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SARS and New York's Chinatown: The politics of risk and blame during an epidemic of fear

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Abstract

This paper examines the production of risk and blame discourses during the 2003 SARS epidemic and responses to those messages in New York City's Chinatown, a community stigmatized during the SARS epidemic despite having no SARS cases. The study consisted of 6 weeks participant observation and 37 semi-structured, open-ended interviews with community members. Stigmatizing discourses from the late 19th century resurfaced to blame Chinese culture and people for disease, and were recontextualized to fit contemporary local and global political-economic concerns. Many informants discursively distanced themselves from risk but simultaneously reaffirmed the association of Chinese culture with disease by redirecting such discourses onto recent Chinese immigrants. Legitimizing cultural blame obfuscates the structural and biological causes of epidemics and naturalizes health disparities in marginalized populations. This research demonstrates that myriad historical, political, and economic factors shape responses and risk perceptions during an unfamiliar epidemic, even in places without infection.

Keywords: Risk perceptions; SARS; United States; Stigma; Emerging infectious disease; Chinese–Americans

Introduction

> For those of you who eat in Chinatown, please be advised that SARS has hit that area. As of today I heard that the owner's son(s) & the entire staff of Fancy Pho have 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. [Email dated April 1, 2003, found at http://urbanlegends.about.com/library/bl-sars-restaurants.htm, errors in original]

During the height of the severe acute respiratory syndrome (SARS) epidemic in spring 2003, stories of infection and warnings (such as the e-mail above) to avoid Asian areas circulated throughout the United States. News media speculated on the possibility of a domestic epidemic, despite the fact that only eight people nationally had laboratory evidence of SARS—and most of these had contracted the virus abroad (Schrag et al., 2004). Fourteen percent of Americans reported avoiding Asian businesses (Blendon et al., 2003), and New York City's Chinatown experienced heightened anxiety and fear of stigmatization (Chen & Tsang, 2003). The above rumor and its news coverage caused a tremendous drop in business and tourism in Chinatown. Even without a single case of SARS,

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the community was identified quickly as a site of contagion and risk. The American public, including Chinatown, had become infected with an epidemic of fear, not of disease.

This research draws on anthropology, sociology, history, and media studies to examine the production of the dominant American risk discourses during the 2003 SARS epidemic, focusing specifically on those who blamed the disease on Chinese culture. I then use ethnographic research to investigate how these discourses played out in New York City's Chinatown. I use the term *discourse* in the Foucauldian sense to refer to the contested field of possible ideas, images, and metaphors that structure the ways in which people understand diseases. Many informants rejected community association with infection while simultaneously deploying dominant discourses to blame recent Chinese immigrants as potential infectors. This discursive strategy distances the self from biological and social risk, echoes discourses produced globally and disseminated by the media, and reflects local concerns related to the community's changing demography. The collected narratives illustrate that many historical, political and economic factors shape responses to an epidemic, even in places without infection.

Background

SARS is a virus spread by close contact with non-specific presentation. Patients generally exhibit a fever of over 100.4 °F, a dry cough, diarrhea, vomiting, and eventually pneumonia (Fan et al., 2006; Liu et al., 2004). From the first known case in November 2002 to its containment in summer 2003, mounting infections and deaths from this unfamiliar disease caused fear and economic disruption as the virus spread from Guangdong, China, to Hong Kong, Vietnam, and other countries including Canada. By the end of its course, over 8000 probable cases were identified worldwide and approximately 900 people had died (CDC, 2003). Fear of contagion spread far beyond infected areas, likely bolstered by the uncertainty of how the virus spread and its non-specific presentation.

Psychosocial responses to unfamiliar epidemics include fear, stigmatization, explanation, and action based on little available information (Strong, 1990). The public and media draw on historical, political and economic metaphors, as well as personal experiences, to interpret and explain the origin of an epidemic, resulting in the collective construction of multiple and diverse narratives (Briggs & Mantini-Briggs, 2003; Farmer, 1992; Moeller, 1999). Narratives can be recontextualized to fit other temporal and social settings, becoming "authoritative" representations of truth in the process (Briggs & Mantini-Briggs, 2003). A historical political-economic perspective that considers both the local and global is therefore crucial for understanding the production of risk and blame.

