Table of Contents

A Personal Note

My reading of the literature of Jewish history and law served as the seedbed for the hypothesis of this work. Two important factors served to motivate the writing of this book: completion of the Lindex project, a National Library of Medicine-supported, Internet-based review of the disease experience of American Jews from 1874 until 1903, and the rising number of large-scale quality prospective studies pointing to the positive economic value of good health. The time was propitious several years ago to begin assembling this volume.

It is quite possible that some of my readers may misinterpret this work as an exercise in ethnocentrism. There is, indeed, a joy I take in the accomplishments of my co-ethnics, coupled with a sense of sadness upon learning of their misdeeds. Nevertheless, as a member of the social science academic community, it is incumbent, once a topic is chosen, to assemble and offer the facts with as much impartiality as possible.

Jacob Jay Lindenthal, PhD, Dr PH

Foreword

The late American Jewish journalist and humorist Harry Golden entitled one of his last books, published in 1970, *So Long As You're Healthy (Abee Gezundt)*. He knew that the Yiddish phrase, usually transliterated as *abi gezunt,* resonated with Jews and, for a time, with the larger American community beyond. On the Lower East Side of New York, he recalled, "if the livelihood was not so good, and even if the shopkeeper went bankrupt, his relatives and friends" would say, consolingly, *abi gezunt*, "so long as you're healthy."[1]

Back in 1938, Molly Picon's signature song in the Yiddish film *Mamele* ("Little Mama") did much to popularize the expression *abi gezunt*. The song's Depression-era message—"*abi gezunt ken men gliklekh zayn,*" (so long as you're healthy you can be happy)—offered a timely rebuke to those who linked happiness to the pursuit of power and money. What was truly important, the song insisted, was good health, the basis for everything else.[2]

A year later, Cab Calloway, the great African American jazz singer and band leader, likewise penned a song entitled "*Abi Gezunt*" ("If You've Got Your Health, You Can Be Happy"). Drawing upon his acquaintance with his Jewish manager, Irving Mills, and clearly influenced by the lyrics of Molly Picon's popular Yiddish song, he mischievously combined African American ("Hepster") slang with the funny-sounding Yiddish phrase , and crooned, "*I'm hip de dip, a*

1 Harry Golden, *So Long as You're Healthy (Abee Gezundt)* (New York: G. P. Putnam's Sons, 1970), 19–20; see Kimberly Marlowe Hartnett, *Carolina Israelite: How Harry Golden Made Us Care About Jews, the South, and Civil Rights* (Chapel Hill: University of North Carolina Press, 2015), esp. 257.

2 Neil Levin, "Abi Gezunt," *The Milken Archive of Jewish Music,* accessed January 24, 2016, http://www.milkenarchive.org/works/view/547#/works/view/547/full. Molly Picon wrote the lyrics; Abraham Ellstein composed the music.

solid sender, a very close friend to Mrs. Bender, Bender, shmender, abi gezunt, *I'm the cat that's in the know!*" As Hankus Netsky has observed, Calloway "knew one of the sweetest secrets of life: that a 'cat' that knows the meaning of *Abi Gezunt* is a cat that's in the know."[3]

Dr. Jacob Jay Lindenthal has spent a lifetime exploring this same secret of life. As an accomplished sociologist and highly respected health educator, Dr. Lindenthal has dedicated a lifetime to exploring social relationships. Indeed, he has personally worked to restore countless people to health and happiness, and he has trained legions of medical students to do the same.

His interest in *abi gezunt*, however, goes far beyond his own medical practice. In this book, he seeks to understand how health shaped the destiny of the American Jewish community as a whole. American Jews' rapid socioeconomic rise, he argues, is connected to their abiding concern with health. Knowledge of risk and protective factors—some mandated by Jewish law, others learned from books, still others passed down mimetically from parents to children—resulted in healthful behaviors. In particular, the high value that Jews placed upon "health, education, cohesive family life and communal social support," he shows, "played a particularly important role in helping immunize the Jews against . . . the deterioration of their health status." Better health, in turn, led to the formation of capital and ultimately to the community's overall socioeconomic rise.

