourses here, coverage of
SARS was not limited to risk discourses of foreign threats, modern and premodern
oppositions, and racializing discourses of blame. Rather, many different discourses of
blame and risk were contained within the same story. As previously discussed, progress
and globalization were labeled culprits in the emergence of new epidemics not just for
bringing “us” closer to the premodern “them,” but because factory farm practices breed
disease, and development pushes us closer to natural reservoirs of diseases.

However, what matters most is which of these discourses are picked up and
repeated in public arenas. People I interviewed in Chinatown repeated the same
narratives found in news articles that dramatized SARS. They blamed the Chinese
government for covering up the epidemic. Many expressed concern that recent
immigrants (not international travelers) would bring SARS into the community because
of their dirty habits and the premodern conditions in which they lived in China.
Community members also expressed fears of globalization and rapid transportation, two
themes identified in the news as potential sources of infection.

10 NBC Nightly News: 4/22/03
Furthermore, media coverage is not just limited to dialogue and text. As discussed before, pictures play a prominent role in creating memorable images associated with a disease, and therefore in who becomes associated with risk and blame. The threat of American factory farms and multi-drug resistant bacteria might have been briefly mentioned by the media, but pictures predominately were of Asians in masks, “primitive” farms, and travelers, particularly Asian ones. Americans didn’t stop eating chickens en masse because factory farms were briefly mentioned as a source of disease, but a substantial drop in tourism and business at Chinatown restaurants occurred because Chinese traditions were tagged as the source of the epidemic, and Chinese people featured prominently in the visual representation of SARS.

**Picturing SARS**

The majority of images used in conjunction with stories about SARS overwhelmingly conveyed that it’s an Asian disease, and the photos of people in surgical masks communicated that the virus is highly contagious and that everyone and everything could be contaminated. Such messages were based on then-current information originating from the CDC and WHO. However, the message communicated was not just that SARS originated in Asia, but that Asians were likely carriers of infection. This message contributed to the virtual desertion of Chinatowns and avoidance of Asian Americans. Such an interpretation is particularly possible when the majority of Asian people in a single publication appear in SARS coverage.

The May 5th edition of Newsweek, TIME, and U.S. News and World Report clearly illustrate the ethnic characterization of SARS. The covers of these magazines
feature nearly identical close-up portraits of apparently non-Asian individuals whose faces are covered by surgical masks. The headlines promise to inform readers of the “Truth About SARS” (TIME) and provide them with information needed in “The New Age of Epidemics” (Newsweek). In contrast to their covers, the magazines’ articles clearly identify SARS as a predominately Asian phenomenon. References to Hong Kong and China, particularly “the Chinese cover-up” (TIME 2003), predominate discussions of SARS.

Even without reading the magazines, however, associations between SARS and Asian-looking people are clearly conveyed through images, particularly those in TIME and Newsweek. Out of a total of eighty pictures of people, including advertisements, Newsweek has ten photos of Asian people, six of which appear in SARS-related pictures. Four of these six pictures feature Asian people in masks. Of the remaining four non-SARS related pictures featuring Asians, two are ads, and the other two are pictures of North Korean and Chinese officials. Aside from the cover, there are only two pictures of non-Asians in masks: a scene from a Toronto emergency room, and a flight crew landing in Hong Kong.

Time Magazine’s images are particularly notable: there is not one picture of an Asian person among the 100 photos in the entire magazine, except in reference to SARS. Out of the seven pictures of Asians, four feature them in masks, while two of the remaining three pictures are portraits of Chinese leaders. One eerie picture (above) features five quarantined people peering through the bars of the gate at the People’s Hospital in Beijing while a man in the foreground walks by completely covered by a
surgical mask, eye goggles, and what appears to be a rain suit on a sunny day. Another features a woman wearing a facemask, her face distorted by her reflection in a mirror. Such images, which came to represent the epidemic, dehumanize Asian peoples.

U.S. News & World Report deviates from the other two magazines in that no Asians appear in masks. Asians appear in five out of eighty photos, two of which are in reference to SARS. However, of the remaining three pictures, two are advertisements and one is in an article about the North Korean nuclear crisis. The argument that these were the only important events in Asia is ludicrous. There is always something of importance happening in this vast region. The question is whether it matters to the media who filter what “matters” to Americans.

At the time these magazines were published, the epidemic was still primarily located in China and Hong Kong, so it may be arguable that these pictures are appropriate for SARS coverage. However, because there are so few images of Asian people in other pictures, the message conveyed associates Asian people with SARS. Further, out of all three magazines, the only non-SARS topic accompanied by pictures of Asian people is the North Korean nuclear crisis. Thus, in these magazines the only events with which Asians are associated are the SARS and nuclear crises.

Briggs and Mantini-Briggs (2003) note that images illustrate and naturalize the text they accompany. However, many of the images I found in SARS coverage do not include an explanation of their content or context. Even if the image is descriptive, the viewer or reader is left to guess the context, including the time and place, of the picture. It is most likely that the viewer or reader will relate the image to what is being stated in the
article or broadcast. For this reason, it is also important to consider what is being said in
the article or broadcast during the time in which an image is viewed. For example, one
news story on NBC featured video of an Asian family arriving at an airport while the host
and guest medical expert discussed the phenomenon of “super-spreaders.” The non-
verbal message conveyed was that this Asian family, and others like them, might be
super-spreaders bringing SARS to the United States.

Another consideration in analyzing media images is their repetition. As Susan
Sontag notes, “Part of making an event real is just saying it, over and over again” (Sontag
1990:78). Repetition encourages a “consciousness of risk” (Sontag 1990:76). NBC’s
Nightly News coverage of the SARS epidemic repeated the same images of lung x-rays, a
bridge connecting the United States to Canada, and emergency personnel in protective
gear. As discussed by Joffe and Haarhoff (2002), images enter the human consciousness
with less critical consideration that do written or spoken messages. Further the circulation
of decontextualized images becomes a representation of an entire people (Briggs and
Mantini-Briggs 2003), as well as the event they portray. The repetition of the
aforementioned images was therefore likely to play a large roll in public understandings
of SARS, including who is at risk and how it is transmitted. In addition, it likely added to
Americans’ sense of vulnerability from foreign threats pouring through our borders.

Conclusion

The news and entertainment media contribute to the association of Asians with
disease through their use of othering metaphors predicated on the modern/pre-modern
opposition that label Chinese as most at risk for infection while also blaming them for the
spread of SARS. The repetitive and decontextualized pictures of Asians in facemasks that dominate all press coverage of SARS undoubtedly naturalized the association of Asian faces with the possibility of infection.

Combined with the historic associations of Chinese communities with disease, it is easy to see how Chinatown became stigmatized as a site of infection. Even discourses that placed blame for SARS onto globalization and progress could be mapped onto the community. Chinatown is very much part of the global economy, employing immigrant labor, selling Chinese and other Asian goods, and maintaining personal and professional ties in Asia. Further, it represents an immigrant gateway into the United States, connecting Americans with a distant country and people of whom they have little knowledge or interaction. The American demand for cheap goods attracts low-wage laborers from the very areas abandoned by the Chinese medical system, where communicable diseases are growing problems (The Lancet 2004). If Chinatown was at higher risk for an epidemic, it was hardly the fault of those seeking the economic opportunities of the United States.

With the majority of Americans learning about China, Chinese immigrants, and Chinatown through popular media that continually dehumanizes Asians, the conflation of SARS and Chinatown in the public imagination was inevitable. This association translated into widespread avoidance of American Chinatowns, Chinese cultural groups, and Chinese restaurants, as well as avoidance of Asians on public transportation. In the

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11 As was noted to me by one Chinatown community member, Americans generally do not distinguish among different Asian groups such that overt discrimination occurred against Asians in general.
next chapter, I will consider how members of New York City’s Chinatown responded to this stigmatization, and how they made sense of these risk discourses.
CHAPTER IV: CHINATOWN’S FALSE EPIDEMIC

In this chapter I explore how Chinatown community members made sense of the epidemic and responded to the circulating discourses of risk and blame, rumors of local infections, and to the stigmatization of their community. While there are many factors that contributed to how community members understood SARS, I focus specifically on how dominant discourses of risk and blame played out at a community level.

By examining narratives of the epidemic, I explore how people understood their own risk of infection and that of the community. I investigate the historical, political and economic dimensions in Chinatown and in China that shaped who was seen as likely to spread SARS and who was vulnerable to infection. I argue that discourses of risk and responsibility in Chinatown were uniquely shaped by its history, the community’s continued ties to China and Asia, and also from community fissures between recent immigrants and the more established residents and elites. Although many informants asserted a unified identity of “Chinese” to refute community association with infection, they often simultaneously drew upon dominant narratives of risk and responsibility to identify recent immigrants as potential infectors. Indeed, these narratives echoed the same “us/them” reasoning found in mainstream American media, but also reflect Chinese constructions of modernity related to both Chinese and Western ideas of progress. Further, these narratives draw attention to community concerns and tensions related to the recent influx of immigration from Fujian. Finally, community discourses that
characterize recent immigrants as an at-risk group are reinforced by material conditions of poverty and labor abuses that place this population at higher risk of disease.

In the following pages I recall the events in Chinatown during the distant epidemic using community member narratives. I have attempted to maintain the integrity of each voice by sparingly editing only for clarity. All personal and place names are pseudonyms to maintain confidentiality.

**Stories and Rumors during SARS**

Most of the people I interviewed said they first heard about the SARS epidemic from the media, both American and Chinese, and/or from friends and family both in Chinatown and in Asia. For many, their experiences during the initial period of the SARS epidemic were marked by their concern for friends and relatives in Asia. Therefore, while dominate discourses in the media at that time revolved around whether individuals should be concerned about an epidemic in the United States, many community members were more concerned about those they knew who were in the middle of the epidemic than they were about their own safety.

Many of my interviewees felt the media might be exaggerating the epidemic, so they relied on friends and family in Asia for accurate information about SARS and to measure its severity. In fact, one doctor at a large local clinic remarked to me that he noticed many community members were taking precautions based on what people in the affected areas were telling them. The following narrative illustrates the importance of personal connections in Asia as a source of information, and echoes concerns about the role of travelers and the Chinese state in creating the epidemic. Keith is a professional in
his mid-30’s who was born and continues to live in Chinatown. His narrative illustrates the concern community members had for family and friends in the infected areas:

Keith: I first heard about it from my sister. At that time it was before it was called SARS. She had mentioned -- because she was living in Hong Kong and that's pretty much where it had spread and... Because initially it was in China. They kept it hush-hush there. My sister told me that the person that had it was a doctor. He was from the Guangdong Province. He was from the hospital in which everyone else had it and died from it. He got scared and wanted some medical treatment. He ran to Hong Kong telling people that he was going to a wedding, but in actuality he was trying to get help. He eventually died. During that time, he was staying in a hotel in which it was an international hotel so then people he would cross in the hallway, or in the elevator got it as well. And then they were international travelers, so then it spread around the world. That's what she had mentioned to me. [...]  

Laura: Did you worry about your sister at all?

Keith: Yeah... yeah. I was worried about that. I called her, you know, make sure everything was all right and... At first, she said not to worry. You know, like "Don't worry so much." Because it's going to be the elderly and children, people with low immune systems. But then closer to the end, someone that was younger -- 30 plus years of age -- got it and died from it. So that's when I got a little more worried. I mean, initially I don't even think my sister was wearing a mask.

In addition to illustrating local concerns for loved ones in Asia, Keith’s story reflects one of the dominant illness narratives that was developed for SARS, what Paul Farmer calls the “prototypical case” (Farmer 1994). The doctor from Guangdong who escaped a secretive China to seek help in Hong Kong was a common character in my informants’ narratives and illustrates the political significance of SARS. For many, SARS reinforced China’s need for transparency and participation in internationally defined health and sanitation standards. This political signification of the epidemic was also common in Hong Kong and American media coverage.
**Chinese Language Media and SARS**

Chinese language media undoubtedly contributed to risk discourses in Chinatown and to how community members understood SARS. Although many of my informants do not read the Chinese language dailies, many of their parents do. Several informants recalled that Hong Kong soap operas incorporated SARS into their plots, and that Chinese tabloid news programs featured pictures of celebrities in masks. Even those community members who do not pay attention to Chinese language media were still likely to hear discourses produced in these settings that were circulating in the community.