High levels of fear and blame during a deadly epidemic are associated with lack of information and perceived loss of control (Des Jarlais, Stuber, Tracy, Tross, & Galea, 2005; Nelkin & Gilman, 1991; Van Damme & Van Lerberghe, 2000). Individuals and groups may project the risk of infection and death onto an "Other" in order to reduce the powerlessness experienced during a deadly epidemic (Crawford, 1994; Joffe, 1999). In this process of othering, disease origins and risk of infection are explained through moralizing metaphors of cultural superiority so as to locate risk and responsibility among marginalized populations. Such discourses often define community membership vis-à-vis one's relationship to modernity, a contemporary metaphor representing purity. Those who are labeled as *unsanitary subjects* (Briggs & Mantini-Briggs, 2003) threaten community health because of their cultural inferiority and thus their status as matter out of place (Douglas, 1966). This othering is crucial to the maintenance of a healthy identity because the boundaries of the healthy self are never secure (Crawford, 1994). The identification of a 'risk group' is part of this boundary maintenance that creates and legitimizes the stigmatization of already marginalized populations, resulting in their identification with a disease (Goldin, 1994).

The media makes distant, often unaffected, populations aware of an epidemic and disseminates the dominant framework by which it is interpreted: the cause, explanation, and vocabulary of risk and responsibility (Briggs & Mantini-Briggs, 2003; Farmer, 1992; Herzlich & Pierret, 1989; Joffe & Haarhoff, 2002; Kasperson, Jhaveri, & Kasperson, 2001; Ungar, 1998). It provides an effective medium for health communication by bridging medical discourses and society, but it also contributes to the formation of social relations and representations around the disease by explaining epidemics in terms of social processes (Herzlich & Pierret, 1989; Joffe, 1999). Further, the media emphasizes dramatic

events (Buus & Olsson, 2006; Moeller, 1999) and risks that are easily tied to moral and political agendas (Joffe, 1999), resulting in higher coverage of rare diseases and relatively little coverage of more common ones (Moeller, 1999).

The media uses familiar symbols to simplify the abstract risk of emerging infections, often by blaming the sick for putting others at risk for premodern diseases by not participating in modern, sanitary society (Beck, 1999; Briggs & Mantini-Briggs, 2003; Farmer, 1992; Moeller, 1999). Media coverage is therefore a good source of data for measuring the dominant stigmatizing discourses during an epidemic. Othering in media coverage is masked by the prominent position of scientists and by cultural reasoning, whereby anthropological terms are used to describe a population's inferiority vis-à-vis their culture (Briggs & Mantini-Briggs, 2003). Indeed, as Barde (2003, p. 161) noted regarding epidemiological advances of the 19th century, discoveries of the causes of disease have "changed only the language of the scapegoating, not the target."

While many scholars agree on the role of the media in disseminating knowledge and risk discourses, the media's effect on risk perceptions is much debated. Sensationalistic media coverage does not necessarily create heightened anxiety of being infected (Bergeron & Sanchez, 2005; Joffe & Haarhoff, 2002). Audiences may instead respond to the messages of reassurance (Ungar, 1998) and locate the risk of infection among those othered by news coverage (Joffe & Haarhoff, 2002). Stigmatized populations may reject being labeled as at-risk by not complying with public health measures that would confirm their inferiority (Nations & Monte, 1996), while sanitary citizens may position themselves outside the defined risk category to create a sense of protection (Briggs, 2004; Joffe, 1999). Finally, variability exists within any group around how individuals respond to risk discourses (Joffe, 1999).

This paper considers how risk discourses are produced and the responses of stigmatized populations in places without infection. I investigate the historical and political-economic dimensions shaping explanations of risk and blame during SARS, and the ways in which these ideas contributed to the production of local epidemic narratives in Chinatown, New York City.

Medical scapegoating of Chinese–Americans

In order to examine the production of these stigmatizing discourses, it is first necessary to investigate their origins. I focus specifically on the medical scapegoating of Chinese–Americans and Chinatowns, although these neighborhoods are not homogenously Chinese, nor was the stigmatization during SARS limited to Chinese people. The historic construction of Chinatowns as disease reservoirs continues to define these communities (Craddock, 1995), despite their relatively recent characterization as successful "model minority" enclaves (Kwong, 1996; Lin, 1998). This is illustrated by the avoidance of Chinatowns during SARS.

