Sick Time: Medicine, Management, and Slavery in Louisiana and Cuba, 1763-1868

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Modern, capitalist ideas of productivity became central to medicine under slavery. They shaped how physicians treated enslaved patients, crafted a scientific basis for medicine, and conceived of themselves as a profession. Between the late eighteenth century and the mid-nineteenth century, white male physicians in Louisiana and Cuba distinguished themselves from other healers: first, by aligning with Spanish colonialism, and then, by making themselves essential to a new form of plantation management that used clock-time discipline, hierarchical divisions of labor, and complex accounting systems. These technologies helped planters precisely interpret enslaved health and illness in terms of productivity. Physicians, who were seeking a rigorous foundation for medical knowledge production, latched onto planter methods of calculating and controlling enslaved health. One of those methods was what planters called “sick time,” which was an allotment of time away from work intended to manage illness enough for enslaved people to return to work.

However, as physicians used plantation management to cast an air of scientific accuracy over their knowledge, enslaved people reconfigured their own medical practices to make themselves less visible and countable. Drawing on nineteen archives across the United States, Cuba, and Spain; plantation account books; agricultural trade journals; medical journals; medical dissertations; travel accounts; narratives of formerly enslaved people; and medical ethnographies, this dissertation traces the encounters between slavery management, physician medicine, and enslaved medicine. I show how enslaved people used their health and healing practices to subvert plantation time discipline, while physicians became the preferred medical consultants for managers and remained so after emancipation.
Sick Time: Medicine, Management, and Slavery in Louisiana and Cuba, 1763-1868

A Dissertation
Presented to the Faculty of the Graduate School
Of
Yale University
In Candidacy for the Degree of
Doctor of Philosophy

By
Liana DeMarco

Dissertation Director: John Harley Warner

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Modern, capitalist ideas of productivity became central to medicine under slavery. They shaped how physicians treated enslaved patients, crafted a scientific basis for medicine, and conceived of themselves as a profession. This development was especially apparent in Louisiana and Cuba, both of which became major plantation slavery economies in the early nineteenth century. During this period, white male physicians distinguished themselves from other healers by aligning with a new form of plantation management that used clock-time discipline, hierarchical divisions of labor, complex accounting systems, and uniform plantation environments. These technologies gave planters the means to visualize enslaved people’s bodies as rational objects that could be quantified and repaired in a systematic fashion. Seeking a rigorous intellectual basis for medical knowledge production, physicians latched onto slavery management. Much like racial science, which was becoming more widespread and influential in the Atlantic world during this period, management science – particularly its ability to quantify health and illness in terms of productivity – gave physicians a seemingly objective framework for diagnosing and treating enslaved Black patients. The result was the creation of two medical cultures for whom the primary focus was not healing enslaved bodies, but properly managing them, through carefully timed systems of labor, medical intervention, and surveillance, in order to maximize their productivity.

One essential method for managing enslaved health was what planters and physicians called “sick time.” Using sophisticated accounting technologies that became widely available in the early nineteenth century, planters could tabulate numerical reductions in productivity by tracking the total number of clock- and calendar-standard hours, days, and weeks of work that slaves missed when they were ill or injured. Planters began to fixate on
reducing the amount of time slaves spent in sick beds or in the plantation infirmary, often referring to this as “time lost,” “work time lost,” or “lost work.” They created elaborate procedures governing everything from enslaved people’s housing, clothing, and diet to their interactions with domesticated animals, all in the hopes of decreasing time lost. One of the most important innovations was sick time, which was an allotment of time away from work duties after which an enslaved person would be considered healthy enough to work again. Planters often determined appropriate lengths of sick time in consultation with physicians.

Crucially, the purpose of sick time was not necessarily to allow enslaved people time to rest and recover, but rather to mitigate time lost and recoup productivity. In many cases, it did not matter if an enslaved person’s illness had actually resolved during their sick time, because once that time had expired, they would be deemed medically fit to work. Furthermore, many enslaved people were forced to make up their sick time by working longer hours on other days, or by sacrificing their Sundays, which were usually the only days of the week when they were not expected to work.

This idea of sick time, and the relationship between medicine and slavery management more broadly, had historical foundations in Spanish colonialism. The Spanish empire held both Louisiana and Cuba during the second half of the eighteenth century, which was a pivotal moment in the history of medicine in the Atlantic world when scientific reason, rational thinking about health and illness, and the physicians who laid claim to such knowledge began to gain power over other kinds of healing and healers. Spanish colonial officials believed that rational medical knowledge was needed for building healthy populations of enslaved people and white settlers who could contribute to economic development, particularly in up-and-coming urban areas like New Orleans and Havana. As
such, the state intervened in the medical marketplace to place white male physicians and their knowledge at the top, granting them not just wider legitimacy but also the power to subordinate other medical practitioners through public health, education, and employment. Medical practitioners of African descent were especially maligned and marginalized, despite the fact that they were still doing much of the everyday medical labor, even in Spanish colonial hospitals. In addition to whitening and empowering the medical profession, the Spanish state also catalyzed a mutually constitutive relationship between white male medical expertise and the administration of slaves.

The Spanish left Louisiana in 1803 and their influence in Cuba waned over the first half of the nineteenth century as the planter class became more powerful. However, the economic and intellectual significance of white male medical experts did not fade. The importance of methodically surveilling enslaved populations carried over from the city to the plantation along with the changing center of gravity in the slavery economy. Many of the same New Orleans- and Havana-based physicians who had risen to prominence under the Spanish became leading experts in both urban public health and plantation medicine. Planters replaced the Spanish state as the most important employers and benefactors of physicians because, like the Spanish, they believed that these physicians possessed the best knowledge for maintaining enslaved people’s health and increasing economic activity. By the late 1860s, the Civil War had brought an end to slavery in the United States and Cuba’s first war of independence against Spain significantly curtailed the expansion of plantation slavery on the island. But physicians had succeeded in establishing themselves as medical consultants who would remain valuable to the management of laboring bodies long after emancipation.
Beyond professional and economic gain, adopting managerial ideas gave physicians a scientific foundation for medicine that pre-dated the laboratory and biomedicine. The technological sophistication of plantation management, its procedural nature, and its mechanistic understanding of enslaved bodies seemed to physicians to be stable frameworks upon which they could build medical knowledge that would be consistent across a variety of environments and patient groups. Time discipline was essential to the sense of stability. Using time as a scaffold for medical thought and practice was not unusual before the mid-nineteenth century, nor was it unique to Western medicine. For example, many medical practitioners interpreted the severity of illness in terms of how long the patient had been experiencing symptoms. The distinguishing feature of physicians’ understanding of time in Cuba and Louisiana was that it was wrapped up in their subjective experience as economically-conscious medical experts. Moreover, it was an idea of time that was explicitly tied to the plantation, the hierarchical, highly controlled sphere of production that, much like the laboratory later on, appeared to be governed by rational laws and based in scientific reason. Although there were plenty of instances where this thinking failed spectacularly – particularly where enslaved people and plantation environs did not conform to managerial expectations – the plantation and its managerial systems provided physicians with the universal laws for health and medicine that they had been searching for.

The notion that healing can be measured in work time rather than patient sentiment, and the idea that a return to work signifies good health, are still with us today. In Cuba, the socialist state guarantees workers the “right” to paid sick time. In the capitalist United States, where there is no state guarantee of paid sick time, employers may choose to extend this “benefit” to their employees. In both cases, an important function of sick time is still to preserve if not increase productivity that benefits someone else: the state or the employer.
Historians of Cuban medicine have argued that labor activism and physician nationalism in the early twentieth century primed Cubans to believe they had a right to health benefits like sick time. So too, scholars of U.S. labor history have shown that New Deal liberals and welfare capitalists eventually agreed that employers should provide some health benefits for their workers (though many workers, women’s groups, and activists criticized the linking of such benefits with private employment). Then, in the postwar period, employee collective bargaining forced employers to provide more assistance with the burdens of ill-health, including access to sick days without fear of termination.\(^1\) However, there is another history of sick time, and a deeper historical explanation for the routing of health through work, which shows how these concepts were once managerial strategies used on enslaved people.

To understand how a seemingly progressive or even class-conscious concept like sick time could have roots in enslavement, we must recognize that the relationship physicians and planters shaped an enduring bond between medicine and capitalism. This bond is based in part on the managerial need to keep the laboring body working, especially the Black laboring body. This dissertation is the first to examine the role of slavery management science in the development of medical knowledge and the rise of the white male-dominated medical profession. Previous histories of medicine and slavery have shown how the institution of

\(^1\) Daniel A. Rodríguez’s study of anti-colonial health activism and physician medical nationalism in early twentieth century Cuba argues that these social movements paved the way for the right to medical care as one of the foundational ideologies of the Cuban Revolution. See *The Right to Live in Health: Medical Politics in Postindependence Havana* (Chapel Hill, NC: University of North Carolina Press, 2021 [hereafter cited as UNC]); for the U.S., Jennifer Klein has argued that insurance companies, welfare capitalists, and New Deal liberals normalized the idea that social benefits should be handled privately despite receiving pushback from laborers, women’s groups, and welfare activists. See *For All These Rights: Business, Labor, and the Shaping of America’s Public-Private Welfare State* (Princeton, NJ: Princeton University Press, 2003); and on collective bargaining for employer-sponsored health care in postwar America see Gabriel Winant, *The Next Shift: The Fall of Industry and the Rise of Health Care in Rust Belt America* (Cambridge, MA: Harvard University Press, 2021).
slavery empowered white male physicians at a crucial moment when the modern medical profession was taking shape. Many of these histories have focused on the changing power dynamics of medicine and healing, showing how enslaved people – especially enslaved women – were among the most ubiquitous healers on plantations until the early nineteenth century when many planters started expressing their preference for white male physicians, whom they believed possessed more efficacious cures. Histories of medicine and slavery in the early modern Atlantic world have shown that Black medical practitioners could become widely respected healers. White physicians’ ascendance to the top of the medical

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marketplace was accompanied by – and no doubt deeply related to – their increasing interest in racial science. Historians have illustrated the ways that physicians, in concert with planters and other racial thinkers, developed racialized ideas of the enslaved body that still influence how doctors treat Black patients today.4

On the question of medicine’s connections to the business of slavery, several scholars have shown that physicians participated in the making of economic abstractions of the enslaved body, including the price of enslaved flesh. Sharla Fett showed that enslavers often called upon white doctors to examine enslaved people and determine whether or not they were “sound in body and mind.” “Soundness” was an overall measure of an enslaved person’s physical health, mental health, and moral character that factored into the pricing of that person’s body in the slave market. Similarly, Daina Ramey Berry has demonstrated the ways that enslavers evaluated enslaved people’s bodies according to a variety of metrics including age, health, temperament, reproductive history, and skills so as to determine their price at different stages of the life cycle. Physician knowledge was needed not just for the

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initial purchase of an enslaved person, but also for calculations of the enslavers’ total assets and insurance policies that could be taken out on enslaved lives. Physicians were often present at slave insurance negotiations, sometimes at the behest of the buyer and other times as representatives of the insurance firm.5

Unlike the market-driven meanings of enslaved health seen in pricing and insuring, the managerial meanings of enslaved health had more to do with how enslaved people were understood within a system of production in which productivity, not price, was the most important economic abstraction. Some sale documents show that an enslaved person deemed medically “unsound” in body, mind, or character might still fetch a high price if it could be demonstrated that the person had been a good worker in the past. In April 1860, Louisiana planter Augustus Koenig purchased an enslaved woman named Annette whom a physician had examined and “fully guaranteed against the inhibitory vices and maladies prescribed by the law with the exception of a disease which she had two years ago, which manifested itself in fits having the character of madness, and of which he [the physician] is unable to say that she is cured.” Knowing this, Koenig still decided to purchase Annette for the full price of $900 because he was “well acquainted” with “the service she has done in years past.”6 Acknowledging that there may have been circumstances left unsaid that

5 Fett, Working Cures, esp. Chapter 1; and Daina Ramey Berry, The Price for their Pound of Flesh: The Value of the Enslaved, from Womb to Grave in the Building of a Nation (Boston, MA: Beacon Press, 2017); for more on physician involvement in slave pricing and insuring see Eugene D. Genovese, “The Medical and Insurance Costs of Slaveholding in the Cotton Belt,” The Journal of Negro History 45, no. 3 (July 1960): 141-155; and for Cuba see Laird W. Bergad “Slave Prices in Cuba, 1840-1875,” The Hispanic American Historical Review 67, 4 (November, 1987): 631-655; literature on enslaved disability is also relevant here, especially Dea H. Boster’s work on how enslaved disability was understood in medical care, markets, insurance, and property. See African American Slavery and Disability: Bodies, Property, and Power in the Antebellum South, 1800-1860 (Routledge, 2013).

influenced Koenig’s decision but had little to do with Annette’s health or work history, the relationship between health, soundness, and the valuation of enslaved life appears inconsistent in this example without a consideration of how planters could view health in relation to production. Koenig may have believed that Annette’s past productivity was a better indication of her value than the medical designation of “unsoundness.”

Physicians who viewed enslaved health along similar lines often emphasized that their medical knowledge was valuable for “preserving” the enslaved workforce and the efficiency of the plantation as a whole. In their writings, these physicians discussed the merits of therapeutic interventions and methods of surveillance in terms of whether or not they were useful for “maintaining” enslaved workers; increasing the number of commodities they could produce; and augmenting the amount of time they spent working versus being marked “sick.” In 1840s, Cuban physicians based in Havana regularly surveyed sugar planters to learn about plantation management, stating that they aimed to create a “comprehensive” body of medical knowledge that would be useful for “preserving the health of the slaves,” but would not “inhibit the work that they do” or “the amount of sugar they produced.” Similarly, Louisianan physicians who published in agricultural trade publications explained that the primary purpose of “maintaining” enslaved health was that it would help planters “save time” and money. Allowing them some time to rest when they were ill was a large upfront cost, but “it would soon be saved out of doctor’s bills and the

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7 Expediente promovido con el fin de mejorar el sistema de los negros esclavos en nuestros campos y continuando sobre el fomento de la ganadería (1846). Legajo no. 945/no. orden 33311, Fondo Gobierno Superior Civil (hereafter cited as GSC), Archivo Nacional de la República de Cuba, Havana, Cuba (hereafter cited as ANC); similar language can be found in two other surveys conducted around the same time that focus on the food provisions needed improving the health of enslaved people: Sobre establecer mejoras en los alimentos de los esclavos de nuestros campos (1846). 945/33309, GSC, ANC; Sobre mejorar el alimento de los esclavos de los campos (1847). 945/33322, GSC, ANC.
sick-list.”

Seeing enslaved health at the level of the workforce and understanding the connection between aggregate enslaved health and plantation efficiency may not have been necessary for the pricing of enslaved bodies. However, these perspectives were vital for extending the work potential of those bodies.

Managerial understandings of enslaved health thus constituted an effort to reconcile the limits of laboring bodies with the demands of production decades before the rise of Taylorism and industrial hygiene in North America and Western Europe. Historians of science and medicine have argued that the Progressive Era was the moment when medical scientists, businessmen, and social commentators began to think about the body as an object within a system of production, such as the factory. Early twentieth century physiologists produced numerous studies of “industrial fatigue” and debated whether the condition was a function of the physiological limits of the body or a psychological barrier in the worker’s mind, the latter of which might be overcome by management. Yet, these historians have not attempted to historicize the basic premise that judicious management might be able to alleviate ill-health enough for laborers to return to work.

It is true that the growth of laboratory-based, experimental methods during the late nineteenth century was a major

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turning point in the history of medicine because they gave medical scientists the ability to produce knowledge using the scientific method in a controlled setting.  

But this was not the first attempt to standardize medical knowledge around a scientific framework, and the laboratory was not the first controlled setting for medical knowledge production about the laboring body.

Studying Louisiana and Cuba together provides further counterweight to the North Atlantic focus in the existing literature, while also resisting the tendency to view the history of medicine, slavery, and capitalism in the United States as an exceptional narrative. While Cuba and Louisiana are classic comparative case studies in the history of slavery, the same cannot be said for the history of medicine.  

There were important differences between the two in terms of medical regulation, education, and professionalization. Cuba remained a colony of Spain and subject to its imperial medical bureaucracy (at least on paper) until 1898, while Louisiana had a largely unregulated medical economy from 1803 until the second half of the nineteenth century. But with regard to the development of plantation slavery, Cuba and Louisiana followed very similar trajectories. Between 1790 and 1820, both moved from what Ira Berlin has called colonial “societies with slaves” to plantation-based, highly profitable “slave societies.” This meant that the changes in professional medical culture that

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were tied to the slavery economy – such as physician focus on enslaved productivity – emerged in both places at the same time.12

Enslaved health was central to this economic shift, which is often called the “acceleration” of slavery. Historians have used terms such as “racial capitalism,” “slave racial capitalism,” and the “Second Slavery” to distinguish nineteenth century slavery from its previous iterations. All of these terms essentially refer to the same phenomenon, which was the rapid economic growth, technological sophistication, and race-based social stratification that occurred in Cuba, the U.S. South, and Brazil as they became the largest enslaving societies in the Atlantic world.13 Some scholars have argued that acceleration was due to increasing importations of enslaved Africans to Cuba beginning in the 1790s and the “domestic” slave trade in the U.S. South, which brought nearly one million enslaved people from the Upper South to the Deep South between roughly 1815 and 1860.14 This wave of forced migration coincided with so-called “Market Revolution,” where mobile workers, land


13 According to Cedric Robinson, “racial capitalism” is both a specific historical phenomenon that can be located in nineteenth century slave societies and a theoretical framework that challenges the conventional Marxist idea that capitalism was a revolutionary negation of feudalism; rather, Robinson argues that it emerged within a European feudal economic order that was already racist, and thus there is no capitalism that is not racial capitalism. See Black Marxism: The Making of the Black Radical Tradition (London, UK: Zed Press, 1983); for “slave racial capitalism” see Johnson, River of Dark Dreams; and for the “Second Slavery,” which distinguishes between the earlier period of Atlantic slavery (pre-1800) and the period after 1800 in terms of technology, racial formation, and geographic locations of major enslaving operations, see Dale W. Tomich, ed., The Politics of the Second Slavery (Albany, NY: State University New York Press, 2016); Through the Prism of Slavery: Labor, Capital, and World Economy (Lanham, MD: Bowman & Littlefield, 2004); “The Wealth of Empire: Francisco Arango y Parreño, Political Economy, and the Second Slavery in Cuba,” Comparative Studies in Society and History 45, 1 (2003): 4-28; Rafael Marquez, Tâmis Peixoto Parron, and Márcia Regina Berbel, Slavery and Politics: Brazil and Cuba, 1790–1850, trans. Leonardo Marques (Albuquerque, NM: University of New Mexico Press, 2016); Anthony Kaye, “The Second Slavery: Modernity in the Nineteenth-Century South and the Atlantic World,” The Journal of Southern History 75 (Aug. 2009): 627-634.

14 On the economic significance of the slave trade in Cuba, especially the approximately 499, 580 enslaved people who were brought to the island between the first official ban on the slave trade in 1820 and 1867, when the ban was finally enforced with effect, see Bergad, Fe Iglesias García, and María del Carmen Barcia, The Cuban Slave Market, 1790-1880 (Cambridge, 1995); on the domestic or internal slave trade in the U.S. South see Alexandra J. Finley, An Intimate Economy: Enslaved Women, Work, and America's Domestic Slave Trade (UNC, 2020).
speculation, and the dispossession of Indigenous lands, alongside faster transportation and communication technologies, compressed the spatial and temporal distances between the city and the countryside. In the realm of slavery management, these changes introduced a sense of regularity and time consciousness in business operations that fit with new rational methods of managing labor and production.

Numerous studies have drawn attention to the significance of plantation technologies in slavery’s acceleration, but they have done so without asking why enslaved people’s health was one of the main objects that planters were thinking about when they used these technologies. As studies of the steam-powered sugar mill, the cotton gin, and the easily pickable “Petit Gulf” cotton strain have shown, proponents of these technologies claimed that they would make work easier for enslaved people by supposedly alleviating some of the stress on their bodies. Several historians have examined the ways in which time discipline and managerial innovations undergirded acceleration. Dale Tomich and Mark M. Smith have argued that the imposition of clock time aided in economic growth in Cuba and the U.S. South. Business historian Caitlin Rosenthal has argued that the advent of

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17 Dale Tomich writes that “increases in output [on Caribbean sugar plantations in the nineteenth century] were achieved by more closing integrated economies of time, time discipline, and the intensification of work.” See Slavery in the Circuit of Sugar Martinique and the World-Economy, 1830-1848 (Reprint: Albany: State University of New York Press, 2016), 48; for a study of clock-based time consciousness in the U.S. South see Mark Michael
hierarchical, multi-divisional labor organization and complex accounting technologies helped enslavers produce more sugar and cotton. These scholars demonstrate that planters valued new technologies because they enabled greater control over enslaved people and, at least in theory, facilitated increases in productivity. But neither they nor historians of the “new history of capitalism” have asked why planters came to believe that scientific and technological improvements could be used to control enslaved health.

To be clear, neither the meticulous management of enslaved health nor the greater prevalence of white male physicians on the plantation lead to better health outcomes for enslaved people. There were higher mortality rates, progressively intense work schedules, and systematic enslaver violence involved in the acceleration of slavery. Planters often

Smith, _Mastered by the Clock: Time, Slavery, and Freedom in the American South_ (UNC, 1997); foundational to these perspectives is E. P. Thompson’s pioneering study of “time discipline,” the imposition of synchronic forms of clock time and work discipline, which began during the Industrial Revolution and aided in the creation of both modern capitalism and the modern state. Clock time, controlled by government and capitalist interests, replaced earlier perceptions of time, such as religious time. See “Time, Work-Discipline, and Industrial Capitalism,” _Past & Present_, No. 38 (Dec., 1967): 56-97; and for more on time under capitalism and its relationship to economic development see William H. Sewell, Jr, “The Temporalities of Capitalism,” _Socio-Economic Review_, Volume 6, Issue 3 (July 2008): 517–537.

Roseenthal, _Accounting for Slavery: Masters and Management_ (Harvard, 2018).

For enslaved mortality rates in Cuba see Manuel Moreno Fraginals, “Africa in Cuba: A Quantitative Analysis of the African Population in the Island of Cuba,” in _Comparative Perspectives on Slavery in New World Plantation_
withheld medical care from any enslaved people they deemed to be less productive, often those who were older and disabled, as these people did not in their view justify such an investment. Moreover, white physicians often performed dangerous medical treatments and experiments on enslaved people that contributed to morbidity and mortality. But planters nonetheless believed that physicians’ medical interventions were improving the health of enslaved people when they led to reductions in sick time. Fewer sick days meant the plantation was more efficient even if enslaved morbidity and mortality were actually on the rise. In short, managerial definitions of good enslaved health did not align with enslaved people’s ideas of good health.

Given that planters and physicians prioritized productivity over healing, enslaved people had to rely on their own medical knowledge to care for themselves and one another. As is the case when discussing “white physicians’ medicine,” “European medicine,” or “Western medicine,” it is difficult and at times problematic to discuss West African medicine as one coherent medical culture. For most of the eighteenth century, the boundaries between European and African medicine were porous, and only towards the end of the century did the social and economic dominance of white medical professionals become truly discernable. Moreover, there were important cultural differences between enslaved people in Cuba and

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21 For the argument that enslavers would be less inclined to pay for a physician to treat an enslaved person if that person was deemed too old, disabled, or difficult see Boster, *African American Slavery and Disability*, Fett, *Working Cures*, and Savitt, *Medicine and Slavery*; for medical experimentation and dangerous medical treatments performed on enslaved people see Cooper Owens, *Medical Bondage*, and Washington, *Medical Apartheid*. 
those in Louisiana. Some enslaved families in nineteenth century Louisiana had been there for more than a century, but many were forcibly brought to the region through the domestic slave trade. Slavery had existed in Cuba since the fifteenth century, but when Cuban enslavers ramped up the importation of enslaved people between 1790 and 1820, this led to an “Africanization” of the Cuban slave population. Cuban enslavers recorded what they thought were the geographic and ethnic origins of recent arrivals and assigned them “nombres de nación,” or ethnic surnames that were based on existing groups of enslaved people in Cuba. Furthermore, there were paths to emancipation in Cuba based on Iberian legal tradition, such as coartación, which was a manumission process by which enslaved people could purchase their freedom in installments.

Despite these differences, enslaved medical cultures in Louisiana and Cuba underwent similar transformations between the late eighteenth century and the nineteenth century as West African medicine became a way for enslaved people to transcend the management of their health. Previous historians have shown that West African medical practices became important tools of surviving and resisting enslavement. European medical practitioners sometimes appropriated West African knowledge – especially botanical knowledge – if it appeared to have economic and/or therapeutic value. This colonization of

22 For a thoughtful discussion of the difficulties in identifying distinct Afro-descended ethnic groups within Cuba see Aisha K. Finch, Rethinking Slave Rebellion in Cuba: La Escalera and the Insurgencies of 1841–1844 (UNC, 2015), 24-28; Cuban social anthropologist Fernando Ortiz produced a comprehensive study of African ethnic groups and subgroups in 1916. Despite the problems of interpreting historical ethnicities under slavery, and the fact that Ortiz viewed physical and behavioral characteristics through a social Darwinist lens, the book remains an important resource for the history of slavery in Cuba. See Los Negros Esclavos: Estudio Sociológico y de Derecho Público (La Habana, CU: Revista Bimestre Cubana, 1916).

23 For more on the differences between enslavement and emancipation in Cuba and Louisiana see de la Fuente and Gross, Becoming Free, Becoming Black; for coartación in nineteenth century Cuba see Claudia Varella and Manuel Barcia, Wage-Earning Slaves: Coartación in Nineteenth-Century Cuba (Gainesville, FL: University of Florida Press, 2020).
medical knowledge continues in Africa today. However, European extraction often fails to capture the ontological, epistemological, spiritual, and sensorial meanings of health and healing as they exist in African and Afro-diasporic social contexts.

What has been largely neglected in the literature on enslaved medical cultures is the great extent to which West African meanings of health and healing were incorporated into enslaved fugitivity, especially practices of fugitivity that involved environments and animals. Pablo Gómez has demonstrated that one distinguishing characteristic of African medicine in the early modern Spanish Atlantic world was the idea that a good healer possessed a body and a disposition that were open to the surrounding environment. The healer would use this openness to engage with divine influences in the environment and generate healing.

Permeability between body and environment took on even greater importance as plantation landscapes in Cuba and Louisiana became highly surveilled and regulated. The idea that enslaved people's bodies were predictable objects working within the larger system of production was of course a crucial part of what made plantation slavery management seem reason-based, scientific, and efficient to planters and physicians. This objectification contributed to enslaved people's dehumanization and exploitation, but at the same time, it rendered other meanings of the enslaved body unimportant and even invisible to planters and physicians. Enslaved people's bodily connections with animals and environments were


25 For more on the evolving relationship between West African medicine and European medicine in the Atlantic world see Gómez, The Experiential Caribbean; Scheibeinger, Secret Cures of Slaver; Scheibeinger and Claudia Swan, Colonial Botany: Science, Commerce, and Politics in the Early Modern Atlantic World (University of Pennsylvania, 2005); Scheibeinger, Plants and Empire: Colonial Bioprospecting in the Atlantic World (Harvard, 2004); Sweet, Domingos Álvares; Covey, African American Slave Medicine; Weaver, Medical Revolutionaries; Fett, Working Cures; Bankole, Slavery and Medicine; and Savitt, Medicine and Slavery.

26 Gómez, The Experiential Caribbean, 93, 176.
ontological terrains that were not accounted for in plantation management, because although planters often tried to manage slaves, animals, and environments together, they found that they could not control animals and environments the way they did slave health. Animals, floods, and storms could not be forced to make up the work time they had compromised.

Enslaved people noticed these limits of planter and physician knowledge and took advantage of them to create what I call fugitive therapeutics, which was a way of healing by making oneself less visible and less countable and by avoiding work or absconding from the plantation altogether. Enslaved people’s connections to animals and environments were especially important because planters and physicians usually did not recognize them as curative or subversive, but enslaved people’s botanical and spiritual knowledge were also reconfigured for fugitivity. As such, fugitive therapeutics had intellectual and cultural roots on the African continent, but were formed in the New World in response to increasingly intensive and violent slavery management and the growing power of physicians.27

Analyzing the social and intellectual evolution of West African medicine requires a wide source base that includes narratives of formerly enslaved people; nineteenth century missionary accounts; twentieth-century oral histories conducted with formerly enslaved people and their family members; and medical ethnographic studies of Black Louisianan,

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Afro-Cuban, Afro-Caribbean, and West African healing traditions. Case studies in this dissertation often begin with the appearance of an enslaved, formerly enslaved, or fugitive person in an archival source. I then build out the person’s story using an eclectic source base to speculate on their knowledge production and embodied experiences of control and fugitivity. This composite approach builds on the path-breaking work of Marisa Fuentes. In *Dispossessed Lives: Enslaved Women, Violence, and the Archive*, Fuentes proposes a new methodology for the history of slavery which utilizes archival “fragments” of enslaved lives together with slave-holder records, travel narratives, missionary sources, colonial records, and literature in an attempt to reconstruct the lives that enslaved women “might have lived.” Building on Michel-Rolph Trouillot’s critique of the archive, Fuentes’ methodology provides a way for historians to contemplate and imagine the actions and aspirations of enslaved people whose voices are often written out of the official historical record.28

Fuentes’ methodology was also helpful for pulling together a diverse set of archival and published sources for the main argument on planter and physician ideas of enslaved health. These sources include colonial records; plantation business records, diaries, and correspondence; physician’s papers and correspondence; medical geographies and travel guides; medical journals; and medical dissertations. I draw on nineteen archives across Cuba, Spain, and the United States. These include the major archives for the history of slavery in Louisiana, such as the Louisiana State Archives; the Historic New Orleans Collection at the

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28 Marisa Fuentes, *Dispossessed Lives: Enslaved Women, Violence, and the Archive* (University of Pennsylvania, 2016); Trouillot argues that inequities in the present shape the material historical record, and that silences are inborn in the production of history, due in large part to the archive and historians’ fetishization of it as the authentic repository of historical knowledge. See *Silencing the Past: Power and the Production of History* (Beacon, 1995); recently, Jennifer L. Morgan has utilized a similar methodology to uncover enslaved women’s experiences of commodification and racialization in the early Atlantic slave trade. See *Reckoning with Slavery: Gender, Kinship, and Capitalism in the Early Black Atlantic* (Duke, 2021).
Williams Research Center; and the Howard-Tilton Memorial Library at Tulane University; and those for the history of slavery in Cuba, such as Biblioteca Nacional de Cuba José Martí and Archivo Nacional de la República de Cuba. I use Spanish archival holdings such as Archivo General de las Indias to examine medicine, public health, and economic development under Spanish colonialism in Louisiana and Cuba. The bulk of the physician sources come from Museo Histórico Nacional de las Ciencias Carlos J. Finlay; the Howard-Tilton Memorial Library at Tulane University; and the Matas Library for the Health Sciences at Tulane University School of Medicine. Important periodicals for slavery and medicine in Cuba are *Memorias de los Amigos del País de La Habana* (1793-1896) and *Anales de la Real Academia de Ciencias, Médicas, Físicas y Naturales de la Habana* (1864-1927); and for Louisiana, the most valuable are *Southern Medical Reports* (1849-1850); *The New Orleans Medical and Surgical Journal* (1844-1952); and *DeBow’s Review* (1846-1884). Taken together, this source base exemplifies the major changes in medicine and slavery management that took place between the 1760s and the late 1860s.

I trace this history in five chapters, moving from the city, to the plantation, and finally to the woods, swamps, and natural springs where enslaved people went to heal. Chapter One focuses on Spanish colonial medicine, public health, and environmental management in the late eighteenth century. Acknowledging that a similar imperial story was playing out in Havana, the bulk of this chapter takes place in Spanish New Orleans to provide a corrective to the existing literature on medicine in early New Orleans which largely disregards the significance of the Spanish period. The chapter closes with an examination of medicine, medical education, and public health in early U.S.-controlled New Orleans (ca. 1803-1830) to
highlight how white male medical expertise and the management of enslaved health
continued to support each other throughout the transfer of imperial power.

Chapter Two moves across the Gulf of Mexico to analyze the development of
plantation management, medical education, and the medical profession in Havana. As Cuban
planters began using new managerial and accounting technologies, they started to seek out
physicians who had anatomical knowledge and clinical experience, believing such knowledge
to be ideal for maintaining the human machinery of the plantation. Medical academics,
public health officials, and prominent physicians in Havana were already interested in these
disciplines, as were many European and North American physicians at the time, but planter
preferences added even more incentive to study them. In teaching hospitals such as the
Royal Hospital of San Ambrosio, University of Havana medical students learned how to
observe patients, repair their bodies, and experiment with medical therapies. By the 1820s,
physicians from Louisiana, the wider U.S., and Western Europe were going to Cuba to study
medicine. But the popularity of the so-called “plantation tour” shows that it was not just
teaching hospitals that drew foreign physicians to Cuba. This tour provided physicians with
access to highly organized, controlled plantation environs that were similar to the hospital,
but contained even more enslaved people who could serve as “clinical material.” Meanwhile,
the plantation tour gave Cuban planters a consistent stream of experienced physicians who
could help maintain their desired pace of production.

Chapter Three switches perspectives from physicians and planters to that of the
enslaved people who lived on sugar and cotton plantations in mid-nineteenth century Cuba
and Louisiana. I reconstruct the lives of two enslaved women: Catalina Gangá, who was
enslaved at Ácana sugar plantation in Matanzas, Cuba during the 1840s, and Charity, who
was enslaved at Marydale cotton plantation in Tensas Parish, Louisiana during the 1850s. The lives that these women might have led demonstrate how West African medical practices became important means of subverting plantation time discipline. Enslaved people transformed their knowledge about flora and fauna into methods of stealing time and space to heal, and in doing so created new definitions of health and well-being.

Women like Catalina and Charity had to create new meanings of health to endure the increasing violence of racial slavery and plantation medicine, which included the concept of sick time. The first half of Chapter Four provides a close examination of the accounting tools, managerial practices, and clock-time consciousness that sugar and cotton planters used to quantify sick time and visualize enslaved people’s productivity. The second half of the chapter demonstrates the proliferation of managerial ideas in medical discourse. In personal papers, medical journals, and dissertations, physicians deployed the language of plantation productivity and the concept of sick time to make their knowledge seem more scientific.

However, there was no equivalent of sick time for work time lost to environmental conditions. Weather and environments could make slaves sick and cause plantation production to grind to a halt, but there was no comparable way for planters or physicians to exactly predict environmental change, let alone control it systematically. Chapter Five shows how, even at the height of racial slavery and plantation medicine, planters and physicians were no better off than Spanish colonial officials had been in the late eighteenth century when it came to developing rational methods for protecting health and economic development from unruly environments. Furthermore, enslaved people recognized this failure of management and medicine. They seized on the dearth of control over environments to create healing practices that fall under what historians of slavery have called
“petit marronage,” or temporary flight from the plantation. Enslaved flight to woods, swamps, and natural springs were especially illustrative examples that also reveal important similarities with watering practices in West Africa and in slave-descended communities in the Greater Caribbean. As such, I speculate that these runaways were adapting West African medicine to New World environments. Furthermore, flight to therapeutic environs shows that enslaved people developed their own practices of sick time.

Enslaved people’s fugitive therapeutics with plants, animals, and watering places shows that the managerial meanings of enslaved health did not go uncontested. Planters and physicians created methods of managing enslaved bodies as rational, mechanistic objects, but the people who inhabited those bodies responded by making new experiences, temporalities, and topographies of healing. Although the institution of slavery (and the archive thereafter) silenced far more enslaved voices than could ever be recovered, even with the determination to speculate, the enslaved people who appear throughout this dissertation provide a glimpse of a vast world of knowledge production that exceeded what planters and physicians knew at the time, and what we as historians can know today.

That said, the untold possibilities of enslaved people’s medical knowledge make the power of slavery management and physician medicine all the more striking. This power did not arise naturally, just as the acceleration of slavery was not a natural evolution of the Atlantic slavery economy. Both were made over time, and in Louisiana and Cuba, they began to take shape in the late eighteenth century under Spanish colonial rule.
Chapter One: Controlling Healthy Populations: State Biopolitics, Medical Expertise, and Racial Politics in Spanish New Orleans, 1763-1803

Sometime in early August 1794, a free woman of African descent named Margarita Goton faced off against her former enslaver and current employer in a courtroom in Pensacola, Florida. Goton alleged that Dr. Juan Rubí, first surgeon of the Spanish Royal Hospital of Pensacola, was refusing to pay her the remaining balance of her wages from ten years of work at the hospital. Rubí had already captured the vast majority of Goton’s earnings per her contract to become “coartada,” or legally no longer a slave. Rubí had purchased Goton in 1781, but in 1784 the two agreed that Rubí would emancipate Goton after she paid him the equivalent of her market value. Ten years later the price was paid and she had her freedom, but by her calculations Rubí had taken 1,235 pesos on top of the coartación sum he had agreed to. At one point, Goton threatened to withhold her labor until she received her money, stating that she “would not spend any more time in service of the hospital and would retire that very night.” She would accept being paid in installments, but wanted Rubí “to certify her total payment in writing so that if there were any more delays in her payments, she would have the official record she needed to get the money she was owed.” Goton’s confidence in the courtroom stemmed from her understanding that people like her were essential to Spanish colonial medicine and public health. She worked in a colonial hospital similar to those in New Orleans, Baton Rouge, and Havana where, more often than not, enslaved and free people of African descent did the vast majority of everyday work, from sweeping the floors to treating patients. Despite this, Juan Rubí flat-out refused to pay her, arguing that he had a right to all of Goton’s wages after being “so liberal and generous in giving her freedom at price and without interest.” He declared Goton’s threats
meaningless, saying that the hospital did not need her labor. Goton, who clearly believed the exact opposite, was caught off-guard.29

This legal case sheds light on medicine and public health in the late eighteenth century Spanish Gulf world and how that world shaped the co-development of medicine and the slavery economy in Louisiana and Cuba during the nineteenth century. In both places, Spanish influence helped to create a powerful association between white male physicians, efficacious medical practices, and the rational management of large groups of people, especially enslaved people. By the 1760s, Spanish medicine was moving away from its traditional basis in Iberian scholasticism as practitioners became more interested in using scientific reason to reveal rational explanations for illness and disease.30 This rise of reason and rationality involved rendering many non-European peoples incapable of reason.31 Yet, historians of Spanish colonial medicine in Mexico, Peru, and Guatemala have shown that people of African descent, Indigenous people, and other non-Europeans were heavily involved in colonial efforts to heal the sick and fight infectious diseases. Martha Few and Adam Warren have shown that Spanish officials often worked with Indigenous medical practitioners during small pox inoculation campaigns in Guatemala and Peru, not just

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29 Diligencias promovidos por la negra libre Margarita Goton sobre la reclamación de salarias (1794). Expedientes Varios, No. 17, Legajo 269, Papeles de Cuba, Archivo General de las Indias, Sevilla, Spain (hereafter cited as AGI); for more on manumission claims in the Gulf South under Spanish occupation see de la Fuente and Gross, Becoming Free, Becoming Black; and for enslaved people’s attempts to monetize their labor after completion of coartación see Adriana Chira, “Affective Debts: Manumission by Grace and the Making of Gradual Emancipation Laws in Cuba, 1817–68,” Law and History Review Vol. 36, Issue 1 (February, 2018): 1-33.

30 Nicolás Fernández-Medina describes this transition in Spanish medicine as “the strive to make sense of nature’s language as it was codified in and through the living body.” See The Life Embodied: The Promise of Vital Force in Spanish Modernity (Montreal, CA: McGill-Queen’s Press, 2018), 20.

because the Spanish needed the labor, but also because they recognized the skills of Indigenous practitioners. As such, there was a disconnect between colonial medical ideology and what was happening on the ground – at least for a little while.

Similar social dynamics existed in the Spanish Gulf, and especially in places like New Orleans, where people of African descent made up the backbone of colonial medicine and public health for much of the Spanish period of Louisiana history (1763-1803). New Orleans was an important military outpost for the Spanish, but it also became a pivotal site of state-led biopolitical projects and transformations in medical authority. The Spanish believed that the rational management of healthy, racialized populations, or biopolitics, was essential for the economic development of Louisiana. They set out to order the urban landscape and expand medical and public health infrastructure to support growing populations of enslaved laborers and white settlers. For this, they relied heavily on the labor of free and enslaved people of African descent, but not out of pragmatism alone. For centuries, people of all backgrounds in Spanish Atlantic had trusted medical practitioners of African descent for their ability to heal by manipulating obscured connections between the body and the natural world. Nevertheless, as reason and rational thinking became the preferred modes of

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34 Pablo Gomez discusses the significance of “black ritual practitioners” as medical knowledge producers in the early modern Spanish Caribbean in *The Experiential Caribbean*. 
knowledge production, the Spanish increasingly discriminated against medical practitioners of African descent and policed public health in New Orleans. This change in colonial medical culture took place against a backdrop of unruly environmental conditions and deadly epidemics, which became further justifications for discrimination.

Situating Spanish New Orleans in its proper imperial context reveals not just its connections to Havana, Cuba, and the wider Spanish Gulf, but also the significance of this epoch of Louisiana medical history. Historians of slavery and empire in Louisiana have shown that the Spanish period was not merely an interlude between the more significant imperial reigns of France and the United States. Rebecca J. Scott has highlighted the role of Spanish imperialism in the development of Louisiana’s “Caribbean pattern of social relations” and Gwendolyn Midlo Hall has demonstrated that the Spanish laid the foundation for a major slave society in Louisiana, ramping up the slave trade by nearly four-fold in their first fifteen years of occupation with many enslaved people coming from Mandé-speaking regions of Senegambia and Upper Guinea in West Africa.35 Comparatively, the historiography of medicine and public health has been far less attentive to Spanish influence. Todd J. Bourque has illustrated that the Spanish played an important role in the development of medical therapies in the region, and Jo Ann Carrigan and Urmi Engineer Willoughby have described Spanish efforts to mitigate yellow fever, but none have displaced

35 Scott, Degrees of Freedom, for quote see 74; Hall estimates that the Spanish expanded the slave trade from roughly 5,600 people per year in 1766 to 20,673 in 1780. See Africans in Colonial Louisiana, 277-8, 284-5, and for the estimate that nearly two thirds came from the Senegambia region, see 29; other works examining the significance of the Spanish period in the creation of New Orleans slave society are Rashauna Johnson, Slavery's Metropolis: Unfree Labor in New Orleans during the Age of Revolutions (Cambridge, 2016); Emily Clark, Masterless Mistresses: The New Orleans Ursulines and the Development of a New World Society, 1727-1834 (UNC, 2012); Gilbert C. Din, Spaniards, Planters, and Slaves: The Spanish Regulation of Slavery in Louisiana, 1763-1803 (Campus Station, TX: Texas A&M University Press, 1999).
John Duffy’s 1950s narrative of the Spanish period. Duffy argues that “the French period merged imperceptibly into that of the Spanish” and that Spanish medical regulations withered after 1803 when there was no longer a strong state to control the medical marketplace. It is true that many medical regulations lapsed after the Spanish left, and that many French medical men worked for the Spanish at one point or another, which is unsurprising given that Spanish and French colonial medicine shared similar intellectual histories and underwent turns towards rationalism at roughly the same time. However, because Duffy does not consider the Spanish imperial context for this period nor the history of medicine as it relates to racial politics, he overlooks how the Spanish state played a fundamental role in the ascension of rational medicine and white male medical expertise over all other forms of medicine in New Orleans. Historians of medicine in the Atlantic world have demonstrated that similar shifts in medical authority took place in French, British, Anglo-American, and Danish colonies, but in these places, change did not come primarily from the state but rather from small groups of white male physicians acting at the local level. Unlike the French before them and other European powers at the time, the Spanish state implemented racialized hierarchies of knowledge to aide in their efforts to control life in a predominately Black enslaving entrepôt.


38 For medicine in the British Atlantic see Suman Seth, Difference and Disease: Medicine, Race, and the Eighteenth-Century British Atlantic (Cambridge, 2018); Hogarth, Medicalizing Blackness; Paugh, The Politics of Reproduction; Turner, Contested Bodies; Morgan, Laboring Women; Sheridan, Doctors and Slaves; for the French Atlantic see Curran, The Anatomy of Blackness; Weaver, Medical Revolutionaries; for the Danish Atlantic see Jensen, For the Health
Focusing on the ideas and labor that went into Spanish biopolitics; the relationship between European and West African medical traditions; and the racialized policing of health and sanitation, this chapter demonstrates that the Spanish entrenched two ideas that would define medicine and public health in New Orleans going forward. The first was the notion that the management of healthy populations was necessary for continually increasing economic activity. The second was the idea that white male medical practitioners were the experts needed for such a task. This relationship between medicine, public health, and power remained intact whether or not there was a strong state because it was incorporated into the white supremacist slave society that was emerging in Louisiana. Contrary to previous scholars who have emphasized a level of racial openness and ambiguity in New Orleans, Cécile Vidal has recently argued that French Caribbean “race-thinking” – especially white/European-descended superiority and Black/African-descended inferiority – existed in the city from its foundation, despite the many free Black, mixed race, and white “Creole” people who sometimes defied binary categorization. By the late eighteenth century, similar notions of superiority and inferiority existed in most Spanish colonial societies, and therefore the Spanish did not disrupt but rather intensified an ongoing process of racialization.39 The

39 Vidal, Caribbean New Orleans: Empire, Race, and the Making of a Slave Society (UNC, 2019); for the links between whiteness and citizenship on the one hand, and Blackness and slavery on the other, as they emerged under Spanish rule in Louisiana, see de la Fuente and Gross, Becoming Free, Becoming Black; and for the same subject in the Spanish Atlantic more broadly see Ann Twinnam, Purchasing Whiteness: Pardos, Mulattos, and the Quest for Social Mobility in the Spanish Indies (Stanford, 2015). NB: In this chapter and in the dissertation as a whole, I present racial, ethnic, and enslavement identification information as it appears in historical records while acknowledging that these sources usually cannot tell us how individual actors conceived of their own identities. Following existing historiography on race and slavery in the Spanish Americas, I use the term “people of African descent” to include people who might be descended from the African continent but not necessarily identified in historical records as “negro/a” (“black,”) which was often interchangeable with “esclavo/a” (“slave”). For example, “people of African descent” would include some people identified as “pardo/a,” which referred to a person of mixed African and Indigenous descent; mixed European, African, and Indigenous descent; or mixed European and African descent (and the latter might also be called “mulatto”). European descent/whiteness was typically indicated by the lack of a racial qualifier or the mention of a European ethnic identity (e.g. “nació en Sevilla,” “born in Seville;” “Francés/a,” French, usually a French person born in France as French-descended
history of medicine provides one lens for understanding this intensification. European-descended medical practitioners were eventually able to subordinate African-descended practitioners during the Spanish period not because their knowledge was necessarily more efficacious, but because they aligned themselves with a colonial government that was ready and willing to privilege them while continuing to exploit the knowledge and labor of people of African descent.

“Improvements,” Populations, and Hospital Labor in Spanish Biopolitics

Spanish medicine’s shift towards rationality over the course of the eighteenth century was tied into concurrent developments in colonial administration, especially the belief that rational thinking could be applied in colonial governance and used to promote population growth, public happiness, and economic prosperity. With branches throughout the Spanish empire, the Royal Tribunal of the Protomedicato was the main institutional apparatus for medical regulation. When the Spanish took over New Orleans, its medical administration fell within the jurisdiction of the Protomedicato branch in Havana, which was emerging as the major intellectual metropole for the Spanish Gulf during the second half of the eighteenth century. Protomedicato physicians often worked with colonial administrators to determine how to use knowledge of the human body to intervene in the health of the body politic. This relationship between medicine and the state was especially visible in hospitals, the vast majority of which were either state-run or state-chartered.40 In New Orleans, Spanish

people born in Louisiana were often identified using the French colonial distinction of “Creole,” which is “criollo” in Spanish).

40 On the connections between medicine, colonial administration, and Enlightenment reason in eighteenth century Spanish America see Few, For all Humanity; Warren, Medicine and Politics in Colonial Peru; Juan José
governors were responsible for appointing the “Primero Protomédico,” the top physician for the city who served as first physician at one of the city’s hospitals and licensed other physicians who were usually Catholic men of French or Spanish descent per Iberian laws of limpieza de origen (purity of origin). The top physician could also license surgeons, pharmacists, blood-letters, and midwives, many of whom were people of African descent. At the same time, esclavos del Rey (“slaves of the King”) and enslaved people hired out from local elites worked in the hospitals and performed day-to-day tasks that were necessary for maintaining public health infrastructure.41 In fact, government correspondence and hospital records reveal that people of African descent did most of the on-the-ground biopolitical labor, and some even permeated the upper ranks of the medical hierarchy despite Spanish preferences for white male physicians.

By the mid-eighteenth century, many Spanish colonial administrators believed that the construction of orderly urban environments was necessary for economic development. These environments were considered fundamental “mejoras” (“improvements”), a widely-used administrative term that referred to the upgrading of urban planning, sanitation, military fortifications, industry, and agriculture, usually using forced labor.42 Antonio Ulloa, the first Spanish governor of Louisiana, fashioned himself as an expert on improvements. As a former naval officer who had also spent eight years administering a mercury mine in Huancavelica, Peru, Ulloa had ample experience directing large groups of Indigenous

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41 For more on the Protomedicato and its hierarchy of medical practitioners see John Tate Lanning, The Royal Protomedicato: The Regulation of the Medical Professions in the Spanish Empire, ed. John Jay TePaske (Duke, 1985).

42 For Spanish state slavery and the building of military fortifications, public works projects, and other improvements aimed at economic development during this period see Evelyn P. Jennings, Constructing the Spanish Empire in Havana: State Slavery in Defense and Development, 1762-1835 (LSU, 2020).
laborers who had been coerced or forced into one of the most poisonous industries in the Atlantic world. He was also a scientist and a naturalist who knew French from his work with the French Geodesic Mission (1736-1744) to measure the roundness of the Earth and the degree of latitude in what is today Ecuador.43

Ulloa displayed his expertise in an extensive survey of economic development in the Viceroyalty of Peru, which he wrote in 1749 with Jorge Juan, a fellow alumnus of the Geodesic Mission. Discussing the mining city of Cuenca in present-day Ecuador, Ulloa and Juan remarked that the city’s surrounding lands were ideally situated for agricultural development with fertile soil and ample water resources located on an elevated, flat plain, but that “either from supineness or ignorance” residents had failed to exploit these circumstances prior to Spanish intervention. Spanish administrators in Cuenca had built defined roadways, elevated tracts of land for the “regular plantation of crops and trees,” and “other rural improvements,” all of which had increased agricultural production while imparting a “delightful appearance all the year round.” Moreover, the Spanish had constructed the city proper in the shape of an orthogonal grid with important administrative buildings in the center surrounded by residential blocks. Wealthier residential blocks were located closer to the center of the grid and were “plentifully supplied” with fresh water from the nearby river thanks to an elaborate water and sanitation system that required “great labor” to maintain. Meanwhile, “Indian” residents were relegated to the neighborhoods

outside of the city walls in lower-lying, “insalubrious” environments without the same access
to infrastructure but still within municipal surveillance.44

Cuenca as Ulloa and Juan saw it illustrates how the concept of “improvements” fit
with the kind of rational biopolitics that the Spanish were installing throughout their empire.
The grid design itself was not unique to the Spanish, but with their considerable interest in
directing health and medicine within their territories, it became a vital tool for visualizing and
managing healthy populations. An urban plan made up of walls, right angles, straight lines of
sight, and clear demarcations of residential spaces seemed to enhance centralized supervision
over racially- and economically-stratified neighborhoods.45 Strategic public works projects
provided top-down control of public health by creating physical and social boundaries that
separated off “insalubrious” or unhealthy environs from a sanitary, well-supplied urban core.
Together with the development of agricultural areas around the city, these improvements
had supposedly contributed to a pleasant atmosphere that bolstered both good health and
economic development.

