Vision Reframed: Sensory Formation and Instrumentalization of Trachoma (1914-1924)

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Declaration of Originality

The intellectual content of this thesis, which has been written by me and for which I take full responsibility, is my own, original work, and it has not been previously or concurrently submitted elsewhere for any other examination or degree of higher education. The sources of all paraphrased and quoted materials, concepts, and ideas are fully cited, and the admissible contributions and assistance of others with respect to the conception of the work as well as to linguistic expression are explicitly acknowledged herein.

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Abstract

Vision Reframed: Sensory Formation and Instrumentalization of Trachoma

Elif Bengüsu Arık, Master's Candidate at the Atatürk Institute
for Modern Turkish History at Boğaziçi University, 2024

Professor Nadir Özbek, Thesis Advisor

This thesis aims to demonstrate how the narrative of trachoma, an infectious eye disease, has become a subject of regulation with the developments in the medical discourse of the early twentieth century. To achieve this, the thesis comprises around five chapters, including an introduction and conclusion. The first chapter focuses on the early twentieth-century debates in which ophthalmologists instrumentalized changes in understanding vision. The second chapter examines how this instrumentalization occurred simultaneously across national borders by analyzing international congresses on medicine and ophthalmology. The third chapter aims to reveal how the new governmental techniques are applied by establishing standards in the sense of sight. This chapter focuses on the experiences of immigrants from the Ottoman Empire to the United States as they underwent medical examinations at Ellis Island, one of the largest centers for implementing these medical and governmental techniques on eye diseases.

27,069 words

Özet

Görüş Yeniden Şekillendi: Duyusal Formasyon ve Trahomun Araçsallaştırılması (1914-1924)

Elif Bengüsu Arık, Yüksek Lisans Adayı, 2024
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Profesör Nadir Özbek, Tez Danışmanı

Bu tez, bulaşıcı bir göz hastalığı olan trahomun anlatısının, yirminci yüzyılın başlarında tıp söylemindeki gelişmelerle birlikte nasıl bir regülasyon konusu haline geldiğini göstermeyi amaçlamaktadır. İlk bölüm, yirminci yüzyılın başlarında oftalmologların görme yetisini anlamaya yönelik değişen paradigmaları nasıl araçsallaştırdıklarına odaklanmaktadır. İkinci bölüm, tıp ve oftalmoloji üzerine uluslararası kongreleri analiz ederek bu araçsallaştırmanın ulusal sınırların ötesinde eşzamanlı olarak nasıl gerçekleştiğini incelemektedir. Üçüncü bölüm, görme duyusunda standartlar oluşturarak yeni yönetim tekniklerinin uygulama biçimlerini ortaya koymaktadır. Bu amaçla, Osmanlı İmparatorluğu'ndan Amerika Birleşik Devletleri'ne göç edenlerin, göz hastalıkları konusunda bu tıbbi ve yönetim tekniklerin uygulandığı en büyük merkezlerden biri olan Ellis Adası'nda tıbbi muayeneden geçerken trahom ile ilgili yaşadıkları deneyimler ele alınacaktır.

27.069 kelime

To my beautiful and talented mother, Lale

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Glossary of Non-English Terms

Alat-ı basariye	Ocular apparatus
Rü'yet	Vision
Çeşm-i bin	Ophthalmoscope
Galat-ı inkisar	Refractive errors
Nüfuz-ı nazar	Visual acuity
Kasrü'l basar	Nearsightness

Abbreviations and Acronyms

BOA	Cumhurbaşkanlığı Osmanlı Arşivi (the Presidency Ottoman Archives)
ICO	International Ophthalmology Congresses

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1

Introduction

An eye watched over my life. This eye was probably what I would probably now call truth, now morality, now human law, now God, now me. ”

–Clarice Lispector, *The Passion According to G.H.*

This thesis aims to demonstrate how the narrative of trachoma, an infectious eye disease, has become a subject of regulation with the developments in the medical discourse of the early twentieth century. To achieve this, the thesis comprises around five chapters, including an introduction and conclusion. The first chapter focuses on the early twentieth-century debates in which ophthalmologists instrumentalized changes in understanding vision. The second chapter examines how this instrumentalization occurred simultaneously across national borders by analyzing international congresses on medicine and ophthalmology. The third chapter aims to reveal how the new governmental techniques are

applied by establishing standards in the sense of sight. This chapter focuses on the experiences of immigrants from the Ottoman Empire to the United States as they underwent medical examinations at Ellis Island, one of the largest centers for implementing these medical and governmental techniques on eye diseases.

Even though the isolation of the chlamydial organism responsible for trachoma was not found until the middle of the twentieth century, its identification was made possible by examining the small granules covering the eyelid. There is a common belief that trachoma attracted the attention of doctors in the medical literature after Napoleon invaded Egypt. This situation was influential in the naming of trachoma as Egyptian ophthalmia. Trachoma has the potential to cause blindness if left untreated. Symptoms such as redness and excessive tearing often overlap with other types of conjunctivitis, creating difficulties in accurate diagnosis. Initially, individuals newly afflicted with trachoma may only experience minor discomforts, such as a sensation of heaviness in the upper eyelids and the formation of small burrs in the eye corners. However, upon closer examination, distinct features become apparent: the upper eyelid may exhibit slightly bloody and thickened tissue, accompanied by small, pale red papillas resembling seeds. This characteristic appearance led to its designation as "zât-ül munzama-i hubeybî" in Ottoman medical literature.[1]

When trachoma is treated effectively, the thickness of the tissue gradually diminishes within a few months. Conversely, if left untreated, the reduction in tissue thickness may take several years to occur, and the granules and blisters within the tissue begin to fade over time. In untreated individuals with trachoma, the condition can progress, leading to curvature of the eyelids and inward-turning of the eyelashes. These inward-turning eyelashes can irritate the transparent and delicate corneal layer without surgical intervention, causing further injury. Trachoma often exhibits a fluctuating course, characterized by periods of worsening and improvement. In advanced stages of the disease, affected individuals

1 Kadircan Keskinbora, "The Congress Held in Brussels in 1902 'Amelioration of the Life Standards of the Blinds' and the Evaluation of an Ophthalmologist Attended from Istanbul." *Turkish Journal of Ophthalmology*, no. 4 (2008): 353-60.

may experience significant difficulty opening their eyes due to inflammation and discomfort.

To understand the unequal dynamics surrounding the trachoma narrative, it is essential to examine studies that explore the social relations embedded in disease narratives rather than focusing solely on the diseases themselves. From this perspective, in her work "The Undying: A Meditation on Modern Illness," Anne Boyer presents her own experience of illness, weaving together the history of the disease, the pharmaceutical industry, disease campaigns, and new screening technologies.[2] According to Boyer, "Patients become information not merely via the quantities of whatever emerges from or passes through their discrete bodies, the bodies and sensations of entire populations become the math of likelihood (of falling ill or staying well, of living or dying, of healing or suffering) upon which treatment is based."[3] Boyer's exploration of her struggle with illness serves not just as an invitation to recognize and confront the disease as a tangible and shared affliction but also exposes the socio-medical obstacles that prevent such acknowledgment.

On the other hand, Anat Mooreville, in her doctoral dissertation titled "Oculists in the Orient: A History of Trachoma, Zionism, and Global Health, 1882-1973", provides a comprehensive analysis of how ocular health in Palestine and Israel from the late nineteenth century to the 1970s was addressed both scientifically and culturally by various medical actors and aid organizations.[4] She analyzes, from the perspective of physicians, how biomedical discourse was produced to view trachoma as a disease of the East, with a particular focus on Ottoman and British Mandate Palestine. Mooreville highlights that "although the trachoma campaign was part of a mission of nationalization and Westernization, it also

2 Anne Boyer, *The Undying* (New York: Farrar, Straus and Giroux, 2019).

3 Ibid, 28.

4 Anat Mooreville, “Oculists in the Orient: A History of Trachoma, Zionism, and Global Health, 1882-1973,” (Dissertation, eScholarship, University of California, 2015).

served as an opportunity to reinforce the separation of all things 'Arab'."[5] Her study goes beyond treating trachoma as a purely biomedical phenomenon, examining the processes involved in forming socio-medical discourse.

Karl Marx famously asserted that "the shaping of the five senses is a labor of the whole history of the world up to the present day."[6] While it may not have been Marx's initial intention, the widespread exploration of sensory perception capacities and sensory acuity as a research subject has unveiled asymmetrical power relations. In his work "Downcast Eyes," Martin Jay introduces and critiques the concept of "ocular-centrism."[7] Jay mainly criticizes visual culture by exposing the dominance of eye-centered narratives. He argues that ocular-centrism illuminates the profound influence of Classical Greek thought and Western languages, which are heavily laden with metaphors about vision and the eye. Jay also draws attention to studies suggesting that the nineteenth century was one of Western culture's most visually orientated periods. Although his priority is to criticize visual culture dominated by metaphors of the eye and the sense of sight, he focuses on developments in ocular apparatus, as he terms them.[8]

Another study in which ocular apparatus were the object of research, in "Medicine and the Five Senses", William F. Bynum and Roy Porter examine the rapid evolution of cumbersome medical research devices into compact, practical and valuable tools. Through their comprehensive analysis, Porter and Bynum show how adopting these new devices has created a new medical market.[9] In the realm of ocular apparatus, the in-

5 Anat Mooreville, "'The 'War Against Trachoma': Colonial Ophthalmology in Mandate Palestine," in *Mandate Palestine: Memory, Media, and Medicine*, 2011.

6 Karl Marx, *Economic and Philosophic Manuscripts of 1844* (New York: Dover Publications, 2007), 109.

7 Martin Jay, *Downcast Eyes: The Denigration of Vision in Twentieth-Century French Thought* (University of California Press, 1993).

8 Ibid, 65.

9 William F. Bynum and Roy Porter, *Medicine and the Five Senses* (Cambridge: Cambridge University Press, 2005), 257.

vention and subsequent use of the ophthalmoscope for diagnosing refractive errors of the eye represents a turning point in the history of ophthalmology.

These developments not only revolutionized the field of science but also established the standards that determine who has a right to produce knowledge on vision and ophthalmology. While refractive errors and eye diseases were not new, what was groundbreaking was the classification of sense of sight deviating from these standards as pathological. With the transformation of the medical landscape, congenital or acquired visual impairments and age-related vision loss have become medicalized phenomena.[10]

When examining the elements that make a discursive practice possible under certain historical conditions, one cannot overlook Michel Foucault's paradigm—they are almost inseparable from the history of medicine. His approach has led to a rich body of research in the history of medicine analyzing the "margin of tolerance" and "threshold of exclusion" through the lens of various diseases.[11] Alexandre I. R. White's conceptualization of "epidemic orientalism" provides one of the broadest possible perspectives on the history of medicine through this concept.[12] White integrates Edward Said's definition of orientalism—a hegemonic Western discourse that dominates, reconstructs, and asserts authority over the East by embedding geopolitical awareness into aesthetic, scientific, historical, and philosophical texts—into the analysis of international medical regulations and exclusionary practices.

White employs this concept to elucidate the mechanisms underlying international regulations concerning disease control, including prioritizing specific diseases for intervention, establishing international collaborations, and cultivating shared responses to perceived threats. White focuses on the deliberations of colonial actors during sanitary conferences

10 See, Gemma Almond-Brown, *Victorians and Spectacles: Measuring, Defining and Shaping Visual Capacity* (Manchester University Press, 2023).

11 Michel Foucault, *The Archeology of Knowledge* (New York: Pantheon Books, 1972), 41.

12 Alexandre I. R. White, *Epidemic Orientalism: Race, Capital and Governance of Infectious Diseases* (Stanford: Stanford University Press, 2023).

held in the nineteenth and early twentieth centuries. Through his analysis, he contends that these international gatherings predominantly addressed diseases such as yellow fever, plague, and cholera. White also reveals that the overall aim of these initiatives is to establish standardized agreements that aim to control diseases while facilitating global trade effectively.[13]

The essential characteristic of epidemic orientalism is that it can be used to illustrate how dominant medical knowledge remains in circulation in fictive geographies where specific characteristics are attributed to the "East'' and "West." Adopting this approach makes it possible to make more accurate evaluations of the sources of asymmetrical relations surrounding medical regulations.

This approach reveals that it is not only the mapping that is fictive but also the ways people sense the disease and are affected by it, which are shaped by this hierarchical structure. Indeed, scholars like David Howes advocate for a historiographical shift known as the "sensory turn," wherein the senses take center stage in historical investigation.[14] Howes's research explored the biased frameworks perpetuated by Western science, which positioned Europeans as rational beings while depicting their subjects as sensory primitives. Howes reveals how hierarchies of the senses are established by highlighting social research that suggests the senses of smell and touch, often categorized as "primitive" senses, are more sharpened in so-called "primitive" humans.[15] Indeed, in diseases such as trachoma, where changes in the understanding of the senses and medical historiography can be traced, considering these dynamics together allows medical regulations to be understood beyond national or international boundaries, as opposed to the overused East-West mapping. This approach allows the field of medical history to explore diverse

13 Ibid, 4.

14 David Howes, *The Sensory Studies Manifesto: Tracking the Sensorial Revolution in the Arts and Human Sciences* (Toronto: University of Toronto Press, 2022).

15 David Howes, "Charting the Sensorial Revolution." *The Senses and Society* 1, no. 1 (March 2006): 113–28. doi:10.2752/174589206778055673.

spatial contexts that function both as incubators for public health policy and as laboratories for scientific experimentation.[16]

There is also a separate literature on eye examinations at Ellis Island, written by researchers such as Anne-Emanuelle Birn, Howard Markel and Krista Maglen[17]. This thesis differs from them by proposing that the hierarchy of the dominant sense of sight can be examined as a subject of interrogation, instrumentalized in both medical examinations and the narrative surrounding trachoma.

Performing eye examinations based on fictive geographies was undoubtedly practical for doctors and provided a "scientific" basis for regulating the workforce by emphasizing the importance of the sense of sight. The symptoms of trachoma, often indistinguishable from those of common conjunctivitis, have circulated for so long that the narrative of trachoma has become entrenched in the body of an Eastern migrant in a timeless context.

"Between 1885 and 1920, approximately 21,000,000 immigrants arrived in America. Roughly 75 percent of them entered through New York Bay and were processed at Ellis Island." [18] At Ellis Island, a small number of doctors from the US Public Health Service were tasked with examining the countless migrants, wielding the power to change their lives with a single word drastically. For many migrants, this was a terrifying ordeal. Doctors would examine their eyelids and eyes for signs of trachoma, often

16 Alan M. Kraut, *Silent Travelers: Germs, Genes, and the Immigrant Menace* (Baltimore: Johns Hopkins University Press, 1995).

17 See, Anne-Emmanuelle Birn, "Six Seconds per Eyelid: The Medical Inspection of Immigrants at Ellis Island, 1892–1914," *Dynamis*, no. 17 (1997): 281-316; Howard Markel, "'The Eyes Have It': Trachoma, the Perception of Disease, the United States Public Health Service, and the American Jewish Immigration Experience, 1897-1924," *Bulletin of the History of Medicine* 74 , no. 3 (September 2000): 525-60; and Krista Maglen, "Importing Trachoma: The Introduction into Britain of American Ideas of an 'Immigrant Disease,' 1892-1906", *Immigrants & Minorities* 23, no. 1, (2005), 80-99.

18 Howard Markel, "Before Ebola, Ellis Island's Terrifying Medical Inspections," PBS, October 15, 2014, https://www.pbs.org/newshour/health/october-15-1965-remembering-ellis-island.

using their index fingers or a buttonhook meant for tying shoes to twist the eyelids for a better inspection. If trachoma was detected, the migrant faced deportation or an indefinite stay at Ellis Island, enduring brutal treatments with corrosive chemicals or extremely painful surgeries. Doctors' responses varied based on the migrants' origins, travel routes, and the validity of their official documents and tickets.

Upon arriving at Ellis Island in 1913, George Avgerakis, from a small village near Istanbul, succinctly emphasized the essential criteria for entry at the border: "Address and your eyes, if you were alright, you go to America; otherwise, they send you back." [19] Charles Tilly also underscores the significance of Ellis Island admission policies in assessing a potential citizen's ties to firms and labor markets. According to Tilly, "kinship, descent, cultural attachment and labor force position were critical in the granting or refusal of citizenship."[20]

In Ottoman Turkish historiography, several studies examine the medical regulation of trachoma. These studies, primarily focused on medical history, explore topics such as the history of ophthalmology, ocular apparatus, and the trachoma agenda within national congresses, as well as the anti-trachoma campaign conducted by the republican administration. There are studies by Gülhan Slem, Haluk Perk, Şeref Etker[21] on the history of ophthalmology and its apparatus; and Sadet Altay and İnci Hot,[22] Especially on the trachoma agenda of the early republic.

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19 Margo Nash, Interview with George Avgerakis, other, The Statue of Liberty – Ellis Island Project, Inc, n.d., acceseed 2023.

20 Charles Tilly, "Citizenship, Identity and Social History," *International Review of Social History* 40, no. S3 (December 1995): 1-17, https://doi.org/10.1017/s0020859000113586.

21 See, Gülham Slem, *Türk Oftalmoloji Tarihi* (Adana: Çukurova Üniversitesi Yayınları, 1997); Haluk Perk, *Belgeler ve Objelerle Göz Hekimliği Tarihi* (İstanbul: Zeytinburnu Belediyesi Yayını, 2015); and Şeref Etker, "Ophtalmoscope Essad," *Osmanlı Bilimi Araştırmaları* IX, no. 1-2 (2007).

22 See, Sadet Altay, "Bulaşıcı ve Müzmin Bir Sosyal Afet: Cumhuriyet'in İlk Yıllarında Trahom Hastalığı ve Mücadele Çalışmaları (1924-1938)," CTAD 12, no. 23 (2016); and İnci Hot, "Tanzimat Sonrası Osmanlı'da Bulaşıcı Hastalıklarla Mücadele", essay, in *Osmanlı'da Salgın Hastalıklarla Mücadele* (İstanbul: Çamlıca, 2015), 113-51.