Following the completion of the transcontinental railroad, discrimination against Chinese immigrants sharply increased in the latter-half of the 19th century, reflecting White Americans' concerns over unemployment and national identity (Craddock, 1995; Kwong, 1996; Zhou, 1992). They were depicted as perpetually foreign, physically and linguistically different, and resistant to assimilation (Craddock, 1995). The press, politicians, and even doctors portrayed the Chinese as a threat to the nation's health, morals, and technological superiority (Ahmad, 2000; Lin, 1998). This helped justify the passage of the 1882 Chinese Exclusion Act, the first law to exclude a single ethnic group from immigration.

In the 1890s, daily newspaper reports disseminated Western medical theories that attributed several plague pandemics to the so-called Chinese "culture", further constructing Chinese people as health risks (Barde, 2003). When the plague hit San Francisco in 1900, the mayor quarantined Chinatown's Chinese residents (McClain, 1988), which was followed by a national quarantine on all Chinese and Japanese (Edelson, 2003). The blaming of this and several other infectious epidemics on the Chinese (Barde, 2003; Craddock, 1995; McClain, 1988) solidified the depiction of their communities as diseased, dangerous, and inferior. In fact, the same discourses that blamed the plague on Chinese food and culture resurfaced in 2003 to explain SARS's origin.

Media coverage of SARS

Most studies of SARS coverage document that mainstream Western media sensationalized "the world war against SARS" (US News & World Report, May 5, 2003) and painted a grim picture of a deadly disease that threatened national borders (cf. Bergeron & Sanchez, 2005; Person, Sy, Holton,

Govert, & Liang, 2004; Schram, 2003; Washer, 2004; Wilson, Thomson, & Mansoor, 2004). Several noted that this sensationalization resulted in the stigmatization of Asians around the world (Person et al., 2004; Schram, 2003), and poor care for those suspected of carrying SARS (Karlberg & Lai, 2003). Wallis and Nerlich (2005) provide a detailed review of the metaphors used throughout the epidemic in British media. They conclude that the usual stigmatizing metaphors and militaristic language were largely absent, perhaps marking a shift in how the media covers disease. In contrast, Washer's study (2004), which samples only articles from March 2003, identifies many instances of othering directed toward Chinese people. My review of American media coverage throughout 2003 more closely mirrors Washer's data. As I will illustrate in the subsequent section, understanding the media's role in risk perception requires identifying the media discourses contained in individuals' explanations of risk and precautionary measures, and connecting these to the local historical and political-economic context. Though the media identified many factors that contributed to the epidemic, I argue that othering discourses that fit personal experience and local concerns have more influence on social responses during a frightening epidemic.

In American mainstream media, discourses of risk and blame reflected heightened fears of foreign threats to national health and security. Indeed, since the 9/11 attacks, metaphors of the diseased immigrant "Other" have increased (Fairchild, 2004). When the epidemic was identified in mid-March 2003, Americans were in the midst of debates over Iraq's weapons of mass destruction. News media abounded with stories of "Dr. Germ's" bio-weapons and smallpox vaccines for military and medical personnel. The public was primed for a frightening epidemic of foreign origin.

China was defined as a diseased threat to the modern healthy world. Descriptions of SARS's origin echoed those of the early 1900s that blamed the plague on the Chinese rice-centered diet (Edelson, 2003) and agricultural practices such as "the promiscuous manner in which the cattle, fowls, and domestic animals are permitted to live in close association with human beings" (Simpson, 1905, p. 177). Almost identical descriptions identified Chinese farms as culpable for SARS:

> 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. (Newsweek 5/5/2003)

The solution to infection thus becomes cultural change, as evidenced by this quote from Newsweek in December of 2003, when the world was waiting to see if the epidemic would re-emerge:

> 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)

Scientists are still debating the origin of SARS—some believe that it may have originated from horseshoe bats (Li et al., 2005). Although how the virus jumps species is unclear, the press still explained this new finding through the lens of culture:

> In Asia, many people eat bats or use bat feces in *traditional* medicine for asthma, kidney ailments and general malaise. (New York Times, 9/30/05, emphasis added.)

Some cultural factors do facilitate the spread of disease. However, the focus on "tradition" obfuscates the many political and economic factors that create at-risk populations, as well as the "modern" Western practices that contribute to emerging infectious diseases and antibiotic resistance (Weiss & McMichael, 2004). At the same time, they provide a sense of security and control by identifying a responsible "primitive" Other (Joffe, 1999) while asserting Western superiority.