One limitation of my research is that because I do not speak or read Chinese, I am dependent on others to remember and recall for me what was being reported in the Chinese language media. Since I conducted fieldwork almost one and a half years after the height of the epidemic, many interviewees had a difficult time remembering exactly what was being said in the Chinese language media. Many did recall, however, that it was a larger news item there than in English language media.

The Chinese language Sing Tao Daily, one of the popular newspapers in Chinatown, is owned by the same company who publishes the Hong Kong Standard, an English language newspaper. Assuming that the English language paper would repeat many of the same discourses found in Sing Tao Daily, I have used it as a reference for what was likely being reported in Chinatown.\(^{12}\) In addition, a summary report released by researchers with backgrounds in business, psychology and law at the Hong Kong-based

\(^{12}\) Unfortunately, the World Journal and local Chinese language radio programs do not have translations on Lexis-Nexis, nor have I been able to find English language equivalents, so I have had to privilege only Sing Tao Daily’s reporting.
think tank Civil Exchange regarding SARS media coverage in Hong Kong has been useful in getting a better idea of what was being reported there. As mentioned before, communication between Chinatown community members and their family and friends in Asia shaped how they understood the epidemic. It is also likely that Chinatown media owned by companies based in these areas was reporting the same information.

In February 2003, immediately prior to the identification of the epidemic in Hong Kong, Hong Kong news media began reporting on a family who fell ill with a mysterious flu after returning from Fujian. It was speculated that the death of the daughter may have been due to the dreaded avian flu. The specific coverage of cases of a deadly disease originating in Fujian may have further contributed to fears that recent immigrants from Fujian be a conduit for disease.

Once SARS was identified, much of the coverage in Hong Kong criticized the mainland government for not being forthcoming about the epidemic and for not releasing information to the public. Indeed, much like the international media, Hong Kong dailies used the SARS epidemic to argue for government transparency and the free flow of information. Taiwanese publications used the epidemic as an opportunity to compare Taiwan to China and Hong Kong:

The public health authorities in Taiwan are thought to have done a much better job of limiting the number of infected cases and containment of the disease when compared with Mainland China, Hong Kong and other hard-hit areas in Asia. (China Post: April 2, 2003)

Characterizing itself as more responsible and effective than its Chinese counterparts is part of Taiwan’s larger project to gain international support as an
autonomous country deserving recognition. Even Hong Kong’s South China Morning Post took the opportunity to print a letter to the editor praising Taiwan for being a “good world citizen by sharing its experience in healthcare promotion, disease prevention and eradication.”

There are a few articles in Hong Kong papers encouraging locals to be more concerned about the welfare of others and how their actions impact other people. However, unlike American press, there are no overt descriptions of Chinese “backwardness” and filth in these English language papers.

“Coughing while Asian”

Eventually many community members started talking about rumored infections in Chinatown, and some became concerned for their own safety. When people described the impact of SARS on Chinatown, one story was central to nearly every account: the rumor of a local restaurant owner who died of SARS. This rumor was spread widely by word-of-mouth in the community, but many believed that it originated in this email:

For those of you who eat in chinatown, please be advised for that SARS has hit that area. As of today I heard that the owner's son(s) & the entire staff of the Fancy Country Noodle restaurant [...] has been infected with the SARS. The owner was infected & has passed away recently due to what have seemed to be flu like symptoms. I think its best that you either stay away from that area or eat in. Please pass this along for those who I might have missed.

Another email warned of infections in all Asian areas across the country:

FYI... Please take caution!!!

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13 South China Morning Post: April 11, 2003
14 Email dated April 1, 2003. Copy of email found at http://urbanlegends.about.com/library/bl-sars-restaurants.htm, errors in original [sic], restaurant name is a pseudonym.
The SARS disease has spread to our neighbor. Today 4-3-2003, the police has shut down Hawaii and [...] Supermarket due to the employee somehow got hit by this virus. Also one of the chief at [...] Restaurant in Alhambra also got this virus. The [...] restaurant in the FOCUS plaza was close early today to avoid getting it.
Friends, please take care of yourself and your family. Avoid going to ASIAN areas!!! This is very serious about life and death and spreading them to the love one. Pay close attention to the Chinese newspaper and be alert about this deadly virus. Please pass this message to all of your friends so they can protect their love one too.15

This second email appears to be directed at Chinese Americans and immigrants, advising recipients to pay attention to the Chinese newspaper.16 However, fears of infection via Asian areas existed outside of these communities, evidenced by the drop in tourism and business in Chinatown.

The owner of the Chinatown restaurant gave me his account of his rumored death and its impact on his business and the community:

Owner: From our experience, this is what happened, and I don't know if it was a business competition or something like that... somebody put out the rumor that said that I passed away from SARS. And then... the people who use this method, because... my father passed away in 2002 near Thanksgiving, but that's from a heart attack. And then maybe I have some business competitor, or somebody doesn't like me or like the way we do... we're some kind of the local restaurant. We've been here fortunately, including today, 18 years. It's a family business. Unfortunately, this epidemic came out in Asia, and then somebody took the opportunity on April Fools of 2003 to say that the owner passed away of SARS. At that time I'd already become the owner after my father died six months before. And then, I stood up. I said, "Wait a minute. This whole thing is a hoax."
But guess what? I'm not the only one who got affected. The whole community got affected. People go to the e-mail. They pass the rumor from one person to the other. And some people don't have solid info. Even my sister had to e-mail the people and say, "Look, he's fine. You can come down here, take a picture with him..." blah, blah, blah... this and

15 Copy of email found at http://urbanlegends.about.com/library/bl-sars-restaurants.htm, errors in original [sic].
16 Indeed fear of Chinatown as a site of contagion was not limited to outside the community. I’ll return to this point when discussing community perceptions of risk.
that. But the problem is, we're a family-owned business. You compare us with other major restaurants, major supermarkets, any part of local major operations -- museums... people canceled visits to museums, people canceled their local trips around here. People canceled restaurant dinners. We're here like a three or four dollar meal. Basically, like a fast food restaurant. And people talk about a $500 dinner, $600 dinner -- most of them just canceled because of the hoax.

I think rumors like that spread so fast on the Internet -- one person to the other. And especially because people use company e-mail addresses. And imagine how many people are in the company. Let's say the company has at least 50 people walking in there. And those 50 people spread the rumor from one person to another. And you see the domino effect? The chain reaction effect? And that's how it made me famous!

[Laughs]

And of course the New York Times interviewed me, and I said the same thing. I say, "Look, we're a small potato here. But the problem is, who ever put this out, this rumor, is hurting the local economy very bad."

But that's only the beginning! And then later on, this spread out to another Chinese community! They even put it on another e-mail something that say, "Especially on public transportation, when you see an Asian cough, stay away from them."

Tourism and business plummeted as the rumors spread beyond Chinatown. An employee of a local museum, himself Chinese American, recalled the resulting stigmatization and its economic impacts:

Laura: What's the first thing that comes to your mind when you think of SARS?

Peter: Vicious, vicious rumors.

Laura: Why vicious?

Peter: Because it hurt Chinatown’s economy a lot on top of 9/11. The museum itself lost a tremendous amount of visitors the week that SARS was initially broadcast in the news. We had a slew of school groups cancel on us, and school groups make up 50% of our revenue in a year. So even to have one school group cancel, one class is like 30 something kids...imagine having four to six groups cancel in one week from the tri-state area. So it wasn’t just a NY thing, it was a regional thing. We had schools calling in and saying “Yeah, we have a lot of students and parents that are afraid to let their children go to Chinatown.”[...]
[He said this all began when the news reported cases of SARS in New York, even though none of the cases were in Chinatown.]

Still there, you know, the first cases of SARS were in China, so people naturally think: China, Chinese, Chinatown. So they try to avoid the area. [...] There was an assumption that because it’s Chinatown, it’s full of Chinese people. There’s a fear people traveling back to China and bringing the disease. People think that Chinese people only live in Chinatown. Chinese people are not the only people traveling to Asia. They're singling out a single race. It's really offensive.

A local tour guide and leader of an Asian American social organization described “Coughing while Asian”:

Jason: Suddenly, no one came out to Chinatown. It was just recovering after the crash in tourism from 9/11, and then SARS hit and the tourism industry crashed again. In the news, the images of Asians in facemasks made people want to avoid Chinatown. It was really noticeable on the trains: if there was an Asian coughing on a train, people would look at them nasty, and move away. It was a good way to get a seat! [Laughs]

The experience of one local priest, who is not Asian, illustrates that residents and the geographical space of Chinatown were perceived sites of infection, not just Chinese- or Asian Americans:

Father Bernardi: Everyone in the New York area felt that you had to avoid Chinatown because of SARS. But it had absolutely nothing...I know of no, absolutely no...I mean, they probably had more cases in Connecticut of SARS! [...] So I go...now, I’m Italian American...and you know the New York area...one of my friends had his 60th birthday in New Jersey. So after mass and everything on a Sunday I go out to New Jersey to this catering hall. And it was a surprise; his kids were giving him a 60th birthday. And I go out there. And these are all people I grew up with; I knew them as kids and everything. And these are all tables of couples. And I walk in and they all go [cringes and draws away] and it didn’t even register [to me] that I was coming in from Chinatown. And I wasn’t Chinese! The Chinese were feeling it. On the subways – if you even looked Chinese, people were getting up and moving away. But I went in and I said, ‘Holy cow, it’s not just the Chinese but the person who lives in Chinatown.’ And
so I went around and breathed all over them. [Laughs] Not only were we getting kinda hyper about it, but people outside were also watching the news and getting concerned.

His story clearly illustrates that the geography of Chinatown continues to be conflated with disease, a tribute to the resilience of this 19th century stigmatization when San Fransisco’s Chinatown was portrayed as the epicenter of plague and smallpox. As noted previously, this stigmatization played a crucial role in the construction of the Chinese “other” throughout the United States. Notions of Chinatown as dangerous and foreign are reproduced by media depictions and the tourist industry that focuses on the exotic. Yet these notions are also reinforced by the problems stemming from the influx of undocumented Chinese labor, particularly the smuggling industry that has both increased crime in Chinatown and produced a visibly impoverished population of Chinese (Kwong 1997). Further, since the terrorist attacks of September 11, 2001 the American public has generally been hysterical over perceived foreign threats to domestic safety and health. This logic resonates with the historical association of Chinese immigrants with danger, but has also been particularly unchallenged in the wake of 9/11. The public, having little personal experience with or knowledge of the Chinese community except for what is presented in the media, is therefore more likely to perceive Chinatown as a neighborhood of unregulated, dangerous bodies. I will discuss these points in more detail later.

The Press and “Outsiders”

Almost all interviewees faulted the press for disseminating the rumors and for fostering the stigmatization. The restaurant owner who was rumored to have died explained why he decided in retrospect that his press appearances did more
harm than good. His narrative illustrates that fear was being produced both inside and outside the community.

Owner: But of course it got worse after the media interview, because it's going to the newspaper, it's going on the headlines, this and that. And people are going, like, "My goodness!"
If I didn't go on the news, some people wouldn't know the rumor. Because a lot of people in this area don't use computers. They didn't realize until after we went on the news. They say, "Oh! Wait a minute..." That's why some people say, "Wait a minute... I'm not going to take a risk." It made it worse.