Kadircan Keskinbora[23] and Mehmet Emin Demirci[24] have authored significant studies on the congresses concerning ophthalmology and blindness attended by Ottoman authorities. Keskinbora also contributed a biographical study focusing on the famous ophthalmologist Mehmet Esat (Işık)[25] In contrast, Demirci's study examines the histories of significant visually impaired individuals and the broader narrative of disability throughout history. It also encompasses a wide-ranging exploration of literature on blindness and its symbolic meaning.

Yücel Yanıkdağ's article "Hygienic Modernity: The Geography of Trachoma in the Late Ottoman and Early Republican Period" examines the narrative surrounding trachoma through the writings of a physician in the early twentieth century.[26] Yanıkdağ's critical perspective addresses the exclusion of traditional medical practitioners from the medical field, the association of trachoma-affected areas with ignorance and filth, and the portrayal of the fight against trachoma as a unique project of the new republic. However, Yanıkdağ reveals that the regions where trachoma was prevalent were perceived as remote and foreign by the ruling elite. To him, this perception persisted from the Ottoman authorities, who were generally unaware of these areas, to the new republic, which mapped and defined trachoma regions with the same sense of obscurity.

In the historiography of Turkey, studies on early twentieth-century migration from Turkey to the United States highlight a different spatial dimension of this obscurity. Although these studies do not specifically focus on the medical and ophthalmological examinations conducted during

23 Kadircan Keskinbora, "The Congress Held in Brussels in 1902 'Amelioration of the Life Standards of the Blinds' and the Evaluation of an Ophthalmologist Attended from Istanbul." *Turkish Journal of Ophthalmology*, no. 4 (2008): 353-60.

24 Mehmet Emin Demirci, *Homeros'tan Aşık Veysel'e Tarihte ve Toplum Yaşamında Körler* (İstanbul: Boğaziçi Üniversitesi Yayınları, 2005).

25 Kadircan Keskinbora, *Göz Tabibi Esat Işık: Bilimde, Siyasette, Milli Mücadelede Bir Işık* (İstanbul: Bahçeşehir Üniversitesi Yayınları, 2014).

26 Yücel Yanıkdağ, "Hijyenik Modernlik: Son Dönem Osmanlı ve Erken Cumhuriyette Trahom Coğrafyası," *Toplumsal Tarih*, no. 296 (2018): 76.

the migration to Ellis Island, they offer the possibility of establishing a connection between trachoma and migration from Anatolia.[27]

In short, this thesis aims to explore the possibilities for integrating self-contained areas of research within historiography regarding the instrumentalization of trachoma. Synthesis of various research sources seeks to illuminate the transformation of the narrative surrounding this disease, especially in conjunction with the understanding of visual perception.

To illustrate this, the first chapter will focus on how ophthalmologists redefined vision. This redefinition prominently features the concept of rü'yet, as referenced in contemporary medical books.[28] The chapter will explore how doctors used the ocular apparatus and significant alat-i basariya (ocular apparatus) of the period, as documented in the archives, to reorganize rü'yet. The discussions will cover how they employed ocular devices to enhance visual acuity, in other words, "nüfuz-ı nazar."

The ocular apparatus in this redefinition includes the ophthalmoscope, in other words, "çeşm-i bin," and scientific spectacles aimed at correcting refractive errors. The chapter will highlight instances where authorities in the field of eye health redefined their roles, leading to the exclusion of some medical actors. The justifications used by the new medical authorities to define trachoma and how these justifications were discussed in the national medical congresses held in Turkey, the first in 1925 and the second in 1927, will be analyzed.

The first National Turkish Medical Congress, held in 1925 and followed by a second in 1927, brought the pressing issue of infectious diseases to the priority of discussion.[29] In 1925, legislation addressing the combat

27 See, Kemal H. Karpat, *Ottoman Population, 1830-1914: Demographic and Social Characteristics* (Madison, WI: The University of Wisconsin Press, 1985); and Rıfat N. Bali, *Anadolu'dan Yeni Dünyaya: Amerika'ya İlk Göçen Türklerin Yaşam Hikayeleri* (İstanbul: İletişim, 2004).

28 Abdi Tevfik, *Göz Hakkında Bir Konferans* (İstanbul: Kader Matbaası, 1930); and Veliyüddin Raşid and Tevfik Halil, *Göz Hastalıkları* (İstanbul: İkbal Kitabhanesi, 1917).

29 Birinci Milli Türk Tıb Kongresi Zabıtnameleri (Ankara, 1925); İkinci Millî Türk Tıb Kongresi Birinci İn'ikad (Ankara, 1927).

against trachoma was enacted, accompanied by infrastructural measures to eradicate the disease. These initiatives encompassed the establishment of hospitals and dispensaries, as well as the deployment of mobile teams to regions with high rates of trachoma, supplementing fixed healthcare facilities.[30]

The report prepared for presentation at the second Turkish Medical Congress discusses a new mapping of the Republic of Turkey based on the trachoma index. Among the primary causes of trachoma, factors such as ignorance, unsanitary conditions, and overcrowded living environments were frequently cited. This section of the thesis particularly examines the association of trachoma with seasonal workers and agricultural laborers, as evidenced by reports from the Second Adana Cotton Congress.[31] It is stated that the Armistice period increased overcrowding and migration, and even the circulation of banknotes was a contributing factor to the spread of trachoma.[32] There was also a common belief that trachoma was a result of individuals neglecting their eyesight, displaying indifference, and being careless.[33] This belief shaped the production of medical knowledge, which suggested that trachoma follows a different course in "natural" versus "unnatural" eye tissues, a critical aspect in discussions regarding trachoma and the sense of sight.[34]

The most concrete examples of how these views were discussed on a global scale are the international congresses organized with the participation of delegates from the Ottoman Empire. The second chapter of the thesis consists of discussions at international congresses. Ottoman authorities followed two main types of congresses concerning eye diseases

30 İnci Hot, "Tanzimat Sonrası Osmanlı'da Bulaşıcı Hastalıklarla Mücadele", essay, in *Osmanlı'da Salgın Hastalıklarla Mücadele* (İstanbul: Çamlıca, 2015): 128.

31 İkinci Adana Pamuk Kongresi Zabıtnamesi, İstanbul; Matbaa-i Amire, 1925. Adana Pamuk Kongresi Neşriyatı.

32 Mehmed Emin, *Memleketimizde İntişar Etmekte Olan Mısır Hastalığı* (İstanbul: Necm-i İstiklal Matbaası, 1921).

33 Yücel Yanıkdağ, "Hijyenik Modernlik: Son Dönem Osmanlı ve Erken Cumhuriyette Trahom Coğrafyası," *Toplumsal Tarih*, no. 296 (2018): 76.

34 Hakkı Hayri, "Trahomun Sirayeti Hakkında," *Sıhhiye Mecmuası*, no. 15 (1928).

and blindness: the "Congresses for the Improvement of the Condition of the Blind" and the International Ophthalmology Congresses. Firstly, this thesis will present the congresses' discussions on improving the condition of blind people, held in Paris in 1900 and Brussels in 1902. Although the 1905 Liège congress was also planned to be attended, the chosen Ottoman delegate could not participate due to his dismissal.[35] Indeed, the 1905 congress aimed to address the situation of visually impaired and mute individuals, as indicated by records in the state archives. In this respect, it differed from the objectives of the 1900 and 1902 congresses. However, tracing the continuity of the 1900 and 1902 congresses in contrast to present-day International Ophthalmology Congresses proves to be complex. Consequently, while combining these two congresses as a unified entity within the discourse of ameliorate conditions for the visually impaired, the international ophthalmology congresses will be defined as a separate research trajectory.

Therefore, this thesis will also examine the critical debates at the International Congresses of Ophthalmology, starting with the first congress held in Brussels in 1857. Within the scope of this thesis, the following congresses will be covered: Brussels 1857, Paris 1862, Paris 1867, New York 1876, Milan 1880, Heidelberg 1888, Edinburgh 1894, Utrecht 1899, Lucerne 1904, Naples 1909, Washington 1922, and Amsterdam 1929.

The discussions at these congresses will reveal the efforts made by doctors to demonstrate that individuals with visual impairments should be treated differently from those impoverished by their defects and deficiencies. These efforts aimed to categorize individuals based on their visual abilities to ensure they could participate in the labor market as cheap labor. This section will highlight the confusion among doctors regarding new inventions, treatment methods, and medicines, particularly the ophthalmoscope, an ocular apparatus. Debates about whether individuals should be tested for visual competence before entering employment with redefined visual abilities will be raised.

35 BOA. BEO. 2652.198887, August 26, 1905.

Furthermore, this chapter will address the involvement of ophthalmologists in medical knowledge production processes that reproduce these geographies through various approaches to treating trachoma in fictional geographies. This will emphasize how this process led to specific reorganizations around trachoma, showcasing the role of ophthalmologists in forming medical narratives and labor practices based on ocular health.

The 1922 Washington and 1929 Amsterdam congresses are crucial in addressing trachoma as a regulatory issue. During the Washington Congress, extensive discussions took place regarding the treatment of immigrants' eye diseases, particularly trachoma, at Ellis Island. The third chapter delves into the profound impact of these discussions on the experiences of immigrants, highlighting the far-reaching consequences of the regulatory measures debated at this congress. The 1929 Amsterdam Congress is critical because it led to the establishment of a separate organization, the International League Against Trachoma, based on the discussions that emerged from that congress. From this point of view, given the scope of the thesis, only the debates between the 1857 Brussels congress and the 1929 Amsterdam congress are discussed rather than addressing the ongoing ICO congresses. Simultaneously, this chapter will explore the contributions of the Tevfik Vacid, Charles de Hubsch, Sarantis Archigenes, Agelastos[36], Georgis Costomyris, Edwig van Millingen, Mehmed Esat, Vefik Hüsnü represented Ottoman state and the newly established Republic of Turkey.

Given the previously mentioned congresses in Washington in 1922 and Amsterdam in 1929, which discussed racial characteristics and immigration in eye diseases, the rigorous eye examinations at Ellis Island have a terrible reputation and deserve detailed insights. Trachoma, in fact, directly affects the mobility of immigrants, particularly during the early twentieth century. Specifically, immigrants from Anatolia to the United

36 Despite searches in Congress reports and ophthalmological history, his first name could not be found.

States were subjected to strict eye examinations.[37] Ellis Island, an immensely vast medical complex that opened in 1852, was a significant gateway through which twelve million immigrants passed over forty years. In this passage, deportation was a common fate for individuals who were deemed physically or mentally unfit for employment in the United States by medical examinations at Ellis Island. However, deportation procedures were often unclear, adding further uncertainty to a challenging migration process.

For many immigrants, this experience also meant separation from their families, leading to Ellis Island being referred to as the "island of tears."[38] The extent to which this thesis reflects George Perec's endeavor to grasp the depth of hope, expectation, risk, excitement, and energy experienced by immigrants at Ellis Island, as depicted in his excellent book[39] of the same name, is open to interpretation. Nonetheless, the final chapter of the thesis deals with the medical examinations of immigrants from the Ottoman region who arrived in the United States. In accomplishing this, reference will be made to the legal frameworks governing the admission or rejection of immigrants.

Given the scope of this thesis, official correspondences from the Prime Ministry Ottoman Archives and the Prime Ministry Republic Archives will be utilized. The first chapter will include publications such as *Sıhhiye Mecmuası*, *İstanbul Seririyatı, Nevsal-i Afiyet*, and *Şark Cephesi Tıp Mecmuası*, along with medical texts from the twentieth century, the written proceedings of the First and Second National Turkish Medical Congresses, and the reports of the Second Cotton Congress. The second chapter will focus on two main lines of congress proceedings: "improve the condition of the blind" and "international ophthalmology congresses," which were closely monitored by the late Ottoman and early Republican administrations. The International Ophthalmology Congress, organized

37 Anne-Emmanuelle Birn, "Six Seconds per Eyelid: The Medical Inspection of Immigrants at Ellis Island, 1892–1914," *Dynamis*, no. 17 (1997): 281-316.

38 "Ellis Island." The Library of Congress. Accesed May 10, 2024. https://www.loc.gov/classroom-materials/immigration/italian/ellis-island/.

39 George Perec, *Ellis Adası* (İstanbul: Sel Yayıncılık, 2020).

in 1857, was of particular importance from 1914 to 1924 because of its unity with the governmental techniques applied in the regulations on vision. The third chapter will mainly focus on the transcripts of interviews conducted by the Ellis Island Foundation with individuals who migrated from the Ottoman region to Ellis Island in the early twentieth century.

2

Reshaping the Medical Landscape

> *She points out that eye infections due to flies are "very common among the Arabs." When she welcomed her husband home in the evening, "In those days, because of this confounded eye infection, I used to liken myself to those Arab women who go out to the gate together with their gummy eyed-child to meet their husbands. Accordingly I welcomed Tevfik Bey with the Arabic greeting, 'ahlan wa sahlan.' He smiled and replied, 'there we are, now you have become just like them'*
>
> – Fatma Rezan Hürmen, *Ressam Naciye Neyyal 'in Mutlakiyet, Meşrutiyet ve Cumhuriyet Hatıraları*

In the winter of 1895, Najib was working on road repairs when he lost his eyesight due to a sewer explosion. Najib wrote to the Ministry of Finance about his situation, explaining that he was now useless and impoverished because he could not work. He demanded a higher salary

than a colleague who had lost only one eye in the accident, arguing that his complete loss of sight warranted greater compensation.[1]

In cases like Najib's, the procedure was clear. The authorities required official confirmation of sight loss in taxation, military exemption, or work accidents. The palace ophthalmologist or chief physician typically conducted the necessary examinations. Additionally, municipal physicians or doctors from the Cem'iyyet-i Tıbbiyye-i Mülkiye could also submit the relevant reports to the authorities. However, it remains unclear what specific ophthalmological care individuals with sight loss, eye disease, or accidental blindness receive.

Historical narratives provide valuable insights into the role of a group colloquially called *"kehhals"* in the context of ophthalmic care across the vast territory of the Ottoman Empire.[2] Recognized for their mobility and expertise in ophthalmic treatments, the *kehhals* crossed geographical boundaries to serve different communities across the Ottoman region. In addition to *kehhals*, "swallows" offer a range of services including eye surgeries and the dispensing of medications.[3] Apart from swallows, barbers played a critical role as healthcare providers. However, reorganizing actors' roles in defining responsibilities for ophthalmological care from the nineteenth century onwards brought significant changes for all these healthcare providers.

An important consequence of the reorganization of the medical landscape was the exclusion of individuals perceived as ineligible for participation in ophthalmology or unable to practice their specialty without formal approval. For many individuals recognized for their expertise in eye care, this meant a change in their role and status in an environment of transforming medical practice and regulation.

Traditionally known for practices like eye treatments, bloodletting, and tooth extraction, Barbers encountered limitations in these services.

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1 BOA. BEO. 716.53666, December 17, 1895.

2 Mehmed Esat, "Cehalet Seyyieleri," *Servet-i Fünun*, no. 541 (September 25, 1901): 27-28.

3 Haluk Perk, *Mahallemizin İlk Sağlıkçıları Berberler* (İstanbul: Kültür Sanat Basımevi, 2017).

In response, Hafız Bey, a physician associated with the prestigious Mekteb-i Tıbbiye-i Şahane, implemented a directive requiring barbers to undergo vocational training at the institution under gendarmerie supervision.[4] This initiative sought to standardize medical care and guarantee that individuals seeking eye treatment received services from adequately trained professionals.

In 1901, a decree was issued to identify and penalize individuals known as "swallows" who traveled around the empire offering treatment for various eye diseases. The intent behind this directive was to regulate and monitor the activities of these itinerant healers, ensuring that their practices adhered to established medical standards and protocols for eye treatments. This measure sought to safeguard the health and well-being of the populace by mitigating the risks associated with unlicensed and unregulated medical care. At the same time, Mehmet Esat, an ophthalmologist trained at a recently established medical institution, strongly criticized the methods employed by the "swallows," branding them as "bands of ignorance" and equating their treatment approach with the act of murder.[5] This reorganization of ophthalmological practices also entailed the closure of existing establishments that did not meet the newly established standards and the denial of *şehadatname* (licensure) to individuals found to be practicing ophthalmology without proper authorization. In 1903, it was noted that individuals employed as barbers, saddlers, and attars were also assuming roles as physicians and ophthalmologists. Consequently, a regulation was enacted to investigate this situation and to prohibit unqualified individuals from obtaining certificates reserved for licensed physicians.[6] In Kumkapı, specific measures were implemented to prevent a woman named Meryem from continuing to administer eye treatments without the requisite credentials, further underscoring the enforcement of regulatory measures.[7] As new developments

4 Rose Aydın, "Water and Wellness: Cholera in the Nineteenth-Century Ottoman Empire" (thesis, 2022).

5 Mehmed Esat, "Cehalet Seyyieleri," *Servet-i Fünun*, no. 541 (September 25, 1901): 27-28.

6 BOA. DH.MKT. 753.69. August 22, 1903.

7 BOA. Z.B. 380.81, December 5, 1904.

emerged and accessibility to eye-related treatments improved, the dynamics of influence and exclusion within the medical field reshaped the quality and accessibility of ophthalmological care. In other words, amidst advances in ophthalmology and the changing paradigm of access to ocular apparatus, the complex interplay of inclusion and exclusion within the medical landscape has remained unchanged.