Dr. Lindenthal's study rests upon a mountain of medical evidence, much of it buried in obscure medical journals rarely consulted by historians. The footnotes and bibliography alone open up a world of long-forgotten articles detailing diverse aspects of immigrant Jewish health. Invaluable data are also found in the appendices. Nobody, to my knowledge, knows this medical literature better than Dr. Lindenthal.[4] Fortunately, he has now created a database and index to this literature—what he calls *The Lindex*, the "first ethnic database of disease"—so that others may follow in his tracks and build upon his extraordinary contribution. Hundreds of studies relating to the diseases and

3 His rendition of the song, translated as "A Bee Gezindt," can be viewed on https://www.youtube.com/watch?v=_-ca4HbD7hY; see Hankus Netsky, "Cab Calloway: On the Yiddish Side of the Street," JBooks.com, accessed January 24, 2016, http://www.jbooks.com/secularculture/Netsky.htm#.

4 For an important earlier survey, see Deborah Dwork, "Health Conditions of Immigrant Jews on the Lower East Side of New York: 1800–1914," *Medical History* 25 (1981): 1–40.

health conditions of Jews (1874-2000) are found in *The Lindex*. Historians of medicine will forever be grateful for his assiduous collection of this primary material.

The question that lies at the heart of this book—how American Jews rose from rags to riches—has long captivated scholars and policy-makers alike. Some, influenced by Max Weber's *The Protestant Ethic and the Spirit of Capitalism*,[5] point to Jewish values and culture, particularly the Jewish proclivity for education, as the engine of their success.[6] Others credit America, observing that Jews did not enjoy the same rapid rise in less hospitable countries. Still others point to freedom and free-market capitalism, which Jews were able to exploit more than some of their peers. Luck, timing, history, even Jews' sexual habits have likewise been adduced to explain their rise. Nor has the last word on this subject likely been written.[7]

Thanks to this book, historians will henceforward also need to consider the vital importance of health in explaining American Jewish success. Knowledge about health, healthy behaviors ("protective factors"), and the avoidance of unhealthy, risky habits and ways have, readers will see, prolonged Jewish lives and increased Jewish wealth.

Abi gezunt encapsulates one of the sweetest secrets of American Jewish life.

Jonathan D. Sarna
Joseph H. & Belle R. Braun Professor of American Jewish History
Brandeis University

---

5 Max Weber, *The Protestant Ethic and the Spirit of Capitalism,* trans. Talcott Parsons (New York: Routledge, 2001 [orig. 1903]).

6 For a recent controversial discussion of "How Education Shaped Jewish History," see Maristella Botticini and Zvi Eckstein, *The Chosen Few* (Princeton: Princeton University Press, 2012), and the critique by Shaul Stampfer in *Jewish History* 29 (December 2015): 373–379.

7 See Nathan Glazer's pioneering discussion in "Social Characteristics of American Jews, 1654–1954," *American Jewish Year Book* 56 (1955): 3–41. Recent discussions may be found in Jerry Z. Muller, *Capitalism and the Jews* (Princeton: Princeton University Press, 2010); Rebecca Kobrin (ed.), *Chosen Capital: The Jewish Encounter with American Capitalism* (New Brunswick: Rutgers, 2012); Adam D. Mendelsohn, *The Rag Race: How Jews Sewed Their Way to Success in America and the British Empire* (New York: New York University Press, 2015); and Rebecca Kobrin and Adam Teller, eds., *Purchasing Power: The Economics of Modern Jewish History* (Philadelphia: University of Pennsylvania, 2015).