Similar thinking undergirded Spanish colonization of New Orleans from the start. In
1762, officials produced a map of New Orleans that showed two versions of the city
simultaneously: the city as it currently existed under the French and the city that might be

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44 Although it was intended to be a confidential report for the Spanish Secretary of State, Ulloa and Juan’s
treatise eventually fell into the British hands a few decades later and it was published under several different
titles including A Voyage to South America and Noticias Secretas de América. The description of Cuenca discussed
here can be found in Jorge Juan and Antonio Ulloa, A Voyage to South America, 2 volumes, trans. John Adams

45 In colonial Mexico, the orthogonal grid “permitted the measurement, classification, division, and
apportionment of space” for different colonial populations. Nesmer, Infrastructures of Race, 35; for more on the
historical relationship between the urban grid and state power in colonial Latin America see R. Douglas Cope,
The Limits of Racial Domination: Plebeian Society in Colonial Mexico City, 1660–1720 (Madison: University of
Wisconsin Press, 1994).
possible with Spanish planning. Placing the existing city within a clearly defined orthogonal grid, they plotted the administrative center in the lower center of the grid and all streets running at right angles to each other, connecting important commercial and medical buildings, with empty blocks on the outer edges of the grid to demarcate where they planned to expand. They then situated this urban grid as an inset in a larger map of the interior environments of the Mississippi Delta, which would also need improvements in order to foster the nascent plantation slavery economy (Figure 1). Like the landscapes of Cuenca, these plans for New Orleans and the Louisianan interior presumed the existence of large labor forces who could be put to work on multiple improvement projects at once and maintain them indefinitely.
As soon as he took power in 1766, Ulloa moved to approve new slave trade contracts, making it clear that the “great labor” he needed for the improvement of New Orleans was in fact enslaved labor. Unfortunately for Ulloa, French merchant and planter elites were put off by the Spanish empire’s strict commercial regulations which required producers to sell their products at certain prices and only in Spanish markets. The arrival of French-speaking Acadian settlers contributed to this anti-Spanish sentiment as Ulloa
attempted to strategically settle the Acadians northeast of New Orleans near the border with British forces in Mobile. The Acadians resented being used as a buffer for British encroachment and in late October 1768 a coalition of some five hundred Acadian and German settlers marched on New Orleans. With the backing of the French merchant and planter elites, they demanded Ulloa’s expulsion. Ulloa, with too few Spanish troops to resist the settler-planter uprising, fled to Havana and never returned.46

In August 1769, former Spanish military inspector general Alejandro O’Reilly arrived in New Orleans with twelve ships and 2,000 men to crush the insurgency. Although O’Reilly’s first act as governor was one of violence, he quickly pivoted to a more diplomatic approach, at least when it came to white settlers and French elites. Hoping to stimulate agriculture, he decreed that all settlers from European lineages with demonstrated evidence of gainful and “honorable” employment in a skilled trade would be granted a plot of land upon arrival in Louisiana. Settlers had to agree that they would begin cultivation of the land in question within one year and that they would not sell their land until at they had produced at least three harvests. Some of these requirements were likely intended to curb land speculation, but they would also increase the likelihood that settlers would establish families and remain there as individual units of economic progress for years to come.47 This white settlement policy was thus another improvement scheme and an important dimension of Spanish biopolitics in New Orleans, and Louisiana more generally, as it linked the

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47 This policy remained in place for the duration of the Spanish period and a later iteration can be found in Instructions issued by Manuel Gayoso de Lemos, Governor of Louisiana, about the admission of new settlers (March 5, 1799), Pierre-Clément de Laussat Papers MSS 125, HNOC; for more on Spanish law pertaining to white settlers see Gilbert C. Din, “Spanish Control over a Multiethnic Society: Louisiana, 1763–1803,” in *Choice, Persuasion, and Coercion: Social Control on Spain’s North American Frontiers*, eds. Jesús F. de la Teja and Ross Frank (Albuquerque, NM: University of New Mexico Press, 2005).
productivity of the land with the creation of a sizable white settler population that was capable of reproducing itself.

With this attention to the relationship between racialized populations and economic growth, O'Reilly set the tone for Spanish rule. Under the leadership of subsequent governors Luis de Unzaga (1769–1777), Bernardo Vicente de Gálvez (1777–1783), Esteban Rodríguez Miró (1785–1791), and Francois Louis Hector, Baron de Carondelet (1791–1799), the New Orleans Cabildo (town council) executed numerous policies aimed at upgrading the urban landscape, and especially medical and public health infrastructure. The Cabildo was the first full-fledged city government in New Orleans and consisted of the Spanish governor and six regidores (councilmen), who were usually wealthy members of the commercial and planter classes. They rebuilt and expanded the dilapidated waterfront, created new building codes, and expanded the municipal tax base to finance the building of roads, levees, canals, and fortifications. Furthermore, the Cabildo and the first Protomedicato formed the top administrative body for medicine and public health. In addition to producing regulations and tracking licenses, they issued fines for violations of weights and measures standards and taxes for taverns and cabarets, allocating these revenues to Charity Hospital of New Orleans. Charity Hospital was established by government charter under French rule in 1736 to treat sailors, poor people, and enslaved people, but during the Spanish period, it also became a central location for the managing the health of white settlers. There were several waves of Acadian settlers between the late 1760s and the early 1780s; thousands of Spanish-speaking Isleños from the Canary Islands between 1788 and 1780; and more than fifteen thousand refugees from the Haitian Revolution between 1791 and 1815. The Cabildo required all ship captains to stop at quarantine check points located down river from New Orleans. A physician or a surgeon would conduct a visual scan of all aboard and instruct captains to
unload any sick individuals for direct transfer to Charity Hospital. To many observers in New Orleans and elsewhere, this appeared to be an effective system for addressing larger public health concerns before they dispersed into the countryside. New Orleans became the model for Spanish anticontagion efforts in Mexican port cities such as Veracruz, and United States officials in New Orleans kept the network of riverine check points in place for most of the nineteenth century.

Crucially, all of these efforts to construct an orderly, healthy city relied on the labor of people of African descent, especially esclavos del Rey, and thus maintaining a large, healthy population of enslaved people was a constant concern for Spanish governors. Correspondence between Governor Luis Unzaga and the office of the Captain General of Cuba in Havana shows that on numerous occasions Unzaga stressed that if they were not able to acquire more “slaves of the King” he would not be able to complete ongoing improvement projects or ensure “the progress of health and happiness in the city.” A continuous supply of new enslaved people was necessary because many were falling ill and dying, and according to Unzaga there were not nearly enough licensed physicians to help mitigate this problem. In November 1771, Unzaga urged officials in Havana to send more

48 For records of Cabildo meetings regarding these municipal policies, regulations, and public works projects in the first two decades of Spanish rule see Books 1 and 2 in Acts and Deliberations of the Cabildo (1769-1803), City Archives, New Orleans Public Library (hereafter NOPL); for the funding of Charity Hospital, see Book 1 pg. 225 for the case of Pedro Morris, who in October of 1775 was permitted to operate several taverns and cabarets provided he pay 140 pesos annually to the Charity Hospital; for the history of Charity Hospital in this period see Bourque, “L’Hôpital des Pauvres to Hospital de los Pobres,” 60; and also Duffy, History of Medicine in Louisiana, 1: 64-7, 102-3, 106-11.

49 For Mexico see Ramírez, Enlightened Immunity, 7-8; for the quarantine system in nineteenth century New Orleans and its role in the fight against yellow fever see Willoughby, Yellow Fever, Race, and Ecology; and Margaret Humphreys, Yellow Fever and the South (New Brunswick, NJ: Rutgers University Press, 1993).

50 For quote see Letter No. 9 Unzaga to Captain General Pascual Cisneros (November 10, 1771). Correspondencia dirigida a los capitanes generales de Cuba por el gobernador de Luisiana, Luis de Unzaga (1771-1774), Seccion XI Capitania General de la Isla de Cuba, Legao 1145, Papeles de Cuba, AGI; and see also similar statements in Letter No. 3 Unzaga to Captain General Marques de la Torre (February 5, 1772), ibid.
physicians because the “suffocating climate” was producing “grave illness amongst the
soldiers and slaves.” Here, Unzaga echoed the sentiments of one of his predecessors,
Antonio Ulloa. In 1767, when Ulloa was lobbying his superiors to hire more physicians and
surgeons for the city’s hospitals, he pressed to have a Cuban physician named Francisco
Guischar appointed to the position of head surgeon at one of the New Orleans hospitals,
stating that Guischar’s experience practicing in Havana and Belize together with his formal
education obtained at the University of Havana made him “a person of skill in his
profession.” Likewise, Unzaga insisted that Havana physicians had the experience needed
for maintaining healthy bodies in the humid climate of New Orleans. In July 1772, he
informed the Captain General of Cuba that the “experienced” French physician, Dr. Joseph
Montegut, who had been serving as the chief surgeon and physician for both Charity
Hospital and the Royal Hospital was planning to retire to private practice, and Unzaga
hoped to replace him with two licensed physicians who had recently located to Louisiana
from Cuba. According to Unzaga, “Dr. José Ayala” of Havana, and “Dr. Aleman,” of the
city of Nuevitas in the Cuban province of Camagüey would be able to apply the knowledge
that they had acquired in Cuba to the similar climate in Louisiana. Officials in Havana
eventually approved the hiring of both physicians, which suggests that they agreed with
Unzaga on the transferability of Cuban medical experience and the importance of having
experienced medical experts who could contribute to economic development.

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51 Letter No. 9 Unzaga to Cisneros (November 10, 1771), ibid.

52 Dispatches of the Spanish Governors of Louisiana, 1766-1972 (S.C. Arthur, comp. New Orleans:
Polyanthos, 1975), Book 1, Vol. 1, pg. 27, NOPL; also in Duffy, History of Medicine in Louisiana, 173.

53 Carta No. 34 Unzaga to de la Torre (July 11, 1772), Legao 1145, Papeles de Cuba, AGI.
However, it was clearly not just relevant medical experience but also the fact that physicians in Havana were more likely to be white which led Unzaga to believe that they would be superior healers for New Orleans. He openly criticized an existing policy that allowed men of African descent to serve as physicians. In February 1770, the Cabildo had decreed local surgeons, many of whom were men of African descent, could be licensed to practice as physicians on a temporary basis as long as they could pass an examination given by the first physician at Charity Hospital or the Royal Hospital of New Orleans, the latter having been established in 1769 to treat soldiers, slaves of the King, and convicts. Applicants also had to agree to serve a six-month internship in either hospital, which ensured a certain standard of training but also gave the Spanish immediate access to a much larger pool of physicians. The decree required all temporary physicians to consult first hospital physicians in serious cases, and after completing their internship they were reexamined before they were allowed to practice independently.54 Clearly, a local level exception to the racial norms of the Protomedicato hierarchy had been deemed necessary if the city was going to have enough skilled medical labor to support Spanish biopolitics. Unzaga despised the practice, arguing that many “graduates” of the hospital internship program were ultimately “useless.”55 But this dismissal only illustrates the great extent to which the Spanish relied on medical labor from people of African descent even as they professed the superiority of European physicians.


55 Letter No. 5 Unzaga to Cisneros (October 31, 1771). Correspondencia dirigida a los capitanes generals de Cuba por el gobernador de Luisiana, Luis de Unzaga (1771-1774), Papeles de Cuba.
Indeed, although this training and licensing program may have been unique to New Orleans, records from Spanish hospitals in New Orleans, Baton Rouge, and Havana show that people of African descent could be found in virtually every other hospital position well into the 1790s. By recruiting people of African descent into their hospitals, the Spanish were institutionalizing certain aspects of the existing medical marketplace while also stratifying the market, placing male, European-descended physicians above all others. In other Atlantic cities, white male physicians were attempting to displace and/or subordinate medical practitioners of African descent – especially women of African descent, who dominated the fields of nursing and midwifery up until the late eighteenth century – but in Spanish New Orleans (and Havana) the state facilitated this process.56 For example, there were enslaved people of African descent working at Charity Hospital when New Orleans belonged to the French.57 A few years before the Spanish arrived, two French officials wrote to their superiors in Paris requesting several physicians for Charity, which was presently operating “without [French] doctors.” There were, however, at least three enslaved people working at Charity Hospital at that moment, doing things such as “cutting wood to keep the building heated.” The French officials also requested royal funds for the hiring of “doctors and nurses” at Charity and did not mention anyone else currently working there, which begs the question of who exactly was treating the many patients who were still “compelled to make use of the resources” of Charity.58 Enslaved people continued to work at Charity under the

56 For more on this transition in British and Anglo-American colonies see for example Cooper Owens, Medical Bondage; Turner, Contested Bodies; Paugh, The Politics of Reproduction; and Fett, Working Cures.

57 For a discussion of enslaved labor at Charity under the French see Vidal, Caribbean New Orleans, 214-22.

58 Letter from F. Dagobert and M. Delaunay (September 18, 1759). Folder 1, Charity Hospital Papers (1759-circa 1939), Medical Documents Collection, MS 589, Louisiana Research Center, Howard-Tilton Memorial Library, Tulane University, New Orleans, LA (hereafter cited as LaRC).
Spanish, but at this point they were incorporated into a medical hierarchy that had clear intentions for them. For most of the Spanish period, Charity typically had one French or Spanish physician who served as first physician as well as three or four subordinate physicians and surgeons, all of whom were men of either European or African descent. Additionally, there were usually between eight and twelve enslaved “servants” who cleaned wards, stocked supplies, cooked food, and maintained the hospital grounds.59

Staffing was similar at the Royal Hospital of New Orleans throughout the 1780s and the early 1790s. Specific jobs and the number of people employed in them varied based on available funds and the number of patients, but typically there was one first physician and one first surgeon, both of whom were Spanish- or French-descended men. Beneath the first physician, there might be one or two other physicians – sometimes identified as “second” and “third” physicians – while the first surgeon oversaw a staff of four or five. Any of these subordinate physicians and surgeons could be people of African descent per the licensing rules in New Orleans. Lastly, there were between ten and thirty enslaved and free people of African descent involved in daily hospital operations such as cleaning, cooking, maintaining supply stores, repairing buildings, and serving as “guards.”60 Considering that Spanish royal hospitals treated slaves of the Kings and convicts, these guards were likely responsible for watching unfree patients and preventing escapes as they did at slave hospitals in early nineteenth century Jamaica and the U.S. South.61

59 See Charity Hospital inventory and administrative records for 1794, Folder 1, Medical Documents Collection, LaRC.

60 See the hospital’s annual reports for 1781-1791, which include employee lists as well as receipts and disbursements for hired out enslaved people and free day laborers in Comprobantes del Real Hospital de Nueva Orleans, 1781-1791, [1796, 1797, 1799], Legajo 539, Papeles de Cuba, AGI.

61 Rana Hogarth and Stephen C. Kenny have demonstrated that slave hospitals in Jamaica and the antebellum U.S. South often kept enslaved patients in prison-like conditions and were important for surveilling and
1792 shows that twenty-two enslaved and free people of African descent were employed at the Royal Hospital of New Orleans, including “Francisco, a black slave belonging to this hospital; black Belle; black Juan; the black belonging to Monsieur Santoma; the black Larro belonging to Madame Dublon; the black Juan of Monsieur Trenone; black Juan of Madame Dublon; black Gabriel of Madame Pisoro; black of Madame Dublon named Francisco; black of Monsieur Santoma; black of Monsieur Caballier; black Dore; black Arensua; black Lafuti of M. Santoma; black Duran of Monsieur Guion; Bautista, a black slave of the King; black of Mr. Ferrio; black Carlos of Monsieur Arno; black Bartolo of Don Ignacio Valdez; black Pedro de Jorry; pardo libre [free person of mixed race] Francisco Martin; and Magdalena, a black slave of the King.” This list does not identify specific roles for each person, which suggests that they had a variety of responsibilities depending on the needs of the hospital.

Meanwhile, the Royal Hospital of Baton Rouge, which the Spanish established in the early 1780s, utilized slaves of the King, hired-out enslaved people, and free French-speaking gens de couleur (people of color). In February 1799, the hospital bookkeeper noted that one “Monsieur Bienville” should be compensated for the “vital work” done by two enslaved men, “Manuel and Cesar.” A “Mr. Morales” and a “Mr. Duplantier” would receive similar payments for the work of their enslaved men. In Havana, where the Spanish had far more resources and white male practitioners, enslaved people and free people of African descent were still doing necessary work. Salary data and employment rosters from 1801-1803 for the controlling enslaved people in the surrounding community. See Hogarth, Medicalizing Blackness, esp. Chapter 5; and Kenny, “‘A Dictate of Both Interest and Mercy’?”

62 “Lista de empleados.” Libro 5, Estancias en el Real Hospital de Nueva Orleans (5 libros), Legajo 526, Papeles de Cuba, AGI.

63 See the records of hospital funds to be disbursed (February 28, 1799). Cargos y datos del guardia-almacen de Baton Rouge (1798-1804), Legajo 681, Papeles de Cuba, AGI.
Royal Hospitals of San Juan de Dios and San Felipe in Havana show that physicians, surgeons, and pharmacists were all white men, but unnamed women of African descent worked as “enfermeras” (“nurses”), cooks, maids, and laundresses while men of African descent served as “attendants” in the hospital wards, gardeners, and carpenters.64

The decision to employ people of African descent in hospitals was born out of the desire to maintain healthy populations and subjugate the medical marketplace. The dearth of white male practitioners in New Orleans likely influenced first physicians and colonial officials to be more lenient with regard to licensing and hiring practices. But even in Havana, where there were far more white physicians, people of African descent were still responsible for maintaining daily hospital operations and looking after patients. The sheer ubiquity of people of African descent, and especially the fact that they could sometimes be found working alongside Europeans, suggests that there was another reason for their presence in Spanish hospitals, beyond pragmatism and control. This reason had to do with the complex history of medical knowledge production under Spanish rule.

West African Medicine in New Orleans and the Spanish Gulf

Margarita Goton was one of the many people of African descent who provided essential hospital labor for the Spanish, but a closer look at the details of her case reveals that she was valuable to colonial officials not just for her labor but also for her knowledge of the human

64 See list of salaries for San Juan de Dios (March 31, 1803) and list of supplies and salaries given to hospital employees at San Juan de Dios and San Felipe (January-October, 1801). Cuentas de hospitales e iglesias, 1794-1811, Legajo 1676A, Papeles de Cuba, AGI; for more on hospitals in Havana at this time see César A. Mena Serra and Armando F. Cóbeo, Historia de la Medicina en Cuba, 2 Vols. (Miami, FL: Ediciones Universal, 1992); Mario del Pino, Apuntes para la Historia de los Hospitales en Cuba (1523 a 1899). Cuadernos de la Historia de la Salud Pública 24 (La Habana, CU: Ministerio de Salud Pública de Cuba, 1963): 29-34.
Historians of science in the Spanish Gulf such as Camron Strang have shown how the Spanish coveted Indigenous and African-descended peoples’ knowledge about flora, fauna, weather, and geography, often extracting ideas from their original contexts for use in the colonial project. The Spanish approach to medical knowledge was very similar. Health and healing sometimes meant different things to people of African descent and Spanish colonizers, but before the eighteenth century the boundary between West African and European medical traditions was porous and imprecise. Similarities and shared ideas created space for some medical practitioners of African descent to become respected healing authorities. However, by the late eighteenth century, Spanish interest in rational explanations for medical phenomena and rational approaches to biopolitics diminished the legitimacy of spiritual and sensorial modes of medical knowledge production. With that change, the people who possessed such knowledge – or even just those associated with it via their race – began to lose medical authority. Legal cases, hospital inventories, and Cabildo records from all over the Spanish Gulf illustrate this shift in what Pablo Gomez calls the “currency of knowledge production in medicine.” These sources also provide the means to analyze the intellectual underpinnings of West African medicine.

65 Strang, Frontier of Science: Imperialism and Natural Knowledge in the Gulf South Borderlands (UNC, 2018); see also Alejandra Dubcovsky’s recent study of Indigenous information networks in the Spanish Gulf South, which makes similar claims about the history of knowledge production and extraction in the region, Informed Power: Communication in the Early American South (Harvard, 2016).

66 Gómez has argued that practitioners of African descent created knowledge by creating “sensorial landscapes in which physical, social, and spiritual as well as moral orders became physically evident,” but this mode of medical knowledge production began to lose its authority in the eighteenth century when the “currency of knowledge production” began to shift towards uncovering the natural laws of the body and disease. See The Experiential Caribbean, 3-8; for the history of African-descended medical knowledge in the eighteenth-century Atlantic world see Londa Scheibeinger, Secret Cures of Slaves; Sweet, Domingos Alvare; Weaver, Medical Revolutionaries.
For many people of African descent living in eighteenth century New Orleans, Pensacola, Baton Rouge, and Havana, the intellectual basis of healing was the healer’s capacity to see and manipulate life forces that flowed through the natural world. In eighteenth century Saint Domingue, some medical practitioners of African descent were familiar with common European therapies and may have blended them with their own knowledge, or adopted local Indigenous knowledge, depending on what seemed to work for the patient and what materials they had access to. But Goton’s legal case shows that there were certain conceptual foundations for medicine of African descent that were recognizable to people who were not from West Africa. Offering testimony in support of her case, Pedro Enrique, a warrant officer in the Royal Artillery Corps, argued that Rubí’s wage theft was particularly offensive given that her work was “indispensable,” especially her ability to “take bad influences from the unfortunate sick people at this hospital.” Enrique did not explain how someone could “take bad influences” out of sick bodies, nor did he specify what those bad influences were, which indicates that he did not need to elaborate on any of this for those present in the courtroom to understand his point. Goton’s ability to extract negative forces was recognizable as a therapeutic process to Spanish soldiers, physicians like Rubí, and the Spanish officials who heard her claims.

According to background information provided for her case, Goton was a forty-year-old “native of the Coast of Guinea” whom Rubí had purchased from a French planter in New Orleans, which suggests that she may have been one of the many Mandé people who

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67 Weaver argues that enslaved healers in eighteenth century Saint Domingue often employed this syncretic approach. See Medical Revolutionaries, 28-30, and chap. 3 “Enslaved Healers on the Plantation.”

68 Diligencias promovidos por la negra libre Margarita Goton sobre la reclamación de salarios (1794). Papeles de Cuba, AGI.
lived in the area.69 Mandés formed one of the most established linguistic-cultural groups in
the city and had a significant presence in most social practices, including healing. Mandé
healers likely had more influence outside of the hospital and beyond city limits where state
medical regulations were more difficult to enforce, but it is possible that some of the
temporary physicians and other hospital-based practitioners were Mandé or possessed some
of their healing knowledge. The Spanish were always uneasy with the size of the Mandé
population and their cultural influence, but it is clear that they also took interest in Mandé
knowledge production, perhaps recognizing that it might be useful for furthering their
objectives.70

Spanish attention to Mandé knowledge of environmental materials and the human
body was evident in a poisoning trial which took place in New Orleans in 1773. The court
convicted two enslaved men with attempted murder of their overseer after it was discovered
that they tried to poison their overseer with the help of two Mandé men recently arrived
from Guinea. The Mandé men, Carlos and Cipion, made a small pouch filled with a paste of
ground herbs and the heart and gall bladder of an alligator, explaining that this “gris-gris,” or
amulet, would bring illness to the overseer. According to their testimony, the two Mandé
men had determined that the Louisiana alligator was a suitable substitute for the crocodile of
West Africa and would therefore possess similar powers to either heal or to harm depending
on how the animal matter was prepared.71 Anthropologists of the Mandé in West Africa

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69 Ibid.

70 On Mandé culture in New Orleans and Louisiana see Matt Schaffer, “Bound to Africa: The Mandinka
Legacy in the New World,” History in Africa XXXII (2005): 349–350; on Mandé natural knowledge see Strang,
Frontiers of Science; and for more on European appropriations of enslaved people’s medical knowledge in the
eighteenth century Atlantic see Scheibeinger, Secret Cures of Slaves.

71 Don Francisco Bellile Legal Case (1773), transcribed and translated by Laura Porteus from the Judicial Court
Records of the Spanish Cabildo, MS no. 77306121, Louisiana State Museum, New Orleans, LA (hereafter cited as LSM); and for more on poisoning trials under the Spanish see Hall, Africans in Colonial Louisiana, 162-3.
have noted that the crocodile has historically played an important role in religious and medical traditions because the animal embodies concentrated amounts of “nyama,” the life force that flows through all nature and generates the power to heal. Mandé healers and spiritual leaders also possessed potent nyama that helped them harness the nyama of other beings and channel it toward a specific person or object. Although the Spanish court criminalized the use of alligator in the 1773 poisoning case, one collection of hospital bills for the Royal Hospital of St. Augustin in Havana shows that “blood of a male alligator” could be found in pharmacy stores as late as 1800. Egyptian crocodile blood, skin, and teeth could often be found in early modern European medical cabinets, and Spanish practitioners working in Havana and elsewhere in the Gulf may have independently recognized that the alligator resembled the crocodile. But it is also possible that they observed people of African descent using alligator to treat patients. Some Spanish physicians working at the Royal Hospital of New Orleans had taken a keen interest in local medical knowledge. In 1793, physician Tomás Prieto examined a variety of local plants that had been “brought to the hospital” by some unnamed person.

If European physicians believed that some healers could use local animal and botanical materials to manipulate forces in the human body, this would help to explain why Margarita Goton’s skills did not require much elaboration at her trial and why she was


73 See the lists of supplies purchased for the hospital in 1800. Cuentas del Contador del Hospital de San Augustin, Legajo 476, Papeles de Cuba, AGI.

74 See the discussion of Prieto’s experiments in Médicos y cirujanos, Legajo 7148, No. 7, Fondo Secretaría de Estado y del Despacho de Guerra, Archivo General de Simancas, Valladolid, Spain.
apparently allowed to use those skills at the Royal Hospital of Pensacola. European observers either knew what she was doing, or trusted that it was sound medicine. The poisoning case, Gorton’s case, and the hospital records all illustrate the idea that there were particular forces outside of the body which could influence forces within the human body. This notion transcended the boundaries between European and West African medicine.

Furthermore, the two legal cases suggest that part of what made Mandé medicine and similar West African medical traditions seem legitimate to a variety of observers was the fact that the practitioner possessed an open disposition that enabled them to see, feel, and channel rejuvenating forces. In this context, medical knowledge production required the continual sensing and incorporating of locally available natural elements, and as such the practitioner’s physical, mental, and spiritual state was often one of awareness and adaptation. For many European observers, this seemed like a valid means of interacting with new climates and their particular influences on the body. Someone who appeared open to interaction with flora, fauna, and other elements of nature in ways that yielded positive results could therefore possess intellectual significance as well as colonial utility, perhaps especially for Spanish colonizers in New Orleans who had convinced themselves that it could be a healthy, thriving port city if they could develop reliable systems for managing health outcomes. Moreover, permeability between the human body and the natural world would seem logical to anyone who understood European humoral or environmentalist interpretations of health and disease. With roots in ancient Greek medicine, this line of medical thinking held that the patient’s “natures” – meaning everything from their physicality to their temperament and intelligence – were deeply related to the quality of

75 Gómez, *The Experiential Caribbean*, 93, 176.
climate, soil, water, and air where they resided. Given the historical importance of environments in European medicine, it is likely that the impulse to meet natural phenomena on their own terms would have seemed like good medicine to many people in New Orleans, Pensacola, and other colonial cities in the Spanish Gulf, even if the logical terrains of that encounter were not derived from European thought and the interpreter was not European.

Nothing in her case definitively explains Goton’s decision to stay at the hospital after gaining her freedom, but perhaps she still had obligations to her former enslaver, or she may have genuinely enjoyed her work. The contractual agreement she made with Rubí and her argumentative style in the courtroom suggest that she not only knew that she had certain rights within the Spanish colonial legal system, but also that she had business savvy. Unfortunately, when she actually tried to deploy her rights, Rubí and other Spanish officials had determined that they either no longer needed her labor and/or no longer trusted in her medical knowledge. In his last statement on the matter of Goton’s missing wages, which he maintained was an “unfounded and malicious demand,” Juan Rubí said he was grateful that the case had been “pronounced in his favor” and he “would no longer be bothered by her


77 For the continuation of affective bonds and dependent relationships between former master and coartadas/os, see Chira, “Affective Debts;” and for the history of slavery, race, and Spanish colonialism in West Florida see Jane Landers, Black Society in Spanish Florida (Illinois, 1999).

78 For more on the ways that people of African descent exercised their rights within Spanish colonial legal systems see Bianca Premo, The Enlightenment on Trial: Ordinary Litigants and Colonialism in the Spanish Empire (Oxford, 2017); and Landers, Atlantic Creoles in the Age of Revolutions (Harvard, 2010).
claims.” Goton apparently never received the backed pay she was owed and the file does not explain what happened to her after this judgment.

Taken together, the rejection of Goton’s rights and the apparent dismissal of her medical authority can be viewed as one moment in the making of a reason-based medical culture that was slowly taking over the Spanish Gulf. Environment-based ideas of the body and healing did not disappear from Spanish colonial medicine entirely, but by this point, medical practitioners of African descent who used environmental interpretations could not rely on the fact that they would be as valuable to Spanish physicians and colonial officials as they had been previously. Methods of sensing, revealing, and negotiating seemingly inscrutable forces no longer fit with colonial desires for explanations of the human body and natural phenomena as rational objects governed by natural laws. Like other European imperial cultures of reason and rationality, the formation of this medical culture was a process that required the marginalization of all knowledge that seemed to escape rational explanation and all practitioners who did not appear capable of rational thought.

In New Orleans, it was becoming increasingly clear that rationally-minded practitioners meant white male practitioners exclusively, as Black medical practitioners trained in European medicine soon found themselves disenfranchised and delegitimized, too. In 1801, the Cabildo made a concerted effort to root out all doctors who were practicing without licenses and identified four men: “Drs. Flood, Fabre, Gravier, and Derum.” Of the four, only Dr. Flood was allowed to sit for the physician’s license exam (and

79 Diligencias promovidos por la negra libre Margarita Goton (1794). Papeles de Cuba, AGI.

80 For more on the historical formation of these cultures and their production of racialized otherness see Wynter, “Unsettling the Coloniality of Being/Power/Truth/Freedom.”
was allowed to continuing practicing in the meantime) while the rest were ordered to close their practices immediately. “Dr. Derum” was most likely James Derham/Durham, a free man of African descent who was born into slavery in Philadelphia in the 1760s and had learned medicine from his first owner, Dr. John Kearsley. Kearsley was a graduate of the Medical Department of the University of Pennsylvania, which was the most respected medical school in British North America at the time and was modelled after the University of Edinburgh. The latter school gained fame in the eighteenth century for its rational approaches to medicine, especially the study of anatomy and physiology, which aimed to understand the functions of specific organs and structures in the body. As a young adult during the American Revolutionary War, Derham was sold to a British naval surgeon named George West and after the war he was sold again to Scottish-born physician Robert Dow in New Orleans. At first Derham worked as an assistant to Dow, but eventually he emancipated himself and in 1789 opened his own practice. Derham did not acquire a license from Spanish authorities before doing this, but his lack of official recognition apparently did not impact his ability to attract patients as his practice earned roughly $3,000 in its first year. Derham also kept abreast of the latest medical news via his correspondence with Benjamin Rush, the widely influential physician who taught medicine at the University of Pennsylvania. Rush attested that Derham was “learned” in both medicine and surgery with particular skill in the treatment of throat diseases. Unfortunately for Derham, his experience and wide regard were not enough for the Cabildo to allow him to sit for exams, and he drops out of

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81 Acts and Deliberations of the Cabildo, Book 4, Vol. 4, pp. 126-8, NOPL.

the archival record after 1801. It is very likely that race played a role in the decision to exclude Derham, and possibly Drs. Fabre and Gravier too, because the only noticeable difference for Dr. Flood was that he was identified as “respectable gentlemen” and “an immigrant from the American colonies.” Flood went on to have a distinguished career as a medical geographer of the lower Mississippi Valley under William C. C. Claiborne, the first United States governor of the territory of New Orleans (1803-1812) and later the territory of Louisiana (1812-1816).

Within a matter of a few years, James Derum and Margarita Goton discovered that their claims to medical authority no longer carried much weight in Spanish colonial societies like New Orleans and Pensacola. Ordinary people still sought out Black medical practitioners, as it is clear that a license to practice medicine did not necessarily determine the public opinion of a healer. But this transition in the currency of knowledge production meant that they would now be at a disadvantage, if not discriminated against outright. Spanish colonial officials were beginning to see that a sense of certainty in medicine and the expertise of white male practitioners were preferable for improving both bodily health and public health, as opposed to embracing the uncertainties of nature and the medical practitioners who could navigate them.

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Environment and the Policing of Public Health in Turn-of-the-Century New Orleans

As the Spanish attempted to remake New Orleans into a robust port city, they began to believe that this task required a significant escalation in the repression of ordinary people of African descent in addition to the subordination of medical practitioners of African descent. The importation of more and more enslaved people was a high priority, but the resulting demographic shift became a source of anxiety for the Spanish and their European allies who over time grew more fearful of resistance from enslaved people, free people of African descent, and self-liberated “maroon” communities. In the early 1780s, the maroon leader St. Malo lead a rebel group of formerly enslaved people, free people of African descent, and Indigenous people in a guerrilla war against European settlers. In 1784, Spanish authorities captured St. Malo and some of his followers and sentenced them to be hanged, but his community remained, as did other maroon communities, deep in the swamps surrounding New Orleans. The Haitian Revolution further inspired Spanish officials to restrict the rights of free people of African descent and grant enslavers more leeway in their abuse of enslaved people in the hopes of curbing the chances of a similar revolution in Louisiana.85 In addition to these circumstances, Spanish encounters with the environment of New Orleans contributed to racialized repression because they inhibited biopolitics. Throughout the Spanish period, hurricanes, floods, and epidemics resisted rational methods of mass control and undercut carefully-laid plans for managing healthy populations. In the 1790s and early 1800s, Spanish officials began to respond to unruly environmental conditions just as they

85 For St. Malo’s community and their guerrilla war see Hall, *Africans in Colonial Louisiana*, 201-36; for the escalation of racialized repression and oppression after the Haitian Revolution see Din, *Spaniards, Planters, and Slaver*, and Johnson, *Slavery’s Metropolis.*
had reacted to the perceived threat of rebellion, implementing sanitary policies that disrupted and dispossessed communities of African descent.

Already what one historian has called “an impossible but inevitable city” before the Spanish arrived, New Orleans was prone to regular flooding and seasonal hurricanes that, along with major fires in 1788 and 1794, put the Spanish in a near-constant state of rebuilding and reasserting their power over the urban landscape. Residents were accustomed to the fact that certain low-lying areas could experience mild flooding practically every time it rained, but this was nothing compared to the deadly hurricanes that descended on the city with little warning, bringing days-long deluges of rain and strong winds that laid waste to buildings, infrastructure projects, and commerce. Historians of hurricanes in New Orleans have noted that the storm seasons of 1766, 1772, 1776, 1779, 1780, 1793, and 1794 severely damaged important buildings, levees, canals, and roads while also contributing to mortality rates in New Orleans and across the Caribbean that were already relatively high due to disease and European imperial warfare in the region. Other cities in the late eighteenth century Atlantic world were certainly experiencing their fair share of death and destruction, but New Orleans had the added problems of geography and climate which regularly overwhelmed the city’s resources.

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87 For New Orleans specifically see Eleonora Rohland, *Changes in the Air: Hurricanes in New Orleans from 1718 to the Present* (New York: Berghahn Books, 2018), 93-7; for more on hurricanes in the late eighteenth century Spanish Caribbean see Stuart B. Schwartz, *Sea of Storms: A History of Hurricanes in the Greater Caribbean from Columbus to Katrina* (Princeton, 2016); Sherry Johnson, *Climate and Catastrophe in Cuba and the Atlantic World in the Age of Revolution* (UNC, 2011); and for the argument that mortality numbers were already high during this period due to war and disease, see John R. McNeil, *Mosquito Empires: Ecology and War in the Greater Caribbean, 1620-1914* (Cambridge, 2010).
Particularly destructive hurricanes became opportunities for the Spanish to institute stricter reforms in medicine, as seen in the paper trail left from the rebuilding of Charity Hospital in the 1780s. Several storms in 1778 seriously weakened the main building of Charity and a major one in September 1779 reduce the building to little more than “a heap of ruins” aside from the “kitchen and storehouse” which were being used “as provisional hospital quarters holding six beds.” After three years of trying to secure enough funds from officials in Havana to rebuild the hospital, the Cabildo turned to Andrés Almonester y Roxas, a Spanish-born civil notary who had come to New Orleans with Governor O’Reilly in 1769. Making use of Spanish policies that encouraged white settlement, Almonester purchased land and enslaved people a few years after arriving in the city and within little more than a decade he became one of the largest sugar producers in the area. Many of his philanthropic pursuits involved hospitals and sanitation, which suggests that he shared the perspectives of Spanish officials who saw a connection between healthy populations and economic growth. In 1782, Almonester donated 114,000 pesos towards the rebuilding and in 1785 the hospital officially reopened as San Carlos Hospital. In 1793, a charter was created for the new hospital which shows that several new buildings and a larger staff were made possible thanks to Almonester’s largess, but so was the completion of a hierarchy of medical labor that no longer included any physicians of African descent. The highest-ranking person of African descent at San Carlos was an enslaved man named Domingo, who was a blood-

88 For quotations on storm damage see the letter from Governor Esteban Miró to the Cabildo (March 20, 1783), Acts and Deliberations of the Cabildo, Book 1, Vol. 1, pg. 172-5, NOPL, and for decision to turn to Almonester see Miró to Cabildo (March 23, 1783). Charity Hospital Records, Book 4092, Docs. 1 and 3, LSM.
letter in the surgery ward, an acceptable position for a person of his race according to Protomedicato rules. \(^89\)

As hurricanes and other environmental shifts provided space for discriminatory medical reforms, epidemics gave the Spanish state justification for new public health policies that specifically targeted people of African descent. Under the U.S., there would be a noticeable expansion in attempts to control Black mobility in New Orleans via the designation of official commercial spaces, the building of prisons, and other attempts to demarcate urban space. By the 1820s, these developments were contributing to a booming export economy built on unfree labor. \(^90\) Such efforts built on what the Spanish had already accomplished, as they were the first imperial power to use public health and environmental policies to create a racially demarcated and stratified urban landscape with the idea that New Orleans could become a major port city. In 1792, Governor Carondelet and the Cabildo began a massive, multi-year infrastructure program to address the mounting damage from storms and flooding while also attempting to increase the city’s economic capacity. In early 1796, Carondelet ordered the creation of new shipping canals in the swamp lands around New Orleans, including the Vieux Carré, which connected the city center to the wider channel Bayou St. John and on to the open waterways of Lake Pontchartrain (Figure 2).

\(^89\) For the description of staffing and mention of the enslaved blood-letter Domingo see Constituciones Para El Nuevo Hospital de Caridad construido en la ciudad de Nueva Orleans (1793). Charity Hospital of New Orleans Collection, MSS 308, HNOC; for background on Almonester see Folder 1, Medical Documents Collection, LaRC; for more on the San Carlos period of Charity Hospital history see Salvaggio, *New Orleans' Charity Hospital*, 20-4.

\(^90\) Johnson describes the creation of racialized “geographies of containment” in early nineteenth century New Orleans and how they facilitated economic growth in *Slavery's Metropolis*. 
Unfortunately for government officials, a major epidemic of yellow fever hit the city in late August of that year, triggering a public health crisis that brought canal-building and all other improvement projects to a grinding halt. Observers reported that first “all the laborers engaged in the [canal] work were carried off” by the disease and then “a violent epidemic ensued,” sending hundreds to the hospitals. The 1796 epidemic eventually claimed some six hundred and fifty lives, though this number only includes deaths recorded in military,
Cabildo, and parish records and does not include unbaptized enslaved people, free people of African descent, or “the Protestants who perished (and they were numerous).” The Vieux Carré project and other public works initiatives resumed in late 1796, but most were not completed before another epidemic of yellow fever swept through the city in 1799 with a similar death toll.91

Fearing that if environmental conditions did not destroy their improvement efforts disease surely would, in 1800 the Spanish launched a crackdown on health and sanitation which disrupted already marginalized communities and divested them of their urban spaces. In accordance with European medical thinking at the time, the governor and most Cabildo members believed that yellow fever was a “miasmatic” disease that emanated from refuse and pools of stagnant water.92 They directed hundreds of slaves of the King, soldiers, prisoners, and day laborers to clean all of the streets and gutters in the city and fill in any areas that seemed likely to collect water, including public squares but also private yards, garden plots, and pastures. Predominately Black neighborhoods such as Congo Square received extensive sanitary scrutiny. The square lay within the urban grid just north of the city center and officials believed that targeting this area specifically would prevent the reoccurrence of yellow fever. Additionally, the Cabildo took aim at cemeteries and burial plots, arguing that some of them were harbingers of disease. Catholic cemeteries were exempt as it was believed that the use of vaulted stone tombs prevented the emanation of

91 Observations of the 1796 epidemic originally published in newspapers are quoted in Edward Barton, *The Cause and Prevention of Yellow Fever at New Orleans and Other Cities in America* (New Orleans: H. Baillière, 1857), 100; for the estimated death toll and quote about Protestant deaths see the Cabildo’s summary of the epidemic (October 21, 1796). Records of the City Council of New Orleans, Book 4079, Doc. 259, LSM; for more on this epidemic and its impact on canal building see also Willoughby, *Yellow Fever, Race, and Ecology*, 43.

noxious elements, but other burial spaces, especially those belonging to enslaved and free people of African descent, were leveled. Families were forced to relocate their dead to new plots outside of the city and the Cabildo repurposed former burial spaces for their own projects or sold them off to the highest bidder. Lastly, the new sanitary policies of 1800 instituted regular surveillance of all city residents and the punitive treatment of people of African descent who tended to live in the poorest, wettest, and least improved areas of the city. Most of these people likely could not afford to maintain sanitary standards on their own and they were given little help in this regard. Instead, the Cabildo deputized some residents to report on the ongoing state of health and sanitation at the neighborhood level, and then used this information to issue threats and heavy fines to anyone who failed to bury their dead in the authorized locations, keep their gutters clear, and their yards level.93

Struggles with environmental shifts and epidemic diseases would remain consistent features of life in New Orleans long after the Spanish left, but so would the idea that these problems might be solved with racialized repression. In 1821, following another season of devastating storms and epidemics, city officials located areas they believed to be in dire need of improvement and took over three properties belonging to people of African descent. Mayor Joseph Roffignac signed off on promises-to-pay property owners for their land, but there is no confirmation that any of them ever received compensation.94 Furthermore, sweeping

93 For descriptions of street cleaning, land filling, and the closure and removal of burial plots see Records of the City Council of New Orleans, Book 4088, Doc. 337, pp. 9-16, LSM; and also Acts and Deliberations of the Cabildo circa March 14, 1800, Vol 4, Book 4, pg. 150-5, NOPL.

94 J. Roffignac order to pay Joseph Savary (March 19, 1821), Rosemonde E. and Emile Kuntz Collection: Municipal Records, MS 600, LaRC; City of New Orleans Promise-to-Pay to Marie Jeanne Villamil (October 18, 1821), Folder 6, Free People of Color Collection, MSS 54, HNOC; City of New Orleans Promise-to-Pay to Janette Doqueminy (October 20, 1821), Folder 7, ibid.
improvement projects and heavy-handed sanitary policies instituted under the Spanish left a lasting impression on slave-holder perceptions of the relationship between health, environment, and economy in New Orleans. In the 1840s, writers in the pro-slavery magazine *DeBow's Review* were still referencing the “great improvements” in the city’s infrastructure and sanitation under the Spanish and how they had contributed to the “awakening of enterprise in the West.”

Racialized medical hierarchies also carried over into the antebellum period, despite the fact that there was little state control over medical licensing in U.S.-occupied New Orleans before the 1850s. The lack of official medical regulation did not impact the shape of the medical expert class, which remained largely intact through the transfer of imperial power. After 1803, prominent French, Anglo, and Spanish physicians who served under the Spanish took positions on various municipal health boards and became founding members of key medical institutions. French physician Joseph Montegut and Scottish physician Robert Dow had lived in New Orleans for almost the entire period of Spanish rule and served in a variety of important medical and public health roles. Montegut first served as first surgeon and inspector of jails and quarantines under Governor O'Reilly. He later did several stints as chief physician of Charity Hospital and the Royal Hospital of New Orleans, as did Dow. In 1804, Governor Claiborne appointed Montegut and Dow to his new board of health explaining that the tri-lingual Dow was “at the head of his profession and universally beloved” and Montegut, though by this point “a gentleman advanced in years,” had “grown up with the City of New Orleans and is much respected in point of character, conduct,

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family, and fortune.” In 1805, Dow, Montegut, and Dr. Santiago LeDuc, a Spanish-born surgeon and physician who previously served as head surgeon at Charity under the Spanish, along with two French physicians, Drs. Robelot and Fortin, became key figures in the founding of the College of Orleans, the first institution of higher education in the region. Although the College eventually shuttered about two decades after its founding, this institution pre-dated the Société Médicale de la Nouvelle-Orléans (f. 1817) and the Physical-Medical Society (f. 1820), the first two medical societies in Louisiana. Importantly, unlike the latter two institutions, which reflected emerging professional rivalries between Francophone and Anglophone physicians, the College of Orleans represented an important early collaboration of Spanish, French, and Anglo-American intellectuals before rivalries became entrenched. Moreover, because Montegut, Dow, and LeDuc had private practices during the Spanish period and after – mostly seeing wealthy enslaver clients and their enslaved laborers in New Orleans – these men served as points of connection between Spanish colonial biopolitics and the plantation-based slavery economy that exploded in Louisiana in the decades after it became the eighteenth state in the Union in 1812.96

Although these men still had to compete with other practitioners when it came to attracting clients in the wider medical marketplace, their institutional power meant that city officials turned to them when it came to establishing official medical opinions and creating public health policies that would impact everyone in New Orleans. People of African
descent continued practicing their own cures and working in hospitals, as their medical labor

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96 See Duffy, *History of Medicine in Louisiana*, for biographical details on Montegut, Dow, and LeDuc, 163-6; for Claiborne’s statements on Montegut and Dow, 306; and for the College of Orleans, 312; notice of the College’s opening can also be found in newspapers see *Louisiana Gazette* (June 25, 1805); and for the first two medical societies, see Duffy, *History of Medicine in Louisiana*, 1: 490-5; more on medicine and public health in antebellum New Orleans can be found in Carrigan, *The Saffron Scourge*; and Willoughby, *Yellow Fever, Race, and Ecology*. 
was still valuable even if their expertise was not. But from the Spanish period onward, those
with medical and political power in New Orleans knew what knowledge was suitable for
managing healthy populations and unlocking economic potential, and they knew who could
lay claim to that knowledge.

Finally, Spanish colonialism established an important link between the cultures of
white male medical expertise in New Orleans and Havana. Historian of medicine Mariola
Espinosa has illustrated how the problem of yellow fever created a shared medical discourse
between the two cities during the second half of the nineteenth century, but there was an
earlier period of connection surrounding the management of enslaved health.97 As this
chapter has alluded to, Havana not only served as the staging ground for Spanish
colonization of Louisiana but was also the regional metropole from which Spanish officials
drew medical expertise. This perception of Havana took on new dimensions as the city
became highly regarded for its advanced public health regimes, hospital management, and
clinical medical education. For some New Orleans physicians, these institutions were
successful models of medical management that they could learn from. Familiarity with
Havana medical institutions – or better yet, first-hand medical experience in Havana or in
Cuba more broadly – showed that a physician had medical knowledge that was useful for
managing enslaved health and advancing a slavery-based economy. As the next chapter will
show, perception was closely related to the growth of plantation slavery in Cuba.

Chapter Two: “Doctors who can accommodate our sugar mills”: Plantation Slavery and the Making of Medical Education in Havana, 1790-1840

The development of medical education in early nineteenth century Havana was closely tied to the expansion and intensification of plantation slavery. Beginning in the late eighteenth century, Cuban planter elites set out to modernize plantation production. They began to use new technologies which helped them manage enslaved people’s bodies as the human machinery of production and situate enslaved health in relation to the time discipline of the plantation system. While these changes were underway in the countryside, there was an elite class of physicians emerging in Havana, most of who were criollo, meaning white, Cuban-born, and male. Like many of their counterparts in New Orleans and elsewhere in the late eighteenth century Spanish Atlantic, these physicians distinguished themselves from other healers by emphasizing that their approaches to health and medicine were based in reason and rationality. In doing so, they had become preferred medical and public health experts in the eyes of colonial administrators in Havana. But Cuban criollo physicians also wanted to modernize and secularize medical education using anatomical science, clinical observation in hospitals, and plantation medicine. With the advent of new plantation management techniques, physicians were beginning to see that the plantation itself, much like the hospital, was a controlled environment ideal for producing and teaching medical knowledge. Planters supported this attempt to modernize medicine, providing significant funding for medical education and public health through the planter-dominated Economic Society of Havana. The result was the making of a highly respected medical education capital at Havana. The city became a model for how to manage health in an enslaving economy, and Cuba became a study abroad destination for physicians from the United States and Europe who wanted access to cadavers and living enslaved people.
After the Haitian Revolution, Cuba succeeded Saint Domingue as the most important sugar producing island in the Caribbean. Between 1790 and 1830, the island experienced a massive economic acceleration, which some historians have called the “Creole Industrial Revolution.” The Spanish empire had paid little to attention to Cuba before the eighteenth century, instead focusing their imperial project on the mineral-rich colonies of Mexico, Peru, and Nueva Granada. But as they endeavored to expand economic development in their imperial peripheries, they devoted more capital to the island’s sugar, coffee, and tobacco industries, while also liberalizing trade and land-holding policies. More enslaved people and plantation machinery came to the island as prominent planters cut down old growth forests and pushed out smaller land-holders to expand their existing enterprises. Sugar plantations became “factory-like” operations where all labor and materials were carefully choreographed towards maximum commodity output. Historians and anthropologists have also noted that economic transformation went hand-in-hand with a social transformation from below as enslaved people and free people of African descent refashioned African and local social and cultural practices to created new strategies for withstanding violence under the intensifying slave system in Cuba. These strategies


included medicine and healing. Although this chapter focuses on medical elites, glimpses of enslaved and free people of color appear throughout the archival evidence, showing how people of African descent experienced and at times challenged physicians’ gaze and their medical interventions.

Prior to the 1990s, much of the historiography of science and medicine in late colonial Cuba celebrated these fields as incubators for Cuban nationalism, largely ignoring connections to the slavery economy, but recent historians of Cuban medicine have problematized this teleology. Spanish historian Armando García González and Cuban historians César A. Mena Serra, Armando F. Cobelo, and Pedro M. Pruna Goodgall have offered institution-focused revisions of Cuban medical history showing how it was not a steady march towards progress but an uneven process wherein criollo physicians had to fight for authority over other healers rather than acquiring it through the supposedly self-evident efficacy of their knowledge and practices. Moving beyond institutional histories, Alejandra Bronfman, Steven Palmer, and Adrián López Denis have centered slavery and race in their analyses of medical knowledge production, showing that young criollo physicians gained medical experience by working on plantations. All three argue that these physicians drew on plantation experience to develop their understandings of embodied racial differences, but

100 González, *Cuerpo Abierto: Ciencia, Enseñanza y Coleccionismo Andaluces en Cuba en el siglo XIX* (Sevilla, ES: CSIC, 2010); *El Estigma del Color: Saberes y Prejuicios Sobre las Razas en la Ciencia Hispano Cubana del siglo XIX*, 2 tomos (Santa Cruz de Tenerife, ES: Ediciones Idea, 2008); for institutional histories of science and medicine see Pedro M. Pruna Goodgall, *La Real Academia de Ciencias de La Habana 1861-1898* (Madrid, ES: Editorial CSIC, 2002); César A. Mena Serra and Armando F. Cobelo, *Historia de la Medicina en Cuba*; for classic examples of the older historiography see the work of José López Sánchez including *La Medicina en La Habana 1550-1730* (La Habana, CU: Ministerio de Salud Pública, 1970); *Vida y Obra del Sabio Médico Habanero Dr. Tomás Rómey Chacón* (La Habana, CU: Editorial Librería Selecta, 1950).
they do not attend to the ways that management science (and physician adoption of it) shaped medical knowledge production, education, and the medical profession in Cuba.¹⁰¹

As a study of medical education at the turn of nineteenth century, this chapter is also in conversation with John Harley Warner’s study of the Paris Clinical School and its role in the making of medical thought and practice in nineteenth century France, England, and the United States. Like British and American physicians who wrote about, visited, and trained at the Paris School, some elite physicians in Cuba looked to Paris as a model for clinical medical education in Havana. Like Paris, Havana became a destination for medical study. The major draw in both cases was access to cadavers and living patients, which were the key materials for anatomical and clinical medical education. In Havana, however, cadavers and patients were often people of African descent, in the hospital and on the plantation.¹⁰² The exploitation and commodification of people of African descent was thus similar to the use of enslaved cadavers in American medical schools.¹⁰³ Indeed, many early nineteenth century medical schools preyed on the poor, while public health reformers crystallized social divisions as they attempted to control disease beyond the university and the hospital. But in Cuba, these processes were deeply rooted in the normative violence of slavery.