The ophthalmoscope was one of the most effective ocular apparatus, or as it is referred to in the Ottoman archives, one of the *"alat-i basariye"* in reshaping this medical landscape. The ophthalmoscope was influential for Ottoman medicine not only with the new version of the ophthalmoscope adapted by the famous ophthalmologist Mehmed Esat but also with the motivations of physicians in categorizing vision. The ophthalmoscope, invented by Hermann von Helmholtz in 1851, greatly facilitated the diagnosis and treatment of numerous eye diseases. Furthermore, the groundbreaking work of Franciscus Cornelis Donders in "On the Anomalies of Accommodation and Refraction" (1864), utilizing Helmholtz's invention, further advanced the knowledge in this field.[8] In the past, opticians and medical practitioners understood the principles of optics. They applied these to the eye to speculate how its shape could affect how the light refracted into the retina. The ophthalmoscope allowed these theories to move beyond the realms of speculation; Donders could observe and determine the position of light refraction and the shape and interior of the eye for the first time. In Ottoman medicine, the ophthalmoscope is referred to as "çeşm-i bin," merging the Persian terms for "eye" and "see." This device comes in various types, each serving the purpose of examining the eye's internal tissues.

It is claimed that Mehmet Esat invented his ophthalmoscope while studying in Paris in 1893, and its use has become widespread since then.[9] In addition to differences in the mirror diameter and central aperture

8 H. J. Simonsz and I. Den Tonkelaar, "19th Century Mechanical Models of Eye Movements, Donders' Law, Listing's Law and Helmholtz' Direction Circles," *Documenta Ophthalmologica* 74, no. 1–2 (February 1990): 95–112, https://doi.org/10.1007/bf00165667.

9 Şeref Etker, "Ophtalmoscope Essad," *Osmanlı Bilimi Araştırmaları* IX, no. 1-2 (2007).

compared to the original ophthalmoscope, there was uncertainty surrounding its distribution. While it is claimed that Dr. Mehmet Esat did not seek a patent for his ophthalmoscope, the ophthalmoscopes produced during his lifetime are prominently marked by his name. This discrepancy suggests that ophthalmoscopes lacking a specific manufacturer's name were personally provided by Dr. Esat and then circulated through various channels, including distribution networks. Johann Paluka, a prominent exporter of clocks and binoculars in Istanbul, was responsible for distributing the ophthalmoscope.[10] This ambiguity highlights the complexity of the manufacturing and distribution process and raises questions about the commercial dynamics surrounding the supply of medical instruments during that period.

Modifying tools like the ophthalmoscope have facilitated the emergence of novel diagnostic methodologies, therapeutic strategies, and conceptualizations of ocular disorders, prompting a reevaluation of perceptions regarding vision. This impact can be observed in Ottoman medical literature through the redefinition of vision.

The term "rü'yet," while initially denoting the act of "seeing" in its literal sense, holds broader connotations beyond mere visual perception. Rü'yet has undergone a notable transformation, particularly in conjunction with advancements in ocular science and the advent of sophisticated diagnostic tools. As ocular instruments gained prominence in medical practice, the definition of "Rü'yet" expanded to encompass a holistic process involving the intricate interplay between the eye, optic nerves, and brain.[11] This refined conceptualization reflects a deeper appreciation of the complexities inherent in visual perception, paving the way for enhanced diagnostic accuracy and treatment efficacy in ophthalmology. Thus, this shift in perspective coincides with the increased recognition of the complex physiological processes underlying visual perception, leading to refined diagnostic methods and treatment protocols in ophthal-

10 Ibid, 157.

11 Abdi Tevfik, *Göz Hakkında Bir Konferans* (İstanbul: Kader Matbaası, 1930), 19.

mology. The concept of refractive errors in the eye, encompassing conditions like myopia, hyperopia, and astigmatism, referred to as "Galat-ı inkisar," was not a brand new notion within the context of rü'yet. Mainly, sources highlight astigmatism and myopia (kasru'l basar). Besides refractive errors, glaucoma has been described metaphorically as "water" or "curtains" in the eyes. What is new is the necessity to redefine rü'yet (vision) and nüfuz-ı nazar (visual acuity). To address this need, efforts were made to establish a standard based on physical capacity.

§ 2.1 Reimagining Vision

Veliyüddün Reşid's and Tevfik Halil's research on "nüfuz-ı nazar" stands out as one of the most exhaustive examples of visual perception. They characterized visual acuity as the eye's capacity to perceive shapes, colors, and light. Also, they delineate the attributes of the eye that contribute to a thorough assessment of sensory faculties. Among these faculties, known as "hiss-i eşkal," entails recognizing objects and discerning their contours and structures. Additionally, the perception of colors, referred to as "hiss-i elvan," plays a crucial role in understanding the nuances of visual stimuli, including distinguishing between different hues and shades. Moreover, the appreciation of light and brightness, termed "hiss-i ziya," contributes to the overall perception of visual stimuli, encompassing factors such as luminance and contrast.[12]

Further, Reşid and Halil's work serves as a comprehensive guide on utilizing ocular apparatus to enhance the measurement of rü'yet. For them, practitioners can obtain a more nuanced understanding of an individual's visual capabilities by employing techniques such as visual field testing, contrast sensitivity assessment, and color vision testing. Similarly, the "alat-ı basariye" (ocular apparatus) facilitate specialists in correcting newly identified visual pathologies. Like Reşid and Halil, Dr. Abdi Tevfik noted in his lectures on the eye, "Regardless of the eye defect—

12 Veliyüddin Raşid and Tevfik Halil, *Göz Hastalıkları* (İstanbul: İkbal Kitabhanesi, 1917), 14-17.

whether it involved myopia, hyperopia or astigmatism—if visual acuity without spectacles exceeded a fraction of the natural visual acuity, individuals were considered fit for military service without needing spectacles."[13] An example of such a case took place in 1912.

The case of Osman Efendi and Hüseyin Hami Efendi, two myopic (kasrü'l basar) police officers from Sivas province, attracted attention. It was determined that their nearsightedness did not prevent them from performing their duties and that their vision could be effectively corrected by wearing spectacles. Therefore, it was not deemed necessary to remove them from their duties. Indeed, when it comes to *alat-i basariye*, spectacles were as groundbreaking an ocular apparatus as the ophthalmoscope. Spectacles served a dual purpose: correcting diagnosable and treatable refractive errors and addressing visual impairments due to natural aging. Archive records indicate that peddlers previously sold eyeglasses alongside items like jewelry, walking sticks, and postcards. Documents reveal the presence of individuals selling eyeglasses and other goods at the docks of the Galata Port.[14] However, medical supply companies began categorizing these spectacles as medical or non-medical. Newspapers warned against the potential harm to eyesight resulting from purchasing substandard spectacles (adi gözlükler) from peddlers, advocating the use of medical glasses *(fenni gözlükler)* instead.[15]

Most of the spectacles appear to have been supplied by factories in Germany, and imports were made through official channels with the advice of ophthalmologists. A noteworthy document from 1918 shows that importing spectacles and similar products, especially from the "Otobenz'' company, was considered illicit, if not forbidden.[16] This correspondence not only shed light on the complexities surrounding the importation of new *alat-i basariye.* The expansion of spectacles and eye examination

13 Abdi Tevfik, *Göz Hakkında Bir Konferans* (İstanbul: Kader Matbaası, 1930), 46.

14 BOA. DH.MKT. 1200.46, September 19, 1907.

15 Mehmed Esat, "Göz Hakkında Bir İki Söz," *Nevsal-ı Afiyet*, no. 1 (1899): 157–59.

16 BOA. BEO. 4536.340196, December 4, 1918.

tools was not merely driven by scientific necessity; somewhat, it was influenced by a complex interplay of factors such as professional reputation and commercial interests in their promotion and distribution.

The controversy surrounding the use of spectacles in the medical landscape was about refractive errors and the protective role of spectacles in infectious eye diseases. In the discussions on ocular health within the Şark Cephesi Tıp Mecmuası, Rıfat Ahmet offers recommendations on the optimal lens colors for various environmental conditions. For instance, specific spectacles are suggested in regions with intense electric light or hot fires. Moreover, Rıfat Ahmet provides insights into selecting suitable lenses in dusty environments where bright light can cause eye strain. He underscores the importance of wearing spectacles by highlighting the role of black flies in hot countries in transmitting germs from eye secretions to others. According to him, this phenomenon predominantly contributes to the spread of trachoma disease, a condition often associated with regions characterized by high chronic incidence rates in the Middle East and North Africa.[17]

The ocular apparatus, known as *alat-i basariye*, is increasingly utilized for newly identified refractive errors and innovative treatment approaches. For many individuals, these advancements promised clearer vision or a remedy for their seemingly incurable diseases. However, it also opened a competitive channel, determining who would wield the authority to utilize, prescribe, or circulate these apparatus. At the same time, this trend has led to a new narrative of disease centered on the reorganized medical market. One of the most striking examples of this medical narrative was trachoma. With no precise diagnosis (as it was often confused with many other forms of conjunctivitis) and no standardized treatment method by medical authorities, trachoma underscored the asymmetries within the medical field. It also became one of the most debated eye diseases of the twentieth century, as a subject to regulation by medical authorities.

17 Rıfat Ahmed, "Gözün Hıfzıssıhhası," *Şark Cephesi Tıp Mecmuası*, no. 4 (January 9, 1922): 156–59.

The discourse surrounding trachoma often intersects with notions of societal development, leading to the stigmatization of certain groups deemed inferior, who are then scapegoated as the source of the disease. Many physicians attribute trachoma to poverty, viewing it as trouble primarily afflicting the economically disadvantaged. The impoverished are criticized for disregarding health practices, their cramped living conditions, and their perceived indifference to personal well-being. Described as a scourge on humanity, trachoma is portrayed as diminishing an individual's productivity by a significant margin. Discussions on contagion highlight distinctions between "natural" and "non-natural" tissues in the Sıhhiye Mecmuası in 1928. According to this discussion, there is little risk in allowing children with natural tissues to reside in trachoma-infested neighborhoods or employing trachoma-infected servants in one's household.[18] This discussion shows how trachoma spreads differently among social classes. It also highlights how people view "natural" and "non-natural" eye tissues based on these social differences.

Trachoma is often associated with rural areas and agricultural laborers, who bear the brunt of its impact due to their living and working conditions. According to Hıfzı Nur's work on Turkey's sanitary and social geography, trachoma is attributed to exposure to smoke and soil in regions where tandoors are used.[19] Additionally, seasonal laborers are identified as key contributors to the spread of the disease.[20] While overcrowding is commonly cited as a factor exacerbating trachoma, Dr. Mehmed Emin suggests that the armistice period intensified this issue by increasing population density and, consequently, the prevalence of trachoma. Emin also proposed that the increasingly widespread use of "banknotes*"(evrak-ı nakdiye)* played a role in spreading the disease[21,] an interesting case where concerns about the circulation have materialized. In addition to

18 Hakkı Hayri, "Trahomun Sirayeti Hakkında," *Sıhhiye Mecmuası*, no. 15 (June 1, 1928).

19 Hıfzı Nuri, *Türkiye'nin Sıhhî-i İctimâî Coğrafyası Kayseri Sancağı* (Ankara: Öğüd Matbaası, 1922), 164.

20 "Trahoma Dair," *İstanbul Serîriyâtı*, no. 3 (July 1, 1919): 50–53.

21 Mehmed Emin, *Memleketimizde İntişar Etmekte Olan Mısır Hastalığı* (İstanbul: Necm-i İstiklal Matbaası, 1921), 7.

the various speculations surrounding the causes of trachoma, addressing this disease had been expressed as one of the top priorities for the new Republic of Turkey.

§ 2.2 Regulating Trachoma

In the early Republic of Turkey, trachoma served as a valuable indicator for addressing public health concerns and signaling the nation's commitment to modernization. In this framework, trachoma was portrayed as a longstanding problem "inherited" from the Ottoman Empire that previous authorities had failed to confront adequately. As a result, the government positioned its campaign against trachoma as a new initiative, symbolizing proactive efforts to address deep-rooted health problems and foster social progress.[22] The discussions about trachoma during the national Turkish Medical Congresses, which began in 1925 and continued with the second one in 1927, also support this perspective.

The national Turkish medical congresses, which commenced on September 1, 1925, and continued for decades, were focused primarily on facilitating the exchange of physicians' experiences and discoveries in treatment protocols and medications and reviewing regional and international literature in the field. Five hundred ninety-two physicians attended the First National Turkish Medical Congress held at the parliament building in Ankara.[23] While malaria and infant mortality were the main agenda of the Congress, discussions on trachoma came to the fore in the closing sessions following Dr. Bedri's presentation. Dr. Bedri presented his report on "Trachoma in Erzurum," shedding light on an urgent regional problem. The allegedly high incidence of trachoma in Erzurum and Kars attracted the attention of many doctors, and these cases were

22 Sadet Altay, "Bulaşıcı ve Müzmin Bir Sosyal Afet: Cumhuriyet'in İlk Yıllarında Trahom Hastalığı ve Mücadele Çalışmaları (1924-1938)," CTAD 12, no. 23 (2016)

23 Ayten Arıkan, "Millî Türk Tıp Kongreleri (1923-1968) ve Türkiye Sağlık Politikalarına Etkileri," *Millî Türk Tıp Kongreleri (1923-1968) ve Türkiye Sağlık Politikalarına Etkileri* (dissertation, Türkiye Tıp Akademisi, 2010), 10.

cited as prime examples in discussions on the impact of altitude and mineral springs on trachoma prevalence.

Some doctors argued that trachoma would not occur in the highlands, while others believed that the highlands were the cause of trachoma. Three years before the Congress, Dr. Rıfat Ahmed highlighted common theories linking trachoma prevalence to environmental factors in the Şark Cephesi Tıp Mecmuası, particularly altitude, temperature, and wind. However, he noted inconsistencies, noting instances where trachoma occurred despite conditions contrary to prevailing theories. Dr. Rıfat Ahmed's observations led him to propose that trachoma might be more closely linked to racial factors rather than climate alone. Indeed, Dr. Rıfat Ahmed's article serves as a poignant reflection of the ongoing confusion surrounding the origins and determinants of trachoma.

It was decided that the Second Congress would be held in Ankara again in 1927. Additionally, it was determined that tuberculosis and trachoma would serve as the primary topics for the upcoming Congress. The Congress opened on October 11, 1927, with a ceremony attended by state officials. In his opening speech at the ceremony, Prime Minister İsmet İnönü highlighted the futility of the longstanding debates concerning which civilization—Eastern or Western—was better suited to the Turkish nation. İnönü asserted that the newly established Republic exemplified the Turkish nation's belief that Western civilization was paramount. While this sense of "in-betweenness" had previously impacted medicine, İnönü expressed optimism that it would now actively contribute to advancing the nation, akin to Western experts.[24]

The initial session of the Congress was dedicated to discussions on trachoma. For this purpose, Deputy Minister of Health İbrahim Refik (Saydam) assigned Dr. Vefik Hüsnü (Bulat), an ophthalmologist and former military physician from Ankara Numune Hospital, to conduct a three-month research in Southern and Central Anatolia. Dr. Vefik Hüsnü's task was to present a report on his findings to Congress.

24 İkinci Millî Türk Tıb Kongresi Birinci İn'ikad (Ankara, 1924), 4.

According to Vefik Hüsnü, trachoma's origins date back to ancient times, linked to regions like Egypt and the Nile River, often associated with deserts and their winds. While acknowledging the challenge of pinpointing when trachoma first appeared in the country, Vefik Hüsnü emphasized that migrants are now the leading carriers worldwide. He argued that for trachoma to spread, infected individuals must enter a new area. Vefik Hüsnü believed that before this movement, "this country was undoubtedly clean and free of trachoma." he identified Egyptians and Greeks as carriers of the disease.[25]

Vefik Hüsnü identified primary and secondary reasons for the spread of trachoma in Turkey. Primary causes included military movements like the Egyptian campaign and İbrahim Pasha's Anatolian expedition. He also pointed to trade relations between ports on the Southern coast and Egyptians, particularly in the timber trade. Secondary factors encompassed race, physical condition, altitude, temperature, climate, humidity, lifestyle, gender, age, overcrowding, and disregard for sanitation practices.[26] Bulat noted that some races' lack of adherence to sanitation rules had more severe consequences within their communities.

Vefik Hüsnü divided Turkey into four regions based on primary and secondary causes, considering factors like latitude, longitude, and water resources. According to Vefik Hüsnü, the first trachoma region is bounded by a line stretching from Seyhan and Ceyhan in the West of Antalya, Mira to Kandıra, and South of Isparta and Konya. The second trachoma zone covers the region East of the Kilis-Fatsa line, including the Tigris, Euphrates, and Çoruh rivers. The third trachoma zone lies between the Büyük and Küçük Menderes rivers and includes provinces in the West. Finally, the fourth trachoma zone encompasses the North-central Anatolia area within the borders of Yeşilırmak, Kızılırmak, and Sakarya rivers.[27]

25 İkinci Millî Türk Tıb Kongresi Birinci İn'ikad (Ankara, 1924), 7.