People didn't take it as the hoax. They only take it as an epidemic of the... of the possibility of the incident. Even the health department came to check me out. I say, "Thank God you're here to do the inspection." Thank God, nobody's hurt - that's the bottom line. But of course the psychological effect is very, very effective way to hurt so many businesses. My business slowed down for four to six weeks. I think we dropped off 70-80% of our business for the first four weeks. Again, a lot of people were hurt around here is well. And fortunately we have a lot of local associations [...], who came in and gave me a local promotion to say, "Look, nothing is wrong here. It's just nonsense."

The restaurant owner eventually decided not to do anymore press interviews, no matter who requested them. He felt that the media attention, instead of dispelling the rumors as he had intended, had actually disseminated them further and had negatively impacted his and other businesses in the area. “The more media, the more hurt and alarm there was.” He asked the Small Business Administration and the local police whether the government could take action in response to these rumors, but he was told that they were powerless because of individuals’ rights to freedom of speech.

Others in the community blamed the resulting stigmatization of Chinatown on the way the press covered the rumors, as well as the rumors themselves. One pharmacist of Chinese medicine described how the press actively sought to portray Chinatown as a panicked community:
I remember there were news... it's so funny... American press, New York press - English press, I should say -- they came down to Chinatown and wanted to do this story, and they were expecting people walking around in masks, hysterical and everything, and they couldn't find it. And they asked, and I said, "Look, no one's panicking. There is no hysteria. People are just cautious and getting ready." But that didn't satisfy them. They said they wanted to take a picture of people in masks. Like, you would see -- if you go back to those pictures, you may see a picture of maybe that one guy walking around with that mask. And then they'd try to paint is whole story like it's total panic when it wasn't. I know. We're here every day. But how many people were walking around with masks? I didn't see that many people walking around with masks, if any!

A museum employee explained that it was the way that the television media presented the news story that led people to believe that people were dying of SARS in Chinatown. He differentiates between print and television coverage.

Peter: I think sometimes people got confused. The news would try to do a "leader" into the actual segment-- a snippet before they cut to the actual story, I should say a “teaser,” something like: "SARS in Chinatown?" or “SARS found in Chinatown?” or “SARS in New York?” And then they’d cut to commercial. And what if people didn't see the rest of it? Or turned the TV off? They’d be like, “What??? There’s SARS in Chinatown???” You know, like, yeah, so people who don’t listen to like the actual segment will not have heard that there aren’t any actual cases. They won’t hear that the only thing SARS is affecting in Chinatown is its business and its people.

Laura: Is that what the news actually talked about in the actual story – that there wasn’t SARS?

Peter: You know what, I don’t think so...In the clips they would show Asian people – Asian people, not Chinese, but Asian people - with surgical masks on or whatever and you know like, that could be anywhere, but hey...What will people most likely assume? Um... I do have to give credit to a lot of print media. A lot of print media called us and they were willing to talk about how it was affecting our businesses. Whether or not that changed anyone’s perceptions, I can’t really say. I can say for us, no it didn’t. I don’t even know if people read the pieces, but...
Andrew, an American-born Chinese man in his mid-20’s, owns a restaurant in Chinatown. He describes how the rumors appeared in newspapers:

*Andrew:* It was a big thing to the Daily News and the NY Times and all the New York local newscasts. They would put it on everyday more and more. And they were actually hurting us in Chinatown, saying that like people were dying in Chinatown from SARS when it really never happened. “People Getting Sick in Chinatown” - something like that, rumors like that that never really happened. And I personally don’t know, but they hurt one restaurant that’s right around the corner. They said that one of the managers, one of the son’s of the owner had SARS, and then nobody would go in there for 6 months. They lost a lot of their business….It was empty for 6 months.

*Laura:* Do you know why that rumor started?

*Andrew:* Yeah, there was this reporter [...] he’s the one who did the story that hurt them. That’s why everybody hates him. He was trying and like...he came in here and did like a report like you’re doing, and he turned everything around. The whole Chinatown was talking about it.

For many people I interviewed, press coverage of the Chinatown rumors was yet another example of how the media and outsiders abuse their power to portray Chinatown and the people in the community in a negative light. On several occasions I was told by individuals that had I not been introduced to them by someone they trusted, they would not be speaking to me at all.

In fact, distrust of my position as an ‘outsider’ made snowballing a difficult method for recruiting interviewees, and likely affected what people told me. How was I going to represent their perspectives? How was I going to represent their community? Indeed, interviewees’ common initial response that “nothing really happened” and “it wasn’t a big deal” may have more to do with their desire to put the events behind them or to play-down the stigmatization of their community. Further, contrary to my
expectations, many interviewees were more responsive when they found out I was a student writing my Master’s thesis rather than an article for the popular press. It wasn’t until after several weeks of explaining my project and spending time with potential interviewees in social settings that, with only one week of fieldwork left, I was finally in a position to recruit a sizable number of people for in-depth interviews. As noted previously, the limitations of snowballing as a method meant that my informants primarily come from Chinatown’s more established Cantonese population.

**Fighting the Fears and Social Risk of SARS**

Anticipating that the news of SARS would affect the community, the Charles B. Wang Community Health Center organized a health press conference with the New York Department of Health and Mental Hygiene in March, even before the rumors began. The press conference focused on the background information on the outbreak and epidemic. One of the clinic’s health educators explained:

*We targeted the press so that the press could do more accurate reporting and not hype up the rumors and create an undue level of anxiety in the community. We thought that this was probably the most important thing we to do.*

In response to the stigmatization that occurred despite the health centers’ efforts, community groups issued press releases rebuking the rumors. Several community groups collaborated and organized a rally drawing attention to the fact that there were no cases of SARS in Chinatown and that the community was safe for tourism and businesses.

*Jason: [SARS was] another reason for people not to come down to Chinatown so that was absurd. That's why we started the rally. It was dead down here! That's why a friend of mine and I started in new*
acronym for SARS: Support Asian RestaurantS. And we called all these people. We had a bigger rally to Chinatown -- I think it was April -- we just walked through Chinatown and there was a lot of press there and we re-declared the opening of Chinatown. So it was really good. We handed out flyers, and people put them in their businesses.

Other organizations collaborated to organize high profile press conferences with figures such as Senators Hillary Clinton and Charles Schumer. Mayor Bloomberg publicly dined in a Chinatown restaurant to reinforce the message that the neighborhood was safe and to counter rumors that one could get SARS from eating Chinese food. Senator Clinton met with local leaders at a café to address the stigmatization. In the summer of 2004 photos of Senator Clinton’s visit were still displayed outside of the café.

In a community marked by fierce competition between various social and political groups (Kwong 1987; Lin 1998), the collaboration between organizations to combat the stigmatization and to mitigate the economic impact is significant. As Lin (1998) notes, public actions such as these rely upon the idea of a unified community, and are temporary moments when different community factions unite under a common cause. Several of the people I spoke with expressed hopes that these collaborations would persist. One community member and employee of a Chinese American cultural organization commented, “People came together as a community. It was great to see organizations coming together to combat the situation and to bring business back to Chinatown.”

However, not all organizations in the community united to combat the rumors. In fact, some avoided talking about the incidents even during the height of stigmatization. When I tried to interview one local community leader whose organization, one of the
oldest in Chinatown, had supported the restaurant during the rumors, he denied that there
had been any panic or rumors circulating in the community:

Laura: Can you tell me what happened in Chinatown during SARS?

Association Representative: Nothing happened. There was no SARS in
Chinatown.

Laura: I’m sorry. I mean, I know there weren’t any cases, but I heard that
there were rumors and that business dropped.

AR: There were no rumors. Nothing happened.

A Chinese American cultural organization representative explained:

Peter: Some organizations didn't want to talk about it, they preferred not
put fuel on the fire, to move on without continually mentioning SARS, 9/11
-- the obstacles. They thought that the attention was creating more of an
association between Chinatown and SARS. They thought it was better
forgotten and moved beyond.

Given the historical association of Chinese immigrants and Chinatowns with
disease, it is no wonder that some would downplay the effects of SARS on the
community. And why shouldn’t they? After all, according to the restaurant owner, it
was his own attempt to dispel his rumored death from SARS through media appearances
that inadvertently led to the rumor’s rapid dissemination.

Further, given the tendency for the media to focus only on problems in Chinatown
(Lin 1998), it makes sense that community leaders wouldn’t want to risk bad publicity.
One Chinese American business owner explained to me the desire to not draw attention
to intra-community problems:

Andrew: The problem is that people are not eager to talk. It's true, the
saying: whatever happens in Chinatown stays in Chinatown. [...] 
Chinatown is really no different than living anywhere else. There are
problems everywhere. People want better things for their family, etc...
And people don't necessarily want to talk about the bad things about the community.

Some expressed an acute awareness of the social risk of being associated with SARS, and articulated this concern when speaking about their decision not to take obvious precautions to avoid illness. One community leader said the people wearing facemasks in Chinatown angered him because they were furthering Chinatown’s association with the epidemic. For many, taking precautions were deemed not only unnecessary, but also an invitation to further association with infection. Some changed their behavior in response to the stigmatization:

Peter: My personal feeling was, how can I present myself so that people don't think I'm sick? I'm already self-conscious about being Asian American -- this made it worse. Like 9/11 was for Middle Easterners, SARS was for Asians. And people don't distinguish Asians -- Koreans from Japanese or Chinese. [...] I feel like I saw more [suspicion] on subway. More eyes of caution if an Asian person came near, especially I feel like [with] an older person of Chinese descent. Then you'd get the eyes – the shifty eyes like “Hmm...” So to answer your question did I take any precautions in terms of health, the answer is no, but I did feel more self-conscious that I was getting these looks because I was – I am Asian, Asian American. That was hard for me. I don't like to admit it, but perhaps I made more of an effort part of the time to look clean. I hate when that happens. I hate having to do that. I hate feeling that I have to prove something. That I have something to prove.

The owner of the supposedly-infected restaurant had a particular interest in making sure no one appeared sick or fearful of the epidemic. I asked him whether his restaurant took any special precautions during the epidemic.

Owner: It would be unnecessary to do that. If we do that people would be curious, with a big question mark. Like, "Well, why are you doing that?" That's why even... I asked my employees, "Look, if you don't feel well, stay at home. That's all." I'd rather lose a few orders than make people have a bigger question like, "Why do you have a runny nose?"
Indeed, even within the community exhibiting cold symptoms incurred social risk and avoidance. One man recounted how his former boss had refused to see a potential client because she appeared to have a cold. Another man described how his mother, who also lives in Chinatown, was avoided because of her cough:

Keith: People here in Chinatown... you could notice that some people did wear masks, but very few. But when you coughed [laughs], oh my goodness! Everyone went crazy! If you coughed - Oh! Everybody stares at you! Because my mom had a cough like from an allergy, and then everyone was like [shields himself] ”Aaaaaa!...” and runs out of the way or something like that. So I guess people were scared enough to notice something... I guess they were scared everywhere, but especially in Chinatown.

Differing perspectives on an epidemic of fear

Whether or not there was rampant panic in Chinatown, as reported in many press accounts, depends on whom you ask. According to the Charles B. Wang Community Health Center, community members experienced higher levels of anxiety during this period (Chen and Tsang 2003). However, others reported to me that no one in the community was afraid. As mentioned before, there are many reasons why community members and leaders want to downplay any fear or stigmatization that resulted from the epidemic. From my interviews, it seems that most people were not terrified, as portrayed by the press, but rather that they responded with caution “just in case” SARS did appear in Chinatown. Further, those in restaurants, positions of authority, or who provide services to the public were forced to respond to the fears of others and the possibility that the virus would come to the community.

It is clear from my interviews, particularly with community leaders, healthcare workers, and pharmacists, that myriad reactions were occurring in Chinatown.
Community members’ descriptions of local responses ranged from ones of panic to the characterization that no one reacted at all.

*Father Bernardi:* After both 9/11 and the SARS epidemic, it was one thing to come in here in the horror for 8 hours a day, and another thing to be here for 24 hours a day including the SARS. [...] The crisis here started because there was a rumor that the owner of a local restaurant, where everyone from the church gets their lunch, had died of SARS. So suddenly everyone was very afraid. Rumors go right up and down the street in Chinatown, and everyone was horrified.