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The Place of Medicine in Political Economy and Plantation Management in Late Eighteenth Century Cuba

In the late eighteenth century, in the midst of revolutions and the crumbling of the imperial mercantilist economic order across the Atlantic world, Cuban planters envisioned a liberal political economy built on technologically sophisticated plantations and expansive enslaved labor forces. The mechanization of the plantation would rely on several key managerial technologies, including the clock; hierarchical, multidivisional labor organization; three-level accounting systems; and the delegation of critical production tasks to specialized experts. Planters continually lobbied the Spanish Crown to increase in the importation of enslaved people, but they also emphasized that there were specific kinds of medicine and medical expertise that would facilitate the longevity and reproducibility of enslaved labor forces. Planters’ desire to incorporate white male physicians with anatomical and clinical training into the plantation slavery economy, and the idea that such men were essential to the modernization of plantation production, can be seen in a wide range of discourse, from high level political economic treatises to the instructional texts given to the administrators of sugar plantations.

One elite planter who saw the economic value of white male medical experts was Francisco Arango y Parreño. Heir to one of the wealthiest families in Cuba and owner of several sugar and coffee plantations, Arango became an instrumental figure in the Creole Industrial Revolution after he traveled to Jamaica and Barbados to learn the latest sugar-making practices, such as the multi-stage boiling process known as the “Jamaica train.”

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104 For biographic details on Arango and his role in the Creole Industrial Revolution see González-Ripoll Navarro and Cuartero, eds., *Francisco Arango y la Invenición de la Cuba Azucarera*; Knight, *Slave Society in Cuba*; and Ortega, “Machines, Modernity, and Sugar.”
1792, Arango wrote an economic treatise to the Spanish Crown arguing that the Spanish state must increase the slave trade to Cuba while also eliminating import duties on plantation machinery and supporting a broad revitalization of agricultural production. He proposed that Cuban sugar planters should visit plantations in Jamaica and other neighboring Caribbean islands “to see the organization, utensils, and machines that the foreigners use to cultivate and process their crops.” He also recommended that planters visit factories in Europe to observe their systems of production and divisions of labor and determine how they might be applied to agricultural production in Cuba. Lastly, Arango insisted that Cuban plantations needed access to agricultural scientists, sugar chemists, botanists, and physicians, preferably on site in permanent positions, as all of these technical experts would help to “promote” Cuba agriculture.

Recognizing that Cuba could fill the void in the sugar market left open by the Haitian Revolution if they acted quickly, the Spanish state indulged Arango’s wishes. The Crown also eliminated import duties on plantation machinery, increased immigration of sugar manufacturing experts from Jamaica and Haiti, and lifted its monopoly on the slave trade, allowing hundreds of foreign slave traders to enter Cuban ports of Havana and Santiago de Cuba during the 1790s. In 1793, Arango became a founder and leading member the Sociedad Económica de los Amigos del País de la Habana, or the Economic

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107 Evelyn Powell Jennings has illuminated the role of inter-imperial warfare and economic competition in the transition from Spanish state slavery to private, planter-dominated slavery in Cuba. See “War as ‘Forcing the Houses of Change’: State Slavery in Late-Eighteenth-Century Cuba,” *William and Mary Quarterly* 3d Ser., LXII (2005): 411–440.
Society of Havana. Through Economic Society, which was made up of prominent planters, urban commercial elites, and civic leaders, Arango and his fellow reform-minded planters had both the political authority and the financial means to invest in agriculture, industry, science, education, public health, and practically anything else that they believed would grow the plantation economy.  

In Arango’s estimation, Cuba was behind islands such as Jamaica and Barbados when it came to plantation technologies and the latest “organization” practices. As Caitlin Rosenthal has shown, prominent sugar planters in Jamaica were not only using the latest machines and employing chemists, skilled sugar manufacturers, and engineers, but they were also developing elaborate hierarchies of slave labor management and methodical accounting practices. The tripartite accounting system of the daybook, the journal, and the ledger was far more complex and detailed than the double-entry bookkeeping that first became widespread during the first few centuries of the Atlantic slave trade. These new accounting books tracked records of profit and loss; the pace of slave labor using notations on enslaved people’s speed and efficiency in each task; and detailed records of enslaved people’s absences, behavior, social relations, and health conditions. These metrics could change daily due to the illness and injury, which meant that maintaining the bodies of enslaved people was a crucial aspect of slave labor management.

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109 As Rosenthal explains, the daybook or “waste book” was “an informal registry of all transactions, noted down in the order in which they occurred. Anyone who could read and count could use this simple book. The journal organized entries from the waste book, rewriting them in the more precise format of debit and credit” while the ledger served as the “central book in the system” that all classified debits and credits by account. See *Accounting for Slavery*, 17, 27.
However, archival evidence suggests that Cuban planters were not as dilatory as Arango thought they were.\textsuperscript{110} Several years before Arango presented his arguments for transforming Cuban agriculture, new managerial technologies and an emphasis on physicians’ medical expertise can be seen in a 1787 document titled “Instructions to be followed by the manager of the mills with black slaves.” The document does not mention an author or a specific plantation, but it is possible that a plantation owner created this list of managerial practices for his subordinates, or that a mayordomo, or “manager,” responsible for the daily administration of the plantation, wrote them down. The instructions provide a brief synopsis of every task in sugar making and guidelines for how enslaved labor should be allocated to each task and managed accordingly. During the harvest, for example, most enslaved people would be stripping cane and transporting it to the sugar mill, or working the grinding and boiling machinery, but there would need to be enough enslaved workers cutting wood to keep the boilers going, and there would need to be another “gang” of enslaved people devoted to clearing new ground to prepare for the next harvest season.\textsuperscript{111}

The instructions also show record keeping and vertical reporting practices that are similar to what Rosenthal has identified in Jamaica. The unnamed author recommended that a few “trustworthy” and “intelligent” enslaved people should be selected to serve as the drivers of work gangs. Drivers would report directly to overseers. Overseers would make notes on each gang in their daybooks, including not only the specific tasks they had

\textsuperscript{110} In her recent study of the British occupation of Havana in 1762-3, Elena Schneider argues against most of the existing historiography which has maintained that British occupation brought modern plantation production and liberal political economic thought to Cuba. As Schneider shows, it was already there. See The Occupation of Havana: War, Trade, and Slavery in the Atlantic World (UNC, 2018).

\textsuperscript{111} Instrucciones que deben seguir los mayorales de los ingenios con los negros esclavos (December 25, 1787). C. M. Sociedad Varios T. 6, No. 17, Biblioteca Nacional de Cuba José Martí (hereafter cited as BNJM).
accomplished, but also the number of clock-standard hours and enslaved people that had been devoted to each task. Task-level information would then be delivered to an onsite plantation administrator, the “manager,” who would compile daybook records in an estate journal and create comprehensive monthly reports on plantation activities. These reports also included relevant environmental information, such as the number of days with and without rain; particularly warm or cool days; and descriptions of storms, which would be especially important to note if they had caused a delay in work. The administrator’s reports were then assembled into an annual ledger which would eventually make its way to the owner of the plantation, who might be primarily located in Havana, or another city even further removed.

Undergirding every aspect of this management scheme was a distinct notion of time discipline which attempted to steer all social relations towards maximum efficiency. Before industrialization, European experiences of time were largely based in religion, with daily and weekly activities following the church bells that summoned parishioners to places of worship. In agriculture, time was also linked to the environment, unfolding in cyclical rhythms of planting, harvesting, and razing based on seasonal differences in climate, weather, and daylight. Generally, then, agricultural work time consisted of the hours of sunlight and work itself was based on an understanding of tasks that needed to be completed to produce a crop each season. This older understanding of agricultural work time gave way to new representations and uses during the middle of the eighteenth century. As Justin Roberts has shown, planters in the British West Indies began thinking about work time in three stages – morning, evening, and night – while also using clocks to record specific moments in complex labor processes. Sugar milling was one process that was carefully timed, but another was sexual violence done to enslaved women. Roberts shows that
Thomas Thistlewood, overseer of Egypt sugar plantation in Westmoreland Parish, Jamaica, used his diary to record the exact clock times for every time he raped an enslaved woman during October 1752.\textsuperscript{112}

In late eighteenth century Cuba, a similar form of time discipline (and presumably similar forms of sexual violence) emerged as planters attempted to remake the plantation into what Sidney Mintz has called the industrial “synthesis of factory and field.”\textsuperscript{113} The new temporal regime built on the existing power of enslaver violence and its use as a labor disciplining mechanism. From the earliest days of the Atlantic slave trade, violence was a crucial means of controlling and extending work time. The threat of the lash could be used to make enslaved people work harder, faster, and longer. The bell, as an extension of the clock, could be used to summon all enslaved people to a specific location or signal the beginning and end of the work day.\textsuperscript{114} Late eighteenth century work time was just as violent, but now it was also specifically tailored to a system of agricultural production that attempted to accelerate production as much as was possible given environmental limits. Planters and their managerial staff used accounting technologies such as daybooks, monthly or weekly journals, and annual reports to visualize work time in whatever increments they needed. Enslaved people’s work hours, their health conditions, and their whereabouts on or off the


\textsuperscript{114} Arguing that “historical struggles are shaped by the ways that historical actors imagine themselves into time,” Walter Johnson has explored the temporal dimensions of enslaver domination and enslaved resistance in the Atlantic slave trade. See “Possible Pasts: Some Speculations on Time, Temporality, and the History of Atlantic Slavery,” \textit{Amerikastudien/American Studies} 45, 4: Time and the African-American Experience (2000): 485-499.
plantation could now be entered into a complex, panoptic information system. Any time lost to enslaved fleeing or refusal to work could be punished in accordance with the precisely measurable impact on work time.

But labor was not the only aspect of enslaved life that had to be considered in relation to work time. The 1787 instructions discussed Catholic religious practices in terms of how much time they would take away from sugar production and how they might be incorporated into existing production tasks. According to Spanish law, all enslaved Africans were baptized upon arrival in Cuba, and it was expected that enslavers would facilitate the Christianization of their laborers by allowing them time to pray and attend mass. Jesuit and Dominican priests sometimes visited plantations to sermonize enslaved laborers and some large plantations had resident chaplains. Planters and their managerial staff knew that the law required time to worship, usually on Sundays, but they also knew that this could cost them valuable work time.115 The instructions suggested that enslaved people could pray while they worked to avoid any slow-downs: “they will congregate in the boiler house to pray, so that those who are on the pots and pans can do it from their work, which cannot be suspended without serious delay [in sugar production].”116

The instructions also stipulated methods for managing enslaved health that demonstrate how managerial concern for enslaved ill-health was fundamentally a concern for work time. For example, sugar mill overseers could mitigate work time lost to enslaved ill-health by limiting enslaved people’s work in the boiler house to shifts of four or six hours.


116 Instrucciones, C. M. Sociedad Varios T. 6 No. 17, BNJM.
and by changing out workers when they were nearing exhaustion. One strategy was to retire a mill gang early and “poach” the rest hours of the next gang by getting them started earlier than usual: “sometimes they cannot be in the fatigue of grinding for the whole time without a serious delay in work or some notable detriment in health, and thus it is required to poach an hour of the next group’s very limited rest” to give to the “previous group.”

This practice of “poaching” rest time and reallocating it as work time exemplifies a view of enslaved health that was rooted in the time discipline of the plantation. Like the grinders that crushed cane and the fires that heated the boilers, planters and managers believed that enslaved health could be adjusted to accumulate work time, increase enslaved productivity, and improve plantation efficiency. This meant that knowledge of enslaved health and enslaved people’s bodies were crucial to the ideal of plantation production. Planters and the men they employed as overseers and administrators needed to be able to recognize fatigue or illness before their enslaved workers collapsed. They needed to know how changes in diet, hygiene, behavior, climate, and environment might impact enslaved health and thus enslaved people’s ability to work.

The 1787 instructions laid out strategies for managing enslaved health as one time-sensitive factor in production, but they also revealed a critical problem, which was the dearth of trained physicians in the countryside. Cuban plantations had long relied on the labor of enslaved people and local healers when it came to medical care for their enslaved workers. Planters’ desires to recruit physicians did not mean that they planned to dispense with that labor altogether. For example, the instructions do recommend that plantation administrators budget an annual “200 to 300 pesos for the cost of black nurses.” But when an illness was

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117 Ibid.
perceived to be beyond the skill of a nurse, managers were left with few options. Some even resorted to sending enslaved workers to urban areas for medical care. The instructions recommended that “after a black slave falls ill with fever or another illness that necessitates prompt cure, send them to the city.”

But even for plantations located near large cities like Havana or Santiago de Cuba, sending an enslaved person off the plantation meant more work time lost. Moreover, if an epidemic swept through the plantation and dozens of enslaved people fell ill at once, the grinders and boilers might be idle for hours or even days.

Cuban planters came to believe that they needed physicians on site who were as skilled as those in the city and understood the role of enslaved health in plantation production. Specifically, planters wanted white, male, university-educated physicians with training in dissection and clinical observation, as well as chemistry, physics, and mathematics. In the early 1790s, thanks in part to pressure from Francisco Arango and other members of the Economic Society, the Spanish colonial government created the Junta de Fomento (Board of Development). This organization was similar to the Economic Society in terms of social composition and political aims, but it primarily focused on developing agriculture in the Cuban countryside. The Board of Development made it clear that improving medicine and medical education in Cuba was essential for improving agriculture.

In July 1795, sugar planters and Board members Pedro Juan de Erice and Nicolás Calvo wrote that all Cuban physicians must learn medical disciplines that were “necessary to have in the sugar mills.” Moreover, they should be able to acquire this knowledge “without the necessity of working on a plantation.” Seeking to create a ready pool of medical experts,

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118 Ibid.

Erice and Calvo proposed an expansion of university faculty in anatomy, mathematics, chemistry, and physics, while also insisting that medical education must include clinical observations and first-hand dissection experience. “It is true that there are medical studies in Cuba,” they wrote, “but what does it matter if, in the absence of anatomy, only the voices of the ancients are taught when students should be learning in ways that effect the senses.” This lack of direct experience through anatomical training apparently meant that planters had great trouble finding “a single doctor in whom they can have confidence.” Erice and Calvo bemoaned that they had to rely on Black “parteras” (midwives), whom they referred to as the “uneducated, ignorant nurses, in whose imperfection it is necessary to trust the health of our slaves.”

Considering that many planters also wanted an increase in the immigration of “good families from Europe and America” who might bring medical, scientific, and manufacturing skills to the island, it is clear that medical experts who could be “trusted” were not just educated in anatomy but were also white. Furthermore, Erice and Calvo’s memorial illustrates that, for Cuban planters, the need to protect the health of enslaved people – or perhaps more accurately, their work time and productivity – was the central motivation behind their call for educational reforms.

120 Memoria de D. Pedro Juan de Erice y D. Nicolas Calvo proponiendo el orden que debe seguir la Junta de Fomento de Gobierno del Consulado en sus trabajos y proyectos (July 8, 1795). C. M. Morales T. 79, No. 31. BNJM.

121 For “good families” see Acta del Cabildo celebrado el 16 de julio en esta ciudad acerca de los medios a seguir para aumentar la población blanca en esta Isla (December 22, 1815). C. M. Morales T. 80, No. 13. BNJM.
Reforms in Medical Education and the Rise of the Hospital

While Cuban planters were busy modernizing their plantations, criollo physicians in Havana were attempting their own reforms. During the eighteenth century, leading Cuban-born medical academics and Protomedicato members pushed for more institutional space for scientific knowledge, especially anatomical science, as well as an overhaul of Havana hospitals to make them suitable for clinical medical education and medical research. Crucially, the development of scientifically-informed, anatomical, and clinical medical teaching in Cuba aligned exactly with the managerial priorities of planters. Hospitals too began to mirror the plantation in their organizational structures and methods of patient control and surveillance, becoming environs where physicians could test medical knowledge that might be useful to the plantation economy on people of African descent. Indeed, the use of people of African descent as clinical material demonstrated not only how ideas of racial inferiority were central to medical knowledge production, but it also that maintaining the health of enslaved labor forces according to planters’ needs was a central prerogative for the emergent criollo medical profession and key to their continued dominance of the medical marketplace.

The eighteenth century was a period of major reform and restructuring of political, economic, and social life in the Spanish empire, and in Cuba, criollo physicians saw an opportunity to take control of medicine and medical education at the local level. Cuban-born Ambrosio Medrano Herrera held the first chair of physiology at Real y Pontificia Universidad de San Gerónimo de la Habana (the University of Havana) in 1730. For criollo

122 This change in eighteenth century Cuban medicine is similar to what Adam Warren has identified in late eighteenth century Peru. See Medicine and Politics in Colonial Peru.
physicians, the creation of chair in physiology and Medrano’s appointment to it represented a significant step towards a more secular and scientific medical culture. In October 1735, the university’s first chair in pathology, Havana-born Dr. José Barrios, succeeded in reforming the university’s medical education system such that medical faculty would be the highest authorities in their respective medical disciplines, which at the time included physiology, pathology, and anatomy. Medical faculty, many of whom also served as Primero Protomedicatos at some point in their career, would now be responsible for medical curricula and final examinations of degree candidates, all of which was previously overseen by Dominican theological faculty.123

Lorenzo Hernández was perhaps the most influential medical reformer in this period, largely responsible for bringing European anatomy and physiology to Cuba. Hernández was an avid reader of the famous Dutch physician Hermann Booerhaave; Swiss physiologist and student of Booerhaave, Albrecht von Haller; the leading Spanish anatomist Antonio de Gimbernat y Arbós; as well as Félix Vicq d'Azyr, the renown French anatomist who was also a major advocate of state responsibility for matters of medicine and public health. Much of Hernández’s career during the 1780s-1790s was devoted to incorporating these Western medical ideas and practices into medical education in Cuba. He received his medical degree from the University of Havana in 1783, after which he served as chair of physiology until 1795 when he took the post of Primero Protomedicato and head physician at San Ambrosio Military Hospital.124

123 For more on the criollo “pioneers” of Cuban medicine see López Sánchez, La Medicina en la Habana 1731-1800.

124 For biographic details and discussions of his European influences see Rafael Angel Cowley, Breves Noticias sobre la Enseñanza de la Medicina en la Real y Pontificia Universidad del Máximo Doctor S. Jerónimo (La Habana: Imprenta y Librería de A. Pego, 1876), 137-140; López Sánchez, La Medicina en La Habana 1731-1800, 265-6.
The growing institutional authority of men like Herrera, Barrios, and Hernández signaled to many criollo physicians that medicine in Cuba was progressing, but they had yet to see comparable improvements in Havana’s hospitals. Much like some reform-minded planters, physicians in Havana bemoaned the lack of hands-on training from experienced physicians in hospital environments. In June 1782, Cuban-born physician Nicolás del Valle toured the Royal Military Hospital of San Ambrosio in Havana and produced a report that was delivered to the Governor of Cuba along with a statement from the chief physician of the hospital, Dr. José Caro. Del Valle’s report painted a grim picture. San Ambrosio was suffering fiscal problems and many of its buildings were falling into disrepair. There were only enough beds for half of the patient population and there was only one Protomedicato-licensed Spanish surgeon available to treat those patients. As was the case in New Orleans, it is likely that people of African descent were doing much of the critical work of looking after patients and running the hospital, but neither del Valle nor Caro mentioned who exactly was seeing to patients beyond the one surgeon. Dr. Caro echoed del Valle’s assessment of the poor state things at San Ambrosio and stressed that more licensed physicians with anatomical training were needed to instruct subordinate medical workers such that they could work independently without fear that their “faults” would impact patient outcomes. Caro explained that an experienced anatomist could “assist them, supplement their faults, or help them,” and such a person could also oversee the “practicing” of anatomical techniques. Both del Valle and Caro argued for a dramatic increase in royal funds for San Ambrosio and other state-owned hospitals, citing the recent

125 Informe de Nicolás del Valle (June 19, 1782). Protomedicato y ciencias de medicina y cirugia, 1755-1824. Legajo 1607, No. 2, f. 16-19, Santo Domingo, AGI.
establishment of a Captaincy-General in Cuba in 1777 as evidence of the island’s importance to the Spanish empire and the availability of funds for such “improvement” projects.\(^{126}\)

The dual pressure from Havana physicians and the planter class paid off, and during the 1780s and 90s the Captaincy-General of Cuba increased funds for hospital improvements and physician appointments in Havana as well as Santiago de Cuba and Camagüey, two other cities that were important nodes for the growing plantation economy.\(^{127}\) The state also closed the most dilapidated hospitals in Havana, such as the Royal Hospital of Our Lady of Pilar, which was created in 1764 for the medical care of convicts and slaves of the King. This hospital was located in a converted warehouse next to the Royal Tobacco Factory in the Jesús del Monte neighborhood just outside the walls of Havana proper. The location probably seemed convenient at first, as enslaved people who worked in the tobacco factory would not have to go far if they became ill, but the building routinely flooded with waters from the Almendares River.\(^{128}\) Furthermore, Our Lady of Pilar had a problem with escapees. In February 1782, “three prisoners Miguel Pastor, Miguel de Sayas, and Francisco de Paula fled the Hospital of Our Lady Pilar on the night of the 17th.” All three prisoners were soldiers of African descent who were being held “in the dungeons,” but together they “overpowered the guard” and made a run for it. The three men were caught shortly after and “returned to the dungeons, where they are now being kept in separate quarters with more guards assigned to watch them.” The administrator of the

\(^{126}\) Exposición de José Caro (July 15, 1782). Protomedicato y ciencias de medicina y cirugía, f. 27, ibid.

\(^{127}\) René Ibáñez Varona, Historia de los Hospitales y Asilos de Puerto Príncipe o Camagüey (periodo colonial). Cuadernos de Historia Sanitaria No. 6 (La Habana, CU: Ministerio de Salud Pública, 1954).

hospital and the commander of the prison guards pressed the leader of the Spanish military in Cuba, Juan Ignacio de Urriza, insisting that they needed more security staff, weapons, and single-occupancy cells to prevent future escapes. Urriza quickly relayed that message to the Captain General of Cuba, Juan Manuel Cagigal, who in turn promised to secure the necessary funds. Perhaps military and governmental officials feared that enslaved patients would try to escape too, if they were not doing so already.

When Our Lady of Pilar closed in 1793, convicts were sent other prisons in the city and all enslaved patients were transferred to San Ambrosio, where there were now 400 beds and a staff that included three licensed doctors, three licensed surgeons, and fourteen “practicantes,” or physician interns, who had recently completed their medical degrees. The hospital also had dozens of “ward attendants” and “servants,” many of whom were likely enslaved or free people of African descent. San Ambrosio was located near the university and thus it became the logic place for post-graduate internships as well as anatomical demonstrations for current medical students.

Most importantly, the remaking of San Ambrosio meant that physicians and medical students now had direct access to a large patient population that included not only soldiers, but also enslaved black people. Medical students and early career physicians could now receive the anatomical training and extensive first-hand experience in hospital settings that planters had been clamoring for. The use of people of African descent as clinical material

129 Urriza to Cagigal (February 18, 1782). Correspondencia dirigida al Capitain General de Cuba, Juan Manuel Cagigal, por el Indendente del Ejercito, Juan Ignacio de Urriza, y minutas de repuestas (1781-2), Legajo 1307, No. 247, Papeles de Cuba, AGI.

130 For numbers of beds and staff see Arce, “El Real Hospital Nuestra Senora del Pilar en siglo XVIII,” 64-66.
meant that medical knowledge produced in the university and the hospital would be transferrable to the plantation.

Additionally, San Ambrosio became a key site of medical experimentation where Cuban physicians tested surgical methods, drugs, and botanical remedies. For centuries, bioprospecting Spanish scientists, natural historians, and clergymen had scoured the Cuban countryside looking for flora with medicinal potential. Bioprospectors sent specimens to royal, scientific, and religious collections in Havana, Seville, or Madrid.131 By the late eighteenth century, however, this extractive process was becoming a plantation economic project in addition to a Spanish imperial project. The therapeutic potential of Cuban flora could now be tested methodically in a hospital setting to determine if they would be useful in plantation settings, where other (often more expensive) medical materials could sometimes be scarce. The experiments with local flora conducted at San Ambrosio Hospital in 1799 provide a particularly salient example of the influence of the plantation economy in medical experimentation.

In early August 1799, Havana physician Miguel Gonzalez experimented with the medicinal qualities of a local flowering plant known as the “agueda,” which he claimed to have “discovered” during his time working on plantations in the countryside. It is possible that Gonzalez had observed local healers or nurses of African descent using agueda roots to treat enslaved plantation workers, although he does not explain how he acquired this knowledge. Gonzalez argued that the roots of the agueda had therapeutic uses similar to those of the Brazilian ipecacuanha, or ipecac, the so-called “fever flower” that was used as

131 For the history of colonial botanical and bioprospecting in the Americas and the Atlantic World see Daniela Bleichmar, *Visible Empire: Botanical Expeditions and Visual Culture in the Hispanic Enlightenment* (Chicago, 2012); Schiebinger, *Plants and Empire.*
an emetic in cases of dysentery, or “flux.” Gonzalez explained that like ipecacuanha – which he maintained European physicians had taken beyond what “the indigenous managed to do with it” – the agueda would be useful for the most “critical circumstances of the day.”

Indeed, flux was one of the leading contributors to enslaved morbidity and mortality during the Middle Passage and on Caribbean plantations.

In a subsequent experiment with agueda roots conducted a few weeks later, another Havana physician named Josef Estévez drew on his knowledge of the Linnaean classification system and the work of “Dr. Mutis” to examine the plant. Mutis was the Spanish-born priest-botanist-mathematician directing the Spanish Royal Botanical Expedition in New Granada (1783-1816). Estévez knew that Mutis had recently “communicated to truth of the ipecacuanha to Linneaus,” which shows that elite physicians in Havana were linked into Spanish imperial intellectual networks. Estévez determined that his colleague Gonzalez was incorrect in claiming that the agueda was in the same genus as the ipecacuanha, as it did not have the dichotomous root structure associated with the “genus asclepias.” Rather, the plant’s roots were “twisted” like the “the French rose, the alba, and the vinca rose” that were known “on this island” to be “poisonous.” Moreover, Estévez did not observe the same “emetic” properties in the agueda when it was given to patients, and it is possible that patient illness or death had led him to further suspect that it belonged with other dangerous plants.

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134 For a more extensive discussion of Mutis and the Royal Botanical Expeditions, see Bleichmar, Visible Empire.
Ultimately, Estévez determined that “the plant that Dn. Miguel Gonzalez has shown to the Royal Economic Society is very distant to the true ipecacuanha,” but nevertheless there should be more “tests” and “observations” in the hospital using different solvents for the agueda root. As he explained:

I still do not espouse all the merits put forth by Gonzalez, but I may in time, provided that a sufficient number of experiments confirm that the flower can replace the ipecacuanha. Make the tests in a hospital, repeat the observations, and if it is seen by the effects that the emetic occurs [when the powdered root is] added to a tonic, because the ipecacuanha is recommended in dysentery, diarrhea, intermittent fevers, etc., then it will be said not that Gonzalez has discovered the ipecacuanha on this Island but that he has found its virtues in the agueda flower, and with justice he deserves a prize.135

Estévez’s statement demonstrates that he, and other elite Cuban physicians, believed that reliable medical treatments could be produced through medical experimentation that was rooted in scientific knowledge and methodically carried out on living patients. The repetition of experiments was a reason-based way of analyzing potential therapeutics and creating medical consensus, and the hospital setting provided a controlled environment with a ready supply of clinical material in its large patient population. Furthermore, Gonzalez and Estévez sent their reports to the two administrative bodies that were most interested in the progress of medical knowledge: the Havana Protomedicato and the Economic Society. As Estévez mentions that Gonzalez first presented his finds to the Economic Society, it is likely that this organization funded the agueda experiments.

135 Exposición de Josef Estévez (August 27, 1799). C. M. Sociedad T. 30, BNJM.
The advent of hospital-based medical teaching and research was the beginning of an institutionalized partnership between physician and planter elites that was built on the exploitation of people of African descent. Although neither Gonzalez nor Estévez provided details that might be used to identify their patients, but people of African descent would have been the ideal candidates for medical experimentation due to the fact that they occupied the lowest rungs of Cuban colonial society, along with the poor and the criminalized, who were also disproportionately Black. As was the case throughout the Atlantic world at this time, many white people in Cuba presumed that there were some bodily, intellectual, and moral differences between races, and thus it seems even more likely that planters and physicians would have wanted to know the effects of medical therapies on Black patients in particular. Furthermore, colonial officials, planters, and physicians all wanted to control people of African descent through public health, sometimes bringing them to the hospital against their will.

136 Ruth Richardson discusses the social history of the body and anatomy in early nineteenth century England, up to and after the Anatomy Act of 1832, which aimed to curb rampant practices of body snatching by allowing physicians and medical schools to utilize the cadavers of the poor. This effectively rendering dissection as a punishment of poverty. See Richardson, Death, Dissection, and the Destitute (Routledge, 1987); Michael Sappol makes an argument for the antebellum United States that is similar to Richardson’s. See A Traffic of Dead Bodies.

137 Historians have demonstrated that there was a crucial shift in European and Euro-American ideas of blackness during the eighteenth century, from blackness as moral difference to blackness as a scientific and medical marker of physical and intellectual difference, although associations between morality and race never disappeared completely. See Seth, Difference and Disease; Hogarth, Medicalizing Blackness; Curran, The Anatomy of Blackness.
Clinical Medical Education and Public Health in Early Nineteenth Century Havana, with a View from New Orleans

As was true in many Spanish port cities, hospitals in Havana served as the central nodes for an urban network of quarantines and smaller infirmaries. But as they were recast as the center of clinical medical education, they began to reflect not only the population management strategies of Spanish biopolitics, but also those of plantation management. The colonial state, planters, and physicians did not necessarily agree on all medical theories and practices, particularly when it came to possible connections between race and disease. There were vociferous debates between physicians on these issues, with some physicians and state officials believing that unique bodily-racial characteristics of people of African descent made them especially vulnerable to yellow fever. This led them to attribute several major epidemics to the importation of enslaved people. Most planters and other enslavers argued against the idea that enslaved people were particularly susceptible to or harbingers of yellow fever, citing cases where Europeans and Americans had fallen ill. Some state officials and physicians – including the chief architect of clinical medical education, Havana-born physician Tomás Romay – actually pushed for fewer slave ships and more white immigration, thinking that whitening the population would improve public health in the city. However, one aspect of medicine and public health that the medical elite, colonial officials, and planters did clearly agree on was the superiority of clinical medical education and its economic significance. Regardless of differing views on race and disease, physicians, planters, and state officials all believed that the University of Havana’s clinical training program at the San Ambrosio

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138 See López Denis’s discussion of physicians, slavery, and white immigration, including the creation of the “White Population Board,” in “Disease and Society in Colonial Cuba,” Chapter 3.
Hospital was creating the medical experts who would be useful for the management of racialized populations in both the city and in the plantation countryside.

The dramatic increase in the slave trade during the first several decades of the nineteenth century was also essential to the progress of medicine, public health, and medical education. After Britain and the United States outlawed the Atlantic slave trade in 1808, their portions of the trade were redirected to Cuba, which did not officially outlaw it until 1820. Historians have estimated that between 1790 and 1820 the importation of enslaved people increased by 578% and the sugar economy in Cuba grew by 147% as slavery financiers in the United States, England, and throughout the Atlantic world invested heavily in the island’s expanding economy.\(^\text{139}\) The infusion of labor, financing, and demand for agricultural commodities inspired plantation enslavers to institute harsher work regimes, punishments, and surveillance of enslaved people, forcing them to meet ever-increasing production quotas.\(^\text{140}\) This troubled some colonial officials who feared that a disproportionately Black population coupled with brutal conditions on plantations might lead to a rebellion similar to the Haitian Revolution. Their concerns were not unfounded. In 1812, a military officer of African descent named José Antonio Aponte became the figurehead of an island-wide movement of enslaved and free people of African descent who attempted to overthrow both colonial rule and the institution of slavery. Aponte’s rebellion was quickly snuffed out, but


\(^{140}\) For more on the increase in enslaver violence and social control over enslaved people during this period, which refutes the idea that Spanish colonies was necessarily more humane simply because Spanish legal system afforded enslaved people some legal rights, see de la Fuente, “Slave Law and Claims-Making in Cuba;” and Manuel Barcia, *Seeds of Insurrection: Domination and Resistance on Western Cuban Plantations, 1808-1848* (LSU, 2008).
the specter of Black revolution remained. Cuban planters were also fearful of rebellion, to be sure. Many instituted policies to monitor enslaved people’s social and religious activities and curtail their interactions with free people of African descent. But most still pushed for more importation of enslaved people. Even after the official abolition of the trade in 1820, slave traders were able to circumvent abolition and the British officials who attempted to enforce it Cuba – usually without much protest from colonial officials, many of whom were content to accept a bribe for looking the other way – and thus an illegal trade existed into the mid-1860s. For Cuban physicians, and those who aspired to become physicians, the high volume of enslaved people arriving to the island meant good business. By the mid-1810s, sugar planters regularly paid physicians to inspect newly arrived enslaved people at the Matanzas harbor and make sure their agents purchased the healthiest slaves available.

Tomás Romay’s description of the University of Havana’s clinical medical education program further demonstrates the influence of the growing slavery economy in Cuban medicine. Clinical education became a requirement for the medical degree in 1804 and was chiefly undertaken at San Ambrosio Military Hospital or San Juan de Dios Hospital, the latter of which had previously served as a convent until 1797 when it was converted to a

141 There is some debate amongst Cuban historians surrounding Aponte’s rebellion: was it a conspiracy or was it actually a widespread social movement? Matt D. Childs argues for the latter and illustrates that Aponte’s rebellion was a movement that encompassed rebels burning plantations and killing white people in Havana and Puerto Príncipe, as well as co-conspirators who were captured by authorities before they could fulfill similar plans in the cities of Bayamo and Holguín. See *The 1812 Aponte Rebellion in Cuba and the Struggle against Atlantic Slavery* (UNC, 2006).

142 The uptick in the slave trade between 1800-1820; stricter plantation regimes; the role of British abolitionists and the making of anti-slavery ideas in Cuba; and the continuation of the slave trade after 1824 are discussed at length in Robert L. Paquette, *Sugar is Made with Blood: The Conspiracy of La Escalera and the Conflict between Empires over Slavery in Cuba* (Wesleyan, CT: Wesleyan University Press, 1988).

143 See the mention of physician inspections in Comunicación acusando recibo de 2 negroes y una mulata, esclavos de D. Pedro Rufín desembarcados de la balaundra americana Roxana (February, 1816). Legajo 23, Nu. 3, Fondo Esclavos, Archivo Histórico Provincial de Matanzas, Matanzas, Cuba (hereafter cited as AHPM).
state hospital. Despite the fact that he saw a connection between the slave trade and the prevalence of yellow fever in Havana, Romay apparently had no problem with planter involvement in clinical medical education or the fact that many patients at San Ambrosio and San Juan de Dios were enslaved and free people of African descent. Like Francisco Arango, Romay came from a wealthy planter family and became heavily involved in efforts to modernize Cuban society, believing that the advancement of science, medicine, and public health were essential to this process. Romay studied under Lorenzo Hernández at the University of Havana and earned his medical degree in 1793, shortly after which he became medical faculty as well as a member of the Economy Society.\textsuperscript{144} According to Romay – who was an avid consumer of European medical texts, much like his mentor – the program of clinical medical education involved little medical theory and instead focused on teaching students through a focus on “the cadaver, the patient, and the effects they can produce on our own sensory organs.” It is possible that Romay and his colleagues decided to use cadavers for anatomical dissections in an attempt to model clinical medical education in Paris. Romay’s writings do emphasize the importance of having students conduct rounds in patient wards and dissections on human cadavers, which John Harley Warner notes was characteristic of the Paris School’s clinical hospital and its “free access to bodies.”\textsuperscript{145} Interestingly, however, Romay also noted that the Economic Society was providing financial support for the new program of clinical medical education under the condition that professors use cadavers for the teaching of anatomy, rather than wax figures.\textsuperscript{146} Planters

\textsuperscript{144} Lópezo Sánchez, \textit{Vida y Obra del Sabio Médico Habanero}.

\textsuperscript{145} Warner, \textit{Against the Spirit of System}, 95-97, for quote see 96.

\textsuperscript{146} See Tomás Romay, “Catedra de Clínica” (August 18, 1818) for cadaver quote and “Plan para el establecimiento de una escuela de medicina clínica en el Real Hospital de San Ambrosio de esta ciudad” (August 31, 1819) which mentions the Economic Society’s involvement. Both can be found in Romay, \textit{Obras
likely imposed this requirement because they wanted to be sure that clinical education would produce physicians with direct experience dissecting human bodies, or those physicians who had learned medicine “in ways that effect the senses,” as the planters Pedro Erice and Nicolás Calvo had put it in the 1790s.

Indeed, over the course of three years of study, medical students at the University of Havana received an education that was similar to clinical medical education in Paris, especially in terms of subject matter, requirements, and plan of study. But their education also clearly aligned with the new rigorous forms of plantation management in Cuba. In their first year, medical students learned case history and theory in faculty-led lecture courses on anatomy, pathology, and physiology. In the second year, they completed hospital rounds with their professors. Faculty performed case presentations, surgeries, and dissections in the hospital wards and then provided critique as their students did the same. Students were responsible for keeping their own records of patient cases and making follow up visits to bedsides. These observation records also included notes on temperature and weather conditions, which Romay referred to as the “state of meteors.” For Romay, and many physicians in the early nineteenth century who proclaimed the virtues of anatomical and clinical medicine, medical knowledge of local environments and climate was still important. Finally, after completing all coursework, hospital rounds, and patient observations, students were allowed to sit for the final degree examination. After receiving their degrees, almost all graduates then sat for the Protomedicato licensing exams, which gave them medical authority in accordance with Spanish colonial medicine, too.147

147 Romay, “Plan para el establecimiento de una escuela de medicina clinica,” ibid, 38-43.
As was the case in New Orleans, most people still went to the medical practitioners they trusted, licensed or not. Clinically-trained and licensed physicians continued to see wealthy white patients and their enslaved people in private homes. These cases certainly continued to count towards the perception of a respectable, experienced physician in the eyes of patients, other physicians, state officials, and planters. But with the rise of clinical medical education, hospital experience was become a distinguishing marker of medical expertise that could only be accessed by white men of means. As Romay put it later in life, those who had been trained in clinical medicine could “take the doctrines from each school that were most in conformity to strict reason” and apply them “to repeated and analyzed facts, and to principles generally admitted, in order to form a collective system, the surest one in the difficult science of curing.”

The hospital, with its numerous patients and medical conditions, provided the foundation for an experience-based, yet eclectic medical tradition that utilized case history and rigorous record keeping while still being flexible enough to serve students well no matter what medical condition they encountered or what environmental conditions they worked in. In both content and methodology, then, the hospital was preparing students for careers in plantation medicine. Plantation physicians would also encounter large patient populations, wide varieties of illnesses and injuries, and environmental conditions that were specific to Cuba. They would need to have the formal knowledge and the first-hand experience to implement the “surest” and therefore most efficient methods of maintaining enslaved health.

Foreign physicians likewise observed that that clinical medical education in clean and orderly hospital settings was an important step towards the making of a highly reputable medical culture in Havana. South Carolina physician John G. Wudermann visited Cuba in the early 1840s hoping that the change in climate would improve his tuberculosis. He published his travel narratives first in the Richmond-based journal *Magnolia* and then as book, *Notes on Cuba*, in 1844. Although he does not say where he earned his medical degree, on several occasions Wudermann mentions his previously travels throughout Europe and that he had “visited” the Paris Clinical School. He likely did this to convey his worldliness and respectability, but this meant that the Paris School was his point of reference for good hospitals and medical education. Like many visitors to Cuba, his first stop was Havana. There he visited San Juan de Dois Hospital and the “creole” guard granted him entrance after Wudermann informed he was a physician. Wudermann described the “huge building” and its interior, including the “spacious ward on the first floor, which was very cleanly, and furnished with iron bedsteads.” This first ward gave way to another even larger one with that was “capable of accommodating more than two hundred patients” and providing them with fresh air via its “lofty ceilings” and “large windows.” Wudermann immediately recognized that he was walking through a highly advanced medical setting, remarking that “a great degree of neatness pervaded the whole place; perhaps not as such as I had seen in the Paris hospitals, but certainly more than I had witnessed in Italy, even Rome itself.”

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149 While dining with one of his Cuban hosts, Wudermann mentioned that he had visited the Paris School and was subsequently asked to “prescribe” for another guest in their house. See John G. Wudermann, *Notes on Cuba: Containing an Account of its Discovery and Early History; a Description of the Face of the Country, its Population, Resources, and Wealth, its Institutions, and the Manners and Customs of its Inhabitants; with Directions to Travellers Visiting the Island* (Boston: J. Munroe and Co., 1844), 106.

150 Ibid, 58.
Another key indication of the advanced state of San Juan de Dios was the fact that physicians were seeing patients on a regular basis and had segregated them by race and class, with enslaved patients held in different wards from “free negroes.” Enslaved patients were housed in the first-floor wards while the second floor had wards for white patients and “freed colored patients” whose “accommodations were not a whit less comfortable than those for the whites.” Wudermann was impressed with the work of San Juan de Dios physicians, who ensured that all patients were “well treated,” “returning to health,” well-fed with “an air of contentment” that was “observable in their faces.” He was especially impressed with the care of patients of African descent, stating that contrary to long-standing presumptions about the “cruelty of Spanish slavery,” “they offer in their institutions for the relief of the sick free negro, an example that might well be followed by many of our Southern States.” Wudermann saw that San Juan de Dios, with its attentive physicians, high standards of cleanliness, and apparently effective therapies, was comparable to the advanced clinical hospitals in Paris. But with its significant capacity and segregated wards, San Juan de Dios was also uniquely suited for an enslaving society that required proper management of healthy populations.

With this assessment, Wudermann was echoing perceptions of medicine in Havana that were by that point commonplace that amongst criollo physicians, state officials, and wealthy enslavers. There were plenty of instances between 1800 and the 1830s where all three groups would bemoan a general state of ill-health in the city, especially during epidemics, when poor, racialized populations were often blamed for failing to maintain

sanitary standards or otherwise contributing to the prevalence of disease.\footnote{See López Denis, “Disease and Society in Colonial Cuba;” and on race and public health in the first epidemic of cholera in Havana in 1833 see Julio Ramos, “A Citizen Body: Cholera in Havana (1833),” Dispositio 19, no. 46 (1994): 179-95; and for similar themes in the social history of the 1832 cholera epidemic in the U.S. see Charles E. Rosenberg, The Cholera Years: The United States in 1832, 1849, 1866 (Chicago, 1962).} Nevertheless, when they were able to control the spread of disease in the city and resume normal economic activities quickly, they often attributed such successes to advancements in medicine and medical education and the revitalization of hospitals. Like New Orleans; Veracuz, Mexico; Charleston, South Carolina; and other major port cities in the Greater Caribbean, Havana suffered the near-annual epidemics yellow fever in the early nineteenth century in addition to epidemics of cholera in 1833 and 1850. Yellow fever was particularly economically disruptive. An outbreak could bring commercial activity to a grinding halt and kill thousands in a matter of weeks, many of whom would be recently arrived white immigrants and enslaved people of African descent who did not have acquired immunity to the disease. Quarantines could be somewhat effective in terms of preventing new cases, but they were obviously undesirable for state officials as well as enslavers and other merchant elites whose profits relied on constant ship traffic. In both Havana and New Orleans, elite physicians focused considerable efforts on locating the exact origins of yellow fever and determining how it might be cured, in part because they understood the economically problematic nature of quarantines. This attention to commerce was attractive to city officials and enslavers, and thus it helped physicians further separate themselves from other medical practitioners.\footnote{For yellow fever in Havana/Cuba see López Denis, “Disease and Society in Colonial Cuba;” and Barcia, The Yellow Demon of Fever; for economic dimensions of yellow fever in early nineteenth century New Orleans see Willoughby, Yellow Fever, Race, and Ecology; Kathryn Olivarius, “Necropolis: Yellow Fever, Immunity, and Capitalism in the Deep South, 1800-1860” (DPhil thesis, Oxford University, 2017); and Humphreys, Yellow Fever in the South.} In Havana, however, physicians could also point to hospital clinics – which
did not seem to interrupt economic activity – to show both the superiority of their medical practices as well as their commitment to the slavery economy.

Some state officials clearly agreed. When the clinical medical education program was just thirteen years old, the Governor of Cuba professed that it had improved the state government’s ability to manage populations of white immigrants, enslavers, enslaved people, soldiers, and the poor. After a string of yellow fever outbreaks in the late summer and early fall of 1813, Governor Juan Ruiz Apodaca was pleased to report to both the Spanish Crown and the Madrid Protomedicato in May 1814 that “the state of public health and sanitation in Havana has been greatly improved in large part thanks to our physicians in the Royal Hospitals.” Apodaca proudly declared that “all leaders of the provinces of America” should be informed “that the state of medicine and science in Cuba are unsurpassed” and that “the University of Havana’s method is to be admired.” During the epidemic in 1813, a network of university faculty, hospital physicians, other licensed physicians and surgeons, and various civil officials had fanned out across the city, locating sick people and containing them in their homes, in military barracks, in churches, and at the port. Some wealthier white patients were referred to smaller infirmaries called “quintas,” where it was thought that they would be able to recover from the disease once physically removed from the noxious environments which supposedly generated it. Although the term quinta meant “country house,” these facilities were located all over the city and in suburban areas. Before the nineteenth century, the colonial state rented out houses to serve as quintas during epidemic times, usually staffing them with physicians and surgeons who reported to the Havana Protomedicato, but after 1820 some wealthy physicians were allowed to open their own quintas. Many of these facilities catered exclusively to newly arrived white immigrants, wealthy enslaver clients and
their enslaved people. However, enslaved, conscripted, and poor people who did not have the same relationship with white enslavers were a different story. They were sent to San Ambrosio, where physicians, surgeons, and recent graduates of the University of Havana had “ordered the clinic” according to “the most advanced medical and sanitary knowledge.”

This public health system certainly still resembled that of late eighteenth century Spanish colonial medicine, particularly in its emphasis on a centralized, rational approach to racialized population management and its deputizing of white male physicians. But now public health achievements were specifically attributed to the hospitals that were part of the University of Havana’s “admirable” program of clinical medical education.

Across the Gulf of Mexico in New Orleans, Anglophone and Francophone physicians looked to Havana as a comparative model for medicine, medical education, and public health. Municipal officials and slave owners in New Orleans did not always agree with physicians, particularly when physicians advocated for quarantines or any public health program that appeared to jeopardize commerce. But they still turned to physicians for medical guidance, or to assemble an ad-hoc public health committee during an epidemic. The city did not have a permanent Board of Health until 1848, but physicians continued to separate themselves from other healers by publishing medical journals such as the *New Orleans Medical and Surgical Journal* (1844-1952) and opening two medical schools. The first school was the Medical College of Louisiana, the historical predecessor of Tulane University School of Medicine, which was founded in 1834 and incorporated as the Medical

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154 For more on quintas see Mena Serra and Cobelo, *Historia de la Medicina en Cuba*, Tomo 1.

155 Juan Ruiz de Apodaca, Estado de las ciencias de medicina y cirugía en la Habana (1814). Protomedicato y ciencias de medicina y cirugía (1755-1824), Legajo 1607, No. 10, f. 597-599; 601-603, Santo Domingo, AGI.
Department of the newly formed University of Louisiana in 1844. The second was the New Orleans School of Medicine, founded in 1856. Both schools used Charity Hospital of New Orleans – the former biopolitical staging ground under the Spanish – as their primary teaching hospital.\textsuperscript{156} Given their marked interest in building institutional power, it seems likely that part of the impulse to compare with Havana was a desire to secure the boundaries of professional medical expertise by making a case for what New Orleans could look like if there was adequate state support for a medical profession. But it is clear that the criollo medical establishment’s methods for teaching medicine and managing health were also worthy of emulation.

Because both Havana and New Orleans were large port cities with similar climate, multi-racial populaces, and trade networks, it should not be surprising that Havana would be a frequent topic of discussion in New Orleans medical discourse. However, considering that many physicians in early nineteenth century New Orleans often attributed their failures to improve health and sanitation to environment, race, and disease, it is all the more significant that they conceived of Havana as a place where medicine and public health seemed to be working.\textsuperscript{157} For these physicians, the key difference between New Orleans and Havana was the latter appeared to have a ready force of trained physicians working in hospitals, smaller infirmaries, and quarantines where patients were closely monitored and segregated by race.

In his treatise “Observations on the Nature and Treatment of Yellow Fever,” published in the \textit{New Orleans Medical and Surgical Journal} in 1851, Abner Hester summarized

\textsuperscript{156} See Duffy, \textit{The Rudolph Matas History of Medicine in Louisiana}, Vol. II esp. chapters 1-2.

\textsuperscript{157} White male physician habits of blaming ill-health on ecology and race are discussed in Willoughby, \textit{Yellow Fever, Race, and Ecology}; and for New Orleans business elites’ habit of blaming yellow fever, ecology, and people of African descent for disruptions in the commodity market, see Olivarius, “Necropolis.”
thirty years of attempts to understand and control the disease in New Orleans. Hester had founded the journal along with another prominent physician, Eramus Darwin Fenner, and the two of them served as its editors until another physician named Bennet Dowler took over in 1854. Hester and Fenner wrote extensively on yellow fever, urban sanitation, climate, and topography in New Orleans and believed that the development of a robust and effective public health system would improve health, commerce, and the respectability of their profession. In his treatise, Hester discussed disease control in Havana as a comparative example, suggesting that New Orleans should adopt measures that were by that point well-established public health practices in Havana. He noted the strict “hygienic measures” enforced in Havana’s hospitals and the strategically placed quintas which provided “salubrious” refuges for white immigrants and visitors. As evidence, he drew upon the testimony of a French naval surgeon who had sailed into the Havana harbor in August 1837 in the midst of a yellow fever epidemic to find a hospital and quarantine system that was well prepared for such an event. The French surgeon explained that “the hospital of M[onsieur] Belot,” which was positioned at “a slight elevation above the level of the sea” at “the most salubrious point of all the bay,” was especially noteworthy in this regard. This “hospital” was actually a privately-owned quinta that belonged to Carlos N. Belot, a physician of Spanish descent who had been born in New Orleans under Spanish rule and had made his way to Havana after completing medical degrees in Paris, Madrid, and Leipzig. For several years he served professor of anatomy at the University of Havana and clinical instructor at the San Ambrosio Hospital alongside Tomás Romay before he retired to private practice. In

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158 For the journal founding see Duffy, Vol. II, 275-6.

1821, Belot opened the aforementioned quinta in the town of Regla, just across the harbor from Havana. Belot’s quinta had 300 beds at its height and almost exclusively served wealthy white residents and white foreigners who fell ill while visiting Havana. The French surgeon’s account described Havana’s methodical quarantine system, which was noticeably better than what he had encounter in Veracruz, Mexico some weeks earlier. Sanitation vessels stopped all incoming ships before they entered the harbor and sent surgeons aboard to conduct thorough inspections of all passengers. If they discovered any hints of disease, all passengers would be ordered to disembark into smaller boats and then sent directly to the city’s hospitals and quintas. Then, a team of sanitary workers would “wash the ships hold with fresh water,” pump out the contaminated water, and repeat that process until there were no more traces of “purification.” The surgeon’s report and Hester’s use of it reveals the lingering influence of Spanish colonial biopolitics in New Orleans – especially the importance of having procedures for managing white populations – and it shows a positive view of Havana’s hospitals and the physicians who were running them.

