

## Childhood health-care practices among Italians and Jews in the United States, 1910–1940\*



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### Abstract

**This paper examines attitudes toward childhood health-care practices among urban Italian and Jewish families in the United States in the first part of the twentieth century. Although women in both groups were concerned about their children's health, Italian and Jewish respondents differed in their attitudes toward home remedies, doctors, and medical advice literature. Jewish women were more likely to turn rapidly to professional medical assistance, typically from Jewish doctors, whereas Italian women were more likely to rely longer on common sense before eventually seeking professional medical intervention outside the family and ethnic group. These differences are evident both in the respondents' recollections of their mothers' and their own child-care practices, and suggest persistent ethnic cultures. That differences in child care are consistent with the mortality differences documented in other sources supports previous speculations about the importance of child care, and thus the role of culture in health transitions.**

### Introduction

Ethnic and racial differences in infant mortality and childhood health have been the subject of considerable attention. These differences are not only of concern to policy makers today, but were noted during the nineteenth and early twentieth centuries in both Europe and America. Speculation about the causes for the differences has been wide-ranging, but definitive answers have been elusive. At the turn of the century, this speculation included cultural explanations, although more recent demographic analyses typically seek explanations in individual-level social and economic characteristics such as education and income.

This paper uses lengthy interviews with a small number of elderly Italian and Jewish women to examine differences between the childhood health-care practices of Italian and Jewish families in the United States in the early decades of the twentieth century. We go beyond the use of ethnicity as an 'identifier' of cultural differences (Hammel 1990). Following Swidler (1986), we consider culture as a 'tool kit', a set of prefabricated strategies for action (see also Greenhalgh 1988, who uses the metaphor of a 'spice rack' rather than a 'tool kit'; Caldwell and Caldwell 1991). In this view, culture does not shape action by supplying ultimate ends or values; rather, it provides a collection of persistent, but not rigidly unchanging, ways of ordering action through time. This approach is particularly appropriate

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here, since the Italian and Jewish mothers we interviewed wanted healthy children, but had different recollections of how they went about achieving this outcome.

Our interest was initially provoked by research that identified differences between the infant and childhood mortality of different immigrant groups in the United States in the early decades of the twentieth century, and by the speculations of both contemporary observers and recent analysts that such differences might be related to child-care practices. In the early years of the immigration that swept into the United States between 1880 and 1920, ethnic differences in child-care practices were not apparent. Impressionistic accounts at the time categorized all the immigrants from Eastern, Central, and Southern Europe as less educated, less ambitious, and altogether less 'civilized' than the immigrants from Northwestern Europe; and, not surprisingly, contemporaries inferred that they were also less healthy. Not only were the 'new' immigrants poorer and thus more likely to live in crowded and unhygienic surroundings, but they were also thought to be less concerned with the cleanliness of their surroundings (see, for example, Riis 1892).

More systematic analyses, however, found that mortality was typically higher among Italians than among Jews. Both groups were similar in many ways: for example, they immigrated in massive numbers between 1880 and 1914; they were poor at their arrival; they generally settled in tenement areas of large cities in the northeast; and they had larger families, on average, than native whites of native parentage. Yet Woodbury (1925) found higher infant mortality among urban Italians than urban Jews, and recent analyses of the 1910 United States Census similarly show higher mortality among Italians than among Jews (Condran and Kramarow 1991; Preston, Ewbank and Hereward, forthcoming). Statistical controls for a wide range of social and economic factors reduced the differences between levels of mortality, but did not eliminate them; and Preston and his colleagues were led to speculate on the role of unobserved differences in child-care practices.

Neither the available quantitative sources nor the interviews reported here permit us to establish a causal relation between child-care practices and mortality: the former sources contain no information on child care; and the interviews do not provide appropriate information for calculating morbidity or mortality rates. Similarly, our interviews do not permit controlling for a wide range of social and economic factors to distinguish between values and opportunities: indeed, we consider them both to be interwoven, jointly shaping behaviour (Pollak and Watkins 1993). Our aim here is more modest—to learn what cultural 'tools' were available and how they were used, and thus to explore, through the filters of memory, how culture might influence the care of babies and children.

### **Differences in health and mortality**

In the early decades of the twentieth century a number of studies documented that the mortality conditions of Jews were generally more favourable than those of other immigrant groups, including Italians. Using vital statistics, Billings (1890) showed that during 1885-1889, Jewish infant mortality levels of 85 per 1,000 births for males, and 77 for females, were 55 and 50 per cent lower than those for the comparable general population. Similarly, Woodbury's (1925) study conducted for the Children's Bureau in 1925 for eight eastern cities found that Jews had exceptionally low infant mortality. Other studies of mortality in New York also found that Jewish infant mortality was 30 to 40 per cent lower than that of the general white population (Schmelz 1971, Table 1). A study of infant mortality in 1915 in Baltimore also documented the Jewish advantage, especially at the lowest income levels: Jewish immigrants with incomes below \$650 had an infant mortality rate of only 49, compared to 106 among Italian immigrants with similar incomes. The differential narrowed very sharply among the higher-income populations (Schmelz 1971:47).