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*College Student:* There was like a few weeks where, um, people were... everybody was afraid of SARS, even me. Because I didn't know what the hell it was. It was almost like another AIDS or something. And it just passed on... I don't know. When you coughed or sneezed anywhere in the same environment, you were just... you were able to catch SARS. And I had a few friends that thought they had SARS when they went to the doctor, but they didn't. Yeah, maybe for a few weeks or so, everyone thought they had SARS. Any small symptom... SARS. So everyone went to the doctor... nothing. I mean, I thought I might have had SARS, but it was just... then I wasn't too worried about it. I was like, "Eh,... I probably don't."

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*Acupuncturist:* Business was not hit in New York’s Chinatown. In my opinion, it did not affect Chinatown... Everyday there was business in Chinatown. I see them. It did not affect Chinatown.

*Laura:* Did you hear people talking about SARS at all?

*Acupuncturist:* People were worried about commuting back and forth to Hong Kong or Taiwan and bringing it back. But there’s no serious concern.

Why do these accounts differ if everyone I spoke to was working or living in Chinatown during the SARS epidemic? First, as I already have mentioned, some people sought to diminish Chinatown’s association with the disease, and so were not eager to
discuss anything that happened in the community during that time. Second, fears of SARS were diminishing because since the epidemic’s containment very few cases of SARS had been reported in the world.

Third, Chinatown is a large, diverse community and, from my discussions with community members in different locations, it seems that certain areas were impacted at different levels. The area around the supposedly-infected restaurant appears to have taken the greatest hit. It is this area, which is often described as the “traditional” or “heart of Chinatown,” that most tourists visit. Given the visual association in the media of Asians with SARS infection, and the press coverage of the restaurant rumor, and the association of SARS with Chinese food, it follows that this area would be more heavily impacted. The people I spoke with in this area described panic, deserted streets, and most noticed a significant drop in their business. Many community members I spoke to also avoided this area because it was the epicenter of the rumor, and because it is generally a crowded space where they felt more at risk for catching an airborne infection. In addition, some avoided sections of Chinatown that they associated with high concentrations of recent immigrants, whom they feared might be carrying SARS.17 The people I interviewed in these areas, therefore, would have been more likely to directly observe fear and the economic impacts of the epidemic.

Finally, people in health services or positions of authority, and those working in restaurants (which were associated with infection) were more likely to have observed people acting fearful of contagion. Many of these individuals were forced to respond to

\[17\] I’ll return to this point when discussing discourses of risk.
community fears and external stigmatizations according to their professional duties. Some did not perceive SARS to be a threat to the community or to themselves, but because they worked with people who felt or were deemed vulnerable, they were forced to respond accordingly. Specifically, those I interviewed took pains to reduce the anxiety of their patrons and patients, as well as diminish any risk of infection. These narratives reveal that, regardless of whether or not there really was panic, many in the community were taking precautions “just in case.”

One pharmacist of Chinese medicine, for example, felt that he had to respond to his customers’ demands for herbal medicines published in a Chinese newspaper, even in cases where he believed they would be ineffective:

_These herbs are generally taken to treat, not to prevent, per their formulations published in the newspapers. But a lot of people took it as a prophylaxis. These herbs are cooling, and they're not good for everybody. But that didn't stop anyone from taking them. [...] What they did was come in -- they cut it [the remedy recipe] out or they copied down from the newspaper. And they'd want it, and they'd have a right to get it. I'd tell them, "Look, you know..." We'd tell them it's not for everyone. But you know, fear is stronger than... What they'd say was, "You know, I'll have it around the house, you know, just in case..."

Likewise a Chinatown travel agent, himself Chinese American and Chinatown native, recounted how he was put into the position of having to assess the risk of travel for his primarily Chinese customers:

_Laura: What sort of interactions did you have with your clients at this point?_

_Travel Agent: Lots of inquiries about Hong Kong and the threat of SARS. I didn’t want to lie to them, so I said if you don’t have to go, don’t go. We had to refund at least 60 tickets. The airlines were nice about it and allowed it for a certain amount of time. So for a few months, we had no business. We were only working on refunding paperwork. I told people_
you can always go next year. I didn't want to lie and be responsible for them getting SARS. And I didn't want them to go over and get SARS because then they would come back and yell at me and maybe give me SARS!

People in positions of authority were forced to respond to fears of a potential outbreak to display responsibility and allay the fears of those who were more worried about the possibility of a local epidemic. The principal of a local Chinese kindergarten had to address the concerns of her students’ parents. Further, her responsibility for the welfare of her students necessitated that she mitigate the possibility of infection, even though she didn’t feel at risk herself.

Principal: Some parents were concerned so they were interested in knowing whether or not the school was going to demand notes back from the children or families who went across seas to either Hong Kong or China. And they asked if we were going to require a doctor's note saying that they were fit to return back to school. Only one parent brought that in, and it wasn't through a request of ourselves. They just brought it in independently.

There were rumors that one student’s aunt came back with SARS. There was lots of gossip like that. But the parents were not persistent about demanding physicals and I wasn't about to investigate...to mandate them because that would have been an invasion of privacy.

But many parents were very conscientious when they brought their child to school. If a child was coughing, or they heard someone coughing for a long time, they were highly concerned. We were also concerned in that case, and we called the parents.

Also during that time it was winter going into spring. And during winter, little kids do get sick. They always have the sniffles. They always have a runny nose, you know. But it didn't affect any teachers’ performance or any of my staff's performance. Everyone was still there.

Laura: Did it change the way you did your job?

Principal: I had to be more conscientious. When parents were prompting me to investigate a little or do something about someone...for example just with those families who went back to Hong Kong and China: what was I going to do about that?
In the school we just sterilized things more, [...]mopping the floors, wiping the walls and windows, and things that could be reached by the kids. I kept a Lysol wipe in the office, but I still would gather the kids in my arms when they cried. I still played with them.

Father Bernardi recalled the decisions the church had to make to address fear within the congregation. His narrative similarly reveals the “just in case” reasoning behind taking precautions, and points to why some people in his Chinese congregation were afraid of Chinatown as a site of contagion:

Father Bernardi: So then immediately we read all the things that were going on in Hong Kong and we decide to change the way we give out holy communion here. We gave out holy communion with the host, and also the cup. See: the precious blood, the wine, the cup. So what would happen was that people would come up and get the host and they would either dip the host into the cup, in the wine, or they would drink from the cup. So we decided to cut that part. The priest would just give out the host, as years ago when the priest didn’t have the cup and the host, we’d just give out the host. So we decided to do that. Then we have communion – Eucharistic ministers – lay people who come up to the altar and help distribute the host. And so a couple of local pharmacies donated to us - I still have cartons upstairs – Purelle. You know Purelle, the hand thing? And I still have probably hundreds of masks upstairs. We did not wear masks during the ceremonies at all. But we, the Eucharist ministers and myself, in the sight of everyone we did the Purelle squirts and you know [makes gestures of rubbing Purelle on his hands]...

...And we felt that...we didn’t know. Now, why did we do it and they didn’t in the Bronx or anything – it’s all New York City – and we did it here? ‘Cause everyone...we bought the rumor that we were most liable or susceptible to have people with SARS here. Because of the traffic back and forth from Hong Kong. But we didn’t, as far as I know, I mean, maybe you know better than I, as far as I know there were no reported cases here. [...] And then we have the kiss of peace during the mass, which is the part we go around and shake everybody’s hands. [...] Well, I cut it because - I was the symbol up in the front, and I went around and gave the Chinese – this is fine, by the way, for Chinese. It’s kinda like a...a sign of respect. It’s like a handshake. And I went up and [clasps his hands together in front of his face to show me]...and some people did that also, but a lot of people still shook the hands and everything. So, it was a mixed
reaction in general, but we felt officially from the altar that we should allay people’s fears.

And I would have to say that some people were really uptight about it in the parish...they wanted me to cut it and to take precautions and such. So different people – and these are all Chinese – reacted to it in different ways, which was interesting to see...the younger people were more uptight. And the more educated. And you know, I can understand that. They were watching the news and they were seeing that this thing was kind of out of control in Hong Kong because probably the worst thing about it was that they didn’t know. They didn’t know what spread this thing.

Laura: Was there a drop in church attendance?

Father Bernardi: No, I don’t think so. Don’t forget, these were all the pariahs. These were the “carriers,” even if they didn’t live here. These people live in Queens and Brooklyn and New Jersey...They were the ones that people were avoiding. So, no, there wasn’t a drop in attendance. I would say that at least half the congregation was appreciative that we were doing that Purelle thing, you know, washing our hands, and the other half couldn’t care less.

It is possible too that Chinese coming into Chinatown from nearby areas to worship were additionally concerned because of the class differences noted by Kwong (1996) between “Uptown” and “Downtown Chinese.” Indeed it was noted to me by one Chinese American woman that she noticed Chinese Americans from Queens avoided Chinatown during that time because they perceive it as a poor and dirty place.

Many described a cautious, but not panicked, Chinatown community. Health workers, such as this pharmacist of Chinese medicine, reported that community members were buying specific face masks believed to be effective in blocking the virus.

I know people were concerned, but there was no...no time that I feel that people were out of control, that people were... you know... people were aware, concerned. People were buying respiratory, N. 95 masks. It was sold out. People bought them not to wear them. People kept them at home "just in case. Just in case." In fact, when we called 3M -- because they’re our distributors -- not just in New York, not just in Chinatown in
New York, everywhere was sold out. So... and they couldn’t make them fast enough. So, it wasn’t just Chinatown or New York that was concerned. A lot of people were concerned. And they just want to have it -- to have their masks, because that was the masks’ specific spec that could prevent the spread of it. Because you couldn’t just have any masks. It had to be that certain mask that germs wouldn’t pass through. So I remember that. And we had some. I didn’t bring any home, because I just didn’t think they would be... but I know a lot of people who bought them who left them at home "just in case..." It’s like watching that movie, Outbreak. You know? You never know... you’d have it and be fighting someone for that mask.

Importantly, the widespread buying of masks in Chinatown mirrors what was happening in Guangdong and Hong Kong. The pharmacists I spoke with speculated that people might have been sending the masks to friends and family in Asia where distributors had sold out of masks due to their surge in demand. However, it is also possible that this precaution was taken because many community members were following the events in Asia through the Chinese language news and through reports from family and friends. Indeed, as previously mentioned, a local doctor commented to me that well before SARS was a news item in mainstream media, he noticed that community members were taking precautions based on what family and friends in Asian were telling them.

In sum, from these descriptions it appears that many community members were generally worried about an outbreak of SARS occurring in Chinatown and were preparing for that possibility. However, unlike what was portrayed by the media, panic was not universal. Asked what their personal assessment of Chinatown’s risk was, people had varying responses. Some responded emphatically that Chinatown was no more at risk
than anywhere else in New York City. I asked one community leader, who had organized
the rally, whether he thought people in Chinatown were more likely to get SARS.

No way! We're at the same risk is people living in Brooklyn Heights! Because it wasn't here. If anyone got it here, they probably would've gotten it from a carrier who brought it over from Asia. But that person coming from Asia could have gone anywhere in the city! It didn't matter if you are living in Chinatown or not.

Community Risk and Personal Precautions

However, while the rally and press conferences imparted an image of a united
community rejecting their stigmatization, individuals’ narratives concerning decisions to
take precautions reveal that a different process was playing out at the community level.

Instead of universally rejecting the idea that Chinatown would have an elevated risk for
SARS, many people responded that the community was vulnerable vis-à-vis its
connection to Asia. When I asked him whether Chinatown was more at risk, one
pharmacist responded:

I would have to give a qualified yes: because people in Hong Kong and other parts in Asia were more at risk. There's a possibility of a higher risk if people come from those areas, happen to be Chinese, and frequent Chinatown, I suppose there's a higher possibility for Chinatown, as New York would be higher. New York is a big city, a cosmopolitan city. People travel here from everywhere. So, it could be higher, but is it significantly higher? Is a higher than if I hang out in Long Island?

