Refugee Health, Healthcare, And Resettlement In New Haven, Connecticut: A Historical Study With Contemporary Implications

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Refugee Health, Healthcare, and Resettlement in New Haven, Connecticut:
A Historical Study with Contemporary Implications

A Thesis submitted to the
Yale University School of Medicine
in partial fulfillment of the requirements for the
degree of Doctor of Medicine

Ezra Samuel Lichtman

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Abstract

Nationally, there is no single clinic model for the provision of healthcare to refugees, and the field of refugee health is perpetually in flux. However, in the New Haven area, there is a well-established system of resettlement, health screening, and healthcare integration for newly arrived refugees. A local agency secures housing, provides education and social opportunities, and coordinates medical visits. And Yale-New Haven Hospital holds adult and pediatric screening clinics for refugees. The origins of this local system lie in the late 1970s and 1980s, when Soviet Jewish and Southeast Asian refugees began to relocate to New Haven in large numbers.

In this thesis, I examine the socioeconomic and cultural circumstances that these two groups of refugees encountered in Connecticut. I then characterize the clinics and other arrangements that healthcare providers created at Yale-New Haven Hospital, at the Hospital of Saint Raphael’s, and around New Haven to care for refugee patients. Finally, I analyze some of the medical and psychiatric conditions from which Southeast Asian and Soviet Jewish refugees suffered, as well as how their health was perceived by the general public, the medical community, and the federal government.

The research presented here serves multiple purposes. First, with archival and oral history data, this paper details what are, to my knowledge, the first formalized refugee health apparatuses implemented in New Haven. Second, it offers examples of ways in which refugees’ resettlement experiences – geographic placement, economic prospects, integration with a co-ethnic community – may affect their mental health, healthcare access, and sustainability of refugee clinics. And finally, this thesis demonstrates some common challenges faced and best practices employed by refugee health enterprises.
Acknowledgements

I would like to express my deep gratitude to all the people who aided me in the research process. To my interviewees: thank you for sharing your time, knowledge, and stories, without which this paper would not have come alive. To the librarians and archivists who assisted me, especially Susan Dee, Marvin Bargar, and Patti Illingworth: thank you for bringing to my attention various sources that I would otherwise have missed and for the coffee, conversations, and kindness that made me look forward to days in the archives. To my research mentor Naomi Rogers: thank you for your guidance, edits, and reassurance. Though I often questioned the direction of my work and my ability to do it justice, I invariably left meetings with Naomi feeling intellectually reinvigorated and personally capable, a testament to her remarkable talent as an advisor. Additionally, this work was made possible by the Yale School of Medicine Medical Student Research Fellowship; I thank the Office of Student Research for its generosity.

I am also immensely grateful to the staff of the Yale Adult Refugee Clinic and Integrated Refugee and Immigrant Services who invited me to join them in their important work. I owe particular thanks to Aniyizhai Annamalai, Lilanthi Balasuriya, Bryan Brown, and Leslie Koons. Not only did my experiences at the clinic augment my understanding of this research project, but I predict these individuals’ splendid teaching, commitment, and warmth will continue to inform the course of my career.

Finally, I am extremely lucky to have many supportive, loving people in my life. Special appreciation goes to my parents, for more than is possible to express, and to Sheridan Finnie, for both encouraging me to pursue this project and helping me every day to grow and experience the world with more joy, more thought, and more depth.
Author’s Note

I would like to address up front two limitations to this paper. The first is that, though I devote significant time to considering the social, political, and medical circumstances of refugees, I do not discuss internally displaced people (IDPs), asylum seekers, or migrants, nor do I explore the often-problematic distinction between these categories. The legal status of “refugee” in the United States comes with an abundance of documentation, making refugees a somewhat easier population to study purely in terms of research logistics. But according to Marietta Vazquez – a Yale pediatric infectious disease specialist who has done advocacy work on behalf of Latinx migrants and asylum seekers at the United States’ southern border – “they basically share all the problems [as refugees], but the very few resources that we have for refugees, the migrants [and asylum seekers] do not have.”¹ Additional research is needed to further characterize the similarities and differences among these groups and evaluate how works such as this thesis about refugees may be relevant to the lives and care of IDPs, asylum seekers, and migrants.

Second, in the course of my research, I was able to interview only a small number of refugees (two) compared to the number of people whom I interviewed who have worked in some capacity providing services to refugees (twenty-four, including the two individuals who came to the United States as refugees and went on to become service providers). Historian Ronald Takaki wrote in his 1990 book Strangers from a Different Shore: A History of Asian Americans, “We must not study Asian Americans primarily in terms of statistics and what was done to them. They are entitled to be viewed as subjects

¹ Marietta Vazquez, interview by the author, New Haven, CT, August 21, 2019.
– as men and women with minds, wills, and voices.” Takaki was referring to Asian Americans at large, but his words are equally applicable to the populations of refugees whom I studied in this paper. My efforts to speak with more people who were, themselves, refugees were unsuccessful for a variety of reasons. What is more important than these individual reasons, however, is an awareness of this shortcoming as one reads this paper. According to sociologist Steven Gold, author of an ethnography of Vietnamese and Soviet Jewish refugees in California in the 1980s, members of both of these groups “resented the paternalistic manner in which resettlement policy was devised and delivered” without their input. Thus, I urge the reader to remember the agency that refugees possess and the power they can and should be empowered to exert over their own situations. Though this thesis is somewhat deficient in firsthand accounts of refugees’ experiences, I have tried to work with these concepts in mind. As Quan Tran – a lecturer in Yale University’s Ethnicity, Race, and Migration Department – wrote in her 2016 Ph.D. dissertation about the Vietnamese diaspora,

The modern world is all too familiar with stock portrayals of refugees as liminal and problems… Moreover, ubiquitous images and narratives of refugees' suffering, vulnerability, and need to be rescued widely circulated in local and international media freeze this frame of reference into perpetuity. Yet, refugees are also historical actors, whose acts of fleeing or leaving assert powerful statements… [and] set in motion complex developments that have multilateral implications.

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4 Quan Tue Tran, “Anchoring Boat People’s History and Memory: Refugee Identity, Community, and Cultural Formations in the Vietnamese Diaspora,” Ph.D. diss., American Studies, Yale University, 2016, 45.
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Introduction

Every Wednesday evening, one wing of the Primary Care Center (PCC) at Yale-New Haven Hospital (YNHH) is reserved for the Yale Adult Refugee Clinic. The PCC, located on Howard Avenue in New Haven, CT, is home to YNHH’s general preventative medicine clinics during normal business hours. As stragglers from daytime appointments walk out the door, a collection of nurses, doctors, medical and nursing students, resettlement agency professionals, interpreters, and refugees fill the hallways and rooms. Though there is always variation in the makeup of the staff, a few nurses consistently pick up shifts at the clinic. One or two clinic directors – attending physicians at YNHH – supervise each week and are occasionally joined by additional attendings who have a special interest in refugee health. A handful of senior YNHH resident physician coordinators volunteer to help the clinic run smoothly, trading off weekly, and every intern in the Internal Medicine Residency Program is assigned a mandatory shift at some point during their first year such that two interns are present every week. These interns are the primary medical providers for patients of the clinic. Yale medical and nurse practitioner students can also choose to see patients at the clinic under supervision.

I, as a senior medical student interested in refugee healthcare, elected to attend the Yale Adult Refugee Clinic regularly starting in August 2019. One evening in the fall of that year, as clinic personnel ate the falafel and babaganoush sandwiches that resident coordinators order each week from a local restaurant, I listened to the informal orientation for staff that takes place before patients are seen between 6 PM and 9 PM. Leslie Koons provides case management for patients of the clinic in her role as a Health

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5 Pediatric refugee patients have appointments on Friday afternoons at the PCC.
Promoter for Integrated Refugee and Immigrant Services (IRIS), New Haven’s refugee resettlement agency. Leslie makes sure IRIS clients know when and where to go for medical appointments, sometimes giving them a ride in her own car. She also shows them the location of the nearest pharmacy to their apartments, keeps track of their medical records, and performs many other essential duties related to refugees’ healthcare. That night, she briefed us on the patients who were scheduled for appointments, including Fereshteh.⁶

Fereshteh had arrived in the United States four weeks earlier and needed a refugee health assessment, a standard part of the resettlement process for which refugees come to the clinic usually about one month after entering the country. Leslie had picked up Fereshteh from her new apartment and brought her to the clinic, and we decided I would conduct her visit.

Fereshteh was a 28-year-old woman from Afghanistan. She was a homemaker, spoke Pashto, and was illiterate. She had two sons and a husband who had worked in Afghanistan with the American military. Fearing reprisal from the Taliban, they applied as a family for a Special Immigrant Visa (SIV), an option akin to refugee status for individuals who have worked with the U.S. forces in Afghanistan. After a number of years, they were granted the SIV and boarded a plane to the United States.

Fereshteh came with a mixture of medical and psychiatric issues. She was missing some routine vaccinations, and a blood test showed that she had been exposed to tuberculosis, meaning she required a chest x-ray to rule out an active, contagious infection. An itchy rash behind her ears was also bothering her. Moreover, she was

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⁶ I have changed the patient’s name and details of her story to protect her privacy.
suffering from a variety of psychiatric symptoms. She had nightmares and difficulty sleeping; she was anxious and sad; and most troublesome to her, she had stopped being interested in and deriving joy from spending time with her children and husband. Fereshteh had no desire to harm herself, but nonetheless, she was clearly in need of psychiatric treatment.

After I gathered her story and performed a physical exam, a nurse administered her missing vaccines. The supervising doctor wrote a prescription for an ointment to treat her rash, gave her instructions on how to get an x-ray, and made her a follow-up primary care appointment in a few weeks with the resident coordinator whom she had met that evening. I informed Fereshteh about the discussion and support groups with other Afghan refugees that IRIS facilitates, but she preferred one-on-one to group counseling. On any given Wednesday, some patients come to the Refugee Clinic for initial health assessments, as Fereshteh did that night, while others who suffer from psychiatric symptoms return to see a psychiatrist. A volunteer psychiatry resident – who also attends the clinic weekly to provide consultations – scheduled Fereshteh for a thorough mental health appointment at an upcoming clinic session. A Pashto-speaking interpreter who works in YNHH’s Language Services Department translated the whole encounter and helped us answer Fereshteh’s questions. Finally, the team debriefed with Leslie and informed her of these upcoming steps before she gave Fereshteh a ride home.

The Yale Adult Refugee Clinic and IRIS provide services and fulfill requirements as components of a large, standardized refugee resettlement system in the United States that can be traced back to the 1951 United Nations General Assembly Convention Relating to the Status of Refugees. The Convention was intended to formalize the
obligations of the international community to the millions of people in Europe who were displaced by World War II. A refugee was defined by the General Assembly as someone who

owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country.\footnote{UNHCR, \textit{Convention and Protocol Relating to the Status of Refugees} (Geneva, Switzerland: UNHCR Communications and Public Information Service 2010), 14, \url{https://www.unhcr.org/protection/basic/3b66c2aa10/convention-protocol-relating-status-refugees.html}.}

The protocols instituted by the Convention were expanded in 1967 to include persons affected by any disruptive events around the globe, not merely those that took place in Europe as part of WWII.\footnote{Ibid., 2.}

According to political scientist Norman Zucker, in the three decades after the 1951 Convention, United States refugee policy consisted of “a series of ad hoc legislative and executive actions which were, in the main, direct responses to a given crisis.”\footnote{Norman L. Zucker, “Refugee Resettlement in the United States: The Role of the Voluntary Agencies,” \textit{Michigan Journal of International Law} 3, no. 1 (1982): 156.} These included the Migration and Refugee Assistance Act of 1962, the Jackson-Vanik Amendment to the Trade Act of 1974, and the Indochina Refugee Migration and Assistance Act of 1975, which addressed Cuban, Soviet Jewish, and Vietnamese refugees, respectively.\footnote{Government policy toward refugee admissions has continued to evolve. The SIV program that Fereshteh utilized was started in 2006 to expedite the entry into the United States of Iraqi and Afghan nationals who worked alongside American forces during the Iraq War and the War in Afghanistan (Garcia, 140).}

refugee admissions that preferentially treated people from northern and western European countries, though entrants from independent Latin American countries were exempt from these quotas. The Immigration and Nationality Act of 1965 abolished quotas based on national origin, instead emphasizing family reunification and the admission of skilled workers, and American refugee policy subsequently shifted.

While the 1965 legislation marked a departure from geographical, as a proxy for racial, entrance criteria – theoretically opening U.S. borders to refugees around the world – in practice the United States began to use refugee admissions specifically as an anticommunist tool. According to anthropologist Betty Hoffman, after 1965 the United States welcomed religious and political refugees especially from communist countries. In his 2010 book, Safe Haven?: A History of Refugees in America, anthropologist David Haines noted that “anticommunism has been crucial to virtually all refugee admissions up until the 1990s.” As of 1980, the bulk of United States refugee admissions came from Southeast Asia, the Soviet Union, Cuba, Afghanistan, and Haiti. Communist governments had been newly formed in multiple Southeast Asian countries and in Cuba, and the Soviet Union, a long-established communist power, had invaded Afghanistan in 1979. In all of these cases except that of Haiti, the U.S. aimed to weaken communist

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13 Ibid.
15 David Haines, Safe Haven?: A History of Refugees in America (Sterling, VA: Kumarian Press, 2010), 4.
influence in a region by offering an alternative place of settlement to large numbers of refugees.

The domestic logistics of resettlement were largely coordinated by non-governmental voluntary agencies, or volags, national organizations that often had a religious mission to aid refugees. Two prominent examples were the United States Catholic Conference (USCC, which adopted its named in 1965 but followed from the Catholic Committee for Refugees, founded in 1938 to aid people fleeing Nazism) and the Hebrew Immigrant Aid Society (HIAS, established in the late nineteenth century to assist Jews trying to escape pogroms in Russia). Local affiliates of these national organizations, such as Catholic Charities of Hartford for USCC and the Jewish Federation of Greater New Haven for HIAS, carried out on-the-ground mechanics of resettlement, including picking refugees up from the airport and finding them apartments. Current day IRIS is the New Haven area partner of the national volag Episcopal Migration Ministries; both were founded in the 1980s.

Through the first half of the twentieth century, volags had full responsibility for the resettlement process, as no formal government policy existed, but beginning with the Corporate Affidavit Program of 1946, the federal government offered partial funding for resettlement services when volags sponsored refugees. This allowed the government to support humanitarian efforts while, according to Zucker, volags continued to provide a financial safeguard against refugees “[becoming] a public charge.”

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20 Ibid.
The government’s role in refugee resettlement expanded further when, responding to a rapid rise in the number of international refugees in the late 1970s, Congress passed the Refugee Act of 1980. This legislation laid out comprehensive procedures for the admission of and provision of services to refugees, and it marked the beginning of modern U.S. refugee policy with the establishment of the Office of Refugee Resettlement (ORR) within the Department of Health and Human Services. Volags and their subsidiaries still executed most of the logistics of resettlement, but they received matching grants from the ORR. Additionally, the ORR implemented temporary financial and health insurance welfare programs for qualifying refugees – Refugee Cash Assistance (RCA) and Refugee Medical Assistance (RMA) – and instituted guidelines regarding health screening of refugees.21

The 1980 act initiated a path toward federal involvement in and standardization of refugee resettlement. However, the fragmented nature of the system – multiple volags providing assistance to thousands of refugees in diverse communities with different resources – allowed inconsistencies in the substance and quality of services for refugees to persist.22 Organizations which served refugees also had to adapt their strategies to subsequent changes in ORR policies, such as a halving of the duration of RCA and RMA from thirty-six to eighteen months in 1982 and a further decrease to eight months in 1991.23 The degree of success with which newly resettled refugees have been welcomed

and integrated into local healthcare systems, in particular, has fluctuated over time and between settings, according to Kelly Hebrank, former Healthcare Coordinator for IRIS.24

Large variations in the number of refugees admitted to the United States, the upper limit of which is specified yearly by the President, also affects the functioning of refugee services organizations. According to the Migration Policy Institute, since the Refugee Act was passed, U.S. refugee admissions have ranged from a high of 207,116 in FY 1980 to a low of 22,517 in FY 2018; most years, the number has been between 40,000 and 120,000.25 The 2021 ceiling for refugee admissions was set by President Trump at 15,000, the lowest in U.S. history, though it is likely many more refugees will be admitted under the incoming Joe Biden administration.26 Volags determine where to resettle refugees on a case-by-case basis, taking into consideration the ability of any family members or personal connections to assist each newcomer. Many refugees are placed in large states such as Texas, New York, Washington, and California, but each year hundreds settle in Connecticut, as many as 837 in FY 2016.27 The number of refugees resettled in Connecticut has dropped dramatically since Trump took office, hitting a low of 57 in FY 2020.28

According to Aniyizhai Annamalai, a dual-trained internal medicine doctor and psychiatrist who runs the Yale refugee health program, these changes have been felt at the YNHH clinic, where recent low patient volume has forced her and other clinic directors to justify its continued existence in the current form to hospital administrators. The clinic has persisted in part due to its close working relationship with IRIS, which increased its resettlement of SIV holders after Trump’s inauguration and thus boosted the size of the patient population.

The number of refugee patients in New Haven is constantly in flux, depending on national and international political circumstances, but the need for timely and appropriate healthcare services for refugees has remained since the earliest attempts to provide such services in the city. Before the current iteration of a Yale refugee health program was created in 2009, other efforts to provide healthcare to refugees came and went. Likewise, before IRIS was well-established – and in some cases, even after – different groups of refugees were resettled around the state by multiple organizations with varying degrees of access to local social services and healthcare resources.

This paper focuses on two groups of refugees, Southeast Asians and Soviet Jews, most of whom arrived in the New Haven area at approximately the same time, from the late 1970s through the early 1980s. In Section I (“Southeast Asian Refugees in Connecticut”), I will discuss the demographics and social circumstances of Southeast Asian refugees who arrived in Connecticut largely between 1975 and 1982, paying special attention to their economic prospects and the effects of geographic dispersal on community formation and mental health. Next, I will employ one family’s narrative to

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30 Ibid.
examine how Soviet culture affected Jewish refugees’ adaptation to American life and interactions with their American Jewish sponsors (Section II, “Soviet Jewish Refugees in Connecticut”). In Section III (“The Boat People Clinic at YNHH”), I will describe the formation, functioning, and legacy of the first dedicated refugee clinic at Yale, founded in 1979 to treat Southeast Asian patients. An additional brief account of a contemporaneous Southeast Asian refugee clinic in Hartford in Section III will elucidate some of the challenges faced by patients and staff of the Yale clinic. I will then outline the history of private and hospital-affiliated Jewish physicians in New Haven and their relationship to the Catholic Hospital of Saint Raphael (HSR) to explain how Soviet Jewish refugees gained access to free healthcare at HSR and at the practices of individual charitable Jewish doctors (Section IV, “A Handshake and Personal Engagement: Soviet Refugees, Jewish Physicians, and the Hospital of Saint Raphael”). Last, I will examine the economic motivations underlying the federal government’s creation of RMA and health screening requirements for refugees; the effects on refugee healthcare of widespread heightened focus on infectious diseases, especially among Southeast Asians; the medical and psychiatric problems that afflicted Southeast Asian and Soviet Jewish refugees; and the difficulties mental health practitioners faced in caring for these patients (Section V, “Refugee Health and American Medicine”).

My study of these two groups during this liminal period in modern U.S. refugee history provides a basis to interpret the experience of Fereshteh, the patient I met at the Yale Adult Refugee Clinic in 2019. It helps explain why the clinic was able to help Fereshteh in the ways it did; how the options available to her have been shaped by decades of local and national developments in refugee health, healthcare, resettlement
systems, and politics; and where there remains work to be done. More broadly, I hope this paper offers insight into how the thousands of refugees who have flourished, struggled, and built their lives in the New Haven area since the 1970s may have first encountered American society and medicine.
I. Southeast Asian Refugees in Connecticut

“Despite the differences among themselves, the Southeast Asians share something unique… The Southeast Asians in the United States were driven to America by the circumstances and powerful forces of war. They did not think and dream about coming; in fact, most of them had no time to plan and prepare for their movement to a new land. Fleeing from the horrors of war, they departed in panic not knowing the country of their destination. They experienced the trauma of refugee camps and the terrible feeling of wondering whether they would have a place to begin life again. They worried about how the receiving society would view them as unexpected guests and refugees rather than desired immigrants with skills…. they cannot go home. More so than the earlier groups of Asian immigrants, the refugees are truly the uprooted.”

Ronald Takaki, Historian, in *Strangers from a Distant Shore: A History of Asian Americans*

In the years following the United States’ 1973 withdrawal from the Vietnam War and the 1975 Fall of Saigon, inhabitants of Vietnam, Cambodia, and Laos – former French colonial Indochina – fled their homelands. Communist governments were established in these three countries, and many South Vietnamese, Khmer (from Cambodia), Lao (from lowland Laos), and Hmong (from highland Laos) feared reprisal for cooperating with American forces and oppression from extremely harsh regimes, such as the Khmer Rouge and Pathet Lao. Ethnic Chinese from Vietnam (known as the Hoa people) also faced targeted persecution in the new Socialist Republic of Vietnam. Attempting to escape this violence and upheaval, hundreds of thousands of individuals began to leave Southeast Asia, giving rise to an international refugee crisis.

The first wave of refugees left Southeast Asia in 1975 and consisted of 138,000 people, largely South Vietnamese military members and their families who escaped the fall of Saigon via airlift or on boats. Most of these refugees – 130,000 – went to the

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32 Ibid., Chapter 11.
33 Ibid., 449, 451.
United States, and 2,500 settled in Connecticut (though secondary migration away from
the site of initial resettlement was common). While Southeast Asian (SEA) refugees
continued to emigrate to the United States in significant numbers in the subsequent years,
over a quarter of all Vietnamese who came to the U.S. from 1975 to 1985 arrived in 1975
alone. By comparison, only 3.6% and 0.5% of the same 10-year cumulative total of
Cambodians and Laotians, respectively, arrived in the United States in 1975.

Fifty-two percent of these initial refugees were male, with a median age of 28.6
years, and 46% had been born in an urban area. They were generally well-educated,
averaging 9.5 years of schooling, and two-thirds could speak some English when they
arrived in the United States. Many had worked in professional or managerial jobs with
the French colonialists and, later, with Americans; according to sociologist Steven Gold
in his 1992 ethnography of refugee communities in California, “[Vietnamese refugees’]
links to Western culture [were] indicated by the fact that almost half were Catholic, even
though well over 80% of all Vietnamese [were] Buddhists.” Gold posited that, although
there were very few Vietnamese individuals in the United States prior to 1975, this
“familiarity with Western culture” allowed them to adapt quickly to American life.