Picturing SARS

Though many studies have focused on disease metaphors, less attention has been paid to the role of images in shaping social responses. Images symbolically represent the news and convey the seriousness and manageability of a risk (Kasperson et al., 2001). Their repetition encourages a "consciousness of risk" (Sontag, 1990), naturalizing the text they accompany (Briggs & Mantini-Briggs, 2003). Repeated images of a particular group of people in disease coverage indicate their heightened risk and potential to spread infection. Indeed,

images such as those of Asians in facemasks may still encourage othering even when accompanying non-stigmatizing text (Wallis & Nerlich, 2005), since they may enter one's consciousness in an uncritical manner, conjuring feelings that are resistant to challenge (Joffe & Haarhoff, 2002).

Though Asian voices were largely absent from SARS coverage in Britain (Washer, 2004) and the United States, their image was not. Innumerable pictures of Asians in facemasks racialized the epidemic by identifying Asian bodies as the source of contagion, contributing to their stigmatization. The May 5, 2003, edition of Time Magazine is particularly notable: there is not one picture of an Asian person among the 100 photos in the entire magazine, except in reference to SARS. Accompanying explanations of contagion and cultural inferiority naturalized this association. One NBC news story juxtaposed a video of an Asian family arriving at an airport with a discussion of "super-spreaders", individuals who were able to pass SARS to an unusually high number of people. The implied message relied on existing concerns over the border as a site of vulnerability to foreign threats, such as this family possibly bringing SARS into the national body.

With the majority of Americans learning about Chinese culture and communities through a popular media that continually dehumanizes Asians (Lin, 1998), and the historic associations of these neighborhoods with disease, the conflation of SARS and Chinatown in the public imagination was inevitable. This association translated into widespread medical racial profiling: public avoidance of American Chinatowns, Chinese cultural groups, Asian restaurants, and Asian people on public transportation.

Chinatown and the American epidemic of fear

Although many Asian–American communities were affected by stigmatization surrounding SARS, I chose to interview people in New York City's Chinatown because of reports of devastating economic impacts in a community that was still reeling from the 2001 terrorist attacks on the nearby World Trade Center. According to the Asian–American Business Development Center, Chinatown businesses experienced 30–70% losses, many on top of the losses they had experienced from 9/11. A local health center survey revealed that patients suffered from increased anxiety during this period, due in part to the economic, health and social risks of contagion and stigma (Chen & Tsang, 2003).

During the summer of 2004, I spent 6 weeks conducting participant observation and 37 semi-structured, open-ended interviews with community members selected from different sectors of the neighborhood using opportunistic and snowball sampling. I defined community member as residents, business owners, and employees who spent much of their time living and/or working in Chinatown during the 2003 epidemic. In order to explore a wide variety of perspectives on SARS and its effect on the community, I interviewed health professionals, local leaders, two school administrators, business leaders, four people who grew up in Chinatown, and one professional who had immigrated to the United States from Fujian less than 10 years ago. To supplement this information, I interviewed public health professionals and representatives from Asian–American organizations outside the community.

I conducted interviews in English, focusing on the events in Chinatown during the epidemic, personal and professional responses, and assessments of individual and community risk. General questions about Chinatown also yielded data on individuals' concerns about community well-being. I transcribed portions of the taped interviews after identifying dominant themes using deductive and inductive coding. I analyzed the narratives that emerged from these interviews using the grounded theory approach, paying special attention to discourses of risk and blame and the social, political and economic signification of SARS.

Language barriers and distrust of researchers limited my ability to recruit informants from a wide socio-cultural background. The majority of community members whom I interviewed were professionals who had either immigrated from or were born to immigrant parents from Guangdong Province, Taiwan, or Hong Kong and most had at least some college education. These populations make up the more elite Chinatown residents (Kwong, 1996). I have tried to compensate for these limitations by seeking diversity in occupation and geographic location within Chinatown. Despite these limitations, informants' narratives illustrate the multitude of factors that contribute to how people understand an epidemic, including personal risk. However, they should not be interpreted as representative of all of Chinatown.

In the following section, I use informant narratives that represent the major themes identified in the interviews to explore how the dominant political and moral signification of SARS played out at a community level. I focus specifically on discourses of risk, although there were many factors that influenced how community members understood and responded to SARS, including having family and friends in infected areas. I have edited primarily for clarity so as to maintain the integrity of each voice. All personal and place names are pseudonyms to maintain confidentiality.