Similar sentiments about Havana’s hospitals and physicians, as well as the University of Havana’s program of medical education, can be seen in the careers of two New Orleans physicians who spent time in Havana during the antebellum period: the French-speaking Michel Halphen and the English-speaking Edward Hall Barton. Together they represented the two most powerful medical factions in nineteenth century New Orleans, the white “Creole” Francophone physicians and the white Anglophone physicians. These groups


disagreed regularly and vociferously on numerous matters ranging from the etiology of yellow fever to the constitutive factors of professional reputation, and the fact that they were often competing for the same wealthy enslaver clients certainly played into this division.162 But if Halphen and Barton are any indication, both groups seemed to agree that medicine in Havana was comparable to medicine in New Orleans. Both men gained entrance to the Havana medical elite, and their trajectories after visiting Cuba suggest that they believed public health infrastructure and medical education in Havana might be transferable to New Orleans.

Halphen was born in France and moved to New Orleans in the early 1810s where he became a member of La Société Médicale de la Nouvelle-Orléans, though he had yet to earn a medical degree. He visited Havana in early 1820s and in 1824 he became a member of the Economic Society, which may indicate that he shared the views of Cuban planters and Havana physicians who saw the economic value of certain kinds of medical education and expertise. Halphen’s personal papers show that he maintained correspondence with high level state officials in Havana after returning to New Orleans in 1825.163 Halphen entered the Paris Clinical School shortly in the early 1830s, while cholera was ranging in both New Orleans and Havana. In 1833, he published his thesis on cholera in New Orleans with the Parisian publishing firm owned by Jean-Baptiste Bailliere, who was one of the most important publishers of French medical and scientific books at the time. Halphen’s dissertation bemoaned the poor sanitation standards in New Orleans hospitals and the fact


163 Biographic details, Halphen’s certificate of membership with the Economic Society, and his letters can be found in Dr. Michel Halphen Société Medicale de la Nouvelle-Orléans papers, MSS 690, HNOC.
that patients were not segregated by race, both of which he saw as contributing to the high mortality rates both in the hospitals and in the city in general. Halphen also linked morbidity and mortality during the epidemic to a degradation of standards at New Orleans hospitals, including staffing standards. During the final years of Spanish rule in New Orleans, most of the important hospitals had clear racialized hierarchies of medical authority where white male physicians were ultimately responsible for patient care. This was obviously even more true in early nineteenth century Havana where the Spanish state still regulated medicine and public health and the rise of clinical medical education meant there were even more physicians or soon-to-be-physicians patrolling the wards. By contrast, some hospitals in New Orleans were operating without “respectable” physicians, or even surgeons, and enslaved people were the “sole guardians” of patients.164 Halphen’s exposure to Parisian clinical medicine undoubtedly shaped his ideas on this, but his critiques and recommendations for how a hospital should be organized and how medical authority should operate were specific to an enslaving city, where racialized population control and the subordination of practitioners of African descent by “respectable” physicians were paramount to improving public health.

Born in Virginia, Edward Hall Barton received his first medical degree from the Medical Department of the University of Pennsylvania before resettling in New Orleans in the mid-1830s. After helping to establish the Medical College of Louisiana in 1835, Barton traveled to Havana in the early 1840s and stayed long enough to earn a second medical degree from the University of Havana. An article in The Boston Medical and Surgical Journal

places him in Havana in 1843, noting that “those from the States who might find it necessary to consult a physician, whilst sojourning in Cuba, could not have a better adviser.” Barton returned to New Orleans in the mid-1840s, and after briefly serving as a military surgeon during the U.S.-Mexican War (1846-8), he became one of the most prolific medical academics in New Orleans, publishing in the *New Orleans Medical and Surgical Journal* and Erasmus Fenner’s short-lived but highly influential publication, *Southern Medical Reports* (1849-1850). Although it was not unusual for early nineteenth century physicians to acquire more than one medical degree, there are noticeable similarities between Barton’s home institution the Medical College of Louisiana and the University of Havana which suggest that Barton’s decision to take a second degree at the latter was based on his perception that such an education would be applicable to New Orleans, where white male physicians were busy building a medical establishment that reflected the political economy of plantation slavery.

The Medical College of Louisiana resembled the University of Havana from its inception, well before Barton went to Havana, but developments in medical education during the late 1840s, after he had returned, show even more similarities and connections. In their initial “prospectus,” the founders of the Medical College explained that New Orleans was the perfect location for a medical school because of the city’s hospitals, the “largest in the Southern and Western States” and “always filled with patients,” would be open to

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students and faculty “for the purpose of instruction.” The founders positioned hospital access as a distinctive and essential feature of their curriculum, ensuring that “practical medicine and surgery can be taught at the bedside of the patient -- the only proper place for their study.” Furthermore, in New Orleans, “the study of anatomy can be prosecuted with more advantage, and at a cheaper rate here than in any other city in the U.S.” The use of Charity Hospital, which primarily treated enslaved and poor people, factored into the perception of “advantage” and “affordability.” Like clinical medical education at the University of Havana and its teaching hospital San Ambrosio, a medical education at the Medical College of Louisiana and Charity was grounded in first-hand observation and anatomical experience with large populations of enslaved people.167 In 1847, after Barton had returned from Havana, he and the faculty of the Medical College were able convince the Louisiana state legislature to pass a law that granted the college “free access” to Charity Hospital for the “purpose of affording their students practical illustrations of the subjects they teach.” State-sanctioned “free access,” “convenient and numerous opportunities at the bedside of the sick,” and “abundant material for the study of normal and morbid anatomy” was an important advancement in the eyes of college faculty, who stood to gain reputation and more revenues from paying students who specifically wanted anatomical and clinical experience with enslaved patients. Indeed, “for the study of disease of the Southwest, and also of the negro race,” there was apparently “no field comparable to that furnished by the Charity Hospital of New Orleans.”168 Charity, like San Ambrosio, was being reframed as a

167 The First Circular or Prospectus of the Medical College of Louisiana (September 23, 1834), University Archives, Howard-Tilton Memorial Library, Tulane University; Stephen C. Kenny has shown how the practice of medicine on enslaved people at Charity Hospital and Touro Infirmary of New Orleans benefitted the enslaved economy. See “‘A Dictate of Both Interest and Mercy’?”

168 The text of the law is quoted in the historical summary of the school’s alumni catalogue, which also describes the significance of Charity hospital instruction and for the “diseases affecting the negro race”
clinical medical education environment. Furthermore, it was being remade as the ultimate setting for the production of medical experts who had extensive knowledge of and experience with the “negro race” who formed the base of the massive plantation slavery economy in Louisiana.

Indeed, by the 1830s, Louisiana was the largest exporter of cotton in the world with enslaved people making up half of its total population, and New Orleans had become a beacon for young physicians who were looking to establish high-paying medical practices treating enslaved people. In 1833, one New Orleans doctor named L.H. Peters wrote to his physician friend in Philadelphia in an attempt to convince him to move to New Orleans. “You could coin money here,” Peters gloated, noting that “rents will be very cheap” and reminding his friend that “the more sickly a country the better cause for physicians.”169 What remains unsaid in this letter is that the ability to “coin money” was due to the high rates of yellow fever amongst visitors and the recent appearance of cholera, but also the many enslavers who were ready and willing to pay for the treatment of their valuable enslaved property. Cuba too was a beacon for physicians who wanted to profit from slavery. But Cuba also had another medical educational institution that bridged the city and the plantation countryside, bringing white male physicians to the bedsides of patients who were not in the hospital, but in the plantation infirmary.

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169 L.H. Peters Letter (March 22, 1833), Mss. 222, Louisiana and Lower Mississippi Valley Collections, Louisiana State Archives, Louisiana State University, Baton Rouge (hereafter cited as LLMVC, LSU).

specifically. See Catalogue of the Alumni from 1834 to 1901, Inclusive, of the Medical Department of the Tulane University of Louisiana (New Orleans: L. Graham & Sons, 1901).
The Plantation Medical Tour

Judging by the involvement of the Economic Society alone, it is clear that plantation loomed over medical education and the criollo medical profession in Havana, but the plantation medical “gira” or “tour” made this connection even more explicit. Beginning in the 1810s and lasting throughout the nineteenth century – even after the abolition of slavery in 1886 – the plantation tour became an important feature of medical education in Cuba. The jurisdiction of Matanzas was the most common destination for the tour because it was the most important sugar producing region on the island and easily accessible from Havana, especially after the opening of the first railroad in Cuba in 1837. Physicians and medical students embarked on the tour because they saw the plantation as another controlled environment for medical training and knowledge production that came with an ample supply of patients deemed socially acceptable for experimentation, intervention, and dissection. Unlike medical education at the University of Havana, where the physician-in-training was part of a cohort, the plantation medical tour was usually a solitary experience which involved months of travel throughout the rural provinces of Cuba. Established physicians could undertake the tour, too. In all cases, the main goals were to encounter as many different cases as was possible and to learn about local therapies in each area. The tour was thus a vital intellectual and professional loop between the city and the countryside which helped elite physicians to further establish themselves as the most authoritative medical knowers, not just in Havana but also across the entire island. Most importantly for plantation managers, the
existence of the tour meant that they would have consistent access to trained physicians who could maintain the productivity of enslaved laborers.170

The plantation tour drew physicians to study on the island, and many accounts of plantation medical tours were written by foreign physicians. Wudermann’s *Notes on Cuba* includes a section describing his time in the plantation countryside and the French émigré physician Honorato Bernard de Chateausalins discussed it in his *Medical Handbook of Cuban Landowners* (1831). Both accounts provide the most detailed descriptions of the methodical management of enslaved health on Cuban plantations and demonstrate how physicians came to believe that plantation experience was immensely valuable for medical education.

By the 1830s, Cuban sugar planters were succeeding in their quest to implement the time discipline and careful, quantitative management of enslaved health which they had aspired to in the late eighteenth century. The scope of these changes was evident in Captain General of Cuba Joaquín Jovellar y Soler’s island-wide survey of plantation social and economic conditions. Conducted in 1842, the survey document asked planters to respond a series of questions regarding the overall state of their plantation operations and how they managed their enslaved laborers, including the health and medical care they provided. A committee of state officials and licensed physicians, all based in Havana, designed the survey questions and reviewed the answers. There was frequent use of terms like “efficiency;” references to the importance of plantation “systems” of management and production; and as overarching interest in “preserving” or “conserving” both work time and enslaved health. The stated reason for the survey was the colonial state’s desire to identify planters who were

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170 Steven Palmer has discussed the emergence of the plantation tour and how it created an intellectual loop between “the plantation and the academy,” but he does not attend to how tour-going students and physicians interpreted managerial ideas of enslaved health. See Palmer, “From Plantation to Academy,” 53-4.
particularly neglectful or brutal in their treatment of slaves. The early 1840s were a period of intense state scrutiny of the plantation countryside following a series of enslaved uprisings that triggered memories of Aponte’s Rebellion, and the colonial state supposedly wanted to curb any practices that might foment unrest.171 And yet, the survey committee divulged their understanding of managerial priorities – especially the need to increase productivity above all else – in their focus on the “hygienic systems” planters had in place for enslaved people.172

The questionnaire itself illustrates the material changes that had taken place on Cuban plantations in an attempt to conserve work time. Questions presumed the existence of established managerial hierarchies, various technical experts, and the time-sensitive nature of enslaved health. First, planters were asked to report on the number of slaves they owned on each of their plantations and “the number of estate administrators, overseers, and sugar manufacturers” as well as “rancheros” (small tenant farmers) and “doctors” on each plantation. Question #2 asked planters what kinds of meat they provided for enslaved workers during “that time of the year when it is convenient to suspend the use of dry corn that produces the common dysentery.” Question #3 inquired about slave clothing: “how many changes of clothing [they should be given] each year and at what times they should be supplied?” Question #4 asked planters to specify how many hours enslaved people should spend working, resting, or eating, “keeping in mind the seasons and the various tasks that are available at different times, either for planting or harvesting.” Question #5 asked planters to describe “the most appropriate nursing system” for enslaved children and their “rules

171 For more on enslaved uprisings and state repression in the 1840s see Barcia, Seeds of Insurrection; and Finch, Rethinking Slave Rebellion in Cuba.

172 Circular a los dueños de ingenios y cafetales (February 23, 1842). Expediente instruido de orden superior para reformar el sistema higiénico, moral y alimentos de los siervos que se emplean en la agricultura. 941/33186, GSC, ANC.
governing the plantation infirmary,” including the “dimensions of the infirmary, its interior
distribution, the average number of patients, the existence of a pharmacy” and the typical
“services done by the doctor and nurse.” In this question, it was explicitly “understood” that
plantation infirmaries had “security measures so that they [patients] do not have external
communication” with people on the outside, “both to avoid the spread of cutaneous
diseases and so that the desire to be in this area disappears without just cause in nursing.”
Two things were taken as given in this question. First was the idea that enslaved patients
might claim illness or injury to get into the plantation infirmary and they might linger there
to temporarily escape work, thus surreptitiously stealing the planter’s work time. Second, the
question indicates that planters designed infirmaries to be hostile, prison-like environments
in an attempt to deter enslaved patients from going there in the first place, especially if they
were not doing the “just” work of reproducing themselves through birthing and nursing.173

Like the Havana-based physicians who designed this survey, physicians on their
plantation tours endorsed carceral treatment of enslaved patients and other methods of
calculating enslaved health. In their minds, such measures of control and discipline provided
the best conditions for medical knowledge production and, ultimately, the best health
outcomes for enslaved people. French physician Honorato Bernard de Chateausalins’ Medical
Handbook of Cuban Landowners captures this perception of plantation management.
Chateausalins was a graduate of the Paris School and originally came to Cuba as a young
man in the late 1810s with the intent to conduct a brief plantation medical “tournée,” but he
ended up staying on the island for decades. Between the 1820s and 1854, he held several
permeant positions on large sugar plantations in Matanzas, became a member of the

173 Ibid.
Economic Society of Havana, and eventually served as a professor of medicine and surgery at the University of Havana. In his handbook, Chateausalins presented himself as an expert on the management of enslaved health and a believer in the utility of a “collective body of healing knowledge” produced through hands-on experience, much like Tomás Romay, whom he almost certainly crossed paths with through his involvement with both the Economic Society and the University of Havana. Chateausalins intended the book to be a “practical guide for curing the majority of diseases” that could be handed to a physician undertaking their tour or to a member of the plantation management staff.174

In this sense, the text is somewhat similar to Dr. David Collin’s 1803 report on “management and medical treatment of negro slaves” in Jamaica, which also pays close attention to planters’ methods of labor “discipline.” Collins described the typical Jamaican plantation “hospital” or “sick-house” in great detail, but he insisted that there was a severe lack of “oversight” of patients. As he saw it, “the business of the sick is committed to the joint labors of the attendant physician and the sick nurse, the former of whom makes an ordinary visit once or twice a week, at the most” when he [the physician] “pops into the hospital” to take pulses or check stools for signs of flux. This “superficial” medical treatment and the fact that the infirmaries were often located far from all other plantation buildings meant that “the negroes are overlooked and forgotten” and “if they recover” one could be “assured that it is nature that has carried them through the disorder.”175

174 Honorato Bernard de Chateausalins, El Vademecum de los Hacendados Cubanos, ó Guia Practica para Curar la Mayor Parte de las Enfermedades (orig. pub. 1831; later edition: La Habana: Depósito de Libros, 1854). Rare Books, Medical Historical Library, Yale Medical School. For bibliographical information and quotes see preface and introduction, IV-XI. NB: All page numbers hereafter correspond to 1854 edition.

175 [David] Collins, Practical Rules for the Management and Medical Treatment of Negro Slaves in the Sugar Colonies (London: Vernor and Hood, 1803), for description of the “hospital” or “sick-house” see 252-66 and for quotes see 254.
planters may have developed managerial practices for enslaved health that were similar to those in Cuba, including the preference for physicians who had anatomical and clinical medical knowledge and professed to understand its value in plantation efficiency. Many physicians in early nineteenth century Jamaica did make their living working for slave owners, especially after closure of the Atlantic slave trade in 1807, which made Jamaican planters more desperate to maintain the health of their existing slaves who they were allowed to keep until abolition on the island in 1834. Physicians in Jamaica were surely similar to those in Cuba in terms of their desires to gain institutional power and further differentiate themselves from other healers. However, there was likely less planter capital for medical education, medicine, and science. Jamaican slavery was largely in the decline by the 1810s, with many wealthy planters and various financial agents of slavery relocating to Cuba, elsewhere in the Caribbean, or the U.S. South. Furthermore, there was no centralized state control over hospitals, medical education, and the medical marketplace in Jamaica, or state enforcement of physician’s power. Given this, it seems unlikely that there was the same level of capital investment in medicine and entanglement between plantation management and the medical profession, at the time of Collins’ writing or in the decades that followed.176

In contrast to Collins’ observations in Jamaica, Chateausalins saw that enslaved housing and the infirmaries on Cuban plantations were proper built environments for preserving enslaved health and conducting medical observation. Throughout the eighteenth century, planters in Cuba and elsewhere in the slave-holding Caribbean had employed slave

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176 For more on the impact of amelioration and abolition on the relationship between physicians and slavery in Jamaica see Turner, *Contested Bodies*; Sheridan, *Doctors and Slaves*; for the decline of the slavery-based economy in Jamaica after the abolition of the Atlantic slave trade see B. W. Higman, *Slave Population and Economy in Jamaica, 1807-1834* (Kingston, Jamaica: University of the West Indies, 1995); and for planters relocating to continue enslaving, often in the U.S. South see Rosenthal, *Accounting for Slavery.*
housing arrangements known as “conucos” or “provision grounds,” which generally involved providing enslaved families with a small “bohio” (cabin) and an adjacent garden plot. At the turn of the nineteenth century, many planters began to eliminate provision grounds as they endeavored to maximize all available lands for commodity production, and in Cuba, planters replaced conucos with austere barracks. The structures could be locked at night and one guard could keep watch over the entire workforce. The guard might be an enslaved person, usually someone who was sick or older who could become productive again through this deputizing process. Barracks ensured that all enslaved people were in the same place each morning and overseers did not have to waste time rounding people up before disbursing them to their various tasks. But the change was devastating for enslaved people who were not only forced into more confined and uncomfortable living conditions, but also lost access to the small gardens where they had grown food as well as medicinal herbs. Enslaved people would often sell their surplus produce too, and some were able to save this income and purchase their freedom. The widespread use of barracks largely foreclosed that possibility.

Cuban planters had made similar changes to their plantation infirmaries, as Chateausalins commented on the fact that both structures secured the “preservation” of enslaved health because they could be “kept locked at night under the care of the administrator or overseer” with each room fitted with a lock. Individual rooms only required

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one small window, which should be fitted with iron bars, so that “the slave cannot communicate with the others.” Chateausalins believed that this practice of solitary confinement would prevent the spread of disease while also offering better protection from the elements. Crucially, barracks curtailed enslaved peoples’ activities outside of work, where they were particularly at risk for disease, injury, and “corrupting influences to their health.” Chateausalins emphasized “how harmful it is to the health of the slave if he is able to leave at night,” as enslaved people might visit romantic partners on other plantations, steal from plantation storehouses, or visit a tavern.178 On several occasions, planters in Matanzas wrote to the governor of the Matanzas asking him to do something to stop tavern owners from serving enslaved people. By “selling slaves brandy at all hours of the night” and thus making said slaves “hopeless for work the next morning,” tavern owners were threatening slave health, and thus, their productivity.179

For Chateausalins, off-plantation activities could also potentially impact the viability of medical knowledge produced on the plantation. If enslaved people were allowed to leave the plantation at night, or on the weekends, Chateausalins believed they would “get drunk and throw themselves on the damp ground with all perspiration open, and usually, come the next day or two after, there will be patients with symptoms of spasms, pneumonia, and other illnesses.” When enslaved people were allowed some measure of mobility on the weekends, “Monday is always the day of many patients” in the infirmary. Fortunately for planters, barracks could be used to “avoid this great inconvenience” of losing a work day, and for

178 Chateausalins, 35-6.

179 Comunicaciones denunciando que los taberneros (July 14-31, 1827). Legajo 23, Nu. 12, Fondo Esclavos, AHPM; for another complaint about tavern owners serving enslaved people alcohol see comunicación al Gobernador de Matanzas quejándose de que en las tabernas les vendan licores y les compren frutos a los esclavos (June 18, 1826). Legajo 23, Nu. 10, Fondo Esclavos, AHPM.
physicians, barracks helped to ensure that the clinical material of enslaved bodies had not been tampered with in ways that might influence the production of medical knowledge. Chateausalins did mention that nocturnal and weekend activities off the plantation might include meeting up with other enslaved people to make plans for rebellion, which makes sense given the general climate of fear surrounding enslaved revolt, but it is clear that protecting enslaved health, work time, and thus the overall pace of production was of primary concern here. He was demonstrating his knowledge of enslaved health as well as the notion that planter surveillance enabled a useful level of control over it, but he was also showing that he understood planter priorities when it came to enslaved health.

John G. Wudermann expressed similar views even as he described the intensity of work on sugar plantations and the sugar planter’s quest for profit, which was paramount and insatiable, “regardless if it be attained at the expense of the welfare of his laborers.” Though he acknowledged that the relentless pace of sugar work was hard on slaves, “tasking them to the upmost,” he believed that the organization, efficiency, and “perfect machinery” of this modern “creole enterprise” had actually improved enslaved health overall. Wudermann conducted most of his plantation tour in Matanzas, where he stayed in large country homes of planters, physicians, and lawyers, some Cuban and others American. He remarked that the Economic Society of Havana had established a branch or “adjunct society” in Matanzas in 1827 and by the time of his writing had “nearly one hundred resident members” who had been “highly instrumental” in advancing the plantation economy in the area. Wudermann

180 Chateausalins, 37.

181 Wudermann, Notes on Cuba, 149-50.

182 Ibid, 111.
visited one sugar plantation near the town of Limonar where management practices appeared to be sustaining both enslaved health and productivity. With steam engines to crush sugar cane; an assembly line of boilers; and a hierarchical workforce that included a plantation administrator, overseers, “engineers,” “sugar masters,” and physicians, who provided “medical attendance” to 100-200 enslaved people, this plantation only allowed enslaved people “but five hours of sleep” and required “inordinate tasking of their physical powers,” but nonetheless helped to “preserve their good looks.” Wudermann spoke to one “intelligent English physician” who worked at the Limonar plantation. The physician explained that before the introduction of managerial and technological improvements, the average death rate was a “fully ten per cent,” but now it “does not exceed two and a half per cent, even including the old.”183 Wudermann went on to say that especially grueling qualities of the labor “exact[ed] from the slaves” on the Limonar plantation was not consistent across the board, and on other plantations, “so well regulated are the tasks that they [enslaved people] do not work more than the English peasant.” The difference in enslaved health had to do with management. Wudermann explained that more “cruelty is exercised” on plantations where owners had left daily operations to a lacking plantation administrator, who, being “expected to make as many boxes of sugar as his predecessor, and if possible a few more,” was more focused on the number of boxes than the number of sick or injured enslaved people in the infirmary.184 A good plantation administrator needed to monitor and manage enslaved people’s sick time in addition to commodity production.

183 Ibid, 152-3.

Wudermann’s descriptions of sugar plantation management, and his runs-in with physician colleagues in the countryside, shows how physicians had become fixtures of the plantation economy in Cuba. The plantation medical tour fueled the creation of more criollo-dominated, planter-subsidized medical and scientific institutions in the decades that followed Wudermann’s visit to Cuba. In 1861, medical faculty at the University of Havana succeeded in convincing the Spanish Crown to create la Real Academia de Ciencias Médicas, Físicas y Naturales de La Habana (Royal Academy of Medical, Physical and Natural Sciences of Havana). Although founders insisted that they were “not only concerned with making sugar and harvesting tobacco, but also the cultivation of science” unrelated to commerce and industry, the plantation economy influenced the institution at every level.185 Upon returning from their plantations medical tours, physicians would often speak at the Academy on the knowledge they had acquired and any interesting specimens they had collected, which included enslaved flesh.

Havana-born physician Nicolás Gutiérrez Hernández, one of the founders of the Royal Academy and founder of Cuba’s first medical journal, *Repertorio Médico Habanero* (f. 1840), regularly solicited physician reports and medical objects extracted from the countryside. After completing his medical degree at the University of Havana in 1827, he went on to serve as “Anatomical Director” at San Ambrosio thanks in part to a recommendation from the planter and by then formidable politician Francisco Arango. Between 1836 and 1837, Gutiérrez studied at the Paris Clinical School and worked with the eminent surgeon Alfred-Armand Velpeau. Upon his return, he became Chief Surgeon of San Ambrosio. By 1849, Gutiérrez had conducted plantation medical tours himself and had

185 For the history of the Royal Academy see Pedro M. Pruna Goodgall, *La Real Academia de Ciencias*. 
amassed a large collection of anatomical specimens, which he kept in a cabinet at the hospital. According to one inventory taken in 1849, Gutiérrez’s cabinet included “three human hands with the muscles of the palm and fingers anatomically prepared to understand their mechanism in movement...A human heart divided in two to know the disposition of the atrial and ventricular headings and to understand the mechanism of the circulation of blood in during vigorous activity” and finally “a body of a man of natural stature, with the skin removed and the cellular tissue intact, representing all of the superficial muscles of the body.” The inventory does not specify who these medical specimens came from, but it can be assumed, from their geographic origins and the fact that enslaved people were very often used in anatomical medical education, that at least some of these specimens came from enslaved people. Moreover, the specific attention to bodily “mechanisms” and circulation during “vigorous activity” echoes the particular medical interests of planters who wanted anatomical medical experts who could repair the enslaved body and preserve its ability to continue such activity.186

It is clear the rise of the criollo medical establishment did not go unchallenged. Archival documents pertaining to the 1850 cholera epidemic in Havana show enslaved and free people of African descent resisting medical control and exploitation. One free person of color, José Jesús Machado of the neighborhood of San Antonio, fought back when public health officials tried to take him to a hospital. Perhaps he had heard about the white

186 For Francis Arango’s recommendation and the anatomical cabinet inventory see Gutiérrez’s hospital employment record, “Hojas de servicios de los empleados en el Hospital Militar San Ambrosio de la Habana” (1849). Hojas de servicios de empleados de Real Hacienda de Cuba, Legajo 287, No. 6, Ultramar, AGI; for other biographical details see García G. Delgado, Nicolás José Gutiérrez: Preceptor y Fundador Científico en Cuba (Academia de Ciencias de Cuba, 1978).
physicians who were testing drugs on hospitals patients and opening up the bodies of the dead. According to the official account of the incident, two physicians, Roman Martínez and Manuel Estevan de Arrondo, suspected that Machado was showing signs of cholera. When they went to his home to examine him, Machado “violently attacked” the physicians. Machado was subsequently arrested and thrown in a prison cell. There is no description of what happened to Machado while he was in that cell, but the report notes that he died a day later and his death was not explicitly attributed to cholera. Rather, the physicians explained that he died due to “advanced age” as well as “changes in the air, food, and water.”

During the same cholera epidemic, some free people of African descent attempted to make contact with patients in hospitals and some slaves of the King refused to do the work of burying cholera victims. In the neighborhood of Horcón, a few residents were caught attempting to make contact with suspected cholera patients in the hospital. This was a major problem for hospital physicians and administrators who were attempting to contain the disease. They increased security guards, “banned all strangers” from entering the hospital, and instructed neighborhood-level civil officials to inform residents that they would be arrested if they tried to enter the hospital. Meanwhile, physicians were having trouble forcing slaves of the King to build the mass sepultras (graves) for cholera victims Dr. Domingo García Velasquez was overseeing burials in the cemetery at Castillo de Atarés, a military fortification near the Havana harbor, making sure that enslaved people properly

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187 Informes de Licendados Drs. Dn. Roman Martínez y Dn. Manuel Estevan de Arrondo (April 23, 1850) y Dr. Gaspar Zeferino, Junta de Sanidad de San Antonio Inspector (April 24, 1850). Expediente participando la Junta de Sanidad de San Antonio, haber reconocido el cadáver del moreno José de Jesús Machado, a quién se suponía atacado del cólera y no haber encontrado síntoma en su cadáver de dicho mal. 1539/80110, GSC, ANC.

188 Expediente en que el Inspector del barrio del Horcón, participa haber recibido la comunicación que trata de que no se permita la entrada en los hospitales a personas extrañas y con este motivo hace presente lo conveniente que sería adoptar las medidas de policía que al efecto propone (1850). 1538/80067, GSC, ANC.
“salted” the corpses before interring them. On April 21, 1850, Velasquez reported that he needed “more slaves to replenish the sepultureros (gravediggers)” who had fled the cemetery the night before. Velasquez explained that the enslaved people “despised” the work of gravedigging and “they are refusing to do it.”

Enslaved and free Black people in New Orleans also knew what was happening in hospitals. There were rumors of “Needle Men” at Charity Hospital who administered drugs to keep Black patients in a sedated or unconscious state and “Black Bottle Men” who killed Black patients to collect more cadavers for dissections. This targeting of Black bodies for medical experimentation and education was a widespread practice in the nineteenth century United States.

One enslaved person who went into a New Orleans teaching hospital and lived to tell his story was Solomon Northup, author of the best-selling enslavement narrative *Twelve Years a Slave* (1853). Northup had been a professional violinist in Hebron, New York when, in 1841, at the age of thirty-two, he was drugged, kidnapped, and sold into slavery while in Washington, D.C. He was then shipped to New Orleans where he was held by a slave trader named Theophilius Freeman. Before Freeman could sell them, Northrup and three other enslaved people – “Eliza, Emmy, and Harry” – fell ill with smallpox. Freeman called for the “head physician of the hospital, Dr. Carr,” who recommended that the sick enslaved people

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189 Informe de Domingo García Velasquez, Inspector de Atarés (April 21, 1850). Expediente sobre las medidas adoptadas a consecuencia de la epidémia Cólera Morbo. 1540/80119, GSC, ANC.

190 “Needle Men” and “Black Bottle Men” are discussed in several Louisiana Writer’s Project interviews with former enslaved people. See Lyle Saxon, Edward Dreyer, and Robert Tallant, eds., *Gumbo Ya-ya: A Collection of Louisiana Folk Tales* (Boston, MA: Houghton Mifflin Co., 1945), 75-8; and for more on the experiences of enslaved people in New Orleans hospitals see Kenny, ““A Dictate of Both Interest and Mercy”?”

be brought to Charity Hospital. Northrup, Eliza, Emmy, and Harry were “put into a hack and driven to the hospital,” which was “a large white marble building, standing on the outskirts of the city.” Northrup described how the wards of Charity Hospital were segregated by race and gender, with the upper floors reserved for black people. He also described the routine that followed patient deaths. When a patient died “the bell tolled—a signal to the undertaker to come and bear away the body to the potter’s field. Many times, each day and night, the tolling bell sent forth its melancholy voice, announcing another death.” Northrup also noted that coffins were made on site, in the back of the building, to facilitate the swift removal of the dead who were not destined for the dissection table.192

Northrup claimed that his time in Charity Hospital worsened his condition. He was in the hospital for “two weeks and two days,” and for three days, he “was entirely blind.” As Northrup suffered, the head physician of Charity Hospital, Dr. Carr, visited his bedside, but apparently Carr did not tell Northrup anything about his condition or whether or not he was likely to survive. This neglect left Northrup with profound feelings of terror and alienation:

I expected to die...though there was little in the prospect before me worth living for, the near approach of death appalled me. I thought I could have been resigned to yield up my life in the bosom of my family, but to expire in the midst of strangers, under such circumstances, was a bitter reflection.

Dr. Carr felt no obligation to tell Northrup what was happening to him, but he did provide Theophilius Freeman with updates. Northrup recalled overhearing a conversation between Carr and a slave named Bob, whom Freeman sent to the hospital “to inquire how we were

192 Solomon Northrup, *Twelve Years a Slave: Narrative of Solomon Northup, a Citizen of New-York, Kidnapped in Washington City in 1841, and Rescued in 1853* (London: Sampson Low & Co., 1853), 82-4; see also Black director Steve McQueen’s film adaptation of Northrup’s narrative: *12 Years a Slave* (Searchlight Pictures, 2013). Run time: 2 hours, 14 minutes.
getting on.”¹⁹³ Most likely, Freeman simply wanted to know how long Northrup, Eliza, Emmy, and Harry would need to be in the hospital. Perhaps he had agreed to send his slaves to Charity in the first place because he believed that the physicians working there were the most effective and expedient healers.

Northrup’s account provides one example of enslaved people’s experiences of medical violence and exploitation in teaching hospitals. Lingering in the background of his narrative is the link between enslaved health, time, and profit, which, by the 1840s, could also be found on the sugar and cotton plantations of Louisiana. To be sure, there were differences in sugar and cotton management, particularly in terms of work regimens, technologies, the number of enslaved laborers, and the size of the managerial staff. But in both cases, managers were attempting to control enslaved health through time discipline while seeing clinical and anatomically trained physicians as the consultants they needed to maintain productivity. Some enslaved people on plantations did overtly resist these developments, just as some resisted urban medical institutions, but others chose more covert forms of finding bodily protection. Enslaved people’s health practices on plantations became more complex and subversive in response to increasingly carceral treatment and timing of health.

¹⁹³ Northrup, 82-4.
Chapter Three: Fugitive Therapeutics on the Plantation, 1840-1860

It was half past nine on the evening of Sunday, November 5, 1843 when an enslaved woman named Catalina Gangá got out of bed for a drink of water. She had retired to her cabin a few hours earlier after working all day in the infirmary on Ácana plantation in Matanzas, Cuba. On that night, Catalina heard a commotion in the distance. From the window of her cabin, she saw a group of enslaved men and women marching towards her from the direction of the neighboring plantation, Triunvirato. Armed with machetes and sharpened sticks, the Triunvirato slaves moved quickly through Ácana’s slave cabins, knocking on doors and demanding that the occupants get up and join their revolt.194 Earlier that night at Triunvirato, a large group of enslaved men and women had attacked their white overseer and stormed the manor house. Triunvirato administrator Domingo Madan tried to “contain” the insurrection and “find a way to pacify the blacks,” but was forced to flee when it became clear that he and his subordinates were seriously outnumbered.195 As Madan fled, more enslaved people joined the rebel group and began burning buildings and piles of discarded sugar cane. After setting the Triunvirato manor house ablaze, the rebels moved on to Ácana.196 Some of the enslaved at Ácana joined the rebellion, but others refused, instead deciding to stay put in their cabins, hide in the cane fields, or flee into the woods.197

According to witnesses, brutal working conditions and cruel overseers were the existential

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194 Statement of Catalina Gangá, f. 107-109v, Contra los autores y cómplices del levantamiento de negros esclavos ocurrido en 5 de noviembre último por parte de las dotaciones de los Ingenios Triunvirato y Ácana en la jurisdicción de Matanzas (1843). Fondo Comisión Militar Ejecutiva y Permanente (hereafter cited as CMEP), legajo no. 30/no. de orden 3, ANC.

195 See statements of Manuel Gangá, f. 19–17v/23–21, ibid; and Narciso Lucumí, f. 43–45, ibid.

196 Statement of Camila Criolla, f. 105v, ibid.

reasons for rebellion, but the decision to revolt on Sunday, November 5 came after Madan forced the enslaved people of Triunvirato to work that day. Sundays were supposed to be days of worship and rest for enslaved people, but Madan wanted to make up work time that had been lost earlier in the week. With their meager rest time stolen from them, the enslaved people of Triunvirato decided that it was time to fight back.198

Catalina Gangá was one of the enslaved people who later provided testimony for the Spanish colonial military’s investigation of this uprising, which was one of several slave rebellions in Cuban countryside between 1841-3 that collectively became known as la Conspiración de la Escalera (Conspiracy of the Ladder). Throughout 1844, also known as el Año del Cuero (the Year of the Lash), the colonial state interrogated, imprisoned, executed, or exiled hundreds of enslaved and free Black people for their alleged participation in the rebellions.199 Records of the military tribunal do not specify whether or not state officials tortured Catalina, but it is possible that she was subjected to pain and coercion before she gave her version of the events. Catalina claimed that she refused to take part in the rebellion and instead “went immediately to give word to her masters,” including her owner, Dr. Francisco de Paula Grima, one of the full-time physicians for the Alfonso family’s properties in the Matanzas, which included Triunvirato and Acaná.200 After notifying Grima, Catalina

198 Numerous eye witness accounts mention working conditions and mistreatment, as well as Madan’s decision to force enslaved people to work on a Sunday, as reasons for the revolt. See CMEP 29/5; 33/1; 33/4; 32/3, ANC; Jane G. Landers has also noted that Triunvirato enslaved people “rose in protest to having to work on a rest day.” See Atlantic Creoles in the Age of Revolutions, 223.

199 Historians of Cuban slavery have debated whether or not and to what extent widespread rebellion conspiracy was invented by colonial officials to justify further repression. Most historians now agree that the conspiracy was, as Aisha Finch argues, “an underground rebel movement” that connected enslaved people in the countryside and free people of African descent in urban areas, triggering a violent overreaction from the colonial state. See Finch, Rethinking Slave Rebellion in Cuba, and for an excellent overview of this historiography see the introduction of Michele Reid-Vazquez, The Year of the Lash: Free People of Color in Cuba and the Nineteenth-Century Atlantic World (University of Georgia, 2011).

200 Statement of Francisco de Paula Grima, f. 76v, CMEP 30/3, ANC.
went to the infirmary and remained there throughout the uprising. The rebels burned the Ácana manor house, too, and then began marching towards the next Alfonso-owned plantation, La Concepción. Catalina insisted that her decision to take shelter meant that she did not see or hear what was happening outside of the infirmary, and she had no knowledge of what happened after the rebels left Ácana.201

If she did know more, Catalina did not betray the rebels. Investigators asked if she “knew any of the blacks who attacked the whites” or if she “knew any of the men who set fire to the manor house and if there was a slave from this farm [Ácana] in that group.” She maintained that she knew none of the slaves who had attacked whites and only admitted to recognizing an Ácana enslaved woman named Fermina among the rebels. Fermina was already dead by the time Catalina gave her testimony, as Cuban authorities had sentenced her to be hanged immediately after they managed to put down the revolt.202 As Aisha K. Finch has argued, Catalina’s answers suggest that she “may have turned to the white masculinist logic of presiding authorities; that is, relying on a self-presentation (one might even say a performance) of docile womanhood” in an attempt to diminish the likelihood of her own participation in the violent uprising. It is also possible that the investigators chose to emphasize the voices of women who condemned the revolt, so as to erase the women like Fermina participated, or those who took the opportunity to escape amidst the chaos.203

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201 Statement of Catalina Gangá, f. 109v, CMEP 30/3, ANC.

202 ibid, f. 108v.

203 Finch offers a rich analysis of the November 1843 uprisings and considers the textual manipulation of enslaved voices in the trial record. See Rethinking Slave Rebellion in Cuba, esp. 99.
However, Catalina may have cooperated with investigators and confirmed what they already knew to deflect attention from her involvement in plantation medicine at Ácana. Although she said she primarily served as “a cook and a washerwoman” for her enslaver Dr. Grima, perhaps she had also assisted him with his medical work. As seen in the story of Margarita Goton discussed in Chapter One, it was not unusual for people enslaved to physicians to be forced into medical labor, and this had not changed despite the rise of physicians professing to be experts in the medical management of enslaved people. Like Goton, Catalina Gangá may have incorporated West African medical practices into her work, too. What had changed between the late eighteenth century and the middle of the nineteenth century was the context within which physicians, planters, and the Spanish colonial state understood West African medicine and the people who practiced it. By the time of Catalina’s testimony, the discrediting of African-descended medical practitioners had reached the point where these practitioners were not just seen as less knowledgeable and legitimate, but also as potential threats to physician, planter, and colonial power. Historians of the La Escalera era have demonstrated that colonial state officials and planters became particularly suspicious Black midwives and healers whose healing techniques they did not fully understand, sometimes accusing these women of using “brujería” or “witchcraft.”

Given this political climate, it makes sense that Catalina might have self-minimized to avoid such accusations and protect her position on plantation.

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204 Reid-Vasquez has uncovered the history of one prominent free black midwife named Maria del Pilar Poveda who was accused of aiding rebels and hiding them in her home. See “Formidable Rebels: Enslaved and Free Women of Color in Cuba’s Conspiracy of La Escalera, 1843-1844,” in Aisha K. Finch and Fannie Rushing ed.s, Breaking the Chains, Forging the Nation: The Afro-Cuban Fight for Freedom and Equality, 1812-1912 (LSU, 2019): 165-72; Finch also notes that the colonial state questioned numerous enslaved people whom they suspected of practicing “witchcraft” in service of the La Escalera rebellions. See Rethinking Slave Rebellion in Cuba, 208-220.
Throughout western Cuba and the lower Mississippi Valley, the rise of managerial ideas of enslaved health and physician expertise had altered the material and social conditions for enslaved medical practices on plantations. Growing distrust, dismissal, and persecution of Black medical practitioners was one factor, but it is also clear that the time disciplining of enslaved health impacted how enslaved people experienced health and illness. With new management practices impacting both enslaved people’s access to medical materials as well as their time to care for themselves, they pursued other modes of health and healing based in fugitivity. Stealing time from managers and physicians, foraging for botanical cures, making amulets, and creating connections with animals helped enslaved people to temporarily escape from or obscure themselves within the plantation system. Moments of reprieve from work, slave-holder violence, and physician authority alleviated pain and suffering while also challenging the explicit demands imposed on enslaved people’s bodies. Such fugitive therapeutics became increasingly important as plantations became ever more regimented, surveilled, and hierarchical, perhaps in large part because planters and physicians often did not understand the healing power they held for enslaved people.

To demonstrate the prevalence of these fugitive medical practices on the sugar and cotton plantations of mid-nineteenth century Cuba and Louisiana, this chapter tells the stories of two enslaved women: Catalina Gangá of Ácana plantation, and Charity, an enslaved woman who worked on Marydale Plantation in Tensas Parish, Louisiana. With a labor force of some 150 slaves, Ácana was in many ways a quintessential Cuban sugar plantation. Likewise, Marydale was a typical, medium-to-large sized Louisiana cotton plantation with a labor force of 44 slaves. Catalina’s testimony allows us to hear her voice (filtered through the colonial archive), but in Charity’s case, the only archival record of her existence is a diary that belonged to her owner, Alexander Blanche. As such, I use narratives
of formerly enslaved people, oral histories, abolition newspapers, plantation records, colonial records, missionary accounts, and medical ethnographies to fill in the archival gaps. This methodology captures the broad spectrum of fugitive therapeutics, while also showing how individual enslaved people – in this instance, a sugar plantation infirmary worker and a cotton field hand – might have used fugitive therapeutics to both survive and contest managerial and physician power.\textsuperscript{205}

**The Materia Medica of Enslaved Flight: Egwes and Amulets**

As planters began systematically monitoring enslaved people’s health, recording their every activity and altering the built environment of the plantation to better surveil them, some of the medical practices that enslaved people had previously used to endure enslavement likely became more difficult, if not impossible. Slave owner suspicions of slave medical practitioners as well as their faith in physicians’ medical expertise likely made the public practice of West African medicine riskier. The building of barracks and the elimination of small enslaved gardens on sugar plantations likely meant that it was more difficult to grow medicinal plants nearby. Even on Louisiana cotton plantations, where enslaved people mostly continued to live in small cabins, many enslavers increasingly devoted all of their arable land to cash crops, which undoubtedly impacted enslaved people’s ability to cultivate their own food and medicine.\textsuperscript{206} Furthermore, managerial surveillance and the growing


\textsuperscript{206} On deforestation in Cuba see Reinaldo Funes, *De Bosque a Sabana: Azúcar, Deforestación y Medio Ambiente en Cuba, 1492-1926* (D.F., Mexico: Siglo XXI, 2004); and for the changing ecology of the expanding plantation economy in nineteenth century Cuba, Louisiana, and Brazil see Dale W. Tomich, Reinaldo Funes Monzote,
tyranny of work time meant that enslaved people likely did not have as much “free” time to prepare and consume medicines. In these conditions, enslaved people’s abilities to forage for medical substances near the plantation and make them out of everyday objects may have become even more important. Taking advantage of centralized medical locations, such as infirmaries; locating and preparing wild healing plants; and making amulets and other objects that could obscure the body from managerial surveillance were all ways that enslaved people could continue to make time for their health amidst the intensification of plantation slavery.

The record of Catalina Gangá’s testimony does not provide many details about her life outside of the events surrounding the uprising, but it does show how the plantation infirmary was a central hub of managerial surveillance, physician power, and of course, sick enslaved people. Catalina likely had extensive contact with other slaves. She was just twenty-five years old when she gave her testimony, but she had already been working for Grima for several years. During that time, she may have seen hundreds, if not thousands, of medical cases come through the infirmary on Ácana plantation, in addition to other enslaved people at neighboring Alfonso plantations whom she may have interacted with when Grima visited them. The concentration of enslaved people in the infirmary, vastly outnumbering the full-time physicians there to manage them, surely made it important place to share information, help one another, and even organize. Catalina’s position may have given her access to medical materials, knowledge, and practices belonging to both physicians and enslaved people. In her study of emancipation in Cuba and Louisiana, Rebecca Scott discusses


Statement of Catalina Gangá, f. 107-109v, CMEP 30/3, ANC; for numbers at Ácana see Finch, Rethinking Slave Rebellion, 83-93.
Barbara Pérez, former slave of Soledad sugar plantation in the jurisdiction of Cienfuegos, Cuba, who learned medicine from the plantation physician, as well as midwifery.\textsuperscript{208} Furthermore, Catalina could have used the infirmary space to provide healing that was more meaningful to enslaved people than what a physician did on behalf of an enslaver.

Catalina may have downplayed all of this during the investigation precisely because her position was a crucial means of subversion, although the subversive goal was not necessarily rebellion, but rather care and comfort. After all, the plantation infirmary was designed for the maintenance of enslaved bodies at best, not their care, and at worst it was a prison and a form of punishment. James Thompson, who was born into slavery in Nassau, Bahamas in 1812 and sold to a planter in Cuba in the 1830s, recalled the punishment he and a house servant named Juana were given when they attempted to “apply for permission to be married,” much to the displeasure of their owner’s son, who was jealous of the union. Both James and Juana were given “250 lashes each” and “a mixture of rum and cayenne pepper was poured upon the wounds” before they were sent to the plantation infirmary and “confined” there for three months.\textsuperscript{209} Yet, Catalina Gangá told investigators that “many slaves gathered at the infirmary” on the night of the revolt. For the enslaved people on Acaná plantation, Catalina may have been someone they could trust, even if the infirmary was also a terrifying space ruled by white doctors.\textsuperscript{210} This would have made her experience similar to vast majority of enslaved people in both Cuba and Louisiana who did not

\textsuperscript{208} Scott, Degrees of Freedom, 266-7.

\textsuperscript{209} See James Thompson’s interview in Anti-Slavery Reporter IV (May 3, 1843): 71-2.

\textsuperscript{210} Statement of Catalina Gangá, f. 107-109v, CMEP 30/3, ANC.
participate in overt rebellion, but did conduct more covert forms of resistance or practices of resilience that still challenged enslaver attempts to dehumanize enslaved people.\textsuperscript{211}

The brutal and hazardous conditions of enslaved labor were of course central motivators in nearly every enslaved rebellion in Cuba and Louisiana and the main reason why plantation infirmaries were never empty.\textsuperscript{212} Common illnesses in the slave-holding Caribbean and the United States South included yellow fever, typhus, dysentery, and tetanus, but many slaves found themselves in an infirmary bed due to work injuries, severe overwork, and sleep deprivation.\textsuperscript{213} Enslaved people were forced to work from “four in the morning till seven in the evening” on sugar plantations for most of the year and during the harvest seasons from “three o’clock in the morning until eleven at night.”\textsuperscript{214} During that stage of sugar production, which typically ran from January to May, they cut down razor-sharp cane and loaded it into carts, often sustaining lacerations on their arms and legs. Meanwhile, at the sugar mill, enslaved people worked the large stone rodillos (rollers), which crushed the sugar cane and extracted the precious juice that was funneled into the boiling house. Many of the slaves who were marked “sin abrazo” (missing one arm) in sugar plantation records had the


\textsuperscript{212} On rebellion and resistance of plantation enslaved people in Cuba during the 1820s and 40s see Finch, \textit{Rethinking Slave Rebellion}; Barcia, \textit{Seeds of Insurrection}; for lower Mississippi Valley slave rebellions such as the German Coast rebellion near New Orleans in 1811 and the conspiracy of a group of enslaved people in Adams County, Mississippi to overthrow and murder their white masters in 1861 see Johnson, \textit{River of Dark Dreams}.

\textsuperscript{213} For common slave diseases see Savitt, \textit{Medicine and Slavery}; Sheridan, \textit{Doctors and Slaves}.

\textsuperscript{214} See for example the interview with William Thomas, who was enslaved to Cuban and American sugar planters near Havana in the 1830, in \textit{Anti-Slavery Reporter} IV (February 8, 1843): 22-3; and the interview with John Homrn who attested to the particularly brutal harvest season hours in \textit{Anti-Slavery Reporter}, Ser. 2, No. 11 (April, 1847): 62-3.
unfortunate job of feeding the cane into the rollers, which were known to catch a hand and pull the person into their crushing vice. Another enslaved person would stand beside the rollers with a machete, ready to cut off the offending arm.\textsuperscript{215} Once the cane juice was in the boiling house, more enslaved people would carry out the meticulous refining process, moving the juice through a line of five to seven boilers until it evaporated entirely, leaving behind a moist, brown semi-granulated product called “mascabado.” The mascabado was then poured into cone-shaped filters, and over the course of several weeks, molasses would drain from the bottom of the filter. After drainage, the filter would be split open to reveal three grades of sugar: white sugar, the most valuable, at the top; yellow sugar in the middle; and brown sugar called “cucurucho” at the bottom. Each grade was separated, packed according to quality, and then shipped out. By the middle of the nineteenth century, some Cuban planters sought to improve this system by introducing new evaporation technologies to accelerate the sugar-making process and accumulate as much of the prime white sugar as possible. In reality, new sugar production technologies were no less labor intensive. In fact, historians of slavery in Cuba have argued that they inspired planters to purchase more enslaved people and work those people even harder.\textsuperscript{216}

Enslaved people in western Cuba clearly understood how new sugar technologies, managerial hierarchies, and plantation time discipline pushed enslaved people to their physical limits to achieve more productivity. John Homrn, who was born in Sierra Leone in 1823 and enslaved in Cuba and Puerto Rico over the course of his life, explained how

\textsuperscript{215} For examples of enslaved people marked “sin abrazo,” see the mortgage documents of the Santa Rosalía sugar plantation in Cienfuegos. Listas que parecen ser de la dotación de algún ingenio, 1867-1871. C. M. Lobo 178, BNJM; Listas de la dotación del ingenio Santa Rosalía, 1879-1887. C.M. Lobo 173, BNJM.

\textsuperscript{216} Sugar labor in mid-nineteenth century Cuba is described in Fraginals, \textit{El Igenio}. Tomo 1; and Rood, \textit{The Reinvention of Atlantic Slavery}, esp. 19-21.
plantation overseers and “drivers” (some of whom may have been enslaved people, too) were “placed over” enslaved laborers to “watch their proceedings, and the slightest cessation [in work] was punished with severity.” Homrn explained that every day of the week “was devoted to labour, and seldom or never was an hour allowed them from it for rest or relaxation.” Life was “one scene of endurance, without any break for rest or improvement.” Moreover, “except in the most extreme cases, illness was not received as a plea for cessation from work.”

As discussed in Chapter Two, Cuban planters believed that barrack housing, like mechanized sugar production technologies and hierarchical divisions of labor, would improve enslaved efficiency and preserve enslaved health. According to accounts of the November 1843 uprising, Ácana plantation still had cabins for enslaved people which were bare and uncomfortable, but may have still had small garden plots behind them where enslaved people could grow food and medicinal plants. Esteban Montejo, in his narrative of plantation enslavement in Cuba, described the significance of enslaved gardens. “It was the small gardens that saved most slaves,” he recalled of his time on a sugar plantation in Matanzas in the 1860s, as “they provided them real nourishment.” However, on many other sugar plantations, barrack housing limited enslaved peoples’ abilities to have their own food sources and medical materials nearby while also extending planter violence into enslaved people’s living spaces.