Preface

A review of American Jewish history reveals two salient facts. The first is that great attention has been paid to the rapid socioeconomic rise of the Jews in America. Some have attributed this rise to a variety of factors, principally the Jews' drive toward education and literacy, the comparatively skilled nature of their occupations upon arrival, and their relatively small family size. The second is that health and disease among the Jewish immigrants—although rarely touched upon in scholarly works—are often treated from the viewpoint of Jewish contributions to the development of the hospital system in America.[1]

Lacking, however, is a comprehensive review of the health of the immigrants themselves. This is strange when we consider the high value placed on health brought to these shores by succeeding waves of immigrants and the very many ways it has been manifested. Two well-thumbed studies[2] deserve our

1 See also Alan M. Kraut and Deborah A. Kraut, *Covenant of Care: Newark Beth Israel and the Jewish Hospital in America* (New Brunswick: Rutgers University Press, 2007); Mary Ann Fitzharris and Jeanne E. Abrams, *A Place to Heal: The History of National Jewish Medical and Research Center; Global Leader in Lung, Allergic and Immune Diseases* (Denver: National Jewish Medical and Research Center, 1997); Dorothy Levenson, *Montefiore: The Hospital As Social Instrument, 1884–1984* (New York: Farrar, Straus & Giroux, 1984); Arthur H. Aufses, Jr. and Barbara J. Niss, *This House of Noble Deeds: The Mount Sinai Hospital, 1852–2002* (New York: New York University Press, 2002). Others have contributed to our understanding of cultural differences in childhood healthcare among Italians and Jews, including Alice Goldstein Susan Cotts Watkins, and Ann Rosen Spector, "Childhood Health-care Practices Among Italians and Jews in the United States, 1910–1940," Health Transition Review 40 (1994): 45–61.

2 One by Alan M. Kraut, *Silent Travelers: Germs, Genes and the "Immigrant Menace"* (New York: Basic Books, 1994), and the other by Howard Markel, *Quarantine! East European Jewish Immigrants and the New York City Epidemics of 1892* (Baltimore: Johns Hopkins University Press, 1997).

attention for their observations on the role of infectious diseases as being largely responsible for inflaming anti-immigrant sentiment. Fifty years before the migrations of Eastern Europeans, the American East Coast groaned under the weight of poor Irish immigrants, bringing with them cholera. There was no question that the disease posed a serious threat: ". . . it raised long-term questions about the origin of disease, the adequacy of public health institutions to protect urban populations being suddenly and rapidly swelled by the foreign-born, and immigrants' need for healthcare institutions tailored to their unique cultural perspectives."[3] American Protestants blamed the hierarchy of the Roman Catholic Church for fostering poverty, oppression, and misgovernment, all conducing to the disease. Bias against the Irish immigrants was reflected in officially sanctioned inflated rates of illness and hospitalization, while acknowledging that these immigrants might have been more susceptible to illness than others. Alan Kraut notes that the Catholic Church met the stigmatization of the Irish with an institutional response: the Catholic hospital not only saved souls from the Protestant menace, but also greatly expanded the availability of medical care and resources to impoverished urban masses.

In *Quarantine*, Howard Markel crystallized the perspectives of the historian, the clinician, the epidemiologist, and the sociologist of two epidemics—typhus and cholera—in New York City in 1892: "Public health, after all, begins with the public, and issues that concern large numbers of people's health become political almost by definition."[4] Those opposed to immigration knew that linking a deadly illness to an undesirable group of peoples and quarantining them would further flame anti-immigration sentiments. "It was . . . a period marked by bouts of economic depression and the closing of the western frontier. It was also a period of social upheaval in the form of urbanization, industrialization, rapid transportation, and labor unrest. For many Americans, the personification of all these social evils was the foreign, impoverished, and unkempt immigrant from Russia, Italy, Austria-Hungary, and other European nations. . . . Widespread nativistic and hostile sentiments that cut across lines of class and geographic location were expressed by both

3 Kraut, *Silent Travelers,* 31.

4 Howard Markel, *Quarantine! East European Jewish Immigrants and the New York City Epidemics of 1892* (Baltimore: Johns Hopkins University Press, 1997), 104.

native-born and well-assimilated foreign-born Americans."[5] Markel demonstrated how class and national origin played a significantly larger role than did bacteriology in determining how the brief cholera epidemic was managed. The Jewish immigrant himself posed a minimal risk of carrying diseases from Europe. Disease was more a function of the conditions on the vessels that carried the Jews to America and served as an infectious substrate.

