Review Article

Improvising Caribbean Medicine in the Age of Slavery

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Pablo Gómez, *The Experiential Caribbean: Creating Knowledge and Healing in the Early Modern Atlantic*. Chapel Hill: University of North Carolina Press, 2017. xix + 291 pp. (Paper US\$ 29.95)

Londa Schiebinger, *Secret Cures of the Slaves: People, Plants, and Medicine in the Eighteenth-Century Atlantic World*. Stanford CA: Stanford University Press, 2017. xiii + 234 pp. (Paper US\$ 24.95)

Rana A. Hogarth, *Medicalizing Blackness: Making Racial Difference in the Atlantic World, 1780–1840*. Chapel Hill: University of North Carolina Press, 2017. xx + 268 pp. (Paper US\$ 27.95)

In spring 2018, the statue in New York City's Central Park honoring Dr. J. Marion Sims as the "father of gynecology" was removed amid an overdue season of American outrage about modern injustices and their historical foundations in the institutions that shape society—including government and police, but also medicine. Like the vanquished Confederate generals who were much later cast in bronze and erected in a spate of early twentieth-century historical revisionism designed to intentionally forget the slavery they fought to extend and to promote a new era of white supremacy, the statue of Dr. Sims silenced the experience of victims. They were the African-American women who were sub-

jects of his experiments, performed without anesthesia and repeatedly (with one woman enduring 30 operations), as he sought to find a surgical solution to vaginal fistulas suffered after rape or obstructed childbirth (or both). How did white control over black bodies at the expense of their well-being become normalized in hospitals and celebrated in public spaces? How did medical doctors establish their authority over the human body based on the outcomes of such experiments?

None of this was inevitable or even predictable, as seen from the seventeenth century in the African-dominated Caribbean spaces claimed by Spain and described by Pablo Gómez in full sensory detail. Here in the urban landscapes of Cartagena, Havana, and the like, experts from Africa and their Caribbean-born kin confronted the challenges of pestilence exacerbated by the transoceanic trade in human beings and the miseries that followed survivors ashore in slavery. These healers, appearing in the local Inquisition records as *mohanes*, created novel ways of knowing truths about human bodies and the natural world through experiential discovery. Far from being simple inheritors of African healing compounds and techniques to be deployed in the new situation of forced exile, the *mohanes* applied their creativity and curiosity to discover protean natural forces that they could manipulate to the benefit of their patients. Their explorations were not limited to the new Caribbean plants, animals, and minerals they prospected; they also borrowed promiscuously from Amerindian healing knowledge and the expanding cabinetries brought by ship to the Caribbean from the increasingly globalized Iberian metropole. They also plumbed the potential of European *materia medica* and Galenic principles that described the universal workings of the interior of bodies. Their success lay in their intellectual mastery as “expert navigators of multiple epistemologies” (p. 71), able to discern particularities and provide bespoke remedies. They were the intellectual ancestors of James Sweet’s eponymous *Domingos Álvarez* (2011), who practiced healing between Africa, South America, and Europe in the following century, as well as Richard Price’s *Tooy* (2010), the twenty-first century Saamaka historian-healer who travels both Atlantic time and space.

Gómez distills the approximate identities of more than a hundred of these *mohanes* from written records, especially those ecclesiastical courts whose demand for testimonies to be recorded verbatim continues to provide a rich vein of source material for scholars to mine. He excels at animating old words to tell stories of lived experiences of the seventeenth century. For the African majority, these were the healing practitioners of first resort and for much of the European-identifying minority they were a critical supplement to the chronically underfunded Catholic hospitals.

Every chapter of *The Experiential Caribbean* begins *in media res* and then the meaning of each episode is revealed—a rhetorical strategy that immerses readers in the performance of healing and impresses upon them the virtuosity of the healers. This narration reinforces the book's central argument: that people use their senses to discover, create, and understand the natural world. Healers of African descent created a heterogeneous method of experimentation in the seventeenth century that impressed not only those Caribeños who saw, heard, felt, and tasted their spectacular feats of care. The circulation of peripatetic *mohanes* across the variegated social spaces of Caribbean maritime ports made them omnipresent at the very places where the modern world was being created. Their centrality seemed to be recognized even in their own time, as their methods of developing new knowledge through interaction (rather than replication of dogma) were borrowed and reinterpreted in Europe to stimulate the development of scientific medicine.