One of the most extensive early studies of ethnic health differentials was Davis's (1921) *Immigrant Health and the Community*. Italians and Jews were among the immigrant groups singled out for

particular attention. For most indicators of morbidity and mortality, Italians were found to have among the highest rates of illness of any immigrant group while Jews had among the lowest. For example, of the reported respiratory illnesses in one district of New York City in 1916, at all ages both the prevalence of cases and the mortality resulting from the illness was highest among Italians and lowest among Jews (Davis 1921:34-36). Similar differentials characterized deaths from infectious diseases such as measles, diphtheria, and whooping cough as reported in 1900 for the registration area for death statistics (Davis 1921:51).

Such differences between Jews and other populations in the United States continued patterns that had been found during the nineteenth and early twentieth centuries in various countries and cities of Europe.<sup>1</sup> For example, Jewish infant mortality in European Russia was about 50 per cent lower than that of the general population; in Poland it was 60 to 70 per cent lower (Schmelz 1971). Perhaps more relevant to the comparisons that are the focus of this paper, Jewish infant mortality in Florence in the 1840s was about 30 per cent lower than that of the total Italian population. Similar and even greater differentials characterized the experience of the populations of Rome, Turin, and Milan (Schmelz 1971).

Analyses of infant and child mortality rates using data from the 1910 Public Use Sample of the United States Census support these ethnic differentials and the advantageous position of Jews.<sup>2</sup> The 1910 Public Use Sample includes information on children-ever-born and children-surviving, as well as a large variety of indicators of social and economic circumstances, including place of birth and mother tongue of the individual and his or her parents, place of residence, literacy, female labour-force participation, and occupation. An analysis by Preston et al. (forthcoming) shows that the children of foreign-born Italians were considerably more likely to die before their fifth birthday than children in the general population; but that children of foreign-born Yiddish speakers were considerably less likely to die before age five than children in the general population.

A set of controls was introduced for social and economic circumstance; these included state-level measures of income as well as the individual-level characteristics available from the 1910 Public Use Sample. The controls reduced the excess mortality of most ethnic groups to such an extent that the infant and child mortality of the Italians did not then significantly exceed the average experience in the United States at the time. Taking social and economic circumstances into account also reduced the Jewish mortality advantage, but Jewish infant and child mortality remained substantially, and statistically significantly, lower than that of the total population. With all the variables controlled, the mortality of foreign-born Jews married in the United States was 43 per cent lower than that of native whites. A similar conclusion was reached by Condran and Kramarow (1991), who also used the 1910 Public Use Sample but focused on the infant and child mortality of Jews. Both analyses conclude that Jewish mortality was unusually low *within* particular social strata. Thus, although statistical controls diminished childhood-mortality differentials between Italians and Jews, they remained substantial.

Various reasons have been advanced to explain these differentials. Condran and Kramarow (1991) isolate six categories of explanation that were used at the time to account for lower Jewish mortality: racial and biological differences; specific Jewish religious practices; personal cleanliness and housekeeping; socioeconomic status; family and child-care practices; and better access to scientific care. Three of these—specific religious practices, personal cleanliness and housekeeping, and family and child care—have cultural overtones. Thus, for example, Fishberg (1911) mentions Jewish dietary restrictions, others note the Jewish rituals of hand washing (Schmelz 1971:78), and Woodbury (1925)

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<sup>1</sup> For an extensive summary of the sources, see Condran and Kramarow (1991).

<sup>2</sup> For a discussion of the sample, see Strong, Preston and Hereward (1989).

found that Jewish women breastfed their children longer than many other ethnic groups. Child-care practices and general hygienic standards are also emphasized by Preston et al. (forthcoming) and Condran and Kramarow (1991). These are, of course, difficult to measure. If child-care practices are limited simply to breastfeeding, which is perhaps the easiest of such practices to measure, both Condran and Kramarow (1991) and Preston et al. (forthcoming) conclude that it can account for only part of the ethnic differentials in infant and child mortality.

Many of the speculations about the cultural causes of well-established ethnic differentials in mortality were derived from the observations of contemporaries. Unlike the turn-of-the-century view of culture as 'a body of autonomous tradition', the more recent view of culture interprets it as the 'commonality of perception that emerges between actors as they establish and conduct their social relations' (Hammel 1990:465-466; see also Keesing, 1974; Hannerz, 1992). Establishing a commonality of perception requires interviewing the actors themselves, a thing that contemporary observers rarely did. Rather the social workers, doctors, nurses, and others engaged in the Progressive projects often complained about the recalcitrance of the people they were trying to benefit (for example, Williams 1938), and appear rarely to have considered them adequate informants about their own behaviour. Our research, by interviewing elderly women about themselves and their foreign-born parents, seeks to address this omission.

## **The interview methodology**

### **Selecting the respondents**

Our respondents were 55 Jewish and 30 Italian women between ages 70 and 97, who were interviewed over the course of several months in 1990-91. We interviewed whomever we could. We asked friends for introductions to their relatives or friends, we went to senior citizen centres and nursing homes, and we contacted the Philadelphia association of Italian lawyers. The women are clearly not a representative sample. Women who survived to these ages would probably not statistically represent those who were born shortly after the turn of the century, many of whom have already died. This would be particularly true of those who lived in families with poor health care, or who were themselves in poor health. It is also likely that women who had more children were more likely to die at a younger age. A sample of survivors might therefore be selective of those who came from families with better health practices or medical care, and who had limited childbearing. It is thus not possible to generalize from these women to a larger population. Nonetheless, because so much of the information was repetitive, and because such clear differences appeared between the generations and the two groups, a larger, representative survey would probably have yielded similar patterns.