Despite this, a 1978 study found that while 45% of refugees had been “professionals” or

34 Quan Tue Tran, “Anchoring Boat People’s History and Memory: Refugee Identity, Community, and Cultural Formations in the Vietnamese Diaspora,” Ph.D. diss., American Studies, Yale University, 2016, 12.
36 David Haines, Refugees as Immigrants: Cambodians, Laotians, and Vietnamese in America (Totowa, NJ: Rowman & Littlefield, 1989), 11, Table 1.6.
37 Ibid.
38 David Haines, Refugees as Immigrants: Cambodians, Laotians, and Vietnamese in America (Totowa, NJ: Rowman & Littlefield, 1989), 63, Table 4.2.
40 Ibid., 58.
41 Ibid.
“managers” in Vietnam, only 9% held equivalent positions after 27 months in the United States.42

A second wave of refugees, the bulk of whom spent some time in camps in neighboring SEA countries before emigrating to the United States between 1979 and 1982, was larger and more diverse than the first. In those four years, over 450,000 Vietnamese, Hoa, Khmer, Lao, and Hmong people arrived in the United States.43 Connecticut’s estimated SEA refugee population increased from 1,600 in 1979 to 6,300 in 1982; the state’s percentage of all U.S. SEA refugees remained steady at 0.9% - 1.0%.44 Connecticut’s percentage of total U.S. population during this time was 1.4%.45 This discrepancy in proportion of refugees to overall population indicates that the state was not a primary resettlement or secondary migration destination, unlike California and Texas.

The Vietnamese contingent of this second wave, referred to as “boat people” at the time due to their route of escape from Vietnam, had less formal education and familiarity with English than their earlier-arriving countrymen. They had an average of 7.05 years of education, and half spoke no English.46 Their geographic and employment backgrounds ranged from urban, white-collar professionals to rural farmers and coastal

45 David Haines, Refugees as Immigrants: Cambodians, Laotians, and Vietnamese in America (Totowa, NJ: Rowman & Littlefield, 1989), 4, Table 1.2.
fishermen.\textsuperscript{47} The percentage of Catholics dropped to 10% by 1979, suggesting this population had less interaction with French colonial culture.\textsuperscript{48}

In his wide-ranging 1990 history of Asian Americans, historian Ronald Takaki described parallels and differences among the Lao, Hmong, and Khmer refugees. Ethnic Lao were more rural but similar in experiences and demographics to second-wave Vietnamese.\textsuperscript{49} Many Hmong had been enlisted by the CIA to carry out military operations during the Vietnam War. Thus, they faced especially harsh retaliation from the Pathet Lao government that assumed power in 1975.\textsuperscript{50} Additionally, 70% of the Hmong could not read or write their native language, which made it difficult for them to achieve literacy in English.\textsuperscript{51} Finally, Cambodian refugees were, by and large, more rural and less educated than the Vietnamese or Lao and “carr[ied] the horrible psychological scars of the war and mass exterminations” at the hands of the Khmer Rouge.\textsuperscript{52} Mary Scully – an APRN who volunteered in Cambodian refugee camps in the early 1980s and has worked at Khmer Health Advocates (KHA) of West Hartford, CT, since 1982 – attested to the effects of the Cambodian genocide on the demographics and challenges faced by Khmer refugees who emigrated to the United States. There was no sizeable pre-existing Cambodian community in the U.S., and “ninety percent of their professional population

\begin{footnotes}
\item[48] David Haines, \textit{Refugees as Immigrants: Cambodians, Laotians, and Vietnamese in America} (Totowa, NJ: Rowman & Littlefield, 1989), 63, Table 4.2.
\item[50] Ibid., 462.
\item[51] Ibid., 463.
\item[52] Ibid., 469.
\end{footnotes}
had been exterminated, so not only did they not have anybody here, but all the natural leadership for organization was gone,” she noted.53

In general, members of the second wave of SEA refugees had difficulty finding jobs, and those who had professional or managerial occupations in their home countries often found employment that was not commensurate with their level of training and experience. According to a 1983 study, 19% of both male and female refugees had been “professional or technical workers” in Vietnam, but just 6% of men and 9% of women were employed in these areas in the United States.54 Takaki attributed depression and frustration in the Vietnamese community in part to the racism in hiring and the fall in social status that many refugees faced when forced to take entry-level or factory work.55

Katrina Axelrod was the Community Director of Asian Community Services (ACS), a social services and English language teaching organization for Asian immigrants in New Haven, CT, that was created in 1979. Axelrod recalled that her clients faced widespread employment discrimination.56 When a number of refugees found work at a United Steel factory near Hartford, “they [held] onto it by their fingernails,” said Axelrod, “because they had found nobody else who would give them a job.”57

The Vietnamese refugees whom Gold studied in Northern California experienced a variety of challenges when looking for jobs, “including… poor physical and mental health stemming from the refugee experience, and family-related needs, such as… health

53 Mary Scully, interview by the author, West Hartford, CT, November 13, 2019.
55 Ibid.
57 Ibid.
care.” A Vietnamese resettlement worker whom Gold interviewed speculated that refugees’ need for health insurance, particularly for large families, was a significant incentive for them to remain unemployed. This was because the low-paying jobs they were able to land had sparse medical benefits, but even the meager income these jobs yielded put refugees over Medicaid eligibility limits. A Yale M.P.H. student named Lester Holcomb conducted a 1980 study of a Hartford-based SEA refugee health clinic. He found that, because the clinic’s patients became ineligible for Medicaid after working for 90 days, many of them faced exactly that choice between unemployment while remaining on Medicaid and poorly paid employment with insufficient medical insurance.

ACS staff attempted to help their clients navigate healthcare expenses and employment options. Axelrod described ACS clients’ reliance on traditional SEA healing practices to the exclusion of Western medical care due their inability to pay:

They tend to rely on herbal medicines and vigorous skin rubbing. That’s helpful in some cases but not in others. A lot of parents are not seeking treatment because the money isn’t there. The idea of going into debt for yourself is too much for them. We’re showing them to clinics with sliding scales.

59 Ibid., 124
60 Ibid. According to a 2014 analysis of the U.S. refugee resettlement system, after the Refugee Act of 1980 established supplemental income and medical insurance programs for refugees, this same reasoning – i.e. that RCA and RMA were entitlements that discouraged self-sufficiency – was used by the Reagan administration to justify reducing the length of these benefits from 36 months to 18 months (Brown and Scribner, “Unfulfilled Promises,”108).
Volunteers at ACS were concerned that predatory business practices contributed to this state of affairs. In a 1984 article about ACS in the *New Journal*, a Yale University student-run magazine, one volunteer recounted rumors of a Connecticut factory that “hired Vietnamese refugees to work eight-hour shifts for $4” (the national minimum hourly wage at the time was $3.35).63

If individuals were unable to find adequate jobs, they could fall back on Refugee Cash Assistance (RCA). RCA was authorized by the Refugee Act of 1980 and provided funds to refugees with low or no income for the first three years after their arrival in the United States. 64 Income requirements were identical to those for the contemporaneous Aid to Families with Dependent Children program for the general U.S. population, but in contrast to the generic policy, refugees were not required to have children in order to qualify for RCA.65 Soon after it was created, however, RCA was curtailed as a result of the Reagan administration’s efforts to limit refugee resettlement and welfare expenditures.66 In many locations without state-level public assistance programs for unemployed adults, including Connecticut, the duration of RCA was cut to eighteen months in 1982.67

The fact that refugees received federal monies such as RCA, combined with a rising national unemployment rate in the early 1980s, led to strife between SEA refugees

65 Ibid.
and other economically marginalized populations that relied on government welfare programs and had difficulty finding work. Takaki quoted Chuong Hoang Chung, a UC Berkley faculty member in the Asian American Studies department: “The presence of the Vietnamese refugees… is viewed as a threat, such as being cheap labor when there is a scarcity of jobs. They are also viewed as a threat in places where the scarcity of low-income housing forces blacks and refugees to compete.”

In his 2013 Yale Department of History Ph.D. dissertation about Southeast Asian refugees, Sam Vong cited a 1975 Gallup poll that found only 36% of Americans supported the admission of Vietnamese refugees, while 54% opposed it, in part due to concerns about competition for jobs and public assistance. Some refugee service providers were aware of these fears. According to Holcomb’s 1980 study of the Hartford clinic, it was essential when designing refugee health projects to consider their impact on the means available to similar programs for other needy groups:

Before discussing the development of refugee screening services, we must address the allocation of scarce urban health resources among all of the urban poor and underserved populations. These new services must be designed so that they do not drain existing clinic subsidies and resources away from the care of other urban residents.

This tension had important policy implications. In its 1982 annual report, the Office of Refugee Resettlement partially explained the decision to cut RCA to eighteen months as

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71 Lester Wood Holcomb, “Developing Health Screening Services for Indochinese Refugees,” M.P.H., Yale University, 1980, Part IV, 1.
necessary “to reduce the degree of special treatment for refugees, which resulted in unequal treatment among low-income populations.”

There was a notable degree of conflict between SEA refugees and Black Americans. Vong interpreted the development of refugee resettlement infrastructure in the United States starting in 1975 as an attempt by President Ford to win public opinion by reframing the country’s role in the aftermath of the Vietnam War as one of compassion rather than defeat. However, “some African American leaders were already highly skeptical of the ways that the U.S. government deployed Vietnamese children and orphans as political pawns to prove its humanitarianism” while neglecting the needs its Black citizens, according to Vong. New Haven was no exception to these dynamics. Interviewed in a 1986 New Haven Advocate article, Axelrod described antagonism between ACS clients and the Black community in New Haven. Her job included having conversations to build trust between Vietnamese and Black neighbors who lived in the same low-income apartment building.

The organizations that sponsored SEA refugees in Connecticut – such as Catholic Charities of Hartford and the Connecticut Lutheran Episcopal Refugee Services Committee (CLERS) – adjusted their resettlement strategies to work around the shortages of affordable housing, adequate employment opportunities, and other resources that worsened when large numbers of refugees arrived in saturated urban areas. According to

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74 Ibid., 63.
76 Katrina Axelrod, phone interview by the author, New Haven, CT, January 2, 2020.
a 1982 analysis of U.S. resettlement voluntary agencies, “cluster resettlement” consisted of “the placement of refugees in groups large enough to enable them to develop their own support systems but not so large as to make them an identifiable minority creating a burdensome social and economic impact on their host community.” Cluster resettlement was practiced to varying degrees by different voluntary agencies, but it was the primary approach taken by the Lutheran Immigration and Refugee Service, a national organization that locally partnered with CLERS. Starting in December 1982, CLERS began to assume an increasing proportion of the resettlement workload of SEA refugees in Connecticut.

Mary Scully, of KHA, observed an early-1980s shift from concentrating new arrivals in large cities to distributing small groups of refugees in suburban and rural towns throughout the state. Cluster resettlement improved housing and employment prospects for refugees, according to Scully, but the degree of geographic dispersal may have hampered the ability of Southeast Asians to support one another, making adjustment more difficult.

Spread thinly across a state with no sizable preexisting SEA population, Buddhist refugees struggled to develop religious communities. A January 1990 *New York Times* article by Robert Hamilton compared the religious experience of SEA refugees in Connecticut over the preceding fifteen years to that of European immigrants. Hamilton

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78 Ibid.
80 Mary Scully, interview by the author, West Hartford, CT, November 13, 2019. See Section III for discussion of how this resettlement pattern affected the development of health clinics for SEA refugees.
noted that, in contrast to Polish immigrants who could easily join a local Catholic Church, there were “no Buddhist temples in the state, and no concentrations of Southeast Asians large enough to have an organized [religious] club.”  

A group of Vietnamese refugees did form the Buddhist Association of Connecticut in 1975, according to a 1983 Hartford Courant article, but the organization’s numbers were small. Its members were mostly limited to Hartford and the surrounding towns, and they had to borrow space from a West Hartford synagogue for their annual celebration of the Buddha’s birthday. 

Many refugees lacked cultural and religious connections where they resettled, but SEA groups did establish mutual assistance associations (MAAs) to aid subsequent arrivals. Due the predominance of Vietnamese among first-wave refugees, a Vietnamese mutual assistance association existed by May 1978. Cambodian, Laotian, and Hmong populations each had created an MAA by October 1981. 

The purpose of these MAAs was manifold and shifted with the needs of their communities. According to Scully, they were initially focused on providing social work services and helping refugees secure jobs, though they took on the responsibility of arranging medical care and interpretation services for refugees over time. KHA was technically an MAA, but it was the only one in the state that was explicitly devoted to the health of refugees from its beginning. Giao Hoang, a Vietnamese-born physician who

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83 Ibid.
86 Mary Scully, interview by the author, West Hartford, CT, November 13, 2019.
came to Connecticut in 1975, also recalled the festivals and holiday celebrations that MAAs organized to pass on language and cultural heritage to the children of refugees.\textsuperscript{87}

In the early 1980s, the \textit{Courant} reported on Tet celebrations for the lunar new year, which included games, stories, and performances (see Figure 1.1).\textsuperscript{88}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{tet_festival.jpg}
\caption{Photos of a 1981 Tet festival in West Hartford, originally published in the \textit{Courant}: “Hong Khang, 1, of West Hartford takes a good seat to watch the festivities, including a Dragon Dance, right.” “Refugees Observe New Year,” \textit{Hartford Courant}, February 1, 1981, Newspapers.com.}
\end{figure}

Despite the work that MAAs put into holding these events, which usually took place in the state capital of Hartford, the SEA population in the greater New Haven area was too small and too scattered to have a strong communal presence. The 1986 \textit{New Haven Advocate} article about ACS reported that “since [Asians in New Haven] don’t have an identifiable community, they are often invisible, neglected and isolated.”\textsuperscript{89}

\begin{itemize}
\item \textsuperscript{87} Giao Hoang, phone interview by the author, New Haven, CT, August 28, 2019.
\item \textsuperscript{88} “Vietnamese Celebrate Tet,” \textit{Hartford Courant}, February 19, 1983, Newspapers.com.
\end{itemize}
The social isolation of SEA refugees had significant detrimental psychiatric effects, according to a 1984 Yale School of Medicine study. Scully also emphasized that, in her practice caring for Cambodian refugees, separation from others with shared experiences often exacerbated the psychological fallout for survivors of trauma. “They didn’t think anyone understood,” said Scully. The mental health consequences of isolation were apparent to ACS staff, as well. Jack Hasegawa was the General Secretary for Dwight Hall – Yale University’s Center for Public Service and Social Justice – from 1980 to 1993, and he was involved with ACS through Yale’s Asian American Students Alliance (AASA). ACS volunteers sometimes performed home visits for their clients, and Hasegawa recalled “families just holed up in a little apartment [with parents] reluctant to let the children out. And often the English classes and related social programming that [ACS] had… was the only time that the families had any contact with the outside world.”

ACS provided needed but insufficient support for SEA refugees in the New Haven area. The organization started as an ad-hoc outgrowth of the AASA in 1979 and was administered with funds provided by Dwight Hall. It became a tax-exempt social services agency independent from Yale in 1981, though it continued to operate out of the AASA building at 295 Crown Street. There were 12 staff members and 32 student

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91 Mary Scully, interview by the author, West Hartford, CT, November 13, 2019.

92 Jack Hasegawa, phone interview by the author, New Haven, CT, November 12, 2019.


94 Correspondence from Katrina Solstad to Norman Harrower, November 23, 1983, Secretary’s Office, Yale University, records concerning community and state relations 1915 - 1986 (RU 53), Series Accession 1190-A-049, Box 7, Folder 381, Manuscript and Archives, Yale University Library.
volunteers at ACS, as of 1984.\textsuperscript{95} Around that time, the organization served 50 clients who were referred by word of mouth.\textsuperscript{96} ACS received some grant funding from charities such as the New Haven Foundation, but newspaper articles, private correspondences, and internal AASA documents regarding ACS reflected its extremely precarious financial situation throughout the early- and mid-1980s.\textsuperscript{97} Though ACS was constantly struggling to stay afloat, Axelrod said in a 1984 interview that “no other agencies in the area provide these services or focus on the language, cultural and social needs of the East Asian and Southeast Asian immigrants and refugees.”\textsuperscript{98}

Second wave SEA refugees who resettled in Connecticut in the late 1970s and early 1980s found themselves in a difficult situation. Largely lacking English skills, they had to navigate an unforgiving and racially discriminatory job market, and when they did manage to find employment, they were often underpaid and received few medical benefits. The federal funds they relied on were inconsistent, as evidenced by the 1982 decrease in RCA duration from 36 to 18 months, and they came at the cost of antagonism from groups who also needed public assistance or who supported Reagan era welfare

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\textsuperscript{95} Correspondence from Katrina Solstad to Martha Chavez-Brumell, February 10, 1984, Secretary’s Office, Yale University, records concerning community and state relations 1915 - 1986 (RU 53), Series Accession 1190-A-049, Box 7, Folder 381, Manuscript and Archives, Yale University Library.

\textsuperscript{96} Correspondence from Katrina Solstad to Norman Harrower, November 23, 1983, Secretary’s Office, Yale University, records concerning community and state relations 1915 - 1986 (RU 53), Series Accession 1190-A-049, Box 7, Folder 381, Manuscript and Archives, Yale University Library.


\end{flushright}
reform. Those refugees who were not first to arrive benefited to some degree in terms of social services and healthcare navigation from the MAAs founded by their predecessors. However, resettlement practices – cluster resettlement at the state level and the small proportion of SEA refugees who were assigned to or stayed in Connecticut – conspired to create a situation in which robust communities did not easily form. This undermined the social well-being and mental health of individuals. Though these circumstances no doubt varied somewhat from New Haven to Hartford to Waterbury and between different ethnic groups, these were important common factors that shaped refugees’ lives and contextualize how they interacted with the healthcare system.
II. Soviet Jewish Refugees in Connecticut

“This Jewish Community Center [in Woodbridge, CT.] became for many elderly people the only place that they could go except their home and feel safe. This building. Why? … Because in this building, [people spoke] Russian, Spanish, English, Hebrew… It was the only place for them to go and to feel, okay, you’re welcome. And I’m just very grateful for whole community and for [the] Jewish Federation.”

Yelena Gerovich, refugee and JFGNH New American Acculturation Program Director

Yelena Gerovich was a music teacher for gifted children in the Soviet Union. Her husband was a helicopter engineer. Yelena’s maiden name was Gelena, a common Russian name that did not sound Jewish, but Gerovich was distinctly Jewish. As a musician, Yelena did not feel discriminated against for her religion. Her husband, on the other hand, had to pay bribes to ensure he passed the basic medical examination necessary to start engineering school despite the fact that he was a healthy young man and had excelled on the school’s written entrance test. While her husband had not grown up in an observant household, Yelena recalled that her childhood was filled with secret holiday celebrations and a constant awareness that when “you go outside your house, you have to think about what you are talking about.”

Yelena’s great uncles were sentenced to death on spurious charges in the late 1930s. When the U.S.S.R. entered World War II, they were given the option to avoid execution by serving in a Soviet army unit stationed on an extremely deadly battlefront. Against the odds, they survived the war and lived for decades after under false names to avoid being recaptured. After the war, Yelena’s grandmother was arrested in a similar manner and sent to a Russian prison camp. For years, she traded the meat portions of her

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99 Yelena Gerovich, interview by the author, Woodbridge, CT, September 12, 2019.
100 Ibid.
meals to other prisoners for their milk to maintain a kosher diet. She spoke a variety of languages and eventually secured a position tutoring the children of one of the camp’s head administrators. She was released after Joseph Stalin’s death in 1953 and returned home before Yelena was born. As a child, Yelena was not told of these events, “but somehow, she put in my head [the] idea that we have to run from this country,” Yelena said.101

In spring 1993, Yelena successfully exploited a miscommunication between two government departments in charge of immigration to obtain exit visas. With this opportunity, she decided it was time to leave Russia. She was able to convince her husband of the need to flee to avoid military conscription for their young sons, as well as to pursue her desire for religious freedom. Yelena hurriedly sold her dearest and most expensive possession – a German piano – for next to nothing and bought a costly passport that would allow her to take her violin out of the country. They were permitted to leave the U.S.S.R. with $200 per person, and in May 1993, Yelena emigrated to the United States with her husband and two children.102

The family moved to Connecticut with help of the Jewish Federation of Greater New Haven (JFGNH) and the Hebrew Immigrant Aid Society (HIAS) – a voluntary agency, or volag, that connected the United States Government to local refugee resettlement organizations. At first, they applied for and received Refugee Cash Assistance, a supplemental income program for refugees akin to Aid to Families with Dependent Children for the general population. Yelena started to volunteer at the Jewish Community Center (JCC) in Woodbridge, CT, and to again teach music. Her husband

101 Ibid.
102 Ibid.
enrolled in software engineering courses at a local college, which soon landed him a job with medical insurance benefits. Caryl Kligfield, a leader of the JFGNH’s resettlement program at the time, encouraged Yelena to interview for a Volunteers in Service to America posting administered through the JCC. Yelena got the position, which included an education stipend that made it possible for her to earn her social work degree. By 1995, she was head of the JFGNH’s acculturation program, teaching newly arrived refugees the basics of American life.103

The Geroviches’ story shares many similarities with those of the hundreds of thousands of Soviet and Russian Jews who came to the United States as refugees from the 1970s through the early 2000s. Soviet society was strictly secular, and religious expression was met with severe penalties.104 Jewish citizens adopted Russian cultural practices and abandoned religious traditions and affiliation in attempts to assimilate.105 They also adapted some aspects of Jewish culture to this new lifestyle. Anthropologist Betty Hoffman studied Soviet and American Jews in Hartford, CT, in her 2001 book *Jewish Hearts: A Study of Dynamic Ethnicity in the United States and the Soviet Union*. According to Hoffman, “as Jews seized the previously religious ideal of education and transformed it into the secular focus of their lives, education for fulfilling and prestigious occupations became the lodestar for many and the center of their identity within the Soviet system.”106 Even in the absence of religiosity, however, the ethnic label of “Jewish” often resulted in barriers to educational and professional advancement such as

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103 Ibid.
those faced by Yelena’s husband when he was nearly denied acceptance to engineering school. Vladimir Tusman, one of the first Soviet Jewish emigrants to New Haven in 1974, explained in a 1978 interview with the New Haven Register, “Discrimination against Jews [in the USSR] occurs in key positions rather than the low paying jobs.”

Sociologist Steven Gold found that some Jews actively sought intermarriage to non-Jews in part to change their passport designation to “Russian” and get around such limitations; others declined to circumcise their male children to prevent them from future persecution.

Conditions in the USSR made many Soviet Jews wish to emigrate. Throughout the 1960s, however, only 7,000 were granted exit visas. Those who were denied visas came to be known as “refuseniks.” The American Jewish community, along with groups in Israel, began to advocate for Soviet Jews’ ability to leave. Over 10,000 people traveled to Washington, D.C., for the 1965 Eternal Light Vigil, which was meant to draw attention to this issue. After the 1967 Six-Day War, activists lobbied to make the rights of Soviet Jews to leave the country a precondition for the USSR to purchase American technologies. This strategy was cemented with the Jackson-Vanik Amendment to the Trade Act of 1974, which tied “most favored nation” trade status for the Soviet Union to more lenient emigration policies.