Cultural factors have surely played a role in shaping the health experiences of the American Jew, particularly from the time of the great migration beginning in the 1880s through the post-World War II era. The Berkman-Glass paradigm describes how the social environment influences health, beginning with broad sociostructural conditions, such as cultural norms, values, social cohesion, and socioeconomic status, which molds social networks having a direct bearing on psychosocial mechanisms.[6] These mechanisms have a direct effect on individual health pathways. L. F. Berkman and T. Glass further offered that the key to health is found in cultural factors that serve as the foundation for developing and maintaining social networks. Their theory supports what the author sought to demonstrate in this book: that the Jews enjoyed relatively good health owing in part to a strong social network.

We further suggest a relationship between economic success and the relative health of the American Jew from the late nineteenth century through the outbreak of the Second World War—the period that set the stage for the economic rise of the American Jew. Those looking for direct causal links will be disappointed until such time as scholars design controlled, prospective studies of Jewish and non-Jewish immigrants, where both initial health and socioeconomic status can be thoroughly assessed. The best we can do at this time is to provide a conjectural analysis drawn from American Jewish history and studies that point to a relationship between health and the formation of capital.

With an eye to the above, we trolled for trends in Jewish history, stopping to examine some of these factors in varying degrees of detail. This examination began more than 20 years ago in an effort that led to the development of the *The Lindex*, the second volume of this set and the first ethnic database of disease. *The Lindex* offers a comprehensive view of the health status of American Jews in

5 Markel, *Quarantine,* 3.

6 L. F. Berkman, T. Glass, I. Brissette, and T. E. Seeman, "From Social Integration to Health: Durkheim in the New Millennium," *Social Science & Medicine* 51 (2000): 843–857.

the medical literature from 1874 through 2000. Over a period of more than 30 years, we collected and reviewed studies dealing with diseases experienced by American and Canadian Jews (95 percent of whom are Ashkenazi, that is, of German or East European origin). As technology permitted, the information we amassed was entered into a searchable database with more than 2,400 entries and approximately 550 diseases/disorders related to American Jews between 1894 and 2003. Additional information on our motivation for developing *The Lindex*[7] is provided in the introduction to that volume. Suffice it to say that our work on *The Lindex* led to the development of this volume to support our understanding of how socioeconomic factors and education—that is, knowledge of risk and protective factors—resulted in healthful behaviors.

The Lindex was designed to collect and organize the literature involving the recorded experience of American Jews. Its purpose is to supplement standard search engines by focusing on one ethnic group residing in North America. It can therefore be considered the first ethnic database of disease. It makes no claim to covering the universe of data available, nor would we have the temerity of even suggesting that the Lindex comes close to including more than a significant sample of the data. Neither PubMed nor Medline, however, categorize articles by ethnicity. There is no comparable database for any ethnic group that covers this array of diseases in this detail over a 129-year period.

Data drawn from studies forming the basis for *The Lindex* are based on what is referred to as "risk-factor epidemiology," a perspective that focuses on individual behavioral and biologically based risks for disease. Limitations of this approach became apparent in the late twentieth century, when it became evident that this line of thinking could not explain the relationship between gradients in morbidity and mortality and socioeconomic status.[8] More consideration needed to be given to both multiple levels of causation and associations between populations and their respective health profiles.

Enter socioeconomic status, a very significant antecedent variable in the "social causes" model in the chain of causes of disease. Bruce Link and Jo Phelan

---

7 The grant number for "The Lindex Study: An Ethnic Database" is 1 G13 LM06902-01A1. Readers may access The Lindex at https://research.njms.rutgers.edu/m/lindex/.