Our respondents were asked about the families in which they grew up, and about their own childbearing years. The women were easy to interview. They had agreed to the interview, most rather quickly understood the aims of our research, and talked easily; indeed, they seemed pleased to tell their stories. Some of the women were concerned about protecting their privacy, and asked in detail what would be done with the interviews. They were told that the interviews were part of a study of immigrant families, that we wanted to know about families 'back then'; we assured them that their names would not be used and that no one reading the study would be able to identify them (we have given them pseudonyms). Most of the interviews were not taped, but extensive notes were taken during the interview and written up immediately afterwards.<sup>3</sup> Quotation marks indicate the women's exact words.

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<sup>3</sup> Transcripts of the interviews are available upon request from the senior author.

Most of the interviews were conducted by three interviewers, two in Philadelphia, Pennsylvania, and one in Providence, Rhode Island.<sup>4</sup> The interviews lasted approximately an hour, varying with the amount of recall and detail. A wide range of topics was covered, including child-care practices, general health concerns, and family planning, in the households in which the women grew up and in those in which they raised their own children. Only issues related to health care are reported here.

### **The interview**

The methodologies of interviewing are quite varied. At one extreme is the method typically used in large demographic surveys, where the questionnaire is fixed and, in principle, interviewers are interchangeable (Babbie 1986:224). At the other extreme is one in which each interviewer is expected to have his or her own style, and in which the interviews are expected to evolve in the course of the study (DeVault 1990). The present study modified the two approaches. The interviews were guided by a questionnaire that was based on our preconceptions. As we stumbled on the unexpected—which frequently happened—we revised the questionnaire. For example, being struck by the contrast between the women's reports that health care primarily comprised home remedies and doctors, and the literature, which emphasized public health initiatives, we revised the questionnaire to include questions about the use of clinics, and thereby uncovered differences in attitudes between the two groups with respect to their use. This led to a separate project (Watkins and Gerstel 1993 summarized below), to examine both the geographical and social access of immigrant Italians and Jews to health facilities in Philadelphia.

The interview began with questions about the women's parents. First, we asked when and where parents were born, when they immigrated, their education, religion, occupation, and names and birth-dates of their children. We then asked 'When you were a small child, how did your mother keep house? We're interested in things like diet, cleaning, rules for her children's safety and welfare. What were her practices regarding nursing? For how long? Why? Did she use a midwife?'. The respondents often had quite clear memories about their usual diet, whether their mother breastfed (almost all did), whether she used a midwife (almost all did), and how often they bathed, but were less certain about handwashing. We then asked, 'How often were the children sick? What did your mother do?', followed (in later revisions of the questionnaire) with a question about non-familial sources of care or advice—clinics, neighbourhood women, advice literature—and whether the family belonged to a benefit society. We then asked about their parents' family-planning practices and interactions with people of other ethnic groups (Spector, Watkins and Goldstein 1991; Watkins and Danzi 1991). To learn about continuity and change, we repeated our questions, this time referring to the women themselves, when they were raising their own children.

A distinct advantage of this semi-structured approach is that it allowed the women to speak discursively in their own words. Reading and re-reading the transcripts, we noted differences in the language they used. For example, Italian respondents often said that their mothers 'let nature take its course', or a similar phrase; the Jewish respondents almost never used this language. Similarly, when we asked about recourse to child-rearing literature by experts, the Italian women typically dismissed such literature, saying, 'What did I have to read about? It was easy in those days', or 'You just used common sense'; although a few Jewish women mentioned reliance on child-care manuals, a more typical response was 'I didn't read, I talked with my doctor'. Thus, although most women in both

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<sup>4</sup> Kitty Kraus participated in a few of the interviews in Philadelphia. In addition, several interviews took place in Harrisburg, Pennsylvania.

groups would have answered a short-answer survey question 'Did you use literature on child care by experts?' by saying 'No', their elaborations suggest that this was for quite different reasons. For this reason, we do not summarize the women's responses in tables; but have selected quotations that capture our understanding of the similarities and differences between the two ethnic groups.

### **Recalling the past**

Research like ours, that requires participants to talk at length about behaviour that occurred in the past, 60, 75, or even 80 years ago, has disadvantages as well as advantages. We expected that much would be forgotten and that events that occurred in the women's childhood may not have been observable or comprehensible to them as children. At times women recalled incidents in childhood in vivid detail, and at other times we had a sense that the women were drawing on a 'feeling' memory, although they could not recall precisely what was said or done. Interviews with sisters (two sets done separately, one in tandem) provided an opportunity to check the accuracy of their descriptions of their childhood home. There was more agreement than disagreement, but events that were vivid to one sibling might not be known at all to another, or might be remembered differently. For example, one sister told us about the abortion their elder step-sister had, while her two other sisters did not mention it; all three, however, told us in detail about how one sister's abscess was treated.

In addition, and more problematically, many have filtered what they recalled through their idealization of the past, or in light of current concerns. In memoirs and novels, as among our respondents, immigrant fathers and mothers are almost invariably presented as labouring under incredible hardship to provide the best for their children. For example, Maria (Italian, b.1910), when asked about hand washing when she was growing up, said she didn't remember but added that all her mother's children were born alive and grew up healthy. Yet a little earlier in the interview, when listing her siblings in response to a less value-laden question, she had told us that of her eight siblings one had died at age six, another at age three, another at age one, and another at five days.