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217 Homrn, 62.

The architectural terror of barracks can be seen in one Cuban planter’s careful instructions for building them. The anonymous planter wrote that the walls of the square structures should be made with “fifty iron rods, at least eight feet high and one foot across,” and each barrack should be “at least 30 feet from the next.” This would prevent enslaved people from speaking to one another without raising their voices and would certainly prevent them from touching or passing things to one another. The instructions went on to say that “there should be blades, each one at least 7 feet high,” which could be raised at night to block the doorway to the barrack, and “surrounding the barracks there should be more blades, again at least 7 feet high.”

Prison-like conditions were surely intended to stop enslaved people from convening in groups, escaping the plantation, or doing anything else that might inhibit work time, but they were also intended to terrify enslaved people relentlessly. Barracks were part of good managerial practice on sugar plantations because they would in theory facilitate increases in enslaved productivity, but they also existed to remind enslaved people of their inferiority by demonstrating that they could not escape the violence of slavery, even when they were trying to sleep.

On top of such working and living conditions, enslavers usually provided only the barest of nutrition and clothing, and sometimes withheld both as punishment. The daily rations for Ácana enslaved workers were probably little more than a few potatoes and perhaps a piece of salted pork. Records of the colonial state’s investigations of slave mistreatment provide a clear picture of extreme deprivation. After reports of mistreatment

219 Notas sobre medidas de barracones (n.d.). C. M. Lobo No. 189, BNJM.

220 Esteban Montejo recalled receiving “beef jerky, ’taters, and bread” mid-way through the work day on his sugar plantation. Biography of Runaway Slave, 24.

221 Several scholars of Cuban slavery have argued for some level of “doctrinal continuity” in Iberian legal statues which held on despite the rise of the plantation economy in Cuba and the growing power of planters to
on La Lima plantation in Matanzas became too numerous for the Governor of Matanzas to ignore, he launched an investigation in late 1837. Investigators noted the “miserable state of the slaves at La Lima…who have very little to eat, not even a ration of meat,” and “many do not have clothes and many more only wear tatters.” With their “thin appearance and sunken eyes…the state of ill health is obvious,” and yet the enslaved people of La Lima “continued their work.” La Lima’s owner was given a warning to improve conditions, but no other punishment came from colonial officials.222

Given the dangerous labor and environments that sugar planters forced upon enslaved people, it is hardly surprising that a large sugar plantation could have dozens of people in its infirmary on a daily basis. A record of patient visits for a single day in the infirmary on the La Ninfa sugar plantation in the western Cuban jurisdiction of Guanabacoa provides a snapshot of typical medical cases. La Ninfa was one of several plantations in western Cuba that belonged to Francisco Arango. As an early advocate and adopter of modern sugar technologies, management practices, and medical and scientific expertise, he had reformed most of his plantations by the 1810s. La Ninfa had a full-time physician who was responsible for maintaining the health of enslaved people, managing the infirmary, and keeping a daily logbook of all infirmary and medical-related activities. The log entry for April 12, 1812 shows that 29 enslaved people were in the infirmary that day, with some suffering from “inflammation of the throat,” “eyes,” “arms,” and “legs”; “flux” and “bubos”; as well

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222 Sobre la desnudes y escaso alimento que se da a la negrada del Ingenio “La Lima,” Jurisdicción de Matanzas (1838). 10/63, GSC, ANC.
as “inflammation of the eyes and head from the garrote.” The garrote was a punishment device that consisted of an iron mask covering the head and face, causing extreme discomfort and preventing the wearer from eating or drinking. There were also a few enslaved people who were “convalescing” and a few enslaved women “recovering from birth” and “caring for their children.” Even though enslaved pregnancy and childbirth were part of the work that was expected of enslaved women, recovery from birth and child care still counted as sick time. Therefore, it needed to be monitored and possibly made up at a later date.

Catalina might have seen a similar number and variety of medical cases in her infirmary, and if she was ordered to look after enslaved patients, she may have been able to make use of that position to provide care or simply ease their pain. Sharla Fett has argued that enslaved midwives and “doctor women” were sometimes able to protect other enslaved people from work and enslaver violence by keeping them in their sick beds and insisting they were physically unable to return work. This arguably became a less viable form of resistance over the course of the antebellum period as white physicians became more prevalent on plantations and more critical of enslaved healers who threatened their authority. Enslaved people still did much of the everyday healing on the plantation, partly because enslavers did not have to pay them and they were always available, but also because, at least in some cases, planters still trusted that their medical practices could be used to maintain enslaved bodies. Esteban Montejo recalled that “there were some black nannies who took care of little slave

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223 “Estado de la Enfermería Hoy 14 de Abril de 1812.” Documentos relacionados con el ingenio “La Ninfa,” 1812-1832, C. M. Pérez No. 516, BNJM; for more on Arango see María Dolores González-Ripoll Navarro, et al, *Francisco Arango y la Invenção de la Cuba Azucarera.*

children and gave them food. When someone was hurt in the field or got sick, those black women would doctor him. With herbs and potions, they cured everything.”

Cuban planter correspondence indicates that enslaved nurses were not only common but sought after on large sugar plantations well into the 1880s, decades after the formation of a criollo medical profession and their authority over plantation medicine. In July 1881, Francisco Ortieza, who was the administrator of the Santa Rosalía sugar plantation in the jurisdiction of Cienfuegos, repeatedly urged plantation owner Manuel Blanco to purchase an experienced enslaved nurse before the ill-health of enslaved laborers became a serious detriment to work time. “I am waiting on you to send me a head nurse,” Ortieza wrote, insisting that he was “losing a lot of time as I have 15 black men in the infirmary and 8 or 9 women. Altogether, this will be a lot to you.” With 181 enslaved laborers, Santa Rosalía was comparable to Ácana in terms of scale and modes of production. Apparently, Santa Rosalía’s managerial staff thought that they still needed the labor of an enslaved nurse, even though correspondence between Manuel Blanco and several different administrators and overseers do indicate that professional physicians came to the plantation once or twice a month during the last seven years of slavery in Cuba (1879-1886). The difference was that although enslaved women were still doing most of the everyday medical labor on large sugar plantations, they were no longer recognized as medical authorities.


226 Francisco Ortieza to M. Blanco (July 22, 1881). Cartas a Manuel Blanco sobre diversas cuestiones del ingenio y de los esclavos, Marzo 20-Octubre 13, 1881. C. M. Lobo No. 13, BNJM; for slave numbers see Listas de la dotación del ingenio Santa Rosalía, 1879-1887. C. M. Lobo No. 173, BNJM.

227 Ibid; regular physician visits are also mentioned in correspondence between Blanco and Ortieza in 1880. See Cartas a Manuel Blanco propietario del ingenio Santa Rosalia, sobre diversas cuestiones del ingenio y de los esclavos, Marzo 28-Mayo 7, 1880. C.M. Lobo 12, BNJM.
In addition to using her position in the infirmary to interact with enslaved patients, and possibly even extend their sick time, Catalina might have treated enslaved people with foraged plants, which likely became more common in enslaved botanical medical practices as arable land was repurposed to grow cash crops. Enslaved foraging can be found in the report on enslavement conditions at La Lima, where enslaved people had apparently taken to “cooking roots, celery, and leaves for supplemental nourishment.”

To the colonial officials who produced the report, foraging was done out of necessity and desperation for sustenance, and which is not unlikely given the deprivation enslaved people experienced. However, seeking out specific “roots” and “leaves” and knowing how to prepare them in different ways was also vital medical knowledge.

Foraging, not just for food but specifically for medicinal plants, had an intellectual basis in West Africa and amongst Lucumí enslaved people in Cuba. The majority of enslaved people on both Triunvirato and Ácana plantations were Lucumí, as were a sizable proportion of all enslaved people working on sugar plantations in Matanzas during the 1840s. The Lucumí nombre de nación (ethnic surname) encompassed Yoruba-speaking people as well as people from other ethnic communities who were captured in Yoruba territory and only learned the Yoruba language and customs once in Cuba. Lucumí could also include Hausas and Fulanis, traditional enemies of the Yorubas, as well as Ijeshas, Ketus, Ijebus, Nupes, Ewe-Fons/Ajas, and other people from ports along the “Slave Coast.”

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228 Sobre la desnudes y escaso alimento que se da a la negrada del Ingenio “La Lima.” 10/63, GSC, ANC.

229 Manuel Barcia has shown that most were African-born and had been stolen from regions that were known to slave traders as “Upper Guinea” (roughly present-day Côte D’Ivoire, Ghana, Togo, Benin, and Nigeria) and “Lower Guinea” (present-day Cameroon, Gabon, Congo, and Angola). See Seeds of Insurrection, esp. Chapters 2, 3, and 4; The Great African Slave Revolt of 1825: Cuba and the Fight for Freedom in Matanzas (LSU, 2012), Chapter 3.
(roughly present-day Benin). Similarly, Catalina’s nombre de nación “Gangá” may have referred to Africans from the Gbangbá river in present day Sierra Leone, or Cuban-born people who identified as primarily Arriero, Longoba, Maní, Firé, Quísí, or Gola. Ultimately, given the way that Cuban enslavers collapsed multiple West African ethnic identities into singular categories, it is difficult to conclusively trace specific enslaved people to specific West African ethnic identities, especially if those people are found only in colonial and slave owner sources. But knowing the general demographics of the enslaved labor forces at Triunvirato and Ácana plantations, and in Matanzas more generally, is significant, because it means that there may have been a Lucumí/Yoruba medical-intellectual context for foraging on Catalina’s plantation.

That context was “egwe” or “ewe,” the latter being a word for leaf in Yoruba. Egwes were commonly available wild plants, herbs, and weeds that were said to possess purgative, curative, or protective powers. Descriptions of Lucumí-made egwes can be found in the writings of French physician Henri Dumont, who conducted a plantation medical tour in Matanzas during the late 1850s. According to Dumont, the Lucumís seemed to believe that a sick person’s blood might be “cleaned” and their health restored through the ingestion, smoking, or topical application of palm leaves. More recent medical anthropological analyses of Yoruba medicine show similar ideas of the body and healing. Some Yoruba


232 Dumont mentions that “Moreno, a distinguished doctor in Guanabacoa” witnessed Lucumi “superstitions” such as the belief in that “palm leaves” could purify the blood and restore the body to equilibrium. See *Antropología y Patología Comparadas de los Negros Esclavos* [1876] (trans. I. Castellanos: La Habana: 1922), 22-23.
practitioners believe the body can accumulate certain unwanted agents (sometimes referred to as “kokoro,” meaning “insects,” or “aron,” meaning “worms”) that can be disintegrated or expelled from the body via the consumption of bitter-tasting plants. In Cuba, knowledge of egwes was passed down through generations of lay people, but the authorities in egwe use were often babalawos, who were spiritual and religious authorities in Lucumí communities in Cuba and in Yoruba-speaking communities in West Africa. Babalawos understood that the location, physical appearance, personality, and temperament of each egwe determined its curative powers. Some egwes that were good for common illnesses were relatively ubiquitous, sprouting out of the soil at roadides or at the edges of cane fields, while cures for rare conditions grew deep in the forest. Some of these plants were timid and highly attuned to the presence of humans and other animals. They might hide amongst other plants or may refuse to reveal themselves to the seeker, especially if that person traipsed about too loudly. Others plants were fickle and tempestuous, requiring great admiration and deference before being touched. Such a plant had to be picked with careful hands, and gently bundled up, or else it would not have the desired effect. The therapeutic powers of egwes could vary based on the time of day, with many being at their strongest in the morning after night of undisturbed rest.


234 Cabrera, *La Medicina Popular de Cuba: Médicos de Antaño, Curanderos, Santeros y Paleros de Hogaño* (Miami, Fla.: Ultra Graphics Corp., 1984), 127-133; according to Cabrera, babalawos protect the potency of egwes by offering something to el monte (“the forest” or “forest spirit”), thus ensuring that proper balance has been restored. See Cabrera’s *El Monte* (La Habana: Letras Cubanas, 1993), 147-8; Amanda Holmes describes egwe as “the plants [that] have spirit(s), and they are alive in multiple ways. These plants can comprise a single tree or a thick rainforest. They can be found along the roadside or in the depth of the wilderness.” Holmes, “Who is Nature? Yoruba Religion and Ecology in Cuba” (Ph.D. diss, University of Florida Gainesville, 2010). 223.
One of the key logical foundations undergirding egwes was the idea that illness could be pulled or purged from the body using certain environmental elements, which echoed long-standing West African perceptions of the porous boundary between human bodies and environments. The use of egwes was not limited to plantation, but with growing planter and physician suspicion of Black medical practitioners, this practice surely became more secretive and subversive out of necessity. With their work, chores, meals, sick, and rest times closely monitored, enslaved people likely had to go to great lengths to steal time to locate and use egwe medicines. In this context, the act of going unseen and unaccounted for would have been a prominent aspect of egwe healing which, in and of itself, may have had therapeutic potential. Even if enslaved escape was temporary, and even if it incurred retribution from the planter, a moment of evasion may have been worth it.

The health-giving experiences that could be achieved through enslaved invisibility and flight from the plantation are clearly captured in the use of amulets, which were important means of both enslaved resistance and everyday healing in Cuba and Louisiana. Like any medicine, amulets or talismans had different meanings depending on what they were made of, their intended use, and the social context they were made in. In many West African medical cultures and enslaved medical cultures in Cuba and Louisiana, they were believed to be endowed with the power to defend against or cause specific diseases, accidents, misfortunes, or negative spiritual influences. As discussed in Chapter One, the amulet or “gris-gris” as it was called in Louisiana often required animal remains, such as a bone, a piece of skin, or a bundle of hair. Amulets might also be pouches filled with roots or root powders, such as asafetida, a pungent-smelling powder made from celery roots, or they
could be rather innocuous objects, like a piece of string, a coin, or a nail.235 “Camphor and asafoetida in de bag round de neck good [was] for de heart,” Henry Lewis of Pine Island, Texas recalled.236 Most importantly, many of these materials were readily available on most plantations and were small enough that they likely would not be missed.

Some enslaved people used amulets to cause illness and misfortune in others or escape the plantation. Patsy Moses of southeastern Texas discussed the powers of “a good charm bag of red flannel with frog bones and a piece of snakeskin and some horse hairs and a spoonful of ashes” which if “left by de doorstep” of an enemy could “make all kind misfortune and sicknesses and blindness and fits.”237 Patsy also remember one enslaved man who used a rabbit’s foot amulet to escape the plantation. After taking “a good, soapy bath so de dogs can't smell him” and saying “a hoodoo over the rabbit foot,” the man waded across a creek and “dey didn't miss him till he clear gone and dat show what de rabbit foot done for him.” To Patsy, the rabbit’s foot was the vessel for a powerful “conjure” that not only helped the man escape unseen, but also made his absence temporarily invisible to managerial surveillance.238 By harming those that would otherwise harm them or attempting to evade

235 For the curative and preventative functions of amulets or “grisgris” in black medical cultures of lower Louisiana and connections to the use of amulets in West Africa see Fontenot, Secret Doctors, 118-123; Hall, Africans in Colonial Louisiana, 45; Landers, Atlantic Creoles, 62; for amulets in West Africa see McNaughton, The Mande Blacksmiths, 58, 62; Robert E. Handloff, “Prayers, Amulets, and Charms: Health and Social Control,” African Studies Review 25 2, 3 (June-September, 1982): 185–194; for the historical and contemporary use of amulets as preventative materia medica in West Africa, and especially Yoruba medicine, see George Eaton Simpson, Yoruba Religion and Medicine in Ibadan (Ibadan, NE: Ibadan University Press, 1980), 85; and Abayomi Sofowora, Plantes Medicinales et Medecine Traditionnelle d’Afrique (Paris: Karthala, 2010), 82.


237 Jenny Proctor, born into slavery in Alabama and later moved to Louisiana and eventually to Texas, discussed several kinds of amulets: “Den dey keeps all kinds of lead bullets and asafoetida balls round our necks and some carried a rabbit foot wid dem all de time to keep off evil of any kind.” WPA FWP SN, Vol. 16, Part 3, 215-216; Patsy Moses, born into slavery in Fort Bend County, Texas, explained the wide variety of illnesses and circumstances wherein slaves would use amulets. See WPA FWP SN, Vol. 16, Part 3, 143.

238 Narrative of Patsy Moses, WPA FWP SN, Vol. 16, Part 3, 143-144.
harm altogether, enslaved people were using amulets not just to resist and escape but specifically to protect their health.

For the people who conspired to revolt in Matanzas in 1843, amulets helped individual rebels connect to the collective power of the movement and heal themselves by feeling as though they were working together and sharing in the same experiences, even when they were miles apart. An amulet is mentioned in the Spanish colonial military’s interrogation of one enslaved man named José María Gangá Longoba who worked on Triunvirato plantation. José told military officials that a free “mulatto” named Benancio Cepero Brachi came to him several weeks before the uprising with an important message. Benancio told José that “all blacks were slaves on the Island of Cuba” and soon they would “kill their enemies.” Benancio insisted that “all of the free people of color are ready” and then handed José a “caracol” (snail shell), explaining that he would “speak to him soon” once plans for the revolt had been finalized. José Longoba did not tell his interrogators what the caracol meant to him or to Benancio, but it is clear that this object represented a clandestine connection between the two men, and between one enslaved man and a larger movement to end enslavement. In this way, amulets could serve as a reassurance of shared experience and future goals, which might generate feelings of belonging and hope that were themselves vitally therapeutic in a plantation society that was built around the destruction of those emotions.

239 Statement of José María Gangá Longoba, f. 160v. Contra los autores y complices de la sublevación intentada por algunos libres y los dotaciones de varias fincas de los Partidos de Rancho Veloz y Ceja. Comisión Militar, Matanzas (1844). CMEP 32/3, ANC.
The emotional and social contexts surrounding the use of amulets and egwes extended to other forms of healing that were not tied to physical flight from the plantation or rebellion, but were also fugitive because they involved the pursuit of experiences that were incompatible with managerial ideas of enslaved health. The life that Charity might have lived on Marydale cotton plantation in Tensas Parish, Louisiana suggests how fugitive therapeutics could mean maintaining social relationships related to health and illness. There were ways to steal time to heal embedded in the social relations of health, and in the everyday choices that individual enslaved people could make, even as their lives became more tightly controlled and their work more intense.

**Escaping by Making Community: Enslaved Pregnancy**

On a typical morning in the late summer of 1852, Charity might rise at four in the morning to wash, prepare food, clean and mend clothes, or tend to a small garden behind her cabin, if she had one. As Isaac Throgmorton remembered of his time on a Louisiana cotton plantation, enslaved people had to wake early to “cook their own grub” and take care of other necessary chores before they had to report to the cotton field, where they would “stand waiting until it was light enough to go to work.” According to the diary of Charity’s owner, Alexander Blanche, she was nearly nine months pregnant in August of 1852, and yet she was in the cotton field six days a week that month. Blanche recorded the names of every slave who fell ill on Marydale plantation and how many days of work they missed, but he did not note any missing days for Charity that month. Given her condition, she was surely

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exhausted and aching on the best of days, but she may have kept this from Blanche, perhaps worrying that he might try to administer medicines or call for a physician, both of which she likely knew could lead to more pain or even death. Moreover, being marked sick on a regular work day might just mean that she had to make it up on a Sunday. Adeline Marshall, who was born into slavery in South Carolina before being sold to a planter in southeastern Texas, recalled that she and others “worked every day 'cept Sunday” but if “anybody git sick week days, he has to work Sunday to make it up.” Perhaps Blanche would not force Charity to make up a sick day if he valued the fetus she carried more than her current well-being. Charity was growing more potential productivity and profits in her belly, and perhaps Blanche would discount her sick time against the future work days he envisioned collecting with ownership of her child. But in either case, short term or long term, a meticulous planter like Blanche would get his work time.

Later that night, Charity might seek out the enslaved healer at Marydale, who was a field hand named Allen. Although Blanche paid a physician to visit the plantation on

241 It was not uncommon for planters, their wives, or their overseers to attempt medical treatments on slaves before calling a physician. Mrs. John Barclay (Sarah Sanders) was born into slavery in Komo, Mississippi and recalled how “if any of us got sick our mistress would 'tend to us herself. If she thought we was sick enough she would call de white doctor.” See WPA FWP SN, Vol. 16, Texas, Part 1, 40; and for the numerous instances where physicians harmed and killed enslaved patients with little regard for their pain, especially child-bearing age and pregnant enslaved women, see Cooper Owens, Medical Bondage.


243 Numerous antebellum criminal cases demonstrate how southern enslaving societies developed legal, rhetorical, and ideological tools to separate pregnant enslaved women from the fetuses they carried. One example was the 1855 Missouri court case State of Missouri v. Celia, a slave, wherein a pregnant enslaved woman named Celia was hanged for the murder of her owner, Robert Newsome, who had repeatedly raped her, but Celia’s execution was delayed until after she had given birth.

244 The details about the conditions of enslavement on Marydale, Charity’s pregnancy, and doctor visits are drawn from Blanche’s diary in Alexander Blanche Papers, Mss. 3342, LLMVC, LSU.

245 William Matthews, born into slavery on Adams plantation in Franklin Parish, Louisiana remembered the long work days: “De slaves git out in de fields fore sun-up and work till black dark. Den dey cone home and have to feel dere way in de house, with no light.” WPA FWP SN, Vol. 16, Part 3, 68.
several occasions in 1852, he ordered Allen to handle most of the everyday medical care for enslaved people, including caring for those who had been beaten or fallen ill with an infectious disease. Allen may have healed enslaved people according to Blanche’s instructions, and he may have used materials and techniques that a physician would have used. Or, he may have been a “traiteur,” or “charm doctor,” known to many enslaved people in Louisiana for their knowledge of medicinal plants and medical objects, including charms and amulets. In any case, it was probably Allen who treated enslaved people after a whipping, perhaps applying poultices to the red ribbons of flesh that covered their backs. In fever times, when Blanche locked the sick slaves in a shack at the edge of the corn field, Allen may have treated them with a bitter weed called boneset, or with an herbal vinegar, both of which were common traiteur cures. During the summer months in Louisiana, many enslaved people on cotton plantations suffered from dehydration and dysentery, thanks in part to the fact that planters did not always provide enslaved people with potable water. For those patients, Allen might coax them to drink teas made of muddled peach tree leaves, mulberry root, or red oak bark.

246 On Marydale plantation, hardly a day passed without one or two slaves being marked “sick,” but there were less than two dozen “physician visits” recorded in Blanche’s diary for the year 1852, several of which were for Blanche’s family members. This suggests that someone else was doing the day-to-day medical work and was not being paid for it. The diary entry for May 22 mentions that “Allen is working on the medical case,” and on July 14, Blanche was pleased to note that Allen was back in the field as there were “no sick ones today.” See Blanche’s diary in Alexander Blanche Papers, LLMVC, LSU.

247 John Moore, born into slavery in Vermillionville, Lousiana, recalled the use of the boneset weed: “Iffen us sick dey make medicine out of weeds, mostly bitter weed, boneset dey calls it.” WPA FWP SN, Vol. 16, Part 3, 126; for slave uses of herbal vinegar and mention of traiteurs, see the narrative of La San Mire, born Ableville Parish to a Spanish-speaking father and a French-speaking mother and enslaved by a Creole planter: “on nearly all plantations there were ‘traiteurs’ (a charm-doctor, always a Negro).” WPA FWP SN, Vol. 16, Part 3, 109.

248 Henry Lewis (born in Texas in 1835) recalled numerous herbal remedies used on his plantation: “Dey’s de fever weed and de devil’s shoestring, and fleaweed cures neuralgy and toothache. Spanish mulberry root, dat good for kidneys. When anybody git swolled feets give dem wild grapevine. Prickly ash bark good for dat, too. Red oak bark good for women's troubles and pumpkin head for de heart.” WPA FWP SN, Vol. 16, Part 4, 13; Jack Bess of Goliad, Texas recalled how “when we gits sick dey jes gives us some kind of tea, mostly made from weeds. Mos of de time we gits well.” WPA FWP SN, Vol. 16, Part 1, 74; Wonda Fontenot notes that
Traiteurs, much like Lucumi babalawos, were known for their medical knowledge, but many people besides Allen would have known where to find medicinal plants and how to prepare them. As Janey Landrum of Texas recalled, “mos’ all the slaves winmin was right good doctors themselves. They git their medicine out of the woods, and the old folks knowed lots of way to cure things.” Charity might have foraged for her own medicines, or asked others to help her with this task. Or, she may have done nothing at all. Perhaps she viewed her pregnancy as another work task that she had to complete every day. Many of the enslaved women whom enslavers identified as good child-bearers knew that pregnancies were part of their work. Irene Robertson of lower Arkansas recalled that her aunt, Mary Buford, did the same work as enslaved men because she could not have children and therefore “wasn’t no multiplying women.” It is not clear whether Charity conceived through her own volition or through a forced sexual relationship, which could have been anything from an arranged union of “good breeders” to rape, both of which were common on lower Mississippi Valley plantations. It is possible that she might have attempted to

 enslaved people in Louisiana used peach tree leaves and red oak bark to make medicinal teas for dehydration and dysentery. See Secret Doctors, 56, 128.

249 As quoted in Hebert C. Covey, African American Slave Medicine, 33-4.

250 Narrative of Irene Robertson, WPA FWP SN, Vol. 2, Part 1, 42; Laura Redmoun (born in Jonestown, Tennessee and enslaved in New Orleans) explained that her mother was given male-gendered dress and male labor roles once she was no longer able to have children: “she said he made her wear breeches and tote big, heavy logs and plow with oxes.” WPA FWP SN, Vol. 16, Part 3, 231; for enslavers’ growing interest in enslaved pregnancy as a way to reproduce enslaved labor forces, particularly after the end of Atlantic slave trade in 1808, see M. Schwartz, Birthing a Slave; and Fett, Working Cures.

251 Planter Thomas Affleck wrote extensively on slave management and demonstrated the common idea that black women were highly fecund and should be encouraged to breed. See “On the Hygiene of Cotton Plantations and the Management of Negro Slaves,” Southern Medical Reports: Consisting of General and Special Reports, on the Medical Topography, Meteorology, and Prevalent Diseases, in the following states: Louisiana, Alabama, Mississippi, North Carolina, South Carolina, Georgia, Florida, Arkansas, Tennessee, Texas Vol. 2 (1850): 429-36. 434; Louisiana slave narratives demonstrate that sexual violence was endemic, with 46 out of 246 interviewees mentioning sexual relationships with white men and 18 interviewees mentioning rape specifically. Andrea Livesey points out that these numbers may be much higher since interviewers were often white and “interviewees commonly betrayed the fact that they were uncomfortable with the interview situation, as well as
terminate her pregnancy at some point. She may have considered swallowing calomel or chewing on cotton roots after learning from other enslaved women that these substances would abort her fetus. Like many free, enslaved, and colonized women in the mid-nineteenth century, Charity may have seen maternity as the creation of a new life and simultaneously as the threat of bodily harm or death.

Most likely, Charity understood what many enslaved people in Louisiana did, which was that her health was being carefully monitored and understood from within the prism of plantation time discipline. Although they forced enslaved people to make up sick days on Sundays and required them to take care of all necessary socially reproductive labor outside of working hours, which surely exhausted them even further and contributed to ill-health, planters still expected enslaved people to remain healthy and working. They would punish anyone who comported themselves in a manner that appeared to infringe on productivity. Isaac Throgmorton explained the consequences for any enslaved person who was late to work after doing all of things needed in order to be able to work: “if a man was not there at the appointed time, he was thrown down when he did come and struck two or three hundred times.” Perhaps Charity believed that Blanche would do the same to her if she


252 On various forms of contraception and abortifacients, including calomel and cotton roots, see Liese M. Perrin, “Resisting Reproduction: Reconsidering Slave Contraception in the Old South,” Journal of American Studies 35, 2 (2001): 255–74; Fett, Working Cares, 176–7; Jennifer L. Morgan has cautioned historians against romanticizing enslaved women who attempted to avoid pregnancies, or those who wanted to have children, by explaining that women’s control of their fertility was deeply dependent on the material context of their enslavement. See Laboring Women, 114-5.

253 Judith Walzer Leavitt has explained the dual perception of maternity that shaped the lives of antebellum women. See “Under the Shadow of Maternity: American women’s Responses to Death and Debility Fears in Nineteenth-century Childbirth,” Feminist Studies 12, 1 (Spring 1986): 129-154. 130, 133.

254 Throgmorton in Blassingame, 434.
did not continue to work and take of herself, or if she attempted to sabotage her pregnancy in some way. Pregnant enslaved women were not exempt physical punishment, and arguably they were even more at risk for it given the increased enslaver scrutiny that came with being seen as both property and a site of compounding capital.255

Despite the priorities that Blanche may have imposed on her pregnant body, Charity may have had her own meanings of pregnancy that mattered just as much to her, or more, when it came to the choices she made. For her, pregnancy might have been an opportunity to experience certain health practices that strengthened relationships between enslaved people and with their surrounding environments. Marydale did not have an enslaved midwife in the early 1850s – or at least, there is no mention of an enslaved “nurse,” “midwife,” or “doctress” in Blanche’s diary. Like his planter counterparts in Cuba, Blanche was convinced enough of the superiority and authority of white male physicians to hire them for many of the more serious medical cases, including childbirths. But in Louisiana, too, enslaved women were still vital to everyday medicine and healing. Indeed, even if there was no recognizable person who did the work of assisting enslaved women with pregnancy and childbirth, it is possible that other enslaved women might have shared their knowledge with Charity. They might have drawn on personal and community experience, and especially the experiences of older women, who had seen more medical cases throughout their years in enslavement. As one formerly enslaved woman named Melinda explained, she “learned many useful things” from her grandmother, who watched her while her parents worked in the field from “sunrise to sunset” on a cotton plantation near Baton Rouge. Melinda’s

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255 Dorothy Roberts has described how pregnant enslaved women were often beaten if it was believed that they did something to potentially harm their unborn children. The legal-medical-social differentiation between enslaved women’s humanity and that of their fetuses was an early example of the “maternal-fetal conflict” which is often discussed in feminist and reproductive justice scholarship. See Killing the Black Body, 39-41.
grandmother “knew the value of herbs and how to prepare remedies for almost every evil.”

For some enslaved women, this “useful” knowledge was based in West African pregnancy practices that had been passed down from older generations. Many of the enslaved people at Marydale and other cotton plantations in Louisiana were likely brought there through the domestic slave trade. Despite this dislocation, some medical knowledge and practices may have endured not just because they were essential for surviving slavery, but also because they were embedded in important social and intellectual processes. There are notable similarities between pregnancy knowledge and practices described in Black women’s oral histories and those found in the accounts of white missionaries who visited several locations in West Africa in the nineteenth century. Similarities of course do not mean that pregnancy practices remained completely intact throughout the Middle Passage and previous generations of enslavement in North America, nor that such practices were remained static in West Africa, for that matter. Rather, such intellectual histories show which health and healing were still viable even with greater planter and physician control over enslaved people’s time and their bodies. They also show that certain health practices were still viable in large part because they were often carried out unbeknownst to enslavers.

For example, in an oral history interview conducted in 1993, Elnora Robinson Colbert of St. Mary’s Parish, Louisiana explained that enslaved women of her great-grandmother’s generation knew that a pregnant woman’s body and her living space should remain as open and free-flowing as possible, so as to avoid the closing of her womb and a

difficult labor. A pregnant woman should go for walks with other women in the evenings, and then these women should help her into bed and wrap her with warm blankets to loosen her body and ease the unborn child’s transition from the womb to the outside world.\textsuperscript{257} American Presbyterian missionary Robert Hill Nassau observed very similar medical practices while he was working in Baraka (present-day Libreville, Gabon); Batanga (Grand Batanga, Cameroon); and the island of Corisco (off the coast of present-day Equatorial Guinea). Nassau observed that pregnant women in these areas kept their living spaces open to other people and kept their bodies loose with light exercise and regular movement. Pregnant women were also advised against closing the doors of their homes, building fences, or driving nails, lest they create a blockage in the environment that might interrupt what was happening in their bodies. Nassau also observed that pregnant women would not eat the flesh of pregnant animals, or certain animal parts such as the heart, the liver, and the entrails. This meat could absorb the flow of life within the mother’s body and possibly make the unborn child’s bones harder, thus potentially complicating delivery. Similar warnings against eating the flesh of pregnant animals can also be found in medical ethnographies of black midwifery in Louisiana, further attesting to the staying power of such ideas.\textsuperscript{258}

\textsuperscript{257} Pregnancy and child-rearing were important social events in Colbert’s great-grandmother’s enslaved community and her interview describes numerous pregnancy practices. See Elnora Robinson Colbert (1940-) Oral History Interview, Mss. 4700.0222, LLMVC, LSU; early twentieth century physician Stuart Blakely observed similar obstetrical “superstitions” practiced by formerly enslaved midwives and black women in the American South. See “Superstitions in Obstetrics” \textit{New York State Journal of Medicine} 22, 3 (1922): 350; the placement of warm blankets around the bed to create a ‘womb-like’ environment for unborn child is discussed in Harold Speert, \textit{Obstetrics and Gynecology in America: A History} (Baltimore: Waverly Press, 1980), 11.

\textsuperscript{258} Robert Hamill Nassau, \textit{Fetichism in West Africa: Forty Years' Observation of Native Customs and Superstitions} (1904), 192-194; Wonda Fontenot’s interviews with black midwives and folk doctors in Louisiana show the medical significance of opening the body and environments as well as the avoidance of meat. See \textit{Secret Doctors}, esp. interviews with Granny Ya and Miss Janey Bea, 53-56; formerly enslaved women’s advice regarding the consumption of meat can also be found in Blakely, “Superstitions,” 350; the passing down and reconfiguring of West African pregnancy and birth practices through intergenerational knowledge-sharing between enslaved women is described in Morgan, \textit{Laboring Women}, Chapter 2 and esp. 65-67.
This context suggests that the coming birth of Charity’s child may have been understood in West African terms, as a time for social enlightenment via the addition of a new person and all the potential they possessed. Some West African people believed that a newborn child would come into the living world with important information from the spiritual world which would manifest in unique talents, aspirations, and destinies. Elnora Robinson Colbert described how these beliefs were reflected in the practice of burying a newborn child’s umbilical cord and planting a tree on top of it. This act not only forged a special bond between the child and the land they were born on, but as the tree grew alongside the child, it would serve as a reminder to the community of the child’s presence and their unique destiny. West African birthing and child-rearing practices were also evident in enslaved naming ceremonies, which usually took place within eight to fourteen days of birth, and which often turned into celebrations with singing, dancing, and storytelling. Among the Yoruba, for example, the “oríkì” (praise song) recited during a child’s naming ceremony told a story of the child’s future and their unique traits. Yoruba birthing songs and celebrations also served the purpose of documenting the community’s achievements. Some planters in Louisiana did not allow enslaved people to gather or celebrate, often believing as Cuban planters and physicians did that any free time to socialize would mean the consumption of alcohol or other behaviors that impacted enslaved people’s health and abilities to work. Phoebe Bost, born on a plantation in near New Orleans recalled that her enslaver did not allow “any recreation, such as singing and dancing.” But if Alexander Blanche allowed celebratory gatherings to take place on his plantation, or if he

259 The practice of burying umbilical cord is described by Elnora Robinson Colbert in her oral history interview. Mss. 4700.0222, LLMVC, LSU.

was unaware that they were taking place, it is possible that Charity was looking forward to these events as opportunities to strengthen existing relationships and forge new ones; to reclaim time to do things other than work or preparation for work; and to make herself healthier and more secure during what was most likely an incredibly physically and emotionally taxing experience.261

These meanings embodied in enslaved pregnancy and embedded in enslaved communities were fundamentally fugitive in nature because they were an escape from planters’ and physicians’ mechanistic, productivity-focused understandings of the enslaved body. The fact that these medical practices and their meanings were often hidden from managerial and physician gazes further contributed to both their fugitive qualities and their therapeutic power. Enslaved people’s connections with animals on the plantation operated in a similar fashion. These cross-species relationships were available to enslaved people due in large part to the way that planters conceived of their labor forces, both human and animal.

Making Therapeutic Connections with Animals

As the official authority of enslaved healers dwindled, and ordinary enslaved people’s access to resources and mobility became more limited, some enslaved people found health and comfort in their relationships with animals. Narratives of former slaves reveal how animals helped them to minimize their exposure to work, stress, and ill-health. In contrast, the enslaved-animal relationships that are visible in planter and physician discourse are largely

261 Narrative of Phoebe Bost, WPA FWP SN, Vol. 12, 10; Fett discusses how times of illness and pregnancy among other medical conditions were opportunities for enslaved people to reclaim some of their lives, and thus some modicum of power. See Working Cures, esp. 181.
evacuated of therapeutic meaning. To planters and physicians, enslaved people’s proximity to animals reflected the proximity between blackness and animality.\(^{262}\) The relationship between slaves and animals was also understood through managerial ideas concerning the coordination of human and animal labor that was needed for commodity production. As such, there were some connections between enslaved people and animals that existed beyond the gazes of planters and physicians, even becoming epistemological and ontological terrains for transcending the calculation and surveillance of the enslaved body. Importantly, planters could not incentivize or manipulate animals in the same way that they could human workers like Charity and Catalina. They could not force animals to maintain their own health, for example, or take responsibility for their sick time or other interruptions in plantation production. Animals formed an essential subdivision of labor on the plantation, but the health of animals as well as their actions could interrupt production in ways that planters could not anticipate, account for, or reconcile.

Echoes of the Spanish biopolitical concept of “improvements” could still be seen in planter perceptions of environments. As plantation slavery expanded across the western jurisdictions of Cuba and up the Mississippi River, planters and state officials continued to view rural land as an input into the plantation system and white settlement as an important accelerant in that process. In 1821, Lieutenant Governor of Matanzas Cecilio Ayllón predicted that sugar and coffee plantations would be particularly productive that year and linked that productivity to an increase of skilled white laborers in the countryside. In a letter to Governor of Cuba Nicolás Mahy y Romo, Ayllón envisioned that Matanzas “will produce

\(^{262}\) For more on the “animalization” of the slave and how it provided religious, moral, and eventually scientific justification for the enslavement of black people see David Brion Davis, *The Problem of Slavery in the Age of Emancipation* (New York, NY: Knopf, 2014).
this year of [18]21 somewhere between 75,000 and 80,000 qq of sugar and 40,000 qq of coffee” thanks in part to a “registered an increase of between six thousand and seven thousand whites, counting among them more than two thousand foreigners of both sexes, some of them farmers and the rest dedicating themselves to mechanical jobs.”263 Similarly, petitions to town councils show that prominent Cuban planters pushed for the immigration of white families to “promote agriculture and industry as well as the progress of civilization on the island.”264 For the state and planters, ever-increasing production coupled with the settlement of white farmers and “mechanical” workers signaled the progress of “civilization” on the island. Like Spanish colonial officials in New Orleans back in the late eighteenth century, Ayllón believed that white families, not just individual laborers, were especially important because it was assumed that they would reproduce themselves and grow the economy over time.

A very similar reading of environments and economic development could be seen in Louisiana, where enslaved labor was central to white settler boosterism throughout the antebellum period. Louisiana’s admission into the United States in 1812 sparked a wave of white colonization in the late 1810s and 1820s. Newly arrived white settlers began

263 Letter from Teniente Gobernador Cecilio Ayllón (July 22, 1821). 887/29859, GSC, ANC. “Qq” was a common abbreviation for quintal, a Castillian unit of weight roughly equivalent to 100 pounds. Demographic statistics for the year 1826 demonstrate a large number of white settlers moving into Matanzas region as sugar and coffee plantations became increasingly productive between 1820 and 1826. See the work of early nineteenth century Cuban political economist and agronomist Ramón de la Sagra, Anales de Ciencia, Agricultura, Comercio y Artes (La Habana: Oficina del Gobierno y Capitanía General, 1827), 147. Demographic and political economic statistics in this period must be approached with an air of caution, as the motivations for producing such data were often expressly pro-slavery and pro-colonization.

264 In 1820, the Havana town council approved a petition made by more than a dozen sugar planters and factory owners from Havana and Matanzas to allow 500 families to immigrate from the Galicia region of Spain. For this and quote see Expediente sobre el fomento de la población blanca de Cuba. 1820. Legajo 35, N. 14, Fondo Ultramar, AGI; in 1830, Manuel Rubio of Santiago de Cuba requested more parcels of land so that he might expand his sugar operations. He cited the Santiago de Cuba town council’s expressed interest in white settlement to support his request. See Carpeta por Manuel Rubio. Legajo 148, No. 12, Ultramar, AGL.
demarcating and enclosing lands that belonged to the Chitimacha, Choctaw, and Houma, among other Indigenous peoples. With the Indian Removal Act of 1830, which forcibly removed the Cherokee, Chickasaw, Choctaw, Creek, and Seminole to territory west of the Mississippi River, the entirety of the Gulf South was deemed opened for white settlement. Southern agricultural periodicals ran reports of immensely profitable sugar cane and cotton yields on “the fertile banks of the Mississippi” and often explicitly stated that enslaved labor was making the land healthy and fecund.265 According to one 1833 article, seasonal flooding and “unwholesome miasma” were still major concerns for white settlers in Louisiana, but there was apparently “no state in the Union with a greater body of first rate land” and “a proper concentrated effort of all the slaves in the State applied to draining and canaling this vast dismal and noxious swamp would render Louisiana the greatest agricultural district in the world.”266 These periodicals sent a message to ordinary white settlers that they too might be able to secure a piece of fertile land in Louisiana and enough enslaved people to transform their land into great personal prosperity.

The transformation of forests into savannahs in Cuba and swamps into fields in Louisiana over the first half of the nineteenth century demonstrated to white settlers and planters alike that rural lands were becoming safe environments for white people and their economic goals. A crucial part of this perception was the knowledge that domesticated animals could be used in efforts to master land and render it productive to the plantation


economy. As Cuban environmental historian Reinaldo Funes has argued, working animals were essential in plantation appropriation of materials and energy from the environment, and thus were key components in plantation social metabolic processes.\textsuperscript{267} Since the earliest days of European colonization in the Americas, domesticated animals such as horses, dogs, pigs, and cows served settlers and planters by providing transportation, protection, companionship, food, and the means of growing food. With the development of systematic plantation management, these “creatures of empire” became not just valuable assets for environmental and social transformation, but also valuable laborers in the production of cotton, sugar, coffee, and other cash crops.\textsuperscript{268} Planters developed strategies for maximizing the economic usefulness of non-human workers that were often reminiscent of what they had for enslaved workers.

Alexander Blanche had many animals at Marydale plantation and he routinely tracked their health and work alongside that of his slaves. As he monitored the specific work duties of his “hands,” Blanche recorded the whereabouts of mules and cattle that were assisting said hands in ditch digging, clearing dead crops, cutting trees, and seeding.\textsuperscript{269} During the cotton harvest season, which ran from the beginning of September through December/January, he kept daily records of the pounds of cotton picked per enslaved

\textsuperscript{267} Funes has argued that ecological devastation of the island accelerated after 1815, when sugar planters won a decisive political victory that allowed them to clear extensive jungles for cane fields and sugar production. Before 1815, planters competed with the Spanish navy, who wanted to conserve timber supplies. See De Bosque a Sabana, for an environmental history of the rise of plantation agriculture in the lower Mississippi Valley, see Christopher Morris, The Big Muddy: An Environmental History of the Mississippi and Its Peoples from Hernando de Soto to Hurricane Katrina (Oxford, 2012), esp. Chap. 4, 5, 6.

\textsuperscript{268} Virginia DeJohn Anderson, Creatures of Empire: How Domestic Animals Transformed Early America (Oxford, 2006).

\textsuperscript{269} See diary entries for February, 1852 for various work done to prepare the land for the growing season, for example February 12th where Blanche listed the farrowing of corn and cotton completed by “seven hands along with two bull cattle and one mule.” Alexander Blanche Papers, LLMVC, LSU.
person with one list for “females” and one list for “males.” Although all enslaved people were apparently doing the same work, Blanche divided them by gender to better compare them based on what he perceived as their different physical capacities as men and women. He also divided his animals by gender, listing his “bulls” and horse “studs” in one column and “heffers” and “fillys” in another. The practice of comparing labor by gender was essentially the same for animals and humans, which shows the dehumanization of blackness via its proximity to animal nature, and also how such ideas played out in the day-to-day management of a plantation. In the eyes of planters like Blanche, enslaved people were similar to animals – bodily, intellectually, and morally – and thus they could and should be managed as such.

Cuban planters and physicians had similar methods for watching the plantation work force and managing human and animal labor simultaneously. On some plantations in Matanzas, plantation administrators signed out every enslaved person and animal who left the plantation, making a note of where they were going, why they were going there, and when they would be back.270 The tight control over human and animal mobility reflected the fact that planters knew this dual labor source was essential to plantation productivity. In his popular plantation management manual, Cuban planter Eugenio de Colona y Garcés described how the union of enslaved and animal labor in sugar production, or “the arms of men, aided by animals and machines,” would “pick your products in abundance.” He maintained that “when they [enslaved people and animals] are united in their work they are

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270 Such a system was used at the San Adrián sugar plantation in Matanzas. See Comunicaciones sobre la prohibición de extraer esclavos, animales sin el consentimiento del administrador (July 2-5, 1841). Legajo 23, Nu. 35, Fondo Esclavos, AHPM.
The most productive” and “at their happiest and most comfortable.”271 The 1842 state-commission, physician-run survey of plantation conditions discussed in Chapter Two shows a similar view. Although the switch to barrack housing had supposedly led to better control over enslaved health, the survey’s physician authors acknowledged that the elimination of enslaved people’s gardens had diminished their food supplies and their morale, both of which might affect their willingness to work. They noted that enslaved health and morale seemed to improve when planters “provided married slaves with a piece of land to sow” while allowing these enslaved couples to “raise pigs, one of each sex.” These arrangements would supposedly “benefit” enslaved couples by giving them a source of animal protein and by encouraging “the best morality of the slaves,” helping them to “appreciate the place where they reside” so as to improve the overall “stability and productivity of the agricultural system.”272 This idea of pairing heterosexual enslaved and domesticated animal couples to improve production shows racist perceptions of the fungibility of enslaved people and animals. It also shows how physicians and planters organized enslaved and animal labor (both manual labor and reproductive labor) at the same time, using the same technologies and concepts, believing this to be the most efficient mode of management and the best means of preserving the health of all labor on the plantation.

The application of similar managerial lens of gender, health, and labor onto both slaves and animals can also be found in plantation asset inventories, mortgage documents,

271 See Manual del Hacendado y Labrador (La Habana: 1861), prologo, 8-9. C-1050, Museo Histórico Nacional de las Ciencias Carlos J. Finlay, Havana (hereafter MCF). NB: “los brazos del hombre” (“the arms of men”) or simply “brazos” was a common shorthand for enslaved labor in Cuba, much like “hands” in the Louisiana.

272 The circular indicated that all responses should be addressed to Don Juan Montalvo and Dr. Don Wenceslao Villa, who served as the group’s secretaries and whose signatures appear on the document. See Expediente instruido de orden superior para reformar el sistema higiénico, moral y alimentos de los siervos que se emplean en la agricultura (1842). GSC 941/33186, ANC.
and sale agreements. Inventories of property at Willow Point and Lake Place plantations in Louisiana contained entries for enslaved people that listed their plantation occupation, such as “hog minder,” “blacksmith,” “grinder” or “ginner,” “child,” “field hand,” and “laundress,” as well as whether or not they had any medical “defects,” such as being “unsound,” “sickly,” or suffering from a “palpitation” or a “hernia.”273 Similarly, a mortgage application for the sugar plantation Santa Rosalía in Cienfuegos, Cuba listed all enslaved people and animals divided by gender and grouped by occupation.274 Like enslaved people, animals such as horses could be described in terms of their age and physical characteristics, but also in terms of whether or not they were “broken,” which meant that they were well-disciplined and ready to work.275

Animals were living inputs into the plantation that also required medical maintenance, and sometimes that maintenance was virtually the same for animals and enslaved people. Correspondence between two Louisiana planters exemplifies this conflation of enslaved and animal bodies. In May, 1835, Louisiana planter Jacob Bieller wrote to Jesse L. Ward, owner of a plantation called The Ridge, explaining the medical treatment for a horse after castration: “apply the Jamestown leaves bruised as a poultice, put on cold, &

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273 The “Inventory of Negroes upon Willow Point Plantation” in Louisiana (dated January 1, 1852) lists 42 slaves and their occupation on the plantation. Most are field hands, but others are “blacksmith,” “child,” “hog minder,” “gin driver,” “seamtress,” “overseer,” “carpenter,” “ferryman,” “cook.” Joseph Toole Robinson Papers, Mss. 1413, LLMVC, LSU; in January, 1853, Samuel Davis bought Lake Place plantation from James Brown for $67,400, which included 50 slaves listed by name, age, and medical “defects,” if known, as well as their specific jobs, i.e. “Moses, has palpitation, 32;” “Sidney, sickly, 37;” “Ned, driver or ginner, 37;” “Macy, has hernia 13;” “Bob, driver, 17;” “Big Amy, unsound.” Joseph Vidal and Family Papers, Mss. 432, LLMVC, LSU.

274 According to an 1882 mortgage application, Manuel Blanco had 181 slaves working on the sugar plantation Santa Rosalía, each of whom was described in terms of their age, ethnicity, and labor occupation. Blanco also separated both slaves and animals into “varones” (males) and “hembras” (females). See Listas de la dotación del ingenio Santa Rosalía, 1879-1887. C. M. Lobo No. 173, BNJM.

275 On August 18th, 1845, Don Luis Acosta sold Dona Josefa Antonia Gonzalez de Massana “a pair of horses, both broken and well raised for six and half years.” Documentos pertenecientes a la familia Massana. Havana, Bayamo, 1820-1849 (No. 25). C. M. Sociedad T. 28, BNJM.
bathe with the juice. It is cooling likewise, and it is good for man & beast in that way, but not to be swallowed.” Bieller was explaining that the same poultice might be used for treating castrated horses and men. In Louisiana and Cuba, as was true in many slave societies in the Atlantic world, castration was a torturous punishment often given to enslaved men who were accused of crimes, including running away or hindering the pace of production. The procedure was also a managerial practice that aimed to stop enslaved men from engaging in sexual relationships that might distract them from their work, or to stop them from procreating if they had been deemed mentally or physically “unsound” – the fear being that they would produce a child who was likewise deficient. In addition to demonstrating the sheer banality of planter violence, Bieller’s letter shows how planters conflated human and animal labor as well as their health.

Interestingly, management-enforced proximities between enslaved people and animals became important to some enslaved people for their own reasons. Daily interactions with animals could lead to breaks in the physical hardship and monotony of work. The enslaved people on Marydale and Acaná who were assigned to work alongside cattle, mules, or horses may have considered themselves lucky to have animals there to share the load. Mary Reynolds, who was born into slavery in Concordia Parish, Louisiana during the late 1830s, recalled the old mule that carried barrels of water throughout the fields, even though “plenty times they was only a half barrel water and it [was] stale and hot.”

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276 Jacob Bieller to Jesse L. Ward (May 9, 1835). Alonzo Snyder Papers, Mss. 655, LLMVC, LSU.


278 Narrative of Mary Reynolds, WPA FWP SN Vol. 16, Part 3, 239.
enslaver, Dr. Andrew Kilpatrick, this mule was the ideal laborer for the task of bringing water to enslaved people in the cotton fields. Bringing water to enslaved people saved time by keeping them at their work, and forcing a mule to do this meant that Kilpatrick did not have to take an enslaved person away from the all-important task of picking cotton. For Mary Reynolds, however, the mule’s water delivery might have stood out because it was break in work time in which she did not have to be picking cotton.

Indeed, working closely with animals could mean opportunities for enslaved people to care to themselves. Relationships with animals might have been largely pragmatic for enslaved people – a means to protect themselves, perhaps by hiding or deflecting some managerial attention – but they might have also been sources of comfort with cumulative, health-giving effects. Even with more managerial control over when and how enslaved people could heal themselves, connections to domestic animals, whether mundane or intentionally covert, were still possible due in part to the fact that planters still very much needed animal labor.