26 Ibid, 8.

27 Ibid, 10-11.

From the first to the fourth districts, Vefik Hüsnü's geographical mapping reflects a spectrum ranging from regions highly susceptible to trachoma to those with lower incidence rates. Similarly, Dr. Bedri undertook a regional classification, dividing Turkey into two distinct zones based on trachoma severity. One region exhibited a higher prevalence of severe trachoma, while the other experienced milder cases. Bedri's approach appears to provide a more direct interpretation of Vefik Hüsnü's categorization, which seems organized along natural boundaries. Specifically, Bedri attributes the severity of trachoma in certain provinces to their proximity to trachoma-endemic regions like Mosul, Syria, and Iraq. He also emphasizes the impact of illiteracy among residents in these areas, which were comparatively less developed than other provinces. In Bedri's mapping, a notable hierarchy emerges between industrial and agricultural laborers. He emphasizes that the "miserable people" residing in trachoma-affected regions not only neglect hygiene practices but also engage in behaviors like burning manure for warmth in winter and sleeping alongside animals in stables. These practices ultimately lead to the spread of smoke and filth, resulting in infections among family members. Dr. Bedri underscores the critical necessity of addressing a disease that poses a significant barrier to the productivity of laborers and agricultural workers, whose livelihoods primarily rely on their physical strength.[28]

According to Dr. Nuri Fehmi (Ayberk), the primary culprit behind trachoma is the failure to adhere to basic hygiene practices. He paints a sobering picture of regions where the sight of individuals reliant on crutches is more common than those who are not. Many have blindness in one eye, while others suffer vision loss. These individuals navigate their surroundings barefoot, evoking a profound sense of pity. Nuri Fehmi underscores the challenge of reaching these communities, particularly during intense agricultural activity and harvest seasons. "Even with the involvement of law enforcement, there is no guarantee of their cooperation."[29]

28 Ibid, 54.

29 Ibid, 31.

On the other hand, Dr. Ahmed Cevdet managed a dispensary established by a factory owner named Salih Efendi. According to Dr. Cevdet, the dispensary received an average of twenty to twenty-five patients daily. While individuals sought treatment from specialists, the existing capacity was insufficient to meet the demand. As a result, there was a pressing need to establish new dispensaries.[30] Ali Naim, another ophthalmologist in Adana, echoed this sentiment, emphasizing the necessity of expanding bed capacity to accommodate the growing number of patients.[31]

The discussion surrounding outpatient versus inpatient treatment, as well as proposals to expand bed capacity or establish new dispensaries, were met with sensitivity by participants at the Congress, particularly in light of limited financial resources. Dr. Niyazi İsmet (Gözcü) addressed this concern, highlighting the potential logistical challenges if rural individuals, instead of city residents, staffed dispensaries in major urban centers. He pointed out that peasants traveling long distances for ophthalmological care might struggle to return home on the same day.[32] Indeed, physicians find themselves torn between attributing villagers' lack of medical care to neglect and understanding the limitations of medical infrastructure.

Another contribution came from Dr. Niyazi İsmet, who presented a paper on treating trachoma. In his presentation, Dr. Niyazi İsmet conducted a comprehensive literature review encompassing pharmaceutical, surgical, physical, and biological treatments. He scrutinized various examples from both local and international cases. In light of his observations, Niyazi İsmet highlights the migration of Kurdish and Turkish laborers to southern provinces as a significant contributor to the spread of trachoma.[33] Notably, newspaper articles often cited seasonal laborers as a common source of trachoma transmission. However, what sets Niyazi İs-

30 Ibid, 37.
31 Ibid, 39.
32 Ibid, 40.
33 Ibid, 23.

met apart is his attempt to conduct a precise cost-benefit analysis. He underscores that trachoma not only inflicts immense suffering but also renders individuals incapable of work due to the damage it inflicts on the eyes. The disease often leads to blindness, leaving individuals reliant on relatives for support. Niyazi İsmet estimates that, on average, trachoma diminishes vision by eight-tenths, reducing work capacity by forty to fifty percent, with ten percent of cases resulting in complete loss of vision and, thus, the ability to work. With the compounding effects of neglect and ignorance, Niyazi İsmet calculates that trachoma incurs a staggering cost of over fifteen million liras annually in Turkey alone. "If we think with human feelings, the situation is different." However, he acknowledged the pervasive influence of economic factors, affirming, "I am convinced that economic feelings play a role in medical affairs rather than human feelings. The value of a man in Adana is higher than anywhere else."[34]

Niyazi İsmet's concerns were somewhat reasonable, considering the economic significance of Adana and Çukurova in Turkish agriculture. Çukurova and Egypt played a crucial role in meeting Europe's cotton demand, particularly after the American Civil War. Unlike mountainous areas, the region also experienced significant seasonal labor migration, driven by the staggered ripening of lowland crops. Despite its agricultural and commercial prominence, labor remained scarce in Adana.[35] The significance of Adana's economic vitality was further highlighted during the Cotton Congress of 1925. The inaugural Cotton Congress took place in 1924. During the opening speech, Trade Deputy Ali Cenani Bey expressed optimism, proclaiming that a bright future awaited the young Republic's trade sector. He envisioned that this would help alleviate poverty, misery, and deprivation.[36]

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34 Ibid, 40.

35 Zafer Toprak, "20. Yüzyılın İlk Çeyreğinde Çukurova'da Emek ve Sermaye," *Toplumsal Tarih*, no. 191 (November 2009): 70–79.

36 Mehmet Ali Karaman, "1925 Adana Pamuk Kongresi Ve Cumhuriyetin Kuruluş Dönemi Pamuk Politikaları," essay, in *Tarihte Adana ve Çukurova* , vol. 4 (Akademisyen Kitabevi, 2016), 229–46.

The second cotton congress, held in 1925 following the previous year's event, shared a common theme with the national Turkish medical congresses: the protection of laborer's health. As the Congress convened, Sabri Bey initiated discussions with an intriguing question: "Is trachoma common among farmers but not among workers?"[37] This inquiry highlighted a glaring issue: the absence of adequate medical facilities in regions like Adana, Tarsus, and Ceyhan, where the disease was notably rampant. This raised a pressing concern: where would workers seek treatment in the event of illness? The potential adverse repercussions for workers and the wider community underscored the urgency of this matter. Sabri Bey urged congress participants to contemplate future implications, envisioning a scenario where the influx of laborers into the Çukurova region would continue to escalate. He stressed the importance of ensuring access to essential provisions such as milk for sick laborers, necessitating additional funds beyond their regular wages. Highlighting the plight of sick laborers, who were compelled to expend 15-20 times their usual expenses on medical treatment due to the inadequate supply of medical facilities, Sabri Bey proposed a solution: establishing a laborers' aid fund to address this pressing issue.

At the Congress, Dr. Hikmet Ziya, the director of the Provincial Directorate of Health, Muavenet-i İçtimaiye, also highlighted the importance of prioritizing the health of laborers. He highlighted the prevalent practice where workers must allocate their funds for health-related expenses instead of being covered by employer-provided or state insurance schemes. Dr. Hikmet Ziya advocated for the state to enact regulations to address this disparity. Specifically, he proposed implementing compulsory measures to ensure laborers are equipped with essential protective gear such as spectacles, masks, and straw hats when working under the sun. If adopted and published as a state regulation, this initiative would significantly enhance the safety and well-being of laborers across various industries.

37 İkinci Adana Pamuk Kongresi Zabıtnamesi, İstanbul; Matbaa-i Amire, 1925. Adana Pamuk Kongresi Neşriyatı. 126.

It is difficult to say what role the themes discussed at the Second Adana Cotton Congress and especially at the Second National Turkish Medical Congress in 1927 played in the establishment of the Turkish Ophthalmology Society on July 16, 1928.[38] However, it is possible to trace traces of the society's publication "Turkish Ophthalmology Newspaper," which started its publication life in 1929. In the introductory article of the newspaper titled *"Gazetemizi Neşre Başlarken''*, the need for physicians, who had been like "a scattered family until now," to know each other's work was highlighted. It is stated that until "since there was neither an ophthalmology society nor an ophthalmology newspaper, ophthalmologists had always remained outside the 'ophthalmology movements' *(oftalmoloji cereyanları)* among nations."[39] The introduction states that "although every nation was invited to the international ophthalmology conference convened on July 12, 1927, no one thought of us. In the face of all these facts, we decided to establish a society and publish the newspaper we have today." On the other hand, it is known that from the first ophthalmology congress held in Brussels in 1857 to the congresses on improving the condition of blind people, delegates representing the Ottoman Empire and Turkey participated. Whatever the reasons for the "confusion" on this issue, it is possible to say that ophthalmologists made attempts to make everyday decisions and consider the needs of the transforming medical landscape.

§ 2.3 Conclusion

The proliferation of ocular apparatus, known as alat-i basariye, has significantly impacted the medical landscape of treating eye diseases and visual impairments. However, despite the availability of these devices, disparities persist in both the discourse surrounding them and access to

38 Gülham Slem, *Türk Oftalmoloji Tarihi* (Adana: Çukurova Üniversitesi Yayınları, 1997).

39 Gülhan Slem, "Derneğin Kuruluşu ve Gelişimi Hakkında Birkaç Söz," Türk Oftalmoloji Derneği, accessed May 10, 2024, https://www.todnet.org/html/todnet.asp?a=dernekhakkinda.

ophthalmic care. These disparities are particularly evident when such instruments are not widely accessible. However, individuals continued petitioning for tax and military conscription exemptions based on visual impairments. This transformation of the medical landscape has not only altered the dynamics of collaboration among medical practitioners but has also influenced the narratives surrounding disease. One notable aspect of this shift is the redefinition of the concept of rü'yet and efforts to standardize measures of visual acuity. As demonstrated by Corinne Doria's research, the standards set for visual acuity beginning in the nineteenth century aimed to establish a protocol applicable in various contexts where individuals' eyesight required assessment. These standards gained prominence with applications in diverse fields such as the military, navy, railways, and occupational accident insurance.

While the narrative of modernization played a significant role in framing anti-trachoma campaigns within the discourse of the new ruling elites, it is important to note that this redefinition did not necessarily lead to a consensus among the various stakeholders involved in discussions on ophthalmology. The proceedings of the First and Second National Medical Congresses in Turkey reveal significant disagreements and conflicts of interest among experts regarding treatment modalities, pharmaceutical companies, and medical supply companies.

As a result of this reorganization in the medical landscape, sight was associated with the active presence of humans, especially in industrial work. Trachoma was regarded as a disaster for humanity as a whole.[40] Those afflicted with trachoma saw their labor capacity diminished by an astonishing factor of a thousand, rendering them akin to "half" human beings from an economic point of view. In the eyes of experts, such an idle and infirm individual represents nothing short of a genuine catastrophe for himself and his family. This led to the association of eye diseases with groups associated with vagrancy at the time. Specifically, seasonal workers and agricultural laborers have been scapegoated, being labeled as il-

40 "Trahoma Dair," *İstanbul Serîriyâtı*, no. 3 (July 1, 1919): 50–53.

literate and blamed for the spread of trachoma. Despite efforts by laborers to address deteriorating health conditions by pooling resources to establish relief funds, the overarching narrative that associates them with a disease expected to affect all individuals and for which no antigen has been identified has resulted in these proposed solutions essentially remaining unimplemented.

Sabri Bey thought that the laborers flowing into the Çukurova region affected cotton farming and the health of the farmers. As a solution, he pointed to establishing farmers' own relief funds. In addition to a similar solution, Dr. Ziya emphasized the need to establish protective equipment. However, the issue of collectively addressing inequalities in access to health care for trachoma remained urgent. The First and Second National Turkish Medical Congresses also sought a solution by placing trachoma at the top of the congress agenda. However, physicians find themselves torn between attributing agricultural populations' lack of medical care to neglect and understanding the limitations of medical infrastructure. The narrative surrounding trachoma, often attributed to individuals and rooted in notions of "backwardness and ignorance, " was further complicated by doctors' concerns to maintain their professional prestige in treating the disease and methodological concerns in a changing medical environment.

The discussions at the first and second national Turkish medical congresses revealed that “both the Ottoman Empire and the Republic had limited knowledge of eastern and southeastern Anatolia, considering it distant and foreign. However, both states aimed to familiarize themselves with these regions, map them, and improve hygiene for the local population.”[41] In conclusion, eye diseases and refractive errors have been recognized. However, the medicalization and categorization of these pathologies have significantly influenced access to ophthalmological care. The establishment of diagnosis criteria, treatment protocols, and healthcare

41 Yücel Yanıkdağ, “Hijyenik Modernlik: Son Dönem Osmanlı ve Erken Cumhuriyette Trahom Coğrafyası,” *Toplumsal Tarih*, no. 296 (2018): 76.

systems has determined who receives specialized ophthalmological care and who is left without access to these services.

3

Beyond Ophthalmological Frontiers

Acırım hallerine ben o za zaîf gözlülerin
Hurda eşyayı görür nûr-ı hakikatı göremez.

– Dr. Mehmet Esat, Göz Tabibi Esat Işık: *Bilimde Siyasette Milli Mücadelede Bir Işık*[1]

During this time, the Ottoman authorities actively engaged in international congresses centering on ophthalmology, vision, blindness, dumbness, and deafness. Analysis of official correspondence brings to light the pursuit of two distinct lines of congresses.

The 1900 Paris and 1902 Bruxelles "international pour l'amélioration du sort des aveugles" congresses were primarily dedicated to disability and the societal reorganization of life, while the "international d'ophtalmologie" congresses, which are still held today, adopted a medical fo-

1 Kadircan Keskinbora, *Göz Tabibi Esat Işık: Bilimde, Siyasette, Milli Mücadelede Bir Işık* (İstanbul: Bahçeşehir Üniversitesi Yayınları, 2014).

cus. Within the scope of this study, thirteen congresses until the 1929 congress, in which an independent league on trachoma was established with the decision of the Congress, will be analyzed.

These ophthalmology congresses were 1857 Brussels, 1862 Paris, 1867 Paris, 1872 London, 1876 New York, 1880 Milan, 1888 Heidelberg, 1894 Edinburgh, 1899 Utrecht, 1904 Lucerne, 1909 Naples, 1922 Washington and 1929 Amsterdam. Despite their institutional divergence, a convergence of concerns emerged in both congress types, particularly about workforce restructuring. Similar issues were addressed in both congresses. For instance, the "international pour l'amélioration du sort des aveugles" congresses occasionally delved into discussions on ocular pathology. In contrast, the medical congresses addressed financial compensation for eye injuries. Intriguingly, there were instances where delegates participated in both types of congresses, revealing a multidimensional engagement by individuals in the discourse surrounding ocular-related matters.

§ 3.1 Congresses for the Amelioration of the Condition of the Blind People

Delegates from the Ottoman Empire closely monitored the "internationale d'ophtalmologie" commencing in Brussels in 1857 and subsequently in Paris and Brussels in 1900-1902 known as "international pour l'amélioration du sort des aveugles" congresses." These congresses played a main role in elucidating controversial perspectives on vision among medical practitioners, diplomats, and educators of the period. Discussions within these meetings revolved around improving vision, advancements in surgical techniques, and efforts to restructure the medical landscape, which led to heated debates.

Official correspondences manifest the Ottoman authorities' discerning interest in the 1900 Paris and 1902 Brussels "international pour l'amélioration du sort des aveugles' congresses, and 1905 Liege congress. Throughout this timeframe, delegates actively participated in all congresses, except 1888 in Heidelberg, 1899 in Utrecht, 1904 in Lucerne, and 1922 in Washington.

These discussions, which examined the fundamental interdependence between members of society, had the potential to pursue an alternative path by establishing a protective system based on solidarity between social components. According to the Congress, “patronage” would ensure the emancipation of visually impaired people through occupations compatible with their innate abilities and human dignity. This raised critical issues regarding the practicality of establishing an international protection system and the risk of patronage becoming a purely philanthropic endeavor. Moreover, the discourse of patronage has sometimes been intertwined with notions of Christian charity, emphasizing that helping the blind is a spiritual duty rather than a purely material obligation.

The focus on emancipation through labor has led to the exclusion or disproportionate emphasis on specific professions. For example, musicianship was one of the main discussion topics, as the visually impaired were thought to be "naturally" predisposed to sound. There was intense debate about whether musicianship should be seen as a lucrative profession or a pastime distracting individuals from "substantive" production. Delegates illustrated the vocational debate with examples from workshops in their countries. They considered it as their aim to enable visually impaired craftspeople to produce high-quality products independently without the assistance of sighted people. Common occupations for the visually impaired included basket making, brush making, lathe work, chair stuffing, can making, net making, paper bag making, cardboard making, and bead stringing for funeral wreaths.

Helmina Segerstedt, the delegate from Sweden, highlighted a municipal initiative to enhance the conditions of visually impaired women by establishing tiny family houses, termed "Colonie d'Aveugles," accommodating fifty individuals annually. In a congress devoted to nurturing social and global solidarity for the amelioration of the visually impaired, the

spotlight on labor productivity was designed as a form of "material patronage."[2] The significant emphasis on the provision of raw materials was notable. In this vein, Société des Ateliers d'aveugles Chief Executive Officer Baron de Shickler expounded on their bulk acquisitions, stating, "We secure goods at wholesale prices, and the blind individuals settle payments upon selling; this mode of patronage has proven to be highly advantageous."[3]

During the Congress, blind individuals were categorized into four distinct groups. The first group comprised those whose parents, endowed with personal resources, could afford to educate their blind children within the confines of their homes. Without a reversal in their fortunes, these individuals were deemed self-sufficient and thus obligated to contribute a significant portion of their future income to charitable causes.

The second category encompassed individuals who experienced blindness slightly beyond the school age but were still relatively young. These individuals had two primary resources: manual labor and small-scale trade. However, to enhance their prospects, this group needed to acquire literacy skills – reading, writing, and counting. Patronage played a crucial role in assisting these individuals by facilitating the sale of handicrafts or providing initial financial support for entrepreneurial ventures. Financial aid recipients were advised to gradually repay the sums received, ensuring the perpetuity of assistance from the patronage fund. They adhered to such practices to prevent abuses that could jeopardize and eventually halt support.

The third category consisted of middle-aged blind individuals with only one viable resource: small-scale trade. For this group, the opportunity to learn literacy skills has disappeared. However, with a relative's or friend's goodwill, this educational gap could be bridged by cooperating with a blind person in a small business. Although the patronage fund could not fully bridge such a large gap, it nevertheless played a role in helping these individuals initially. For this particular category of blind

2 *Congrès International Pour l'amélioration Du Sort Des Aveugles Tenu À Paris Du 1ie Au 5 Août 1900* (Versailles: Société des imprimeries Gérardin, 1900), 78.

3 Ibid, 87.

people, small-scale trade was preferable to manual labor. The last group consisted of individuals who became blind towards the end of their lives and, "unfortunately," their only recourse was to seek treatment in a hospital.