When we asked whether their mother's child care was similar to or different from that of other women, most answered that their mother or they themselves did pretty much the same as other women they knew: 'We all did the same thing'. Many women recalled their mothers' exchanging advice about treating sick children with other women, and many said that they themselves did the same thing as they chatted with other women in the playground, or in the card groups to which many of them belonged. Thus, some of their recollections no doubt reflect fairly well their particular slice of the ethnic world, the friends and neighbours who were primarily, but not always, in their own ethnic group.

Our respondents probably also drew on ethnic stereotypes, of their own group and others, created through decades of conversation. This would have the effect of reducing variation and increasing the appearance of cultural consensus. The women sometimes characterized their ethnic group for us. Thus, one Jewish woman, Beatrice (1907), dismissed the role of income in seeking medical attention by saying that when she was growing up 'Jews would dig ditches in order to take their children to the doctor'. Several others emphatically denied that their mothers used public-health services. When we said we understood that some women around that time did use public services, an Italian woman answered rather indignantly, 'I don't want to knock anyone but maybe they were on welfare. My father was a very proud man. We did with what we had. I never even knew of their existence' (Teresa, 1912). This may have been true, or they may have forgotten or not known that their mothers used clinics for their siblings. But we suspect that their image of public-health services is associated with a view of those services that they hold today, and thus they interpreted their mothers' not using public-health facilities in terms of their families being too proud to accept charity.

### Respondent characteristics

Our Jewish and Italian respondents had similar personal characteristics in terms of age at interview, age at immigration and age at marriage (Table 1). In part, this is a function of our selection process; in part it reflects the many similarities among the two groups of immigrants and their children. In the discussion that follows we do not distinguish between women who were foreign-born and women born in the United States, because almost all the foreign-born immigrated as young children and thus their experiences were essentially similar to those of the native-born. For convenience, we refer to the parents of our respondents as the 'first generation', and to the respondents themselves as the 'second generation'.

The oldest respondent was 97 and the youngest 70; most respondents were in their 80s, and most of their children were born in the 1930s and the early 1940s. When the respondents are talking about their own childhood, they are typically referring to the period around World War I and the early 1920s; when they are referring to the children they raised, most are likely to be referring to the period from the mid-1930s to the 1940s. Since the aim of this paper is to understand ethnic differences in child-care practices, the absence of precise dates is a lesser problem than it would be for analyses of mortality differentials. To aid in locating the women in time, when we refer to the experience of an individual woman we give her date of birth in parentheses.

The major point of divergence between the respondents is in their educational profiles. A much higher percentage of Jewish than Italian respondents were educated beyond high school and a much smaller percentage had less than a high school education. Insofar as education is highly correlated with social status this finding points to class differences between the two groups. Other indicators, including occupation of both husbands and wives, also point to some class differences between Italians and Jews, especially in the second generation. The differences are less in the first generation. Few of our respondents' mothers had much education, and respondents in both groups indicated that they had been poor but never went hungry, although a few were quite poor. During the 1930s, when most of them were raising their own children, most lived quite modestly and some continue to do so (although some others were clearly well-off). We did not ask about income for either generation, but our impression was that the Jews were typically somewhat better off.

**Table 1**  
**Characteristics of respondents**

	Jews	Italians
Age at interview (years)		
Mean	84	82
Range	70-97	75-93
Immigration		
United States-born (%) <sup>a</sup>	68.0	72.0
Foreign-born (%) <sup>b</sup>	32.0	28.0
Mean age at immigration (years)	6.6	8.0
Education at marriage (%)		
Eighth grade or less	35.0	74.0
Completed high school	20.0	21.0
More than high school	45.0	5.0
Age at marriage (years)		

Mean	24.4	23.6
Range	18–42	18–39
Number of cases	55	30

<sup>a</sup>With one exception all of those born in the United States had at least one immigrant parent.

<sup>b</sup>All foreign-born Jews were from Eastern Europe (most from Russia); all of the foreign-born Italians were from Italy.

We turn now to what we learned from our respondents about health-care behaviour. We begin with their recollections of their parents, and then turn to the years when they were raising their own children. In each instance, we seek to gain insights that will help to explain the wide differences between the mortality of the two groups as reported by contemporary sources and revealed by analyses of statistical data.

### Health practices in the respondents' childhood

Both Italian and Jewish women reported that their mothers had been quite concerned about the health of their children. Our elderly respondents recalled their mothers as having been devoted to their children, this devotion taking the form of following what are today considered routine hygiene and health practices.

When we asked 'How often were the children sick?', most answered by recalling *serious* illnesses—a sister with polio, a brother who died of pleurisy. We had to probe for home remedies, asking 'What did your mother do when you had a cold or a stomach ache?'. Many respondents in both groups reported that their families resorted to a number of traditional home remedies for minor ailments. Common to both was recourse to chicken soup for colds, and flannel cloths, often permeated with Vicks or camphor (or goose fat among Jews) placed on the chest to relieve coughs. The Italian women often mentioned chamomile tea, *malva* (herb grasses brewed into tea), and bags of garlic suspended around the neck. Similarly, Jewish women mentioned *goggle moggle* (a drink of hot milk, egg, and honey), camphor bags, and *bankes* (hot cups applied to the skin to draw the infection from the body). Interestingly, however, although all the Italian women recalled that home remedies were used in their childhood, a number of Jewish women did not. One who said she did not remember them added that her cousin Frank was a doctor: 'If mother thought the kids were sick she'd call Frank' (Fannie, 1911).