In particular, recent immigrants were identified as the most likely group to bring
and spread SARS to Chinatown, as discussed further below.

Sure Chinatown was at risk. It had the biggest risk in all of New York because of the immigrants coming back and forth. Unfortunately, it spreads disease, coming in contact with them.
Still others were more ambivalent about whether the community was at higher risk. The explanations of Joshua, a Chinese American college student who was born and raised in Chinatown, and Nathan, a Chinese American pharmacist of Western medicine, reflect the sense of community risk based on the uncertainty of the epidemic.

Joshua: I really don't know. I think everyone's chances are equal. I mean... if you travel... it originated from China. It could have originated from anywhere, not just China, but it just happened to be in China. If it originated in Africa, or maybe in Europe, they would have had a higher chance of getting it.

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Nathan: I mean, I just... same is everywhere else, I guess. You know, New York is so compact. You watch out, people were coughing... if someone looked sick you kind of stayed away... I mean, it's about the same is anywhere else, depending on, um... I mean, if I know that they just come back over or something like that, I guess you'd be a little bit more careful and stuff. But... I mean, I didn't. I didn't take any extraordinary precautions or anything. I just... you know how lucky you are you didn't catch it. There was nothing else you could really do, actually.

Many responses regarding personal or community risk emphasized this aspect of luck. Several people answered that there was nothing you could do. “Things are going to happen and there is nothing you can do about it.” However, many of these same people still took specific actions to prevent getting sick, despite the emphasis they placed on fate. In fact many of those who responded that they didn’t personally feel at risk still took precautions. The decision to personally take preventative actions appears to be a response to both uncertainty of the epidemic and the supposed risk of contagion represented by recent immigrants.

In talking to community members about whether they were afraid of becoming sick and/or took precautions, it became apparent that many of my informants
differentiated between their personal risk of infection and the vulnerability of Chinatown to a SARS epidemic. For that reason, even those who personally didn’t feel at risk of infection took precautions “just in case” they were wrong, or when they found themselves in certain circumstances. Informants’ explanations of when and why they took preventative measures reveal who and what were labeled as “risky” during SARS. I will explore these points further in a moment.

The uncertainty of the epidemic’s course resulted in people taking actions on the little information they had, even if they were fairly sure they weren’t at risk. For example, some people avoided eating out, especially at the restaurant where the staff was rumored to have SARS.

Joshua: I heard about someone made up a story that there was SARS in that restaurant. [...]  

Laura: Did you believe the story when you heard it?  

Joshua: I don't know. I had three friends tell me three different things ... I was like, "I don't know what to believe. I'm staying away from that restaurant, that's all I know!" They said that along the whole Bayard Street, there was SARS. So I stayed away from that area, really.

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Andrew: I tried not to eat in certain restaurants...Chinese restaurants. I actually cut down on my [restaurant rumored to have SARS]. I didn't go there for a while, just in case. I mean, I could go somewhere else for food, so why take the chance?

In larger discourses of risk evident in mainstream media, “exotic” Chinese food was identified as a potential source of infection, particularly after civet cats were purported to spread SARS. This risk discourse was repeated by some of my informants
who noted that people in rural or less “modern” areas of China were more likely to eat exotic, and perhaps dangerous, foods.

In addition, Chinese restaurants may have further represented vulnerability vis-à-vis their employment of recent Chinese immigrants, who represent a direct connection to China. As noted to me by one resident in an email:

Keith: Recent immigrants exhibit more of the ‘typical’ characteristics of their motherland, i.e., even I believe that China is more filthy than I wish it to be; wishing they have an agency like the EPA. I don’t know if people knew or even now know how SARS was developed so people just wanted to stay away from anything that was associated with it. Therefore, anything CHINESE-RELATED.

By observing who was taking precautions in the community, in addition to paying attention to the risk groups identified by health authorities and the press, people made decisions about who was at risk for infection. Most respondents identified the elderly, children, and people with weak immune systems as those most at risk. These conclusions echo what was being reported in the press and by health authorities. Individual observations that the elderly were more likely to wear facemasks might also have confirmed for some their status as an at risk group. However, some respondents felt that the older members of the community might have been reacting more to the association of Asians with SARS than not the actual possibility of infection. Andrew, a 20-something restaurant owner, explained why younger people felt less at risk.

I mean, it’s like I think I’m an American...an Asian American, so if I’m wearing a mask...I think the Caucasians, Hispanics – they should be wearing masks. So if everyone starts doing it, then I might think that I should wear a mask. I see it in Chinatown: a couple of old ladies wearing masks, but that’s about it. Cause all us young, we didn’t mind. Because we knew it was just rumors. We knew that it wasn’t going to happen here.
And if it did happen here, we knew that the government, they would do something about it right away.

Many respondents reported that their parents were more afraid, took more precautions, and urged them to do the same. Amy, a Chinese American woman in her mid-20’s, and Joshua, a college student, described their parents’ reactions.

Amy: People were saying to be safe by not being out in Chinatown too often, and by wearing the facemasks. My mom went so far to say, "Take a mask." And I said, "no way!" [Laughs]

Laura: Did your parents wear masks?

Amy: No, they didn't, but they had them prepared and ready in case it became prevalent in the city. But what they did do was wear the mask at work because they worked in a factory. Well, my mom works in a factory. So everyone there... for some parts, some of them already wear masks because of the cumulative dust, but now it gave them another reason to wear it because of SARS and all that. They work in tight quarters, the conditions are just very musty. She kept telling us to go buy masks for her so she could give them out to her friends in the factory.

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Joshua: I heard my parents talking about something. They didn't know what it was called. They just said, "Oh, there's this thing going around. So just be careful. Don't walk around. Don't walk around too much." I ignored them, because if I had to go somewhere, I just had to go.

However, while parents, children and the elderly emerged in conversations as at risk populations, it is evident that they were not considered “risky” populations. No one I spoke to conveyed that they avoided the elderly because of their at risk status. Indeed even travelers, who the press and health authorities identified as the reason SARS spread globally, were not indiscriminately avoided. Instead, by examining the circumstances that led to respondents’ decisions to take precautions, recent immigrants emerge as the risky population most likely to spread SARS.
Risky Places and Risky People

Although many people said that they were more careful when interacting with someone who appeared sick, especially if they were coughing, the single population that was identified as potentially sick, even with the absence of symptoms, was that of recent immigrants. Several respondents avoided places associated with recent immigrants, such as the eastern side of the community. Even one man who was traveling internationally during the epidemic expressed more fear that he could catch SARS from a recent immigrant than from his own travel. Others were particularly cautious in their interactions with recent immigrants.

Matthew: I feel I if I saw people who seemed like they just came from China... like recent immigrants, I would tend to keep an eye on them. I would like look, and think, "Hmm...do they have it? Do they not have it?"

A Western medicine pharmacist located in the predominately recent immigrant area of Chinatown explained his decision to take precautions.

Pharmacist: Was I afraid? I wasn’t afraid, but we tried to take precautions. We definitely took precautions.

Laura: What sorts of precautions did you take?

P: Wouldn’t talk to the customers directly if we knew...had the inclination that they were from China, things like that. And we would ask them, “Have you just recently arrived?”

Laura: How would you not directly talk to them?

P: Well, you’d talk to them in more of a distance.

18 In contrast, public health officials identified travelers, especially those going to Asia, as those at particular risk for infection.
Contextualizing Discourses of Risk and Responsibility

Fears that recent immigrants would spread SARS reflect a larger othering discourse that blamed SARS on dangerous Chinese cultural practices and agricultural lifestyles, evidenced in dominate media coverage. However, unlike dominate risk and blame discourses in American media, discourses in Chinatown were additionally informed by personal and anecdotal knowledge of China, and by existing economic and political tensions related to the recent influx of Chinese immigrants. Language of sanitary citizenship and othering contained in narratives of risk and prevention should therefore be analyzed not only as strategies to distance personal vulnerability to and responsibility for infection, but as expressions of other concerns. Such discourses express concerns about unregulated bodies connecting Chinatown to an unhealthy China, particularly during the 2003 SARS epidemic that occurred on the heels of an epidemic of avian flu in Asia. They also reflect social, political and economic inequalities in Chinatown and in China, as well as the simultaneous demands and exclusion American society forces on immigrant and minority communities. In order to contextualize these discourses, I will begin by reviewing Chinatown’s demographic shift since the 1990’s.

Recent Immigration and Demographic Shift

The 1990’s brought with it a huge influx of immigrants from Mainland China, primarily from Fujian Province. The presence of these immigrants, many of whom are undocumented and are smuggled into the United States, drastically changed Chinatown’s labor market and economy. The enormous debts with which many of these immigrants arrive force them to accept very low paying jobs, and their arrival has driven down already low wages in Chinatown. Indeed employers, both Chinese and non-Chinese, use
this population to drive down wages and to push unions out of their businesses. Employers fire documented workers and replace them with these unprotected laborers because they can pay them far less for working in terrible conditions without the fear of reprisal from either the workers or American authorities (Kwong 1997).

This practice has undermined the bourgeoning labor movement in Chinatown. In 1994, for example, a major Chinatown restaurant fired all of its unionized employees since it could pay non-unionized, illegal workers far less (Kwong 1996; 1997). According to Peter Kwong (1996), a class struggle has ensued the recent immigrants’ arrival due to the negative effect their presence has put on local wages and job opportunities. More established residents resent the threat recent immigrants pose to job security and wages (Kwong 1996).

The rhetoric of the “model minority” community contributes to Chinatown’s labor abuses and human smuggling, which in turn contribute to problems with crime in the community. According to Peter Kwong (1996; 1997) and Jan Lin (1998) many Chinatown business owners, who dominate the positions of power, point to “ethnic solidarity” and “ethnic enclave” reasoning (discussed in Chapter 2) to justify the so-called cultural appropriateness of what amounts to slave labor. Likewise, U.S. officials fail to intervene to curb labor abuses, citing Chinatown’s self-exclusion, ethnic solidarity, and community members’ acceptance of poor working conditions.

The “model minority” characterization is a racist construction that enables policy makers to blame racial and ethnic minorities who do not realize the so-called economic achievements of Chinese Americans. As noted previously, the idea of the “model
“minority” emerged out of the 1970 Census whose data indicated that Chinese Americans achieved higher levels of education and professional success than the national average. Although these data were misleading in that they disguised the achievement disparities between wealthy and poor Chinese, all Chinese Americans nevertheless became known as the “model minority” (Kwong 1996). Chinese Americans were characterized as succeeding on their own, thus allowing the government and law officials to turn a blind eye to community needs, crime and despicable labor practices (Kwong 1996; 1997).

In the few instances where American authorities have tried to disrupt the human smuggling of undocumented Chinese workers, they have been largely unsuccessful. While repayment is locally enforced by a brutal network of gangs who maintain control through physical force, the trade itself is based in China, often with the help of Chinese authorities. Chinatown’s tight job market combined with recent immigrants’ perpetual debt to their smugglers has resulted in many Fujianese involved in crime, working to enforce the rule of the same people who smuggled them into the country (Kwong 1996; 1997). This reinforces the ideologies of inequality that dismiss Chinatown as dangerous and beyond the law.

Finally, much like how the general American public has little knowledge of Chinese Americans, the Fujianese are historically a mysterious population to many Chinese. Geographically isolated from the rest of China, the Fujianese are known to be very closed and even more family centered than other Chinese. Further, Fujian’s dialect is unintelligible to almost all other Chinese (Kwong 1997). Therefore, like the broader
American public, non-Fujianese Chinese are likely to rely on the information of others to understand their Fujianese neighbors who make up the majority of recent immigrants. For all of these reasons, recent immigrants are frequently blamed for anything that is wrong in Chinatown. As noted by Kwong, “The old residents who remember quieter, more peaceful days live in constant fear for their livelihood and personal safety” (1996:185). One of my respondents noted that he had observed an elevation in crime in recent years, which he attributed to the influx of undocumented immigrants. This new population, therefore, was already perceived as a threat to community safety before the SARS epidemic in 2003. This perception is reinforced by personal observations in China and Chinatown related to poverty, poor sanitation, disease, and crime.