The delegates presented a dual discourse, affirming the potential empowerment of the visually impaired through employment yet concurrently expressing concerns about entrusting education to this group. Frere Mederic, the delegate from Orleans, France, addressing the "disconcerting appearance of the blind upon their arrival at school, their hesitant and uncertain gait, their unsettling tics—manifestations of the unfortunate consequences of the inadvertent habits acquired during unattended hours—raises the question: 'Can the prolonged idleness in which they have lived adequately prepare them for serious work? To what extent will we encounter challenges in facilitating their engagement in labor?'"[4] To Abbe Vitali, vice-president of the Congress from Italy, the condition of the blind is to be pitied even more than that of the deaf and dumb: "For a blind man, the profession of teacher of the blind is one of the most beautiful, the most suitable, the most honorable, the most useful occupations that can be provided for him; he brings to it all his abilities, all his inclinations; he brings not only all that is necessary to succeed even in comparison with sighted people, but also all that leads him to progress by the double intellectual and moral movement of his mind."[5]

Sighted teachers faced complexities arising from the disability and mental state of their visually impaired pupils, as well as the appropriate pedagogical methodologies. Simultaneously, blind teachers encountered constraints in acquiring new knowledge due to limited resources. Striking a balance was deemed challenging, leading to the contention that while artistic and vocational education could be entrusted to blind teachers given their familiarity with specialized processes, including “clairvoyant” individuals was posited to enhance the comprehensiveness of such instruction.[6]

4 Ibid, 193.

5 Ibid, 146.

6 Ibid, 155.

A similar complexity about visually impaired education is reflected how delegate perceive eye diseases in different countries. Delegate Cunenod draws attention to the significant incidence of granulation and trachoma cases in Tunisia. According to him, the primitive traditional medicine practiced by Tunisians to combat granulation demands eradication. It is deemed unacceptable that the government tolerates the activities of local amateurs (referred to in the text of the speech as poor and overconfident devils) who, in public spaces, grind a contagious mixture of various elements and apply it between the eyelids of unsuspecting individuals.[7] Conversely, Dr Widmark cites statistics from the German ophthalmologist Magnus revealing a substantial number of trachoma patients in Norway. This is attributed to the isolated lifestyle resulting from mountainous settlements, leading to a prevalence of consanguineous marriages. Addressing this issue necessitates legal interventions.[8]

The Ottoman representative Tevfik Vacid also made a speech emphasizing the necessity of legal arrangements. Vacid underscored the significance of ocular hygiene and legal frameworks as pivotal elements in mitigating the prevalence of blindness. In drawing parallels to the International Hygiene Congress convened in Geneva in 1882 and The Hague Congress in 1884, he accentuated the imperative nature of legal interventions. Vacid articulated that legal measures were indispensable in addressing diverse factors contributing to visual impairment, encompassing aspects such as childhood conditions, the period of schooling, occurrences of Egyptian ophthalmia, occupational hazards, alcoholism, infectious maladies, and a spectrum of injuries. In Vacid's perspective, students afflicted with granulosis demanded meticulous and systematic attention from school physicians.

Furthermore, he advocated for the comprehensive inspection of all educational institutions by health commissions, with the authority to close down any school failing to meet legal requisites. The pervasive and

7 Ibid, 252.

8 Ibid, 256.

calamitous ocular disease, colloquially known as granular and trachomatous conjunctivitis, was purportedly introduced to Europe by Napoleon's defeated troops in Egypt, thereby acquiring its widespread nomenclature. Extensive military campaigns propagated this infectious malady among civilized populations, evolving into a devastating epidemic across various nations. Purulent discharges played a pivotal role in its rapid dissemination, with occasional causes such as the congregation of individuals in barracks, schools, retirement homes, mental hospitals, and other social institutions facilitating its continental invasion. In the regions of Turkey, the disease exhibited advancement over the past two decades compared to preceding periods. Vacid succinctly characterized this disease as cosmopolitan, underscoring its universally acknowledged contagious nature. He contended that palpebral granulosis posed a threat to social life, asserting that medical doctrines would prove futile unless governments enacted legislative measures for both military and civilian populations. Vacid outlined a dual-pronged strategy for combating the disease, emphasizing stringent enforcement of hygiene measures to prevent its propagation and the provision of appropriate treatment. Soldiers afflicted with granular forms should undergo specialized training in battalions, with mandatory weekly medical check-ups and a prohibition on sending untreated patients to their homes. Granular patients, particularly those with the trachomatous form, were exempted from the as per the Ottoman army regulations mentioned by Vacid.[9]

In 1902, the Brussels congress witnessed the participation of District Governor Mehmed Esat, an Ophthalmology instructor within the Mekteb-i Tıbbiye.[10] At the Congress, he mentioned the incredible musical talent of the visually impaired in the Ottoman Empire, their highly developed memory skills that enabled them to recite memorized prayers in mosques, and their earning their living by begging.[11]

9 Ibid, 218-223.

10 BOA. HR.TH. 271.75, July 23, 1902.

11 *Congrès International Pour l'amélioration Du Sort Des Aveugles: Tenu À Bruxelles, Du 6 Au 10 Août 1902* (Manage: Impr. de l'ècole Professsionnelle, 1902), 55.

During the proceedings, the pathology of ocular conditions was systematically categorized into four groups. The first encompassed congenital or acquired predispositions, elucidating ocular manifestations resulting from conditions such as retinitis pigmentosa, syphilis, and various intoxications. This group also included afflictions such as glaucoma, cataracts, diverse ocular manifestations of rheumatism, complications arising from visceral diseases, diabetes, and albuminuria. The second category addressed blindness stemming from general or local infections, encompassing maladies such as smallpox along with purulent and granular ophthalmia. The third classification delved into social factors affecting ocular health, mainly focusing on occupational and educational settings. This section expounded upon conditions such as nystagmus and myopia prevalent among coal workers. Lastly, the fourth group scrutinized ocular impairments from occupational and accidental traumas.[12]

Delegates strongly argue that trachoma, a severe eye disease, should be a top priority on the Congress agenda due to its devastating impact on the working-class population. According to the Anvers Delegate Doctor Mets, trachoma is the most prevalent eye disease in Belgium, serving as the primary cause of persistent unemployment and eventual blindness.[13] Mets emphasize the historical ubiquity of trachoma, citing its mention in the Bible and recognition by the ancient Greeks as "trachoma," while the Romans referred to it as "aspretudines." Notably, he points out the prevalence of trachoma in hot, tropical climates, explicitly mentioning its flourishing in Egypt.[14]

The delegate from Cairo, Dr Eloui Bey, has made an important challenge to the long-held Western perception that Egypt is the primary source of eye diseases and an ideal environment for blind people. Abbate argues that this perception, which previously created a kind of "ophthalmophobia" among foreigners, is no longer valid. Indeed, Egypt has made significant strides in the field of ophthalmology, dispelling the notion that

12 Ibid, 221.

13 Ibid, 218.

14 Ibid, 225.

it remains a center for eye diseases and highlighting the need for a more comprehensive understanding of the epidemiology of eye diseases.

Delegates uniformly underscored the imperative of robust rural healthcare in the battle against trachoma. They highlighted the link between immoral conduct among the youth, excessive indulgence in alcohol and tobacco, and other immoderate behaviors as potential contributors to blindness. Additionally, discussions delved into the prevalence of eye-related injuries in industrial centers.[15]

The proposed remedy to address the root causes of blindness revolves around the consistent application of hygienic principles. The delegates advocated universal access to the four essential elements of well-being: air, water, sun, and physical activity. They stressed the importance of disseminating knowledge about these principles through highly effective propaganda, ensuring that everyone has the means to implement them and addressing resistance when it arises.[16]

The delegates urged a reflection on the positive impact that preventive and hygienic measures could have, particularly in regions like the East, where severe ophthalmia prevails under the “intense glare of the sun.” The congress hall even echoed Victor Hugo's famous "Peuplons tout l'Orient de magiques Congrès!" lines with enthusiastic applause. They called for the East to be filled with transformative congresses, akin to magical gatherings, to bring about positive change.[17]

Even though there were no “enchanting congresses” in the East were not held for a while, the delineation between complete blindness and visual impairments was evolving, giving rise to concerns regarding the right to education and employability.[18] Eventually, with new developments, Individuals with refractive errors like astigmatism, myopia, and hyperopia

15 Ibid, 223.
16 Ibid, 237.
17 Ibid, 345.
18 Ibid, 137.

were able to have average vision through optical technologies and modern spectacles.[19] This led ophthalmologists to argue that the blind deserved different treatment than those impoverished by their own "defects and deficiencies."[20]

Under congressional debate, while some highly skilled individuals could master crafts considered inaccessible to blind people, the time investment required of a blind person made the endeavor less rewarding than for sighted counterparts. Congress recognized these difficulties, noting that a blind artisan might have to either deter customers by inflating the cost of the object or settle for wages consistently below the necessities of life. To mitigate the damage, a proposal for a division of labor between blind and sighted workers emerged. Dr Mascaro, Delegate for Lisbon, addressed concerns about remuneration, emphasizing the commitment to fair treatment and assuring that blind assistants would willingly accept lower wages under similar conditions.[21]

Ultimately, working with sighted workers was not always advantageous, as there were reservations about the potential for foreign workers to bring "dissolving elements."[22] The Congress's overarching message was clear: a superficial sense of satisfaction does not contribute meaningfully to the education, training, or employment of the blind or visually impaired. A blind individual specializing in musicianship might encounter challenges in workshop settings where delicate fingers are underutilized, highlighting the importance of acquiring multiple trades. Industriousness and debt repayment were underscored as prerequisites for patronage, with a sober acknowledgment that not all doors would readily open for blind people.

19 Ibid, 252.
20 Ibid, 119.
21 Ibid, 102.
22 Ibid, 107.

Another congress that the Ottoman administration prioritized aimed at "improving the condition of the blind and dumb." The authorities decided that since no special official would be appointed to the congress, a suitable person would be designated by the Brussels Embassy.[23] However, there was ultimately no official participation in the congress. Mihran Kavafian, a diplomat in Belgium at the time, was dismissed from his post the same year due to allegations of corruption and misconduct, which may have contributed to this oversight.[24]

§ 3.2 International Congresses of Ophtalmology

In the historical context of 1857, the first Ophthalmology Congress convened in Paris, marking the inception of the first international medical Congress. Charles de Hübsch, renowned for his articles on ophthalmology and contributions to medical discourse in publications such as Gazette médicale de Paris: journal de médecine et des sciences accessoires and Gazette des hôpitaux civils et militaires (Lancette française), represented the Ottoman government at this significant event.[25] 28 The primary discussions in the inaugural Congress echoed thematic elements that would recur in subsequent gatherings.

The 1857 Ophthalmology Congress commenced with exploring the transmission of purulent ophthalmia, colloquially known as military ophthalmia and trachoma, before the 1900 and 1902 Congresses. Subsequent deliberations focused on the most effective measures to prevent the onset and dissemination of this condition. These measures included treating soldiers currently afflicted, disinfection protocols for various establishments (barracks, prisons, hospitals), prevention of the spread and exacerbation of ophthalmia, and strategies to avert relapses following the cure of the disease.[26]

23 BOA. HR.TH. 322.106, August 19, 1905.

24 BOA. BEO. 2652.198887, August 26, 1905.

25 *Congres d'opthalmologie de Bruxelles: Compte-Rendu. Session de 1857* (Paris, 1858), 28.

26 Ibid, 9-15.

The second major issue of discussion at the Congress revolved around the transformative impact of the invention of the ophthalmoscope on the diagnosis and treatment of eye diseases. In fact, by enabling precise examination of the eye, the ophthalmoscope revolutionized the diagnosis of diseases that were previously challenging or even impossible to discern. Delegates exchanged insights and recounted their experiences utilizing the ophthalmoscope for diagnostic purposes.[27]
A significant portion of the discourse centered on whether certain cataracts could be addressed without surgery and explored potential alternatives to surgical intervention. In addition, delegates turned their attention to a categorization of disease, granulations, in particular trachoma. The presentations described the forms of granules in the eye according to their physical characteristics, and trachoma was also categorized.

An additional agenda item of the Congress delved into the efficacy of private organizations in treating eye diseases. Beyond the general hygiene standards applicable to all hospitals, the discussions emphasized the departmentalization of ophthalmic institutes, measures to ensure their sanitation, and considerations regarding their interior features.[28]

In 1862, at the Ophthalmology Congress convened in London, the Ottoman delegation was represented by Sarandi Archigenes, a scholar who, alongside Hübsch, had authored one of the earliest political economy books in the Ottoman Empire and had pursued medical studies in Paris.[29] Notably, the London Congress became a stage for a spirited debate on conjunctivitis.[30]

The dispute unfolded between Sperino Borelli, the delegate from Turin, and Schnepp Abbate, the delegate from Egypt. Borelli staunchly advocated for his technique of scraping tough, fibrous granulations, including trachoma, employing an instrument he termed "scardasso."

27 Ibid, 95.
28 Ibid, 475.
29 *Congres d'ophtalmologie de Paris: Compte-Rendu. Session de 1862* (Paris, 1863), 12.
30 Ibid, 48-57.

According to Borelli, this method was well-received by patients who preferred eyelid scraping over the application of caustic agents such as silver nitrate or copper sulfate. He asserted that his approach induced a copious blood flow, swiftly reduced inflammatory swelling without the lingering pain associated with cauterization, and significantly expedited the healing process. Contrastingly, Abbate raised concerns about the historical use of the scraping method, noting its periodic resurgence, and emphasized the imperative to avoid conjunctiva destruction and the formation of inodular tissues at all costs. Amidst the ongoing discussion, the congress president was petitioned to include the discourse on Egyptian ophthalmia in the agenda for the subsequent session. Drawing from personal experience in Egypt and citing observations from Fischer, Pruner, and official reports to the Egyptian government, Abbate asserted his authority to challenge the presumed specificity of Egyptian ophthalmia within the nosological framework.[31] Ultimately, the deliberations failed to yield a consensus, prompting the decision to convene the next Congress in Vienna.[32]

Despite the initial plan for the third Congress to be held in Vienna, it was postponed by a year due to the Austro-Prussian war and ultimately relocated to Paris.[33] Agelastos, in the company of Hübsch and Archigenes, participated in this Congress.[34] One of the main focus of this gathering revolved around refractive errors and the introduction of optical apparatus. Additionally, Julius Mannhardt presented his experiences with cataract operations conducted in Constantinople. Mannhardt highlighted the challenging conditions under which he performed many cataract operations in Constantinople. Most of these procedures took place in a Turkish hospital that was ill-suited for such purposes, lacking essential equipment, with rooms featuring large, sun-exposed windows devoid of curtains and experiencing excessive temperatures. This underscored the

31 Ibid, 48–53.

32 Ibid, 213.

33 *Congres d'ophtalmologie de Paris: Compte-Rendu. Session de 1867* (Paris, 1868), 9.

34 Ibid, 16.

inadequate care provided to patients undergoing cataract surgery in that setting.[35]

The Ottoman delegates to the London Congress in 1872 were the same as those at the second Paris Congress. The discussions at this Congress included sharing experiences regarding quinine use in treating granular ophthalmia—a notable pharmaceutical product encouraged in the medical field and documented in the pharmaceutical codices and patent medicines of the period. Another main focus of the Congress was examining the ability to discern objects in size and shape at specific distances. These discussions on visual acuity played a crucial role in establishing a standard for it, aiding in differentiating refractive errors such as myopia and astigmatism from blindness.

The Fifth International Congress of Ophthalmology convened in New York in 1876, with Ottoman delegates Hübsch, Archigenes, and Agelastos in attendance.[36] The New York Congress featured discussions on trachoma alongside the proposition of racial influences. A doctor from Washington, Swan M. Burnett's paper titled "A Note on Trachoma as Influenced by Race" challenged the conventional beliefs that climate and altitude were sufficient explanations for trachoma. Burnett argued that race and nationality played a more decisive role in the prevalence of trachoma. He asserted that trachoma was notably rare among "negroes," despite their crowded living conditions, inadequate nutrition, and clothing, suggesting a form of immunity to the disease even in less-than-ideal hygienic habits.[37] Doctor Henry Noyes of New York stated that the "negroes" were not a happy exception to trachoma and that his institutions frequently received blacks with trachoma.[38]

In 1880, Georgis Costomyris represented the Ottoman delegation, focusing primarily on ancient medical texts.[39] This Congress marked the

35 Ibid, 72.

36 *Fifth International Ophthalmological Congress Report* (New York, 1877), 12.

37 Ibid, 134–136.

38 Ibid, 137.

39 *Congres d'opthalmologie de Milano: Compte-Rendu. Session de 1880* (Milano, 1881), 5.

first instance of an Ottoman delegate presenting a paper. Costomyris performed a new cadaver-based operation for treating trichiasis, covering a spectrum of complexities, and delivered a paper on this surgical technique.[40]

The 1880 congress stood out as it included discussions on the visual functions of railway and navy workers, a professional group distinct from the military. Notably, After the 1880 congress, it is noticeable that more and more discussions centered on diverse vocational groups.

In 1888, the Ottoman authorities opted not to send a representative to the Congress held in Heidelberg, Germany, citing a lack of official invitation.[41] Nonetheless, official correspondence reveals that deliberations occurred regarding potential attendance. If a delegate were to be sent, Miralay Behçet Bey, the second deputy of the medical department of the Bab-ı Seraskeri, was considered.

Edwig van Milligen attended the 1894 congress in Edinburgh.[42], son of Julius Michael Milligen, who had previously served as a physician to the Ottoman Court and had been Lord Byron's physician. A proposal to amalgamate this Congress with the National Medical Congress was on the agenda for the Scottish doctors. In 1893, the Rome Medical Conference, featuring Edwig van Milligen and Mehmet Esat, had also been organized with specialized sections. This particular Congress witnessed an extensive debate on whether myopia, another refractive error, could be effectively treated with surgery. There was skepticism surrounding the use of surgery for refractive errors due to the associated risk of blindness.[43]

The congresses held in Utrecht in 1899 and Lucerne in 1904 were events the Ottoman government chose not to attend. While discussing efforts to standardize eye charts at these congresses, a parallel theme emerged, reminiscent of the 1900 and 1902 congresses, involving financial

40 Ibid, 87.

41 BOA. Y.A.HUS. 332.19, July 11, 1895.

42 *Congres d'ophtalmologie de Edinburg: Compte-Rendu. Session de 1894* (Edinburg, 1894), 5.