Many in both groups did not remember precisely the regimes regarding hand washing. Although some said their mothers were quite careful, this may be hindsight coloured by current usage. Others were vague, and it is hard to know whether they simply did not remember or whether hand washing was not then seen as very important. Bathing seems to have been quite regular, typically once a week or sometimes twice, even though many homes lacked indoor plumbing. Most women remembered baths in tubs, or going to public baths. These reports of good hygiene contrast sharply with reports of conditions by social workers and government officials working with the immigrants (Riis 1892; Hapgood 1902; Gabaccia 1984:65-83). They suggest somewhat faulty memories among some of our respondents or that they were recalling practices instituted some years after their immigrant parents had arrived in the United States. It may also be that the social workers were unduly critical of the immigrants.

Despite the similar experiences reported by our respondents, some clear ethnic differences emerged from the interviews. Particularly striking were those that had to do with the role of medicine in general, and of doctors in particular. We do not claim here that doctors actually made a difference in infant and child mortality (see McKeown 1976): that can be established neither by analysis of statistical

data nor by the interviews. Indeed, in an analysis of the 1900 census, Preston and Haines (1991) show that the survival chances of doctors' children were no better than those of other children.

The differing attitudes toward doctors and medicine, however, do point to differing attitudes toward sickness and health. Doctors featured far more centrally in recollections about health-care practices of Jews than Italians. Although both groups of women typically recalled their mothers as beginning with home remedies and then calling the doctor if the illnesses were 'serious', Jewish mothers called the doctor for a wider range of illnesses and at an earlier stage. Italian mothers were more relaxed, treating more illnesses with home remedies and letting 'nature take its course' longer before calling a doctor. Only three Jewish women said their mothers relied primarily on home remedies, calling the doctor only if the illness were quite serious; conversely, only two Italian women said their mothers would not hesitate to call the doctor if they were sick.

These differences in attitude were expressed in a number of ways. Italian women recalled that doctors were called only for the most serious illnesses:

[What would your mother do when you and your brothers and sisters got sick?] Maria (1910) said that the doctor came when her sister died of flu, and that a brother died of pleurisy in the hospital. Otherwise, her mother would rub her chest with a mustard roll. 'She would give us medicine and we'd survive without doctors or anything. You'd go to the pharmacist and he'd tell you what to do... Everything was done at home, you had to be really sick to go to the doctor'.

Carmela (1905) reported, 'My mother would never call the doctor'. Her mother gave the children hot tea and rubbed them with olive oil. She recalled seeing a Dr. Henry from Pennsylvania Hospital, but added emphatically that there was no need to get a doctor, that she and her siblings were healthy and her mother knew what to do. For measles, she said, 'they knew what to do then, stay in bed, keeping the shades down'. [Did others in your neighbourhood do the same thing?] 'No one ever went to the doctor, I never saw no doctor around'.

Dorothy (1915) said that her mother called the doctor only if 'we had a high fever. Mostly she did her own doctoring, because we couldn't afford a doctor'.

Peggy (1909) recalled a Dr. Higby, who was free (from the company for which her father worked as a labourer): 'She [her mother] would never call the doctor right away, we'd have to be pretty sick. She'd wait a day, she didn't believe in calling the doctor right away. My mother didn't believe in doctors even when the doctor was free'. If they were sick, she would put her finger down their throat, wrap their feet and heat a brick, make chicken soup: 'She'd say "Oh, no, the medicines are no good"'.

The doctor was only for serious illnesses. Mother 'would try to keep us home first to see if the fever would go down' (Julie, 1913)

Several of the Italian women reported that when the doctor was consulted, it was at the hospital clinic. Similarly, most indicated that the immunizations they received were also given either at school or at clinics.

In contrast, Jewish women were much more likely to report that their mothers used doctors, both for immunizations and illnesses: typical was some version of ‘My mother always saw that we had a doctor’.

Sandra (1915) recalled a family doctor ‘for whatever was necessary’, for example regular checkups and immunizations. ‘There was never any stinging about doctors’.

Reba’s (1908) sister, who was fragile, was the only one of the three children who went to the doctors. ‘We were referred to Dr. Lowenberg—a very big doctor... He demanded \$25 up front. We always had a family doctor who came to the house. We never went to the hospital or the clinic’.

‘I remember once Dr. Jacobs came to see me, had me stand naked on the kitchen table’. [Why, what were you sick with?] ‘I had a cold, I wasn’t a sickly child’. (Lena, 1909)

[What did your mother do when you had colds?] Vera (1914) replied that they inhaled hot water or camphor for congestion, but if this didn’t work her mother readily called a doctor; her mother did not, she said, ‘let nature take its course’.

Ida (1912), who had no recollection of the use of home remedies, said her parents (who were socialists) ‘thought they were superstitious’. Her mother took her to a doctor or a clinic, but once her father started to make a ‘regular living’ they went to a private doctor, adding ‘If there was a vaccine we got it’.