**Unregulated Sick Bodies**

Perceptions that recent immigrants are a threat to community health are likely reinforced by their high rates of health problems. Many suffer from TB, hepatitis, asthma, insomnia, headaches, pinched nerves, heart palpitations, back and neck pain as a result from long hours of working in poor conditions. As noted by Peter Kwong (1997), rest and exercise are not options for undocumented workers. With few monetary resources, they first seek to treat their ailments with herbs before consulting one of the many unlicensed doctors along East Broadway (Kwong 1997).

Lack of healthcare for recent, especially undocumented, immigrants in Chinatown is a visible problem. Along Bowery, Canal and East Broadway, RVs line the sidewalks offering low-cost health insurance and healthcare in Chinese to passersby. Around the neighborhood, particularly in community centers and associations, signs announce free
hepatitis B screenings in Chinese and English. Chinese medicine clinics are a common sight in areas where there are a high concentration of recent immigrant residents. Some of these, according to Peter Kwong (1997), are scam artists preying on a vulnerable population who cannot afford to get sick. One of my informants noted that all residents who do not speak English are limited in their options for healthcare and must rely on local clinics who he said often take advantage of them.

One informant related a story from his brother, a local doctor, that the illegal immigrants he treats often suffer from tuberculosis and hepatitis. These two diseases are an increasing problem in rural Chinese communities where healthcare is inadequate due to privatization since the 1980s (The Lancet 2004), which may be why they are appearing in Chinatown. Indeed, between 1978 and 1992 rates of tuberculosis in all of New York City more than tripled (Ho 2003). However, Ming-Jung Ho (2003) argues that the high percentage of tuberculosis cases among New York immigrants (58% of all TB cases in 1999, many of whom are Chinese) may in fact be more to do with deplorable working and living conditions, rather than being cases imported from China. In addition, undocumented immigrants may be more at risk for contracting tuberculosis en route to the United States due to malnutrition, unventilated and cramped living quarters, and physical abuse that renders them vulnerable to infection (Ho 2003).

For many community members, undocumented immigrants symbolize a risk as an uncontrolled and unaccounted population. Daniel, who grew up and works in Chinatown, voiced concerns echoed by many respondents about unregulated bodies that may be sick.
His narrative also echoes community anxiety about local crime related to immigrant smuggling:

Daniel: There are a lot of new immigrants -- probably over half of which are illegal. I'm sure you heard about the Golden Venture? Well, it was a ship that got stranded in Long Island with at least 100 refugees. Because the ship got grounded, the police went out, and found all these smuggled immigrants in the storage. It's very lucrative to smuggle people rather than drugs, because you get a lesser sentence for smuggling people than drugs. There's a better profit. That's why lots of people in Chinatown smuggle people rather than drugs. [...] They call these people snakeheads. They're well-organized, and probably part of gangs.

There are a lot of illegals in Chinatown. They're the new immigrants in Chinatown. They're making lots of money and spending lots of money. They have to pay back the snakeheads. Some of them hold three or four jobs. The attractive women go into prostitution. The men are mostly day laborers. So there's lots of money exchanging hands. [...] I was scared about the illegal immigrants [during the epidemic]. I thought maybe one of them might have got into a boat and landed in New York without anyone knowing. We were lucky. There are so many illegal people coming into Chinatown, it's amazing no one got sick.

Although omnipresent throughout Chinatown, undocumented immigrants are an “invisible” population of unknown numbers whose health needs remain largely unaddressed. Indeed, public health has had a difficult time attending to the health needs of the ever-increasing number of undocumented immigrants. One informant at a local Asian American social organization reported that a recent health program failed because city public health officials were not even aware of the language needs of this population. Finally, recent immigrants connect Chinatown to China, whose health status is perpetually in doubt. This fact, combined with their lack of healthcare access, and often linguistic and cultural differences, make undocumented immigrants a “risky” population.
China as Unsanitary Subject

Despite the efforts of many to rebuke the association of Chinatown with SARS, many interviewees accepted the discourses that placed their community at a higher level of risk. Dominant discourses that placed blame for the epidemic on Chinese politics and “culture” (specifically diet, farming practices, unsanitary lifestyles, and an indifference to the health of others) fit neatly into pre-existing concerns about recent immigrants believed to both represent and connect Chinatown to China’s “backwardness” manifested in China’s health problems. Although many narratives were couched in terms that describe China as “backward,” it is important to remember that China does have health problems and that the SARS epidemic was a real event devastating the country. These problems reinforce community members’ anxieties over the unregulated, direct connections to China posed by undocumented immigrants.

For many informants, China’s dubious health status was further placed in doubt by their handling of the SARS epidemic. Indeed, distrust of China’s government and health system commonly emerged in discussions about SARS. Many respondents blamed the spread of SARS on the Chinese government for covering up cases until they were forced to respond by the international community. Further, SARS was the latest of several health crises in China to cause concern among some Chinatown community members. A local Chinese American principal recalled that the parents of her students were concerned that their children not eat chicken during the previous Asian epidemic of avian flu. One respondent characterized SARS as the last straw in his decision to avoid traveling to China and Asia.
Andrew: That’s why I won’t fly back to Asia. Because I think China is a very dirty country. Not anymore. Not after this all these epidemics - there’s an epidemic of everything now and the government doesn’t care. There’s the AIDS epidemic, there’s the... Did you hear about that they were having a blood donation where they took blood from anybody and they wouldn’t test it? It was on TV. That’s how I found out. And they did a show about it... how Asia, how they pretty much spread it [AIDS] through that... because they weren’t testing their blood that was being donated to them. And a lot of villages are dying from it. Now the government is trying to do something because they realized there is an epidemic. That’s why I won’t go back.

Rural China represents a particular health concern to many of my informants who had visited their parents’ villages, which they generally described as dirty and lacking in sanitation. Others drew on anecdotal knowledge from their family and friends to describe rural sanitation problems. Concerns about rural immigrants and sanitation overlapped at certain locations perceived as potential sites of contagion. Restaurants in particular represented one such space of overlapping risks because of their employment of recent immigrants, in addition to a perceived indifference to sanitation on the part of the owners and the supposed connection between SARS and Chinese food.

Matthew is a professional in his mid-30’s who grew up in Chinatown. His narrative illustrates the overlapping of concerns on specific Chinatown locations:

Laura: Can you describe Chinatown for me?

Matthew: It’s a very dirty place. [Laughs] Well, actually, that’s not really true. Certain parts are very dirty. A lot of places are mainly where they have these like small mom and pop shops where they cater to a lot of the recent immigrants. And the recent immigrants, they’re the ones who are really, really dirty. ‘Cause I guess like the etiquette from the rural areas or the villages in China are sicker than city life. So they kind of like spit. They have no regard for garbage. They’ll like throw garbage on the floors, on the streets. Even like the restaurant workers. Some of those small mom and pop restaurants. Some of those are so dirty that in the
evening, they’ll like throw pails of greasy water and stuff like that right into the streets. And they don’t really care about sanitation and stuff. That’s some of the really dirty areas. But certain places, they’re like fairly clean. I guess like most of the touristy areas [...] is like very clean, because you have a lot of tourists going through there, so there’s a lot of money coming into the restaurants. So they try to keep the store fronts a little bit cleaner than the less traveled streets of Chinatown.

Laura: Which would be?

[He names some streets and areas of Chinatown that other people have told me have higher concentrations of recent immigrants.]

Laura: What makes you think that rural life in China is dirtier than in the villages?

Matthew: Well, ‘cause like from what I hear, like...Some of my friends they tell me like when their cousins or relatives come from China, they come from like the villages, they tell me that when they come to Chinatown, they’ll be eating like...let’s say, for example, like food with bones, and let’s say a chicken leg, or like a chicken wing. After they finish the bone, they don’t put it on the side of the plate, they don’t put it on the side of the table, they take the bone and throw it under the table! [Laughs]

Indeed, the large surge in recent immigrants does put a strain on the local infrastructure (Kwong 1997). To many, they also pose a health risk. These sentiments were expressed by many people I interviewed. Like Matthew, some respondents attributed trash in the streets to recent immigrants. While some explained that an abundance of trash was the fault of the City for not providing adequate trash pickup, others attributed the trash to a rural Chinese disregard for sanitation and the health of others. The presence of trash, as well as crime related to human smuggling, is particularly worrisome to those who are trying to reinvigorate Chinatown as a tourist and entertainment destination.
Chinese “Culture” and Disease

The fact that many informants perceived recent immigrants as potential SARS vectors due to their customs indicates that some Chinatown community members may have accepted dominant discourses that blamed SARS on Chinese “culture” and customs. Indeed, adherence to previous customs or lack of familiarity with American customs appears to be the determining factor as to whether someone is considered a recent immigrant, and may be a reason why they were considered a potential source of infection.

The term “recent immigrant” is quite ambiguous, and appears to describe people from diverse class backgrounds. While Peter Kwong (1996; 1997) describes recent, illegal immigrants as hailing from families with substantial capital, Zhou (1992) characterizes them as mostly rural and poor. Although the people I spoke with often used the term “recent immigrant,” they could not identify a temporal limitation to “recent.” One key informant defined recent immigrant for me:

Keith: If they stay in the realm of where the recent immigrants live and work as well as they are maintaining their customs from the previous country, then they are still considered ‘recent’.

One such rural Chinese custom that some respondents identified as a potential source of infection was spitting. This may have been a pre-existing concern among community members prior to the epidemic, but it also was a theme disseminated by international media to explain why SARS emerged in Guangdong, China (Loh, et al. 2004; Washer 2004). Spitting was a custom identified by the media that characterized
Chinese culture as “pre-modern.” As I will discuss in a moment, for community members spitting may represent the so-called backwards nature of specifically rural China.

**Modernity in China**

In addition to being informed by anecdotal knowledge and dominant risk discourses that blamed SARS on “backwards” rural Chinese culture, the conflation of rural China with filth and ideas of pre-modernity reflects Chinese discourses related to the constructions of national Chinese identity and modernity. As the definitions of modernity produced in city centers have been adopted by even those in rural areas (Schein 1997), it follows that they would appear in Chinatown, given its continued connections to China. Indeed, community discourses of modernity that explain away health inequalities in China reflect a centuries-long history of othering those considered inferior, meaning the politically and economically marginalized.

Louisa Schein (1997) considers how China’s cultural recuperation in the 1980’s, following its quest for cultural homogenization during the Cultural Revolution between 1966 and 1976, resulted in the simultaneous celebration and stigmatization of the premodern and traditional by city elites. Schein calls this domestic othering *internal Orientalism*. Across China, people sought to be associated with the symbols of modernity, while the “rural” and “nature” were designated as backwards and premodern. Schein notes that people in rural and minority communities have a particularly difficult time achieving a modern status because they are “suspended in time by the representations and implicit injunctions of urban culture” (Schein 1997:80). Jan Lin notes that urban Chinese, particularly those in Beijing and Shanghai, consider the mostly rural
provinces of Guangdong and Fujian to be unsophisticated (email to author, January 21, 2005).

Several respondents made comparisons between urban and rural Chinese when describing the possible origins of the SARS virus and epidemic. One Chinese pharmacist’s description of the civet cat (which at that point was believed to be the origin of the virus’ species jump) echoes sentiments that rural people are backwards compared to urban populations.

And you know, I think if you went to Guangzhou, the more modern areas of town... you're not going to find civet cat on every menu. You know, it's more of the rural, you know, people with rural roots. Sort of like people from Kentucky...you know how people make that "my Kentucky cousin"... it's like your country cousin, that type a situation in China. It's more of the rural restaurants or small town restaurants where they still eat a lot of game stuff. You know, people in the big city, if you ask them, they say: "Ohhh, I don't want to eat thaaaaat...”