8 P. M. Lantz, J. S. House, J. M. Lepkowski, et al., "Results from a Nationally Representative Prospective Study of U.S. Adults," *Journal of the American Medical Association* 279 (1998): 1703–1708; M. G. Marmot, G. Davey Smith, S. Stansfield, et al., "Health Inequalities Among British Civil Servants: The Whitehall II Study," *Lancet* 337 (1991): 1387–1393.

observed that the relationship between socioeconomic status and disease prevalence has been a constant at least over the last two centuries regardless of the specific disease pattern of a specific era.[9] In the words of the originators of this concept, ". . . the essential feature of fundamental social causes is that they involve access to resources that can be used to avoid risks or to minimize the consequences of disease once it occurs."[10] The importance of such resources is that they define individual health behaviors. Thus, knowledge about risk and protective factors ranks as the single most significant determinant of health.[11]

Jews have been variously described as a group defined by religious tenets and an ethnic group united by a system of values and associated behavioral patterns. Whichever definition is emphasized, there can be agreement that the Jews share an articulated set of values, beliefs, traditions, attitudes, and behavioral patterns, many of which bear on the management of health and disease.

A SPECIAL NOTE TO MY READERS

After years of trolling through the literature, it was becoming evident that the time was drawing near to share the evidence for the working hypothesis of a relationship between health and wealth among American Jews. Chapters in this brief volume should be considered points of departure and as seedbeds for future research and discussion. Students of American history, ethnicity, medical

9 Bruce G. Link and Jo C. Phelan, "Controlling Disease and Creating Disparities: A Fundamental Cause Perspective," *The Journals of Gerontology: Series B Psychological Sciences and Social Sciences* 60 (2005): 27–33; Bruce G. Link and Jo C. Phelan, "Social Conditions as Fundamental Causes of Disease," *Journal of Health and Social Behavior* 35 (1995): 80–94.

10 Link and Phelan, "Social Conditions," 87.

11 Historians and social scientists harbor their own unique perspectives when considering the sources and consequences of health. In arguing on behalf of the historical perspective, Stephen Kunitz stressed that: "Accurate prediction is unlikely to rest upon deductive science and more likely to result from stitching together all that one can know about the context—institutional, cultural, political, epidemiological—in which particular populations live and work. . . . When [social epidemiology] is successfully predicted, it is not likely to be because it is based upon deductions from scientifically valid generalizations that are true across time and place, but because analysts understand more or less intimately the people and places with which they are concerned, and because they can extrapolate sensibly from relevant experiences and groups elsewhere" (Stephen L. Kunitz, "Sex, Race and Social Role—History and the Social Determinants of Health," *International Journal of Epidemiology* 36 [2007]: 10). Readers should remain alert to the historical perspective and of the possibility that the strength of the relationships of some variables may vary in time and place.

sociology, and public health among other disciplines, may choose to devote more attention to specific chapters and some may understandably argue for a difference in their ordering leading to the suggested hypothesis of the economic value of health.

I elected to begin with an all too brief review of the *halakha*, a massive compendium of Jewish religious laws derived from the written and oral Torah involving rules and practices affecting every aspect of life and in this case, those dealing with the promotion of health and prevention of disease. I then examined the premium placed on specific values brought to these shores by late nineteenth-century Jewish immigrants, including education and literacy, as well as those involving social support, strong family ties, and the health-conducing behaviors of breast-feeding and child spacing.

The following three chapters discuss implications for the promotion of health by the low incidence of alcoholism followed by the management of risks associated with a poor housing environment and employment profile during the latter part of the nineteenth and early twentieth centuries. The journey continues with the suggested hypothesis, of an as-yet-to-be quantified contribution of a health culture to the social and economic rise of American Jews, and ends with some of the implications for the future for more recent immigrants to this country.

Acknowledgements

This manuscript includes the contribution of many individuals representing different intellectual disciplines. My first debt of gratitude is to those whom I would almost certainly fail to acknowledge with sufficient respect and gratitude.

Identifying an appropriate editor can be long and arduous until one finds a competent wordsmith, who is fluent in the subject matter and willing to treat it as a learning experience.

My search ended on the first try in 2003, when I was introduced to Ms. Sandy Paton, President of Caduceus PA, LLC, while in the process of creating *The Lindex*, which led to her editing *The Lindex* and subsequently this book. It was apparent immediately that Ms. Paton possessed the necessary editorial skills and ability to cohere all-too-often inchoate thoughts into the desired message. And to my unending admiration and appreciation, Ms. Paton took it upon herself to become familiar with primary source esoterica. I was indeed very fortunate having Sandy at my side.