The production of epidemic narratives: stories and rumors during SARS

When community members described the impact of SARS on Chinatown, one story was central to nearly every account: the rumor of a local Vietnamese restaurant owner who had supposedly died of SARS. Tourism and business plummeted as the story spread beyond Chinatown by word-of-mouth, email, and news coverage. An employee of a local museum, himself Chinese–American, recalled the resulting stigmatization and its economic impacts:

> Peter: 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. […] 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."

A local tour guide and leader of an Chinese–American political organization described what some called "coughing while Asian", a reference to the racial profiling term "driving while black":

> 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 the geographical space of Chinatown was associated with infection:

> Everyone in the New York area felt that you had to avoid Chinatown because of SARS. […] So I go…now, I'm Italian-American…[…]one of my friends had his 60th birthday in New Jersey. […] And these are all people I grew up with; I knew them as kids and everything […] 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! […] I said, 'Holy cow, it's not just the Chinese but the person who lives in Chinatown.'

Almost all interviewees faulted the press for disseminating the rumors and for fostering stigmatization by the way they covered the epidemic and rumor.

> Pharmacist A: American 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 a 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!
>
> 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, […] something like: "SARS in Chinatown?" […] 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???"

Fighting stigmatization

Community members actively fought their stigmatization using the same tool that disseminated the rumors and discourses of Chinese inferiority: the media. Even before the rumors began, the largest community health center organized a press conference to curtail any possible discrimination and unnecessary anxiety. Once stigmatization of

Chinatown and Asians became widespread, community groups issued press releases and organized a rally to refute the rumors. Other organizations collaborated to organize high-profile press conferences with New York politicians, including Senator Clinton. These actions relied upon the idea of a unified community and successfully brought together competing social and political groups for a common cause (Kwong, 1996; Lin, 1998).

Avoiding social risk

However, not all organizations united to reject the stigmatization. When I tried to interview a local leader whose organization had supported the supposedly infected restaurant, he denied that there had been any panic or rumors circulating in the community. Given the historical association of Chinese immigrants and Chinatowns with disease and the tendency for the media to focus only on the neighborhood's problems (Lin, 1998), it follows that some would downplay the impact of SARS.

> 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.

Fear of social risk occurred at the individual level as well. The same informant, who commuted to Chinatown every day, explained how SARS stigma changed his behavior:

> Peter: My personal feeling was, how can I present myself so that people don't think I'm sick? […] 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.

For many, taking precautions invited further stigma. I asked the owner of the supposedly infected restaurant whether his staff 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?"

Community risk and personal precautions

Despite the image of a united community rejecting their stigmatization, individuals' narratives concerning who were at-risk, and personal decisions to take precautions, reveal that a different process was playing out at the community level. Many differentiated between their personal risk of infection and the vulnerability of Chinatown to SARS. For that reason, even those who personally did not feel at-risk took precautions "just in case" they were wrong, or when they found themselves in certain circumstances. Pharmacists described a cautious, but not panicked Chinatown:

> Pharmacist B: [T]here 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. […] It's like watching that movie, Outbreak. You know? You never know… you'd have it and be fighting someone for that mask.

The uncertainty of the epidemic made rumors all the more important in individual decisions regarding whether to take precautions, as evident by this college student's account:

> Joshua: 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 Burrard Street, there was SARS. So I stayed away from that area, really.

Rumors and other narratives helped people create order during this atmosphere of uncertainty and fear by connecting the abstract risk of infection to recent immigrants, a symbol of pre-existing concerns regarding community health and safety (Beck, 1999; Briggs & Mantini-Briggs, 2003). Understanding risk discourses, therefore, requires examining their symbols and embedded concerns, as well as identifying those that determine individual precautionary actions.

Narratives detailing precautionary actions identified recent immigrants as the population most likely to *spread* SARS. Informants identified parents, children and the elderly as at-risk populations, but no one avoided these populations. Indeed even travelers, whom the press and health authorities identified as the reason SARS spread globally, were not indiscriminately avoided. Instead, informants identified recent immigrants as at-risk and potentially contagious, even with the absence of symptoms.

Several respondents avoided areas associated with this population, or were particularly cautious in their interactions. Matthew is a professional in his mid-30s who grew up in Chinatown:

> I feel 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?"