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109 Ibid., 29
Throughout this time, American Jewish sympathizers traveled to the Soviet Union on the pretense of tourism; in fact, they aimed to establish communication with refuseniks. Kligfeld recalled several trips during which she clandestinely contacted refuseniks and collected names of people who wanted to leave the Soviet Union. When she returned to the United States, she used this information to “manufacture the invitations” required for their applications to get official approval.\(^{112}\)

Media coverage also featured the plight of Soviet Jews and efforts of their American advocates. In Connecticut, an October 1976 *New Haven Register* article titled “Russian Jew Hassled” described a Westville resident who acted as a pen pal for a Soviet Jewish dissident in order to “keep up [his] morale.”\(^{113}\) When Anatoly Sharansky – a relatively religious Soviet Jew – was arrested in 1977 for distributing lists of refuseniks to Americans, his case became a cause célèbre. The *Register* covered a September 1977 rally that drew 750 New Haven area Jews to protest Sharansky’s imprisonment and call for increased emigration.\(^{114}\) Sharansky was sent to a gulag, where he remained until a detainee trade between the United States and the USSR led to his release in 1986, at which point he moved to and settled in Israel.\(^{115}\)

The consequences of the Jackson-Vanik Amendment and political pressure from widespread public attention resulted in increasing numbers of Jews receiving approval to leave the Soviet Union, with a peak of 51,000 in 1979.\(^{116}\) Some of these émigrés traveled

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\(^{112}\) Caryl Kligfeld, interview by the author, Woodbridge, CT, August 19, 2019.
to Israel while others settled in the United States.\textsuperscript{117} Between 1979 and 1980, over 46,000 Soviet refugees entered the U.S., and 503 of them resettled in Connecticut.\textsuperscript{118} The JFGNH recorded 196 Soviet Jews who came to the New Haven area between 1974 and 1981.\textsuperscript{119} These numbers decreased substantially in the early 1980s due to a deterioration of U.S.-U.S.S.R. relations beginning with the 1979 Soviet invasion of Afghanistan.\textsuperscript{120} Soviet refugee entry into the U.S. hit a nadir in 1985 at 664 with just 6 people resettled in Connecticut.\textsuperscript{121} However, following the 1985 implementation of glasnost policies by U.S.S.R. leader Mikhail Gorbachev, the number of Soviet entrants again began to rise steeply to a high of 49,802 in 1990, 746 of whom initially took up residence in Connecticut.\textsuperscript{122}

Soviet Jewish refugees in the United States were relatively old compared to other immigrant and refugee groups, with a mean age of 40.5 years as of 1982.\textsuperscript{123} They also had smaller families, on average consisting of three people.\textsuperscript{124} The focus on education that many Jews had embraced in the Soviet Union resulted in this refugee population’s

\textsuperscript{117} There was considerable debate amongst Israeli and American Jewish communities as to where Soviet refugees ought to be accepted. Broadly speaking, Israelis and large segments of the international Jewish community, including many American Jews, thought émigrés should go to Israel to boost the country’s population and fortify the Jewish state. As Hoffman put it, “At the heart of this debate was the conflict between the Zionist ideal, which advocated all Jews settling in Israel, or the primarily American Jewish view that individuals should be free to choose to live wherever they wanted” (Hoffman, 143). According to Gold, those who did not choose Israel were labeled neshrim, or dropouts and sometimes faced delays awaiting resettlement (Gold, \textit{Refugee Communities}, 30). In my interview with Rabbi Herbert Brockman, of Hamden, CT, he summed up the opposing, and ultimately winning, case for refugees’ freedom to pick where they settled: “Our ancestors had the choice. My parents had the choice. They chose to come here. These Jews deserved the same.”


\textsuperscript{121} Office of Refugee Resettlement, \textit{Refugee Resettlement Program} (Washington, D.C., 1986), Table 4.


\textsuperscript{124} Ibid.
average of 13.5 years of formal schooling in 1983 (greater by 1 year than that of U.S. population at large). A 1990 article in the Connecticut Jewish Ledger urged local employers to hire these “New Americans,” as they were often referred to, citing their experience in a variety of fields, including medicine, dentistry, engineering, business, education, arts, and skilled trades. The group of refugees that Hoffman studied encountered far fewer anti-Semitism-based limitations on their choice of career and opportunities for promotion than they had in the Soviet Union.

High education levels and significant professional experience notwithstanding, Soviet Jews faced a number of obstacles in their search for employment in the United States. Low rates of English language proficiency, differences between Soviet and American practices in various lines of work, and the economic downturn of the early 1980s all forced refugees to take lower-paying, less prestigious jobs than many had held in the U.S.S.R. According to Hoffman, this had deleterious consequences for the self-esteem and personal image of many New Americans. Yelena said she and her husband were fortunate that neither music instruction nor software engineering required English fluency, but she recalled that “a lot of people, like teachers in Russian, teachers in Russian history, they could not find a job at all.”

As a group, however, Soviet Jewish refugees had success finding work and becoming financially self-sufficient. Of the subset that came to the United States between

125 Ibid.
128 Ibid., 181.
129 Ibid.
130 Yelena Gerovich, interview by the author, Woodbridge, CT, September 12, 2019.
1972 and 1980, 60% of men and 34% of women were employed within 6 months of arrival.\textsuperscript{131} A study of Soviet Jews in Connecticut found that their median income in 1983 was $38,600, more than $11,000 higher than that of comparable American families at the time.\textsuperscript{132} The New Americans were assisted in these matters by organizations such as their local Jewish Family Service (JFS) and the Jewish Federation, which played a role in fulfilling basic resettlement requirements but also helped with resume preparation, job searches, and interview coaching.\textsuperscript{133} Kligfeld described how Lew Lehrer – who had survived WWII in Ukraine, immigrated to Connecticut in the 1950s, and become the Russian-speaking Chairman of the JFGNH’s Refugee Resettlement Committee – handpicked refugees who would do well in New Haven:

When the trickle started, Lew personally every Monday… went down to New York to the HIAS offices and… went through the applications. He said, “This one will be good for New Haven. The profession, I can get him a job. And this person, I know that we can work with them and we can have a successful klita,” which is Hebrew for absorption into the community.\textsuperscript{134}

Lehrer exhibited a remarkable level of care in selecting individuals to come to New Haven, but his efforts were undergirded by a robust infrastructure of services for refugees and immigrants within both the state and national Jewish communities. Herbert Brockman, a rabbi for many years at Congregation Mishkan Israel in Hamden, CT, who participated in local resettlement work, attributed the existence of this infrastructure to Jews’ history of being “turned away.”\textsuperscript{135} He cited the \textit{MS St. Louis} that carried Jewish

\textsuperscript{132} Ibid., 183.
\textsuperscript{133} Ibid., 180. The New Haven resettlement program was run by JFS, a constituent of the JFGNH, until 1981, when the Federation took over. See section on the relationship between the Hospital of Saint Raphael and New Haven’s Jewish community for further discussion of this transition.
\textsuperscript{134} Caryl Kligfeld, interview by the author, Woodbridge, CT, August 19, 2019.
\textsuperscript{135} Herbert Brockman, interview by the author, Hamden, CT, September 3, 2019.
refugees from Nazi Germany and was denied entry into the United States, as well as Jewish poet Emma Lazarus’ “The New Colossus” on the pedestal of the Statue of Liberty: “We’ve been doing this for a hundred and something years, always involved in immigration and refugee work.”136

HIAS was established in 1881 and, according to a 1982 analysis of volags by political scientist Norman Zucker, the organization “helped ameliorate the trauma of almost every major refugee migration to the United States” to that point.137 HIAS’ clients were not exclusively Jewish, but the majority of Soviet Jewish refugees were resettled by the Society. Zucker lauded HIAS’ system, writing, “The structure that seems to have a nearly uniform incidence of responsible, successful resettlement is the HIAS structure, with its reliance on local organized Jewish communal agencies and their professional social service personnel.”138 Jewish Family Services and Jewish Federations around the country and in New Haven organized numerous services for refugees. According to Gold, these included “job training and placement, social activities, religious socialization, and mental health programs,” in addition to the securing and furnishing of housing, English language tutoring, healthcare coordination and translation, memberships at synagogues, enrollment at Jewish day schools, and more.139 In Connecticut, newly arrived refugees were usually met at the airport or train station by resettlement staff and presented with challah (a traditional Jewish bread; see Figure 2.1).140

136 Ibid.
138 Ibid., 170.
139 Steven J. Gold, Refugee Communities: A Comparative Field Study (Newbury Park, CA: Sage Publications, 1992), 44.
140 “N.H. Family Service Helps Resettle Soviet Emigres,” New Haven Jewish Ledger, December 8, 1977, RG 1-6, Box 1, Folder 9, Jewish Historical Society of Greater New Haven Archives, New Haven, CT.
HIAS also could rely on donations from well-established Jewish charities that were amplified by a federal matching grant to make the organization’s funding per refugee well above the amount that other volags were able put towards resettlement in the early 1980s.\textsuperscript{141} This allowed the local agencies affiliated with and financially supported by HIAS (e.g. JFS, JFGNH) more freedom to choose where they housed new arrivals. For example, they could take into consideration a neighborhood’s crime rate and its existing Jewish population.\textsuperscript{142} In New Haven, the JFS’ New Americans Program 1978 manual recommended that “families should live near each other and help each other;

\begin{figure}[h]
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\includegraphics[width=0.7\textwidth]{image}
\caption{Rabbi Wayne Franklin (right) welcomes Soviet Jewish refugees Liza (center) and Edward (left) Ginzburg with a loaf of challah. “N.H. Family Service Helps Resettle Soviet Emigres,” \textit{New Haven Jewish Ledger}, December 8, 1977, RG 1-6, Box 1, Folder 9, Jewish Historical Society of Greater New Haven Archives, New Haven, CT.}
\end{figure}

\textsuperscript{142} Ibid., 44.
provide moral support, comfort amongst others like self, socialization and transportation.”

Resettlement professionals in the late 1970s and early 1980s were particularly concerned about preventing animosity between impoverished American citizens, often members of racial minorities, and refugees over competition for affordable housing and government benefits. Zucker noted HIAS’ efforts to “utilize the skills of professional caseworkers, sensitive to the political and social nuances of the local community, to dampen and avoid, if possible, conflict.” He also described instances in Chicago and Philadelphia in which JFS advised clients to avoid renting from landlords who had evicted minority tenants in hopes of attracting refugees.

HIAS sought to minimize friction over housing between refugees and other underprivileged Americans. However, having grown up in Soviet culture, some New Americans came with conservative, prejudiced views about race and social issues and a suspicion of government and authority figures that occasionally strained relations with their sponsors. From the Soviet Jews that Gold studied in California, he heard complaints “about homosexuals, minority groups, graffiti, the crime rate, drug use, pornography, and the lack of discipline in schools,” which were at odds with the more liberal views espoused by much of the American Jewish community. Blossom Rose – former healthcare coordinator for the JFGNH’s Refugee Resettlement Committee – recalled a

143 “Jewish Family Service – New Americans Program,” January 17, 1978, RG 1-6, Box 2, Folder 3, Jewish Historical Society of Greater New Haven Archives, New Haven, CT.
145 Ibid. In these examples, HIAS’ clients were Southeast Asian refugees, but branches of the organization around the country employed similar practices generally.
story that Lehrer had told her. Lehrer was driving with a recently arrived refugee teenager on Whalley Avenue in New Haven when she abruptly ducked to the floor of the backseat upon seeing the Black occupants of another car. “You have to be careful; they’ll kill us,” the teenage girl had said. Rose explained, “That’s what Russia indoctrinated into them.”147 According to Rose, Lehrer attempted to disabuse the young girl of this type of egregious racial prejudice, which she abandoned after living in Connecticut for some time.

In addition to conservative (and sometimes grossly misinformed) social and racial attitudes, New Americans brought with them a distrust of authority and a tendency to try to game the system shaped by years of living under authoritarianism and dealing with Soviet bureaucracy. Deborah Dyme, a social worker who worked for New Haven’s JFS in 1981, recalled a relative of hers who, even after emigrating, would whisper when discussing the U.S.S.R. Dyme interpreted this as a manifestation of her relative’s belief that “the walls have ears,” reminiscent of the discretion that Yelena learned as a child.148 According to Dyme, many of her refugee clients held similar suspicions, which made it difficult for her to perform aspects of her job, particularly when it came to psychotherapy. As a JFGNH resettlement leader, Kligfeld heard grievances from home health aides and welfare agency workers who were put off by refugees’ unwillingness to fully cooperate

147 Blossom Rose, phone interview by the author, New Haven, CT, August 21, 2019. There is evidence that the KGB attempted to stir up racial animosity in the United States, particularly between Jewish and Black Americans. An example of these efforts in 1971, described in Christopher Andrew’s 2001 book The Sword and the Shield: The Mitrokhin Archive and the Secret History of the KGB, involved “the fabrication of pamphlets full of racist insults purporting to come from the extremist Jewish Defense League” that were “mailed to a series of militant black groups” in New York (Andrew, The Sword and the Shield, 238). I was unable to find examples of explicitly anti-Black Soviet propaganda, and in fact, the U.S.S.R. vocally drew attention to the United States’ legacy of anti-Black racism as a political tool to deflect criticism of its treatment of ethnic minorities, as discussed in Julia Ioffe’s 2017 Atlantic article “The History of Russian Involvement in America’s Race Wars.”

148 Deborah Dyme, interview by the author, Southbury, CT, October 30, 2019.
with them. This prompted Kligfeld to conduct training sessions with groups of service providers to explain the Soviet context and promote an understanding of the New Americans’ experiences.

Even so, some members of the Connecticut Jewish community felt trepidation about interactions with refugees. Hoffman summarized her findings on this matter within the Hartford population:

Because of their previous experience with Soviet government agencies and entitlements, some New Americans tended to treat the Jewish Family Service as if it were a Soviet bureaucracy, demanding services and material goods they felt were their due. Despite the Communist collective ethic, people—as individuals—have had to fight to achieve or acquire everything they had in the U.S.S.R., leading to this type of persistent, aggressive behavior, which had produced visas and propelled them out of the Soviet Union. This did not work in America, alienating those who were trying to assist them.

Heni Schwartz and her husband Mark (a physician who provided free medical care to the refugees) decided to sponsor the New Haven-area resettlement of a Soviet family in the late 1980s. Before the family arrived, acquaintances who had previously sponsored émigrés warned Heni, “The personalities of those Russian people are such that they’re going to take advantage of you and then they’re not going to appreciate what you did for them.” The Schwartzes went ahead anyway – “We were doing it because we wanted to and not because we needed to be appreciated or thanked,” said Heni – and though she noticed divergent cultural norms around expressing gratitude, she and Mark formed a good relationship with the family.

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149 Caryl Kligfeld, interview by the author, Woodbridge, CT, August 19, 2019.
150 Ibid.
152 Heni Schwartz, phone interview by the author, New Haven, CT, November 5, 2019.
153 Ibid.
Some refugees, meanwhile, balked at the double indignity of leaving positions of relatively high status behind and then being expected to continuously express thanks for whatever was provided to them. Stephen Donshik, former New Haven JFS Director, remarked in a 1981 meeting of the Russian Resettlement Task Force that “the Russians become angry at the New Haven Jewish community for having the idea that the Russians are unsophisticated and should be extremely grateful for any kindness.”154 According to an emigrant whom Hoffman interviewed, “We couldn’t understand why they were bringing us old clothes. We had our own clothes, but Americans probably thought about the stories of their grandparents—how they came, and they didn’t have anything.”155 These frustrations were humorously depicted in The Cosmopolitans, a novel by author Nadia Kalman who, like the Molochnik family in her book, immigrated to Stamford, CT, from the Soviet Union in 1984. After seeing the portrayal of Russian Jews in Fiddler on the Roof, the matriarch of the fictional Molochniks says,

So, this Fiddler is big education for me. …For example, I know now why American ladies say when we arrive, “Look, is shower,” “Look, is toilet.” Why are they telling me with such big smiles? Are they engineers who built the toilet? No, they think this is first toilet we ever see. They think we came out of shtetl fighting over if horse was mule. We were intelligentsia. …And then they take us to supermarket and expect that we will have fainting over food. Five different kinds of apples… And these women, they bring me their old chulki, stockings, stretched out, torn, not washed and I am supposed to say, “Thank you, thank you, in Russia we had no such things, only skin of bears for legs, teeth for control top.”156

154 Russian Resettlement Task Force meeting minutes, August 3 1981, RG 6B2, Box 3A, Folder 4, Jewish Historical Society of Greater New Haven Archives, New Haven, CT.
156 Nadia Kalman, The Cosmopolitans (Livingston, AL: Livingston Press, University of West Alabama, 2010), 121-122.
Moreover, many refugees’ experiences in Connecticut did not live up to the expectations of American life that they had formed from books, films, and news reports. Hoffman found that, while some aspects of day-to-day living such as well-stocked and unrestricted supermarkets were appealing, Soviet Jews who had lived in major urban centers like Moscow “were very disappointed when [they] came to Hartford.”157 One émigré recalled, “We looked at each other as if to say, ‘Okay, when’s the horse and buggy going to come by?’”158

An additional point of contention between refugees and the groups that organized their resettlement was the anticipation on the part of the welcoming communities – primed by the high-profile but unrepresentative stories of religiously devout refuseniks such as Sharansky – that the newcomers would embrace American Jewish religiosity and expressions of Jewishness. Karl Zuckerman, a former national leader in Jewish Federations’ Soviet resettlement programs, said in 1979, “There is probably no aspect of the Soviet Jewish resettlement program which is of greater concern to the North American Jewish community than the extent to which our new arrivals feel a Jewish identity and are involved in Jewish communal life.”159 Kligfeld confirmed that this was a focus of the New Haven resettlement effort, explaining that Federation members would provide candles and challah for New Americans’ first Shabbat. “They should know that it was the Jewish community that was welcoming them,” said Kligfeld.160 As Gold notes in his study of refugees in California, some Soviet émigrés eagerly engaged with Jewish

158 Ibid.
159 Ibid., 153.
160 Caryl Kligfeld, interview by the author, Woodbridge, CT, August 19, 2019.
communal life through JCCs, synagogues, day schools, or other avenues. Yelena, for example, was insistent that she work at the JCC: “I am going to be a volunteer here no matter what. If you want me to do cleaning, I just want to be in this building,” she remembered saying soon after she first arrived.

Usually, however, refugees had limited knowledge of and enthusiasm for religious observances or communal Jewish identity. As anthropologist David Haines wrote in his 2010 book Safe Haven?: A History of Refugees in America, “Having lived their lives in a secular society, they had to come to terms with a Jewish community that supported them extensively but also tended to expect from them a degree of religiosity with which they had little experience.” Yelena recalled when one refugee was invited to a Passover Seder at an observant American family’s house and showed up with cake, which is decidedly unkosher during the holiday. And, according to Dyme, relatively few Soviet Jews became consistent synagogue attendees.

Some male refugee children were uncircumcised, an attempt on behalf of their parents to ease their assimilation into Soviet society. Orthodox rabbis at the New Haven Hebrew Day School, which offered tuition-free enrollment for some refugee children, felt strongly that male attendees should be circumcised, and they considered revoking the admission of a number of these boys. Rabbi Brockman (who practices Reform Judaism) emphasized that, although he recommended circumcision, in his discussions

162 Yelena Gerovich, interview by the author, Woodbridge, CT, September 12, 2019.
163 David Haines, Safe Haven?: A History of Refugees in America (Sterling, VA: Kumarian Press, 2010), 37.
164 Yelena Gerovich, interview by the author, Woodbridge, CT, September 12, 2019.
165 Deborah Dyme, interview by the author, Southbury, CT, October 30, 2019.
166 Herbert Brockman, interview by the author, Hamden, CT, September 3, 2019.
with the rabbis from the Hebrew Day School, his “insistence was that they choose to be circumcised, that the Jewish community would not withdraw its support over that issue” and that alternative schooling options be offered if this was to be a sticking point at the Orthodox school.\(^{167}\) Brockman added that, even in absence of this controversy over circumcision, many New Americans felt uncomfortable with the idea of sending their children to Jewish day schools.\(^{168}\)

In Gold’s analysis, the fact that the New Americans and the American Jewish community shared close ties – most American Jews had immigrated from Eastern Europe within the preceding century, and they had “been crusading for the Soviets’ right to emigrate since the 1960s” – made it difficult to reconcile their differences.\(^{169}\) Hoffman identified different conceptions of what it meant to be Jewish as the root of this discord: American Jews felt they belonged to a religious community, whereas Soviet Jews, influenced by “the hostile forces of institutionalized anti-Semitism,” saw themselves as part of an cultural group or a nationality.\(^{170}\) Yelena understood the Soviet viewpoint and tried to bridge the gap in her role as acculturation program director. “A lot of people came here, and they hated to be Jewish people,” she said,

Why? Because it was discriminated. They just did not want to be Jewish people. Some of them changed their last name to pretend that they’re not Jewish. And then they are here, and in their mind, “Okay, now I am American.” And my job was to let them know that, first of all, you escaped from Russia because you are Jewish. It was your ticket to the freedom. Maybe it is a good idea for you to figure out your history and all this.\(^{171}\)

\(^{167}\) Ibid., emphasis in original.
\(^{168}\) Ibid.
\(^{171}\) Yelena Gerovich, interview by the author, Woodbridge, CT, September 12, 2019.
Some emigrants wished to practice a form of self-determination that had been impossible in the U.S.S.R. and leave behind a label which had caused them trouble and from which they had not been permitted to derive the benefits of community or tradition. Yelena hoped to convince them that in the American social context, Jewishness represented a mix of culture, ethnicity, and religion that, in spite of its previous negative consequences for them, they could and should appreciate.

Though Soviet Jewish refugees and the American Jewish community did not always see eye to eye, there is no doubt that the collective efforts of JFS and JFGNH staff and volunteers created a valuable and dynamic support system for the new arrivals to Connecticut. As Kligfeld recalled, “People came right out of the woodwork to volunteer… This was not a foreign group of people that were coming. They may not have been able to speak our language, but this was us… We all had our roots in the former Soviet Union… It felt really like family.” JFS provided many of the aforementioned types of assistance common to the HIAS resettlement strategy elsewhere. A 1978 Register article described Janna Tusman, who came to New Haven in 1974 with her husband Vladimir, as “overwhelmed” by the furnished apartment and already-stocked pantry. Early on, JFS was able to hire a part-time Russian-speaking social worker to provide counseling related to “the emotional and psychological impact of resettlement and the language barrier,” according to a 1976 annual report. Rose praised Lehrer and the other volunteers who spoke Russian for often being available when refugees needed

172 Caryl Kligfeld, interview by the author, Woodbridge, CT, August 19, 2019.
174 JFS 1976 annual report, 1976, RG 1-6, Box 1, Folder “JFS Minutes & Correspondence,” Jewish Historical Society of Greater New Haven Archives, New Haven, CT.
interpreters for medical appointments. At one point, a group of refugee couples wished to be remarried with a traditional Jewish wedding ceremony that had been impossible in the Soviet Union, and the Federation organized and financed the event.