This manuscript has been reviewed by a diverse group of individuals representing a broad range of interests and competencies. Each made unique and much appreciated comments. The list includes, but is not limited to, in alphabetical order, Rabbi Saul Berman, JD, adjunct professor and Rotter Fellow, Columbia University School of Law and chairman of the Judaic Studies Department, Stern College for Women of Yeshiva University; Stanley Cohen, MD, emeritus professor and former chairman, Department of Pathology and Laboratory Science, Rutgers–New Jersey Medical School; Lisa Jacobs, MD, MBA, Department of Psychiatry, the University of Pennsylvania; Kenneth M. Klein, MD, professor, Department of Pathology and Laboratory Science, Rutgers–New Jersey Medical School; Lorelle N. Michelson, MD, clinical associate professor of plastic and reconstructive surgery, Department of Surgery, Rutgers–New Jersey Medical School; Rabbi Elazar Hurvitz, PhD, of Yeshiva University and Samuel Belkin, PhD, professor of biblical studies and Talmudic

literature, Yeshiva University; Stanley J. Robboy, MD, Department of Pathology, Duke University School of Medicine; Jonathan Sarna, PhD, The Joseph H. & Belle R. Braun Professor of American Jewish History, Brandeis University, and chief historian of the National Museum of American Jewish History; and Claudewell S. Thomas, MD, MPH, professor emeritus of psychiatry and biobehavioral sciences at the Geffen School of Medicine UCLA.

I have long wished to acknowledge a long overdue debt to my professors whose teaching both within and out of the classroom have served as a great source of inspiration. Most are long gone, but not forgotten, and their efforts in my behalf suffuse every page of this manuscript. At the Columbia University Mailman School of Public Health, they include the late Lowell Eliezer Bellin, MD, MPH, professor and head of the Division of Health Administration, and Harold Fruchtbaum, PhD, adjunct associate professor of the history and philosophy of public health. At the Rutgers–New Jersey Medical School, Neil S. Cherniack, MD, professor of medicine and physiology; at Yeshiva University, Nathan Goldberg, PhD, professor of sociology, and Hyman B. Grinstein, PhD, professor of American Jewish history; at Yale University, August de B. Hollingshead, PhD, Sumner Professor of Sociology, and Jerome K. Myers, PhD, professor of sociology. It is impossible to recompense them.

The skills and devoted assistance of many research librarians were required in the writing of this manuscript and assembling *The Lindex*. Immediately coming to mind is the late Dina Abramowicz, longtime doyen of Yiddish literature and distinguished librarian at the YIVO Institute for Jewish Research, a division of the Center for Jewish History in New York City; Judy S. Cohn, MLS, assistant vice president for Information Services and director of Health Sciences Libraries, Rutgers; Roberta Bronson Fitzpatrick, MSLIS, associate director of the George F. Smith Library of the Health Sciences and capable staff members; Barbara Robey, MLS, retired, Columbia University, and the competent librarians of the New York Academy of Medicine, and Columbia University (and my many colleagues and medical students who reviewed this manuscript, as well as many generations of medical students at the Rutgers–New Jersey Medical School. Special thanks are owed to the anonymous reviewers for their helpful comments).

Introduction

Some readers will recall the ever-popular Yiddish song, "Abi Gezunt," featured in the film *Mamele*. The music by Abraham Ellstein may be familiar; however, the lyrics by Molly Picon were to prove prescient. Words in the first stanza, *A bisl zun a bisl regn; a ruig ort dem kop tzu legn; abi gezunt ken men gliklakh zayn*, translate loosely as, "a little sun, a little rain; a quiet place to lay one's head; so long as you are healthy, good fortune will follow." The lyrics of this song address a relationship between health and fortune that underlies the theme of this book. Consonant with sustained upward mobility, but deserving far more attention, has been Jewish interest and concern for health—whether on the personal or community level.