‘Mother didn’t believe in *bubba meises* (old wives’ tales). She learned modern ways from father reading to her. She’d call the doctor for explanations’ (Edith, 1898)

‘Thank goodness we weren’t old fashioned and used doctors’ (Selma, 1916)

Unlike our Italian respondents, the Jewish women often mentioned their parents’ use of private doctors, both for illness and immunizations. Those who were less well off used the ‘lodge doctor’ or a pharmacist, who was often a relative. But even some who were quite poor called the doctor. For example, Dora (1921), who said her parents were very poor—‘we never had real money’—nonetheless said that her mother took her to a paediatrician who diagnosed her as anaemic and prescribed bacon. Ruth (1909), whose father was a grocer—‘not rich, he just got by’—said ‘If I was too pale or I wouldn’t eat, she’d take me to the doctor’. Rose (1910), who lived in a cold-water flat in South Philadelphia, said ‘My mother always called the doctor for everything’, although she remembers being immunized at school.

That doctors were used extensively and perhaps even excessively is documented by the recollections of the son of a Jewish paediatrician who served the immigrants of his community:

Morris operated his practice almost entirely through use of the telephone followed up by house calls. The phone rang at all hours and most of the questions were trivial. One memorable call at 7am (awarded the most-ridiculous-call-of-the-week prize!) was made by an anxious mother who asked the doctor to go outside to see how cold it was and then advise her on how to dress her child.

Two points emerge from a review of these differing sets of recollections of health practices in the childhoods of our respondents. First, the use of doctors was often equated with 'being modern'. Italian women emphasized that experts from outside the family were not usually necessary: for most childhood illnesses, their mother's lore of traditional remedies and her common sense sufficed. In contrast, Jewish women (who were much more likely than the Italians to originate in urban places) may have arrived in America with more 'modern' attitudes and values and therefore have been more receptive to change.<sup>5</sup> Furthermore, the Jewish community already established in the United States made great efforts to encourage modernization through special classes, neighbourhood institutions and ethnic newspapers. Perhaps reflecting this, Lilian (1902) said that although her mother was illiterate, she 'learned about modern things because father read to her and she talked to the doctor whenever one of us was sick and had him explain matters'.

Secondly, the use of doctors seemed to be facilitated when they were members of personal networks (relatives, or relatives of friends) or the same ethnic group. Both Italian and Jewish women placed great stress on the importance of the extended family in their lives, and much of social organization for these two ethnic groups revolved about the family (see also, Sklare, 1958; Gans 1962; Gabaccia 1984). The familial relationship was clearly important in their relationship with doctors. One Italian woman, offered a tubal ligation by her doctor (after ten children) said 'I wasn't his sister, he didn't have to help me'. In contrast, many Jewish women spontaneously pointed out that the doctor was a brother, a cousin, or the brother of a friend. This allowed them to take advantage of modern medical care while remaining within the family.

If family members were not directly available, the Jewish network was nonetheless more likely to include a Jewish doctor<sup>6</sup> than the Italian network was to include an Italian doctor. The testimony of the son of a Jewish doctor indicates, for example, that one Jewish paediatrician served almost the entire Jewish immigrant community in Boston in the early decades of the century and that two Jewish doctors covered most of the Jewish population of Providence, Rhode Island. These Harvard-trained, Yiddish-speaking doctors could be accepted as 'one of the family', and were therefore able to bridge the gap between traditional behaviour and modern medicine for the Jewish immigrants. Such doctor-patient relations were rarer within Italian communities. With one exception, the Jewish respondents who recalled a doctor by name mentioned one with a Jewish name; the exception was a woman who lived in an ethnically mixed neighbourhood and briefly used an Italian doctor recommended by her sister-in-law until she moved and switched to a Jewish doctor. In contrast, although some Italian women recalled doctors with Italian names, others pointed out spontaneously that the doctor was not Italian.

The apparently easier access Jews had to doctors within their own ethnic group is confirmed by information from the manuscript census for 1910. Geographical access to health facilities (hospitals, clinics, dispensaries) was rather similar for both groups, largely because they lived in the same wards of Philadelphia. But social access differed. There were far more doctors (and other medical practitioners) per capita for the Jewish immigrant population living in Philadelphia in 1910 than for the Italian immigrant population; indeed, there were nearly five times as many Jewish as Italian doctors (122 and

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<sup>5</sup> Glenn (1990) emphasizes the Jewish orientation toward modernity, although her study is not comparative.

<sup>6</sup> Medicine has been a desirable occupation for Jews at least since the Middle Ages. Since the profession was one of high status not only within the Jewish community but in modern times, in the wider community, it became a valued path to social mobility (Goldscheider and Zuckerman 1984). Moreover, such an occupation not only permitted the individual practitioner considerable latitude in setting hours and meeting the particular ritual requirements of Judaism, but also enabled him to prescribe in ways acceptable to the patients and their families.

27, respectively), although the Jewish population was only about twice the size of the Italian (Watkins and Gerstel 1993).