Contextualizing local discourses of risk and responsibility

A multitude of local and global factors contributed to the production of risk discourses in Chinatown. 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 mainstream media coverage. However, discourses in Chinatown were additionally informed by personal and anecdotal knowledge of China, and by existing political-economic tensions related to Chinatown's demographic shift since the 1990s. The othering contained in narratives of risk and prevention should therefore be analyzed not only as a strategy to distance the self from risk of infection and stigma, but also as an expression of pre-existing concerns symbolized by recent immigrants. These include unregulated bodies connecting Chinatown to an unhealthy China, particularly because the 2003 SARS epidemic occurred on the heels of several avian flu cases in Asia publicized in the Chinese language press. They also reflect power struggles and social, political and economic inequalities within the community.

A large influx immigrants from mainland China arrived in Chinatown in the 1990s, primarily from Fujian Province. Many were undocumented and smuggled into the United States, dramatically changing Chinatown's labor market and economy. The enormous debts of undocumented immigrants to their smugglers forced them to accept substandard pay. Employers, both Chinese and non-Chinese, used these unprotected laborers to drive down already-low wages and to pressure unions (Kwong, 1997). According to Kwong (1996), the more established residents resented the threat recent immigrants posed to job security and wages.

This immigration wave dramatically increased the population with ties to mainland China, challenging the hegemony of the primarily Cantonese elites who have historically stood in opposition to the communist government (Kwong, 1996). Further, according to Lin, immigrants who arrive with investment capital can open restaurants and merchant organizations that compete with those of the established elite (e-mail to author, January 21, 2005). The participation of undocumented workers in Chinatown's labor movement contributed to the rise of additional unions and grassroots community mobilization that drew public attention to intra-community abuses and inequalities. Recent, especially undocumented, immigrants therefore represent a threat to those elites who hide behind the rhetoric of "ethnic solidarity" (Kwong, 1996).

Unregulated sick bodies out of place

Perceptions that recent immigrants compromise community health are likely reinforced by their history of health disparities that are well-known to the community. Fifty-eight percent of all tuberculosis cases in the city in 1999 were immigrants, many of whom were Chinese (Ho, 2003). Poor working and living conditions have contributed to high rates of disease and injury (Ho, 2003; Kwong, 1997). Further, lack of healthcare for recent immigrants is a visible problem represented by RVs that line the sidewalks offering low-cost healthcare in Chinese and signs in community centers announcing free hepatitis B screenings in Chinese and English. Informants from community health and social organizations, as well as public health professionals, reported that the system has difficulty attending to the needs of this growing population due to economic and language barriers, as well as patients' immigration concerns.

For many informants, undocumented immigrants symbolize danger as an uncontrolled and unaccounted population of bodies out of place (Douglas, 1966). Daniel, who grew up and works in Chinatown, voiced concerns echoed by many

about local crime and unregulated bodies that may be sick:

> 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. […] 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. […] 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 they are assumed to be omnipresent throughout Chinatown, undocumented immigrants are an "invisible" population of unknown numbers. In informant narratives, the lines defining documented and undocumented were blurred and all recent immigrants were perceived as uncontrolled threats.

China as unsanitary subject

Recent immigrants connect Chinatown to China, whose health status is perpetually in doubt. The Chinese government's initial concealment of the SARS epidemic reinforced this sentiment and was the latest of several Chinese health crises to worry community members. A local kindergarten principal recalled that parents insisted that the school not serve chicken during previous reported episodes of avian flu in Asia. Andrew characterized SARS as the last straw in his decision to avoid traveling to Asia. His narrative illustrates the importance of the media in the formation of risk perceptions.

> 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.

Chinese "culture" and disease

Many informants perceived recent immigrants as potential SARS vectors due to their customs and disregard for public health, indicating an acceptance of the dominant discourses blaming Chinese "culture". Indeed, adherence to customs of the country of origin and lack of familiarity with American ones, rather than time of arrival, appears to be the determining factor as to whether someone is considered a "recent immigrant." This further links them to a dangerous China.

> 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'.

Many drew on the modern/pre-modern dichotomy to explain the epidemic and community risk vis-à-vis recent immigrants. Several made comparisons between urban and rural Chinese when describing the possible origin of SARS. One Chinese pharmacist's description of the civet cat (then the suspected origin of the virus' species jump) echoes these sentiments:

> 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 of 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…"

Dangerous food, rural inferiority, disregard for others, and recent immigrants as threats overlapped at sites such as restaurants, as is evident in the following narrative:

> Matthew: Certain parts [of Chinatown] 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, 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. […] And they don't really care about sanitation and stuff.