Just how these founding fathers were so quickly forgotten is the focus of Londa Schiebinger's *Secret Cures of Slaves*. The growth of investments in agricultural commodities, especially sugar, in the eighteenth-century West Indies brought new English and French attention to developing medical solutions to the health challenges of sailors, settlers, and slaves. Immigrant Europeans worked initially with plantation experts. While most (known) *mohanes* of the seventeenth-century cities were men, on the early eighteenth-century plantations there were also women who were recognized as experts at providing health care beyond just midwifery and neonatal care. Plantation clinics offered opportunities for enslaved experts to treat Guinea worm, tetanus, snakebites, lacerations, and more. Plantation clinics were also places of employ for itinerant European doctors, where they could observe African, Amerindian, and creole practices. Their "discoveries" of what others already knew about the uses of flora and fauna were then appropriated for testing according to European protocols.

Illustrative of Schiebinger's technique is the case of A.J. Alexander, a Scotsman in Grenada, who became experimentally minded in search of a cure for yaws, then plaguing his plantation. The disease was thought to be a venereal disease due to symptomatic similarity to syphilis. Standard treatments with mercury only made the sick sicker. Alexander then tested the suggestion of a "Negro who understood the Method of treatment in their own Country," presumably somewhere in Africa (p. 50). Two sick slaves were treated with induced sweating (in a cask of water heated over a fire) and given a medicine made from two types of wood, including *bois fer* ("ironwood"). A second group received experimental treatments of caustic agents by a visiting surgeon. When the first group recovered quickly and the second did not, Alexander sought to replicate

the study's proof of efficacy to establish scientific validity. Four more persons were cured of yaws, then the treatment was applied with even more success, and Alexander reported this remedy to his former professor in Edinburgh. Significantly, Alexander gave credit to this "Negro Doctor," though he did not name him. Schiebinger shows that enslaved people were "knowledge brokers" in the Caribbean but faced barriers to achieve recognition as experts and discoverers due to their lack of literacy, their exclusion from formal education, and the demeaned social status that both bestowed.

From the 1780s, white Anglophone doctors developed systems of medical knowledge to describe innate racial difference. Rana Hogarth explores the methods and motivations of those working in the Americas, particularly in South Carolina and Jamaica, which she describes as one axis in the "Greater Caribbean." Her examination of doctors is wonderfully complex and ironic—which is to say, humanistic. They were not "mere agents" (p. 7) of proslavery politicians whose armchair arguments about innate racial difference benefited from the imprimatur of scientific validations. Yet they were fully a product of their professional milieu and completely invested in the new epistemology of scientific medicine. Hogarth situates each physician within the local politico-economies of plantation slavery or the fluidities of urban life in Charleston and Kingston, focusing on three episodes, including panic about yellow fever, concern over a specific form of pica ("dirt eating"), and the development of charitable hospitals and medical schools. Each of her book's three parts presents paired chapters on Jamaican antecedents and South Carolinian outcomes. Charleston physicians drew on the professional expertise of peers in Jamaica, whom they admired for their longer-term experience treating larger numbers of enslaved people. Those Jamaican doctors also enjoyed continuing access to the professionalized medical networks of the British empire for decades after America's war for independence—which is the point in time where Hogarth's study begins.

Repeated outbreaks of yellow fever in the eighteenth century across the Atlantic world stimulated study of the disease and the search for effective treatments for this most-feared sickness. Although prominent African-American leaders Absalom Jones and Richard Allen, of Philadelphia, revealed yellow fever to be an equal-opportunity disease in 1794, this argument fell mostly on deaf ears in the white medical establishment. White doctors were wedded to the notion that Blacks inherited racial immunity to the fever, a tragic misunderstanding that gave scientific support to the unique suitability of Africans to work as slaves in the "Torrid Zone." This pseudoscientific theory had its early roots in the anecdotal observations of colonial military leaders worrying over thinning muster rolls, where white soldiers seemed more likely to

become infected with the deadly fever than African-descended conscripts. It found fuller explanation by John Lining, an immigrant Scottish doctor and witness to the 1748 epidemic in Charleston, South Carolina. Lining's academic pedigree and position among the city's *élite* endowed his argument of innate black immunity with both credibility and professional medical authority. He attributed this immunity to a generalized internal, and therefore unseen and untestable, "constitution" that was superior in this specific way to the fragility of indigenous people and Europeans.