One respondent, an immigrant from Fujian, blamed what he saw as unsanitary practices of rural immigrants on their poor education.

Aaron: The Chinese people, when they doing something they....I’m Chinese, so... I’m sorry but I need to say [this]. When they doing something, they not to thinking about other people. They just by their own. They say...like this: spit on the floor or something. They don’t care about that these things will cause another peoples’ health going bad. They just don’t care about it. So for this things, if someone gets SARS over there, it just gets fast and fast [will spread rapidly]. [...] I think that these things depends to the peoples’ education. But the Fukanes peoples’ education is a little bit lower.

Laura: That’s why they spit?

Aaron: Mm hmm. Because in the Fukien no body care about these... in Fujao or someplace like that....because this is country area. Not in the city, right? Those people are all from country areas. [...] 

Laura: Oh, I see. In the city, like Fujao, people wouldn’t spit? But the
country people would?

Aaron: Uh huh. Because the country people, their education is very low.

Pharmacists and other residents I spoke to in Chinatown likewise voiced concerns that recent immigrants spit and do not cover their mouth when coughing or sneezing. One pharmacist said this becomes a particular concern on his during flu season, when many of his clients are sick. Such concerns could be seen in American mainstream press as well, who reported that SARS was forcing China to crackdown on public spitting.

**Threatening Political and Economic Hegemony**

Finally, discourses of risk and blame targeted at recent immigrants are emblematic of political and economic competition in Chinatown. Jan Lin notes that some recent immigrants threaten the political and economic hegemony of Chinatown’s elite. According to Lin, those who arrive with investment capital are able to establish expensive restaurants and merchant organizations that compete with those of the established elite (email to author, January 21, 2005). Furthermore, the participation of illegal immigrants in Chinatown’s labor movement has contributed to the rise of additional unions and grassroots community mobilization who draw public attention to intra-community abuses and inequalities (Kwong 1996). Recent immigrants therefore represent a threat to Chinatown’s hegemony that, according to both Kwong and Lin, hides behind the rhetoric of “ethnic solidarity.”

Competition between the established elite business owners and bourgeoing immigrant businesses and associations may additionally manifest itself in discourses that characterize the Fujianese as money-obsessed and exclusionary. These notions are
additionally informed by the Fujianese reputation for maintaining close social networks, perpetuated by their geographic remoteness in China. Further, in Chinatown they are known to work in dangerous neighborhoods and under terrible conditions, lending credence to the idea that they are cutthroat and dishonest business competition (Kwong 1996; 1997). The notion that Fujianese are exclusionary and ruthless contributes to their designation as a dangerous “other” in Chinatown.
CHAPTER V: CONCLUSION

For people in Chinatown, it would appear that the same sources that alerted community members to the so-called infections were also responsible for the diminishment of the fear and economic losses: media attention and word of mouth. Factors that respondents identified as the reasons some community members became cautious and/or afraid (the close-knit community, the tendency for community gossip, and the media) were also those by which people measured whether there was continued local risk of infection. The disappearance of the rumors and media attention eventually calmed some people in the community, who slowly returned to the stigmatized restaurants and businesses. The following comment, made by a local Chinese American college student, was indicative of several responses I received to the question, “How did the epidemic end?”19

From my perspective, when the news stopped talking about it, that's when it ended. [...] And people just realized [shrugs]: "Uh, if nobody's dying..." If nobody's getting sick that they know of... Usually news spreads pretty fast in Chinatown. You know? First, like, with all the apartments, you know, these apartments with 10 different people living in them. People just talk to people, and they just talk to other people, and... I didn't hear any news through other people, so I guessed it wasn't really a problem.

However, the external stigmatization of Chinatown continued even after the rally and press conferences. Chinatown continued to struggle with a loss of business and tourism, even one year after the epidemic. Indeed, as one comment made to me by a

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19 I deliberately worded this open-ended question ambiguously so that respondents could define what they meant by the “epidemic”. This respondent immediately began talking about the epidemic of fear in Chinatown.
New York City resident after hearing about my research illustrates, it is not clear that the rally or the accompanying media attention mended the damage done by the rumors outside of Chinatown:

_Oh yeah, I remember the rally. They did that because they finally cleaned up Chinatown, right?_

**Continued External Stigmatization**

Chinatown continues to be perceived as an exotic, foreign, dangerous, self-isolated community whose members prefer to take care of themselves. Community members aren’t powerless in countering these stereotypes. Indeed, many people are involved in reinventing Chinatown in the public imagination, particularly by drawing attention to its unique cultural contributions, economic importance, and historical significance in New York City. The stigmatization surrounding the 2003 SARS epidemic, however, illustrates that they have no small task ahead of them.

One problem is that many of the primary sources of knowledge production regarding Chinatown (the media, the tourism industry) lie outside the community. They are not accountable for the image they produce of the community, and instead perpetuate the entrenched historical stereotypes of Chinatown. Several of my informants are involved in efforts to introduce tourists to the ‘real’ Chinatown through walking tours, exhibitions, and festivals that focus on the neighborhood’s historical and cultural significance of the neighborhood. However, their efforts will continue to be difficult as long as guidebooks, entertainment and news media continue to describe Chinatown as an invading, dirty, exotic sprawl of people plagued by crime and disease.
Tourism & Modernity

This externally-produced image of Chinatown creates an expectation of the “exotic” and “dangerous” among tourists, who are a vital part of the neighborhood’s economy. Attracting tourists, therefore, necessarily involves community collusion in selling and producing the “exotic” expected by Western visitors, a process that mirrors the internal Orientalism of China. According to Schein, current othering strategies in China reflect the country’s “cultural intercourse” with the West (Schein 1997:92). This new internal Orientalism incorporates Western ideals resulting from these interactions, such as Western tourism. China’s attempts to attract Western tourists simultaneously results in collusion to appear exotic while at the same time creating products and services to match “modern” Western tastes. Schein (1997) describes the dilemma of minority Chinese, who must participate in the perpetuation of their own stigmatization as an economic strategy of tourism.

This same process plays out in Chinatown, where the community’s violent past and its “otherness” are brought to the fore, often to the exclusion of its significance as an integral part of New York City. Those who wish to attract tourists must constantly negotiate a balance between selling the exotic and the dangerous demanded by Western tourists while simultaneously fighting against negative stereotypes and promoting the beauty, contributions, and significance of Chinatown and Chinese Americans. Community members are well aware of the social and economic risks of being associated with danger. As noted previously, some community members’ reticence to discuss the rumors and stigmatization surrounding the SARS epidemic was due to a desire to avoid further perpetuating the association of Chinatown with infection.
The contradiction of having to reproduce the same discourses of the “exotic” and “dangerous” that other the community is part of the demands American society places on the “model minority” community, which I will discuss in a moment. Recent immigrants may be perceived as a threat to realize these demands because they symbolize China’s “backwardness,” and are associated with community crime and sanitation problems.

Indeed, sanitation is a widely held concern that emerged in my interviews, and one that complicates efforts to attract tourism. An important source of employment for rural immigrants, street vending is considered by many community members to be an impediment toward Chinatown’s economic modernization (Lin 1998). Further, the concentration of recent immigrants, especially those who Kwong describes as “milling about looking for work” (Kwong 1996:177) may remind established residents and urban immigrants of the social and economic problems resulting from rural to urban migration in China. This demographic shift has resulted in inflation, unemployment, and street children in Chinese urban centers, all of which remind people of the desperate conditions in which many lived prior to 1949 (Kwong 1996).

The idea that Chinatown is plagued with sanitation problems is aided by the consequences of economic pressures on local businesses. Fierce business competition, exacerbated by cheap immigrant labor, compels restaurant owners to cut wages and sanitary measures to stay afloat. In the 1980’s, Chinatown restaurants were regularly cited for sanitation violations (Kwong 1987). According to many of my informants, restaurant sanitation in the community has never improved. As noted previously, informants sometimes linked these sanitation problems to the presence of recent
immigrants. Thus, many established residents perceive recent immigrants as a danger to the community health, safety, and economy. Even prior to the SARS epidemic, some of these residents disassociated themselves with the Fujianese in general (Lin 1998).

For Chinatown’s tourism to thrive, the public must deem it to be a safe space. The problems associated with illegal immigrants threaten Chinatown’s image as safe and sanitary. In particular, media attention during the early 1990’s to illegal Chinese immigrants and the brutality of the human smuggling trade revitalized the image of Chinatown as dangerous, foreign, and beyond state control (Lin 1998). Community members, including the Fujianese, have tried to counter these stereotypes. In response to being stereotyped as drug and human smugglers, several Fujianese community leaders erected a statue of Lin Ze Xu, a 19th century Fujianese official popularly known as the first soldier in the war on drugs. Lin Ze Xu fought against British importation of opium, and is thus credited with instigating the Opium Wars. His statue faces “Little Fuzhou”, the area where many Fujianese live, to remind them to fight these stereotypes.

Cheap Labor and Unregulated Bodies

Despite public cries for the curtailment of poor immigrants and the militarization of the border, undocumented immigration is not likely to disappear. Political and economic hardships in China as well as the American economy’s thirst for cheap labor and goods continue to encourage the immigration of disadvantaged, and often illegal, laborers. Chinatown has become a production center for our de-centralized industries, and thus the major destination for undocumented Chinese laborers who enable our
continued demand for cheap goods but represent our collective fear of unregulated, and thus potentially dangerous, bodies.

American industries utilize subcontractors, many of whom have related their production centers to poor immigrant neighborhoods such as Chinatown (Kwong 1996; 1997). Unable to speak English, and with little free time, these low-wage laborers are segregated geographically and socially from the larger society. This segregation combined with the rhetorics of “ethnic solidarity” in the face of a hostile American society reinforces their dependence on exploitative employers. Many Chinese immigrants thus are discouraged from challenging poor working conditions, lost wages, and low salaries. Further, increasing legal barriers to immigration and the militarization of the border make human smuggling a lucrative business, thus raising the debts undocumented immigrant must repay and escalating the smuggling-related crime that affects everyone in Chinatown (Kwong 1997)

In spite of community concerns regarding illegal immigration into Chinatown, a few members benefit from undocumented labor and from the rhetoric that excuses American officials from curbing it. Chinatown’s power structure, for example, relies on the myth of ethnic solidarity and self-sufficiency that enables illegal labor practices, human smuggling and crime (Kwong 1996; 1997). Further, these laborers enable Chinatown to maintain its reputation as a place where one can find great food and beautiful goods at low prices. Indeed, the low cost of Chinatown is one of its main attractions and is in fact one of the reasons that I am able to conduct fieldwork in the community as a student.
The Myth of Self-Sufficiency and Irrelevance

Chinatown is further perceived as irrelevant to and unaffected by the larger society. One Chinese American described his anger during the SARS epidemic:

*We were frustrated. Any other time of year no one talks about Chinatown. Only when something bad happens do people start talking about Chinatown.*

That Chinatown is not isolated from the larger New York community is illustrated by the dual effects of the terrorist attacks of September 11, 2001 and the impacts of the 2003 SARS epidemic. Chinatown is intimately tied to New York City economically, politically and socially. Public policies that treat it as somehow separate and self-sustaining are irresponsible to the people of Chinatown, and yet they continue. I heard several complaints that in the wake of 9/11 Chinatown businesses received less aid than businesses in the nearby financial district. Just recently Park Row, once a major vein into Chinatown from the economic district, was finally re-opened for partial traffic after 4 years of residents’ demands. The street was closed immediately after 9/11, supposedly because of security concerns, severely impacting Chinatown restaurants that depended on lunch customers from financial offices. It is suspicious that Park Row’s partial re-opening coincides with Mayor Bloomberg’s attempts to gain support from Lower Manhattan Assembly Speaker Sheldon Silver for the construction of an Olympic stadium in order to host the 2012 Olympics. Silver had previously criticized the mayor for not responding to his repeated requests for the street’s re-opening. The belated and only partial reopening of the traffic vein strengthens community perceptions that city officials are only interested in Chinatown when they need support from the community.
The lack of attention by public officials to the needs of the Chinatown community, furthermore, reinforces community sentiments that they are irrelevant or, even worse, that they are victims of a hostile American society. This perception, according to Peter Kwong (1997), is imparted on immigrant Chinese workers by their Chinese employers in a strategy to reinforce “ethnic solidarity” and discourage complaints of labor abuses.