Achieving a state of health involves a partnership between providers and consumers. A century ago, infectious diseases, such as diphtheria, influenza, and tuberculosis, were the scourge of the time, only to be followed by chronic diseases, such as heart disease, hypertension, and stroke. Steady innovations and influences outside the field of health sciences and medicine have provided continued impetus for improvements in health. Public health professionals have long pointed to increases in longevity preceding the advent of effective medical treatment from a variety of means, including advances in nutritional science and sanitary engineering, education, and increased income.[1]

A review of material on the Jews of Middletown, Connecticut, which involved a comparative retrospective cohort analysis of birth, death, and marriage certificates belonging to Jews and non-Jews for the years 1873-1935, revealed that the Jews were far more likely to travel to the Grace New Haven

1 R. G. Evans, M. L. Barer, and T. R. Marmor, *Why Are Some People Healthy and Others Not?* (Hawthorne: Aldine de Gruyter, 1994); J. B. McKinlay and S. M. McKinlay, "The Questionable Contribution of Medical Measures to the Decline of Mortality in the United States in the Twentieth Century," *Milbank Memorial Fund Quarterly* 55 (1977): 405–428; T. McKeown, "The Direction of Medical Research," *Lancet* 2 (1979): 1281–1284; Leonard. A. Sagan, *The Health of Nations: True Causes of Sickness and Well-Being* (New York: Basic, 1987); John Mirowsky and Catherine E. Ross, *Education, Social Status, and Health* (Hawthorne: Walter de Gruyter, Inc., 2003).

Hospital, the major hospital of the Yale University School of Medicine to seek optimal care, rather than care at local hospitals or with local physicians.[2] Today, the 25-mile plus journey takes about 45 minutes on the highway. A century ago, it might have involved several hours on much narrower and more treacherous roads. But the Jews of Middletown, when faced with serious illness, sought the New Haven Yale specialists.

Education and economic well-being have been shown to be predictors of improved mortality among diseases amenable to medical intervention. A century ago, Elias Auerbach demonstrated that the Jews of Budapest were less likely to die as a result of such diseases.[3] Similarly, when these diseases occurred in America, the Jews took immediate action to eliminate them. Today, epidemiologists differentiate between diseases that are potentially avoidable through appropriate medical attention and those that are not.[4] The relationship between social class and mortality associated with diseases amenable to care has been widely substantiated with at least one study crediting education as "a slightly better indicator of avoidable mortality than income."[5] This was corroborated in a study by Marshall and colleagues, who found that the death rate attributed to amenable causes of mortality among men in New Zealand among the lowest socioeconomic group was 3.5 times higher than it was among men in the highest socioeconomic group.[6]

In a meta-analysis by Sandro Galea and colleagues that examined the causal impact of mortality in the United States for the years 1980 through 2007, deaths attributed to factors such as low education and poverty were comparable to the number of deaths related to pathophysiologic conditions,

---

2 Jacob Jay Lindenthal, "Early History of the Jews of Middletown, Connecticut" (PhD diss., Yeshiva University, 1973).

3 Elias Auerbach, "Die Sterblichkeit der Juden in Budapest 1901–1905," *Zeitschrift für Demographie und Statistik der Juden* 11 (1908): 161–168.

4 D. D. Rutstein, W. Berenberg, T. C. Chalmers, et al., "Measuring the Quality of Medical Care: A Clinical Method," *New England Journal of Medicine* 294 (1976): 582–588; D. D. Rutstein, W. Berenberg, T. C. Chalmers, et al., "Measuring the Quality of Medical Care: Revision of Tables and Indexes," *New England Journal of Medicine* 302 (1980): 1146–1150.

5 E. Wood, A. M. Sallar, M. B. Schechter, and R. S. Hogg, "Social Inequalities in Male Mortality Amenable to Medical Intervention in British Columbia," *Social Science & Medicine* 48 (1999): 1751–1758.