Hogarth emphasizes the consequences of giving potent social and clinical value to superficial physiological traits. Where previous generations of doctors trained in the European tradition explained the underlying universality of humans, the crucible of modern slavery in the Caribbean fostered new emphasis on inalienable differences. Scientific doctors were not immune to the contexts in which they worked. Abolition and suppression of the legal slave trade to the United States and the British Caribbean had the perverse effect of creating economic incentives to invest in improving the health of enslaved people so as to reproduce the wealth of their owners and thereby extend slavery in time and space.

Both Schiebinger and Hogarth describe the development of modern hospitals in the insular Caribbean and the American South as Janus acts of charity and self-dealing. Wealthy Whites and Creoles created clinical spaces and recruited experts to attend privately to themselves, but these hospitals acquired control of wards for slaves deemed so acutely sick and chronically infirm as to be an economic burden to their masters. In Kingston, "deserted" slaves were also seen as dangerous loiterers prone to join rebellion, and thus in need of institutionalization. Shed of their productive value on plantations, those sent or forced into hospitals and asylums were particularly vulnerable to becoming unwilling participants in medical experimentation. Rising emphasis on anatomical knowledge required dissections to reveal the physical inner-workings of humans. In death, black bodies were not spared commodification and were sold by masters to hospitals as cadavers for medical education. The development of antebellum-era teaching hospitals—the forerunners of modern medical schools—led to a demand for cadavers in numbers that could not be adequately satisfied by slave-owners, and so created an illicit economy in robbing graves of freedmen.

Schiebinger and Hogarth explicitly identify their own contemporary awareness of injustices in the more recent past to draw moral questions from this history. For Schiebinger, the notorious Tuskegee experiments of 1932–72 are the touchstone. For decades, government doctors withheld proven, cheap antibiotic treatment from rural African Americans sick with syphilis because the

doctors wished to have a “control group” to observe the progress of the disease. President Bill Clinton offered the nation’s apology only in 1993. In the middle portions of her book (chapters 3 and 4), Schiebinger seeks to explore how and why medical experimenters in the seventeenth century found human subjects before the great expansion of slavery in the West Indies, how enslaved people became particularly vulnerable thereafter, and the extent to which the ethics of these medical experiments ranged on a sliding scale from grotesque to those that abided to the enduring Hippocratic precept to do no harm.

Both Schiebinger and Hogarth apply present-day values to actions in the past to evaluate the morality of the doctors’ activities. Schiebinger finds that masters’ ownership of slaves stripped their human property of the legal protections arising from the sort of “natural rights” then being developed for white men themselves in the eighteenth century. The enslaved had no standing to freely “consent” to becoming experimental subjects, nor to decline participation or otherwise actively resist, given the omnipresent threat of violent punishment. Hogarth excoriates the continuing medicalization of blackness, with examples familiar from U.S. governmental divisions borrowed and recirculated by popular media. The methodology of correlating rates of particular varieties of poor health to racial groups is fruit from the poisoned tree. Such thinking is flawed even on its own measure of objectivity, as scientific researchers mistake social constructions of race to be biological facts of difference. Moreover, they use these purportedly self-evident taxons to describe in-group commonality of discrete populations that are in fact aggregates of diverse, self-identifying persons. Hogarth finds fault with medical researchers who lapse into lazy racial thinking and shows that medicine is not yet a neutral field of inquiry. Just as in antebellum Charleston, doctors today are not insulated from the contexts in which they live. Comparing incidence of poor health across imposed racial categories opens a logical pitfall in which those superficial differences are instead attributed to root causality, and has the effect of re-victimizing the oppressed by deeming them to be pathological. These are issues that continue beyond the nominal conclusion of Hogarth’s book in 1840.

In the decade that followed, Dr. Sims, born and raised in South Carolina, would begin his gynecological experiments. The boom in cotton culture put increasing value on the wombs of African-American mothers. Charleston grew anew as a source of academic training using black bodies, spurred by economic incentives as well as new, French ideas from polygenesis of the races that buttressed the denial of natural equality and therefore citizenship.

Together the three books under review here demonstrate the continuing vitality of the subject of health and medicine in the scholarship of the Atlantic-era Caribbean. Compared to the instrumentalism of disease and plants in the

environmental history of Alfred Crosby's *Columbian Exchange* (1972) and the biological study of Kenneth Kiple's *The Caribbean Slave* (1984), all three avoid retrospective diagnoses and decline judgment on the efficacy of particular treatments. Instead they illuminate the intellectual lives of the doctors themselves over three centuries of change. Further expansion of the geographical scope to include Africans in Africa as fully historicized partners as they engaged Lusophone strangers will expand the temporal boundaries that mark the origins of modern medicine.