**Risk Discourses: Reality versus Rhetoric**

Community members’ risk discourses regarding SARS draw attention to a multitude of concerns within Chinatown, as well as the fallacy of the ideas of “ethnic solidarity” and the “model minority” used by public officials to explain away their apathy to the concerns of this Chinese American community. Further, SARS discourses in Chinatown reveal that ideas of risk produced in the dominant American media, as well as those in Asia, informed how community members understood the disease and risk.

Although there were many public demonstrations decrying the stigmatization of Chinatown, community members did not universally reject discourses that placed the neighborhood at higher risk for SARS. The fact that some community members identified recent immigrants as potential sources of SARS contagion indicates that the dominant American discourses of risk that portrayed SARS as a pre-modern disease resulting from backwards “culture” and political dishonesty were largely accepted. Further, these discourses were recast vis-à-vis existing ideas of the “other” and the pre-modern produced in both China and the West to place recent immigrants at the center of risk of contagion. Dominant ideas of risk and blame were mapped onto recent immigrants
because they already represented many of the concerns believed to characterize the SARS epidemic: danger, premodernity, the free movement of bodies from an unsanitary state, and lack of concern for the health and wellbeing of others.

It would be easy to characterize community discourses of risk and blame as merely strategies to distance the self from social risk, or as a purely internal class or ethnic struggle within Chinatown. However, these discourses bring to the fore real problems in the Chinatown community. Human smuggling of undocumented Chinese has contributed to a rise in crime in Chinatown, as well as a drastic decline in wages and working conditions (Kwong 1997). Further, recent immigrants do suffer from many visible health problems that contribute to their association with disease. These problems reinforce the construction of recent immigrants as the “other,” particularly those from rural China.

Indeed, rural immigrants tend to be economically and educationally disadvantaged compared to their urban counterparts due to the stark contrast in development between urban and rural China. Rural immigrants are generally poor, and they often can’t speak English. Many arrive in the United States with little education and few transferable skills, and are thus dependent on cheap labor opportunities in Chinatown. Further, they are less likely to have family in the United States, making it more difficult for them to immigrate (Zhou 1992). Indeed, according to Peter Kwong (1997), the majority of recent and undocumented immigrants are actually from Fuzhou, not from rural areas of Fujian province. However, as is evident in several of my informants’ narratives, this distinction may be lost on some community members who
attribute trash, spitting, and health problems to educational deficiencies and health problems in rural China.

Discourses that blame SARS on rural Chinese, apparent in British (Washer 2004) and American press as well as in Chinatown, normalize the inequalities that put these communities at higher risk for contagious disease. Indeed, as is evident from the 2003 SARS epidemic, concerns about “emerging” infections are uni-directional: they are only of importance when they “emerge” from a poor population to threaten a wealthy one. SARS became a central item of news, and thus a perceived threat to American health, when it spread from a lower-income area of Mainland China to the wealthier Hong Kong (Farmer 2003). This is significant for two reasons. First, Hong Kong is popularly associated with economic success and democratic resistance to the Chinese government’s attempts to change the rights of its residents who formerly lived under British rule. In American press coverage, Hong Kong medical officials were rarely blamed for the spread of SARS, while the people, government, and so-called “culture” of Mainland China were. Hong Kong is a city of sanitary citizens, while China is a country of unsanitary subjects.

Second, the fact that SARS was of little importance to the news media prior to its appearance in Hong Kong illustrates how diseases that effect the global economy and the wealthy are far more likely to be seen as crises than other diseases that routinely claim the lives of hundreds of thousands of poor across the globe (Farmer 2003). The discourses that blamed rural Chinese and residents of Guangdong for the epidemic disguise the real sources of SARS: the state’s abandonment of the rural health system and the economic gulf between those who can afford healthcare and those who cannot. As the
Chinese government pursued economic development it invested fewer and fewer resources in rural healthcare, believing instead that economic growth would necessarily improve local health (The Lancet 2004). Indeed, China devotes less money to its health system than most developing countries (Lei 2005). The result has been an enormous gap in healthcare access between rural and urban residents. As discussed previously, large companies in urban areas are able to provide healthcare for their employees in company-owned hospitals, while rural residents are dependent on under-funded and under-equipped doctors. In these areas, parents cannot afford to pay for their children’s vaccinations, much less basic healthcare. Further, increasing rural poverty has created a growing class workers migrating from areas where communicable diseases such as tuberculosis and hepatitis are prevalent (The Lancet 2004).

The construction of the “modernity” and “superiority” of the urban within discourses of blame for SARS displaces culpability for rural disease and poverty from the Chinese state onto the backs of rural and poor Chinese who suffer its effects. The cultural reasoning that frames rural China as “backwards,” furthermore, distracts attention from how globalization and market reform thrust people into poverty, deepening the gap between rich and poor while simultaneously proclaiming universalized access to its benefits: technology, information, capital, and goods (Briggs and Mantini-Briggs 2003).

Demands on the “Model Minority”

By highlighting my informants’ discourses of blame, I do not mean in any way to place culpability onto community members for associating recent immigrants with dominant ideas of risk and blame with regard to SARS. Rather, I am arguing that the
economic inequalities, political and moral rhetoric that privilege white middle- and upper-class society are acted upon the racialized immigrant body by members of the same immigrant community in a way that disguises the racist, political and economic inequalities that contradict the ideology of “the American dream.” This does not mean that community business and political elites do not benefit from othering within Chinatown. As Wolf argues (2002), such conceptualizations are required for the social division of labor that benefits those at the top of the hierarchy. However, the fact that many immigrant and first generation Chinese and Chinese Americans find themselves at the bottom of this political and economic hierarchy that remains largely uninterrupted by the American state reflects larger national productions of inequality.

Further, all of Chinatown was stigmatized as the dangerous diseased “other” during the SARS epidemic. The community’s political and economic elites, primarily comprised of business owners, suffered the economic impacts as their tourist and local patrons avoided the supposedly infected neighborhood. The unfortunate fact of the risk discourses within Chinatown that stigmatize recent immigrants is that they repeat, and thus help to perpetuate, the same racist discourses that label all Chinese as the dirty, dangerous, diseased “other.” These discourses not only divide the working class within Chinatown, as discussed by Kwong (1997), they also fracture a population othered by the larger society. Internal othering thus serves to distract community members from the larger processes of inequality that marginalize all Chinese Americans.

Although my research is currently limited by the fact that many of my informants are American-born Chinese, their perspective is enlightening because it expresses the
bind of trying to navigate through and fulfill the expectations of a white-dominated society while also retaining and celebrating their cultural heritage. As Fanon describes, not being white becomes a problem at the moment of discrimination because the racialized person is denied humanity. “Then I will quite simply try to make myself white: that is, I will compel the white man to acknowledge that I am human” (Fanon 1967:98). While I do not believe that my informants want to be white, and are in fact quite proud of their Chinese heritage and identity, they are still subject to American society’s demands for assimilation that simultaneously denies them full membership into the American identity. This is particularly more likely for American-born Chinese and those community members with higher education and language skills who are not dependant on Chinatown for employment. Those who work, spend time outside of Chinatown, or whose clientele are non-community members are more likely to come in contact with such demands.

Informants’ fears about recent immigrants’ “premodern” Chinese customs reflect the demands American society places on immigrant and minority communities to assimilate and comply with white middle-class American norms. Despite the valorization of multiculturalism and preservation of traditions, we still expect compliance in American practices that are normalized as “common sense.” Yet the demands for assimilation are unattainable, first because of political and economic barriers that prevent many immigrants from achieving these standards, and second because American society continues to racialize people and spaces. Recent Chinese immigrants and Chinese Americans are outside the construction of the American national identity, particularly
because they are also racialized subjects. Racialized populations are constructed in essentializing ways that place them in opposition to national society (Briggs and Mantini-Briggs 2003). This is particularly true of Chinese immigrants, who are often portrayed as traditional and timeless in both the media (Chavez 2001) and academia (Ong 2002).

Further, Chinese Americans are continually portrayed as either dangerous, stupid, or in other essentializing ways that deny them full humanity. This fact is not lost on my informants, many of whom referenced American Idol contestant William Hung as an example of popular culture’s continual negative portrayal of Asian Americans, particularly men. 20 American society must continue to construct the “other” and the foreigner in order to define itself, just like “white” needs the minority (Fanon 1967), and the “modern” needs the “other” (Briggs and Mantini-Briggs 2003). Further, these discourses are essential in creating the healthy American identity, versus the dirty immigrant “other”, that are inherent in arguments to limit immigration from poor countries whose populations are considered to be “people of color.”

The “model minority” is part of a dialectic that simultaneously requires and denies assimilation. This characterization perpetuates Chinese Americans’ status as racialized subjects: successful but foreign. In addition, the rhetoric of the “model minority” implies that other so-called races are intellectually inferior and less interested in achieving success, thereby shifting blame away from the institutionalized white privilege, while simultaneously reinforcing socially constructed racial categories.

20 William Hung was an American Idol contestant in 2004 who became famous for his terrible, and thus comic, version of Puerto Rican pop-star Ricky Martin’s She Bangs.
Further, this paradigm demands its homogenized Chinese subjects to achieve the same levels of income and education that more wealthy Chinese immigrants, often from Taiwan (Kwong 1996), have attained. Chinese Americans are thus thrust into a phenomenon similar to what Fanon called the “racial distribution of guilt” (Fanon 1967:103), pitting members of the same community against each other. The foreign and premodern represented by recent immigrants’ difference threatens efforts to realize the demands American society puts on Chinatown: be exotic, be foreign, be part of our “cultural fabric,” but don’t be more different than American consumers and tourists can tolerate. Thus Chinatown’s efforts to achieve these demands deepens the fissures between established residents and recent immigrants, distracting them from the institutions that other and discriminate against them both.

**Significance of SARS Epidemic**

The stigmatization of Chinatown and Asian Americans during the 2003 SARS epidemic throws into relief how the rhetorics that excuse political and economic inequalities shape the social phenomenon of an epidemic including the production of fear and social meaning. Further, SARS revealed that American society continues to label Chinese Americans as a diseased “other”, despite the idea of the “model minority.” Indeed, for all its praise of their supposed economic and educational success, the “model minority” characterization perpetuates their status as racialized, foreign subjects, or bodies out of place. This construction has a historical precedence dating back at least to the 19th Century, and is part of a larger discourse that defines the American white middle-class identity as superior and healthy. Further, this construction is essential to anti-
immigrant and anti-foreigner discourses that have gained additional strength in the wake of 9/11. The construction of the “other” is crucial to define “American.”

Events surrounding the SARS epidemic reveal that responses to a disease are not limited to places of infection. Rather, rapid media enables the globalization of epidemic psychology, including the dissemination of dominant explanations, discourses of risk and responsibility. These explanations, although produced globally, originate predominately from Western institutions. In the case of SARS, they reflect Orientalist ideas of China and political criticisms of the Chinese state. These constructions of risk and blame were mapped onto Chinese Americans, illustrating the political signification of SARS and the global reach of epidemic psychology.

Further, responses within New York’s Chinatown to the 2003 SARS epidemic reveal the myriad factors, both global and local, that contribute to the signification of an epidemic. Epidemic narratives and discourses of risk within New York’s Chinatown reflect those produced in Asia and those disseminated by dominant American media. In addition, they throw into relief community economic, political and social concerns related both to the recent surge in Chinese immigration and to the general indifference paid to Chinatown by the public and the state.
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