In July, 1830, Jacob Bieller received a letter from one of his estate administrators, Edward McKey, who predicted that a recent bout of sickness amongst enslaved workers combined with the ill-health of animals would translate into a dismal cotton for the year:

I am of the opinion that I shant make more than half a crop if that. We have had some sickness among the negros, and some at this time, but none too dangerous – Agness and Jenette are a little on the mend, but very slowly indeed. The hogs have been on the decline since you left here and many of them have died and some looks very bad now…We have had very bad luck with turkeys, all the old hens are dead but one, and we did not raise any youngane.\(^{279}\)

\(^{279}\) E. McKey to Jacob Bieller (July 14, 1830). Alonzo Snyder Papers, LLMVC, LSU.
The fact that McKey mentioned the enslaved women Agness and Jenette by name points to one key difference with regard to the management of enslaved and animal health. Agness and Jenette may have had individualized work quotas that they were missing when they were sick and may have been punished for failing to recover quickly. McKey’s decision to name them was a way of recording time lost that would need to be made up in the future. But McKey’s letter also reveals that he could not use violence to manipulate animal health in the same way that he could enslaved health. McKey, and his employer Bieller, knew that there was no way to punish animals with the expectation that said animals would respond by caring for themselves, changing their behavior, or working faster. Indeed, when Bieller hired a man named Garret Rawlings to serve as an overseer on one of his plantations in 1834, Bieller stipulated that Rawlings would “take charge of the plantation and negroes, teams of horses, mules, and oxen” and “manage the negroes with prudence and regularity, punishing when they commit a fault & encouraging them when they perform well.” Bieller and his managerial staff were attempting to manage the health, work, and behavior of enslaved people and animals in a simultaneous fashion, but ultimately they knew that their typical modes of violence and coercion would not work on animals.

Perhaps enslaved people noticed this too. They would have seen that owners, administrators, and overseers needed animals, but could not threaten them like they did enslaved people, even if both were property of a slave-holder who ultimately held the power to decide if they lived or died. Enslaved people might have noticed key faults in the

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280 For the rise of individualized work quotas on cotton plantations in the antebellum South see Rosenthal, *Accounting for Slavery*, Chapter 3 “Slavery’s Scientific Management: Productivity Analysis in the Antebellum South.”

281 *Contract with Garret R. Rawlings (June 23, 1834)*. Alonzo Snyder Papers, LLMVC, LSU.
conflation of blackness and animality, such as the fact that animals in could remain silent in ways that people could not. Animals were not expected to explain their decisions or describe their physical conditions, and they could not divulge information on other animals. Enslaved people likely observed these differences and may have used those insights to shape their own ideas and experiences.282

The limits of managerial attempts to steer the health of enslaved people and animals towards productivity could therefore become spaces in which enslaved people could create therapeutic relationships. The tension between blackness and animality as conceived under the plantation system could have provided openings for different ways of thinking and being that were similar to those spaces that emerged between European and Euro-American ideas about the relationship between blackness and transness. As C. Riley Snorton has shown, dominant ideas about blackness and transness actually reveal the profound mutability of those identities, and thus the great potential for practices of fugitivity in the spaces between and around the shifting edges of the categories of “human,” “black,” “female,” and “male.”283 Perhaps some enslaved people found therapeutic meaning in the space between definitions of blackness and animality, and between the different managerial controls for enslaved workers and animals.

Ultimately, domesticated animals had their own set of limitations, as they were also the counted, surveilled, and carefully maintained, which was why there may have been even

282 Simone Brown uses the concept of “dark sousveillance,” or Black epistemologies of surveillance, to describe enslaved peoples’ “keen and experimental insight of plantation surveillance” which some people used to “escape and resist” plantation surveillance. Brown’s descriptions of the knowledge-making at work in the act of watching the watchers is particularly helpful for thinking about how enslaved people might have learned about and used plantation management for their own therapeutic ends. See Dark Matters: On the Surveillance of Blackness (Duke, 2015), esp. 22.

283 C. Riley Snorton, Black on Both Sides, see esp. introduction and Chapter 2.
more fugitive and subversive potential in enslaved people’s relationships with wild animals. Plantation records and narrative of formerly enslaved people show that enslaved people were very aware of the animals that lived on the plantation but did not work for the planter. Considered “pests” by planters and managers, these animals often worked against the productive imperatives of the plantation machine. Charity and Catalina may have witnessed wild animals such as crows, birds, and rodents eating their masters’ precious crops. Perhaps they saw fellow enslaved workers ordered to patrol the fields with guns and shoot any offending animal on sight. Sending armed enslaved people into the fields was what Edward McKey finally resorted to in an attempt to stop “the crows, squirrels, perrikeets, and koons [who were] all very busy at work on the corn.” What might Charity, Catalina, and other enslaved people have thought about these birds and critters that ate what they wanted, went where they pleased, and apparently answered to no one?

For Moses Grandy, who was enslaved in Louisiana during the 1830s, wild birds provided a sense of “freedom” and way to think about another life away from the plantation. In his narrative, he recalled a vivid dream where he transformed into a bird: “I felt so light, I almost thought I could fly, and in my sleep I was always dreaming of flying over woods and rivers.” By thinking of himself in the body of a bird, Grandy momentarily transcended his human flesh, which his overseer tortured so regularly with a “very tough sapling” that after one particularly bad beating Grandy was back at work before noticing that a piece of the

\[284\] In a letter date July 14, 1830, Edward McKey told Bieller that “the crows, squirrels, perrikeets, and koons is all very busy at work on the corn. I have to keep a hand in the field steady with the gun, shooting among them and it appears to have but little affect. I wish you would send me more shot as I have not more than will last till they return.” Alonzo Snyder Papers. LLMVC, LSU.

\[285\] Moses Grandy, *Narrative of the Life of Moses Grandy, Late a Slave in the United States of America* (London: C. Gilpin, 1843), 25; scholars of African-American folklore have noted that dreams of flying and relating oneself to birds was a way to envision the return to Africa. See Michael A. Gomez, *Exchanging Our Countrymarks*, 117-8; Grandy’s dream is also mentioned in Walter Johnson, *River of Dark Dreams*, 209.
branch was lodged in his stomach. Grandy’s relationship to birds was a way to ease the daily pain of enslavement because it allowed him to imagine himself in a smaller, delicate body that did not carry the weight of his past experiences. When he was a bird, Grandy could leave the plantation, both physically and emotionally.

Wild birds were also important to Esteban Montejo while he was hiding out in the forested mountains of western Cuba. Unlike fugitive slaves in the U.S. South who fled with the goal of traveling to places where slavery was illegal (usually the North, the West, or Canada), Cuban runaways had different spatial limits and therefore created different ideas and practices of marronage. Some runaway enslaved people fled the plantation temporarily, knowing they would return after a few hours or days, and others, like Esteban Montejo, fled with no intention of returning. According to Montejo’s narrative, he lived in a cave deep in a forested, highland area and did not communicate with another human for several years. But he did develop relationships with wild birds. As he explained: “what I do remember well are the birds in the woods. I haven’t forgotten that. I remember them all. There were pretty ones and some right ugly ones. At first, they put a lot of fear into me, but later I became accustomed to hearing them. I really believed they were watching out for me.” Some birds, like the cotunto, were “bothersome” and chirped at Montejo when he ate food that the bird had been saving. But the barn owl was a “witch” who protected Montejo from harm. “When I saw a barn owl in my path, especially when she went back and forth, I wouldn’t go on,” Montejo explained, “because by doing that she was giving warning that there was an enemy

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287 For more on the complexities of marronage and the importance of “petit marronage” (running away a little) as a freedom practice in the Caribbean see Neil Roberts, *Freedom as Marronage* (University of Chicago Press, 2015). NB: the therapeutic dimensions of “running away a little” to natural springs and other environs will be discussed in Chapter 5.
or death itself nearby.” The barn owl was “wise and strange” and Montejo recalled that “the male witches had a lot of respect for her and did magic with the barn owl, or Susudamba, which is what she is called in Africa.”

“Male witches,” who may have been babalawos or other spiritual authorities, believed that owls saw everything and would make their presence known when they wished to warn humans of potential misfortunes. With their ability to see at night, turn their heads 360 degrees, and fly silently through the forest, owls were allies for runaway enslaved people. For Montejo, the barn owl and other wild birds were collaborators who helped him create his own network of surveillance to guard against slave catchers and anyone else who would do him harm.

Whether they were wild or working animals, enslaved people’s connections to animals offered protection and moments of reprieve for health and healing. As plantations became environments of systematized management and hyper-surveillance, enslaved people’s connections to animals emerged as a branch of fugitive therapeutics that was largely unrecognizable as “medical” or “therapeutic” to planters and physicians. In this way, connections to animals helped enslaved people reclaim some of their bodily autonomy and self-determination.

With the rise of plantation management science and physician medicine, eluding plantation time discipline with the help of plants, objects, community, and animals became important

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288 Biography of a Runaway Slave, 53-4.

289 For a discussion of the owl in Montejo’s narrative and the role of the owl as a powerful spiritual entity in Afro-Cuban literature, religion, and folklore see Angelita Dianne Reyes, Mothering Across Cultures: Postcolonial Representations (University of Minnesota Press, 2002), 51-2; see also the short story “Susudamba no se muestra de día” (“the Owl does not show herself by day”) in Lydia Cabrera’s collection of Afro-Cuban short stories Cuentos Negros de Cuba (Madrid, ES: Ramos, Art. Gríf., 1972), 101-119.
ways for enslaved people to heal. Fugitive therapeutics thus subverted the expectations and conditions that planters and physicians forced on slave bodies, even if they could not be stopped altogether. Charity could have had her own ways of staying health and perhaps even enjoying her pregnancy, even if she could do little to disrupt Blanche’s routine for handling pregnancy and child birth.

Charity’s baby was born on September 8th, 1852, but according to Blanche’s diary, an enslaved woman named Fanny began “nursing Charity’s baby” on that day and Charity herself was sent back to work. Perhaps Charity’s child was taken from her immediately and she was not even allowed to hold her child before she was sent back to the field. Like many planters, Blanche had designated enslaved wet nurses who cared for newborns so that their mothers would not lose any work time caring for them. Jeptha Choice, who was born into slavery on a cotton plantation near Henderson, Texas in 1835, recalled that newborn enslaved children were “wet nursed by women who didn’t work in the field” and kept “separate quarters.” Only “in the evening,” after the work day ended, were “their mammies were let to see ’em.” Such treatment of enslaved mothers, wet nurses, and children was a widespread and particularly cruel form of racialized subjugation, but it was also a standard managerial practice. It was intended to remind these enslaved people that they were property, unworthy of compassion, and it was a calculation to save precious work time.

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290 See entry for September 8 in Blanche’s diary, where Blanche wrote “Charity’s baby born” and Charity’s cotton yield for that day, which was 28 pounds; Choice also mentioned that older enslaved women (“grannies”) took care of enslaved children after their weening until the children were about three years old. Alexander Blanche Papers, LLMVC, LSU; Narrative of Jeptha Choice, WPA FWP SN Vol. 16, Part 1, 218.

291 For more on the forced labor of wet nursing and natal alienation as a form of racialized subjugation see Schwartz, *Birthing a Slave*, and Sasha Turner, *Contested Bodies*. 
The next chapter will analyze some of the strategies that mid-nineteenth century sugar and cotton planters used to preserve enslaved health, save work time, and increase total productivity. The first half of the chapter focuses on plantation records – planter diaries, ledgers, correspondence, and business documents – as well as agricultural trade journals where planters discussed the science of management. The second half of the chapter examines physicians’ personal papers, medical journal articles, and medical dissertations to show how physicians adopted managerial concepts and used them to undergird their own knowledge production.
Chapter Four: “Days lost”: Time, Productivity, and Race in Planter and Physician Discourse, 1840-1868

Charity’s child died on September 13th, 1852, after living just five days. From September 13th until October 11th, Charity was marked “sick” in Alexander Blanche’s diary and presumably did not work. Blanche did not note the causes of the child’s death or Charity’s sick time, but it seems likely that the two were related. Perhaps both Charity and her child became ill and only Charity survived. Perhaps she was not sick but pretended to be and Blanche either bought the act or, for whatever reason, chose not to force her to work. It is also possible that Blanche suspected Charity killed her child and her sick time was the result of his violent retribution that left her unable to work. Many planters believed that enslaved mothers would terminate a pregnancy or commit infanticide if given the chance. Such sabotage to property and production was a serious offense. However, Blanche did note the total number of work days that he had “lost” while Charity was sick, which was “27 days.”

Blanche’s meticulous accounting of Charity’s sick time and her infant’s brief life shows how planters in mid-nineteenth century Louisiana and Cuba used time discipline and productivity to interpret the health of their slaves. Planters allowed some enslaved people to take what they called “sick time” or “sick days,” with the idea being that small amount of time for recovery – usually at the onset of illness – would reduce the amount of time needed for recovery over all, thus protecting the pace of production to the greatest extent possible. Systematic recording of sick days for both individuals and the workforce as a whole was now possible with planters’ panoptic and technologically sophisticated managerial practices. For

292 See Blanche’s diary entries for September 13 through October 11, Alexander Blanche Papers, LLMVC, LSU; when an enslaved woman failed to conceive, suffered a miscarriage, or the child became sick or died, planters and physicians were quick to suspect foul play. See Turner, Contested Bodies; Schwartz, Birthing a Slave; and Fett, Working Cares.
Blanche, sick time helped him forecast potential impact on productivity and then adjust enslaved labor going forward to make up the lost work time. Monitoring health data in this way made planters feel that they were “maintaining” if not improving enslaved health as long as they were able to keep enslaved people working. They even argued that this strategy of reducing “days lost” or “work time lost” and maximizing work actually “preserved” enslaved health and the health of the plantation system. Such language can be seen in plantation records and agricultural trade journals across western Cuba and the lower Mississippi Valley. It can also be found physician writing.

Physicians gravitated towards these concepts because they saw plantation management science as a stable foundation for making medical knowledge about slave bodies. Managerial technologies like the clock and the ledger enabled the quantification of enslaved health via the quantification of productivity, which seemed to physicians to be a systematic way of determining the severity of enslaved people’s conditions and how to treat them. Moreover, with its predictable procedures and clear hierarchies of knowledge and power, the plantation seemed to be an ideal environment for testing medical theories and generating evidence on the efficacy of healing practices. These physicians still thought, like most medical practitioners in the mid-nineteenth century, that there were important differences in health and healing based on local climate and environments. They knew no plantation environment was exactly the same as another, but they could believe that the managerial practices were consistent across environments. As such, they treated time

293 The enduring importance of local knowledge in medical practice in the nineteenth century United States South is discussed extensively in Steven Stowe, *Doctoring the South*; Warner, *The Therapeutic Perspective: Medical Practice, Knowledge, and Identity in America, 1820-1885* (Harvard, 1986); and for the important role of place, environment, and climate in physicians’ understandings of medicine and the body more generally see Conevery Bolton Valenčius, *The Health of the Country: How American Settlers Understood Themselves and Their Land* (Basic Books, 2002).
discipline and other planter-imposed conditions as established facts on which they could produce widely applicable medical knowledge.

Some historians of medicine and slavery have acknowledged the “unshakable bond between slave health and plantation productivity” in physician discourse and the fact that physicians were extensions of planter surveillance. But these historians have not attempted to explain why thinking about enslaved health through the lens of productivity made sense to physicians. They were not simply trying to corner the plantation medical market. It certainly helped that many planters and physicians largely agreed on the characteristics of medical expertise, which included whiteness, maleness, anatomical and clinical medical training, and previous experience treating slaves. But there were important intellectual reasons behind the noticeable increase of managerial concepts in medical writing by the 1850s. It reflected how physicians viewed plantation management as a scientific discipline.

Crucially, technologies and practices that supposedly “conserved” health by “preserving” the efficiency of plantation production appealed to planters and physicians because they fit with what they already knew about blackness. They believed that Black bodies were biologically equipped to endure hard labor in hot, tropical climates. As a scientific and medical theory of race, this idea had existed in the Atlantic world in some form for centuries. Prior to the early nineteenth century, many Western physicians were “monogenesists,” rooting their understanding of racial difference in the philosophical position that all peoples came from one common human ancestor but had developed separately and distinctly, as variations in climate produced different physical characteristics

and susceptibility to diseases over time. However, by the 1840s, doctors, scientists, naturalists, and other racial science thinkers were beginning to argue that there was no single “human race” but rather multiple original “races” with inherent physiological and mental differences, some of which remained largely intact no matter climate and environmental conditions. This “polygenesist” view gained more support with the emergence of biology and its hierarchical classification of living organisms with their own distinct evolutionary origins. By the middle of the nineteenth century, physicians discussed how immutable biological characteristics of blackness impacted the prevalence of disease in enslaved bodies and the fitness of those bodies for labor. Such medical discourse quickly became justifications for enslavement, and later, explanations for why emancipated black people appeared to be worse off once they were out of the paternalistic cocoon of slavery. With biological ideas of race and managerial ideas of enslaved health at their disposal, mid-nineteenth century physicians in Cuba and Louisiana believed that they could prove the long-held notion that Black bodies were racially suited for slave labor by showing that there were systematic ways to foster their “naturally” robust productive capacities.

The first section of this chapter examines planter management of enslaved health and focuses on the specific language, techniques, and technologies planters used to account for health and productivity by tracking lost work time. The second section analyzes the functions of managerial concepts in physician writing on “plantation medicine,” “plantation

295 For the history of the medical ideas of blackness between the mid-eighteenth century and the mid-nineteenth century see Hogarth, Medicalizing Blackness; for the rise of polygenesist theories in the 1830s and 40s in U.S. medical education see Willoughby, “His Native, Hot Country”: Racial Science and Environment in Antebellum American Medical Thought,” Journal of the History of Medicine and Allied Sciences, Vol. 72, Issue 3 (July 2017): 328–351; for the use of medical ideas of blackness in pro-slavery arguments, emancipation and Reconstruction, and slavery apologia thereafter see Jim Downs, Sick from Freedom; and on racialized medicine in the nineteenth century more broadly see Engineer Willoughby, Yellow Fever, Race, and Ecology; Cooper Owens, Medical Bondage; Washington, Medical Apartheid; Savitt, Race and Medicine; Roberts, Killing the Black Body; and Peard, Race, Place, and Medicine.
hygiene” and “the management of negro health.” I show how physicians created medical therapies focused on increasing productivity, which included sick time; keeping enslaved people at work as much as possible; and constant monitoring for malingering and illness fraud. The final section of the chapter will demonstrate the intersections of managerial science and racial science in physician writing. Here, there were noticeable differences between Cuba and Louisiana, as physicians in both places believed that Black people’s bodies were the most naturally conducive to productivity, but in Cuba there were different degrees of blackness that needed to be taken into consideration.

**Timing Enslaved Health in Plantation Management**

Plantation managers tracked the hours, days, and weeks that enslaved people missed when they were sick in order to visualize production in the present and make adjustments that might increase productivity in the future. Alexander Blanche often described his most successful work days in terms of their lack of enslaved sick time, such as on July 14, 1852 when he had “no sick ones today, for the first day in sometime” and on August 9 of that year when he had “only one sick at present.”

For Blanche, these notations conveyed that most enslaved people were working consistently and that he was doing an adequate job of maintaining their health and the efficiency of his plantation. All of this thinking rested on his use of the clock, the calendar, and accounting ledgers, which together helped him determine how to manage enslaved health according to the daily, weekly, monthly, and yearly rhythms of cotton production.

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296 See entries for July 14 and August 9 in Blanche’s diary. Alexander Blanche Papers, LLMVC, LSU.
Planter used time discipline and accounting technologies to arrange all aspects of enslaved people’s lives, often arguing that such precise control would improve enslaved health. Louisiana cotton planter Joseph Acklen’s “Rules in the Management of a Southern Estate” exemplified this managerial philosophy. At the pinnacle of his enslaving career, Acklen owned nearly 1,100 people and several cotton and sugar plantations along the Mississippi River in West Feliciana Parish. After his death in 1863, the management of his plantations fell to his wife, Adelicia. Adelicia Acklen, like Rachel O’Connor, another successful woman planter in West Feliciana Parish, proved that Stephanie E. Jones-Rogers is correct in her recent assertion that white women were heavily involved in the economic dimensions of enslavement.\footnote{Stephanie E. Jones-Rogers, \textit{They Were Her Property: White Women as Slave Owners in the American South} (Yale, 2019).} White women like Adelicia Acklen clearly excelled in plantation business and management science, as she was able to expand on her husbands’ business after his death and even remain in the black after the Civil War, when many plantations went under.\footnote{This was actually the second time that Adelicia Acklen had taken over plantation management after the death of a spouse. Previously, she had become one of the wealthiest women in 1840s Tennessee after inheriting her first husband’s plantation properties. For biographic details on the Acklens see Richard Follett, \textit{The Sugar Masters: Planters and Slaves in Louisiana’s Cane World, 1820-1860} (LSU, 2007).} But before his wife took over the business, Acklen’s rules appeared in 1857-8 in \textit{DeBow’s Review}, a trade journal of “agricultural, commercial, and industrial progress” that enjoyed wide circulation in the American South from 1846 until 1884. Founded by planter, industrialist, and staunch pro-slavery politician James Dunwoody Brownson De Bow of New Orleans, the magazine was firmly pro-slavery prior to emancipation and even after it continued to function as forum for sharing managerial advice on plantation agriculture.
One of Acklen’s first rules for creating a successful cotton enterprise was hiring an overseer who understood that enforcing time discipline and strict daily schedules were essential to maintaining control over the valuable resource that was enslaved people’s health. “Order and system must be the aim of everyone on this estate, the maxim strictly pursued of a time for everything and everything done in its time, a place for everything and everything kept in its place, a rule for everything and everything done according to rule,” he explained, adding that “in this way labor becomes easy and pleasant” for enslaved people, but “no man can enforce a system of discipline unless he himself conforms strictly to rules.”299 It was an overseer’s responsibility to think about the productivity of the plantation in the short term and long term, keeping written records and overseeing daily hygiene regimens and health checks. Ultimately, overseers were beholden to time discipline, too. “Recollect that while in my employ your time is not your own,” Acklen warned, “I pay for it, and shall consider any neglect of my business as so much unjustly taken out of my pocket.” Even after the work day was done, Acklen wanted overseers to be planning for the next day, stating they should “every night before going to bed write up your diary, and think over what is to be done next day, and make a memorandum of it on your slate,” and each morning, “after rising, do not idle about, but go directly to the business of the day. If any of the negroes have been reported sick, without delay see what ails them, and that proper medicine and attendance are given.”300 The fact that the first item of “the business of the day” each day was the counting of sick slaves and arranging their treatment shows that it was a core managerial task. As


300 Ibid, 619.
Acklen explained, “the preservation of the health of the negroes, and the care of them when sick, will require your best attention.”

Tips for enforcing time discipline over enslaved health were ubiquitous in agricultural journals by the 1850s. One Louisiana planter writing in *DeBow’s Review* explained how the clock functioned in his “system” for “controlling of negroes:” “My hours of labor, commencing with pitching my crop, is from daylight until 12; all hands then come in and remain until 2 o’clock P. M., then back to the field until dark.” Beginning in May, when the days became hotter and longer, he might “prolong the rest three hours” during the afternoon, “if a very hot day, even four hours.” However, “breakfast is eaten in the field” and “dinner is carried to the hands” there as well in order to maximize the amount of time enslaved people could work. In addition to his daily timing of rest, sustenance, and work, this planter had a weekly schedule for the maintenance of enslaved people’s health and hygiene. “I give all females half of every Saturday to wash and clean up….The cabins are scoured once a week, swept out every day, and beds made up at noon in summer, by daylight in winter.” Finally, he advised plantation managers to make a jail on the premises for any enslaved person who needed to be punished, including those who had been “hard to manage in order to get a day’s work:” “put up a hewed log-house, with a good substantial door, lock and key, 12 feet high… Have air holes near the ceiling well protected by iron bars. The first negro that steals, or runs away, or fights, or who is hard to manage in order to get a day’s

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301 Ibid, 367.

work must be locked up every night as soon as he comes in from work and turned out next morning.” This was a time-saving, labor-controlling, and health-preserving practice that closely resembled what the ways that planters and physicians in Cuba talked about the prison-like barracks on sugar plantations.

Cuban planters saw time discipline as a cornerstone of modern agricultural production, like the division of labor and carceral housing. Some believed that imposing it consistently, as a key part of a “scientific” production schema, could be a way to reduce labor exhaustion. In August 1859, the planter-backed Matanzas periodical *El Eco de Matanzas* ran an article discussing the “application” of Adam Smith’s principles of production in Cuba sugar mills and highlighting the virtues of their “division of labor.” One anonymous Matanzas planter was quoted as stating that this “European advancement” had been “easily acclimatized among us” and had contributed greatly to labor efficiency by making it possible for enslaved people to labor perpetually and at a steady pace that suited production. As the article described it, “the main benefits produced by the division of labor,” were not just “increasing the product in a given time,” but also the fact “that workers do not waste time in changing occupations, place, position or instruments, nor are they distracted by imagination with new objects.” Most importantly, when enslaved people were subjected to such modern managerial principles, their “spirit and body acquire extraordinary ability to perform simple and continuously repeated operations.” A highly organized, sub-divided workforce together with time discipline could apparently improve the bodies and minds of enslaved people such that they would be able to overcome exhaustion and become the most efficient and productive sugar workers. As this example suggests, Cuban planters had figured out a

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managerial fix for labor exhaustion, at least for their purposes, long before Progressive era business owners, physiologists, and psychologists set their attention to the problem of “industrial fatigue.”

The Eco article went on to explain that the division of labor was a “palliative” if not a “remedy” for those plantations that suffered from high death rates of enslaved people and a lack of access to the illegal trade of enslaved people of African descent. The trade in unfree Chinese “coolie” laborers, which had existed in Cuba since the late 1840s, was one “advantage” that was helping to alleviate the problem of slave death. For the sugar planters who did not hold Chinese labor contracts, “the lack of noticeable arms demands that it [division of labor] be applied as palliative, or hopefully, as a remedy.” This was “much more doable today as the improvement of the devices and the advances that daily apply science to steam engines” had “greatly facilitate the above-mentioned division.”*305 A similar claim about the health-sustaining benefits of the division of labor and plantation management advances generally could be found in Revista de la Habana, a popular biweekly covering science, arts, and commerce in Cuba. In 1854 Revista editors claimed that the planter elite of the island as well as “foreign visitors” widely acknowledged that Cuba’s plantations were cutting-edge operations, exceeding what was possible on “farms of the same kind in the United States and even in Brazil” in terms of their use of technology, sugar manufacturing

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305 Ibid, 43; in March 1846, the Cuban Junta de Fomento (Board of Trade and Development) accepted an offer from the Spanish-British firm Zulueta and Company for the importation of six hundred laborers from China. Since the enslaved uprisings of 1841-1843, some Cuban planters pushed for the importation non-black laborers who would be less likely to conspire with black slaves and libres de color. See Libro 195, pgs. 21-37, in Fondo Junta de Fomento, 195/8746, ANC; background on the coolie trade in Cuba and its aftermath can be found in Kathleen M. López, Chinese Cubans: A Transnational History (UNC, 2015); Daniel Rood has illustrated how Cuban sugar planters changed their racialized labor systems (and subsequently, their understandings of race) to incorporate Chinese “coolie” laborers in the 1840s and 50s. See The Reinvention of Atlantic Slavery.
expertise, and organization of labor, all of which aided in the “preservation” of enslaved labor.  

As a key part of this “preservation” of labor, planters planned medical care for enslaved people to maximize the amount of time they spent working. For one Louisiana sugar planter, it was critical that sick enslaved people be sent to the “plantation hospital” as soon as it was discovered that they were ill. There they would be evaluated and would “receive such medicine and care, as is necessary” for them to be sent back to work. On his plantation, all tools, technologies, and basic aspects of enslaved life – including feeding, bathing, dressing, and sleeping – were examined with “regularity” and deployed “in an efficient manner.” Medical care for enslaved people was no different. In order “to accomplish a full day’s work,” enslaved people’s bodies, like “ploughs, wagons, harness, and all the tools” had to be “planned and provided for” and “kept in working order.” Planters and the managerial staff had to be diligent in their investigations and continual surveillance of enslaved health because “no slighting of any kind of work is allowed.”

As Joseph Acklen put it, “nothing can so much contribute to the good health of the negroes, as the strict enforcement of the system of discipline and police.” His “prescriptions” for this system included the use of bell to signal the beginning of the work day, key intervals, and the end of the work day. The first bell each morning would be used to summon enslaved people, requiring them to assemble at a specific location within “twenty minutes after ringing the bell.” The overseer would take attendance, noting any absences, before dispensing work assignments, but “all sick negroes will be required to report to the

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306 Revista de la Habana: Periódico Quincal de Ciencias, Literature, Artes, Modas, y Teatros, etc. Tomo I: Septembre 15, 1853–Marzo 1, 1854 (La Habana: Imprenta del Tiempo, 1854), 7.

manager at morning, either in person, if able to do so, or through others, when themselves confined to the house.” After taking “morning call,” checking all supply stocks, and seeing to the proper feeding and gearing of the cattle and horses, the overseer was allowed to break for breakfast, but “immediately after, he will visit and prescribe for the sick” and furthermore “the sick should be visited, not only every morning immediately after breakfast, but at such other times of the day and night as cases may require.” Sick enslaved people would be treated with “suitable medicine, diet, and other treatments” which would be “administered by the nurse, or, in more critical cases, the physician should be sent for.” Acklen added that “an intelligent and otherwise suitable woman will be appointed as a nurse upon each plantation…to administer medicine and otherwise attend upon the sick.” Overseers also had to inspect enslaved people’s food to make sure it was adequately nutritional as well as their clothing and housing every Sunday to ensure they were “kept clean and in order.” Enslaved people were not allowed to spend any time outside of work fraternizing with enslaved people on other plantations, or “free negros,” and those who were married to other enslaved people off-plantation were regulated to visiting their loved ones on one day of the week. Echoing the concerns of Chateausalins, the French physician in Cuba whose 1831 medical handbook noted that time off the plantation contributed to ill-health, Acklen emphasized that “all running about at night is strictly prohibited, and any negro found out of his or her quarter after the last bell, without permission or good reason, must be punished.”

The correspondence of José Blanco, administrator of the Santa Rosalía sugar plantation in Cienfuegos, shows that sugar planters in Cuba measured the health of enslaved

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people and the health of the plantation using productivity and the same language of “working days,” “sick days,” and “days lost.” Even in the last decades of slavery in Cuba, as the sugar market was on the decline and Cuban creole nationalists engaged in open revolution against Spain in the Ten Years War (1868-1878), managers on large plantations in western Cuba had not deviated from their habit of seeing enslaved health through the prism of time discipline. In a letter to his brother, Manuel Blanco, the owner of Santa Rosalía, José was pleased to report that Santa Rosalía plantation had been particularly productive in March, 1876: “it is my honor to tell you that we have had the boilers going all month long and we have produced 24 barrels as of 5 this morning. We worked on the morning of Sunday 28th so that we have a total of 26 days of work this month.” This steady streak of work time, which ran up until the very morning of José’s writing, was evidence that the plantation machine itself was in good health. He wrote that “the cane fields, the milling, and the slaves” were “more robust and healthier than this time last year.”

José María Pérez, an overseer at Santa Rosalía in the late 1870s, wrote of the days said enslaved people had lost while in the infirmary, as well as whether or not they were working fast enough to make up that time. Whereas José Blanco’s correspondence showed a positive correlation between health and working days, Pérez’s correspondence showed the opposite, as well as the lengths management would go to make sure that all time lost would eventually be recovered. In a letter to Manuel Blanco dated June 18th, 1879, Pérez stated that “yesterday afternoon a strong shower fell and the water turbines were shooting spent cane,”

309 Similarly, as Rebecca J. Scott has argued, Cuban enslavers in the major sugar districts such as Matanzas and Cienfuegos did everything in their power to retain their slavery-based systems of sugar production after emancipation because they still believed the slavery was the most productive and profitable labor system. See Slave Emancipation in Cuba: The Transition to Free Labor, 1860-1899 (Princeton, 1985).

310 Letter dated March 30, 1876. C. M. Lobo No. 15, BNJM.
but apparently enslaved health was not cooperating and the plantation was still losing work
days. “There are no new developments regarding the stomach aches,” he said, and “there
were 16 in the infirmary this morning.” Pérez knew that the days lost to stomach aches in
June needed to be made up in July, and thus it would be necessary to force enslaved people
to work on Sundays and holy days, when they were otherwise expected to attend mass. On
July 16th, Pérez noted that he had been making the sick slaves work on Sundays and some
“feast days” to make up for “the days they have missed.”

An enslaved person at Santa Rosalía might be able to avoid work and seek care in the infirmary – especially if there was
someone working there who could be trusted – but the sick time would be noted, and
ultimately, it would fall on them to make it up.

This strategy of recording and then recovering days lost to enslaved illness gets at the
core purpose of sick time: it was not time for an enslaved person to heal, but rather time set
aside to medically manage their condition enough for them to return to work. The writings
of Thomas Affleck, one of the most influential figures in plantation management science in
the U.S. South, exemplify this definition of sick time. Affleck owned several cotton and
sugar plantations in Mississippi, Louisiana, and Texas at different points during his life and
regularly published in agricultural trade journals. In 1847-8 he published Cotton Plantation
Record and Account Book: Suitable for a Force of 80 Hands, or Under and Sugar Plantation Record and
Account Book. Both texts were part instructional manual and part pre-printed ledger
containing the various accounting tables and fill-in forms. Affleck’s texts were widely
popular and went through several editions before the Civil War.

311 For both letters see C. M. Lobo No. 10, BNJM.

312 For a discussion of Affleck’s cotton record book and the circulation of pre-printed managerial record books
throughout the South and the Anglophone Atlantic world see Rosenthal, Accounting for Slavery, 71-79.
In two articles published in *Southern Medical Reports* and *DeBow’s Review* during the 1850s, Affleck demonstrated how he regulated the amount of time devoted to enslaved people’s health conditions and how to strategically allow some sick time to lessen the impact of illness on production. The piece in *Southern Medical Reports* was a question and answer style interview where Affleck responded to a series of questions from the editor of the journal, New Orleans physician Erasmus Fenner, who stated that Affleck was one of the “most scientific agriculturalists in the Southern States.”

Fenner’s questions covered a variety of topics from proper food, clothing, and housing for enslaved people to whether or not Affleck believed “whites and blacks are equally liable to the customary prevailing diseases” in the southern climate (his answer was yes, but “negros have diseases peculiar to themselves” and often showed different symptoms compared to white people). It was the eighth question, on the “ordinary management of negro children,” that prompted Affleck’s longest and most detailed response. This task required precise schedules for enslaved mothers, their children, and the “careful old women” who would take care of the children while their mothers worked:

> Upon every plantation working, say, twenty hands or more, there is a nursery, with a careful old woman, whose business it is to take care of them, wash them, cook for them, etc. Every mother carries her cradle, blankets, mosquito-bar and child to the nursery, before she goes out in the morning, after suckling. Whilst under nine months, the aim is to have the child suckled every three and a half to four hours, the mother coming in for the purpose; and this rule is rarely exceeded. Where the distance is great, say over three or four hundred yards, good managers have a large, dry, airy shed in the field where the hands are at work, and there the children, cradles and all, are taken by the nurse, in a cart, or otherwise, so soon as the dew is off — an excellent practice.

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To make sure enslaved mothers were still able to reach their maximum productivity, Affleck had calculated exactly when, where, and how often they were allowed to nurse their infants. If the walk from the field to nursery was far and would take up too much work time, the entire nursery could be brought to “where the hands are at work.” For planters who could not or did not prefer to force some enslaved women to serve as wet nurses for other women’s children, this was an efficient solution to the problem of enslaved mothers needing time to care for their children.315 It allowed planters to maintain the productivity of current enslaved people and safeguard the health of the future workforce simultaneously.

In his 1855 article on “The Duties of an Overseer” in De Bow’s Review, Affleck again stressed that maintaining enslaved health and productivity simultaneously was one of the most pressing responsibilities for managers. “The health of the negroes under your charge is an important matter,” he wrote, for “much of the usual sickness among them is the result of carelessness and mismanagement.” Affleck believed an overseer should be able to “competently manage” the majority of medical cases, but if not, he should “send for a physician.”316 He provided several general recommendations for medical care, many of which focused on reducing inflammation, irritability, and improving enslaved people’s behavior. After he explained that “stimulating articles of diet or medicine should be avoided,” Affleck suggested periods of “rest and quiet, to prevent undue excitement in his system” while also aiding a “whole catalogue of diseases.” Where some therapies like bleeding and purging might be “more likely to be productive of injury than benefit,” these

315 For more on this problem see Turner, Contested Bodies; and Morgan, Laboring Women.
periods of rest away from work did not carry the risk of worsening the condition, which would of course mean more sick time in the end.\textsuperscript{317} Instead, a diligent overseer could decide to sacrifice some work time upfront, avoiding a longer interruption in production, and while making a record that could be used to ensure accountability later on.

Sick time was therefore one method of mitigating lost time that in theory benefited the enslaved patient, who would have a break from work to recover. In practice, however, it was similar to other violent productivity innovations that planters unleashed on enslaved people during the acceleration of slavery. Planters and overseers could now track the speed and the total output of individual enslaved people and force them to maintain or increase their numbers from the previous day. Cotton planters in the U.S. South recorded the weight of each enslaved person’s pick sack on a daily basis during the harvest, comparing the haul to what the enslaved person had picked on previous work days. If the weight was higher than previous days, it became the new quota, but if it was lower the enslaved person might be punished proportionately to the number of pounds missing from the sack, e.g. five pounds less than the day before meant five lashes. Caitlin Rosenthal has argued that the mass labor processes involved in sugar production largely prohibited sugar plantation managers from developing similar individualized production quotas.\textsuperscript{318}

Yet, plantation records from the final years of slavery in Cuba do indicate that some plantation overseers were monitoring and comparing enslaved people’s typical work speeds on an individual level. On July 22\textsuperscript{nd}, 1879, Santa Rosalía overseer José María Pérez explained to Manuel Blanco that “according to reason” he had “scolded the negro Panfilo for not

\textsuperscript{317} Ibid, 343.

\textsuperscript{318} Rosenthal, \textit{Accounting for Slavery}, 86–7; see also Calvin Schermerhorn, \textit{Unrequited Toil: A History of United States Slavery} (Cambridge, 2018), esp Chapter 8 “Industrial Discipline.”
working as fast as he did on Saturday morning. The machines will not work themselves of course.” Apparently, when Panfilo failed to work faster to meet or exceed the standard speed that Pérez had in mind for him, Pérez threatened to “scold” all of the enslaved workers as further punishment for Panfilo’s shortcomings. Although Pérez did not explain what this “scolding” entailed, the punishment delivered to Panfilo coupled with further threat to harm other enslaved people on Santa Rosalía seems to have worked, as Pérez wrote that “he [Panfilo] and the others have been tolerable ever since.”

Another strategy for recovering time lost was to reallocate sick or otherwise indisposed enslaved people, fitting them into another subdivision in the plantation workforce so that they could continue to be productive even if they were not able to perform the major sugar making tasks in the field, the mill, or the boiler house. In the late 1850s, Robert Ruffin Barrow of Terrebonne Parish, Louisiana owned more than a dozen sugar and cotton plantations across Louisiana and Texas. Records from his Residence Plantation in Terrebonne demonstrate that he and his managerial staff created work “gangs” of enslaved people with specific health conditions. In fact, all of the enslaved people at Residence were assigned to a specific role or work gang in the plantation “system” using a table for the “classification of han[d]s,” which was regularly edited to reflect specific work tasks that needed to be completed throughout the year. This table helped Barrow and his staff picture the “balance of hands” across each work task and how enslaved people’s health conditions impacted the status of each task. New tasks were added to the table as needed or noted in daily summaries of work accomplished. When measles swept through the plantation

319 Letter from José María Pérez to Manuel Blanco (July 22nd, 1879). C. M. Lobo No. 10, BNJM.

in December 1857, just before the sugar harvest was scheduled to begin, Barrow’s top manager Ephraim Knowlton formed a “measles” gang made up of enslaved people who were believed to be suffering from the disease but according to Knowlton could still perform lighter tasks that would ensure the “cutting” began on time. At other points during the year, Knowlton created a “suckler’s gang” of nursing enslaved women after realizing that these women could be put to work “cleaning cane fields” and “clearing ditches” while they nursed enslaved children, and possibly white children, too.321 From the managerial perspective, reallocating enslaved women in this way helped to diminish the problem of sick time, and it also meant that nursing enslaved women could be made into doubly-productive laborers. Nursing enslaved women could be forced to recuperate some work time in the short-term while they contributed to the long-term productivity of the plantation via the reproduction of the enslaved class.

Louisiana cotton planter Joseph Toole Robinson also used tables and other accounting tools to regulate enslaved people’s activities and enforce hygienic standards with the goal of reducing sick days. Robinson, who was owner of the Willow Point Plantation in Red River Parish, ran a smaller operation than Acklen, Affleck, Blanco, or Barrow, but he was an avid consumer of agricultural trade journals and pre-printed record books. For the years of 1854-5, Robinson used a copy of J. Randolph’s best-selling Plantation and Farm Instruction, Regulation, Record, Inventory and Account Book as his primary managerial reference book, accounting ledger, and daily journal. His handwritten notes in the book include bracketing of Randolph’s recommendation that managers perform weekly inspections of

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enslaved people’s cabins to ensure that they were “clean and in good order” and Randolph’s suggestion that enslaved people “put on clean clothes every Sunday morning.” Lack of cleanliness or injury resulting from wearing torn clothing must be avoided so as not to inhibit the pace of production.322 Robinson had a copy of Affleck’s *Cotton Planation Record and Account Book* for the year of 1859, making use of its standardized table of “Physician Visits to the Sick” to record the dates of physician visits; the cost of their services; the slave(s) they attended and what “diseases” they treated; and enslaved people’s sick time, which was noted in a column marked “date when the patient entered and left the hospital” (Figure 3). The cost of slave illness in work time was just as important to Robinson as the cost of the physician’s bill.

322 See Robinson’s daily journal entries for 1854-1855 in Vol. 1, Joseph Toole Robinson Papers, 6 vols, Mss. 1413, LLMVC, LSU; and for the annotated version of *Plantation and Farm Instruction, Regulation, Record, Inventory, and Account Books* (Richmond, VA: Randolph, 1852) see pg. 10, Vol. 2, ibid.
Robinson also recorded enslaved health data alongside daily productivity data, which included the number of hours enslaved people worked, how many pounds of cotton they picked, and other numerical data on work tasks. In January 1859, as he was preparing for cotton planting, Robinson noted that the male slaves of Willow Point together had split “1000 rails” and that “Fanny delivered dead child on the 10th mid-day.” This notation of a still-born infant did two things for Robinson: it was a reminder that Fanny did not work on January 10th and it was a record of an interruption in production. Robinson could use the information to account for any dip in productivity and make adjustments to enslaved labor
going forward. Whether he was making monthly summaries of plantation activities or daily entries, he always made sure to name the enslaved people who were sick and the number of days that they had missed. Those who were sick had to make up their days on Sundays, and if they were sick too often, they might be punished with “whipping, standing in the stocks from Saturday night until Monday morning, or deprivation of the meat ration.”

Robinson use of Affleck’s record book is significant because it reveals how planters learned about the management of enslaved health in part by doing it with mass-produced accounting technologies. But such ideas and practices were not limited to planters who could afford books and the time to read them. By the mid-nineteenth century, management science had permeated plantation business culture at all levels. Some Louisiana cotton planters extended threats regarding lost time to other plantation laborers, so not only were enslaved people held responsible for lost days, but so were white wage workers. There were very important differences between the two, to be sure. Franklin Hudson, owner of the Blythewood Plantation in Iberville Parish, Louisiana noted enslaved people’s sick days on a daily basis in 1854-1856 and indicated when they were made up, but he also made it clear to his overseer that he would dock his pay should he lose significant time to illness. “I have bargained with H. G. Lockett as overseer at the rate of $250 to commence on the 3rd of this month,” Hudson wrote, adding that “it is verbally understood that if he loses 3 or 4 weeks by sickness then a deduction is to be made of the lost time.” Hudson could remind Lockett that wages came from his time and any infringement on that time due to ill-health would need to be recovered at a cost to the worker. But Hudson could not force Lockett to

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324 Hudson Diary, vol. 2 (1854-1856), 7-23. Franklin A. Hudson Diary (1852-1859), MSS 2290, SHC.
work if he took too many sick days. It is also likely that Hudson, like most planters, believed Black people’s bodies were more capable of hard labor in the first place. This meant that the relationship between health, labor, and time that he saw in a Black enslaved body was not the same one he saw in a white wage-working body. For an enslaved woman named Nelly, who appears to have been the person providing most of the medical labor at Blythewood, the threat Hudson gave to Lockett simply was not necessary because Hudson owned her, her time, and any money she received for medical services off the plantation. In April 1857, Nelly attended a carpenter’s wife and eventually help her to deliver a child, but the $15 she was paid went to straight to Hudson.325

The connections that planters drew between health, labor, and time thus had some mobility across categories of labor, with some clear racial differences, and they were also somewhat adaptable to scale. The malleability of managerial knowledge has already been demonstrated in the fact that the same concepts and practices could be found on sugar and cotton plantations. The former usually have ten times the enslaved people of the latter, as well as more managerial staff, experts, and technology to meet the demands of a much more complicated production process. But for some planters who did not have the money to accumulate more than a few of enslaved people, knowing simple healing techniques was one way to possibly extend work and increase productivity overall. One such planter was Everard Green Baker of Jefferson County, Mississippi. As he does not mention an overseer or any doctor visits in his writings, or even the total number of enslaved people he owned, it is possible that Baker’s cotton plantation was much smaller than Robinson’s or Hudson’s. All

325 Hudson recorded Nelly’s midwife services as such: “Nelly called to Mr. Ventress’s carpenter’s wife last night, April 2nd 1857 - $5. Paid $5 on April 3rd 1857. Nelly called to Mr. Ventress’s place a second night - $5. Delivered woman. Nelly called April 8th to Mr. Ventress’s carpenter’s wife - $5.” Hudson diary, vol. 2, 68, SHC.
the same, Baker’s business records and diary contain ideas that were similar to those that existed on large plantations, including notes on how to conserve resources and time in medical care for enslaved people. Instead of calling for a physician, Baker had his enslaved people consume an “invigorating drink…when one feels debilitated and unwell from disorder of the stomach.” This drink was easy to make, “mixing together a teaspoonful of salt and as much as pepper and vinegar as palatable,” but was particularly good for those undertaking “strenuous work.” Furthermore, Baker’s diary demonstrates that he conceived of his wealth and his time as a direct result of the bodily exposure and exhaustion that he forced upon his slaves. On February 13th, 1849, Baker wrote that he intended “to be henceforth stingy as far as necessary expenditure” of money and time as he believed “a man should not squander what another accumulates with the exposure of health and the nearing out of the physical powers.” Baker understood that his time – for his own work and other pursuits – and his wealth ultimately came to him through “the negro by the hardest labor.”

Managerial ideas also had traction outside of management discourse altogether, as seen in the papers of Dr. Joseph S. Copes, who was a well-known physician and medical academic in Louisiana. In addition to his medical career, Copes ran side businesses in contract slave labor, insurance, and legal services. After receiving his medical degree from Jefferson Medical College in Philadelphia in 1833, Copes had moved to Mississippi to take advantage of the booming cotton economy. He married the widow of a wealthy planter in Tchula, Mississippi in 1835, acquiring both enslaved people and cotton plantations, all while becoming a prominent doctor in the Jackson area. He relocated with his family to New Orleans in the late 1840s and continued to manage his plantation holdings from afar.

326 Everard Green Baker diary and plantation notes, I: 37; II: 3. Everard Green Papers, MSS 41, SHC.
Alongside his lucrative private practice in New Orleans, Copes was involved in the administration of Charity Hospital, where he helped establish the hospital’s first Board of Physicians and Surgeons in 1851.\textsuperscript{327} He was also an active member of several Anglophone medical institutions and a co-founder of the Mechanics Institute of New Orleans, a vocational school that taught trade skills to improve the “intellectual and moral habits of workers.” The Mechanics Institute ended up being the site of one of the bloodiest racial massacres in postbellum Louisiana. In 1866, a group of Freedmen gathered at the Institute to protest the state legislature’s refusal to extend voting rights to Black men. A mob of white rioters, many of whom were former Confederate soldiers, attacked them, killing somewhere between 34-50 Black people and injuring as many as 150.\textsuperscript{328}

Copes’ interests in reforming medicine, public health, and labor may have grown out of his views on plantation management science, including the notion that ill-health was a problem chiefly because it was a problem for productivity. In 1851, he “hired out” several of his slaves to work in a brick factory in Biloxi, Mississippi and his correspondence with the overseer of the factory demonstrates that at some point he had begun using the exact same ideas and language that planters used to managed enslaved sick time. On February 23\textsuperscript{rd}, 1852, overseer Walter G. Baylor provided Copes with a list of the “lost time of your hands” from June 10\textsuperscript{th}, 1851 to February 23\textsuperscript{rd}, 1852 (Figure 4).

\textsuperscript{327} See the biographical summary that accompanies his papers in Joseph S. Copes Papers, MS 733, LaRC.

\textsuperscript{328} For quote see letter from Copes’ co-founder colleague, Dr. David Macaulay (October 14, 1848), Box 7 in Joseph S. Copes Papers, LaRC; for the 1866 massacre see W.E.B. Du Bois, \textit{Black Reconstruction} (New York: Russell and Russell, 1935), Chapter 11: “The Black Proletariat in Mississippi and Louisiana.”
In this letter, Baylor, the overseer, was reporting on the health of Copes’ slaves, but he only included the most important information, which was the amount of work time each slave had missed. The sick days of enslaved laborers Edmond, Osborne, Willis, Becky, Cloe, Esther, Sally, Adeline, and Ned had cost Copes a total of $63.31 in profits and a grand total 204 ½ working days. “As you see I have mad[e] the distinction between lost time from sickness & from accidents, casualities, &ce,” Baylor explained. Perhaps time lost to injury was considered the fault of a careless worker and who might then receive extra punishment, beyond possibly having to make up the work day at some point in the future.

As the Copes correspondence shows, on plantations all over western Cuba and the lower Mississippi Valley – and apparently in some brick factories, too – the enslaved patient
was becoming something more than a sick person. They were also becoming the embodiment of their master’s work time that was in the process of expiring. This inspired planters to seek out the medical consultants whom they believed possessed the most trustworthy and efficient healing methods, and a self-conscious class of such experts was emerging to meet demand.

**Physician Writing on the Management of Enslaved Health**

New Orleans physician Erasmus Fenner praised Thomas Affleck’s efforts “to introduce more system and order in the management of plantation affairs.” Fenner was impressed with Affleck’s “Plantation Record, a blank book which has been admirably arranged” to carry out such systematic management. This accounting innovation enabled precise “calculations” of agricultural production that far exceeded what was typically possible in “that homely primeval employment, (tiling the ground,) which is by far the most important pursuit in this great and growing republic.” Fenner valued Affleck’s insights into the medical management of enslaved people because he saw that they were based in quantifiable information, copiously gathered using sophisticated accounting tools, modern, industrial-like production and organizational practices, and the strict enforcement of time discipline. Fenner stated that Affleck’s interview in the *Southern Medical Reports*, “in connection” with a paper from New Orleans physician Samuel Cartwright in the same volume, was to be “the beginning of a series, to appear from year to year, which, we trust, will promote the true interest of the master and ameliorate the condition of the slave.” The explicit purpose of this joint intellectual venture between physicians and “scientific agriculture” was therefore to create
medical knowledge that would lessen the total number of sick days on a plantation and boost productivity, which was the “true interest of the master.”

For Fenner and other physicians who shared this perspective, planters like Affleck had made a standardized way to think about and even predict how the body would respond to health, labor, and illness. In their minds, productivity-tracking management practices could be reliably reproduced across plantation landscapes, enslaved labor forces, and agricultural commodities. Consistency gave these physicians-writers the confidence that they were producing widely effective plantation medical knowledge, even though many of them actually lived and worked in cities like New Orleans and Havana. The assumption that they, as erudite, urban-dwelling physicians, had the most expertise in the management of slave populations reflects the history of Spanish colonial medicine and biopolitics. By the middle of the nineteenth century, these physicians could strengthen their already plausible claim to economically-conscious medical expertise by displaying their knowledge of plantation managerial science and their understanding of the significance of continuous productivity.