Overall, Soviet Jewish refugees in New Haven benefitted from the organization and resources of the resettlement programs of JFS and the JFGNH. These organizations’ roots in the American Jewish community also provided a cultural point of connection that spoke to some refugees more than others. As will be discussed in Section IV, incorporation of Jewish religion and culture into the resettlement effort also affected the healthcare options that were available to Soviet émigrés in New Haven.

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175 Blossom Rose, phone interview by the author, New Haven, CT, August 21, 2019.
176 Ibid.
III. The Boat People Clinic at YNHH

“This was a, I won’t say one and done, but it was a transient clinic to meet a refugee health crisis, or what we thought could be. The patients had enough health problems that we probably ended up doing good and getting people into treatment... So, it was actually a lot of fun and pretty meaningful.”177

David Coleman, co-founder of the Boat People Clinic at YNHH

By 1979, most of the first wave of refugees who had left Vietnam in 1975 had settled in the United States, and a second wave of “boat people” fleeing Vietnam, Cambodia, and Laos was cresting.178 An estimate of Connecticut’s Southeast Asian population that year was 2,016, largely split between Hartford and Bridgeport, with the rest dispersed in New Haven, suburban, and rural areas.179 The census from April 1, 1980, recorded 2,548 Southeast Asians in Connecticut,180 and an August 1980 State Department publication on refugee resettlement estimated that number to have grown to 3,609.181

The federal government required health screenings promptly upon arrival in the United States for all refugees, and this rapidly increasing population of Southeast Asian refugees came with diverse medical concerns.182 Thus, there was a growing need for services throughout the state. The first Connecticut project focused on the health of these

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177 David Coleman, phone interview by the author, New Haven, CT, September 5, 2019.
178 Quan Tue Tran, “Anchoring Boat People’s History and Memory: Refugee Identity, Community, and Cultural Formations in the Vietnamese Diaspora,” Ph.D. diss., American Studies, Yale University, 2016, 12. See Section I for further discussion of these refugees’ resettlement and demographics.
182 See Section V for further discussion of the particular health needs of this population and the health topics on which government and healthcare institutions focused.
refugees was the University of Connecticut-Burgdorf Clinic in Hartford, which opened on June 26, 1979, under the direction of Dr. Roy Erickson and Dr. Giao Hoang.183

Hoang had emigrated to Connecticut as a refugee from Vietnam in 1975. Though he had worked as a physician for nine years in Vietnam, he had to complete a medical residency in the United States in order earn his license to practice in Connecticut. After finishing his U.S. medical training at Saint Francis Hospital and Medical Center in Hartford in 1979, he was about to launch a private internal medicine practice when Erickson approached him regarding plans to start a clinic for the new wave of refugees. According to Hoang, many doctors in the area were hesitant to treat Southeast Asian patients due to the language barrier and their unfamiliarity with cultural practices and regional endemic diseases.184 Hoang was well equipped to care for many of these patients, as he spoke Vietnamese and was acquainted with Vietnamese cultural practices and diseases.

A Yale M.P.H. student named Lester Holcomb wrote his 1980 thesis about the UConn-Burgdorf Clinic. For readers who wished to start their own refugee health programs, Holcomb included a transfer manual in which he emphasized the benefits of having a Southeast Asian physician at the clinic to overcome linguistic, cultural, and medical ignorance on the part of American doctors.185 However, Hoang recalled that at the time there were few physicians in the area with similar backgrounds to his. As a result, many Southeast Asian families came to see him as patients. “I was the only one,”

184 Giao Hoang, phone interview by the author, New Haven, CT, August 28, 2019.
said Hoang, “so they would come from all over the New England area. They would travel from Massachusetts down to” Hartford.\(^{186}\) Hoping to disseminate the knowledge necessary to treat these patients, Hoang and Erickson authored two journal articles based on their experience at the Burgdorf Clinic, published in the *American Journal of Public Health* in 1980\(^ {187}\) and in *JAMA* in 1982.\(^ {188}\)

The demand for healthcare services for refugees in Connecticut outstripped the supply, and in 1979, Dr. David Coleman, an internal medicine resident at Yale-New Haven Hospital (YNHH), became aware of this problem. According to a July 24, 1980, *Yale-New Haven Hospital Bulletin* newsletter, Coleman was struck by the “three- and four-month waiting lists at the state’s (then) only clinic in Hartford.”\(^ {189}\) Dr. Michele Barry, also a YNHH resident in 1979, recalled that the general primary care clinic at YNHH, where some refugees were being seen, “was not set up for them.”\(^ {190}\) The existing clinic lacked the multidisciplinary collaboration among adult physicians, pediatricians, psychiatrists, tropical disease experts, and other specialists necessary to effectively care for this population, according to Barry.\(^ {191}\) Such was the situation when, in 1979, Barry and Coleman decided to start a venture at YNHH similar to the UConn-Burgdorf Clinic.

Though not personally connected to the refugee crisis as Hoang was, both Barry and Coleman were drawn to working with refugees. Barry attended Bryn Mawr College for her undergraduate education and earned her MD from Albert Einstein College of

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\(^{186}\) Giao Hoang, phone interview by the author, New Haven, CT, August 28, 2019.


\(^{188}\) Giao N. Hoang and Roy V. Erikson, “Guidelines for providing medical care to Southeast Asian Refugees,” *JAMA* 248, no. 6 (August 13, 1982): 710-714.

\(^{189}\) “Refugee Clinic Doctors Praised for Efforts,” *Yale-New Haven Hospital Bulletin*, July 24, 1980; 3(15), 1.

\(^{190}\) Michele Barry, phone interview by the author, New Haven, CT, August 13, 2019.

\(^{191}\) Ibid.
Medicine before beginning her medical internship at YNHH in 1977. She cited a desire “to make a difference politically” as a motivation for wanting to become a doctor, and she saw this clinic as a way to put that desire into practice while providing care for a population in need.\textsuperscript{192} Prior to starting residency at YNHH in 1976, Coleman had been an undergraduate at Stanford University and received his MD from the University of California, San Francisco. He was also “driven by a humanitarian interest” to integrate Southeast Asian refugees into the healthcare system.\textsuperscript{193}

Both Barry and Coleman had an academic passion for the overlapping fields tropical medicine and infectious disease and wanted experience in these fields that was sometimes hard to come by in Connecticut. The first Infectious Diseases (ID) fellow at Yale graduated in 1966, but the American Board of Internal Medicine did not nationally standardize ID as a specialty until 1972.\textsuperscript{194,195} Coleman went on to complete his ID fellowship at YNHH in 1980-1981. No such educational track in tropical medicine existed at the university. Instead, Barry traveled to Washington, D.C., in 1980 to complete a course of study at Walter Reed Army Medical Center before returning to Yale and continuing her work at the clinic.\textsuperscript{196}

Treating patients who had recently arrived from Southeast Asia, some of whom had parasitic and latent tuberculosis infections rarely seen in the general Connecticut population, represented an opportunity for Barry and Coleman to fill a gap in services.

\textsuperscript{192} Ibid.
\textsuperscript{193} David Coleman, phone interview by the author, New Haven, CT, September 5, 2019.
\textsuperscript{194} Lynn Gambardella, phone interview with the author, New Haven, CT, November 5, 2019.
\textsuperscript{195} “Exam Administration History,” American Board of Internal Medicine, \url{https://www.abim.org/about/exam-information/exam-administration-history.aspx} (accessed November 5, 2019).
\textsuperscript{196} Michele Barry, phone interview by the author, New Haven, CT, August 13, 2019.
and simultaneously pursue their interest in these areas of medicine.\textsuperscript{197} Recalled Coleman, “We were both interested in infectious disease, and we were both interested in addressing this need and thought it was important for the department and the hospital to step up at a time when there was a social crisis.”\textsuperscript{198} The two residents approached YNHH administrators in the departments of General Medicine and Infectious Disease and, in September 1979, convinced them to sign off on the creation of a primary care clinic for Southeast Asian refugees living in southern Connecticut.\textsuperscript{199}

The clinic, known as Boat People Clinic, initially operated out of the Primary Care Center (PCC) offices on Thursday evenings and was staffed exclusively by volunteer nurses, house staff physicians, and interpreters.\textsuperscript{200} Services included laboratory screening tests and medical history questionnaires administered on site by a specially trained translator one week prior to patients’ first visit with a physician; adult and pediatric primary care; infectious disease treatment; and social work.\textsuperscript{201} Because of the degree of trauma experienced by many refugees, psychiatrists were often available in the

\textsuperscript{198} David Coleman, phone interview by the author, New Haven, CT, September 5, 2019.
\textsuperscript{200} “Refugee Clinic Doctors Praised for Efforts,” Yale-New Haven Hospital Bulletin, July 24, 1980; 3(15), 1. A number of nurses who volunteered at the clinic are listed in this article. Those whom I was able to locate and contact, however, did not recollect working at the clinic. The complete list is as follows: Donna D’Eugenio, Aurora Buckingham, Bernadette Davidson, Mary Ann Thompson, Rosemary Harte, Rosalie Bell, Kathy Miller, Eileen O’Connor, Kathleen McKiernan, Mary Beth Pennoni, JillVentrella, Cynthia Torony, and Marge Glass.
clinic, and dermatologists also saw patients. According to Barry, the multidisciplinary nature of services at the Boat People Clinic was novel.

Though it incorporated a variety of services, the clinic was intentionally not comprehensive. With limited capacity for longitudinal care, the “goal was not to provide continuity of care,” according to Coleman, but rather to see patients a handful of times for initial screenings and minor treatments. The clinic was “a bridge solution to help expedite [refugees’] integration into the New Haven/Connecticut communities,” said Coleman.

Catholic Charities of Hartford, the agency that organized resettlement for the majority of Southeast Asian refugees in Connecticut at the time, arranged scheduling and transportation for clinic patients. There was not extensive coordination between the clinic directors and members of Catholic Charities beyond “warm handoffs in the clinic,” but Coleman remembered that the organization was “incredibly helpful and kind to the patient population and… wonderful to work with.” Catholic Charities ensured refugees received medical evaluations within six weeks of arrival in the United States, and frequently all members of a family were examined during one appointment.

By July 1980, Barry was the principal director of the Boat People Clinic, which had moved to regular business hours on Thursdays and included paid staff members. These developments helped ensure stability of the clinic and may have improved its

202 Ibid.
203 Michele Barry, phone interview by the author, New Haven, CT, August 13, 2019.
204 David Coleman, phone interview by the author, New Haven, CT, September 5, 2019.
205 Ibid.
206 Ibid.
208 Ibid.
accessibility. The UConn-Burgdorff Clinic had also started as an evening enterprise, but Holcomb’s study revealed that many of its patients required appointments during daytime hours because of their second-shift employment (i.e. during the afternoon and night).\textsuperscript{209} A similar need likely existed at the Boat People Clinic, as a survey of New Haven’s Southeast Asian refugee population conducted by Boykin et al. (researchers from the local Asian Community Services agency) and published in 1984 found that factory assembly line jobs were one of the refugees’ primary sources of employment.\textsuperscript{210}

However, the change in hours of operation also created new difficulties. The July 1980 \textit{YNHH Bulletin} article reported on the scarcity of interpreters after the schedule adjustment:

A number of those who volunteered evenings cannot take time away from work to assist during daytime clinic hours. “We really need help,” Dr. Barry affirmed. Her plea was reinforced last Thursday as one Vietnamese Catholic nun ran from room to room, doctor to patient, singlehandedly translating each exchange.\textsuperscript{211}

That article concluded with a telephone number to call for Vietnamese-, Cambodian-, or Laotian-speaking people who were “willing to help out from time to time” as interpreters.\textsuperscript{212}

During the clinic’s first 14 months, 142 patients were seen, with as many as 15 visits in a single day.\textsuperscript{213} According to a 1981 \textit{New Haven Register} article, the clinic was

\textsuperscript{209} Lester Wood Holcomb. “Developing Health Screening Services for Indochinese Refugees,” M.P.H., Yale University, 1980, 7.


\textsuperscript{211} “Refugee Clinic Doctors Praised for Efforts,” \textit{Yale-New Haven Hospital Bulletin}, July 24, 1980; 3(15), 2.

\textsuperscript{212} Ibid.

designated by the state of Connecticut in January of that year as one of seven regional centers for the treatment of Southeast Asian refugee patients.\textsuperscript{214} By July 1981, the clinic was sometimes referred to as the Southeast Asian Refugee Clinic, and 300 patients had been seen by nurses and resident physicians, with an average of 8-10 patients per clinic day.\textsuperscript{215} At that point, the staff consisted of Barry, Coleman, a third YNHH internal medicine resident (Dr. Joseph Craft), Alison Rossiter (head nurse), a second nurse, a part-time social worker, and Sister Pia, the aforementioned Vietnamese-speaking nun and representative from Catholic Charities’ Indochinese Refugee Services.\textsuperscript{216}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure3.1.jpg}
\caption{“Four generations of a Vietnamese family arrive at the clinic for their appointments” (left). “The children look after each other in the clinic corridor, waiting their turns with the doctors” (right). As the individuals pictured were patients, I have omitted their names. “Refugee Clinic Doctors Praised for Efforts,” Yale-New Haven Hospital Bulletin, July 24, 1980; 3(15), 1.}
\end{figure}

Patients during the clinic’s first two years were approximately 50% Vietnamese, 30% Cambodian, and 9% Laotian, with the remaining 11% split between Thai and ethnic

\textsuperscript{214} Walt Platteborze, “2-year-old refugee clinic gives more than physical care,” \textit{New Haven Register}, July 5, 1981, New Haven Free Public Library. I was unable to find information about this designation in the press, in government documents, or in hospital archives. Thus, I am unsure of its significance or the other sites chosen. If nothing else, it indicates a degree of official sanctioning of the clinic at the level of the state government.

\textsuperscript{215} Ibid. It was called both the Boat People Clinic the Southeast Asian Refugee Clinic in different sources. I will continue to refer to it as the Boat People Clinic.

\textsuperscript{216} Ibid.
Chinese from Vietnam. The patient population was quite young, with a median age of 19, and one-fifth of families that used the clinic had 6 or more members, many with three generations present during visits. A photo (Figure 3.1) from the 1980 YNHH Bulletin article highlighted one such multigenerational, eight-person family. Patients were, by and large, “very, very, healthy,” according to a 1981 interview with Barry in which she estimated only 5% had a symptomatic physical ailment. Asymptomatic intestinal parasite and latent tuberculosis infections were relatively common, as were psychiatric conditions.

New arrivals were often eligible for Medicare, Medicaid, or special non-Medicaid Refugee Medical Assistance, and some had employer-sponsored health insurance. According to Boykin et al., those refugees who were insured were more likely to frequent the Boat People Clinic, whereas those we were not supported by an organization like Catholic Charities or who did not receive insurance through their employers “relied more heavily on traditional Southeast Asian medical practice either alone or as a supplement to Western medical care.”

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222 See Section V for further discussion of Refugee Medical Assistance.
Dermatologic consultations at the clinic were common given misunderstandings on behalf of staff – likely compounded by the shortage of interpreters – about skin markings that resulted from traditional healing practices, such as cupping and coining. “We didn’t realize that some of the cupping mechanisms of giving traditional care were being diagnosed as abuse, child abuse,” Barry said. Hoang remembered a tragic circumstance in Hartford in which a Vietnamese father died of suicide after being accused of child abuse due to bruises his son had acquired from coin scratching. This event drove Hoang to write the articles on caring for Southeast Asian refugees that he and Erickson published in *AJPH* and *JAMA*. Neither Barry nor Coleman nor Craft recalled such dire consequences of cultural misunderstandings that transpired at the New Haven clinic, though they acknowledged that any misdiagnoses were serious and extremely regrettable.

Despite the parallels between the Hartford and New Haven clinics, their creators did not correspond with one another. This is particularly notable given the fact that Holcomb’s 1980 Yale M.P.H. thesis about the formation of the UConn-Burgdorf included a transfer manual containing suggested considerations for individuals who planned to start their own clinic for Southeast Asian refugees. Holcomb touched on the socioeconomic situation of refugees, their insurance status, the benefits of hiring or consulting with a Southeast Asian physician, how to recruit and best use interpreters, how to train both clinical and administrative clinic staff, and more. Some of the challenges identified in Holcomb’s study were, indeed, encountered at the YNHH clinic, such as

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224 Michele Barry, phone interview by the author, New Haven, CT, August 13, 2019.
225 Giao Hoang, phone interview by the author, New Haven, CT, August 28, 2019.
226 Lester Wood Holcomb. “Developing Health Screening Services for Indochinese Refugees,” M.P.H., Yale University, 1980, Section IV.
scheduling problems and lapses in accounting for cultural differences between providers and patients. When, in June 1983, Barry, Coleman, and their colleagues published two articles about their clinic in *JAMA*, they cited Erickson and Hoang’s 1980 *AJP*H paper but not their 1982 *JAMA* follow-up, which included a thorough discussion of traditional Southeast Asian concepts of health, disease, and medicine (e.g. coining). More than anything else, perhaps, this speaks to the rapid pace at which their clinic was set up and the difficulties in communication and research for busy residents prior to the internet age. It also highlights the somewhat improvised nature in which these early efforts at refugee healthcare were implemented.

In addition to medical care, there is evidence that the clinic played a social role in the lives of some refugees, easing the isolation of resettlement. The title of a 1981 *Register* article about the project – “2-year-old refugee clinic gives more than physical care” – reflected this function, as did the substance of the piece:

“For some it’s a big social event,” said Dr. Michelle [sic] Barry… Scattered about New Haven County in small family units, the refugees who use the clinic “are very isolated” culturally, Barry explained. “This is where they meet friends. They bring food; they hang out. It is a social event.”

Craft similarly recalled that the clinic “was a social scene.” This extra-medical benefit of the Boat People Clinic may have been quite important to its patients, as isolation and loneliness were identified as key problems with consequences for the mental health of this population by the Boykin et al. study. Sister Pia also performed counseling related

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229 Joseph Craft, interview by the author, New Haven, CT, October 2, 2019.
to these issues during home visits she made as part of her position at Catholic Charities, Inc.\textsuperscript{231}

From the providers’ perspective, the clinic was a difficult but rewarding endeavor. It was “arduous because we were on every third night, and we were working really hard and still wanted to donate time,” said Barry.\textsuperscript{232} Coleman also recalled the long hours of evening clinic and celebrated the work for its compelling medical problems and the enthusiasm of the volunteer students, residents, faculty, interpreters, and staff who “really wanted, genuinely wanted, to help the patients.”\textsuperscript{233}

The public response to the clinic was also positive. The 1980 YNHH newsletter and 1981 \textit{Register} article both emphasized the accomplishments of clinic staff. Moreover, in July 1980, Barry and Coleman were given an award for “humanitarian efforts and selfless dedication” by the U.S. Catholic Conference of Hartford, which had sponsored many of the refugees (Figure 3.2).\textsuperscript{234}

There is little record of the YNHH Boat People Clinic after 1984. Its counterpart in Hartford closed after only a handful of years due to a dwindling patient population, despite the growing number of Southeast Asian refugees in Connecticut. This was partially due to resettlement organizations’ increasing use in the early 1980s of “cluster

\textsuperscript{232} Michele Barry, phone interview by the author, New Haven, CT, August 13, 2019.
\textsuperscript{233} David Coleman, phone interview by the author, New Haven, CT, September 5, 2019.
\textsuperscript{234} “Refugee Clinic Doctors Praised for Efforts,” \textit{Yale-New Haven Hospital Bulletin}, July 24, 1980; 3(15), 1.
resettlement,” whereby small groups of refugees were placed in towns around the state rather than concentrated in urban centers. The new resettlement approach made refugee clinics unsustainable, as Southeast Asian families were too geographically scattered to reliably attend visits in New Haven or Hartford. Mary Scully started working as an APRN at the West Hartford-based Khmer Health Advocates in 1982 and witnessed the effects of cluster resettlement: “In terms of healthcare, that meant that there was no local place for them to go, so you weren’t seeing Southeast Asian clinics... because there weren’t enough numbers.”

UConn-Burgdorf Clinic co-founder Hoang also attributed the shrinking pool of patients in Hartford in part to the establishment of Southeast Asian mutual assistance

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235 See Section I for further discussion of the effects of cluster resettlement.
236 Mary Scully, interview by the author, West Hartford, CT, November 13, 2019.
organizations (MAAs) that could arrange for interpreter services at private providers’ offices closer to where refugees lived, reducing the need for a specialized clinic.\textsuperscript{237} A Vietnamese MAA existed as early as 1978, and similar organizations for Connecticut’s Cambodian, Lao, and Hmong populations came into being in the early 1980s.\textsuperscript{238} Scully recalled that MAAs initially focused on helping their constituents find jobs, but they had limited success “because the community was ill.”\textsuperscript{239} Thereafter, “MAAs start[ed] doing a lot of healthcare… a lot of interpreting with doctors.”\textsuperscript{240}

Cluster resettlement and the increasing capabilities of MAAs likely affected New Haven-area refugees, as well, and with fewer patients coming to the Boat People Clinic, the project dissolved.

Coleman went on to hold the position, among others, of Chief of Infectious Diseases at the VA Connecticut Healthcare System. Barry joined the faculty at Yale channeled her interest in tropical medicine into the creation of a travel clinic that opened in the spring of 1982 and, according to an October 1983 New York Times profile, was an “outgrowth” of the refugee clinic.\textsuperscript{241} Barry continued to provide departure and return evaluations for international travelers at the clinic throughout her time at Yale, which ended in 2009.\textsuperscript{242}

After the Boat People Clinic’s closing, New Haven did not have a substantial program focused on refugee healthcare for two-and-a-half decades. The resulting lack of

\textsuperscript{237} Giao Hoang, phone interview by the author, New Haven, CT, August 28, 2019.
\textsuperscript{239} Mary Scully, interview by the author, West Hartford, CT, November 13, 2019.
\textsuperscript{240} Ibid.
\textsuperscript{242} Michele Barry, phone interview by the author, New Haven, CT, August 13, 2019.
services affected refugees from Sudan, Yugoslavia, Iraq, Cuba, Kosovo, Liberia, and Southeast Asia who settled in the area.243 Integrated Refugee and Immigrant Services (IRIS) – the local agency that was founded in 1982 under the name Diocesan Refugee Services Committee and went on to take responsibility for the majority of New Haven area resettlement – struggled during this time to find healthcare for these refugees. According to two long-time IRIS staff members – Kelly Hebrank and Linda Bronstein – case workers navigated long waiting lists at the YNHH and Saint Raphael’s PCCs; private physicians had no access to interpreters; and Department of Public Health clinics were inadequate. Consequently, IRIS staff were forced employed other patchwork solutions, such as standing with clients on a street corner for an hour to be first in line when the mobile Community Health Care Van arrived.244 Though some refugees may have been seen at Barry’s travel clinic, it was not a major avenue for them to access care.

The situation briefly improved in the early 2000s when Dr. Karen Brown, then head of the YNHH PCC, tried to re-establish a center for refugee healthcare, drawing on Barry’s experience. Barry “wasn’t in charge of it, but she [provided] a lot of advice,” recalled Brown, “She kind of knew everything.”245 Similar praise for Barry’s clinical knowledge and dedication to refugee medicine over the years was echoed by her other colleagues and representatives from IRIS. However, the new clinic faltered when Brown left Yale in 2005.