43 Ibid, 173–180.

compensation for those who had been injured or lost their sight completely.[44]

In the context of these discussions, French labor law stipulated that, in cases of partial and temporary incapacity, an injured worker should receive an allowance equal to half the reduction in wage-earning capacity and two-thirds in cases of total and permanent incapacity. The speaker argued that, under the current system, an individual who suffered the total loss of an eye might encounter significant challenges in securing further employment. This was because, from a compensation perspective, such an individual was deemed a risky hire, as an accident to their remaining eye could render them totally and permanently incapacitated. Mr. McHardy proposed that compensation equivalent to at least 50 percent of the loss of earning capacity should be permitted.[45]

Then, a commission was established with representatives from each country, with Mr. J. Priestley Smith and Mr. George A. Berry representing Great Britain. The ensuing agenda item involved deliberations on the proposals the French Ophthalmological Society put forth for the formula of visual acuity. This topic was closely related to the previous subject of financial compensation and emphasized the need for a simple method of documenting the visual acuity of workers at their first employment.

At the 1909 Naples Congress, a committee was established to review the eye charts for measuring visual acuity. The primary objective was to establish an official visual standart, a topic that had been discussed previously in Congress. During the Naples Congress, ophthalmologists were generally skeptical about expanding this scale beyond its existing scope. This skepticism stemmed from the fact that eye charts had already been widely adopted before the scientific community reached a consensus on a unified standard.[46]

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44 Corinne Doria, “Searching for the Normal Vision: Measuring Visual Acuity in the 19th Century,” *Histoire, Médecine et Santé*, no. 18 (November 11, 2021): 113–28, https://doi.org/10.4000/hms.3379.

45 Congrès d’ophthalmologie de Lucerne, 202-205.

46 Doria, Corinne. (2021). "Searching for the Normal Vision. Measuring Visual Acuity in the 19th Century". Medicina Historica 5 (2).

Ophthalmologists themselves often advocated for the broader adoption of their specific charts, employing what could be described as marketing strategies to promote their preferences. Intense competition existed among doctors to establish standards, determine appropriate methods, or popularize their inventions. Numerous challenges, ranging from adopting technological advances by the optical and glass industry to conflicting opinions and interferences among doctors involved in these new approaches, added complexity to the Congress agenda.

3.2.1 *1922 Washington Congress and Ellis Island*

In the 1922 Washington Congress, no delegate was representing Turkey. However, this meeting exemplified this complex dynamic between physicians. The President of Congress, George de Schweinitz, must have found it frustrating that the most significant scientific contribution was demonstrating an improved version of a colleague's invention. He "jokingly" referred to his colleague as a "gentleman with a lamp" in medicine, drawing a parallel to Florence Nightingale.[47]

Also, the discussions on trachoma during the 1922 Congress highlight the intricate nature of contemporary approaches. William John McMullan, a prominent figure in the United States and Ellis Island's medical examinations and the exclusion of immigrants with trachoma, asserted that the treatment of trachoma was increasingly leaning towards surgical interventions. However, during medical examinations, immigrants were often subjected to various interventions that could be deemed experimental.[48]

In 1929, Vefik Hüsnü Bolat, representing the Republic of Turkey and renowned for his efforts in combating trachoma[49], participated in the

47 G. Ravin, "Gullstrand, Einstein, and The Nobel Prize," *Archives of Ophthalmology* 117, no. 5 (May 1, 1999): 670, https://doi.org/10.1001/archopht.117.5.670.

48 *An International Congress of Ophthalmology: Proceedings* (Washington, D.C., 1922), 102.

49 Hülya Öztürk and Nilüfer Demirsoy, "Nationalisation Effort in the First Years of Turkish Republic and Evaluation of Nationalizational Studies in Health," *Turkiye Klinikleri Journal of Medical Ethics-Law and History* 27, no. 1 (2019): 11–24, https://doi.org/10.5336/mdethic.2018-61148.

Congress held in Amsterdam. The thirteenth Ophthalmology Congress played a pivotal role in establishing international cooperation, forming the "International League for the Campaign Against Trachoma." The organization's statutes were officially adopted during a meeting in Geneva in 1930. Tevfik Vacid from Turkey served on the league's executive committee. The primary objectives of this league included fostering collaboration among various organizations dedicated to addressing trachoma, working in conjunction with international public health organizations, promoting research on trachoma, and organizing conferences to enhance the scientific foundation of the campaign against trachoma.[50]

§ 3.3 Conclusion

The Pour L'amelioration congresses held in Paris in 1900 and Brussels in 1902 provided a critical platform for deliberations on the concept of "patronage," central to the discourse surrounding the potential emancipation of the visually impaired through lucrative employment. The multifaceted nature of work was not merely seen as a means of achieving financial independence but was also underscored as a moral obligation for individuals grappling with blindness. Within this framework, the visually impaired were stratified based on age, social standing, and financial resources, giving rise to conflicting perspectives on the most efficacious approaches to education among the diverse congress participants. One of the primary reasons for the differences in educational perspectives lies in the hierarchical value attributed to the senses, with visual perception often placed at the top. The widespread belief in the superiority of sight has underscored the challenges of integrating traditional educational methodologies for the visually impaired people.

Simultaneously, ophthalmological congresses during this era accentuated the contagious attributes of eye diseases. However, there is a

50 "International Organisation for the Campaign Against Trachoma," *British Journal of Ophthalmology* 14, no. 10 (October 1, 1930): 526–27, https://doi.org/10.1136/bjo.14.10.526.

marked difference in the way delegates Dr. Cuenod and Dr. Widmark addressed the trachoma cases in Tunisia and Norway. Dr. Cuenod presented traditional medical, "primitive" methods of disease treatment by non-specialists for the trachoma outbreak in Tunisia. On the other hand, Dr. Widmark explained the cases in Norway in terms of natural conditions such as mountainous settlements and isolated living. Delegates agreed that legal regulations and sanitary measures should be taken to prevent infectious eye diseases.

Indeed, as the 1902 congress showed, for some delegates, trachoma was a disease that required urgent action as a major cause of permanent unemployment and eventual blindness. On the other hand, there were delegates who pointed out that the current "ophthalmophobia" at the congress did not reflect reality. They advocated for universal access to air, water, sunshine and physical activity to prevent trachoma. However, this was not the predominant topic of discussion in an agenda that created the narrative of a disease that is timeless and has existed since time immemorial.

The other line of congresses described in this chapter, the international ophthalmology congresses, had similar agendas of discussion. Summarizing the discussions from the first one in 1857 to the establishment of the International Trachoma League in 1929, this chapter shows that the discussions at these congresses began with the categorization of ocular pathology and included the introduction of pioneering ocular apparatus and surgical methods, as well as the impact of race and nationality on trachoma.

The 1857 Brussels Congress focused on discussions regarding ocular apparatus, the classification of trachoma, and the provision of healthcare infrastructure. At the 1862 Paris Congress, the classification of trachoma continued to be a major topic. By the 1867 Paris Congress, refractive errors and ocular apparatus were introduced. The 1872 London Congress discussed drugs used for eye diseases, pharmaceutical codices, and attempts to standardize visual acuity. At the 1876 New York Congress, debates centered on the relationship between trachoma and race, with

some delegates arguing that Black individuals had some racial exception to trachoma, while others rejected this notion. The 1880 Milan Congress addressed what could be done about visual impairments and eye diseases in different occupational groups. Unlike other congresses, the 1894 Edinburgh Congress discussed the proposal to unite ophthalmology congresses under the umbrella of the medical congress. The 1909 Naples Congress tackled the issues of compensation for incapacity due to refractive errors and eye diseases, proposing that compensation equivalent to at least half of the loss of earning capacity should be provided in cases where an eye injury renders an employee "completely and permanently incapacitated."

During this period of technological advances in the optical and glass industry and the reorganization of approaches to eye diseases, disagreements and debates among doctors were evident in the agenda of the 1922 Washington Congress. This congress also featured the organization of the Ellis Island eye examinations and discussions on trachoma treatment methods by experts known for their policy of deporting those with trachoma. The 1929 Amsterdam Congress was attended by Vefik Hüsnü Bolat, a physician known for his efforts in the fight against trachoma, representing the Republic of Turkey.

Although there was no delegate representing the Ottoman Empire at the 1888 Heidelberg, 1899 Utrecht, 1904 Lucerne, and 1922 Washington congresses, the narrative of trachoma was consistently recreated, circulated, analyzed, categorized, and ultimately marketed through ophthalmologist's specific treatment methods. Recurring themes in both congress lines included the formulation of medico-legal regulations, the establishment of visual acuity, and the proposal of efficiency-enhancing methodologies in education and working life, reflecting the dynamic landscape of ophthalmology.

4

Instrumentalizing Trachoma At Ellis Island

"Give me your tired, your poor,
Your huddled masses yearning to breathe free,
The wretched refuse of your teeming shore.
Send these, the homeless, tempest-tost to me,
I lift my lamp beside the golden door!"

– Emma Lazarus, *The New Colossus*

Between 1892 and 1924, almost 12 million people passed through Ellis Island.[1] In the huge redbrick structure of the main building of Ellis Island, in a sea of cumbersome bags and hats, the long and perilous journey of millions of people across the Transatlantic continued in a new direction. Uniformed officials ordered around the new arrivals, often in a language they did not understand. As they walked twenty paces down the rows of desks in the big hall, the doctors had to ask and answer hundreds of questions about the migrants in their minds. This fact would be recognized if the immigrant showed any signs of illness if he was deformed,

1 "Overview + History: Ellis Island," Statue of Liberty & Ellis Island, September 26, 2022, https://www.ellisisland.org/ellis-island/overview-history/.

even down to a crooked finger. If the immigrant was healthy and the examination found no reason to keep him or her, the immigrant was accepted. However, if there were the slightest suspicion in the minds of the doctors that something was wrong with the person, a chalk mark would be placed on the lapel of his jacket for further examination. This medical examination at Ellis Island was just one of a series of increasingly stringent measures to limit immigration. For arrivals, the Ellis Island examination caused fear and desperate attempts to remedy physical defects. The number of potential immigrants who chose to stay home rather than risk a medical examination cannot be measured.

The notable frequency of eye diseases leading to rejections among migrants at Ellis Island, despite their treatable and non-fatal nature, prompts an investigation into the underlying factors. This occurrence raises inquiries regarding the prioritization of medical conditions during the screening process, where less severe diseases appear to be given greater significance compared to potentially more severe illnesses diagnosed at Ellis Island. This ambivalence underscores the need for a nuanced examination of the decision-making processes and criteria employed in assessing migrants' health, shedding light on the complex interplay of medical, social, and policy considerations during this historical period.

Trachoma, an easily recognizable, non-lethal disease, led to far more deportations than diseases and defects such as syphilis and tuberculosis, which politicians and restrictionists vehemently condemned. Between 1897 and 1925, the average annual number of trachoma cases diagnosed at American ports and borders was about 1,500 - far less than 1 percent of the annual number of immigrants seeking entry during this period.[2] Nine out of ten immigrants diagnosed with trachoma on arrival were refused entry. At its Annual Meeting in 1903, the American Public Health Association reported that effective quarantine methods have eradicated diseases

2 Howard Markel, "'The Eyes Have It': Trachoma, the Perception of Disease, the United States Public Health Service, and the American Jewish Immigration Experience, 1897-1924," *Bulletin of the History of Medicine* 74 , no. 3 (September 2000), 526.

subject to ordinary quarantine. However, some infectious diseases classified as disgusting or dangerous contagious diseases do exist among immigrants. Of the total cases of disgusting or dangerous diseases detected in immigrants, 87% were caused by trachoma and 10% by favus.[3]

Until 1957, the causative agent of trachoma had not been fully identified, so there was no unexpected disagreement among experts in diagnosing trachoma. For this reason, even any redness in the eyes of the immigrant after a long Pacific voyage could be labeled as a symptom of trachoma. Trachoma, originally directly linked to immigration from the East, was also endemic among poor Americans. "The overwhelming majority of trachomatous patients in the United States were not even immigrants, but Native Americans in the Southwest and poor rural whites living in what was known as the "trachoma belt," extending through Virginia, Kentucky, Tennessee, Missouri, Arkansas, Alabama, and Oklahoma."[4] It was also a common cause of blindness among the Appalachians, a social group that USPHS trachoma specialist Dr. John McMullan distinguished the "new immigrants" as "the good and honest Anglo-Saxon people of the mountains.

With its conceptual intricacies, the connection between vision and migration policies is evident in discussions similar to those presented by Alphonzo Chaurize. He was born in Iraq at the start of the twentieth century and later worked as an officer in the Immigration and Naturalization Service. In an interview with the Ellis Island Foundation's oral history project, Chaurize emphasizes that his surname means "destroyer of darkness": "We want to uncover anything which is hidden and put it into public in the right way. There is no crook, idea, there is no confusion idea, there is no hidden work; everything should be into *chaurize*[5], knocker of darkness and bring it to light, and I think this kind of mentality was

3 Anat Mooreville, "Oculists in the Orient: A History of Trachoma, Zionism, and Global Health, 1882-1973," (Dissertation, eScholarship, University of California, 2015), 26.

4 Ibid, 30.

5 Alphonse Chaurize states in his interview that "chaurize", which he uses as a verb, is a Persian word. It comes from Chev, which means darkness or night, and rize comes from richeton in Persian. "It means the destroyer of darkness".

brought up not only in me but in all our family, but especially I who went to Europe and have my final education. (...) Oh, I could say more. Well, the immigrants are nice people. They are just fresh land. They are like tender clay. They come to this country attracted by what they heard, attracted by their own son and children to gather together. The family will be united. That is very true. But they are tender clay. They have all eyes open on America."[6] The emphasis on the ocular-centric perspective in Chaurize's mission and expectations at Ellis Island does not exist in isolation; rather, it tangibly intersects with the deportation policies implemented at Ellis Island, contributing to the construction of a narrative surrounding trachoma.

Although not as dedicated as Chaurize, for other Ellis Island officials, who moved with great speed and often made split-second decisions in directing this flow of people, it involved many conflicting practices, both for medical examinations and diagnosis and treatment. These contradictions can be seen in officials' attitudes towards migrants and how resident illness narratives influence the examination process. Despite complaints from immigration officials about perceived leniency in doctor decisions, the examination outcomes sometimes continued to favor migrants, highlighting the complexity and ambiguity inherent in the practices at Ellis Island. Gertrude Slaughter, one of the first woman physicians to serve at Ellis Island, observed: "I approached my task with considerable misgiving, feeling that I had become part of the crushing mechanism. I soon learned, however, that although I was one of the watchdogs at the gate, I was expected to show as much kindness and consideration as possible."[7] As well as doctors and interpreters, one of the most important links between doctors and migrants, also intervened on behalf of migrants. A number of them had come through Ellis Island themselves. One

6 Alphonse Chaurize interview by Margo Nash. 21 April 1975. NPS-94. Oral History Project, Ellis Island Foundation Archives.

7 Lorie Conway, *Forgotten Ellis Island: The Extraordinary Story of America's Immigrant Hospital* (New York: Smithsonian Books : Collins, 2007), 58.

interpreter named Edward Ferro wrote that some of the "softhearted" interpreters "hated to see people being deported." They sometimes reworded the immigrants' answers in a way "to benefit the [person] and not the government."[8]

"It was harrowing to see families separated because the precaution had not been taken [examining them in their home country]. Sometimes, if it was a young child who suffered from trachoma, one of the parents had to return to the native country with the rejected member of the family. When they learned their fate, they were stunned. They had never felt ill. They had never heard the word trachoma. They could see all right, and they had no homes to return to. I suffered because I was so powerless to help these poor people." In his memoir about working on Ellis Island, Dr.Victor Heiser wrote, "Ours would be the painful duty of singling out one of the children, and of saying, 'She has trachoma. She cannot enter.' The mother and the rest of the children would have to return to Europe with the diseased one, and until the boat sailed, the father, wretched and unhappy, would haunt the detention quarters while his family kept up a constant wailing and crying."[9] Expressing a comparable empathy, Josephine Friendman Lutomski, who worked as a ward maid between 1922 and 1923, said she almost cried when she saw the difficulty in finding the veins of the very nice but “very black people” who came to Ellis Island: “But they had glaucoma. They had eye disease. And they were kept separately. We had a special room for them. And I would have to take them down for blood tests, I remember I went down one day and this doctor down there was trying so hard to find their veins and he was having such a problem because she could not find their veins to get the blood out and it was real.”[10]

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8 Patricia Brennan Demuth, *What Was Ellis Island?* (New York, NY: Grosset & Dunlap an imprint of Penguin Group (USA) LLC, 2014), 53.

9 Lorie Conway, *Forgotten Ellis Island: The Extraordinary Story of America’s Immigrant Hospital* (New York: Smithsonian Books : Collins, 2007), 60-72.

10 Edward Applebome, Interview with Josephine Friedman Lutomski, other, *The Statue of Liberty—Ellis Island Foundation, Inc*, n.d., accessed 2024.

In an interview with Robert L. Leslie, who served as a Public Health Service doctor between 1912 and 1914, he recalled that the number of people turned away during examinations was small. "We turned away people with disabilities we couldn't help."[11] Primarily those related to speech, hearing, and sight. Further, In 1914, Syrian-born Sarah Baz, who traveled through Jamaica at the age of four, remembers her father and sister being sent back to Jamaica from Ellis Island after her sister was diagnosed with trachoma. The doctor who examined her sister in Jamaica referred them to Haiti. The doctor in Haiti tells Mr. Baz, "I am black but my hands are white, I will try and help her."[12] In this way, his sister and father, whose trachoma was cured, were able to come back to Ellis Island and pass the examination. Numerous instances can be cited where Ellis Island officials oscillated between this hierarchy of sensations, diseases, pities, and indulgences, as in the testimony of the doctor who treated Sarah Baz's sister, unveiling the racial categorization to which the officials were also subjected.