Physician acceptance of the segmenting of time according to production was critical to all of this. Historian of medicine Steve Stowe has argued that nineteenth century southern physicians often conceived of time in relation the amount of time they spent on various medical cases. Stowe posits that physician experiences of this case time shaped how they thought about illnesses and their own identities as healers, as the accumulation of case time became a way of self-making expertise. It was common for physicians writing on plantation health management to draw on evidence from past cases and the temporality of those case likely influenced their work. For example, the numbers of sick days taken in past cases where

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the patient recovered (at least enough to work again) might influence how the physician treated the same condition in the future. However, with advent of plantation management science, physicians were necessarily thinking about both time and their patients in terms of an explicit realm of production that was governed by rational laws. Important too, plantation time discipline was standardized, unlike the case time that was largely built through personal experience. Plantation time provided a seemingly universal, objective means for understanding health through the calculation of individual and collective productivity.

New Orleans physicians brought plantation time discipline and productivity metrics into the realm of urban public health when they fretted over “working days” and “capital” lost when laboring populations fell ill. Discussing the significant “pecuniary loss” from some 6,687 cases of yellow fever amongst free and enslaved laborers in the city, prominent New Orleans physician and sanitary reformer J.C. Simonds calculated that “the number of days' sickness was, then, 10,579,800…equal to 28,985 years of sickness,” given that the average length of the illness was two weeks. Simonds estimated that “one-half the amount of sickness” occurred in patients who were in their working years – the “producing period of life.” Furthermore, “supposing that that there are 300 working days” with “fifty-two Sundays and thirteen days lost by holydays,” this meant that during the last “four and one fourth years, the city has lost a product of 4,347,750 days” to sickness. The financial impact of sick days was further compounded by the “expenditure of money for medicines and medical services,” including hospital stays. Charity Hospital charged “$1 per day for slaves.”

In addition to the language of working days and sick days, the most striking example of the naturalization of time discipline and managerial priorities into medical discourse was

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physicians’ adoption of sick time, the remedy for enslaved ill-health that was actually a remedy for work time lost. Samuel A. Cartwright understood how planters used sick time. Cartwright was born in Virginia and practiced medicine in Alabama, Mississippi, and eventually New Orleans. He received criticism from other physicians for his theory of drapetomania, which he described as a mental condition that afflicted enslaved people with the desire for freedom. Whether or not they supported slavery, most physicians on both sides of the Mason Dixon line attributed enslaved flight to the brutal conditions of enslaved labor, not a mental illness that was specific to Black people. Cartwright also differed from his contemporaries in his belief in monogenesis (the idea of common human descent), whereas most physicians of his ilk had moved on to polygenesist ideas of racial difference by the 1850s.331 However, Cartwright was no different from other physicians in the lower Mississippi Valley when it came to his views on plantation management science as a structure for medical thought and practice.

In an 1851 DeBow’s Review article on the “Diseases of Negros - Pulmonary Congestions, Pneumonia,” he explained that allowing enslaved people some time off from work was an important prevention against conditions that accompanied “hard usage” and “over-tasking.” He considered it “bad government” to let sick enslaved people languish “without inquiring into its causes” and if necessary “removing them” from the workforce for a certain amount of time depending on the severity of their condition. This temporary reprieve from work would supposedly interrupt the “continuance” of symptoms such that they would not progress any further and may even begin to lessen. Thus, sick time was a key

331 For more on Cartwright’s views see Christopher Willoughby, “His Native, Hot Country,” and “Running Away from Drapetomania: Samuel A. Cartwright, Medicine, and Race in the Antebellum South,” Journal of Southern History 84, no. 3 (2018): 579-614.
component of good management and good medicine for enslaved people precisely because it seemed to reduce the duration of illness.³³²

Another physician and cotton planter in Mississippi claimed that sick time it was one of the most effective strategies to “preserve the health and promote the general well-being of the slave.”³³³ Sick time was the last and most vital step in a standard procedure that was activated as soon as an enslaved person was discovered to be ill:

When a negro is taken sick, he should be at once taken to the hospital; his dirty clothes taken off, and his whole person thoroughly cleansed before being put to bed. He is then ready for medical treatment with a fair prospect of obtaining all the benefits to be derived therefrom…The patient is at once placed beyond the reach of the noise and bustle of the family, the crying of children, the opening and shutting of doors, and various other disturbances, always extremely annoying to the sick. But more than this; we are enabled to protect him from atmospheric vicissitudes, and without this it would be unreasonable to expect much benefit from medicine or anything else we could do. Under these advantageous regulations, convalescence will not only be hastened, but rendered doubly sure.

For this planter-physician, sick time shortened the duration of illness while also increasing the likelihood that the enslaved patient would recover. Placing patients in solitary confinement in the hospital and under constant surveillance was critical to the effectiveness of sick time, because only then could planters and physicians be sure that patients were not doing anything that might hinder their recovery and therefore disrupt both the managerial timing of enslaved health and their visualization of production, as well as the physician’s ability to assess illness and treat it swiftly.


Underlying physician prescriptions of sick time was the idea that work itself was therapeutic for enslaved people, and that keeping them working under “good management” was one of the best measures for prolonging their health. Though physicians often plainly acknowledged the extreme brutality of slave labor, they believed that using plantation management science to keep enslaved people working could actually prevent many of the ill effects of enslavement. They claimed that work and the cultivation of habits to better facilitate work were some of the best therapies for ill enslaved people. Together with sick time, cleanliness, and an aesthetic lifestyle, continuous work supposedly helped enslaved people recover swiftly, if not avoid illness. These treatments were hallmarks of what both planters and physicians considered “good management,” and according to many physicians, their absence was indicative of the kind of “bad government” or “mis-management,” which accelerated the deterioration of enslaved people’s bodies and their productivity.

Cuban physicians were convinced that work was one of the most effective therapies for enslaved people, as well as free people of African descent and other marginalized groups who had been deemed “mad.” As historian of Cuban medicine Jennifer Lambe has shown, labor as treatment was a consistent theme at Mazorra, an asylum located just outside of Havana which was founded in 1857 and remained Cuba’s only public psychiatric hospital until the Cuban Revolution in 1959. Although the institution itself, as well as the definition of madness, changed over time with different political contexts, for more than one hundred years Mazorra physicians emphasized that “locura” or “madness” often resulted from a dearth of strenuous labor, particularly when it presented in patients of African descent. As Lambe shows, that the centrality of work treatment throughout Mazorra’s history was an artifact of the institution’s “umbilical connection to the sugar-slavery complex.” Not only was Mazorra founded on a sugar plantation, but many of its early patients were ordered to
work in the sugar mill and in factories making tiles and bricks. These patients included
destitute people of African descent, both men and women; “emancipados” (formerly
erslaved people); and captured runaway slaves. Patients were also forced to live in barracks
which, according to one observer, closely resembled the prison-like barracks that planters
had built to house enslaved people, “with the same scarcity of light and absence of
ventilation.”

This idea that work, efficient lifestyles, and good management were the best
treatments for sick slaves can also be found in medical dissertations produced outside of
Louisiana and Cuba. Three dissertations submitted to the Medical College of South Carolina
(established in Charleston in 1823) show evidence of therapeutic regimens designed around
preserving productivity. Franklin Perry Pope’s “A Dissertation on the Professional
Management of Negro Slaves” (1837); M.D. McCould’s “Hints on the Medical Treatment of
Negroes” (1850); and H. W. Moore’s “A Thesis on Plantation Hygiene” (1856) all referenced
the “great advancements” in agricultural science underway in Louisiana and Mississippi, by
then the most profitable region of the U.S. South. They did this to establish the relevance of
their dissertation topics, but also to flag the scientific knowledge they were drawing on.
These references alone would not be enough to definitively prove that all southern
physicians who adopted managerial ideas of enslaved health did so specifically because
physicians in the lower Mississippi Valley did. However, the fact that Fenner and other
advocates of plantation management were prolific writers, widely referenced in medical
writing across the South during the 1850s, suggests that their views mattered to other

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For the quote about the barracks see 95; for the complete history of Mazorra until the Revolution see Lambe,
Madhouse: Psychiatry and Politics in Cuban History (UNC, 2016).
physicians of their race and class. Louisiana contributions to southern medical discourse, together with the expansion of the immensely profitable cotton economy, likely inspired medical students in other southern states to create medical knowledge that took plantation management as well-documented, scientific fact.

Indeed, it should be noted that as managerial thinking became more prevalent in medical writing during the 1850s it coincided with a significant increase in the numbers of people seeking medical degrees in the United States. In many states, leading physicians were beginning to see that requiring an M.D. in order to join their ranks was a way to ensure cohesion of medical philosophy, build a respectable profession, and eliminate competition from so-called “irregular” practitioners, once and for all. In the South, slavery was another major driver behind medical school enrollments because it brought more people, capital, and institutional infrastructure into the region. In 1861, there were 133 graduates of the Medical College of Louisiana in New Orleans, which was up from 33 just a few years earlier. Other major southern medical schools such as the Medical College of South Carolina and the Medical Department of Transylvania University in Lexington, Kentucky (established in 1818) saw rising enrollment rates during the decade leading up to the Civil War. All of these institutions claimed to offer education in the “distinctive” medical knowledge that was relevant to southern climes and the “peculiar” southern institution.


336 Stanford E. Chaillé, Historical Sketch of the Professors and Alumni of the Medical Department of the University of Louisiana (New Orleans: Bulletin Book and Job Office, 1861), 18.

337 For the place of “distinctiveness” in southern medical thought and education see Warner, “A Southern Medical Reform.”
The Medical College of South Carolina dissertations show that slavery’s influence on medical education during this period was not merely economic and ideological, but also intellectual, by way of management science. Like their colleagues in Louisiana and Cuba, all three dissertators argued that work and the regulation of enslaved “modes of living,” “habitation,” and diet were important preventatives against ill-health. Moreover, all of them displayed a tendency to measure enslaved health in terms of time and productivity. Franklin Perry Pope, author of “A Dissertation on the Professional Management of Negro Slaves,” stated that enslaved health could be gauged by “the amount of labor performed by a negro in the course of the year.” Pope’s dissertation included a section on “labor” which described, in chronological order, all of the work tasks demanded of enslaved people on cotton plantations, noting which were more strenuous and suitable for younger, stronger, and healthier enslaved people as well as the relatively light tasks, which could be assigned to “women and weak hands.”

According to Pope, improving enslaved health meant increasing the amount of labor they could perform, or the number of days they could work compared to the number of sick days they would need to take. This could be accomplished by designing enslaved housing to mitigate the “deleterious influence” of climate and weather, ensuring that all slave cabins to have some distance between them, adequate ventilation, and water tight roofs. Pope also discussed common illnesses on cotton plantations, including yellow fever and dysentery. He explained that the latter was largely the fault of enslaved people, as the “disease is most apt to occur when heavy falls of water succeed drought” and

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338 Pope, “A Dissertation on the Professional Management of Negro Slaves” (1837), 4-6. Waring Historical Library, Medical University of South Carolina, Charleston, SC (hereafter cited as WHL).

339 Ibid, 1-2; similar recommendations regarding the use of housing to conserve work time by mitigating environmental impacts can also be seen in Moore and McCloud.
enslaved people took to “drinking pond or ditch water.” Pope did not acknowledge the rather obvious managerial error at hand, which was the failure of planters to provide enslaved people with access to safe drinking water. Instead, he placed the blame on enslaved people, insinuating that they did not know the health hazards associated with stagnant water.

In attempt to further distinguish himself as a health management “professional” with deep knowledge of enslaved people and plantation production, Pope criticized enslaved nurses and midwives for their “improper management” of common ailments which apparently resulted in “trifling ill effects” for patients and the plantation as a whole. “Among the black females, prolapsed uteri is quite a common disease,” Pope explained, adding that “we believe it to be almost invariably occasioned by planters trusting so much to the ignorant Negro Midwives, to whose improper management we attribute at least nine tenths of the cases.” According to Pope, enslaved midwives were in the “habit of causing the patient as soon as delivered to arise from her bed, stand erect, and if the placenta does not then come away she is then taken by the shoulders and shaken severely, a practice in our opinion sufficient to shake them out of this world.” For Pope, this practice contributed greatly to enslaved mortality on the cotton plantation, as did the prevalence of tetanus, which was “generally occasioned by the Nurse or Mother carelessly suffering the infant to lie in wet clothes, particularly the bandage around the umbilicus, by which means the child takes cold and death soon closes.” Of course, in implying that physicians like him should, at the very least, be called to the plantation to provide “directions to the nurse” or enslaved midwife, Pope was admitting that planters showed no signs of terminating their reliance on enslaved medical laborers.

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340 Ibid, 11.
M. D. McCloud and H. W. Moore attempted similar rhetorical moves in their dissertations to distance themselves from other plantation medical practitioners, but unlike Pope, they located their expertise in the management of Black bodies specifically. Both McCloud and Moore opened their dissertations with musings on the “negro race,” whom, in Moore’s words, had “become naturalized among us” and “necessary to the welfare and prosperity of this country.”

In describing how the Black enslaved person had become “dependent on the white man” and now “looks to him for protection and guidance” and “to afford this protection and guidance is the master’s duty,” Moore invoked the typical paternalist defense of the master-slave relationship that other pro-slavery southern writers used, arguing that Black people could not exist without the diligent care of their masters. In both the U.S. South and Cuba, it was common for pro-slavery writers to point to communities of free Black people, whose supposed propensities towards crime, vice, vagrancy, and ill-health proved that Black people were naturally fit for the plantation and in fact achieved their maximum health toiling there.

For physicians like Moore, this was because improving Black health required the kind of scrupulous management that only slave-holders – and plantation slave-holders best of all – could provide.

Moore compared slave health to the health of other racialized laborers to demonstrate the therapeutic power of proper plantation management, but his comparative group was the “immigrant poor,” many of whom found work in the plantation economy as day laborers. Moore was especially impressed with housing standards on large cotton plantations in the South. He argued that enslaved cabins built on raised platforms and with separate rooms, good chimneys, and proper ventilation, did far more for health and “moral

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341 Moore, “A Thesis on Plantation Hygiene” (1856), 5. WHL.

342 Ibid, 5; and again see Downs, Sick from Freedom.
elevation” compared to the numerous hazards found in immigrant homes, such as the “demoralizing effects of this crowding together of sexes” in “the narrow dens of our city alleys” in “filthy abodes” with “stinking roofs.” Moore did not specify a racial background of his “immigrant poor,” but his imagery – particularly the idea that their “den”-like interior spaces were source of ill-health and disease – is very similar to the kind of language that U.S. public health officials used to demonize Chinese immigrants later in the nineteenth century.\textsuperscript{343} Importantly, Moore believed immigrant laborers suffered more illnesses than slaves, in part because they had no one managing them.

McCloud did not make explicit comparisons to other racialized laborers, but he did employ another common racist trope, which the notion that the “peculiar condition” of the “black race” made Black people especially suitable for intensely laborious work in hot climates – provided they were well-managed, of course. McCloud argued that slavery was “an affair of geography, rather than of choice,” as no other mode of production would be able to thrive in such “insalubrious” environs of the South. He also insisted that no other race besides the “negro race” would be able to endure the conditions of enslaved labor and southern climes. Thus, all of his recommendations for implementing effective health management were contingent on the fact that the plantation labor force was made up of Black slaves, but as long as this was true, his guidelines could be applied “universally” with expectation of good results.\textsuperscript{344}


\textsuperscript{344} McCloud, “Hints on the Medical Treatment of Negroes” (1850), 1-2. WHL; for the typical environmental determinist pro-slavery argument, see William Elliott, The Anniversary Address of the State Agricultural Society of South Carolina, delivered in the hall of the House of Representatives, November 30, 1848 (Columbia, SC: South Carolina Agricultural Society, 1848), 43.
McCloud’s dissertation stands out among the three in terms of the visibility of plantation time discipline in his writing. For him, one of the most important characteristics of a true medical expert was the ability to spot when enslaved people were not being truthful about their illnesses and were taking sick time without just cause. McCloud provided a long list of ‘‘symptoms’’ that could indicate when an enslaved person was lying to get out of work, which included falling ill or suffering an injury the day of a particularly grueling work task or during the cotton harvest, when the days were the longest and most difficult. Placing the topic of illness fraud at the very beginning of his dissertation, McCloud explained that

The nature of the daily avocations of the negro is frequently so disagreeable that sickness is feigned in order to escape the unpleasant tasks assigned to him. He will complain of violent pains in the head and limbs, of a loss of appetite and of many other anomalous symptoms. The master will administer medicines for days in succession, but no good result will follow. The negro prefers to take the medicine until the time when more agreeable work is to be done on the plantation; he then recovers rapidly and soon is at work again. Such cases frequently fall under the observation of the physician, and to detect the imposture constitutes a most difficult task; one which requires all his discrimination and acuteness.\(^{345}\)

By frankly stating that he often doubted enslaved people’s own assessments of their bodies, McCloud was clearly participating in the broader medical discourse on blackness where physicians often argued that Black people possessed sturdier bodies and thicker, tougher skin that made them more resistant to injury and pain.\(^{346}\) They supposedly did not require the same recovery time that white people did after serious physical activity and any request for it should be automatically treated with suspicion. McCloud was also utilizing plantation

\(^{345}\) McCloud, 2.

management science in this statement, specifically its fundamental law of minimizing work time lost to enslaved ill-health in order to improve health, morale, and productivity. Implying that he, a white male physician, not an enslaved nurse, had the “discrimination and acuteness” for the “most difficult task” of recognizing enslaved people’s malingering, McCloud presented himself as someone who fully understood the purpose of medicine – and therefore medical professionals – in the plantation sphere of production. They were a stop-loss for slave labor productivity.

In many ways, medical discourse on illness fraud, the benefits of work, and the necessity of meticulous management supported a kind of social amnesia surrounding the sheer physical atrocities of slavery. The management of enslaved health functioned as ongoing justification for exploitation while at the same time pathologizing the violence and trauma of slavery. It made enslaved people’s suffering and pain into problem of time, “habit,” and dearth of work, all of which could be solved with good management. Echoes of this thinking would appear later around the turn of the twentieth century in medical discourse on industrial fatigue. Those physicians and physiologists, knowing that worker productivity was the upmost concern for business owners, argued that worker fatigue was evidence of a lack of managerial oversight and properly applied Taylorist principles, both of which could ensure that the body’s finite energy reserves would not deplete so fast as to cause them to be unable to work. But long before these medical scientists speculated on the therapeutic value of scientific management, physicians in slave societies emphasized that precise, technologically sophisticated management could reduce the rate of illness on the

347 For more on this Rabinbach, *The Human Motor*, and Blayney, “Industrial Fatigue and the Productive Body.”
planted and solve the problem of lost productivity, no matter the horrible conditions of slave labor.

**Racializing Productivity in Cuban Medical Discourse**

Physicians felt confident making such claims because they synced with widely-held ideas of racial difference. As Moore and McCloud’s dissertations show, part of what made the management of health seem “universally” efficacious was the fact that it almost always tapped the notion that Black bodies had their own medical “peculiarities.” Indeed, knowledge of racial science and management science together formed a dual argument for medical expertise. In the same way that they showed fluency in medical, scientific, and philosophical ideas of the “negro race,” physicians could show that they could be trusted with medical care for enslaved people by demonstrating that they knew how planters quantified health. The medicalization of productivity therefore bolstered the medicalization of blackness that had been underway since the eighteenth century.  

In Cuba, this process was more complex because blackness and race were more complicated than they were in Louisiana (though Louisiana was arguably more racially layered than the rest of the U.S. South due its unique imperial history). In general, Cuban physicians had to be much more careful than their southern colleagues. Before putting forth suggestions for improving enslaved health, they had to ask themselves what is the ethnic

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348 For more on the medicalization of blackness see Hogarth, *Medicalizing Blackness.*

breakdown of the enslaved labor force on this plantation? How many people of African
descent had been born in Cuba ("ladinos") and how many were new arrivals to the island
("bozales")? After 1847, physicians also had to know if there were any Chinese "coolie"
laborers on the plantation, whom Cuban state officials, planters, and physicians often called
"Asiatic colonists." These were not necessarily pressing questions for Louisiana physicians,
who usually took for granted that all slaves were Black and all plantation workers were slaves
unless otherwise specified.

Perhaps unsurprisingly given their extensive exposure to plantation management,
alumni of the plantation medical tour often emphasized that medical thought and practice in
Cuba needed to recognize various stratifications of race and ethnicity in African-descended
enslaved populations. Cuban criollo physician Juan Santos Fernández and French physician
Henri Dumont were especially interested in developing categories of racial difference. Both
conducted plantation tours in the 1860s and later drew on their experiences to produce
medical knowledge about specific diseases and how they affected the so-called "black races"
on the island. Fernández's memoir, *Recuerdos de Mi Vida*, and Dumont’s anthropological
study, *Antropología y Patología Comparadas de los Negros Esclavos*, demonstrate how Cuban
physicians wove together their knowledge of management science, racial science, and the
racial caste system of Cuban society to work out medical insights and therapeutic regimens
that would increase productivity according to perceived differences in Black bodies.

Fernández was born to a sugar planting family in Matanzas in 1847 and attended the
University of Havana for his bachelor's and medical degrees. From there, he ascended the
ranks of the Cuban medical profession, conducting several plantation medical tours, joining
the Royal Academy of Sciences, and using his familial wealth to travel in Paris, Madrid, and
Barcelona to study ophthalmology and bacteriology. Returning to Cuba in the late 1870s, he
advocated for the construction of laboratories like those he had seen in Europe where Cuban physicians and medical students could use microscopes to study tiny disease-causing agents. He also acquired international acclaim for his 1879 studies of myopia and other eye diseases found in the “diverse races” of Cuba. Along with Cuban national hero Dr. Carlos J. Finlay, who was the first to demonstrate that the *Aedes aegypti* mosquito was transmitting yellow fever, Fernández became a key intellectual figure in fin-de-siecle Cuban medical and scientific nationalism following the end of Spanish colonial rule and the establishment of U.S. neocolonial hegemony on the island in 1898. In August, 1900, he led the Cuban delegation to the thirteenth International Medical Congress in Paris. He presented a paper on “eye diseases in blacks and mulattos” that drew heavily on his time in the Cuban countryside. He also brought “the skulls of blacks, mestizos and whites” to the conference to demonstrate how racial differences could be located in such “anatomical data.” Perhaps Fernández had acquired some or all of the skulls through his plantation medical tours, which would have been in keeping with the tour tradition of collecting “clinical material” for medical knowledge production in Havana. Slavery had been officially abolished in Cuba for fourteen years by the time of the Paris conference, but racial insights and objects extracted under slavery were hardly irrelevant to the international medical community.


351 For the mention of the skulls see Dr. Manuel Casabó’s editorial introduction to Juan Santos Fernández, *Recuerdos de Mi Vida*, 2 tomos (La Habana: Llorido y Ca., 1918-1920), I: xii.
Many of Fernández’s earlier ideas about racial medicine and its connections to plantation management science can be found in his memoir. Reflecting on his travels throughout Cuba, Fernández echoed what previous physicians had said about the plantation medical tour, explaining that it provided access to “abundant clinical material and good remuneration, and within a few years those who were active and studious came back to the capital with a fortune and no small experience.” Like his predecessors, Fernández saw the high concentration of patients in plantation infirmaries as the means for building medical experience, reputation, and earning power, and he believed that Cuban planters had valuable knowledge when it came to enslaved health. Fernández noted that part of this was due to enslavers’ straight-forward financial interests in maintaining enslaved people. At the end of the day, he knew their bodies were “commodities” which needed to be healthy to fetch decent prices. But it is also clear that he believed planters had not just the economic motivation but the intellect, the practices, and the understanding of physicians’ medical expertise that was needed to measurably improve enslaved health. Fernández praised the “meticulous governance” over the “great endowments of slaves” in “those infirmaries of the great mills” as well as planters’ willingness to embrace (and pay for) well-trained physicians. As he explained, they “looked for the best doctor to treat them [enslaved people] and paid him well if they got sick.” Such standards did not exist on all Cuban plantations. Fernández acknowledged the brutality of sugar labor and the deplorable health conditions on some plantations at numerous points in his memoir. But where “scientific” planation managerial

352 Fernández, I: 310; quote is also in Palmer, “From Plantation to Academy,” 59.
practices could be found, they were effective, and slave health was better because “their labors [were] more productive and efficient.”

Fernández maintained that planters’ systematic practices produced the kind of practical knowledge about racial medicine that could not be taught in medical schools. He recalled one interaction with a sugar planter in Matanzas who had started out as an overseer on another plantation but was now “the landowner of a property worth more than three hundred thousand pesos.” When Fernández told him that he was a physician, touring plantations to learn more about eye diseases and how they presented in “blacks and mulattos,” the planter took Fernández to his infirmary and showed him “with an example” that he [the planter] “did not need to waste time studying medicine” like Fernández did. Fernández did not explain who or what the “example” was, but it seems likely that this encounter involved an enslaved person of African descent. The planter boasted that he “had often given lessons to doctors” in the curing of “whitlow,” a blistering and painful skin infection that was supposedly “very frequent in the black slaves,” but less frequent in “mulattos,” whose mixed racial lineage made them less susceptible. Fernández remarked that this was one of his “first lessons in pathology,” which almost made him reconsider a career in medicine, since it was clear that one could acquire and produce meaningful medical knowledge as a planter. In this instance, Fernández and the planter agreed on the idea that different manifestations of the same disease could be tracked to the patients’ degree of blackness. Crucially too, they concurred that experienced planters with large enslaving operations provided insight into how and when such racial distinctions became medically

353 Fernández, I: 310-1.

354 Ibid, I: 15-16.
relevant. For Fernández, plantation management was thus an existing intellectual basis for racial medicine as well as guide for physicians who wanted to do it on the ground and in everyday medical practice.

The ability to see racial differences as differences in capacity for hard labor and pain was very appealing to Cuban physicians. As Fernández saw it, the long history of slavery in Cuba had conclusively proven that “fully black” enslaved people, especially those who had grown up in Africa, were the most physically “resilient” laborers, capable of working long hours tirelessly and without breaking down. Meanwhile, mulattos were much weaker on average and some possessed “extremely poor physical and moral nature” that would make some planters want to avoid using them for sugar work altogether. Moreover, Fernández believed planters had proved over time that “black slaves” were the ideal candidates for experimentations with painful medical treatments, such as a cure for “chigger” infestations, which involved cutting open the patient’s flesh to extract the tiny insect that had buried itself there. The open wound would require some time to heal, but such an intervention would prevent more serious conditions that could inhibit work or render the slave worthless. Enslaved people’s suitability for this “treatment” was not just that it was “lawful to do everything” to slaves, but it was also the fact Cuban planters and physicians were convinced, not unlike their counterparts in the U.S. South, that black skin was extremely tough and thus Black people hardly felt the scalpel. The major difference for Cuban planters and physicians was that they had to consider many more physical and cultural degrees of blackness when producing racial medical knowledge. Interestingly, though Fernández


seemed convinced that blackness was medically distinctive and it correlated with productivity, and that this helped to explain why slavery had existed in Cuba for so long, he stressed that there was no “race hatred” in Cuba after slavery. Racism, “the most terrible scourge that can befall a people,” was a problem in Cuba’s “giant neighbor” to the North, but Cuban society had overcome such limitations. Fernández, like many other white intellectuals in Cuba’s early national period (1902-1933), helped maintain the myth that racism in Cuba was not the result of the country’s violent history of slavery, which was supposedly solved with abolition in 1886 and the end of Spanish colonial rule in 1898. Rather, it was an import from the United States and part of their neocolonial influence over the newly independent Cuban nation.357

French physician Henri Dumont was similarly fascinated with the relationships between race, health, and labor. By the time he conducted his first plantation tour in 1864, he was already an established physician who had practiced in France and the French Caribbean for nearly two decades. A graduate of the Paris Medical School who also taught at the University of Havana after completing his tour, Dumont’s particular medical interests lay in discovering the processes by which people became immune to diseases and how those processes differed according to “biological” origins. He was drawn to Cuba because of the island’s large and ethnically diverse Black population, which he believed was ideally suited for a long-term medical-anthropological study of disease immunity. Spending over two years in several sugar-producing jurisdictions, Dumont conducted countless medical examinations on people of African descent, observed their behavior, and conversed with planters and

357 Ibid, I: 283; for more on the elite promoters of this perception of racism see de la Fuente, A Nation for All: Race, Inequality, and Politics in Twentieth-Century Cuba (UNC, 2001).
slave traders. He began organizing his field notes in 1866 and had most of *Antropología y Patología Comparada de los Negros Esclavos* written by 1876, though it was not published in Spanish until 1922. Although the focus of Dumont’s book was disease immunity, his descriptions of Black ethnic groups and their supposed differences in physical, hygienic, and moral characteristics almost always related to back to questions of labor and plantation production. For him, looking at racial-ethnic differences in enslaved work and productivity was a reliable way of figuring out racialized disease immunity.

Dumont believed he could contribute to medical knowledge of race and disease as well as Cuban slavery management by determining which ethnic group was biologically suited for hard labor and strict managerial oversight. He had heard from planters that Lucumí enslaved people were the healthiest and the most effective and efficient workers of all African “races.” They took great care of their hygiene on their own – or rather, they appeared to have internalized the importance of clean bodies, clothing, housing from plantation management – and they also possessed inherent physical characteristics that made fit for hard labor no matter the environment they worked in. According to Dumont, all Lucumís were tall, strong, and “infatigable.” Even if they occasionally suffered from anemia and suicide, their “disposition and musculature” enabled them to “develop the capacity for hardest labor.” As such, Dumont explained that Lucumís could be found “in all the warehouses and mercantile deposits of Cuba’s ports, as well as on the plantations.” However, Dumont suggested that Carabalís were comparable to Lucumís in terms of health and manageability, and that planters should consider them ideal workers too, especially if

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Lucumís were not plentiful in their area. Like Lucumís, Carabalís were strong, intelligent, and hard workers but were even more likely to comply with overseers. According to Dumont, enslaved workers who should be avoided included Minas, who were weak, “delicate,” more susceptible to practically all diseases, and also “greatly exaggerate their state and pain, if it exists at all.” As was the case in Louisiana, doctors in Cuba believed that they had the professional responsibility to detect fraud, and such medical surveillance was in and of itself one of the most important therapies for enslaved Black people. Because this thinking was imbued with ideas of racial difference, it could be used to rank Afro-Cuban ethnicities according to the length of their sick time and the apparent propensity for feigning illness in addition to other potential concerns for both health and production.

Dumont’s approach to medically categorizing Afro-Cuban ethnicities was not entirely new. Late eighteenth and early nineteenth century debates around racial susceptibility to yellow fever certainly lay important groundwork for the emergence of biology-based racial science and medicine in Cuba. During that time, many Cuban medical thinkers believed that race was rooted in a combination of social, moral, environmental, and physical differences, including skin color and strength. In the context of plantation medicine specifically, the desire to analyze disease across different ethnic groups went back to Francisco Barrera y Domingo, a Spanish surgeon who worked on several sugar plantations in the late 1790s. In 1798, he published a nearly 900-page treatise on the common diseases of Cuban plantations and how they affected different ethnic subgroups of African enslaved people. According to Cuban historian of medicine Adrian López Denis, the treatise became a popular medical text

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359 For his description of Lucumís see Dumont, 21-8; for Carabalís see 33-6.

360 For Minas see ibid, 29-32.
in Cuba and beyond despite Barrera being only a surgeon who never studied medicine in a university setting. The great extent of his knowledge about plantation health and medicine was enough to trump the emerging medical educational hierarchy, likely due in no small part to the fact that such knowledge was directly relevant to the plantation economy. Barrera’s book claimed to show how the distinct cultural practices, moral character, and sentimentality of each Afro-Cuban ethnicity influenced how they dealt with common plantation health concerns, from tetanus and diarrhea to suicide and resistance to enslaver authority.361

In the decades between Barrera and Dumont, the rise of biological notions of race and managerial ideas of enslaved health had inspired physicians to focus not just the relationships between race and health but the specific interplay between health, race, and production. Cuban physicians now believed they could use both racial science and management science to determine how degrees of blackness would shape an individual enslaved laborer’s productivity. The systems of management in sugar production, and the controlled environment of the plantation, made physicians like Dumont feel confident that they were studying racial biology and medicine in the most objective setting, where the true nature of their human subjects would manifest. This knowledge could then be used to make medical knowledge that would be applicable wherever people of African descent could be found or wherever their labor was needed.

Other than his descriptions of Afro-Cuban groups, the influence of managerial perspectives in Dumont’s knowledge production can be seen in the “doctor’s questionnaire” he developed for the treatment of enslaved Black patients. The questionnaire was intended to be a tool for investigating the racial-ethnic background of enslaved patients, their health

361 See Adrian López Denis, “Melancholia, Slavery, and Racial Pathology in Eighteenth-Century Cuba.”
status, and how those two things might combine to influence their ability to work. The first
two questions asked for racial identification information: “What nation do you belong to?”
and, for those who were not born in Cuba, “How long has it been since you came from your
land?” Natal and temporal distance from the African continent apparently needed to be
considered to determine racial susceptibility to disease and fitness for work. Next came a
series of questions about the body: “Are you sick?” “Does your head hurt?” “Your belly?”
“Your chest?” “Your back?” “Do you feel hot?” “Weak?” “Fatigued?”; and questions about
hygiene, such as “What have you been eating?” After going through the interrogatives, the
physician would perform a full examination of the patient’s body. The combination of the
survey form and the physical exam would help the physician (or the planter or manager) who
wanted to “swiftly identify” any current or potential ailments.362 Further emphasizing that he
was thinking about planters’ time and their priorities, Dumont provided translations of all
questions in the Lucumí dialect, which was based on the Yoruba language. This seemed
eminently practical to Dumont because, other than Spanish, Lucumí language was “the most
spoken in the warehouses, sugar mills, and hospitals of Cuba.”363 Dumont knew that both
enslavers and physicians would appreciate having a tool to quickly and methodically
investigate slave health even if the patient did not speak Spanish.

Dumont’s research methods and his wide-ranging comparisons of Cuba’s “black
slaves” made an impression on the medical elite in Havana. In the late 1860s and early 1870s,
as he was living in Havana and analyzing his field research, Dumont became a friend of
Nicolás Gutiérrez, the head of the Royal Academy in Havana.364 Dumont presented his

362 Dumont, 65.
363 Ibid, 64.
research to the Academy in 1870 where it was commended for its usefulness to both the medical community in Cuba and the Cuban economy, though neither by that point appeared to have a promising future with slavery. By 1876, the Ten Years’ War against Spain had hastened the decline of slavery in Cuba, but not the economic importance of scientific and medical knowledge about Black people. One physician member of the Academy noted that Dumont’s study had shown the kind of comprehensive and thorough research into “different races that populate the island and their cross-breeding” that was possible under slavery. He maintained that Dumont’s work would be especially valuable to future researchers who would not be able to study Black health under such ideal conditions of control, without which “the habits of these races that will soon be lost for science and history.”

Dumont’s work was preserving fleeting racial medical knowledge that would be unavailable, at least in a direct sense, without slavery. It would surely be applicable after slavery, though, because Cuban physicians – like planters and other white elites – were assuming that people of African descent would still make up the majority of the laboring class, free or not.

Cuban physicians did have more to consider than their Louisiana counterparts when it came to race, but it is clear that physicians in both places combined their knowledge of racial science and slavery management to produce medical knowledge that promised to maintain the productive capacities of Black labor forces. The science of plantation management

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365 See Dr. Montané’s comments the significance on Dumont’s work, “Informe acerca de una obra intitulada ‘antropología y patología comparadas de los hombres de color africanos que viven en la isla de Cuba,’ presentada a la academia con opción a uno de sus premios anuales,” *Anales de la Real Academia de Ciencias Médicas, Físicas y Naturales de la Habana* 13 (La Habana: La Antilla, 1876): 122-136, for quotes see 122-3.
seemed have rigorous and trustworthy methods in place for observing racialized working bodies and making medical ideas about the correlations between race and productivity. Moreover, management science made the plantation into the controlled testing environment, the living laboratory, that could ensure objective study of both racial biology and the laboring body. Alexander Blanche’s careful noting of Charity’s sick time was not just valuable information for her individual medical case. It was a cluster of data points that would inform how Blanche treated her and other enslaved people who suffered from similar ailments in the future. It also contributed to the making of a factual basis that physicians could draw on to produce authoritative knowledge about medicine for slaves.

However, as planters developed what they thought were reliable methods for tracking, calculating, and controlling enslaved health, they came to realize that they could not do the same for environment. No matter how objective and universally applicable the relationship between enslaved health and enslaved productivity seemed, they could not create similarly reliable ways of accounting for environmental conditions. Crucially, just as they had done with regard to the limits of managerial control over animals, enslaved people noticed the environmental limits of management science and acted on them.
Chapter Five: The Environmental Limits of Management Science

Managerial knowledge for improving enslaved productivity made it appear as though plantation management was an objective science, but environmental conditions remained consistent problems for plantation management and physician medicine right up until the end of slavery in Louisiana and Cuba. Planters were not able to know and control environments through time discipline, managerial technologies, or medical expertise. They could use their clocks, account books, and divisions of labor to see how enslaved health shaped production, but they could not do the same for environments, which also affected health, labor, and the efficiency of the plantation system. Planters tried to use atmospheric science to discipline environments. They made meticulous daily recordings of weather, soils, and levels of inundation or aridity, but this data did not necessarily help them predict changes in productivity. Moreover, they could not account for environmental change or reconcile it through sick time, work, and surveillance. Similarly, physicians were unable to fully grasp how atmospheric and environmental phenomenon changed bodily health. They could locate racial-biological differences in laboring bodies, but there was no comparably scientific means of understanding the permeability between bodies and environments. Complex events such as hurricanes, floods, and epidemics were especially troublesome to planters and physicians, just as they had been for Spanish colonial officials a century earlier. These environmental shifts were still largely unpredictable and often widely devastating, but physicians and enslavers were no closer to mastering them.

Historians of slavery, capitalism, and environment have shown that planters were always searching for ways to grow bigger crops and reap larger profits, but they often only
succeeded in exhausting the land and then searching for more land to consume.\footnote{On soil exhaustion and its connection to the spread of slavery in the U.S. see for example Steven Stoll, \textit{Larding the Lean Earth: Soil and Society in Nineteenth Century America} (New York, NY: Hill and Wang, 2002); Eugene D. Genovese, \textit{The Political Economy of Slavery: Studies in the Economy and Society of the Slave South} (Second edition Wesleyan University Press, 1989); and for a recent reworking of David Harvey’s material “limits to capital” thesis, which links environmental exhaustion with the turn towards imperial slaver politics in the late antebellum Mississippi Valley, see Johnson, \textit{River of Dark Dreams}.} As they implemented more advanced management practices of the first half of the nineteenth century, many planters started hiring surveyors, agronomists, and botanists and reading scientific literature in all of these fields in the hopes of increasing commodity production.\footnote{On the use of scientific experts in plantation agriculture and industry in the U.S. South see John Majewski, \textit{Modernizing a Slave Economy: The Economic Vision of the Confederate Nation} (UNC Press, 2009); for agricultural experts in Cuba see Stuart George McCook, \textit{States of Nature: Science, Agriculture, and Environment in the Spanish Caribbean, 1760-1940} (Austin, TX: University of Texas Press, 2010); and Funes, \textit{De Bosque a Sabana}, on environmental expertise in the history of slavery more generally, including the still-understudied roles of black and indigenous expertise, see the essays in Thomas Blake Earle and D. Andrew Johnson, eds., \textit{Atlantic Environments and the American South} (University of Georgia, 2020); and Judith Ann Carney, \textit{Black Rice: The African Origins of Rice Cultivation in the Americas} (Harvard, 2001).}

Meanwhile, historians of medicine have shown that local environmental history played a significant role in medical knowledge production throughout the nineteenth century, even towards the end of the century as biomedical understandings of the body and disease became commonplace. There were many instances where local knowledge of environments seemed more relevant to physicians than knowledge that came through case history, theory, and clinical experience.\footnote{For the nineteenth century see Valenčius, \textit{The Health of the Country}; and Elaine LaFay, “Atmospheric Bodies: Medicine, Meteorology, and the Cultivation of Place in the Antebellum Gulf South” (PhD Diss, University of Pennsylvania, 2019).} Bringing these historiographic strands together, this chapter takes up Christopher Seller’s recent call for historians of medicine to pay closer attention to the intersection of medicine and environment as one way of recognizing how significant the history of medicine is to the history of capitalism.\footnote{Sellers has recently suggested that studying the intersection of medicine and environment can be a “springboard” for placing the history of medicine in the history of political economy generally and the new history of capitalism specifically. See “To Place or Not to Place: Toward an Environmental History of Modern Medicine,” \textit{Bulletin of the History of Medicine} 92, 1 (Spring 2018): 1-45.} I argue that plantation management and
physician medicine converged over ideas of health, environment, and production, but both consistently failed to make knowledge that was useful for protecting productivity. The boundaries of their knowledge were particularly noticeable in their anxieties over the harm that environments could do to bodies and economic development simultaneously.370

I also show that planters and physicians were not the only people who took note of the environmental limits of management science. Similar to how they had discerned the uneven edges of planter power over animals, enslaved people navigated plantation environs to improve their health and well-being in ways that were concealed, both physically and intellectually, from planters and physicians. Temporarily running away to watery landscapes, such as swamps and natural springs, became a core fugitive therapeutic practice that subverted the management of enslaved health. Prior to the mid-nineteenth century, enslaved people in the Caribbean and the U.S. had been undertaking what scholars have called “gran marronage” (permeant flight) and “petit marronage” (“running away a little,” with the intention of returning to enslavement). But with plantation management science and physician expertise curtailing other medical practices, temporary flight became a way for enslaved people to take sick time on their own terms.371

370 For the persistence of white settler anxieties over environmental impacts on human bodies see Valencius, The Health of the Country; and LaFay, “Atmospheric Bodies.”

371 Scholarship on enslaved flight, maroon communities, and resistance in the Atlantic world is vast, but the most important texts for this chapter are Marcus P. Nevius, City of Refuge: Slavery and Petit Marronage in the Great Dismal Swamp, 1763-1856 (University of Georgia, 2020); Neil Roberts, Freedom as Marronage; Sylviane A. Diouf, Slavery’s Exiles: The Story of the American Maroons (New York University Press, 2014); Alvin O. Thompson, Flight to Freedom: African Runaways and Maroons in the Americas (Kingston, JA: University of the West Indies, 2006); Richard X. Price, Maroon Societies: Rebel Slave Communities in the Americas (Johns Hopkins, 1979); and for Cuba specifically, Finch, Rethinking Slave Rebellion in Cuba; Gabino La Rosa Corzo, Runaway Slave Settlements in Cuba: Resistance and Repression (UNC, 2003); Los Cimarrones de Cuba (Editorial de Ciencias Sociales, 1988).
Some of the healing power of enslaved sick time surely came from the fact that it often interrupted the pace of production, and sometimes directly challenged planter power by contributing to broader anti-slavery efforts. However, it is clear that the healing power of flight also depended on which environment an enslaved person fled to, not just the act of flight itself. Using archival sources, travel accounts, print culture, and local histories together with anthropological studies of religion, comparative medical anthropology, and speculative approaches to historical analysis, I posit that swamps and springs appear again and again in cases of temporary flight from the plantation because these environments had specific therapeutic meanings derived from West African medicine. Petit marronage was thus not only a practice of resistance, survival, and freedom, but also a West African medical practice that was adapted for New World environments.

The Uneasiness of Bodies and Environments

Environmental shifts could destroy planter property and frustrate the productive imperatives of the plantation. Louisiana and Cuba experienced significant rainy seasons that ran from spring through early fall and overlapped with a hurricane season that spanned summer and fall. With much of its land mass below sea level and its flat landscape devoid of natural barriers, Louisiana was an especially wet place. Rain was necessary to grow crops, of course, but rains could also inundate the plantation such that production would cease for hours or even days. Driving rains and subsequent flooding could swamp fields before seeds could take root; they could make it impossible for slaves to work in said fields; and they could hinder the transportation of commodities. Enslaved people in the lower Mississippi Valley understood why hurricanes were so catastrophic for planters. Former slave Adeline Marshall explained that she would “tells folks when dat storm comin’” because “some way” she
always knew. Perhaps she understood the low-lying, riverine environment in ways that were unavailable to her various masters, or she simply had more experience with hurricanes than they did. Adeline stated that her enslavers often laughed at her when she warned them that a big storm was coming, but ultimately their patronizing dismissal did not bother her because she was usually proven right. The storm would come “and dey lose horses and cattle and chickens and houses.” \(^{372}\)

With its comparatively higher elevation and landscape dotted with limestone hills and scattered mountain ranges, western Cuba may have been better off than Louisiana when it came to storm surges and flooding, but that did not mean that Cuban planters were any less frustrated by the winds and rains that regularly descended on their plantations. Deluges of rain could leak into sugar mills, damaging machinery such that they would require costly repairs, as well as work time to make repairs. Rain could also destroy the finished sugar product before it even left the plantation. The destructive power of rain can be seen in correspondence between José and Manuel Blanco of Santa Rosalía sugar plantation. In a letter to Manuel, José confessed that the “sugar store house has many leaks, and when there is even a short shower, water gets into the barrels of sugar. When the rains come, I often fret over the loss of the entire year’s crop and how much work it has cost.” \(^{373}\) Driving rains also prevented enslaved people from working at Santa Rosalía. One of the overseers wrote to Manuel Blanco stating that “the slaves have cleared the new crop fields and cleaned out the

\(^{372}\) Narrative of Adeline Marshall, WPA FWP SN, Vol. 16, Texas, Part 3, 47.

\(^{373}\) Letter from J. Blanco to M. Blanco (March 9, 1876). Cartas de José Blanco a Manuel Blanco sobre cuestiones del ingenio. Ingo. Santa Rosalía, Febrero 28–Julio 12, 1876. C. M. Lobo No. 15, BNJM.
old ones for planting on the first day that there is no rain….All of the fields are clean and ready, if only we could have a dry moment.”

Cotton plantation managers in Louisiana also noticed when weather was costing them work days or causing the plantation system to “regress.” After nearly twenty years serving as the head plantation administrator and estate lawyer for a wealthy planter named George Matthews, David Flowers had developed meticulous systems for managing health, labor, inventory, and shipping on Matthews’ cotton plantations in West Feliciana Parish, including Buck Hill plantation, where Flowers made his primary residence. One overseer at each plantation sent weekly reports to Flowers, who then sent monthly ledgers for each plantation to Matthews. Like administrators on sugar plantations in Cuba, Flowers often provided the number of days lost each month to precipitation, but he also tried to predict how stretches of time without rain would alter production timelines and total crop numbers. In one letter, Flowers reported that “the weather is now favorable to being dry and I am more afraid at this time of it being too dry for the cotton crop.” He hoped the crop would still produce what he and Matthews had been expecting, but due to the unusually dry conditions at the moment, the crop was looking far worse “than was expected,” so much so that plant development seemed to be going “backwards.”

Enslaved people were usually put to work in other ways when storms and rains kept them from the fields, or when overly dry conditions changed the timelines for growing and

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374 Letter from V. Piñón to M. Blanco (April 25, 1880). Cartas a Manuel Blanco propietario del ingenio Santa Rosalia, sobre diversas cuestiones del ingenio y de los esclavos. Marzo 28–Mayo 7, 1880. C. M. Lobo No. 12, BNJM.

375 David Flowers to George Matthews (August 15, 1835). Box 4, Folder 2, Edward Butler Family Papers, Mss. 4315, LLMVC, LSU. Flowers’ correspondence to Matthews, which provides insights into his system for managing the West Feliciana Parish properties, dates from 1817-1843.
picking. But when they were in their cabins, for hours or even days on end, or when they were collecting wood, repairing fences and buildings, or doing other tasks that were perhaps not as closely surveilled, they may have had more opportunities to care for themselves.

Weather could be an advantage to enslaved people in this way, allowing them to steal time for health and comfort in spaces that were not controlled like fields and sugar mills, where overseers could quickly count heads and watch for anyone who was not moving fast enough. This is not to suggest that cabins, ginning rooms, sewing rooms, and infirmaries, or edges of fields and blindsides of buildings were somehow exempt from slave-holder violence, but rather it suggests that managerial power differed depending on weather and space, and that enslaved people may have been attuned to these differences.

Weather was a variable input into production which planters could not control using the technologies and practices that they had developed for the management of enslaved health, but these technologies did allow them to see – in methodical, quantitative ways – that weather and health were closely related. The writings of planter-physician Andrew M. Kilpatrick of Concordia Parish, Louisiana exemplifies how weather and environment posed significant problems for the health of the body and the plantation system. In 1850, Kilpatrick produced an extensive narrative on topography, meteorology, and disease in Concordia and Catahoula Parishes for the second volume of *Southern Medical Reports*. The piece provides a clear illustration of planter methods of meteorological record-keeping using “day books” that were very similar to the ones they used to track enslaved health on a daily basis. At the end of each month, these daily records were summarized in the form of table showing the highest and lowest temperatures and barometer readings obtained that month; the averages or “means” for both temperature and barometric pressure; the number of overcast days; the directions of “prevailing” winds; and notes on thunder and lightning; and
(if relevant) more significant storms like hurricanes. These tables also featured the exact number of days with rain (including the total inches of rainfall for the month) as well as number of days with frost, ice, and hail. This information was relevant not only for tabulating monthly precipitation totals, but also for counting the number of days where outdoor work on the plantation had likely been suspended (Figure 5).

**Figure 5.** Kilpatrick's meteorological table for the months of October and November 1850 showing his counting of days with significant precipitation in the top left of each monthly table. Source: Andrew M. Kilpatrick, “Report on the Medical Topography, Meteorology and Diseases of Trinity, La and its Vicinity during the Year of 1850,” *Southern Medical Reports* Vol. 2 (1850), 164.

Despite his attempts to track environmental conditions and understand them in the same visual form month to month and year to year, Kilpatrick’s accompanying narrative description of weather conditions shows typical planter anxieties surrounding the adverse
health effects of rain and inundation. After explaining that rainfall during the years 1849 and 1850 had greatly exceeded expectations, and that 1850 “will be long held in memory as one pregnant with misfortune to the inhabitants of the swamp lands of this state,” Kilpatrick argued against the notion “contended by many persons” that regular floods were good for agriculture. “There had been a prevalent belief here that the waters were never high two consecutive years,” he wrote, but this had proven to be a “delusion hypothesis” as consecutive years of higher than “average” rainfall had not replenished farm lands with a new layer of “sedimentary deposits” but had in fact “washed it all away, especially in the fields.”

Kilpatrick described how various methods of ditching and draining fields did little to stop the constant rush of water from the rivers and bayous which “bifurcate and inosculate like the blood vessels of the human body.”

Even though the “line of levees has been extended up the Mississippi River” to Concordia Parish – north of Baton Rouge – and the “population of the country has increased very much since 1840” with more labor being directed towards “leveeing,” this had not stopped severe inundation or deadly epidemics of disease that were exacerbated by the “overflow” from rivers and bayous. Although Kilpatrick swiftly reassured his readers that Concordia Parish was “as healthy a country as any in the South” and that the “negroes, especially, do well here with ordinary treatment,” he admitted that the parish had suffered immensely from cholera, measles, and whooping cough in the past ten years, all of which he linked to wet weather. Moreover, it was not just epidemic diseases but also regular bouts of illness that seemed to stem from overflowing environs. There had been several cases of

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enslaved people who were forced to continue working in the inundated fields, including one enslaved woman named Adaline, a “mother of five children,” who in the fall of 1849 had developed severe respiratory problems that were “nearly suffocating her.” Kilpatrick explained that the physician who examined Adaline had forced her throat open with forceps and cut out “inflamed” tissue, which “restored” her ability to breath but left a wound that soon turned into a “gangrenous condition of the lungs,” which then became exacerbated by the “cold and wet” conditions and eventually killed her. Kilpatrick merely expressed his “regret that there was no post-mortem examination” he could draw to provide more details on the case.378

To say nothing more about his utter disregard for Adaline’s humanity – which is one example of the sheer banality of medical violence under slavery – this passage shows a method of describing environment through its effects on the body that was well-established in the antebellum Mississippi Valley and not limited to people with medical degrees. Early nineteenth century planters, settlers, and travel writers often used bodily metaphors to explain how the ill-health of the land could trigger ill-health in humans.379 By the mid-nineteenth century, some planters like Kilpatrick were trying to track and quantify environmental conditions to determine how they impacted health, but metaphors and narrative descriptions still had their place because new techniques were not necessarily leading to greater understanding. Lack of understanding led to fear, or rather, the persistence of the same fear that had accompanied economic development of the interior of Cuba and

378 Ibid, 160-1; for descriptions of cholera, measles, and whooping cough cases see 166-85; for Adaline’s case see 183-4.