6 S. W. Marshall, I. Kawachi, N. Pearce, B. Boorman, "Social Class Differences in Mortality from Diseases Amenable to Medical Intervention in New Zealand," *International Journal of Epidemiology* 22 (1993): 255–261.

such as cancer and heart disease and behavioral diseases, including those resulting from smoking and alcohol abuse.[7] The leading social cause of death in the year 2000 was low education, harvesting approximately 245,000 individuals, followed by racial segregation, which took 176,000 lives. Other social causes of death included low social support (162,000), individual-level poverty (133,000), income inequality (119,000), and area-level poverty (39,000). Galea and colleagues further noted that the number of deaths attributable to low education in 2000 was similar to the number associated with fatal acute myocardial infarction (192,898); whereas the number of deaths attributable to lung cancer (155,521) was similar to the number associated with low social support.[8]

Many of my readers will recall the work of Edwin Chadwick and William Farr, who documented health conditions in mid-nineteenth-century England. Their work drew attention to the wide disparity in morbidity and mortality among different segments of the British population and subsequently laid the foundation for succeeding generations of public health students. It is appropriate that we devote space to their contributions, as scholars have since drawn upon their analyses to examine public health issues.

By contrasting mortality rates in healthy and unhealthy districts of England in 1846, Farr observed a relationship between poor public health conditions and increased mortality.[9] The disparity in life expectancy between the educated and uneducated was remarkable. Those in the professional classes lived an average of 35 years, while tradesmen and their families lived 22 years, and laborers, mechanics, and servants lived 15 years. Sixty-two percent of deaths occurred among children younger than 5 years of age. Chadwick delved into factors known to influence health, including alcohol abuse, personal hygiene, and family solidarity in poverty-ridden areas. There, whiskey shops outnumbered bakeries 79 to 12. When a poor resident of

7 Sandro Galea, Melissa Tracy, Katherine J. Hoggatt, C. DiMaggio, and A. Karpati, "Estimated Deaths Attributable to Social Factors in the United States," *American Journal of Public Health* 101 (2011): 1456–1465.

8 Galea et al., "Estimated Deaths Attributable to Social Factors in the United States," 1464.

9 *Ninth Annual Report of the Registrar General* (London: HMSO, 1846); J. M. Eyler, *Victorian Social Medicine: Ideas and Methods of William Farr* (Baltimore: Johns Hopkins University Press, 1979); S. Halliday, "William Farr: Campaigning Statistician," *Journal of Medical Biography* 8/4 (2000): 220–227.

Edinburgh was asked when he was last washed, he responded, "When I was last in prison."[10]

Chadwick took pains to evaluate the economic burdens posed by preventable illness, an issue of considerable relevance to the underlying hypothesis of this book. He suggested that improving the working conditions of tailors would extend their lives by ten years, and improving sanitary conditions in the worst districts would reduce sickness by at least one-third. He found that society cast burdens on even the most industrious survivors. "Widowhood most often remains permanent . . . even when the children are by good training and education fitted for productive industry. When they marry, the early familiarity with the parochial relief makes them improvident."[11] Education and health were not priorities among the poor in Liverpool and Edinburgh. And even when education offered a promise, it was not kept. Without social support, little could be done to move a man from a path bound toward destruction.

Although much has been written about the role of education in the rise of American Jews, the contribution of the supremely held value of health to that mobility has not been adequately reviewed. This volume inquires into the value of health and education and other social variables that might have operated together, particularly in the early part of the twentieth century, and that contributed to raising the socioeconomic status of American Jews. It further offers that the rise of this ethnic group can be attributed at least in part to their paramount regard for health, education, and other social variables that helped propel their upward social mobility.

Health has always been of the utmost importance to Jews. Discussions at bar mitzvah celebrations often begin with talk about children and other family members in medical or dental schools. As fatigue sets in, the discussion turns to personal health problems and assorted remedies. Is there a relationship between the rise of American Jews and their concern for health-related matters? We suggest that such an association exists and on the following pages aim to begin a discussion of that relationship. The relationship between the rise of American Jews and their concern with human capital, in this case health, is the hypothesis.

10 Edwin Chadwick, *The Sanitary Condition of the Labouring Population of Gt. Britain* (Scotland: Edinburgh University Press, 1842).

11 Chadwick, *The Sanitary Condition*, 21.