Undoubtedly, the late 19th and early 20th centuries marked a period in which these dynamics unfolded concurrently with significant immigration stories to the United States from various parts of the world. During this period, there was a greater focus on the prevalence of trachoma, and it began to be seen as a harmful and vicious disease rather than a humanitarian health condition. The acceptance or rejection of migrants believed to have or be infected with the shifting demands for trade and labor predominantly determined trachoma. The passage across the ocean via Beirut and Marseille, the most prevalent path taken by those from the East to reach New York, was undoubtedly one of the most infamous. Hence, a biased disease narrative took shape, associating trachoma with individuals from specific regions and those traversing particular migratory routes.

11 Robert L. Leslie interview by Dana Gumb. 14 August 1986. AKRF-17. Oral History Project, Ellis Island Foundation Archives.

12 Sarah (Souria) Baz interview by Paul E Sigrist. 27 April 1995. EI-603. Oral History Project, Ellis Island Foundation Archives.

§ 4.1 Regulating Immigration Law

After the 1848 American Civil War, business elements hungry for labor power developed a growing appetite for overseas sources of labor, in part to combat strikes staged by burgeoning trade unions.[13] Numerous businesses used recent immigrants to break strikes, angering native-born employees and inciting xenophobic militancy. As depression reappeared and intensified in the early 1890s, high unemployment rate became more dangerous to the social order than it was serviceable for lowering wages. Organized labor, which had previously opposed only contract laborers, began to perceive all newcomers as threatening competitors for scarce jobs. Workers were encouraged to channel hostility against immigrants in protecting their jobs instead of challenging big business. Labor groups worried that advances in workplace legislation, such as moving towards an eight-hour day, would be jeopardized by the millions of newcomers quickly channeled into substandard jobs.[14] Public health was not the only thing on Commissioner Powderly's mind. "In the 1890s, as head of the powerful Knights of Labor, he had railed against the large numbers of immigrants coming into the country, telling a congressional committee that they "lived like beasts" and were taking jobs that belonged to Americans."[15]

Employers often hired recent immigrants as strikebreakers, angering native-born workers. Francesco Nitti, a Southern Italian economist and later the prime minister of Italy, suggested that emigration served as a "powerful safety valve against class hatreds." This situation progressed with the legal construction of racial and national distinctions and found

13 John Torpey, *The Invention of the Passport: Surveillance, Citizenship and the State* (Cambridge, United Kingdom: Cambridge University Press, 2018), 96.

14 Anne-Emmanuelle Birn, "Six Seconds per Eyelid: The Medical Inspection of Immigrants at Ellis Island, 1892–1914," *Dynamis*, no. 17 (1997): 281-316.

15 Lorie Conway, *Forgotten Ellis Island: The Extraordinary Story of America's Immigrant Hospital* (New York: Smithsonian Books : Collins, 2007), 54.

expression in the Chinese exclusion laws, which were almost stereotypical for the whole world in curbing immigration flows. "The Chinese had previously been welcomed into the United States, and many were in the country legally; the new law made it critical that they establish that they had a right to remain in the United States or reenter if they left - conditions that could only be met by recourse to documents. In order to sort out the eligibles from the ineligible, the measure thus mandated an elaborate system of registration, certification, and identification."[16]

In addition to the laws that started to restrict the entry of the people from China to the U.S from the 1880s, the American Government expelled the convicts, lunatics, idiots, and persons likely to become public charges from the borders of the country with the law enacted in 1882. It took only a short time for this law to be accompanied by a medical inspection that could bring racial and cultural distinctions to a scientific level and enact them. In 1892, a medical examination began determining whether emigrants showed signs of severe or dangerous contagious diseases or mental disabilities. Beginning in 1907, when the medical exam became more strict, each immigrant was given a trachoma test.[17]

As the 1891 Act allowed, the steamship company that brought the immigrants to the United States was liable for a fine of $100 and was responsible for returning them to their port or frontier of origin when they were rejected, either upon arrival in the country or, for offenses committed within a year of arrival. However, employers frequently saved money by sending debarred migrants back to their last port of departure at closer British ports to avoid paying the entire expense of the journey back to Eastern and Central Europe. In 1913, Dr. John McMullan, who worked at the Locust Point Immigration Center in Baltimore from 1911 to 1913, pushed for a tight ban on the entry of trachoma: "Deportation is unquestionably a hardship, and so is isolation in smallpox, but who would say

16 John Torpey, *The Invention of the Passport: Surveillance, Citizenship and the State* (Cambridge, United Kingdom: Cambridge University Press, 2018), 97-104.

17 Anne-Emmanuelle Birn, "Six Seconds per Eyelid: The Medical Inspection of Immigrants at Ellis Island, 1892–1914," *Dynamis*, no. 17 (1997): 281-316.

that the latter should mingle with others because of the dread of the pest house? One had better have smallpox than severe trachoma. . . . [changes in the immigration laws] would mean the addition to our population of these thousands of trachomatous aliens whose emigration to this country is now prohibited.[18]

In the aftermath of the First World War, the influx of immigrants to Ellis Island experienced a significant decline between 1914 and 1918. However, following the conclusion of the war, there was a notable resurgence in the number of immigrants arriving. "The city health director has announced: "Patients from Ellis Island should never be allowed into the city limits. They are a source of infection from the moment they leave the island until they reach the foot of East Sixteenth Street."[19] Recommendations were made after joint congressional committee hearings to determine the goals of US immigration policy, with the stated intention of "not restricting immigration, but sifting it, separating the desirable from the undesirable immigrants, and permitting only those to land on our shores who have certain physical and moral qualities." In order to attain this goal, immigration restrictions started to focus on persons who would be a financial burden on the Government and those thought "unassimilable" or otherwise unworthy of membership in the American civic body.

Not all newcomers were subject to the same level of scrutiny. First and second class passengers received special shipboard inspections claimed to be identical to the line by immigration officials PHS inspectors ferried to the mouth of the harbor and climbed aboard the steamers via rope ladders. "As each ship made its way up the bay, the officers examined high-paying cabin passengers, yet believed that diseased persons are not usually found in the first [class] cabin of the better lines."[20] Individuals

18 Howard Markel, "'The Eyes Have It': Trachoma, the Perception of Disease, the United States Public Health Service, and the American Jewish Immigration Experience, 1897-1924," *Bulletin of the History of Medicine* 74 , no. 3 (September 2000): 525-60.

19 Lorie Conway, *Forgotten Ellis Island: The Extraordinary Story of America's Immigrant Hospital* (New York: Smithsonian Books : Collins, 2007), 40.

20 Anne-Emmanuelle Birn, "Six Seconds per Eyelid: The Medical Inspection of Immigrants at Ellis Island, 1892–1914," *Dynamis*, no. 17 (1997): 281-316.

with conspicuous diseases such as trachoma were advised to travel first class if they could afford it. This recommendation stemmed from the consideration that the medical examination conducted by stewards overseeing the cabins was comparatively milder for passengers in first-class accommodations. More extensive medical examination was reserved for poorer passengers who traveled in wagons and were expected to work in the factory.

The vague narrative surrounding migrants at Ellis Island unfolded within the context of influential connections playing a crucial role in circumventing mandatory medical examinations. Those lacking such affiliations and facing rejections could turn to the judicial pathway for reconsideration, albeit this avenue remained largely inaccessible to recent arrivals. Their precarious position, coupled with limited negotiating power and the inherent complexities of legal processes, underscored the challenges they confronted. Simultaneously, migrants faced a paradoxical situation—criticized for allegedly flooding the labor market, while the scrutiny on eye diseases and the associated ambiguity provided authorities with a functional basis for deportations. Beyond medical inspection and "the legal system, there are many other social practices in which the state takes on this form of the program, as a structure set apart from what is programmed: codes, regulations, policies, targets, plans, statistics, and all the ubiquitous new forms of official expertise."[21] Recommendations arising from congressional hearings aimed to delineate the goals of U.S. immigration policy, emphasizing a balance between facilitating immigration and implementing discerning measures.

When Viktor Ritz, a 23-year-old Russian citizen who arrived from Palestine in 1923, underwent his first general medical examination at Ellis Island, he observed that the process was short. However, it was when immigration officials meticulously examined his eyes that Ritz characterized this eye examination as undeniably "real." "They examine you thoroughly, you know, you know," he reflects, encapsulating the profound and

21 Timothy Mitchell, *The Effect of the State*, 1989, https://blogs.cuit.columbia.edu/tm2421/files/2018/01/Mitchell-Effect-of-the-State-1989-1.pdf.

comprehensive nature of the ocular assessment.[22] In a parallel vein, Emma Babaian's recollection of her medical examination at Ellis Island, following her arrival on the Acropolis ship from Yenikapı, Istanbul, bears distinctive imprints in her memory. She recounts an exchange during the examination, with an official noting, "Oh, you're coming from the East? Your eyes."[23] This interaction underscores the meticulous scrutiny of ocular health, a precautionary measure rooted in historical concerns about an eye disease prevalent in the Middle East. Babaian reflects on the absence of complications, speculating that perhaps the expeditious nature of their processing was attributable to the absence of such health issues. This narrative aligns with the overarching theme of the scrutinized medical assessments conducted at Ellis Island, wherein the scrutiny of specific health conditions, in this case, ocular well-being, played a crucial role in the immigration proceedings.

Eye examinations leave a lasting impression on migrants, not only due to medical reasons but also because of their symbolic, cultural, and historical significance. By far the worst part of the medical examination for migrants was the trachoma test, because it was both the most notorious part of the medical examination and a means of identifying one of the most likely medical reasons for sending migrants home. The button hook was a small curved tool used for buttoning women's shoes. But doctors at Ellis Island used it to turn them inside out when searching for diseased tissue on the eyelids. "One recalled. [The] inspector has acquired an amazing speed and accuracy. He stands directly in the path of the approaching immigrant, holding a little stick in his hand. By a quick movement and the force of his own compelling gaze, he catches the eyes of his subject and holds them. You will see the immigrant stop short, lift his head with a quick jerk, and open his eyes very wide. The inspector reaches with a swift movement, catches the eyelash with his thumb and

22 Nancy Dallett, Interview with Viktor Ritz, other, *The Statue of Liberty—Ellis Island Foundation, Inc*, n.d., accessed 2024.

23 Emma Babaian interview by Grace Oflazian. 16 April 1993. EI-279. Oral History Project, Ellis Island Foundation Archives.

finger, turns it back, and peers under it."[24] A significant number of Ellis Island guests were undergoing their first eye examinations by experts for the first time in their lives, an experience often characterized by confusion and fear. If any evidence of the eye disease was detected, the migrants were marked with chalk.

Perhaps the most intriguing critic of the examinations conducted at Ellis Island was President Theodore Roosevelt. Long sensitive to the needs and, more acutely, the political clout of immigrants who became naturalized citizens, Roosevelt visited Ellis Island several times during his presidency. In 1906, he worriedly wrote his secretary of Labor and Commerce, Victor H. Metcalf, about the poor sterile technique employed by the Ellis Island physicians: "I would like a report from Ellis Island as to some scheme for improving the examination of the eyes of immigrants to discover whether they have trachoma. When I was at Ellis Island myself I was struck by the way in which the doctors made the examinations with dirty hands and with no pretense to clean their instruments, so that it would seem to me that these examinations as conducted would themselves be a fruitful source of carrying infection from diseased to healthy people."[25]

Following the confirmation of trachoma infection during subsequent examinations, afflicted migrants were subjected to mandatory quarantine in medical facilities, enduring distressing treatments primarily involving silver nitrate, blue stones, and cauterization. The treatment duration varied significantly, ranging from a few days to an intensive twenty-month regimen. Achieving a cure required the deliberate destruction of living tissue housing trachoma bacilli through painful procedures such as

24 Henry Arthur, "Among the Immigrants," *Scribner's Magazine*, 1901.

25 Howard Markel, "'The Eyes Have It': Trachoma, the Perception of Disease, the United States Public Health Service, and the American Jewish Immigration Experience, 1897-1924," *Bulletin of the History of Medicine* 74 , no. 3 (September 2000): 525-60.

periodic scraping with an abrasive stone and the application of a corrosive liquid to scar the underside of the eyelid.[26]

In 1922, Mary Belemjian and her family, upon their arrival at Ellis Island when she was 15 years old, experienced a four-day detainment, ostensibly due to concerns regarding her father's eye disease. Mary recalls the disquieting atmosphere, despite the ostensibly favorable conditions, as they anxiously awaited the outcome of her father's examination.[27] The eventual revelation that her father's eyesight was unimpaired alleviated their apprehension.

A year before Belemciyan, Samuel Frank arrived at Ellis Island. His journey to America was affected by the ups and downs of his trachoma infection, which had changed during his travels in Egypt and Trinidad.[28] However, when he started his new life in the United States, five or six eye doctors at a top New York hospital found something surprising. They were amazed that Frank had passed the examination at Ellis Island because he still had trachoma in his eyes.

James J. Arraj recounts that when he arrived at Ellis Island from Lebanon in 1920 at the age of eight, his eldest brother was detained for three days after it was discovered that there was "something wrong with his eye". He does not recall undergoing an eye examination, adding that he remembers having difficulty understanding what was going on owing to the language barrier, even with an interpreter who spoke Arabic. "Did they find out what was in your brother's eye?" he laughs when asked by the interviewer. "No, no, they just said, as a matter of fact, he does not have to wear glasses even today (he laughs) so whatever it was, he outgrew, had no problem with his eyes, never wore glasses."[29]

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26 Lorie Conway, *Forgotten Ellis Island: The Extraordinary Story of America's Immigrant Hospital* (New York: Smithsonian Books : Collins, 2007), 94.

27 Mary Belemjian interview by Paul E Sigrist. 12 July, 1994. EI-500. Oral History Project, Ellis Island Foundation Archives.

28 Samuel Frank interview by Nancy Dallett. 5 February 1986. AKRF-134. Oral History Project, Ellis Island Foundation Archives.

29 James J. Arraj interview by Dana Gumb. 28 May 1986. AKRF-164. Oral History Project, Ellis Island Foundation Archives.

Like Frank Samuel's story, Hagop Nersesian, whose trachoma had a fluctuating course, was born in Turkish Armenia before entering the island in 1922. Before starting his transatlantic voyage from Aleppo, Syria, he was found to be infected with the disease and underwent an operation on his eye. The person who performed the operation was not a real surgeon, so Nersesian believed he had not fully recovered. He first came to France. In France, he had his eye examined by a doctor who told him that he could be treated and that it would take three to four weeks. Despite the second treatment, his eye did not improve, and by the time he arrived at Ellis Island, it was a good enough reason for deportation. When Nersesian learned he would be deported, he called his uncle, who had already been to the United States. Through bribery and the intervention of a congressman, his uncle convinced the authorities that his nephew should be treated in a hospital. Nersesian found himself outside Ellis Island in a mixed ward of 18-20 people, old and young, mainly Chinese. No one was trying to treat his eyes, and it was not a hospital. After being there for about three weeks he wrote to his uncle "they are going to deport me again, please tell Mary (Nersesian's aunt)". Mary wrote a letter to her doctor, and Nersesian forwarded it to him.

"Doctor," I said, "Please, this is for you." He opened up and read it, and that was the end. He would look at me and said, "I want to see your eyes." So he looked at me and called out the nurse, male nurse. There is no female nurse down there, male nurse. He said, "I want you to prepare this boy," he says, "and until tomorrow I come in certain hours, I want to look at his eyes." So he took hot water with some cotton. He closed my eyes. Oh, about a half an hour like that. All of a sudden the doctor come in, look at me. He says, "You got troublesome eyes." I didn't say anything. "Doctor," I says, "they operated on me twice, but there was some trachoma in there." He says, "Don't worry," you know. The next morning he come in, my eyes he puts some kind of medicine. I don't know if , but he put my

eyes and oh, it hurts, it hurts. So I was almost crying, you know. About three months every other day he was looking at me, every other day."[30]

These cases provide examples that illustrate the inherent variability and subjectivity in the assessment process, where medical conditions, exemplified by trachoma, may avoid comprehensive identification or nuanced interpretation, may be associated with capitals that migrants do and do not possess, and may consequently lead to entirely different outcomes for migrants. The post-First World War era witnessed a heightened exacerbation of this circumstance, marked by articulating distinct inequalities.

§ 4.2 Implementation of Immigration Quotas

The biggest change in Ellis Island procedures following the end of the First World War was the introduction of quotas. 29th U.S. President Warren G. Harding signed a law imposing a quota on the number of immigrants a country could send to the United States in a year, limited to 3 percent of its citizens already living there. The Temporary Quota Act, which passed overwhelmingly in the House of Representatives and the Senate, was widely praised. The implementation of quotas facilitated the immigration process for individuals from nations like the UK, Sweden, and Germany, whereas it posed substantial challenges for those originating from countries such as the Ottoman Empire, Italy, and Poland. Asians and Africans were effectively prevented from entering. In a speech at the Statue of Liberty that same year, 30th U.S. President Calvin Coolidge said, without irony: "Those who do not wish to share in the American spirit should not settle in America.[31] Both the deportation rates for those from "non-white" places and the fear experienced by migrants have become more overwhelming. The gravity of the situation escalated notably in

30 Hagop Nersesian interview by Francy Bockoven, 3 July 1978, NPS-109. Oral History Project. Ellis Island Foundation Archives.

31 Lorie Conway, *Forgotten Ellis Island: The Extraordinary Story of America's Immigrant Hospital* (New York: Smithsonian Books : Collins, 2007), 186.

Marseille, a pivotal hub for migrants traversing the route to and from New York.