244 Kelly Hebrank, interview by the author, New Haven, CT, July 18, 2019; Linda Bronstein, interview by the author, New Haven, CT, August 9, 2019.
245 Ibid.
A few later, Barry became a close advisor to a YNHH internal medicine resident named Teeb Al-Samarrai. Al-Samarrai had immigrated to the United States with her family from Iraq and graduated from the Yale School of Medicine in 2006. During medical school, she was exposed firsthand to refugee healthcare when she volunteered at a camp in Beirut, Lebanon. As an internal medicine resident at YNHH in 2007, she happened to be in the PCC one day when an IRIS caseworker asked her to translate for a pair of Iraqi twins who were there for a pediatric appointment. This sparked a conversation about the lack of consistent services for refugees, and with Barry as an advisor, Al-Samarrai then spearheaded the project that became Yale’s current adult refugee health program.246

The experience that Barry gained from starting the Boat People Clinic in 1979 continues to inform refugee healthcare at Yale to the present day. However, the lack of continuity between each version meant that Brown and Al-Samarrai in some ways had to reinvent the wheel, each time devising anew practices that had been in place at the 1979 clinic, such as family visits, ahead-of-time lab draws, integration of psychiatric care. Brown described how “revolutionary” some of these strategies seemed when she instituted them in 2003.247 In fact, Barry expressed frustration, not with her colleagues but with institutional failure to trace YNHH’s refugee health program to its roots when many of the same medical and logistical considerations have persisted through multiple variants.248 She highlighted a July 2019 article published on the Yale School of Medicine website that reported that Yale’s refugee clinic had started in 2009 but failed to discuss

246 Teeb Al-Samarrai, phone interview by the author, New Haven, CT, August 14, 2019. The entire preceding paragraph draws on this interview.
248 Michele Barry, phone interview by the author, New Haven, CT, August 13, 2019.
any earlier efforts. A similar article in a 2011 issue of *Yale Medicine* mentioned that “an adult refugee clinic at Yale had closed when its organizers left the medical school,” referring to the early-2000s attempt, but it did not delve any further into the history.

When asked about the level of institutional memory that existed regarding the Boat People Clinic, Brown said,

> Did it feel like I was starting from scratch? I don’t know. Nothing in medicine is truly new, right? It’s always you’re refining something that came before. So, yes, we were assessing refugees. Yes, Michele Barry was there to lend her wisdom if we needed it… So, in some senses we were continuing what happened before.

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### IV. A Handshake and Personal Engagement: Soviet Refugees, Jewish Physicians, and the Hospital of Saint Raphael

“We came here in 1993. Family of four. Me, my husband, and two kids, age eight and fifteen… All our medical bills were covered from Jewish Federation, and any hospitals… I don’t know what was the agreement with Jewish Federation, but we paid nothing. Great experience for me. We came here without money and we had our coverage.”

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252 Yelena Gerovich, interview by the author, Woodbridge, CT, September 12, 2019.
Yelena Gerovich, refugee and JFGNH New American Acculturation Program Coordinator

At the beginning of the 20th century, New Haven was home to significant numbers of Catholics and Jews. In 1910, the two largest foreign-born nationalities in the city were Italians and Irish, both largely Catholic and comprising a combined 16.5% of the city’s population.\(^{253}\) Jews made up between 4.6% and 7.8% of the New Haven population.\(^{254}\)

There were two local not-for-profit hospitals at this time: New Haven Hospital and Grace Hospital, which merged in 1945 to form Grace-New Haven Community Hospital and, twenty years later, affiliated with the Yale School of Medicine to become Yale-New Haven Hospital.\(^{255}\) Despite the relatively large Catholic and Jewish presence in the city in the early 1900s, physicians who belonged to these groups were denied practicing privileges at these institutions.\(^{256}\) Moreover, the hospitals often neglected the preferences of Catholic and Jewish patients. They did not allow visitation by chaplains of

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\(^{256}\) Hospital of Saint Raphael, *Answering the Call: 100 Years of Hope and Healing at the Hospital of Saint Raphael*, (New Haven, CT: Hospital of Saint Raphael, 2008), 6. In his history of *Jews in New Haven*, David Fischer draws a distinction between early 20th century Jews who were passed over for promotion and acceptance at Yale Medical School due to being immigrants, which was in keeping with the University’s nativist policies at the time, and American-born Jews who, in his analysis, were generally treated fairly (Fischer, *Jews in New Haven*, 119). It is possible a divergence also existed between foreign-born and native physicians, Catholic or Jewish, and their employment prospects at New Haven’s hospitals. Fischer asserts that “Jewish physicians had no problems with staff privileges at the Grace Hospital,” though it is unclear if this statement refers only to those who were born in the United States (Fischer, *Jews in New Haven*, 128).
these faiths, for example. Kosher food was also unavailable and Jewish rituals, such as observance of the Sabbath, were not practiced.

Comparable challenges were faced by Catholic and Jewish medical professionals and patients elsewhere. As a result of this discrimination, in addition to a religious mission to serve the destitute, Catholic and Jewish organizations in many cities started their own hospitals focused on the needs of their respective communities that could provide doctors of those affiliations a place to practice. Mt. Sinai Hospital in Hartford, CT, for instance, was founded in 1923 and catered to the state capital’s Jewish population. In New Haven, the two religious groups collaborated. Rabbi Herbert Brockman – who retired in 2018 from his 32-year post at Congregation Mishkan Israel in Hamden, CT – explained that Jews “in communities like New Haven, which had small Jewish communities, did not have the sufficient wherewithal to create their own [hospital, so they] got together with the Catholic community.”

In 1907, fourteen physicians – nine Catholics, three Jews, and two Protestants – approached the Sisters of Charity of Saint Elizabeth, an order of Catholic nuns based in New Jersey that operated various charitable institutions in surrounding states, to request that they start a hospital in New Haven. The Sisters agreed to do so, and the Hospital of Saint Raphael (HSR) was born on March 14, 1907. Mishkan Israel was a prominent

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257 Hospital of Saint Raphael, *Answering the Call: 100 Years of Hope and Healing at the Hospital of Saint Raphael*, (New Haven, CT: Hospital of Saint Raphael, 2008), 6, 10.
259 Ibid.
260 Herbert Brockman, interview by the author, Hamden, CT, September 3, 2019.
261 Ibid.
262 Though not of immediate relevance to the current discussion, the gender dynamics involved in the administration of Catholic hospitals – the vast majority of which were operated by women, at least initially – are fascinating and discussed in depth in Barbara Wall’s book *American Catholic Hospitals: A Century of*
donor during the hospital’s infancy. For example, synagogue leadership hosted fundraising events such as “Hospital Sunday” to encourage gifts from the congregants.\textsuperscript{263}

Though predominantly a Catholic institution, from its start HSR explicitly and consistently welcomed Jewish patients and professionals. The hospital’s founding charter set forth the goal of creating “a hospital to receive and care for all patients who might apply for admission without regard to creed or race… and to offer the institution to those of the medical profession who desire to care for their own patients.”\textsuperscript{264} In the case of Jews, the hospital achieved this goal. Dr. David Fischer – the editor and author of \textit{Jews in New Haven Volume IX} and 1980 HSR Staff President – wrote,

\begin{quote}
To my knowledge… no qualified Jewish physician was denied staff privileges [at HSR] because of his religion. Many Jewish physicians chose HSR as their primary hospital and many Jewish patients preferred it for several reasons, not the least of which was the availability of kosher meals there at an earlier time than at the other hospitals.\textsuperscript{265}
\end{quote}

According to Fischer, this stood in contrast to Yale-New Haven Hospital, where Jewish physicians, including Fischer himself, perceived noticeable anti-Semitism from some leaders.\textsuperscript{266} When Fischer went into private practice around 1970, his application for staff privileges at Yale-New Haven was rejected. “It was not at all clear that I wasn’t on the staff [at Yale-New Haven] because I was Jewish,” recalled Fischer, “but the person in

\textit{Changing Markets and Missions}. Though an all-male group of physicians asked the Sisters of Charity to start the hospital, Saint Raphael’s was led by a succession of female nuns until 1986.\textsuperscript{263} Cushing/Whitney Medical Library, “The Founding of the Hospital of Saint Raphael,” New Haven’s Hospitals, May 2000, http://doc1.med.yale.edu/news/exhibits/hospitals/saintraphaels.html.\textsuperscript{264} Ibid. Other Catholic hospitals used similar inclusive wording to describe their missions. Though again not directly related to this paper’s topic, Wall’s \textit{American Catholic Hospitals} includes an interesting analysis of the ways in which, despite such wording, with a few exceptions these institutions participated in racial segregation as the 20\textsuperscript{th} century progressed. “While continuing to provide needed services to the poor and indigent, [Catholic hospitals] generally fell behind when it came to race relations and integration practices” (Wall, 101).\textsuperscript{265} David S. Fischer, \textit{Jews in New Haven Volume IX} (New Haven, CT: Jewish Historical Society of Greater New Haven, Inc., 2009), 125.\textsuperscript{266} David Fischer, phone interview by the author, New Haven, CT, November 7, 2019.
charge of staff at that time was a pretty well-known anti-Semite. He made it slow to happen.”

He then applied to HSR and “they accepted [him] by return mail.”

The connection between the Jews of New Haven and HSR was also important to the identity of the hospital itself. A section titled “This Is Our Story” from the HSR 1971 annual report touted the religious diversity of its staff and patients. HSR employee newsletters throughout the 1970s and ‘80s included descriptions of Jewish holidays and the shared values of Judaism and Catholicism. And a history of HSR published by the hospital in 2008 boasted that “Saint Raphael’s has had a special relationship with the Jewish community from the very beginning.”

Oscar Roth was a notable beneficiary of and contributor to this relationship. He and his wife, Stephanie Roth, were doctors in Vienna, Austria, and came to New Haven in 1938 after having narrowly avoided being detained by Nazi soldiers. A 1978 retrospective New Haven Register article described how, at a time when foreign-trained physicians found it difficult to land residency spots in the United States, Oscar had been able to get an internship at HSR: “Roth recalled that the late Sister Rose Alexis, who was then chief administrator of the hospital, had ‘a big heart’ for refugees from Nazism, and had him taken on as a resident physician.” A cardiologist, Roth went on to found HSR’s Coronary Care Unit in 1965, which represented a pivotal advancement in the

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267 Ibid.
268 Ibid.
269 1971 Hospital of Saint Raphael Annual Report, 1971, Reference Files, Box 2, Folder “History – Hospital of Saint Raphael,” Hospital of Saint Raphael Archives, New Haven, CT.
270 Gauzette (multiple issues) and Inside HSR (multiple issues), Hospital of Saint Raphael Archives, New Haven, CT.
271 Hospital of Saint Raphael, Answering the Call: 100 Years of Hope and Healing at the Hospital of Saint Raphael, (New Haven, CT: Hospital of Saint Raphael, 2008), 73.
272 “‘Breakfast for Champions’ To Honor Cardiologist,” New Haven Register, 19 November 1978, Reference Files, Box 1, Folder “Roth, Oscar,” Hospital of Saint Raphael Archives, New Haven, CT.
hospital’s ability to offer acute care services (Figure 4.1). Both Oscar and Stephanie (who had trained as a gynecologist in Austria) later provided services to the subsequent Jewish refugees from the Soviet Union.

The historical link between HSR and the local Jewish community helps explain how – as an outgrowth of a program to provide circumcisions for refugee boys and men who had not had a bris in the Soviet Union but who wanted the procedure done when they came to the United States – this Catholic hospital became one of the principal sources of medical care for Soviet Jewish refugees in New Haven. In the Soviet Union, Jews encountered professional discrimination and strict limitations on religious expression, as well as food scarcity and “the general oppression of the Communist

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273 Hospital of Saint Raphael, *Answering the Call: 100 Years of Hope and Healing at the Hospital of Saint Raphael*, (New Haven, CT: Hospital of Saint Raphael, 2008), 89.
274 I did not find evidence to suggest that Stephanie got an internship akin to Oscar’s, but she did become officially affiliated with the hospital (*Answering the Call*, 54).
society” shared by all Soviet citizens at that time. However, few were allowed to leave the Soviet Union until Congress passed the Jackson-Vanik Amendment to the Trade Act of 1974, which linked Soviet emigration policy to favorable trade status. After passage of the bill, Jews’ applications for exit visas from the Soviet Union began to be accepted in increasing numbers. In Fiscal Years 1979 and 1980, over 46,000 Soviet refugees entered the United States, 503 of whom resettled in Connecticut. According to records from the Jewish Federation of Greater New Haven (JFGNH), one of the organizations responsible for local resettlement, 196 Soviet Jews came to New Haven between 1974 and 1981.

As anthropologist Betty Hoffman discussed in her 2001 comparative ethnography of American and Soviet Jews in Hartford, CT, one way that Jews in the Soviet Union attempted to assimilate and protect their male children from persecution was to forgo the bris, the circumcision ceremony usually performed when a baby boy is eight days old. Blossom Rose, former Healthcare Coordinator for the JFGNH Refugee Resettlement Committee, explained, “One of the reasons they didn’t do that in Russia, even if they had somebody to perform it, is it would mark them as Jewish… God knows what could happen to them.” Thus, when Soviet Jews first immigrated to New Haven in 1974, Elliot Brand, a Jewish urologist at HSR, offered to perform circumcisions for them.

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277 Ibid.
281 Blossom Rose, phone interview by the author, New Haven, CT, August 21, 2019.
(Figure 4.2). Brand convinced HSR administrators (at that time led by Sister Louise Anthony) to furnish the necessary space and equipment to allow him to perform circumcisions free of charge. HSR radiologists and anesthesiologists also donated their time. These brises continued intermittently through the 1980s, and after Brand’s retirement in 1988, at least one other Jewish urologist, Alan Malitz, stepped in to continue performing circumcisions.

Circumcision is a somewhat riskier and more involved operation when performed on older patients compared to infants. Nonetheless, some refugees took the opportunity to complete this religiously important rite. In Rose’s recollection, “Mostly, the adults wanted it done. And they would always say, ‘Now I’m really Jewish’” afterwards.

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282 Caryl Kligfeld, interview by the author, Woodbridge, CT, August 19, 2019.
283 Correspondence from Sister Anne Virginie Grimes to Dr. Frank Troncale, 3 January, 1991, Sister Anne Virginie Subject Files, Box 1, Folder “Jewish Federation of Greater New Haven,” Hospital of Saint Raphael Archives, New Haven, CT.
285 Correspondence from Blossom Rose to Sister Anne Virginie Grimes, 3 November, 1989, Sister Anne Virginie Subject Files, Box 1, Folder “Jewish Federation of Greater New Haven, Hospital of Saint Raphael Archives, New Haven, CT.
286 Blossom Rose, phone interview by the author, New Haven, CT, August 21, 2019.
Another motivation for refugee parents to have their school-age male children circumcised may have been disapproval from the leadership of the Orthodox Hebrew Day School. According to Caryl Kligfeld – former Soviet Jewry Task Force Chair for the JFGNH – when they arrived, some of the children in refugee families were given tuition-free enrollment at the local Jewish day schools.\textsuperscript{287} Orthodox rabbis thought circumcision should be a precondition for attendance at the Hebrew Day School.\textsuperscript{288} Though JFGNH resettlement workers and other community leaders such as Reform Jewish rabbi Herbert Brockman negotiated alternate schooling options that were less religiously strict, it is

\textsuperscript{287} Caryl Kligfeld, interview by the author, Woodbridge, CT, August 19, 2019.
\textsuperscript{288} Ibid.
possible that some refugees’ decisions regarding circumcision were influenced by this controversy.

As a consequence of secular Soviet society, many Jewish refugees were not particularly religious.\textsuperscript{289} Deborah Dyme – social worker and former Russian Resettlement Coordinator for Jewish Family Services (JFS, a constituent organization of JFGNH that administered refugee resettlement until 1981) – was unaware and surprised to learn of Brand’s arrangement. “I just don’t know how important that was [to the Soviet Jews],” Dyme said.\textsuperscript{290} Indeed, the procedure was not especially common. The total number of circumcisions performed at HSR for Soviet Jewish refugees between 1974 and 1990 was 24.\textsuperscript{291} Nevertheless, this was an important issue for some of the more religious refugees, as well as for the community that sponsored them.

It also provided the foundation for a deal between JFS/JFGNH and HSR that allowed approximately 1,800 Soviet Jewish refugees to receive free healthcare at the hospital over the following three decades.\textsuperscript{292} Reflecting on the evolution of this arrangement in a 1991 letter to a local physician, Sister Anne Virginie, who took over from Sister Louise as HSR President in 1978, wrote:

> It was Dr. Elliot Brand who initiated this program fifteen years ago – at first to provide circumcisions, but soon covered [sic] a wide variety of exams, procedures, et al. He coordinated the various departments involvement and had continuous support from his professional colleagues and the Hospital. Were he

\textsuperscript{289} Differing degrees of religious observance and conceptions of Jewishness as an ethnicity versus a religious identity led to tension between Soviet Jewish refugees and the American Jewish community. Two books – Betty Hoffman’s \textit{Jewish Hearts: A Study of Dynamic Ethnicity in the United States and the Soviet Union} and Steven Gold’s \textit{Refugee Communities: A Comparative Field Study} – provide excellent analyses of these differences. See Section II for further discussion of this topic as it related to Soviet refugees in New Haven.

\textsuperscript{290} Deborah Dyme, interview by the author, Southbury, CT, October 30, 2019.

\textsuperscript{291} “Russian Resettlement,” 1990, Restricted Files, Folder “Federation (1/2),” Jewish Historical Society of Greater New Haven Archives, New Haven, CT.

\textsuperscript{292} Hospital of Saint Raphael, \textit{Answering the Call: 100 Years of Hope and Healing at the Hospital of Saint Raphael}, (New Haven, CT: Hospital of Saint Raphael, 2008), 73.
alive he would be very pleased to know that the program continues to respond to the needs of people. After all, that is what the healing ministry is all about.  

By January, 1980, representatives from HSR had agreed that one adult refugee per day could be seen in the HSR primary care clinic. The hospital had also agreed to offer return visits for any problems identified during the initial exam and hospitalizations, if necessary, as well as pediatric clinic visits for all refugee children. Volunteers and staff from JFS coordinated the scheduling, transportation, and interpretation for appointments.  

Prior to 1980, there was no federally standardized medical insurance program for all refugees, and according to a 1980 JFS quarterly report, many Soviet Jews were uninsured for up to three months after arriving in the United States. HSR provided medical services during this period, by the end of which many refugees had secured employer-based insurance and most others had applied for Medicare or Medicaid. With the exception of prescription medications, for which JFS paid a reduced price at a local pharmacy, these services were provided without charge to the patients or JFS.  

The hospital’s beneficence was partly a consequence of its having received funding through the Hill-Burton Act for construction of a new building that opened in 1976. As a condition for accessing federal monies in this way, HSR was required to

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293 Correspondence from Sister Anne Virginie Grimes to Dr. Frank Troncale, 3 January, 1991, Sister Anne Virginie Subject Files, Box 1, Folder “Jewish Federation of Greater New Haven,” Hospital of Saint Raphael Archives, New Haven, CT.
295 Ibid.
296 Ibid.
297 Ibid.
298 Ibid.
299 Ibid.
300 “Hill Burton’s new name: HSR Financial Assistance,” Inside HSR, September 27, 1990, Hospital of Saint Raphael Archives, New Haven, CT.
provide some amount of free care to patients who were unable to pay.\textsuperscript{301} The services for Jewish refugees went toward fulfilling this obligation.\textsuperscript{302} The Refugee Act of 1980 created the Refugee Medical Assistance (RMA) insurance program for refugees who fell below income levels that were based on (though slightly more lenient than) the Medicaid qualification criteria in their state of resettlement.\textsuperscript{303} Even after some refugees became eligible for RMA, HSR continued to donate services during their initial 3-month resettlement period.

In March, 1981, an agreement between JFS and HSR regarding the provision of medical care to Soviet Jewish refugees was formalized in writing (Figure 4.3).\textsuperscript{304} This document laid out the timeframe for services, as well as procedures for JFS to notify HSR of any appointments scheduled and the socioeconomic, welfare assistance, and resettlement status of each patient.\textsuperscript{305} It also included billing details for the hospital, such as “[HSR] will adjust all accrued charges to Free Work”; “monthly billing statements will be addressed to Jewish Family Services”; and “documentation indicating the amount of free service made available to Jewish Family Service will be maintained by the Patient Accounts Manager.”\textsuperscript{306}


\textsuperscript{302} Correspondence from “JK” to “JF, KDZ, SG” with subject line “Re: Field Visit to New Haven, Conn. On December 2, 1980,” December 12, 1980, RG 6B2, Box 3B, Folder 3, Jewish Historical Society of Greater New Haven Archives, New Haven, CT.


\textsuperscript{304} “Restating Policy: Jewish Family Services,” March 6, 1981, RG 6B2, Box 3B, Folder 4, Jewish Historical Society of Greater New Haven Archives, New Haven, CT.

\textsuperscript{305} Ibid.