In this way, the rumor about the local restaurant represented both the political and moral signification of SARS found also in media coverage: foreign bodies and an "inferior" culture.

In sum, many established residents already perceived recent immigrants as a danger to community health, safety, and economy. Even before the SARS epidemic, some residents disassociated themselves with the Fujianese in general (Lin, 1998). Dominant SARS risk discourses fit neatly into these pre-existing concerns and justified the existing social hierarchies within the community.

Conclusion

Epidemic risk discourses and social responses are produced by many historical, political and economic factors within global, national and local contexts, and may stigmatize marginalized populations in places without infection. These communities may resist discourses that other them, yet they may also perpetuate and even legitimize these same discourses by redirecting them towards the marginalized members of their own community. (Indeed, this problematizes the notion of community.) This research has shown that these two processes can occur simultaneously. Though we may never fully eliminate othering during an epidemic, numerous studies have identified its origins, paths of dissemination, local and global manifestations, and effects on public health such that we can begin to chart ways to reduce its incidence and consequences.

First, scholars concerned with health and stigma need to pay attention to the ways in which people are othered *within* a community, not just externally. This necessarily requires paying attention to the ways in which risk discourses legitimize power inequalities within a community, which may in turn contribute to lower health status and higher risk of disease among the stigmatized.

We need to vigorously criticize othering in the media and in public health statements, and do so to an audience beyond the social sciences. News media is a crucial tool for rapid health communication in the midst of an epidemic, but it also contributes to and disseminates misleading discourses of risk and blame. Journalists need to understand the human consequences of constructing an epidemic in terms of protagonists and antagonists.

Finally, studies of stigmatization need to be integrated with those of cultural constructions of disease to understand more fully the ways in which people perceive a disease, their risk, and the appropriate measures for prevention. Othering is not simply a result of the social construction of an epidemic; it is part of the process and shapes further responses to a disease. As is evident by the reappearance of historical discourses blaming Chinese people for disease, othering perpetuates, legitimizes, and repeats particular forms of discrimination during and after an epidemic.

As we move further into an era of increasingly identified emerging infectious diseases, where the idea of a pandemic flu periodically looms large in the public imagination, locating and addressing othering beyond academic circles is paramount. Othering hampers the containment of contagion during an infectious epidemic by compelling people to reject public health instructions (Briggs, 2004; Briggs & Mantini-Briggs, 2003; Nations & Monte, 1996). Furthermore, it hinders the curtailment of emerging and re-emerging infections by normalizing illnesses affecting marginalized populations. Risk discourses that attribute disease to intractable "tradition" label the sick as willfully dangerous and inferior (Briggs & Mantini-Briggs, 2003; Farmer, 1992). The result is that these populations are blamed for their own infection, and their higher rates of illness confirm their inferiority and marginalization. Thus, sufficient investment in fighting diseases is only justified when they threaten wealthy populations, for whom infection is considered aberrant. As is evident from the 2003 SARS epidemic, international concerns about emerging infections are uni-directional: they are only of importance when they "emerge" from a poor population to threaten a wealthy one (Farmer, 2003). Diseases such as tuberculosis have therefore been allowed to persist among the world's marginalized, contributing to these pathogens' mutation and drug resistance (Farmer, 1999).

The SARS epidemic illuminates the ways global discourses of risk and blame naturalize the poverty deepened by the processes of globalization and simultaneously contribute to the (re)emergence of

diseases. Indeed, many of the discourses in Chinatown reflect concerns related to the processes of globalization that restructure economies and encourage migration. Further, globalization has created global cities, such as New York City, and transnational family networks that are connected by rapid international air travel (Ali & Keil, 2006). SARS dramatically demonstrates the possibilities for rapid worldwide spread of infections and the need for a coordinated global public health body. Cultural change as a solution to infection diverts attention from the poverty, poor sanitation, and deterioration of public health systems that facilitate the emergence and re-emergence of infectious diseases, both in the United States and abroad (Briggs & Mantini-Briggs, 2003; Farmer, 1992). Without access to appropriate drugs and vaccines, emerging infections, such as a potential influenza pandemic, will likely be very severe (Weiss & McMichael, 2004). As cultural scholars, we must draw attention to the social and biological causes of disease and actively work to find ways to correct the historically entrenched pattern of using cultural reasoning to blame infection on the "Other."

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