Aelyas Kasab, born in Damascus, says he was scared to death in Marseille ten years before the war started: "Because we saw lots and lots of refugees, not refugees, of ah, people that want to come to New York, not refugees, like myself. (...) They had been returned from Ellis Island. That's the reason I'm telling you this. We were scared to death. Because there were three conditions that would prevent you from entering the United States. (...) If you had trachoma, no, never. If you don't have money, the United States didn't want you. And if you don't have anybody to look after you, you don't go in. No, you have no trachoma."[32]

In a correspondence dated 1906, Minister of Foreign Affairs of the Ottoman administration, Ahmed Tevfîk Paşa highlighted the imposition of limitations by American government officials on individuals with eye diseases, leading to the frequent rejection of immigrants from Anatolia. The prevalence of these eye diseases in Central Asia served as a basis for such dismissals. Consequently, prospective immigrants were advised to undergo specialized medical examinations before embarking on their journeys to Marseille. This recommendation held particular significance for Muslim and Armenian Ottoman citizens, who, in pursuit of American immigration, arrived in Marseille on ships from the Black Sea. While some of these migrants succeeded in their endeavors, others faced deportation due to contracting epidemic diseases or an insufficient financial capacity to continue their journey. As the number of immigrants surged, calls were made for proactive measures to address this burgeoning issue.[33]

A parallel emphasis on this matter is discernible in Marseille Consulate correspondences, which underscored the impediments faced by immigrants who could not continue their journeys by constitutional law. The circular issued by Minister of the Interior Hüseyin Hilmî Pasha fur-

32 Aelyas Kassab interview by Nancy Dallett, 27 November 1985. AKRF-89. Oral History Project, Ellis Island Foundation Archives.

33 BOA. DH.MKT. 2731.51, February 6, 1909.

ther expounded on the requirement for prospective American immigrants to undergo medical examinations by specialists to ensure compliance with health standards. Additionally, individuals were expected to amass sufficient financial resources for departure and return.[34] Another circular, issued in the same year, underscored the imperative for Ottoman citizens to familiarize themselves with immigration laws, emphasizing the importance of informing citizens about the treatment and legal requirements entailed in the American immigration process.[35]

Halim Pasha's correspondence responded to a petition inquiring about the predicament of twenty-seven individuals stranded in the Kharpert Hotel in Marseille. In advising their registration as crewmen and firefighters on ferries, or their economical relocation to Dersaâdet, Halim Pasha underscored the prerequisites for entering America, including freedom from contagious and ocular diseases, adequate financial resources, and a degree of linguistic proficiency. He underscored the vulnerability of those unfamiliar with these requirements to manipulation by migration agencies.[36] Moreover, the letter highlighted the adverse economic impact of the encouragement of emigration by these agencies, wherein citizens, driven into debt, experienced destitution upon their return, thereby negatively affecting the state treasury. This collective correspondence provides a comprehensive view of the multifaceted challenges faced by Ottoman citizens seeking immigration to America during this period.

The Ottoman authorities, operating along major migration routes, notably Marseille, proactively formulated numerous proposals to mitigate the repatriation of Ottoman citizens from the United States. They carefully monitored the practices adopted by other governments to determine their own strategies in this regard. Cognizant of the elevated deportation rates, immigrants actively sought alternative migration routes to circumvent stringent medical examinations. According to the *takrîr-i şifâhî* from the Dutch Embassy, it is emphasized that those who emigrated

34 BOA. DH.HMŞ. 27.3, February 6, 1909.

35 BOA. DH.EUM.KLU. 1.15, August 17, 1914.

36 BOA. HR.İD. 15.73, April 30, 1914.

to America, who were afflicted with eye diseases, were traveling via Curaçao in order not to be subjected to the quarantine in America and that there would be no difference in treatment between those who traveled from Curaçao and those who traveled directly from Europe in terms of the rules applicable to those who emigrated to America. It is stated that those who go to America via Curaçao will not only be subjected to medical examinations but also waste time and incur more expenses.[37]

The parallel discussions on immigration in the United States and the Ottoman Empire during the early 20th century underscore a shared concern for regulating entry into these nations. The Consul of Fiume, Noradunkyan Efendi's memorandum[38], emphasizing the stringent medical examination and financial prerequisites for Ottoman citizens intending to immigrate to America, mirrors the same sentiment expressed by the American Secretary of Labor. Both instances reveal a common objective: to establish comprehensive measures that govern immigration, ensuring the health and financial stability of prospective migrants.

The culmination of these debates materialized in the form of the 1924 law, representing a more stringent iteration of the 1921 legislation. This legislative shift significantly reduced immigration to the United States, effectively halving the influx of newcomers. While the 1921 law had initially endorsed a 3 percent quota for Congress, the subsequent 1924 measures took a more stringent stance. Congress opted for a new quota system, limiting each foreign national to 2 percent based on the 1890 Census. Additionally, an overall ceiling of 287,000 quota immigrants was established. Despite the demographic shifts recorded in the 1910 census and the substantial changes since the peak immigration year of 1907, when Ellis Island witnessed the highest number of arrivals, Congress opted to anchor the quota calculations on the 1890 census.[39] This legislative move marked a pivotal moment in shaping immigration policies, reflecting a

37 BOA. HR.İD. 15.74, June 30, 1914.

38 BOA. HR.İD. 15.53, September 28, 1919.

39 Lorie Conway, *Forgotten Ellis Island: The Extraordinary Story of America's Immigrant Hospital* (New York: Smithsonian Books : Collins, 2007).

deliberate effort to regulate and curtail the flow of immigrants to the United States.

As John Alabilikian, born in Yozgat, emphasized, his journey in 1922 meant that after that date, those coming from the East had to be accepted at the border: "We were the last ship to come to Ellis Island. After that, the quota started, and then they tightened up on immigration, and they passed laws for various reasons. But we were the last one to enter this country without too much trouble, without too much trouble."[40] The 1924 law introduced a significant alteration in the process of medical examinations for immigrants. Subsequent to the enactment of this legislation, immigrants were mandated to undergo medical examinations at consulates in their home countries rather than at Ellis Island. This shift marked a departure from the previous practice and decentralized the medical examination process. Consequently, inspectors at Ellis Island were tasked with verifying the documents of incoming immigrants rather than conducting the medical examinations themselves. This change in protocol represented an integral aspect of the broader immigration reforms encapsulated in the 1924 law, indicating a reconfiguration of the entry procedures for those seeking to immigrate to the United States.

Rooted in both international consensus and the dynamic evolution of medical practice mobilization, the 1924 law reflects a pivotal moment in shaping immigration policies. This legislative framework reflects an international acknowledgment of the need for more stringent immigration regulations, as witnessed in the global discussions and concerns regarding immigration during that period. The number of people deported also increased. "From 1910 to 1918, an average of 2,750 immigrants were deported each year. By 1921, over 4,500 immigrants were deported annually, and by 1930, that figure had skyrocketed to 16,631, as the nation's mood increasingly soured toward immigrants

Naomi Ouzounian's testimony, delineating the increasingly corrosive conditions experienced by migrants, encapsulates salient elements that

40 John Alabilikian interview by Nancy Dallett. 23 October 1985. AKRF-58. Oral History Project, Ellis Island Foundation Archives.

warrant scholarly examination. Ouzounian, coming from Ottoman territory, arrived at Ellis Island in 1922, having escaped the clutches of soldiers during her arrival at the concentration camp in Aleppo amid the 1915 deportations. Recounting her experiences in an interview, she revealed facing threats of deportation when authorities contested whether she possessed sufficient professional credentials to cross the border, a dispute intensified by the quota system in place. Pointing to a graffiti on Ellis Island, Ouzunian made it clear that the imposition of quotas added another layer of inequality for immigrants already grappling with the challenges of migrating to the United States, transforming their pursuit of a better life into a desperate struggle against poverty and, at times, life-threatening circumstances: "Ever since the end of the war, say 1919, for three years immigrants had crowded the Ellis Island in America, all the resources, and by then probably people I speak of, the people behind the desks and the people behind the halls, people in the shower rooms, they were saturated and they had become hard and unfeeling. There was an inscription on one wall. It said, "Why should I fear the fires of hell? I have been through Ellis Isle."[41] On the other hand, in 1922, Reverend Vartan Hartunian's arrival at Ellis Island from Marash faced the determining influence of the quota system, with his mother's profession playing a pivotal role. In contrast to Ouzounian's experience, Reverend Hartunian's mother, being a teacher, proved instrumental in securing their approval for passage. However, their journey encountered a new hurdle, as his parents' eye problems resulted in their failure to pass the medical examination, compelling them to stay on Ellis Island for a duration of two months.[42]

An illustrative instance exemplifying the interplay between quotas and professions involves health workers, James Melcon, born an Armenian in Harpoot in 1912, experienced significant changes when he and his family traversed Ellis Island in 1920. "Until 1920, the immigration regulations were very relaxed. Anyone could come in. The doors were wide

41 Naomi Ouzounian interview by Margo Nash. 18 June 1975. NPS-96. Oral History Project, Ellis Island Foundation Archives.

42 Reverend Vartan Hartunian interview by Debbie Dane. 3 February 1986. AKRF-166. Oral History Project, Ellis Island Foundation Archives.

open. After 1920 the immigration laws were getting stricter. And they were more or less against the Mediterranean people, dark-skinned people. The Irish, the Swedes, the English, could come wide open. But those of us from the Mediterranean area, there was strict quotas. So my father had just managed to be outside of that, but the reason we were able to come was that he was a pharmacist.[43] The regulations said a pharmacist, doctor, or dentist could bring their family outside the quota. Moreover, that period between 19, June 5th and the 26th changed that regulation.

§ 4.3 Conclusion

How eye examinations were conducted for the nearly 12 million immigrants from the Old World who landed on a small island in New York Harbor between 1892 and 1924 is an intriguing example of conflicting ideas in which medicine and law intertwined during the late nineteenth and early twentieth centuries. This is notably reflected in the exclusion of migrants based on trachoma despite its non-lethal and comparatively benign nature in the spectrum of global diseases during that period.

Consequently, the ambiguous definition of ophthalmia, especially in diagnosing trachoma, was skillfully exploited by Ellis Island authorities to guarantee the employment of physically capable individuals by employers and to facilitate the organization of deportations. This ambiguity was reflected in the way immigration law itself was shaped according to the needs of the new world, especially after the end of the First World War. "The creation of so many disabled bodies from the wars of the early twentieth century and the accident-rich layout of industrial capitalism in the West led to a shift in the ocular language of disability towards rehabilitation and to the removal of deficiencies in the body.36 To address this situation, authorities devised a compensatory strategy by introducing

43 James Melcon interview by Janet Levine. 6 July 1993. EI-344. Oral History Project, Ellis Island Foundation Archives.

immigration quotas, first in 1921 and subsequently reinforcing them in 1924 with a more stringent version of the law. At Ellis Island, this sequence of inequalities became crystallized, leading Harry Harootunian to reflect on how his family, were able to find their way to the United States, they encountered the unwelcome prospect of facing another challenge of survival."[44] Hence, the consequence for migrants traversing the Pacific to Ellis Island exacerbated their pre-existing inequalities.

44 Harry D. Harootunian, *The Unspoken as Heritage: The Armenian Genocide and Its Unaccounted Lives* (Durham: Duke University Press, 2019). 2.

5

Conclusion

Ay! A city to your village I come from the great world—where men have eyes and see.

– H.G. Wells, *The Country of the Blind*

In line with its aim, this thesis reveals how trachoma—a contagious, non-fatal, and preventable disease that can only lead to vision loss if untreated—became a subject of regulation on a global scale at the beginning of the twentieth century. The first part focuses primarily on famous ophthalmologists of the late Ottoman period who authored significant works on ophthalmology, adapted ocular instruments that greatly facilitated the diagnosis of eye diseases and refractive errors, and participated in mapping Turkey's geography based on trachoma by the health policies of the First (1925) and Second (1927) National Turkish Medical Congresses and the ruling elites of the early republic.

The proliferation of ocular apparatus, crucial in the diagnosis and treatment of eye diseases (emraz-ı ayniye) and refractive errors (galat-ı inkisar), led to a new definition of vision (rü'yet). This development is well-documented in the significant ophthalmological texts of the period. Main ocular apparatus such as the ophthalmoscope (çeşm-i bin) and scientific spectacles were critical in this redefinition. With these advancements, experts began discussing a new concept of visual acuity (penetrated nazar). This redefinition of vision directly influenced the narrative surrounding eye diseases. As Anat Mooreville's comprehensive study indicates, Israeli ophthalmologists' ability to operationalize bio-medical discourse contributed to framing trachoma as "the blinding scourge of the East '' in Palestine. Like Mooreville's research, this thesis, in mapping trachoma alongside poverty, illiteracy, and backwardness, marked trachoma-infected areas where vision was already neglected, attributing the lack of ophthalmological care to individual responsibility or inadequate infrastructure. On the other hand, this thesis draws on Alexandre White's concept of epidemic orientalism in the narrative formation of trachoma to emphasize the fictionality of the mapping of "East" and "West."

The thesis highlights, through medical books, journals, and professional congresses of the period, that sight was closely linked to the active participation of individuals in industrial labor. For instance, the literature of the time suggested that a person whose labor power was diminished was considered a "half" human being. "Imagine a laborer afflicted with this disease and falling behind in his work for a long time. Such an idle and infirm man is nothing but a real misfortune for himself and his family." This perspective established a cause-and-effect relationship between agricultural activity, labeled as "backwardness," and trachoma. Consequently, eye diseases were often associated with groups perceived as lazy, parasitic, and indifferent.

This viewpoint not only led to unfruitful debates, such as whether trachoma was more prevalent among laborers or farmers, as seen during the second Adana Cotton Congress, but also hindered the development of initiatives like establishing workers' own relief funds. This thesis aims to

demonstrate how these associations and debates shaped the medical and social responses to trachoma during this period.

In the second chapter of the thesis, two significant lines of international congresses, closely followed by the Ottoman authorities, are examined. The first line consists of the congresses on the "improvement of the condition of the blind," organized in Paris in 1900 and Brussels in 1902. Although participation in the 1905 congress in Liège was officially considered, it ultimately did not materialize. Official correspondence reveals that attendance was sometimes declined due to the absence of a formal invitation, while other times, decisions were based on evaluating the congress agenda.

The second line of congresses is the International Congress of Ophthalmology, which began in Brussels in 1857 and continues to hold meetings to this day. This thesis covers discussions from the first Congress to the thirteenth Congress held in Amsterdam in 1929. The 1929 congress holds symbolic significance as it led to the establishment of a separate international organization focused on trachoma. Delegates selected to participate in these congresses could be ophthalmologists or consular administrators where the Congress was held. International ophthalmological congresses were often organized with international exhibitions, which might explain why such assignments were made for practical reasons. This part of the thesis sheds light on the Ottoman Empire's engagement with international medical discourse and its impact on regulating eye diseases during that period.

Conversely, although the first line of congresses focused on disability policies and the second on direct medical motives, both lines still discussed similar themes. The Congress on improving the situation of blind people emphasized the need for a classification initiative that treated ocular pathologies and blind people, or those impoverished by their own defects, differently. It was argued that blind individuals and those with visual impairments could contribute to society by working for less or entering the professional world under the supervision of a sighted person.

At the International Congress of Ophthalmology, there was a natural emphasis on ocular apparatus and ophthalmological treatment methods.

However, confusion among specialists regarding the non-isolated cause of trachoma emerged, exemplified at the Paris Congresses of 1862 and 1867. The 1880 Milan Congress included discussing regulating vision and eye diseases among occupational groups like railway and navy workers. The 1904 Lucerne and 1909 Naples congresses addressed measuring visual acuity for recruitment, standardizing eye charts, and determining financial compensation for vision loss. The 1922 Washington Congress was significant for its discussions on trachoma treatment methods and the medical controls at Ellis Island amidst intense immigration to the United States.

The third chapter of this thesis problematizes the relatively low incidence of trachoma at Ellis Island compared to other potentially fatal diseases detected during migrant examinations, yet it was one of the most important reasons for rejecting immigrants. This chapter focuses on oral history narratives from immigrants of Ottoman origin, revealing that immigrants from the East were frequently presumed to have trachoma due to regulations in American immigration law, statements from the ruling elite, and directives from public health officials at Ellis Island.

After the 1920s, the implementation of immigration quotas increasingly required immigrants to demonstrate satisfactory financial status. Wealthier passengers, who traveled in first-class cabins, often faced less rigorous eye examinations. In contrast, other immigrants had to document their family connections (to prove they had support if needed) or present evidence of their connection with a specific labor market.

Narratives from migrants indicate a range of experiences: some were infected with trachoma, some had recovered from it, some were suspected of having it, and some were falsely accused of having it—only to learn years later that they were never infected. These diverse accounts include stories of deportation and intensive treatment sessions at the Ellis Island complex. The chapter argues that the fictional mapping of poor eyesight and the assumed prevalence of eye diseases among Eastern immigrants significantly contributed to the dramatic increase in deporta-

tions at Ellis Island. These practices exemplify how trachoma was instrumentalized in the evaluations, reinforcing prejudiced perceptions and policies.

This thesis, conveyed through three interconnected thematic axes, underscores the unity of trachoma and vision regulation within late Ottoman and early Republican governmental techniques. This coherence necessitates examining these regulatory methods on a global scale, mainly through the discussions in international congresses highlighted in the second chapter. The thesis also emphasizes the significance of professional categorizations in shaping sensory experiences, as evidenced by the deliberations at international congresses. This perspective illustrates the effectiveness of treating the history of the senses as a legitimate object of scholarly inquiry.

The first chapters illustrate how the intertwined regulations on trachoma and the sense of sight were instrumentalized. The final chapter focuses on the intersections of medical regulations, sensory categorization, and migration. Hence, this thesis offers new insights into the possibility of investigating medicine not through fictional geographies but through changing understandings of sensory perception.

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