\textsuperscript{306} Ibid.
This written policy stayed remarkably consistent for at least a decade. Comparing a 1989 revision to the 1981 version, the only alterations reflected changes in the required
duration of services from three months to four months and in the organization responsible for administration of resettlement switching from JFS to JFGNH.\textsuperscript{307}

As a result of this program, HSR received much praise and gratitude from the local Jewish community. In 1980, the Executive Director of the JFGNH, Arthur Spiegel, wrote, referring to HSR’s contribution as well as those from private physicians, “The medical field has saved us many, many thousands of dollars in expenses by its volunteerism.”\textsuperscript{308} Some years later, the \textit{Connecticut Jewish Ledger} – a publication which claimed to be “mailed to every Jewish home in the Greater New Haven area” – lauded

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure4.4.jpg}
\caption{Officials from the JFGNH presenting Sister Anne with a plaque recognizing HSR’s fifteen years of service to Jewish refugees from the Soviet Union. From left to right: Blossom Rose (JFGNH refugee resettlement program healthcare coordinator), Sister Anne Virginie (Saint Raphael Healthcare System president), Stephen Saltzman, Esq. (JFGNH president), Lew Lehrer (JFGNH refugee resettlement volunteer), Susan Shimelman (JFGNH executive director), and Daniel Rissing (HSR president and CEO). “Saint Raphael’s Recognized by Jewish Federation for Service and Commitment to Immigrants,” The Advisor, 8 January 1991, Sister Anne Virginie Subject Files, Box 1, Folder “Jewish Federation of Greater New Haven,” Hospital of Saint Raphael Archives, New Haven, CT.}
\end{figure}

\textsuperscript{307} “Restating Policy: The Jewish Federation of Greater New Haven,” August 1989, Sister Anne Virginie Subject Files, Box 1, Folder “Jewish Federation of Greater New Haven,” Hospital of Saint Raphael Archives, New Haven, CT.
\textsuperscript{308} Correspondence from Arthur Spiegel to Sidney Horton, July 2 1980, RG 6B2, box 3B, Folder 3, Jewish Historical Society of Greater New Haven Archives, New Haven, CT.
HSR for the program.\textsuperscript{309} In 1991, the JFGNH bestowed HSR with a plaque in honor of the hospital’s service (Figure 4.4).\textsuperscript{310}

This positive reception also included HSR’s two prominent leaders, Sister Louise and Sister Anne, who received multiple awards from the Jewish community. In 1984, both HSR presidents were celebrated by the JFGNH “for many outstanding services to Soviet Jewish Immigrants.”\textsuperscript{311} The Anti-Defamation League also presented Sister Anne with the Torch of Liberty Award during a 1991 ceremony at Congregation B’nai Jacob in Woodbridge, CT.\textsuperscript{312} Kligfeld and Rose were effusive in their praise of Sister Anne for her advocacy. Rose recalled when the JFGNH increased the duration of its resettlement support for each refugee from three to four months and wanted to secure an extra month of medical assistance from HSR, as well:

If I needed something extra – after a while, our government raised it to four months of care – I would call her… and I remember she’d say to me, “Blossom, four months, five months, whatever you need is yours.” They were absolutely fantastic. …That Sister Anne Virginie, I could have asked her to cut her head off, and I think she would have done it.\textsuperscript{313}

Sister Anne even served alongside Kligfeld as Honorary Chair of the 1988 Women’s Plea for Soviet Jewry, an important fundraising and publicity event for the refugees’ cause.\textsuperscript{314}

\textsuperscript{309} Untitled article, *Connecticut Jewish Ledger*, 8 February 1990, Sister Anne Virginie Subject Files, Box 1, Folder “Jewish Federation of Greater New Haven,” Hospital of Saint Raphael Archives, New Haven, CT.
\textsuperscript{310} “Saint Raphael’s Recognized by Jewish Federation for Service and Commitment to Immigrants,” *The Advisor*, 8 January 1991, Sister Anne Virginie Subject Files, Box 1, Folder “Jewish Federation of Greater New Haven,” Hospital of Saint Raphael Archives, New Haven, CT.
\textsuperscript{311} Hospital of Saint Raphael, *Answering the Call: 100 Years of Hope and Healing at the Hospital of Saint Raphael*, (New Haven, CT: Hospital of Saint Raphael, 2008), 73.
\textsuperscript{312} “Torch of Liberty Award,” April 24 1991, Sisters of Charity Files, Box 8, Folder “Recognitions and Awards,” Hospital of Saint Raphael Archives, New Haven, CT.
\textsuperscript{313} Blossom Rose, phone interview by the author, New Haven, CT, August 21, 2019.
\textsuperscript{314} 1988 Women’s Plea for Soviet Jewry flier, 1988, RG 6B2, Box 3A, Folder 1, Jewish Historical Society of Greater New Haven Archives, New Haven, CT.
Although the spontaneous and informal nature of the relationship between HSR and JFS/JFGNH – illustrated by the way in which Rose negotiated changes to their agreement with a friendly phone call to the HSR President – allowed these organizations to adapt to the refugees’ needs, it also led to some hiccups for the program. According to minutes from a 1981 meeting of the JFS Refugee Resettlement Task Force, the written policy originally was created because “St. Raphael’s hospital had a movement afoot to cut off any medical services to the Russians.”\textsuperscript{315} Dyme, the Resettlement Coordinator for JFS, “discovered this fact and managed to arrange a written contract with the hospital.”\textsuperscript{316}

The 7-year-old tacit understanding between the organizations was apparently nearly lost. A similar issue arose in 1981, when officials at the JFGNH wished to take over resettlement from JFS due to differing opinions about how the process should be run. Kligfeld recalled,

\begin{quote}
We wanted to deal with them as mishpacha, you know, as family, as friends… And JFS had this social work mentality. They were clients, and there was strict confidentiality that they were very concerned about, and there was a barrier between the volunteers and the professionals.\textsuperscript{317}
\end{quote}

In Dyme’s recollection, JFS leadership was most concerned about accountability and the necessity to keep accurate records, given the federal funding they received for resettlement.\textsuperscript{318} Members of JFS and the JFGNH debated whether or not it would be advisable to transfer resettlement responsibilities to the JFGNH at a May, 1981, meeting.

\textsuperscript{315} Russian Resettlement Task Force meeting minutes, August 3 1981, RG 6B2, Box 3A, Folder 4, Jewish Historical Society of Greater New Haven Archives, New Haven, CT. I have been unable to find information about why HSR may have tried to stop providing services, though it is possible the introduction of RMA may have played a role.
\textsuperscript{316} Ibid. In our interview, Dyme did not recall this incident or her role in securing the contract.
\textsuperscript{317} Caryl Kligfeld, interview by the author, Woodbridge, CT, August 19, 2019.
\textsuperscript{318} Deborah Dyme, interview by the author, Southbury, CT, October 30, 2019.
of the JFS and JFGNH Joint Russian Resettlement Steering Committee. According to minutes from this meeting, the JFS Executive Director Stephen Donshik cautioned… that certain relationships have been established between JFS and other service providers and that these relationships cannot be treated lightly. For example, JFS now has an agreement with St. Raphael’s… If the [New Haven Jewish] community expresses a desire to wind down the [JFS] Resettlement Program and later decides to reactive it [through the JFGNH], the same deal with St. Raphael’s may no longer be available.\(^\text{319}\)

Donshik was concerned that the deal with HSR would be lost during the transfer from JFS to the JFGNH. While this assertion may have been made as part of an argument for his organization to retain control of the resettlement program, it underscored the tenuous nature of this venture, which was not based on sustainable infrastructure – such as a dedicated clinic – to address refugee health needs, but was rather an improvised response to those needs that relied on familiarity and good will between the involved parties.

In the early 1990s, an internal HSR correspondence indicated confusion around billing and which ancillary services were available for the refugee patients, suggesting that a lack of clearly defined obligations and procedures continued to hinder the program.\(^\text{320}\) Indeed, in a 1991 memorandum, Sister Anne noted how the provision of care for Soviet Jews faltered after Brand retired in 1988 and Rose and Eileen Scalesse – a hospital administrator with whom Rose worked closely – stepped down from their

\(^{319}\) Joint Russian Resettlement Steering Committee meeting minutes, May 22 1981, RG 6B2, Box 3A, Folder 4, Jewish Historical Society of Greater New Haven Archives, New Haven, CT.

\(^{320}\) Interoffice memorandum from Kathleen Cantiello to Sister Anne Virginie and Louise Sepkowski, July 12 1990, Sister Anne Virginie Subject Files, Box 1, Folder “Jewish Federation of Greater New Haven,” Hospital of Saint Raphael Archives, New Haven, CT.
respective positions. Sister Anne wrote, “With the departure of these principals, the process of servicing these immigrants has broken down somewhat.”

In that same memo, an HSR radiologist expressed concerns about the generalizability and equity of the program. “Dr. Wescott questioned what we would do if other ethnic groups asked for similar assistance. Those requests would have to be evaluated at the time,” noted Sister Anne. Wescott’s inquiry alluded to the problem, central to this paper, of how healthcare institutions should best provide sustainable services to refugees, who all share a legal status and have some situational commonalities but who also represent distinct, shifting populations with diverse medical and social needs and varying degrees of connection to existing co-ethnic communities where they have been resettled.

The healthcare benefits for refugees of having a well-established Jewish community in New Haven went beyond Jewish Family Services’ and the Federation’s facilitation of their ability to access care at HSR. These organizations also called upon the generosity of individual Jewish doctors to provide free supplementary care to refugee patients. Both Kligfeld and Rose recalled the willingness of members of the medical community, whether in primary care or specialty areas, to contribute their services. Said Rose, “Nobody ever turned me down. They were really wonderful.” A 1980 report about JFS’s resettlement efforts listed doctors who had agreed to see patients as part of their private practices, including Oscar and Stephanie Roth (cardiologist and

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321 Interdepartmental memorandum titled “Health Services for Russian Immigrant Jews,” March 18 1991, Sister Anne Virginie Subject Files, Box 1, Folder “Jewish Federation of Greater New Haven,” Hospital of Saint Raphael Archives, New Haven, CT.
322 Ibid.
323 Blossom Rose, phone interview by the author, New Haven, CT, August 21, 2019.
gynecologist), Edward Etkind (generalist), Mark Schwartz (generalist and rheumatologist), and Elliot Brand (urologist). A 1990 JFGNH document mentioned in-kind donations to refugees by “local dentists, pediatricians, a Russian speaking psychiatrist, dermatologists, and gynecologists.”

As with HSR, JFS and the Federation asked private physicians to donate services for the first three months after a refugee arrived in the United States. If patients acquired insurance coverage, the 1979 JFS/JFGNH policy stated that “payment to [the] doctor should be paid where applicable even if free service [is] still available.” JFS and the Federation sent Russian-speaking interpreters to appointments with refugees, though sometimes patients’ family members translated.

While a few physicians who were not explicitly named in the JFS/JFGNH records may have been non-Jewish, those who were identified were Jewish immigrants themselves or were engaged with the Federation and felt a commitment to help their fellow Jews. Meyer Etkind was born in Russia in 1907 and had emigrated to the United States when he was 2 years old. At an event celebrating him in 1980, a speaker stated, “Meyer is a honored name among the recently arrived Russian refugees in New Haven for his fine medical services.”

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326 Joint Russian Resettlement Steering Committee meeting minutes, October 3, 1979, RG 6B2, Box 3A, Folder 4, Jewish Historical Society of Greater New Haven Archives, New Haven, CT.
327 Ibid.
328 Deborah Dyme, interview by the author, Southbury, CT, October 30, 2019.
329 Obituary of Dr. Meyer Etkind, New Haven Register, July 6, 1984, RG 6I, Box 1, Folder “Physicians, Dentists, Nurses not at Yale,” Jewish Historical Society of Greater New Haven Archives, New Haven, CT.
330 B’nai B’rith Youth Services Award Breakfast honoring Meyer G. Etkind, M.D. speech transcript, June 8, 1980, RG 6B2, Box 3B, Folder 3, Jewish Historical Society of Greater New Haven Archives, New Haven, CT.
refugees from Austria in 1938. Mark Schwartz was also involved in the JFGNH, and his wife, Heni, remembered many refugees coming to his office. Not only did Mark volunteer medical care, but the Schwartzes also sponsored a Soviet Jewish family to resettle in New Haven in 1988. Myron Brand, a gastroenterologist and JFGNH donor (no relation to Elliot Brand), treated refugee patients in the late 1970s. Brand explained his motivation to help, “I felt I was Jewish and… it was my obligation to take care of these people if they came to me.” Elliot Brand, the instigating force behind the Federation’s agreement with HSR to provide circumcisions and free care, was also a JFGNH member. Thus, the social and professional network provided by the JFGNH and New Haven’s Jewish community ensured an ample supply of physicians willing to see refugee patients for free. Rose explained,

A lot of the doctors were also active in Federation. So as [refugees] came in, we would talk, and they’d say, “If you need me, call me.” And even if they didn’t say that, if I needed, I called them anyway… Plus, I had two relatives that were physicians in New Haven.

Myron Brand recounted one particularly memorable experience that demonstrated how word-of-mouth information about Jewish healthcare providers in New Haven reached refugees even before they arrived in the country:

There was one I remember very well that… came off the plane. I guess he had a bleeding ulcer. And somehow or other he had a note – he didn’t speak any English – he had a note pinned to him saying, “Contact Dr. Brand.” … I have no idea how he got my name, but I know he came off the plane with a thing pinned to him. Somehow, I’m sure somebody must have called the Jewish Federation before he left… The guy had a bleeding duodenal… ulcer.

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331 “‘Breakfast for Champions’ To Honor Cardiologist,” New Haven Register, 19 November 1978, Reference Files, Box 1, Folder “Roth, Oscar,” Hospital of Saint Raphael Archives, New Haven, CT.
332 Heni Schwartz, phone interview by the author, New Haven, CT, November 5, 2019.
333 Myron Brand, phone interview by the author, New Haven, CT, August 26, 2019.
334 Caryl Kligfeld, interview by the author, Woodbridge, CT, August 19, 2019.
335 Blossom Rose, phone interview by the author, New Haven, CT, August 21, 2019.
336 Myron Brand, phone interview by the author, New Haven, CT, August 26, 2019. It is possible this story is apocryphal, as Dr. Frank Troncale, one of Myron Brand’s colleagues, recounted the same incident in a
Perhaps because there were a number of American Jewish physicians and Jewish physicians who had immigrated decades earlier willing to see these patients, the JFGNH did not recruit Soviet physicians to earn American medical licenses and treat New Haven refugees. Rose discussed one man who had been a doctor in the Soviet Union and wanted to continue practicing after he arrived in Connecticut. The Federation advised him to move to Philadelphia due to the greater availability of jobs for foreign-trained doctors. “We said, ‘You’ll never find work here,’” Rose recalled. In her ethnographic study of Soviet Jewish immigrants to Hartford, CT, Hoffman found that, for a variety of reasons, many Soviet doctors decided not to complete the two- to three-year retraining required for hospital-based positions. Some felt too old to restart their career, while others were deterred by the intensity of residency programs and difficulty achieving English proficiency or passing board examinations. In areas with more robust resettlement programs, such as Northern California, refugee physicians often went into private practice and became the primary medical care providers for large groups of refugees, according to sociologist Steven Gold.

Even in the absence of ex-Soviet doctors practicing in New Haven, the ability of JFS and the JFGNH to arrange for two relatively reliable pathways for Soviet Jews to access medical care – one at HSR and one with private physicians – speaks to the significant role that a co-ethnic community with cultural ties to a refugee population can

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1990 letter to Sister Anne Virginie, except he wrote that the patient was female. It is also possible Troncale was simply mistaken as to the details of the story.

337 Blossom Rose, phone interview by the author, New Haven, CT, August 21, 2019.
play in advocating for the health of that population. The free care provided by HSR was the closest thing in the New Haven area to a formalized clinic for Soviet Jewish refugees. The fact that the original basis for this care was a circumcision program set up by a Jewish physician – the bris holds much symbolic weight in Jewish tradition – at a Catholic facility highlights the power of the ties between two groups which had been historically rejected from hospitals as providers and mistreated as patients. Due to its longstanding relationship with the local Jewish community, HSR was well positioned to provide necessary services to Soviet Jewish refugees. According to Alison Stratton, the State Immigrant and Refugee Health Coordinator for Connecticut, it was not unusual for a Catholic hospital to be involved in providing healthcare to refugees. Stratton explained that religiously affiliated organizations “form the backbone of the resettlement program… We rely on faith-based organizations for a lot of things.” Nevertheless, the relationships between HSR, Jewish physicians, and JFS/JFGNH created a distinct set of circumstances that shaped the healthcare options available to Soviet refugees.

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340 Alison Stratton, interview by the author, New Haven, CT, 6 August 2019.
V. Refugee Health and American Medicine

When Southeast Asians and Soviet Jews began to arrive in Connecticut in the 1970s and 1980s, their status and experiences as refugees affected the healthcare that they needed and that they received. On a national level, the federal government established a medical insurance program for refugees and stipulated health screenings that they had to complete upon arrival. These actions were, in part, meant to keep refugees healthy as they worked toward economic self-sufficiency. Refugees were also seen by some members of the public as threats to public health, which in turn influenced how the medical system treated them. Though concerns about them being vectors of communicable disease were overblown, refugees did suffer from a variety of medical conditions that made accessible care a necessity. These included a lack of routine preventive health measures (e.g. immunizations and family planning options); infectious diseases endemic to their countries of origin; inherited and acquired hematologic conditions; and psychiatric illnesses produced and exacerbated by their traumatic experiences.

Responding to swelling numbers of international refugees in the late 1970s, Congress passed the Refugee Act of 1980, creating for the first time a comprehensive set of policies to regulate the admittance of, resettlement of, and provision of services to all refugees destined for the United States. The Act created the Office of Refugee Resettlement (ORR), housed within the Department of Health and Human Services (HHS), to administer these policies. One of the primary goals of ORR-administered
services was “to help refugees achieve economic self-sufficiency as quickly as possible” so as to avoid long-term reliance on public assistance.\(^{341}\)

In part to prevent refugees from becoming indigent, the ORR attempted to ensure their good health. The 1980 ORR Annual Report explained the decision to finance various health initiatives: “Recognizing that refugee medical problems… deter their effective resettlement and employment, ORR has provided support to state and local health agencies.”\(^{342}\) In their 1985 book *Indochinese Refugees in America: Problems of Adaptation and Assimilation*, political scientists Paul Strand and Woodrow Jones, Jr., emphasized the connection between the health-related aspects of U.S. resettlement programs and the ability of refugees to become economically self-sufficient. “Present resettlement policy,” they wrote, “includes a health component, as health status can directly affect other aspects of resettlement such as labor force participation and the demand for public assistance.”\(^{343}\)

The ORR devoted a substantial portion of its resources to the screening, treatment, and medical insurance of refugees. State governments were required to submit to the newly established ORR

a plan which provide[d] for the identification of refugees who at the time of resettlement in the State [were] determined to have medical conditions requiring, or medical histories indicating a need for, treatment or observation and such monitoring of such treatment or observation as may be necessary.\(^{344}\)

This meant that refugees usually received two medical screening exams. The first was conducted abroad, overseen by the Centers for Disease Control (CDC), and meant to


\(^{342}\) Ibid., 11.


identify individuals with conditions that would require quarantine, a delay in admission, or immediate treatment upon entry into the United States.\textsuperscript{345} Refugees then needed to receive a domestic health assessment shortly after arrival. Funding for sites that performed this second exam was provided by the Public Health Service (PHS, a constituent organization of HHS) and the CDC (a constituent of PHS).\textsuperscript{346} On-the-ground logistics of the domestic health assessment were coordinated by local representatives of the national voluntary resettlement agencies, or volags, that partnered with federal and state governments to carry out resettlement policies.\textsuperscript{347}

The deadline for completion of the domestic health assessment was imprecise. The contractual agreement between volags (e.g. the Hebrew Immigrant Aid Society [HIAS] and U.S. Conference of Catholic Bishops) and the State Department compelled local agency affiliates to “encourage and assist the refugees as soon as possible after arrival to seek health services.”\textsuperscript{348} Given the heterogeneity in the resources available to and approaches taken by resettlement organizations, however, “as soon as possible” had varied meanings. In his 1982 \textit{Michigan Journal of International Law} article about the role of volags in U.S. refugee resettlement, political scientist Norman Zucker summarized, “Local conditions create a wide disparity among the different volags and within the same volag. For example, the practice of taking clients for a complete medical and dental examination within a few days of arrival is not standard.”\textsuperscript{349} According to the

\textsuperscript{346} Ibid., 11.
\textsuperscript{347} Ibid., 40.
Connecticut State Immigrant and Refugee Health Coordinator and veteran New Haven resettlement agency professionals, up until the creation of the ongoing Yale-New Haven Hospital (YNHH) Refugee Clinic in 2009, the complexities of finding appointments for refugees newly arrived in the area resulted in inconsistent timing of the domestic health assessment, ranging from within the first thirty days to many months.350

From its inception during the Carter Administration in 1980, the ORR was also tasked with paying for refugees’ medical insurance.351 This insurance took the form of Medicaid or refugee medical assistance (RMA).352 Those refugees who met standard Medicaid eligibility criteria (i.e. those who fell below state-specified income and resource limits) could enroll in their resettlement state’s Title XIX program, and the federal government, through the ORR budget, shouldered the portion of costs normally borne by the state.353 Those refugees who were not eligible for Medicaid based on income requirements but who encountered “medical expenses which [brought] their net income down to the eligibility level” could receive RMA.354 RMA was functionally the same as Medicaid and was fully paid for by the ORR.355

Initially, an upper limit of 36 months was placed on the ORR’s authorization to pay for Medicaid and RMA.356 However, as part of the Reagan Administration’s efforts to cut welfare expenditures – as well as “to reduce the degree of special treatment for

350 Alison Stratton, interview by the author, Hartford, CT, August 6, 2019; Linda Bronstein, interview by the author, New Haven, CT, August 9, 2019; Kelly Hebrank, interview by the author, New Haven, CT, July 18, 2019.
354 Ibid., 10.
refugees, which resulted in unequal treatment among low-income populations” – the duration of RMA was reduced to 18 months on April 1, 1982.  

This move occurred in conjunction with a broader curtailment of the Aid to Families with Dependent Children Program and Medicaid that the Administration enacted in late 1981. Refugees who were eligible for Medicaid continued to receive benefits for the full three years, but those who received RMA had to qualify for an existing state or local general assistance program in order to receive federally funded medical assistance for the second 18 months. According to a May 1982 New York Times article, government officials in states with parsimonious welfare offerings provided refugees with a list of states with more generous aid programs. Connecticut was not on the list.

The Refugee Act went into effect on April 1, 1980. During Fiscal Year 1980, the ORR’s budget for Medicaid and RMA was $90.5 million. This was 17.5% of overall ORR appropriations for FY 1980, which totaled $516.9 million. A 1980 State Department publication suggested that RMA funding be increased to $139.4 million for FY ’81, with $26.5 million additionally requested for refugee Medicaid payments. Combined, those sums amounted to 25.6% of the $648.6 million ORR budget in FY

357 Office of Refugee Resettlement, Refugee Resettlement Program, (Washington, D.C., 1983), 8. RMA was linked to refugee cash assistance (RCA), and both of these benefits created animosity between refugee populations and disadvantaged Americans, often members of racial minorities, who relied on welfare programs and resented competition for resources. See Section I for further discussion of this topic.


Federal spending in this year for all refugee assistance programs, including those run by departments other than HHS, was projected at $1,687.3 million, making expenditures related to health insurance approximately 10% of overall costs.