### **The health-care practices of our respondents**

The period between their mother's childrearing and that of our respondents was one in which a great deal of emphasis was placed on the mother's role in assuring the health of her children, albeit under the careful guidance of professional experts (Halpern 1988; Meckel, 1990; Litt, forthcoming). Our respondents were bearing their children primarily in the 1930s, although some of the higher-parity births occurred in the 1940s as by the time our respondents had their own households and families, both Italian and Jewish women were generally connected with the modern health-care sector. Both groups reported using doctors when children were ill, and a number of our Italian respondents made a point of indicating that their doctor was Italian. Many also reported giving their children regular check-ups and all recommended immunizations.

Even so, the Italians in this second generation also appear to have delayed more in resorting to medical professionals, while the Jews were quicker to seek expert guidance. For example, the Jewish woman (Sandra, 1915) who had described her mother as never 'stinging' about the doctor, told us about coming home from her brother's wedding because her daughter had a nosebleed, and sleeping across the daughter's bed fully dressed in case they had to go to the hospital. This led into a story about an aunt who put a thermometer in the baby's crib to make sure the sheets were warm enough. Another woman, May (1900), indicated that she was very conscientious about her family's nutrition and medical care and became quite aggressive if she thought a doctor was not providing the proper treatment:

'We went to New York to visit my husband's family when our first son was an infant. The child became ill and the family doctor prescribed some medicine. There wasn't any improvement, so I insisted my husband go with me in a taxi to Presbyterian Hospital to get better treatment'.

Beatrice (1907), who had noted that first generation Jews would 'dig ditches' to get the money to go to a doctor, said that she herself went to the doctor 'for the least little thing'.

Only a few Italian women were as relaxed as their mothers. Mary (1901), who recalled of her own childhood that 'We never got sick in those days... We never had a doctor', said that her own children never got injections, only vaccinations: 'I think they got them at school. They never went to hospitals in those days'. And Corlenda (1912): 'When I thought something was serious the doctor was the first one I called, but I didn't call the doctor every few minutes'; she went on to contrast her own behaviour with that of her daughter-in-law, who she said called the doctor a lot.

There was clearly a shift from one generation to another. Almost no Italian women mentioned using traditional remedies, other than bed rest and chicken soup, for her own children. Dorothy (1915) told us that although some of her friends used 'old fashioned remedies, and still do', she didn't, 'Because I never thought of it. If something is serious, that *malva* is not going to do any good'. For colds, she would give chicken soup, or call Dr. Giordano, a 'baby specialist': 'He'd prescribe over the phone. Maybe I'd take them in once in a while'.

The intergenerational shift is captured nicely in these comments from Connie (1907):

[What did you do when your children were sick?] 'First I would do is what my mother did, *malva*. And then I'd call the doctor right away'. [For a cough?] 'Yes, I'd call the doctor'. [Did you go for regular checkups?] 'Yes, I was afraid'. [Did you call the doctor more than your mother?] She answered yes, there were differences, but that it really wasn't different because neither her mother's children nor her own were sick very much.

Women in both groups occasionally characterized the differences between second generation Italians and Jews much as we have. One Jewish respondent, a doctor herself, implicitly compared Jewish women with others: 'The Jewish women would call doctors all the time. They were scared stiff something would happen to their children' (Ida, 1912). The most articulate was an Italian woman (Peggy, 1909) who lived in a neighbourhood of Jews while her children were growing up:

[Were Jewish women different about doctors?] 'Oh yes, the Jews called the doctors more. They'd say Peggy aren't you going to call the doctor? It looked like they had more fear about their children. I'd let nature take its course, but they wouldn't'.

In addition, our findings are consistent with those of Mechanic (1963), who found that Jews were likely to call the doctor for a lower degree of fever than were Italians. They are also consistent with Zborowski's (1958) finding that Italians and Jews differed in their reactions to pain: Italians expressed satisfaction when the pain disappeared; but Jews continued to worry that they might be sick even though the pain had disappeared.

The differences between Italian and Jewish approaches to child care in the period when our respondents were raising their own children is even more evident in what they say about the literature on childrearing by experts than in their comments on doctors. Some women in each group took this literature seriously. Bella (1902) a Jewish woman, called the doctor, who was a close friend, whenever her child had a fever. She also used all the government books on childcare: 'I always believed in listening to the experts'. Typically, the Italian women rejected the expert literature in favour of commonsense and Jewish women rejected the expert literature in favour of paediatricians:

Sarah (1913), whose cousin was 'a famous neurologist', said that many of her friends read books on the developmental tasks of childhood, but 'My husband and I laughed at that. Our paediatrician would tell us if anything was wrong'.

Emma (1900), whose brother was a doctor and whose cousin was a paediatrician, said that she received no information on child care from reading, 'only from my brother'.

Sandra (1915), who slept across her daughter's bed when she had a nosebleed, did have a child-care book, but didn't use it much: she took the children to a paediatrician for regular checkups, and early in their illness.

The second-generation Italian women's spontaneous comments about child-care advice literature sound quite different.

Dorothy (1915), whose mother did not even want to use the free doctor provided by her husband's employer, said she herself read *Ladies Home Journal* and *Good Housekeeping*, and another one which she couldn't remember. 'But a lot of them I didn't approve of. Some things I thought were ridiculous. Every child is different, you have to use common sense'.

Carmela (1905), who said that her mother never called the doctor—'They knew what to do then'—said she would read advice literature and would follow some of the advice but not all: 'You had to use your common sense'.