The importance of funds provided for medical care for refugees, even at a time when the Reagan Administration was slashing federal funding for Medicaid, may have been boosted by attention among medical and public health professionals to communicable diseases carried by emigrants and the public’s unsubstantiated fears regarding the attendant public health risks. Research, as well as public concern, was primarily directed at Southeast Asian refugees, and a sizable amount of academic literature was published in the late 1970s through early 1980s about the screening and treatment of newly arrived Southeast Asian patients. Michele Barry and David Coleman, who started the YNHH Boat People Clinic in 1979, identified their professional interests in tropical medicine and infectious disease as one impetus for their creation of the clinic. Together with three colleagues, they published a 1983 *JAMA* report about clinical findings at the clinic in which they underscored – citing three issues of the CDC Morbidity and Mortality Weekly Report and multiple academic articles – the amount of scrutiny directed at infectious diseases in refugees. “Although more likely to represent personal rather than public health problems,” they wrote, “tuberculosis, intestinal parasitism, and HBsAg [hepatitis B surface antigen] carrier state have received much

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366 Michele Barry, phone interview by the author, New Haven, CT, August 13, 2019; David Coleman, phone interview by the author, New Haven, CT, September 5, 2019.
attention from health officials.”\textsuperscript{368} ORR annual reports from the early 1980s all echo the assertion made by Barry et al.: “Refugee medical problems, while not constituting a public health hazard,” negatively affected individuals’ health and their ability to build new lives.\textsuperscript{369}

In spite of reassurances as to the limited public health consequences of infectious diseases – and perhaps because of the spotlight placed on them by government agencies and health researchers – the public and some healthcare providers harbored concerns about contagion. Strand and Jones found instances in California, Maryland, Virginia, and Washington in which local communities criticized ORR policies for “the superficiality of the medical screening process given the impact of refugees on disease rates.”\textsuperscript{370} In Connecticut, a 1980 Yale School of Public Health study of the Hartford-based UConn-Burgdorf Clinic for Southeast Asian refugees described one reason for the creation of the clinic:

The process would allay some of the concerns of other providers and potential employers of communicable disease described in the news media based upon reports from the west coast… For example, the dental clinic would only screen patients after they had a physical and were found free of communicable disease.\textsuperscript{371}

This emphasis on providing medical services to quell public fears was reiterated in a 1982 \textit{JAMA} publication, “Guidelines for Providing Medical Care to Southeast Asian Refugees,” written by doctors at the Hartford clinic. The article recommended screening soon after a refugee’s arrival, “particularly as it reassures the sponsors and community of

\begin{footnotes}
\item[368] Ibid.
\item[371] Lester Wood Holcomb, “Developing Health Screening Services for Indochinese Refugees,” M.P.H., Yale University, 1980, Part II, 3.
\end{footnotes}
the absence of public health problems.”  

Giao Hoang, one of the authors, described a memorable call from an agitated school nurse to one of his colleagues regarding a refugee child whose vomit contained live parasites: “When they see the kids having complained of abdominal pain and then they start to throw up, and she sees… worms, Ascaris [a genus of intestinal roundworms], coming out from their nose or their mouth, that would be very traumatic for the school nurse.”  

Though he acknowledged that this spectacle could incite fear in someone not used to seeing it, Hoang, who had practiced in Vietnam prior to emigrating in 1975, was aware that Ascaris did not pose a threat to public health in Connecticut. Barry et al. supported this contention, writing “intestinal parasitism in Southeast Asians is rarely a public health hazard when immigrants move to areas observing standard hygienic practices.”  

Barry and Coleman did not think that such public worry significantly affected the Boat People Clinic or its patients. Recalled Coleman, “I remember there being some concern about whether they might have TB and their employability based on that, but I honestly don’t remember that there was a lot of hysteria about their having communicable diseases.” The opening sentence of a 1981 New Haven Register article supports this assessment, suggesting a benign discourse in the city at the time: “Staffers of the Southeast Asian Refugee Clinic at Yale-New Haven Hospital are used to seeing...

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373 Giao Hoang, phone interview by the author, New Haven, CT, August 28, 2019.
374 Ibid.
376 David Coleman, phone interview by the author, New Haven, CT, September 5, 2019.
perfectly healthy people stroll into the offices on Thursday, clinic day.” However, according to Katrina Axelrod – director of a local social services agency for Asian immigrants and refugees at the time – her clients faced hostility related to the public’s fear of contagion. “These people are sick. They’re going to make us all sick. There’s going to be an epidemic,” Axelrod recalled being told by New Haveners opposed to refugees’ resettlement in the city.378

Doctors and resettlement organization professionals who worked with Soviet Jewish refugees did not recall a stigma around infectious diseases for their patients and clients.379 Yelena Gerovich emigrated to Connecticut from Russia in 1993 and remembered her children, as well as many members of the Jewish refugee community, getting false-positive skin test results due to having received the anti-tuberculosis BCG vaccine in the Soviet Union. She denied feeling prejudice from healthcare workers or the public related to this, however: “Nobody was like, ‘Oh, you are infected.’ No, it was good.”380

Nonetheless, there exists a long history in the United States, both in governmental policy and in public perception, of linking immigrants and the threat of infectious diseases. Medical historians Howard Markel and Alexandra Minna Stern have examined this topic in their essay, “The Foreignness of Germs: The Persistent Association of Immigrants and Disease in American Society.” Of efforts to “to exclude persons perceived as foreign” they wrote,

379 Myron Brand, phone interview by the author, New Haven, CT, August 26, 2019; Caryl Kligfeld, interview by the author, Woodbridge, CT, August 19, 2019.
380 Yelena Gerovich, interview by the author, Woodbridge, CT, September 12, 2019.
Metaphors of germs and contagion have never lurked far beneath the surface of such rationales… more often than not these arguments have been motivated by, and closely intertwined with, ideologies of racialism, nativism, and national security rather than substantiated epidemiological or medical observations. Not surprisingly, these attitudes have deterred rather than encouraged many immigrants from seeking medical care.\footnote{Howard Markel and Alexandra Minna Stern, “The Foreignness of Germs: The Persistent Association of Immigrants and Disease in American Society,” The Milbank Quarterly 80, no. 4 (December 2002): 780.}

Though Markel and Stern did not explicitly discuss Southeast Asian or Soviet Jewish refugees, they provided various examples throughout the 20\textsuperscript{th} century of the exclusion and vilification of earlier Asian and Jewish would-be entrants and warned of “durable biological metaphors” that continued to influence public opinion and refugee policy.\footnote{Ibid., 758. The historic preoccupation of refugee and immigration policies with communicable diseases affects the structure of refugee health programs to this day. In an interview with Alison Stratton, Connecticut’s State Immigrant and Refugee Health Coordinator, she remarked on her position’s seat within the state’s tuberculosis program as a “historical artifact of immigration” and observed that “there’s a lot of us, refugee health coordinators, who are also in the infectious disease programs or epidemiologists.” She went on to explain the heavy emphasis on infectious disease in reports she is required to submit to the ORR, as well as what she saw as the sometimes-illogical way in which the ORR collects data. For example, at points they have collected only positive tuberculosis test results without a denominator of overall number of tests performed. “What they indicated to me,” she said, “was that they really didn’t know what to do with the data. Or the epidemiologists, if there are any on staff, were not having enough of a voice in this.”}

Certainly, attending to the infectious diseases that may afflict refugees was not necessarily misguided or prejudiced, as these conditions can pose risks to the individual and to public health. Latent tuberculosis, for example, is not contagious and is curable, but if left untreated or inadequately treated, the disease can reactivate in individuals with weakened immune systems, becoming personally dangerous and infectious for others. Rates of tuberculosis infection have been significantly lower in the United States than in Russia or Southeast Asian countries for many years.\footnote{Philippe Glaziou, Charalambos Sismanidis, Katherine Floyd, and Mario Raviglione, “Global Epidemiology of Tuberculosis,” Cold Spring Harbor Perspectives in Medicine 5, no. 2 (February 2015): Figure 1.} In 1980, the prevalence per 100,000 of active tuberculosis (i.e. symptomatic and contagious) among Southeast Asian refugees, citizens of the Soviet Union, and the American public was 1137.8, 45-50, and
11.3, respectively. Thus, according to a 2017 analysis of U.S. refugee medical inadmissibility criteria, while “media reports have heightened public concern,” identification of persons infected with *Mycobacterium tuberculosis* was and remains a crucial component of U.S. refugee screening programs.385

Dr. Katherine Yun, now a pediatric refugee health specialist, was a resident at YNHH and a key player in establishing Yale’s current pediatric refugee health clinic in the late 2000s. She was cognizant of how historical and contemporary stereotypes of contagion interact with the necessity to focus on infectious diseases of particular relevance to her patients. In addition to noting that conditions such as latent tuberculosis and chronic viral hepatitis in children often posed a limited risk to public health, Yun said,

> We obviously eschew the offensive, inaccurate rhetoric in both the popular media and anti-immigrant media and people who feed that trope. We, I would say, do tend to be as thoughtful as possible in how we talk about our work because infectious disease is very important for refugees. We see more cases of hepatitis C. We see more kids with latent tuberculosis… We don’t want to pretend that infectious disease isn’t an important part of refugee health. We also don’t want to feed into stereotypes.386

Southeast Asian refugees who went to the Boat People Clinic did have high rates of infection with organisms endemic to their countries of origin. In one study of 142 patients seen over the course of 14 months from 1979 to 1980, Barry et al. found

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386 Katherine Yun, phone interview by the author, New Haven, CT, July 22, 2019.
intestinal parasites in 81 patients (59%), though many had no symptoms.\textsuperscript{387} Anti-parasitic medication successfully cleared the infection in about 70% of those treated.\textsuperscript{388} They diagnosed one case (0.7% of population) of active tuberculosis, while 49 patients (35% of population) had suspected or confirmed latent tuberculosis requiring antibiotic treatment.\textsuperscript{389} Tests for hepatitis B were performed in 83 adult patients and revealed 13 asymptomatic carriers of the virus (i.e. 16% of those tested were potentially infectious and at risk of future complications).\textsuperscript{390}

Most of these infections were asymptomatic, and the majority of Southeast Asian refugees in the New Haven area reported feeling physically well. Barry, interviewed in 1981, estimated that 5% of the clinic’s patients had a physical complaint, while 90% came because they were encouraged to do so by their resettlement sponsors.\textsuperscript{391} This fact was possibly related to the overall youth of the population; patients of the Boat People Clinic had a median age of 19 years.\textsuperscript{392} Nonetheless, in addition to asymptomatic infectious diseases, many patients had gone years without access to important preventative medical and dental care. For example, some patients were missing vaccinations or had no medical records, half of all patients had dental caries, 63% of men over 16-years-old smoked, and only 6 out of 33 women of childbearing age used oral

\textsuperscript{388} Ibid.
\textsuperscript{389} Ibid., 3202.
\textsuperscript{390} Ibid.
contraceptive pills or intrauterine devices.\textsuperscript{393} In a 1986 interview with the \textit{New Haven Advocate}, the director of a New Haven social services organization that served Southeast Asian refugees described the stigma and financial difficulties caused by inadequate sexual health education and family planning options: “One of our clients, a 15 year old [sic] became pregnant... Her family was just about torn apart by it.”\textsuperscript{394}

Doctors at the New Haven clinic also found evidence of chronic and acute malnutrition in newly arrived children, with 47\% of pediatric patients 1-12 years old falling below the 5\textsuperscript{th} percentile in stature-for-age and 22\% below the 5\textsuperscript{th} percentile in weight-for-stature during their initial visit.\textsuperscript{395} Barry et al. noted that all the children appeared healthy on examination and that “most standard growth curves [were] composed of groups of white children,” calling into question their clinical utility in this population.\textsuperscript{396} A 1981 \textit{American Journal of Public Health} study by Peck et al. on the “Nutritional Status of Southeast Asian Refugee Children,” cautioned against using these homogenous growth charts to compare different populations but endorsed their utility in tracking nutritional status over time within individual children, regardless of their racial or ethnic labels.\textsuperscript{397} Peck et al. also found significant nutritional deficiencies in the

\textsuperscript{393} Ibid., 3201-3202.
\textsuperscript{396} Ibid., 3202.
\textsuperscript{397} Richard E. Peck, Margaret Chuang, Gordon E. Robbins, and Milton Z. Nichaman, “Nutritional Status of Southeast Asian Refugee Children,” \textit{American Journal of Public Health} 71, no. 10 (October 1981): 1148. Today, the reference population for growth charts published by the CDC is representative of the U.S. population, according to the CDC website. The organization advocates using these inclusive charts rather than racial- and ethnic-specific charts “because studies support the premise that differences in growth among various racial and ethnic groups are the result of environmental rather than genetic influences” (Centers for Disease Control, 2019). To support this recommendation, the CDC specifically cites the high prevalence of low height-for-age in Southeast Asian refugee children compared to white American children.
children in their study, supporting the accuracy of the conclusions drawn by Barry et al. that malnutrition was a significant problem for their patients.

The Boat People Clinic staff published a second 1983 JAMA article, “Hematologic Abnormalities in Southeast Asian Refugees,” about the rates of anemia (i.e. low numbers of red blood cells) and microcytosis (i.e. smaller than normal red blood cells) they observed in the clinic’s population. Specifically, 25 of 142 patients (18%) had anemia, and 49 patients (35%) had microcytosis. The majority of these anemias were due to iron deficiency (a common cause of anemia worldwide), but a significant portion of patients had genetic mutations in hemoglobin (hemoglobin E or thalassemia minor) that were relatively common in individuals of Southeast Asian descent but rare in the broader United States’ population at the time. These hemoglobinopathies, as well as iron deficiency, were also responsible for almost all the cases of microcytosis. Thus, Craft et al. suggested adding “hemoglobin electrophoresis [a test to identify hemoglobin E and thalassemia] and serological tests for iron stores to the customary evaluation of anemias” when treating Southeast Asian refugees. The findings in both articles published by the Boat People Clinic doctors were largely consistent with those reported in other contemporaneous studies of Southeast Asian refugee health, including two written by staff of the Burgdorf Clinic in Hartford.

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399 Ibid. 3205. These mutations are thought to provide protection against infection with the organism that causes malaria, similar to the mutation implicated in sickle cell disease.
400 Ibid.
402 Antonio Catanzaro and Robert John Moser, “Health Status of Refugees from Vietnam, Laos, and Cambodia,” JAMA 247, no. 9 (1982): 1303–8; Roy V. Erickson and Giao N. Hoang, “Health Problems in the early 1980s which decreased and was practically the same between the two populations by 1993, reflecting the dominant impact of environmental circumstances over race on growth.
There was significantly less public discussion and academic research about the health of Soviet émigrés, both in Connecticut and nationally. This is likely due to a variety factors, including Soviet Jews’ position as members of the majority white racial group in the United States and the lower prevalence of eye-catching infectious diseases, such as intestinal parasitism, in Eastern Europe compared to Southeast Asia. Regardless, Soviet refugees sought healthcare to treat a range of conditions. In 1981, the average Soviet Jewish refugee was in his or her mid-thirties upon arrival in the U.S., and 15% were older than 60. In his study of refugees in California in the 1980s, sociologist Steven Gold found that, partly due to cultural norms and partly because of their older age, Soviet Jews utilized the healthcare system at a high rate. In New Haven in 1981, refugees’ frequent primary care appointments, hospitalizations, eye exams, and dental problems caused the local organization in charge of resettlement to redouble its efforts to find doctors willing to see these patients. Dental care in the Soviet Union was particularly “notorious,” according to Rabbi Herbert Brockman and Caryl Kligfeld, both involved in New Haven area refugee services.

Soviet Jewish refugees could more easily access family planning options in New Haven than they had been able to in the Soviet Union, where contraception other than the rhythm method, withdrawal, and abortion were in short supply. Blossom Rose – then among Indochinese Refugees,” *American Journal of Public Health* 70, no. 9 (1980): 1003–1006; Giao N. Hoang and Roy V. Erikson, “Guidelines for providing medical care to Southeast Asian Refugees,” *JAMA* 248, no. 6 (August 13, 1982): 710-714.

406 Herbert Brockman, interview by the author, Hamden, CT, September 3, 2019.
healthcare coordinator for the Jewish Federation of Greater New Haven’s (JFGNH) Refugee Resettlement Committee – recalled group educational sessions about birth control run by gynecologist Stephanie Roth, who had been a Jewish refugee herself and had emigrated from Austria just before World War II. Rose also recalled relying on Planned Parenthood to provide abortions for some women.  

Other than routine preventative medicine and family planning needs, many Soviet Jewish refugees suffered bacterial gastrointestinal infections which, in 1992, the CDC attributed to unmaintained water-purification systems in Russia. While some of these GI infections were self-limiting, others continued to affect Jewish refugees after emigration to the New Haven area. Myron Brand, a local Jewish gastroenterologist who treated Soviet refugees in the late 1970s and 1980s, recalled, “The Russian water supply system was contaminated with Helicobacter pylori [a bacteria that can cause stomach infections and peptic ulcers]… I saw a lot of Russians with peptic disease.” Consequently, he treated a number of patients for sequelae of Bilroth II anastomoses, a surgical procedure indicated for serious peptic ulcer disease. Brand also remembered that the Soviet “blood banking system was contaminated with what we now call hepatitis C but then was non-A non-B hepatitis, so there was a lot of Russians that I saw with abnormal liver functions.”

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408 Blossom Rose, phone interview by the author, New Haven, CT, August 21, 2019.
410 Myron Brand, phone interview by the author, New Haven, CT, August 26, 2019. A scientific consensus about H. pylori’s central role in the pathogenesis of peptic ulcer disease was not reached until the 1990s (Marshall, 1995), so Brand’s recollection may have benefitted from hindsight. Even if the etiology of their ulcers was unknown at time, however, refugees still required treatment for their symptoms.
411 Ibid. The CDC listed the prevalence of hepatitis C in the United States in 1982, the first year it collected statistics on the disease, as 1.1 per 100,000, though it noted these early data were unreliable (Centers for Disease Control, n.d.). The United States did not enact universal screening of donated blood until 1992. The consequences of H. pylori and hepatitis C infections were important for a segment of the Jewish
Finally, both Soviet Jewish and Southeast Asian refugee populations experienced high rates of mental illness. Though exact prevalence is difficult to establish, depression, post-traumatic stress disorder (PTSD), and other diagnoses are quite common among refugee populations due to the significant hardships in most refugees’ experiences. A 1980 paper written by Hoang and Roy Erickson, found a 10% prevalence of “significant psychiatric problems” among patients of the Burgdorf Clinic. In New Haven, the *Register* article about the Boat People Clinic reported, “Despite their good physical health, clinic patients are often afflicted with psychological problems caused by resettlement in a strange culture, little or no ability to use the language, and the absence of family members who have remained in Southeast Asia.” In studies of Soviet Jewish refugees’ health and health attitudes, depression and other mental health disorders were found to be of substantial concern, though specific rates were not reported.

Some psychiatric services existed in New Haven for these populations. Barry recalled that a psychiatrist was often present at the Boat People Clinic to see patients who

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refugee population, but it is uncertain how large that segment was relative to the proportion of the United States’ population afflicted with the same problems. I was unable to find historical epidemiological data about hepatitis C in the Soviet Union.

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413 Roy V. Erickson and Giao N. Hoang, “Health Problems among Indochinese Refugees,” *JAMA* 70, no. 9 (1980): 1004. Other studies cited in a refugee health textbook found significantly higher rates of PTSD, major depressive disorder, and anxiety depending on the patient population (Annamalai, ed., *Refugee Health Care*, 157-158). Of note, Cambodian refugees who survived the genocide perpetrated by the Khmer Rouge had a lifetime prevalence of depression as high as 87% (D’Avanzo and Barab, “Depression and Anxiety among Cambodian Refugee Women”), PTSD as high as 62% (Marshall et al., “Mental Health of Cambodian Refugees”), and anxiety as high as 62% (Lopes Cardozo et al., “Mental Health Survey among Landmine Survivors”). While direct comparisons are challenging because these studies used multiple assessment tools (e.g. the Harvard Trauma Questionnaire and the Hopkins Symptom Checklist), they paint a grim picture of the effects of refugees’ trauma on their mental health.
endorsed experiencing psychiatric symptoms.\textsuperscript{416} A Vietnamese nun named Sister Pia who worked with Indochinese Catholic Charities of Hartford also traveled to refugees’ homes to provide counseling until funding from the State Department of Mental Health was discontinued in 1981.\textsuperscript{417} Social workers at Jewish Family Services (JFS) and the JFGNH offered psychotherapy for Soviet refugees in the early 1980s.\textsuperscript{418} And later, by 1990, a local Russian-speaking psychiatrist volunteered to see Soviet Jewish patients.\textsuperscript{419}

Nonetheless, the mental health care options available to refugees were often insufficient in number and ineffective in practice. A 1984 study of health services utilization by Southeast Asian refugees in New Haven found that “while there is an assortment of health care facilities that can effectively treat a refugee’s physical ailments, there are few comparable psychiatric facilities. Furthermore, the psychiatric counselors that are available often lack a cultural understanding of this refugee.”\textsuperscript{420} Gold argued that, among the refugees in California that he studied, this cultural disconnect in psychiatric care existed because

most Soviet Jews and Vietnamese lack the cultural prerequisites of a successful, American-style therapy interaction, such as willingness to confide in bureaucrats, a belief in the unconscious, and the ability to openly criticize parents. Finally, most refugees do not see a connection between the process of therapy and the problems that, for them, are most pressing.\textsuperscript{421}

\textsuperscript{416} Michele Barry, phone interview by the author, New Haven, CT, August 13, 2019.
\textsuperscript{418} Deborah Dyme, interview by the author, Southbury, CT, October 30, 2019.
\textsuperscript{419} “Russian Resettlement,” 1990, Restricted Files, Folder “Federation (1/2),” Jewish Historical Society of Greater New Haven Archives, New Haven, CT.
\textsuperscript{421} Steven J. Gold, \textit{Refugee Communities: A Comparative Field Study} (Newbury Park, CA: Sage Publications, 1992), 151. See Annamalai, ed., \textit{Refugee Health Care} Chapter 11 for a summary of transcultural psychiatry and how this evolving field is applied in refugee healthcare.
Academic literature and the individual experiences of professionals in Connecticut have borne out some of Gold’s claims regarding how refugees’ cultural norms limited the care they received and shaped their attitudes toward that care.

A 1992 study of Russian émigrés argued that negative opinions of mental health services among Jewish refugees were the result of the stigma associated with psychiatric diagnoses in the Soviet Union, with their “severe economic and social consequences, ranging from loss of social status to imprisonment.”422 Similarly, a former New Haven JFS social worker attributed difficulties she encountered in counseling her clients to their distrust of authority resulting from their experiences with totalitarianism and institutionalized anti-Semitism in the Soviet Union.423 Additionally, some American-trained practitioners had trouble recognizing depression, anxiety, and other mental illnesses in Soviet émigrés because they were not used to seeing the somatic presentations of psychiatric illness (e.g. intractable abdominal pain) that were common in this population, a topic discussed in Kohn, Flaherty, and Levav’s 1989 “Somatic Symptoms Among Older Soviet Immigrants: An Exploratory Study” and more broadly in Goldberg and Bridges seminal 1988 paper “Somatic Presentations of Psychiatric Illness in Primary Care Setting.”424

According to a 1983 *Western Journal of Medicine* article about Southeast Asian refugees’ experiences with the American healthcare system, similar issues of stigma and somatization arose during interactions between Southeast Asian refugee patients and

423 Deborah Dyme, interview by the author, Southbury, CT, October 30, 2019.
providers. In New Haven, Barry saw a “tremendous amount of undiagnosable abdominal disease and undiagnosable headaches that we attributed to PTSD and stress” at the Boat People Clinic. Though the medical doctors at the clinic sometimes referred patients to their psychiatry colleagues, mental health care was not a primary focus; neither article written by the clinic staff in 1983 discussed mental illness.

Perhaps this reticence to investigate refugee mental health problems stemmed from the medical community’s nascent understanding of trauma’s psychiatric consequences at the time. Mary Scully, an APRN who has treated Cambodian refugees in camps and in Connecticut since the early 1980s, identified civilian practitioners’ unfamiliarity with treating survivors of violent conflicts as a major obstacle to effective psychiatric care:

[Cambodians had] been through a genocide… We knew that the healthcare system here couldn’t deal with it, primarily because they [civilian medical practitioners] don’t understand it… People who come from war go to the VA [but refugees do not] … We knew there was no consistent way of doing the trauma history and evaluating trauma.

Moreover, PTSD was not recognized as a diagnosis until the Diagnostics and Statistical Manual of Mental Disorders III was published in 1980. Scully recalled dispute within the medical community at that time as to its validity. “It’s really an entity. It’s really not. It’s weak people come back with PTSD and strong people don’t,” she summarized.

426 Michele Barry, phone interview by the author, New Haven, CT, August 13, 2019.
428 Mary Scully, interview by the author, West Hartford, CT, November 13, 2019.
430 Ibid.
Crocq and Crocq’s 2000 “History of Psychotraumatology” described the debate that Scully witnessed as following from centuries of back-and-forth psychiatric and neurologic theorizing and accusations of malingering.\textsuperscript{431} As recently as 2001, a highly-cited \textit{BMJ} article by Derek Summerfield questioned the legitimacy of the diagnosis.\textsuperscript{432}

According to Aniyizhai Annamalai – who is trained in psychiatry and internal medicine and currently directs the YNHH refugee health program – though PTSD is often given the most attention, a broader conception of psychiatric injury should be applied to refugees’ experiences, and a patient’s degree of distress is sometimes more important than specific diagnostic criteria. “Classic PTSD… [is] related to one incident,” said Annamalai,

[but] when we think about PTSD, we still don’t think about the trauma at multiple layers. Repeated traumas that have been followed by the trauma of upheaval, followed by the trauma of resettlement and getting started in a new place, the trauma of new poverty, and all those things… But in the refugee world… there is growing recognition that, even though trauma is an important part of their experience, that a lot of other social, political, [and] economic factors play a role in their experience.\textsuperscript{433}

While our understanding of how different types of trauma affect refugees’ mental health continues to evolve, it is clear that Southeast Asian and Soviet Jewish refugees came to the United States and to Connecticut with significant psychological burdens, in addition to infectious illnesses acquired in their home countries or in camps and primary care needs often heightened by their previous lack of access to healthcare. The Boat People Clinic and others like it, as well as private physicians, furnished much-needed

\textsuperscript{432} Derek Summerfield, “The Invention of Post-Traumatic Stress Disorder and the Social Usefulness of a Psychiatric Category,” \textit{BMJ} 322, no. 7278 (January 2001): 95–98. Academic debate around PTSD has continued throughout the years since it was first defined, including many articles published regarding the current DSM-V criteria for the disorder.
\textsuperscript{433} Aniyizhai Annamalai, phone interview by the author, New Haven, CT, January 14, 2020.
medical services to address these conditions, though adequate psychiatric help for refugee populations was difficult to achieve, often due to cultural misunderstandings and providers’ insufficient training in trauma-informed care. Clinicians paid special attention to infections present at higher rates among refugees than among the general population. This legitimate focus on communicable diseases influenced and was influenced by widespread but unwarranted anxiety about the public health impact of those diseases, especially in regards to the Southeast Asian population. Such concern was reminiscent of an unfortunate American historical tradition – which remains alive in modern popular discourse – of associating foreigners and contagion.434 The health-related programs that ensued from the Refugee Act were implemented inconsistently in different locations and at different times, but overall, they facilitated refugees ability to access care. Intended to encourage economic self-sufficiency, the 1980 legislation imposed requirements and supplied resources – though they fluctuated with the political developments of the Reagan era – to screen and treat refugee patients. These were some of the most important individual, local, and national factors that affected the health of refugees in the 1980s and how they engaged with the American medical system.

Conclusion

The details of Southeast Asian and Soviet Jewish refugees’ stories are varied and individual, but their experiences upon arriving in Connecticut in the late 1970s and 1980s were shaped by interrelated local and national socioeconomic, political, cultural, and medical forces. Though resettlement and healthcare organizations, professionals, and volunteers in New Haven faced various obstacles, they made notable accomplishments, sometimes pioneering influential practices, in their provision of services and healthcare to these refugees. There are many parallels that can be drawn between these historical events and ongoing issues in refugee health and resettlement.

Over a million Southeast Asians fled violence and upheaval in the aftermath of the Vietnam War. Diverse in education, experience, and familiarity with the English language and Western culture, many refugees who arrived in the United States from 1979 to 1982 had difficulty finding employment. They often faced racial discrimination in hiring and were forced to accept low-paying jobs without medical insurance. Beneficiaries of Federal programs like Refugee Cash Assistance (RCA) and Refugee Medical Assistance (RMA) created by the Refugee Act of 1980, they were seen by the Reagan administration as a drain on public funds and by other welfare recipients as competition for government services. Voluntary resettlement agencies’ practice of cluster resettlement mitigated some of these difficulties by dispersing Southeast Asian refugees who were assigned to Connecticut across different towns. However, cluster resettlement also socially sequestered them from fellow refugees with similar experiences. Mutual assistance associations (MAAs), social services agencies (such as Asian Community Services [ACS]), and resettlement organizations (such as Catholic Charities of Hartford)
attempted to create community amongst these refugees and help them navigate the complexities of constructing a new life in Connecticut.

Comparable hurdles confront many refugees today. Various individuals I interviewed highlighted the importance for refugees of the opportunity to interact with and learn from people who have a shared language and culture where they are resettled. Katherine Yun directed Yale’s pediatric refugee clinic before assuming her current position as attending physician at the Children’s Hospital of Philadelphia’s Refugee Health Program. Said Yun, “My experience over the years is that if there’s an established co-ethnic community… it’s just a very different experience… You don’t actually learn how to access care from the physicians… That really gets done in the community setting.”

Without that support system in their initial place of resettlement, some refugees soon move to an area with a larger co-ethnic population, according to Yun. This not only creates additional turmoil in refugees’ lives but also suggests an inefficient use of the many government and non-government resources that go into resettlement.

Comprehensive support from resettlement organizations can ameliorate the challenges encountered by refugees who do not have a significant community to join. In the early 1980s, ACS attempted to teach English, coordinate medical appointments, and promote socialization among Southeast Asian refugees in New Haven. Unfortunately, ACS struggled financially. This stands in contrast to the current Yale Adult Refugee Clinic’s partnership with Integrated Refugee and Immigrant Services (IRIS). Aniyizhai Annamalai, director of the Yale clinic, reflected, “We are very fortunate that Chris George [Executive Director of IRIS] is a very entrepreneurial, successful fundraiser…

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435 Katherine Yun, phone interview by the author, New Haven, CT, July 22, 2019.
That’s why they’re able to provide intensive case management… after the initial resettlement period, things that probably many other places do not have around the country.” IRIS’s accomplishments are especially notable given the fact that many other resettlement organizations have recently closed as result of the dwindling numbers of refugees accepted into the United States under Trump administration policies.

The experience of Soviet Jewish refugees in New Haven serves as an alternative example of the benefits and struggles that came with having a robust co-ethnic community. Jews in the Soviet Union suffered religious persecution, professional discrimination, and strict limitations on emigration. As a result of sustained advocacy by American and Israeli Jews, they were allowed to leave the Soviet Union in increasing numbers starting in 1974. Many Soviet Jews were highly educated, and with the assistance of a well-organized system of American Jewish resettlement and social services organizations (such as HIAS and local chapters of the Jewish Family Service [JFS] and Jewish Federations), they were quickly able to find employment in the United States. These organizations also did their best to avert conflict between refugees and other groups in need of affordable housing or government welfare by having locally knowledgeable case workers find appropriate apartments and job opportunities. Other boons to Soviet refugees that resulted from their association with the large, well-established American Jewish population included memberships at Jewish community centers (JCCs), spots at private Jewish day schools, access to translators for medical appointments, and more.

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However, the relationship between these refugees and the American Jews who aided them was sometimes strained by refugees’ Soviet-infused attitudes towards bureaucratic agencies that were seen by Americans as aggressive or manipulative. Refugees’ conservative social and political views clashed with the more liberal American Jewish disposition. Further, American Jews’ misconception of Soviet Jewry as devout and desirous of opportunities for religious expression led to tension between these groups when Soviet refugees – largely secular and often proud of their Russian or Ukrainian cultural heritage – did not demonstrate the religious enthusiasm expected of them.

Religious and ethnic affiliation can provide “a kind of social and cultural capital” for refugees, according to anthropologists Janet Bauer and Andrea Chivakos in their 2010 essay on faith-based refugee resettlement in Hartford, CT. But this type of connection comes with its own distinctive snags. Much like Soviet Jews who lacked the religiosity expected by their American supporters, Meskhetian Turkish refugees, who came to the United States in the mid 2000s “from a more secular, post-communist society,” felt alienated when they were offered assistance “through specifically Muslim initiatives or local mosques,” argued Bauer and Chivakos. Soviet Jews’ and Meskhetian Turks’ resettlement experiences suggest that, while the presence of a co-ethnic or co-religious community may be helpful, the resettlement process should not force refugees to be dependent on the services provided through that community, nor should those services

439 Ibid.
replace options from the government or from religiously unaffiliated resettlement organizations.

Kelly Hebrank, the former healthcare coordinator for IRIS, identified another area in which utilizing community networks can yield mixed results: translation. At times and in locations without adequate interpreter services, community members have often been used to translate for non-English speaking patients. Though this may be necessary in an emergency situation or when no other options exist, it is usually not good practice “because if you’re relying on a community member to translate, there’s a lot of private information that people may not want to share with a respected member of the community,” said Hebrank. Yelena Gerovich – a Soviet refugee who came to Connecticut in 1993 and eventually led an acculturation program at the Woodbridge JCC for other émigrés – recalled being put in exactly that scenario as an interpreter:

Hospitals, they had my phone number, and sometimes they called me in the middle of the night… [After almost ten years] they made certified translators because the issue of privacy. No privacy at all. Some people ask[ed] to call me because they knew that I’d keep my mouth shut, but some people fe[lt], “Okay, we don’t know her. How come that she’ll be translating?”

Though community networks are beneficial in many ways for newly arrived refugees, hospitals or resettlement organizations should employ trained professionals to provide vital services such as medical interpretation.

Soviet Jewish refugees in the 1970s and 1980s had a variety of medical problems necessitating access to healthcare. They had often previously lacked access to primary care, dental care, and birth control options. They had higher rates of tuberculosis,

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440 Kelly Hebrank, interview by the author, New Haven, CT, July 18, 2019.
441 Yelena Gerovich, interview by the author, Woodbridge, CT, September 12, 2019.
bacterial gastrointestinal infections, and viral hepatitis than the general American public at the time. And many suffered from depressive or anxious mental illnesses.

Efforts by the Jewish Federation of Greater New Haven (JFGNH) and the JFS to secure healthcare for Soviet refugees represented an approach to refugee healthcare that was in many ways successful but, ultimately, ungeneralizable. After being shut out of medical practice at existing hospitals at the beginning of the twentieth century, Catholic and Jewish physicians found a professional home when the Sisters of Charity of Saint Elizabeth founded Hospital of Saint Raphael (HSR) in 1907. For the next seventy years, Jewish doctors contributed to and were welcomed at this Catholic institution.

When Soviet Jews started arriving in New Haven in 1974, HSR leadership permitted Jewish urologist Elliot Brand to use hospital resources to offer circumcisions to refugees who had forgone a bris due to fear of persecution in the Soviet Union. This arrangement soon broadened, and over the following three decades, 1,800 Soviet refugees were treated, free of charge, in HSR primary care clinics and on inpatient wards. HSR did not set up a dedicated clinic for Soviet Jewish refugees but rather worked them into existing services and maintained close communication with the JFS and the JFGNH to keep track of who qualified for free care. However, due to the informal nature of this understanding, at multiple points Soviet refugees nearly lost their ability to seek care in this way, including when responsibility for resettlement changed hands from the JFS to the JFGNH and when Brand stepped down from his position at the hospital.

The JFS and the JFGNH also depended on private Jewish physicians around New Haven to donate their services and see refugee patients. While HSR and private Jewish doctors were able to provide two options for Soviet refugee patients in the city to access
care, these pathways existed due to a singular set of circumstances and personal relationships that are not easily reproducible.

Southeast Asian refugees had some similar medical issues to those of Soviet Jews and some distinct ones. Their primary medical problems were lapses in routine preventative healthcare and dental care, inherited and acquired anemias, intestinal parasitic infections, viral hepatitis, and high rates of latent tuberculosis. Additionally, they suffered a range of psychiatric conditions that were provoked or worsened by the events that had caused them to flee their homelands, as well as the cataclysm and isolation of resettlement.

Both the medical community and the public were preoccupied with infectious diseases among Southeast Asian refugees. This was partly due to justified concerns about the risks posed by conditions such as reactivated tuberculosis to individual refugees and public health; was partly due to the academic interests of American physicians curious about tropical medicine; and was partly a manifestation of the historical tendency in the United States to rationalize xenophobia and racism under the guise of hygiene and prevention of contagion.

While the modern public conversation around refugees and immigrants continues, at times, to denigrate them as germ carriers, many refugee healthcare providers attempt to combat harmful stereotypes without ignoring the true risks posed to their patients by infectious diseases. Both Annamalai and Teeb Al-Samarrai, who helped start the current adult refugee health program at YNHH, spoke of efforts to shift the focus away from communicable diseases and toward the major cause of morbidity for their patients: chronic diseases such as hypertension and diabetes. “Every year there’s an increase in
awareness that infectious diseases are not the primary driver of refugee illness…
Actually, it’s chronic diseases that are more the issue,” said Annamalai.\textsuperscript{442} Even so, Annamalai acknowledged that “that narrative is still there, that refugees come in with more infectious diseases.”\textsuperscript{443} She noted that the providers who volunteer to work in refugee clinics often have an interest in infectious diseases and that the textbook on refugee health that she edits includes a number of chapters on infectious disease screening but only one on chronic disease (though additional chronic disease chapters will be added in a forthcoming new edition).\textsuperscript{444} In some ways, this makes perfect sense given the increased prevalence of specific infectious diseases among some refugee populations relative to that of the United States.\textsuperscript{445} However, it is incumbent upon refugee healthcare providers to follow the examples of Annamalai, Al-Samarrai, Yun, and others whom I interviewed and thoughtfully consider how their work interacts with the broader discourse about refugees.

Worries about Southeast Asian refugees acting as vectors for communicable illnesses were inflated, but these refugees did need access to healthcare upon their arrival in the New Haven area. Michele Barry and David Coleman started the Boat People Clinic at YNHH in 1979 in order to provide that care. The clinic evolved from an all-volunteer, evening venture to a daytime clinic with some paid staff. In both settings, its directors encountered logistical difficulties and intermittent interpreter or clinical staff shortages.

\textsuperscript{442} Aniyizhai Annamalai, phone interview by the author, New Haven, CT, January 14, 2020.
\textsuperscript{443} Ibid.
The care administered at the clinic was innovative and multidisciplinary, with screening laboratory tests drawn a few days prior to each patient’s initial appointment, entire families seen at a single visit, frequent consultations to in-house psychiatrists and dermatologists, and interpretation performed by a Vietnamese nun from Catholic Charities of Hartford. Doctors saw patients only a few times, as the Clinic was not set up to offer longitudinal care, but they diagnosed and treated many of the minor conditions and infections mentioned above. While psychiatrists treated patients to a degree, the clinic was unable to adequately address many refugees’ mental illnesses, possibly as a result of both the cultural disconnect between providers and patients and the field of psychiatry’s lack of consensus regarding post-traumatic stress disorder’s legitimacy as a diagnosis and ideal treatment.

After three years, the Boat People Clinic closed, chiefly because of shrinking patient numbers. The height of Southeast Asian refugee resettlement had passed, and the increasing adoption of cluster resettlement by voluntary agencies meant that many new refugees were placed in rural towns. The rise of MAAs allowed these refugees to avoid trips to New Haven by furnishing interpreters for appointments with private physicians closer to where they lived. Moreover, much of the Yale clinic’s staff were volunteers and residents, which led to organizational instability and a vulnerability to fluctuating resettlement patterns.

Subsequent refugee clinics at YNHH – a short-lived attempt in the early 2000s and the current program that has existed for over a decade – encountered some of the same structural complications as the Boat People Clinic. Annamalai described how, with a declining patient population due to low refugee admission limits in the first years of the
Trump administration, nursing support was almost pulled from the present-day clinic and its continued existence was jeopardized, just as the Boat People Clinic succumbed to low patient volume in 1983. The program was maintained in its current structure by virtue of an argument that it would be difficult to reinstate the clinic if refugee numbers rebounded, combined with IRIS’s increase in resettlement of Special Immigrant Visa holders (who are not technically refugees and have different criteria and ceilings for admission but are still served by IRIS and the clinic). 446

Continuity of personnel was a problem for the early 2000s clinic. Though Yun was not at Yale for the years of its operation, she knew of its fate. “What they… found with that [clinic],” said Yun, “is that it’s great when you have volunteers, but if that changes… you don’t have something that’s institutionalized.” 447 Hebrank, who helped establish the current program’s link to IRIS, recalled, “That’s what we realized: this couldn’t be just one really nice person who had an interest in refugee health… because this was just going to keep happening where someone left, and then it would end again.” 448 The process to which Yun and Hebrank referred is reminiscent of how HSR almost shut down its Soviet Jewish refugee program when Brand and two other key figures retired.

It is also worth noting that the most substantial type of institutional memory that guided the establishment and functioning of the later clinics at YNHH – in the form of the advisory role played by Michele Barry – existed only fortuitously because a single individual happened to be still at Yale and willing to provide assistance. Clearly, an

447 Katherine Yun, phone interview by the author, New Haven, CT, July 22, 2019.
448 Kelly Hebrank, interview by the author, New Haven, CT, July 18, 2019.
enduring and successful refugee health program ought not rely solely on the efforts of individual providers or on volunteer and resident staff. Moreover, it must be resilient in structure to the unpredictable national and international political nature of refugee admissions and crises. Though difficult to achieve given the frenetic work lives of many healthcare professionals, documentation of issues faced by refugee clinic coordinators (e.g. within departmental records) would help ensure reproducibility in the event that their ventures do temporarily shut down.

Looking forward, there are lessons to be taken from the past refugee healthcare efforts in New Haven. Some of the practices used at the Boat People Clinic have been reprised at the current Yale Adult Refugee Clinic to good effect. When designing the current clinic, Al-Samarrai recalled thinking, “What is unique about caring for refugees and immigrants?” and “How should we design this optimally in a patient-centered way?”449 With Barry as an advisor, Al-Samarrai’s answers to these questions included drawing labs ahead of time, recruiting in-person interpreters, having psychiatrists on site to quickly see patients and reduce the stigma of mental illness, and scheduling long visits to allow adequate time to hear refugees’ stories and answer their questions. Hebrank praised this clinic structure and the investment of YNHH in refugee health:

When the clinic started at Yale, when it was a project of the hospital and medical school, that was not unheard of, but [it was] very, very rare. Chris [George] and I would go to national conferences every summer, and people would be like, “What do you have?” They were very, very jealous. So, it really was a model nationwide for how this could be done really well for all parties.450

449 Teeb Al-Samarrai, phone interview by the author, New Haven, CT, August 14, 2019.
450 Kelly Hebrank, interview by the author, New Haven, CT, July 18, 2019.
A description of the Yale clinic published by Annamalai in a 2015 issue of *SGIM Forum*, the Society of General Internal Medicine’s newsletter, supports Hebrank’s assessment that it may serve as a model for screening clinics elsewhere.\(^{451}\)

The current program has faced difficulties, however, and during our interview, Annamalai discussed “why it’s hard for a [refugee] clinic to survive.”\(^{452}\) First, while she receives some reimbursement from the hospital for her time spent providing medical care at the clinic, as director she is not given protected, paid time in her schedule for the many hours that go toward administering the program each week. This work includes coordinating with IRIS; interfacing with hospital administrators to secure necessary resources; supervising and teaching medical students who volunteer as patient navigators; and requesting support from other clinics when patient volume has been too high.

Second, indispensable parts of the clinic are hard to secure. The psychiatric care provided by Annamalai and other volunteer psychiatry attendings is entirely unpaid, and the psychiatry resident who attends clinic weekly had to personally search for her replacement prior to her graduation. Moreover, clinic directors have had to make the case to hospital administrators for the necessity of paying for in-person interpreters.

Third, given the language barrier and cultural unfamiliarity that many refugees face initially, intensive care coordination is crucial to ensure patients are able to attend their appointments, pick up their medications, and otherwise participate in their care. Though IRIS is able to provide this service for the YNHH clinic, refugee healthcare...
efforts elsewhere do not always have access to a partner organization with such capabilities.

Last, “as in everything within our healthcare system,” said Annamalai, “it’s all about how can you make the finances work.” Refugees are eligible for insurance through RMA for the first eight months after arrival in the United States (the duration of RMA and RCA was reduced from eighteen to eight months in 1991). However, this program reimburses at the same relatively low rate as Medicaid, so primary care provided to patients with RMA loses money for hospitals. According to Annamalai, some alternative clinic models exist in states with large refugee patient populations, such as Minnesota and Washington. For example, according to the same *SGIM Forum* article in which Annamalai explained Yale’s program, the University of Washington’s Harborview International Medicine Clinic in Seattle has persisted and grown since its 1982 establishment. It provides the same screening functions as Yale’s clinic, but it also operates as a longitudinal clinic for refugees years after they arrive in the United States. With 12,000 visits per year as of 2015, providers at the Seattle clinic have patient panels consisting mainly of refugees, and the program can financially operate like any other primary care clinic. However, this model would likely be unfeasible in locations such as New Haven with significantly smaller numbers of refugees.

The design and administration of refugee healthcare enterprises has been at times improvised and innovative, successful and challenging, and further research is needed to identify best practices in different settings going forward. In this thesis, I have attempted

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453 Ibid.
455 Ibid.
to characterize and analyze some of the many elements at play in the ongoing history of refugee health, healthcare, and resettlement using the examples of Southeast Asian and Soviet Jewish refugees in New Haven. Though many questions remain yet to be investigated, it is clear that refugee services demand sustained investment of financial resources, manpower, and energy from government agencies, non-governmental resettlement organizations, health systems, and individuals. In 1980, Victor Palmieri, the U.S. Coordinator for Refugee Affairs under the Carter Administration, wrote:

Despite all the problems in our cities today, despite all the burdens that our communities are bearing with unemployment, inflation, housing, and taxes, you should recall that the record of history is clear: Whenever we have helped others to come here and build a new life… there have always been those who would close the golden door, but afterwards we have always been able to say, “By helping these people, we have helped ourselves.”

Our role as a beacon of freedom in a darkening world is too precious a part of our tradition, too central to our strength as a free people, to allow it to weaken even in the hardest times. If we ever determine that the Statue of Liberty has become obsolete, we may find that we have become obsolete also.456

These words, though written forty years ago and somewhat romantic in their portrayal of American idealism, ring true today. The work of ensuring refugees’ health is often complex and difficult. However, as was crystallized during the various conversations I had with refugees, resettlement staff, and healthcare providers, it is work worth doing that betters all involved and needs champions perhaps now more than ever.

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