Many of our Jewish respondents told us that they considered caring for children 'hard work' to explain why they generally had only one, two or three children. In view of the comments they made about their concern with their children's health and their relatively extensive use of doctors, such an explanation becomes quite understandable.

The Jews' more extensive use of formal medical care, already obvious among the first generation, clearly persisted into the second generation, even though a considerable amount of convergence between Italians and Jews had taken place. The desire for Americanization, of which 'modern' medical practices was a part, no longer seems to have been a factor for the second generation as it was for the immigrant families, yet patterns of behaviour with regard to health care persisted among, and to some extent differentiated, Italians and Jews. An important distinguishing factor here, not documented by our respondents, but clearly evident in the findings of Gans (1962:136-141), is the persistence among the Italian population of a sense that doctors were outsiders to the community and not to be trusted.

### **Discussion**

This research was stimulated by provocative speculations that cultural differences in child-care practices might account for at least some of the differences between the mortality of Italian and Jewish immigrant groups living in the United States at the turn of the century. Analyses of available quantitative sources cannot resolve this issue since the census did not ask about child-care practices. Rather the issue was explored in interviews with elderly Italian and Jewish women who were either part of the immigrant generation, or the children of immigrants.

We believe that these interviews contribute important insights into similarities and differences in health-care practices, and the ways these can be shaped by culture. In both groups, our respondents and their mothers are seen to be concerned about their children's health. And the contents of their cultural tool kits are similar. When our respondents' mothers were faced with a child's illness, they began with home remedies and then, if the illness was considered serious, called on a doctor. But Jewish mothers were more likely to define an ailment as requiring early professional attention, whereas the Italian mothers were more likely to 'let nature take its course' and to wait longer before calling on professional assistance. It was more likely for Jewish than Italian women that such assistance came from a doctor who was not only a member of their ethnic network, but also within the family network. Although both Italian and Jewish families were poor, and although the mothers in both groups had little education, neither Italian nor Jewish respondents recall their mothers making much use of public-health facilities.

In the second generation, that of our respondents themselves, the women in both groups turned to doctors more readily, not only for illnesses they judged to be serious, but also for routine immunizations and check-ups by paediatricians. Again, there appears to have been rather little use of public-health facilities. By this time their cultural tool kits included the plentiful advice literature on childrearing. But again, the Jewish women were more likely to reject such literature in favour of seeking advice from their paediatrician, whereas the Italian women continued to emphasize 'commonsense' rather than literature. The contents of the tool kit changed from one generation to another, but preferences for one tool over another remained rather persistent, and were apparently shared by relatives and friends in their own ethnic group.

In their attitudes and behaviours toward professional health care, Jewish immigrants in the United States resembled Jews living in other countries (Marks 1991; Ransel 1991). The same differences are evident in their family-planning practices as well: Jewish women in the 1930s were more likely to receive abortions and contraception from medical professionals: Italian women were more likely to use condoms and withdrawal and to refer to abortions as either self-induced or aided by a neighbourhood woman (Spector et al. 1991). In the 1920s and 1930s Jewish women preceded Italian women in the medicalization of childbirth, switching earlier from home to hospital births (Danzi 1993).

In this paper we have described different cultural approaches to child care. By culture, we mean here not only 'culture as autonomous tradition', expressed in symbolic forms such as ritual practices (which indeed did not seem to be important in the health care of our respondents) but also, and primarily, shared and persistent interpretations of sickness and health, and shared and persistent strategies of action (Swidler 1986; see also Hannerz 1969). The cultural boundary between the two groups was not firm: some Italian mothers as described by their daughters would be nearly indistinguishable in our transcripts from Jewish mothers as described by their daughters. Yet for most, what they did and, perhaps more importantly, the way they talked about what they had done, and the moral justification they gave, were sufficiently different to indicate distinctive cultures.

All our respondents understood that there had been a great shift in child-care practices between their mother's generation and their own: 'We're different now, there's a different environment around, we wanted to better ourselves'. Those who remembered their mother's frequently calling the doctor emphasized that she had wanted only the best medical care for her children, and would go to great lengths to achieve it, even when the family was poor. But those who recalled their mother's use of doctors as infrequent did not criticize her. Rather, after saying that their mothers did not use doctors much, they pointed out that there was no need to do so because 'we were healthy children', or because their mothers were skilful in the use of home remedies. One Italian woman, Carmela (1905), whose mother did not use doctors for these reasons, herself took the children regularly to a private doctor. When asked why she differed from her mother, she said that her mother was dead, and she didn't remember what her mother's remedies were—a morally acceptable explanation.

Our qualitative data thus allow us to fill an important gap in our understanding of cultural differences in health care. Both Italian and Jewish respondents live in the present; their recollections of the past are filtered not only by memory but also by their current understanding of good health-care practices. Yet differing attitudes toward home remedies, doctors, and the medical-advice literature are voiced so repeatedly by the respondents, in such a variety of contexts, and in distinctive language, that we can have confidence in the conclusions. Our sample is too small and too selective to permit the direct linkage of child-care practices and mortality in individual families. Nevertheless, that the differences in child-care practices are consistent with mortality differences supports earlier speculations about the importance of these patterns. In addition, and perhaps more importantly, the nature of the differences that we have uncovered suggests directions that research could take in other situations, such as in developing countries today, where it would be possible to gather data on both child mortality and child-care practices, and thus to elucidate the role that culture plays in health transitions.

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