379 For the argument that knowledge of bodily health was often used to interpret environments and sometimes vice versa see Valenčius, The Health of the Country.
Louisiana since the late eighteenth century. Generally speaking, physicians in both places believed that the rural countryside was more conducive to good health than cities such as Havana and New Orleans, both of which seemed to become more crowded, dirty, and prone to disease with every passing year. But physicians also worried about what could happen to bodies – their own and enslaved bodies – in the seemingly “wild,” “savage,” and “unruly” environments that existed beyond the boundaries of municipal control, plantation agriculture, and their own knowledge.

An early example of this bodily and intellectual unease can be found in one Spanish-born Jesuit priest’s account of his missionary activities in the countryside of western Cuba during the 1780s. In 1795, Friar Josefe María Peñal, who referred to himself as a “man of God,” a “naturalist,” and a “medicinal botanist,” produced a “dictionary of rural terms that will be needed to direct and perfect development of the countryside.” He believed that knowing “the exact language of this country” would be “helpful for plantation owners as well as naturalists.” To this end, he provided the Spanish, “Indian,” and “creole” terms for “the great diversity of plants and flowers” he found in the countryside (here “creole” refers to people of African descent born on the island). Peñal remarked on the “fertility of the land,” the “doubly large crops of many grains,” the “abundance of fruits,” and the “multitude of rivers” which could be found beyond the urban municipalities of Cuba, but he also warned of the “strong zephyrs” which blew across the island and sent many “locals and visitors into hiding for days at a time,” for fear that some “great harm” would come to them or that they would be “carried off.” Although he does not use the term “huracán” – the common name for such storms in the Spanish-speaking Caribbean – Peñal’s description of winds strong enough to carry bodies off the ground suggests that these were not typical
windy conditions. Peñal also warned about the “impenetrable jungles” filled with “every imaginable tree” which even the “well-worn footpaths” would not traverse. Interestingly, he admitted that the “black people” he encountered knew quite a lot about these dense forests, including where to find the ingredients for “creole foods” such as “Funche, Fu-fu, Quimbombo” as well as “medicinal plants” and other “natural features.” The three foods he mentioned are still staples of Afro-Cuban cuisine to this day, though it is not possible to determine who these “creole” “black people” were as Peñal does not list their ethnic surnames, whether or not they were enslaved, nor where exactly he encountered them. What is clear, however, is that Peñal expressed concern regarding environmental “harms” that could be done to bodies and that he was very cautious, and perhaps slightly envious, of people of African descent’s knowledge of environments.

In Louisiana, hurricanes were the most significant, bafflingly complex, and foreboding events out of an array of environmental shifts that posed threats to bodies and economic development. Moreover, with the long history of maroon communities in the region, white Louisianans knew that enslaved people knew the topography of natural environments much better than they did, especially the woods and swamps. Early nineteenth century medical geographies of Louisiana show how white settlers feared what environments could do to

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380 The Spanish “huracán” and English “hurricane” both derive from the Taíno name for the temperamental spirit who controls the weather. The Taíno are an Awarak-speaking indigenous group who were the largest indigenous group in Cuba before Spanish colonization and remain one of the largest in the Caribbean today. See Louis A. Pérez, Winds of Change: Hurricanes & the Transformation of Nineteenth-century Cuba (UNC, 2001). 17; and Schwartz, A Sea of Storms.

381 Diccionario provincial de voces Cubanos por Fray Josefe Maria Peñal (1795). C. M. Morales T. 80, No. 4, BNJM. NB: “Funche” is a boiled grain dish similar to hot cereal and often served as breakfast; “fu-fu” is a staple of West African cuisine consisting of a boiled starchy paste made of canvassas, yams, or plantains; “quimbombó” is base for soups and stews usually made with pork, okra, and/or plaintain balls. For more on Afro-Cuban food history see Natalia Bólivar Aróstegui and Gonzalez Diazde Villegas, Afro-Cuban Cuisine: Its Myths and Legends (Editorial José Martí, 1998).
bodies, while also worrying about Black people’s knowledge of uncharted and undeveloped environments. U.S. army surgeon Jabez W. Heustis was sent to Louisiana during the War of 1812, and in 1817 he published the first extensive medical geographic survey of Louisiana, *Physical Observations and Medical tracts and Researches on the Topography and Diseases of Louisiana*. This text is prime example of medical boosterism. Heustis justified U.S. expansion by insisting that U.S. presence “civilized” the region, and works like his inspired white settlers to relocate there and make use of various “agricultural advantages.” But Heustis also confessed that potential “acquisition of wealth” in Louisiana was to “a great degree counterbalanced by the tax that nature imposes on health.”

Heustis explained that yellow fever, dysentery, and scurvy were the most common diseases in Louisiana, which makes sense given that he primarily observed U.S. army soldiers who did not have prior exposure to yellow fever and would have been likely to suffer from common camp diseases anyway. But he also stressed that the “wild” and “forbidding” environments of Louisiana posed uniquely “devastating” threats to white people’s health. Unlike newly arrived soldiers, there were “outcasts” and “strangers from polite society” who found not only “safe retreat from the encroachment of their white countrymen” in Louisiana’s riverine environs, but also good health, “the greatest of worldly blessings.” These “outcasts” were likely Indigenous people and maroons, both of whom are mentioned throughout the text. These people inhabited the “impassable morass” of dense swamps that surrounded sugar plantations in the southeastern portion of the state and extended up the Mississippi River, covering the “most fertile soils in the state” while also creating a barrier.

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between the river and more distant prairielands, which Heustis suspected were less ideal for cash crops but very suitable for ranching. \textsuperscript{383}

Moreover, the inhabitants of these swamps had natural protections in the form of trees and “falling banks” along the Mississippi River and its many bayous. Heustis said that navigating the Mississippi and its multitude of offshoots was “attended with many difficulties,” as there were two types of trees, “sawyers” and “planters,” which lay waiting to capsize boats or tear open their hulls. Using bodily metaphors and animating language, he described sawyers as “the bodies of trees” with their roots “fastened into the bottom of the river,” allowing them to move with the currents and “frequently disappear from one to 20 minutes, and then raise their trunks with great swiftness, from one to 10 feet above the water.” “The unfortunate boat against which they may happen to strike,” would be “immediately destroyed.” Even worse, there were “sleeping sawyers” which “approach only within 12 or 15 inches of the surface, and from being concealed, are still more dangerous.” Similarly, “planters” were firmly bedded in the soft sandy bottom of the river” and “at night they are peculiarly dangerous.” If a vessel did manage to avoid sawyers and planters, they might still be “destroyed” by “falling banks,” where the current had “undermined” the soil such that whole “pieces of them, frequently more than an acre in extent, are constantly falling into the stream.” Heustis went on to explain “bayous,” which formed along the major rivers “in consequence of the lowness of the adjacent country” and “the force of the inundation from the river.” He warned that “when a boat is passing one of these bayous, great care is necessary, in order to guard against the danger of its being carried away by the

\textsuperscript{383} Ibid, 16-8.
current, and lost in the swamp.\textsuperscript{384} Clearly, all of these natural features could threaten both the bodily well-being and economic ambitions of white people venturing into rural Louisiana, but in doing so, they also protected the bodies of the people who lived in the swamps.

For some enslaved people in Louisiana and Cuba, there were certain protective powers in trees which were not intelligible to white missionaries, settlers, physicians, or planters. As discussed in Chapter Three, enslaved people in western Cuba knew that there were forest herbs, plants, and trees which were actually egwes that could be used to make herbal remedies and amulets. There were also other egwes that could not be collected, but could conceal and protect enslaved people who were running from their plantations. One of these larger egwes was the siguaraya, a tall and wide tree with long, gnarled, leaf-covered limbs. According to some Afro-Cuban religious traditions including Santería and Palo Monte, this tree is capable of opening up hidden pathways through the dense tree cover, provided it received an acceptable offering first. At night, or perhaps right after they had finished work for the day, an enslaved person might approach a grove of siguaraya trees and perform the necessary offering by leaving herbs, natural fibers, animal remains, or an amulet at the base of the tree. The siguarayases might find this offering satisfactory and raise their low-hanging branches, revealing a path through the foliage. Once the enslaved person was through, the tree would lower its branches and conceal the path before anyone else was the wiser. In Santería and Palo Monte, the siguaraya has important healing uses based on this ability to provide access to hidden places. According to scholars of these religions, the expansion of plantation slavery over the course of the nineteenth century was understood

\textsuperscript{384} Ibid, 21-2.
not just as the cutting down of forests, but also the “cutting” or “severing” of connections
with environments that could “restore” body and mind. These ideas are also evident in the
lyrics of the popular Afro-Cuban song “Mata Siguaraya,” which describes powerful
“morichas” (“forest spirits” in Santería) who live within the siguaraya. Only with their
“permission” should someone “cut it down.”

As far as most planters in Cuba were concerned, siguaraya groves like other
“maniguas” (woodland areas) were useful markers for the property lines because they often
grew along the banks of waterways and at the edges of pastures. But they were also suspect
spaces. With their close growth formations, their many twisted limbs, and dense foliage,
siguarayas obscured too much. Some planters and overseers worried that free people of
African descent living in siguaraya groves near their property might entice enslaved people to
leave the controlled environment of the plantation. For example, at Santa Rosalía plantation,
overseer José María Pérez learned that a neighboring plantation owner had allowed a group
of free men of African descent to “camp” in the siguaraya grove that separated the two
plantations. In a letter to Santa Rosalía’s owner Manuel Blanco, Pérez stressed that the camp
was “going to have very bad results…very harmful to your interests.” Pérez explained that
he had not caught any of Santa Rosalía’s enslaved people trying to make contact with the
people living there, but he suspected that such ventures would lead to enslaved people
imbibing in “vices.” “If you give me the order I will learn what is going on there,” Pérez

385 A history of the siguaraya and its the reoccurrence in Afro-Cuban poems, songs, oral histories, and religious
traditions dating back to the early nineteenth century can be found in the annual publication of the Cuban
Writer’s Union, La Gaceta (La Habana: Unión de Escritores y Artistas de Cuba, 1993), 23-5; for the siguaraya in
Santería and Palo Monte, understandings of environmental change, and the song, see William W. Megenney,
216; there are also several versions of “Mata Siguaraya” available on YouTube, including Afro-Cuban big band
March 2, 2020. URL: https://youtu.be/rj8B3oGEuRE.
insisted to his boss, adding that “we want to avoid any hiccups and therefore we must guard ourselves ahead of time.” Pérez and Blanco’s main concern surrounding marronage – even if it was temporary and nearby – was that it could jeopardize enslaved health and cause a “hiccup” in the pace of production. Pérez wrote this letter to his boss in 1879, just seven years before the abolition of slavery in Cuba and at a point when sophisticated methods for managing enslaved health and production had been in use at Santa Rosalía for decades. But even with highly developed managerial systems, and even after vast swaths of western Cuba had been devoured and metabolized into commodities, the remaining uncultivated environs, however few and far between, still posed significant threats to white settlement, plantation slavery, and bodily health.

Data Collection and Time-Keeping in Medical Geography

As their feelings about trees suggest, settlers and planters in Cuba and Louisiana were always thinking about ways to make rural environments profitable, but they were also always worrying that some environments could do them harm. With the cutting of forests, the draining of swamps, and the leveeing of rivers – all of which were typically done with enslaved labor – it was clear that environments could be noticeably “improved” for agricultural development, but improvements in health were another matter. Having built their professional identity around their supposed ability to improve enslaved health and productivity, physicians set out to develop new practices for knowing environments and alleviating their ill effects.

386 Pérez to Manuel Blanco (July 10, 1879). C.M. Lobo No. 10, BNJM.
Once again using the language of plantation management science, physicians devised new “systems” or “routines” of medical geography to assess the combined impact of climate, weather, and environmental features on the body. Beyond merely recording the natural history of an area, local anecdotes, and personal observations, these physicians measured environmental conditions using the tools and techniques of meteorology, physics, and chemistry. They began using aneroid barometers (which were smaller and more portable than their predecessors) and “pluviometers” (a graduated cylinder with a weighted gauge used to measure total rainfall and intensity of the droplets over a given period of time) as well as chemical analyses of rain, water sources, and soil.\footnote{For the history of atmospheric science and medicine see LaFay, “Atmospheric Bodies;” Ludmilla J. Jordanova, “Earth Sciences and Environmental Medicine” in Jordanova and Roy Porter, eds., \textit{Images of Earth: Essays in the History of Science} (Chalfont St. Giles, UK: British Society for the History of Science, 1979); and for histories of meteorology that discuss the development of meteorological thought and key measuring technologies in the nineteenth century see Katharine Anderson, \textit{Predicting the Weather: Victorians and the Science of Meteorology} (Chicago, 2010); James Rodger Fleming, \textit{Meteorology in America, 1800-1870} (Johns Hopkins, 2000).} Equally important was the development of methodical recordings of environmental data. Like planters who counted days of precipitation, tracked winds, and measured heat and moisture in their daybooks and monthly journals, physicians tried to create universal knowledge for understanding the health quality of environments using systematic approaches to data collection and interpretation.

Havana-born and educated physician Ramón Piña y Peñuela exemplified this new approach to medical geography. In 1855, he published an extensive survey of nearly every jurisdiction on the island of Cuba covering data on prevailing diseases each month of 1854 as well as monthly maximum, minimum, and average wind speeds, barometric pressures, and air temperatures. He also counted the numbers of days with precipitation (which was mostly rain) and noted the elevation and the mineral qualities of soils and waters in each jurisdiction. He referred to all of this information collectively as the “climate” information.
for each jurisdiction. Piña explained that his “routine” for analyzing disease and climate information together to map the health of a jurisdiction was developed with the help of more than twenty “professors of medicine” who had served as faculty at the University of Havana and/or Protomedicato public health officials. Piña warned his readers that any physician who would forgo such comprehensive practices of data gathering, perhaps by “using a unique method in curing a disease without taking into account climate,” would be seriously misinformed. It would “be an incorrect practice,” he explained, “a criticizable routine, harmful to the humanity” and would “discredit the physician in public and among his colleagues.” Of course, a good medical geographic routine “should not only attend to the climate where the patient lives, but also to their current medical constitution,” including their race, “which always modifies the amount of suffering” and “imprints them with a certain character” that makes them “predisposed to some diseases rather than others.” Although Piña did not calculate the number of cases of disease by race, he did describe the racial demographics in each jurisdiction, including the demographics of the major sugar plantations, towns, and cities; the kinds of labor each racial group typically did; and the common diseases that afflicted each group. Both race and labor therefore factored into the typical “medical constitution” of each group. However, race and labor did not seem to vary as much by jurisdiction compared to environmental conditions such as proximity to water sources; the quality of said water sources; elevation and proximity to higher terrain; and the density of vegetation. Essentially, the environmental conditions as they pertained to health were not as regular across the board, perhaps because Piña and other Cuban physicians did not think they were as knowable and controllable as race and labor.\footnote{Ramón Piña y Peñuela, Topografía Médica de la Isla de Cuba (La Habana: Impresión y Encuadernación del Tiempo, 1855), for list of contributing physicians see 321; for passage warning against “unique methods” and...}
Around the same time that Piña and his colleagues in Havana were working towards a new methodology for measuring environmental influence on health, Louisiana physicians Erasmus Darwin Fenner and Edward Hall Barton were attempting figure out the same thing. Both men were still primarily based in New Orleans, but like their Cuban counterparts, their writing on medical geographic “systems” often spanned the urban-rural divide, incorporating the experiences of planters and physician colleagues who worked in the countryside full-time. As discussed in Chapter Four, Fenner was very familiar with plantation management science. His medical geographic writing in the second volume of *Southern Medical Reports* suggests that he believed multi-level recording practices and time discipline could also be used to better understand the relationship between health and environment.

After noting that the previous volume of *Southern Medical Reports* covered the details of “locality and climate” for New Orleans, including average temperature, rainfall, and “prevalent diseases” per month but also “the plan of streets and the system of drainage, the water-works, gas-works, levees, markets, cemeteries, and privies,” Fenner began the second volume with an article on his methods for obtaining such information. He described how he recorded all of this information in “a journal of observations taken down at the time of occurrence” as well as a daily “diary of particulars” both of which he then “carefully summed up” into a yearly narrative “journal” for the year 1850, which was the “form” he ultimately published. This “system” or “plan” of occurrence-based journal, daily diary, and yearly narrative journal was necessary according to Fenner, as “memory” was “too...

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describing the importance of measuring both climate and individual “medical constitution” see 20-1; after a general introduction, the text is organized by jurisdiction and notes on racial make-up and typical labor for each jurisdiction appear throughout.
treacherous to be relied on, even for a month.”389 Fenner went on to describe his aspirations for this “plan of forming a faithful record of passing events,” beyond the accomplishments it had achieved thus far:

If I should be spared to continue it many years, I trust I shall amass a fund of practical information that will be of some value to those who succeed me on the stage of life…Medicine can never make much progress as a science till we bring ourselves down to the drudgery of carefully noting our observations at the time of occurrence. It is vain for any man, whatever may be his talents, who waits for leisure…to attempt to sit down and deliberately record all the important particulars he has observed respecting the state of the weather, the diversified symptoms of disease, and the effects of remedies. Labor as he may, he can then make up nothing but a mass of generalities, which will convey but a faint idea of what he has witnessed.390

Although it is impossible to say for sure that Fenner was borrowing from plantation management science when he devised this system, the three-fold record-keeping for hourly “occurrences,” days, and months does closely resemble the daybook, journal, and ledger accounting system that many sugar and cotton planters used in Louisiana and Cuba.

Furthermore, the meteorological table that Fenner included with his article resembles Andrew Kilpatrick’s. At the end of his article, Fenner included a meteorological table made by his colleague Edward Barton, who had prepared the table for the newly “reorganized” Board of Health in New Orleans (Figure 6). Similar to Fenner and his system for recording meteorological data, Barton also employed a rigorous method of recording conditions, but


he followed clock-time even more closely than Fenner, who recorded his daily observations “as they occurred.” For each month of 1850, Barton provided averages of temperature, dew point, “moisture” in the air, “elasticity of vapor,” and “weight of vapor” in the air taken at four intervals during the day: sunrise, 9 a.m., 3 p.m., and 9 p.m. Barton also used a pluviometer not just to measure total “quantity” of rainfall each day, but also to the degrees of moisture and dryness in the air, which he probably calculated according to atmospheric scientific principles using a pluviometer and a barometer.

Figure 6. Edward Hall Barton's meteorological table for the year of 1850 showing meticulous record-keeping practices that are similar to planters' meteorological records and also careful attention to the time of day when recording weather information. Source: Fenner, “Report on the General Aspect of Weather,” 38-9.

As stated in Fenner's year-long “journal,” he and Barton were working together and comparing their records to try to figure out how changes in the weather could impact the...
prevalence of certain diseases such as yellow fever, cholera, and dysentery. But they were not solely interested in the total number of cases of each disease. They were actually trying to determine how the exact timing of certain weather changes could trigger an increase or decrease in the number of patient cases. Again, these sources do not conclusively prove that these men had plantation management in mind when they crafted their methods, but they do reveal that clock time discipline was becoming essential to medical geographic knowledge production, too. Physicians, like planters, wanted a routine or a system to help them recognize and interpret patterns that they were sure existed somewhere, and clock time helped them do that. Both plantation management and medicine wanted to become more scientific in this specific way, using technologies, careful data collection, and time discipline to create knowledge that would be useful in the future.

Barton’s attention to time is further evident in his “Report on the Meteorology, Vital Statistics and Hygiene of the State of Louisiana,” which was published in the same volume of *Southern Medical Reports*. Like Fenner and Piña, he stressed the importance of wide-ranging and detailed environmental data collection practices in order to better understand the impact of environment on health, but Barton was explicitly thinking about planters when he envisioned the ultimate benefactors of this knowledge. It would not just useful for physicians who needed to improve their craft, but it would also vital for “agriculturalists.” Even more than the other two men, Barton saw medical geography as a realm of medical expertise adjacent to the maintenance of enslaved peoples’ bodies which could prove crucial to the plantation economy in Louisiana and the wider U.S. South. It was also one realm of plantation medical expertise that could be unquestionably dominated by white male physicians who had access to the necessary technologies, record-keeping practices, and the
knowledge about meteorology, environments, and health that was available in medical and plantation managerial journals.

In general, Barton seemed impressed with the state of agriculture in Louisiana, which fits with his time of writing in the early 1850s when cotton production was booming again after downturn in the market during the late 1840s. Even with the perpetual cycle of booms and busts throughout much of the late antebellum period, Barton had personally witnessed the immense geographic expansion and the technological and managerial acceleration of slavery in the lower Mississippi Valley since his arrival in New Orleans in the mid-1830s. However, to him, this transformation in “the great science of agriculture” had persisted “without unfolding the truths and science of meteorology,” meaning that agriculture, and the planters who practiced it, had not been able to fully understand and incorporate crucial environmental influences on their own. Barton stressed that medicine must be the field to tackle this pressing problem, as the subdiscipline of “medical geography” already had a long history of tracing the role of environmental phenomena in the making of (ill-)health. He explained that the influences of climate on prevailing diseases – by which he meant the influence of temperature, winds, seasons, and latitude – were already “well-established facts,” but far less was known about the influence of atmospheric bodies, such as hurricanes, and specific environmental conditions, such as flooding. These circumstances were especially crucial in Louisiana where the many rivers and lakes, swamps, and regular “deluges” of rain

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meant that “about one-eighth of the state is constantly underwater and more than two-fifths subject in inundation.” Barton maintained that the inability to predict or control the effects of hurricanes and high water levels posed a critical problem for “agaliculturalists in this state,” because “if man was in his perfect condition, and all hygienic rules are fulfilled, and we had the means of knowing all meteorological conditions, we should probably be able to explain his entire liability to disease, and then probably prevent or correct the greater part.”

“Man” in this case was likely a reference to the enslaved people who labored on plantations where a repertoire of managerial “hygienic rules” had already been developed to provide some measure of control over enslaved health.

Regrettably for Barton, there were no established truths, facts, or rules to consistently “prevent or correct” the ill effects of heavy moisture in the air and watery landscapes, but there were some “improvements” which could at least “ameliorate their injurious influences.” Interestingly, Barton’s choice of words and his ideas here demonstrate that some things had not changed since the late eighteenth century, when Spanish colonial administrators and physicians in New Orleans prioritized environmental “improvements” in an attempt to improve the overall health of populations. Barton recommended that planters “subdue the soil and adapt it to the purposes of man by removing the forest growth and draining the swamps” in and around their fields, because by “cultivating the soil we might lessen the amount of moisture (which with us is of the greatest injury).”

Just as they had in the late eighteenth century, white physicians in mid-nineteenth century Louisiana still believed that they would be better able to control enslaved health if they could somehow

393 Ibid, 110, 113-4.

394 Ibid, 119.
manage environments. In addition to recalling this longer history of environmental thinking, it is also important to remember that Barton travelled to Cuba in the mid-1840s and received a medical degree from the University of Havana. Although Barton makes no mention of Cuba or any colleagues in Havana in this article, the similarities between the two medical geographic cultures during the 1850s, in especially in terms of their specific interests in devising “routines” or “systems,” suggest that medical geography’s usefulness for plantation agriculture may have been an important topic of discussion when Barton was in Havana.

Although Barton, Fenner, and Piña demonstrated confidence that there were essential “facts” and “truths” about climatic, meteorological, environmental conditions which could and would soon be revealed to physicians, this confidence was undercut by their consistent recognition of their own limitations. They could develop routines and systems for gathering data, but they could not conclusively prove that these methods produced universal ideas that could be applied to any and all environmental situations. Underneath these admissions were long-held anxieties about wild, undeveloped environments, what they could do to human bodies, and what enslaved people and people of African descent knew about those environments. While planters and physicians only knew for sure that unknown and unmanaged environs could cause harm, and thus should be controlled, enslaved people may have figured out how they could heal.

**Enslaved Sick Time in Swamps and Springs**

David Flowers of West Feliciana Parish knew that enslaved flight was a variable he had to consider in his administration of George Matthew’s plantations. Illness, injury, or death that appeared to come as a result of leaving the plantation could mean more loss of work time.
One summer, Flowers had a serious problem: enslaved people were running away from Buck Hill plantation, and often in groups. Far worse than losing just one person, the coordinated effort was a major threat to the cotton production timeline. When a group of five men disappeared in early August, Flowers decided the disruption was significant enough to pay someone to find them. Hired slave catchers found the runaways a few days later and brought them back to Buck Hill. In a letter to Matthews, Flowers emphasized that he need not worry any longer because the men were “safe at home again” – or at least, all of them “except the cripple Dempsey,” who had been “one of the first that ran off.” The letter also conveys that one of the overseers at Buck Hill, “Mr. Collins,” was tasked with beating the four runaways. It appears that this was done not just as punishment but also to extract information on Dempsey’s whereabouts, as Flowers states that the men eventually told Collins that they “left him [Dempsey] in a swamp as he was unable to travel further with them.” Flowers explained that he had considered paying for runaway advertisements in the local newspapers, but was now leaning against the idea, as “from the account Collins has given me, I have very little doubt he died in the swamp.” Flowers promised Matthews that he would contact the “vendor” who sold Dempsey to Matthews to get compensation for selling an enslaved person who ran. Dempsey is not mentioned again in Flowers’ letters, which may mean that Flowers was not able to recover him, or his corpse, and was not able to recoup any money on Matthew’s behalf. In any case, it likely means that Dempsey never came back to Buck Hill.

395 David Flowers to George Matthews (August 15, 1835), Edward Butler Family Papers, LLMVC, LSU; for the comparison between antebellum slave laws in Louisiana and modern “lemon laws” for used cars see Johnson, Soul by Soul.
There is no way to know for sure that Dempsey died in the swamp. There is also no way to know if Dempsey and the other men had planned to return to the plantation, or if this was intended to be a permanent escape. Given that Flowers mentions multiple incidents of flight before he finally hired the slave catchers, perhaps these same men had escaped to the swamps before. The temporality of enslaved flight – especially the fact that it meant taking time from someone else – may have been important to its therapeutic power, in addition to the specific environments that people absconded to. Knowing that one was returning to work and most assuredly to punishment surely shaped therapeutic meaning, too. The ability to be away from the plantation for some time must have been worth the potential punishment, and perhaps the healing power of flight influenced that choice.

Several scholars of slave marronage have shown that temporary flight was increasingly common in the major slave societies of the nineteenth century like the U.S. South, Cuba, and Brazil. This was because enslaved people in those places were very aware of the significant political, geographic, and material constraints they would have to overcome to reach societies where slavery had been outlawed. Enslaved people in Louisiana knew not just that they would have to traverse thousands of miles to freedom, but also that the vast network of runaway slave advertisements, slave catchers, and pro-slavery sentiments north of the Mason-Dixon line increased the odds that they would be discovered and returned to slavery. Furthermore, after the passage of the Fugitive Slave in 1850, the U.S. federal government took charge of apprehending escapees, and average citizens in the North became legally obligated to turn over escaped enslaved people. In Cuba, runaways had to deal with the simple fact that they lived on an island, and even those who could buy passage or stow away to a free society may not have had the money or the connections needed to actually survive on their own. As Neil Roberts and others have argued, these circumstances
contributed to a rise in “petit marronage,” or “running away a little” on a temporary basis to
nearby locations, as opposed to the “gran marronage” of attempting to run away
permanently to societies where slavery had been abolished.396

Marronage was indeed an act of survival and resistance, but it also could have been a
therapeutic practice. Fleeing to specific environments such as swamps, woodlands, and
natural springs – especially when it was done as a temporary reprieve from enslavement –
may have been health-giving, and not just because it involved disrupting the plantation
system and resisting enslaver violence. These environments may have been places where
enslaved people could rejuvenate and protect themselves against future harms using
knowledge that had roots in West Africa.

In this context, it is possible that “the cripple Dempsey” was not intending to escape
from enslavement forever, or necessarily trying to make life difficult for Flowers and his
managerial team. Rather (or additionally), he may have fled to the swamp to heal himself.
Dempsey may have figured out how to get to the swamp and what to do there on his own,
or he may have learned where to go and what to look for from other enslaved people,
maroon communities, and free Black people living in the surrounding areas. Despite the
increase in white settlement, plantation slavery, and social surveillance of Black people
throughout the first half of the nineteenth century, maroon communities in Louisiana
thrived in swampy and forested areas that settlers and planters could not to cultivate. The
maroons of Bas du Fleuve, who lived in the marshes around Lake Borgne, to east and south
of New Orleans, first came to prominence under the leadership of the rebel leader St. Malo

396 Roberts, Freedom as Marronage and for more on slave marronage see Nevius, City of Refuge; Diouf, Slavery’s
Exiles; and Thompson, Flight to Freedom.
during the Spanish period. This maroon community existed (albeit with different numbers and in different locations) well into the 1880s and remained a constant source of antagonism and anxiety for planters, civic leaders, and white residents of New Orleans who accused these “below the river” maroons of peeling off enslaved people and robbing plantations, steamboats, and travelers.397

Indeed, maroon sabotage resulted in loss of property and potential disruptions in commerce, but it also disrupted white people’s feelings of safety, ownership of the land, and good health. In 1850, Maria Louise DeLoach, the wife of a wealthy planter in DeSoto Parish, wrote that her visit to the “medicinal baths” of White Sulphur Springs near Jena, Louisiana would have been pleasant and restorative if it were not for the “fear of an attack from a runaway negro” who had been seen “lurking around in the woods.” What was more, while en route to these springs, DeLoach’s party came across the remains of a camp that had been hit by a “band of robbers,” whom they believed to be a group of formerly enslaved people.398 DeLoach’s narrative is yet another example of long-standing white anxieties over bodily harm in unknown, underdeveloped environments as well as fears of the Black and Indigenous people living in those environments. But even in New Orleans, the most developed and heavily settled area of the state, there were maroons who lived in the cypress swamps that bordered the city (Figure 7). Most of these people were men, as was true of marronage throughout the Atlantic world. Women often had children and other care responsibilities that made flight more complicated and difficult.399 Many of these men made

397 For more on the maroons of Bas du Flueve see Diouf, *Slavery’s Exiles*, 157-186.

398 Maria Louise DeLoach, “A Sketch of My Travels Through Sabine While Looking at the Country” (1850). MSS 370, HNOC. For quotes see pgs. 9, 13.

399 On the gendered differences in enslaved flight see Camp, *Closer to Freedom.*
their living by sneaking into town at dusk to sell firewood, and then robbing white households on their way back to swamps. Newspapers reported on the “band of runaway negroes in the cypress swamp” who “had been committing depredations.” The group’s “outlaw slave leader” named “Squire” was hunted down and killed in the swamps by a “group of soldiers” who had accused Squire of killing several white men. Squire’s corpse was put on display for several days in Jackson Square as a warning to all who would question white supremacy in Louisiana.400

Figure 7. “Negroes Hiding in the Swamps of Louisiana” from an article on maroon communities in Louisiana, including those near New Orleans and the more famous St. Malo community. Source: Harper’s Weekly (May 10, 1873), pg. 396.

400 For “band of runaway negroes” see Louisiana Advertiser (June 8, 1836) and an account of Squire’s murder see New Orleans Picayune (July 19, 1837).
In addition to subverting slavery and white supremacy, however, runaway enslaved people may have chosen swamps, woods, and natural springs as their places of refuge because these were emotionally and empirically significant environments. In discussing the “ideological bases” of marronage and how they corresponded to different forms of marronage practice, Alvin O. Thompson has argued for the particular significance of short-term absences from slavery which helped enslaved people restore feelings of “safety and well-being,” even though they knew they would be returning to enslavement. These feelings grew if marronage was undertaken in solidarity with other enslaved people and if the runaways knew that they were headed to an environment that was in one way or another protected by natural barriers, such as thick forests, steep hillsides, and swamplands which were not just difficult to navigate by foot (let alone on horseback or by boat) but also constantly shifting depending on water levels and stability of soils.401 The ideological bases of marronage, the protective advantages of maroon environments, and the mortal danger they posed to those who did not know the environments well, all could have contributed to their therapeutic power.

The social contexts and spatially liminality of maroon spaces could also help in this regard. Aisha K. Finch has discussed how plantation escapees and free people of African descent in western Cuba met up in “linderos” (uncultivated forests between plantations). Though they were often transitory spaces which enslaved people went through on their way to somewhere else, Finches argues that lindero environments generated the feelings of safety and solidarity that were necessary to foment cross-ethnic and cross-class Black political

401 Thompson, *Flight to Freedom*, for quote see 55 and for discussion of military advantages of environments see 145-7.
radicalism during the 1840s.\textsuperscript{402} It can also be assumed that such positive sentiments
developed as enslaved people learned how to navigate their way off the plantation into these
uncultivated, uncontrolled spaces, thus transcending what Clyde Woods and Katherine
McKittrick call “the tension between that which is mapped and that which is unknown.”\textsuperscript{403}

Marronage sites were also spaces of knowledge production about environments,
which means they were empirically meaningful places, too. As Marcus Nevius has shown,
some people in the famous marronage community in the Great Dismal Swamp utilized their
knowledge of trees to their protective and economic advantage. This swamp spanned the
coastal plain of southeastern Virginia and northeastern North Carolina. Enslaved people first
began to flee there in the early eighteenth century and the community existed until long after
the Civil War. Recognizing that cypress trees and large hardwood species were highly
valuable building materials, these Dismal Swamp residents were able to participate in the
informal timber economy, which sustained both their community and white settlers in the
Chesapeake region. Participation in the timber economy must have required knowing how to
distinguish the right trees; how to take them down safely without damaging them; how to
transport them; and how to maintain the ecological integrity of the swamp such that this
space would still provide its protective benefits. Moreover, maroons living in the Dismal
Swamp developed knowledge of rivers and forests, which became economically and
politically vital for resistance plots that sought to undermine slavery.\textsuperscript{404}

\textsuperscript{402} Finch, \textit{Rethinking Slave Rebellion in Cuba}, 62-3 and more generally Chapter 2 “Rural Slave Networks and
Insurgent Geographies.”

\textsuperscript{403} As quoted in Finch, 63.

\textsuperscript{404} Nevius, \textit{City of Refuge}, see esp. 41-2, 52.
The most substantial body of evidence for enslaved people’s empirical medical knowledge about environments – and therefore the best scholarly circumstances for critical speculation about that knowledge – is evident in Cuba. Unlike other major sugar islands such as Saint Domingue and Jamaica, and other Spanish colonial territories such as Mexico, Cuba did not have large “cimarrón” (maroon, runaway) communities before the nineteenth century. El Portillo, which consisted of a group of roughly twenty cimarrónes living in the Sierra Maestra mountains of eastern Cuba, was the largest community in the eighteenth century before it was broken up in 1747 by the Spanish military. But as plantations expanded across the island, turning tropical forests into savannahs broken up by roads and railroad tracks, it became more common for cimarrónes to cluster in mountain communities rather than attempting to re-assimilate into Cuban society as free people of African descent. Most of the large runaway communities existed in the central and eastern jurisdictions of the island, where the density of plantation complexes never reached that of western jurisdictions such as Cienfuegos, Matanzas, Havana, and Pinar del Rio. Many of these people never returned to enslavement and their communities posed formidable threats to colonial and planter power, as they often raided plantations and supply lines. These communities got the name “palenques” – the Spanish word for “fortresses” – because colonial soldiers and “cazadores” (slave catchers) were often unable to penetrate their environmental defenses, which included dense forests and steep, rocky hillsides.405

Although there were fewer large maroon communities on the western end of the island, there was no shortage of marronage to surrounding environments. Indeed, there was likely a higher frequency of “petit marronage” as opposed to “gran marronage.” There were

also two notable runaway destinations in the western sugar-producing jurisdictions that had therapeutic meanings to enslaved people and white people.

By the 1850s, physicians in Cuba were beginning to talk about the “unsurpassed” health-restoring benefits of the “mineral waters” in two rural towns: San Miguel in the jurisdiction of Matanzas and San Diego in Pinar del Rio. Nestled in pastoral valleys, these spring towns were ideal destinations for health retreats, much like White Sulphur Springs in Louisiana. Eventually, the “Baths of San Diego” and the “Baths of San Miguel” became extremely popular health tourism destinations for wealthy white people from Havana. By the 1860s, both had hotels, restaurants, ballrooms, and recreational sports in addition to constructed bathing facilities, where tourists would “take the waters” according to physician-prescribed regimes. But before they were high-class “baths,” these watering places were places where enslaved people went to escape the violence and brutal, repetitive work of plantation slavery in Matanzas and Pinar del Rio.

According to histories of the healing waters in San Miguel and San Diego, both springs were originally “discovered” by enslaved men. These discovery stories demonstrate knowledge of environmental healing that can also be found in enslaved communities in Cuba; in West Africa; and in the Atlantic world more broadly. For San Miguel, physicians’ chemical analyses, colonial geographic surveys, local periodicals, and tourism pamphlets ranging from the mid-nineteenth century to the mid-twentieth century describe the “legend” of a sick enslaved man named “Miguel” who “took refuge” in a cave hidden in the limestone hills surrounding the town of San Miguel. Miguel had fled enslavement at La Diana, a sugar plantation in San Miguel owned by Juan José Morell. Some sources maintain that “no one knows” the enslaved man’s real name, which is why he was named after the town of San
Miguel, while other sources do not name him at all and instead refer to him as “el negro de la cueva” (the black man of the cave). Nevertheless, all sources seem to agree that Miguel resided in the cave for several days, eventually finding a pool fed by sulphurous spring waters bubbling up from beneath the earth. At some point, Miguel decided to bathe in these waters. Some sources claimed that Miguel suffered from digestive problems; others said he had a “loathsome skin disease;” and still others said his “débil” (“feeble” or “weak”) body had prompted him to bathe. After bathing for several days, Miguel experienced a “miraculous” recovery. In some sources, Miguel’s story concludes with him deciding to leave the cave and return to La Diana, where he presumably resumed his normal work duties. Other sources maintain that slave catchers tracked down Miguel and killed him, and as a warning to all other runaways, they hung Miguel’s lifeless body at the entrance to the cave.406

The discovery stories for the waters of San Diego in Pinar del Rio do not contain the same gruesome alternate ending, but there are numerous similarities in everything from practices of marronage to the qualities of the water and the specific diseases they healed. Chemical analyses of the San Diego waters, medical travel guides, and recent histories of public health in Pinar del Rio all seem to agree that an enslaved man named Taita Domingo discovered this natural spring. Much like Miguel, Taita worked at a sugar plantation and was suffering from a skin disease that was exacerbated by the heat of the sugar boiling house. However, some sources maintain that Taita was actually suffering from leprosy and that his

406 Versions of Miguel’s story can be found in Dr. Joaquín F. de Aenlle’s 1866 analysis of the waters. At the time, Aenlle was a professor of chemistry and pharmacy at the University of Havana. See Apuntes para el Estudio de las Aguas Minero-medicinales de la isla de Cuba y relacion de todos los analisis que de las mismas se han practicado hasta la fecha (La Habana: Imp. de Villa, 1866), 36. MCF; see also Spanish imperial surveys of “medicinal mineral baths” such as Reglamento Provisional de Baños Minero-Medicinales para las islas de Cuba, Puerto Rico y Filipinas (La Habana: Imprenta del Gobierno, 1870). MCF; twentieth century local periodicals such as the publication for the rotary club of San Miguel, Revista Rotaria de San Miguel de los Baños (Diciembre, 1953), Periódicos, BNJM. n.p.; and twentieth century tourism literature produced by American expats in Cuba, including Roger Le Fébure, e.d. The Blue Guide to Cuba (Havana: R. Le Fébure, 1948), 139.
master discovered his illness and removed him from the plantation, lest he infect other enslaved people. In this telling, Taita’s master “locked him in a cabin several leagues from the plantation” and left him there for several weeks. But whether it was from the cabin or from the plantation directly, Taita eventually escaped to a limestone cave system in the hills around San Diego. There was a river running through this cave system, and he decided to follow the river until he ended up at several large pools of water. After a few days, Taita started bathing in the pools. He bathed for several hours each day and after a “long time,” Taita’s illness “entirely disappeared” and “his health was restored” such that he decided to return to the plantation. Taita’s master was apparently astonished by his recovery and not only allowed him to resume his work on the plantation, but according to some sources, his master “kept him close to his person” from then on.⁴⁰⁷

Although these writers treated the stories of Miguel and Taita as quaint myths, reading these sources in conjuncture with medical anthropological studies of water healing in West Africa and in formerly enslaved societies in the Caribbean can be used to speculatively reconstruct the therapeutic knowledge that may have influenced Miguel and Taita’s decisions. As discussed in Chapter Three, Yoruba medicine played a significant role in many enslaved medical cultures in western Cuba given the fact that Lucumí made up a significant percentage of the labor forces on sugar plantations. Although the stories of Miguel and Taita do not mention that either belonged to a specific nación, they did not necessarily need to be

⁴⁰⁷ See Anelle’s study of the San Diego waters Informe Químico sobre las Aguas de San Diego (La Habana: Imp. de Villa, 1861), 7-8. MCF; medical travel guides mentioning Taita’s story include Antonio Pons Codinach, Guía práctica para el uso de las aguas minerales de San Diego de los Baños de la Isla de Cuba (La Habana: Imp. del Gobierno, 1853), 3. MCF; Francisco Alvarez Alcalá y Constatin James de Paris, Guía para el uso de las Aguas Minerales, especialmente de las sulfurosas y salinas (1877), 7. MCF; and American health tourist Samuel Hazard’s Cuba with Pen and Pencil (Hartford, CT: Hartford Publishing Company, 1871), 374-376; see also twentieth century public health texts such as Gregorio Delgado García, ed., Monografía histórica sobre San Diego de los Baños. Cuadernos de Historia de la Salud Pública 59 (La Habana: Historiador Médico del MINSAP. Escuela Nacional de Salud Pública, 1974), 11-12.
Lucumí or have any connections to the Yoruba territories in West Africa in order to learn Yoruba ideas and practices. Miguel and Taita may have trusted in Yoruba medical knowledge because of its prevalence in their communities. As several anthropologists of Yoruba medicine in Nigeria have demonstrated, water has been a healing mainstay for centuries, even with the introduction of Western biomedicine over the course of the twentieth century. The healing properties of certain waters are based on their empirical and spiritual significance, which often overlap and cannot be easily disentangled, as is true for many forms of medical knowledge, past and the present. Nonetheless, some specific meanings can parsed by noting the two groups who are most likely to become water healers: “oníseègùn,” who are medicinal herbalists with extensive knowledge of healing plants; and “babaláwos,” priests of Ifa, the Yoruba god of divination, who are typically responsible for maintaining of cultural heritage, health and the well-being of their community, but also possess deep knowledge of plants and where to find them. Babaláwos in Lucumí communities in Cuba were also regarded as religious and spiritual authorities who knew where to find healing egwes, and as such they may have been key intellectual authorities when it came to finding watering places.

According to anthropologists of Yoruba water healing, water healers use their connections to divine authorities to identify which waters can heal and how to go about using them. In Nigeria, consuming water and bathing in water – or doing both at the same time – can improve health and bodily functions in ways that are similar to the purifying and

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“flushing” actions of Lucumi egwes. Like palm leaves when they are smoked or eaten, drinking this water alone or in combination with other medicines can expel certain the illnesses from the body. For example, consuming certain medicinal plants with water can heal the rough cough that usually comes with tuberculosis, as the water will move the medicine where it is needed to flush away the disease. To find healing waters that are suitable for bathing, healers must be able to recognize indications from the goddess Osun, the daughter of Yemonja. Osun is responsible for all rivers and streams, whereas her mother Yemonja is regarded as the goddess of all waters. Osun is also a fertility goddess by way of her power to imbue certain waters with the ability to restore fecundity to barren women. She can also heal the sick by creating medicinal qualities in water. In the city of Ile-Ife (or Ife) in southwestern Nigeria, anthropologist Eva-Marita Rinne learned that bathing in river waters could cure various illnesses such as headache, stomachache and other stomach disorders and sluggishness, as flowing waters could flush out both illness and misfortune. Furthermore, water healers in Ile-Ife emphasized that location played an important role in the power of healing waters. A flowing river or stream, or the confluence of several rivers or streams, were ideal locations for gaining the attention of Osun or other divine entities and ancestors who would aide in the therapeutic process. Timing was also essential, as not only did the patient need to wait until they got the attention of the appropriate spiritual authorities, but sometimes one dip in the waters would not suffice. For some ailments, patients needed to bathe multiple times over the course of several days. Taita Domingo’s story also featured a flowing river that swirled into a pool. Moreover, in both Miguel and Taita’s stories, the men waited for a certain amount of time before bathing and then bathed in their respective water

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sources over the course of several days. This indicates that their sense of time and the act
making of bathing routines may have mattered in the therapeutic process of water healing in
western Cuba as well.

Although it is certainly true that water healing practices can be found in many
medical cultures all over the world, there are empirical similarities between Cuba and Nigeria
which indicate that Miguel and Taita’s practices may have been derived West African medical
practices. Water healing, like other varieties of what Kevin Dawson has called “aquatic
expertise,” likely came with enslaved African people to the New World.410 Further support
for this claim can be found in an examination of water healing in enslaved-descended
medical cultures elsewhere in the Caribbean. These watering healing practices also provide
some insight into how the experience of marronage shaped water healing, and vice versa.

Medical anthropologists have noted that the marronage experience was essential to
the formation of water healing in many Maroon communities in Surinam, where inhabitants
are the present-day descents of enslaved people who ran away from plantations that were the
under control of Dutch, French, or Portuguese Jewish settlers. Slavery existed in Surinam
between the 1650s and 1863, and slave traders brought African people to Surinam from
several areas of West and Central Africa, including what was sometimes referred to as the
“Windward Coast” (present-day Sierra Leona, Liberia, and Côte d'Ivoire); the “Slave Coast”
(Ghana and Benin); and the Kingdom of Loango, which occupied southern Gabon and
northern Angola between 1550-1883. Enslaved people in Surinam and neighboring French
Guiana often escaped from slavery into the dense tropical rainforests that cover most of the

410 See Dawson’s recent study of aquatic knowledge and cultural values in the African Diaspora, Undercurrents of
Power: Aquatic Culture in the African Diaspora (University of Pennsylvania, 2018), 11.
central and southern regions of those countries. By the late eighteenth century, there were numerous well-established runaway communities there.411

Maroon ethnic groups in Surinam today still use medical practices that have West African roots and New World historical contexts, and this is especially true for medicinal herbal baths. For Saramaccan and Aucan Maroon communities, ethnobiologists and anthropologists have identified six common herbal baths that differed from one another according to the age of the patient, their physical condition, and their spiritual health. There are baths designed for babies and adults as well as baths made for certain skin disorders, respiratory ailments, spiritual ailments, and genital conditions, including venereal diseases. The act of bathing usually involves the community’s designated herbalist, or an older lay man or woman, who douses the patient in water mixed with herbs and often focuses the dousing on the specific area on the body where the illness is located. Alternatively, the patient might submerge themselves entirely in a basin, or a natural pool of water, possibly by a river’s edge. Sometimes herbal baths are individual endeavors, meaning that the patient alone would be doused or submerged, but other times multiple people engage in the bathing process, as this can add to the curative power of the practice.412 Miguel and Taita’s stories do not indicate that their bathing practices involved other people, but of course marronage in nineteenth century Cuba – and also in Louisiana and throughout the U.S. South – was not always a solo endeavor. People sometimes ran off together, as the enslaved people at Buck Hill plantation did. The cave locations of the healing waters of San Miguel and San Diego

411 For the history of slavery in Surinam see Aviva Ben-Ur, Jewish Autonomy in a Slave Society: Suriname in the Atlantic World, 1651-1825 (University of Pennsylvania, 2020).

may have been places where runaway enslaved people gathered with the intention of joining
forces to heal one person in particular, or many people at once.

Indeed, anthropological observations of Saramaccan and Aucan Maroon water
healing reveal that the practice is a common way for groups of people to heal and/or
strengthen their bodies together before undertaking specific forms of physical labor. If
several people in a given community found themselves suffering from a common or
communicable skin disease at the same time, all of them might decide to bath at the same
time using the same waters to increase the therapeutic power of the waters and thus the
likelihood that all participants would not just recover but would do so much faster.

Meanwhile, adults who do not have specific illnesses might take a “strengthening” herbal
bath whenever they feel especially tired or are suffering from aches after a long day of
manual labor. Men often take strengthening baths preemptively before they begin intensive
physical tasks such as cutting down trees and clearing fields for agriculture, or building a
boat or house. Women, who are generally responsible for planting and harvesting in
Saramaccan and Aucan Maroon communities, take strengthening baths on a frequent basis
during the planting and harvesting seasons. For strengthening baths, the woody liana vine is
often the herbal substance of choice for both genders.\textsuperscript{413}

Given the fact that it was not at all unusual for a group of enslaved people to find
themselves suffering from the same illness or disease on a plantation, whether due to
epidemics diseases or the terrible living and working conditions which they all experienced, it
seems even more likely that groups of enslaved people may have worked together to heal
themselves, perhaps by sharing knowledge, resources, and experiences of healing waters.

\textsuperscript{413} van ’t Klooster et al., 6-7.
Moreover, the communal dimensions of this practice seem especially advantageous if they could accelerate the healing process, thus helping sick people avoid enslaver violence, which might be the lash or being forced to make up missing work time at a later date. Interestingly too, the specific conditions and the labor contexts pertaining to water healing in Surinamese Maroon communities reveal similarities with water healing as described in Miguel and Taita’s stories. Skin diseases are mentioned in numerous versions of their stories. Some of the sources for Miguel’s story explain that he went to the waters of San Miguel because his body was “weak” as a result of the taxing physical labor he endured on a sugar plantation. Both men could have escaped their respective plantations to heal skin conditions or restore their tired and broken bodies, or they could have decided to bathe in healing waters in an attempt to fortify their bodies ahead of particularly difficult work task that they knew was coming for them sooner or later. In this way, enslaved people’s sick time with healing waters might have been both preventative and rehabilitative.

As these comparisons show, enslaved water healing practices in western Cuba had spiritual and epistemic roots in West Africa. Comparisons to Surinam suggest avenues for thinking about how such practices fit into marronage and emerged as specific responses to the precise managerial and medical controls that governed mid-nineteenth century plantations. Similar speculations might be drawn about swamps and woodlands, which, though more geologically common in the Americas, are not necessarily less significant. As such, in many instances of marronage in Cuba and Louisiana, the illnesses that prompted enslaved people to run, the environments they chose to escape to, and the social and temporal dimensions of their escapes all reflected the heightened levels of violence and surveillance that characterized this epoch of both plantation slavery and physician medicine.
The history of watering places in Cuba and Louisiana thus offers one opportunity to analyze the internal logics of knowledge production in Black communities in ways that do not necessarily privilege the place of European epistemes. Admittedly, such a scholarly goal is problematic to begin with, though its problematic nature does not diminish its importance.414 Medical writing, local histories, and anthropological comparisons do suggest that enslaved people used their own methods of locating and testing healing waters, which means that they valued investigation, observation, and the making of general consensus, though not always for the same reasons that white people did. In doing this, enslaved people created fugitive therapeutics as a body of knowledge similar to (and likely overlapping with) other Afro-diasporic medical cultures, such as Santería, which, in the words of Steven Palmer and Marcos Cueto, emerged “as alternative, hybrid form of popular scientific rationalism” during the nineteenth century.415

The ideas and practices that enslaved people may have used to make healing environments did not prevent white people from colonizing those environments and turning them into their own healing spaces. Planters and physicians did not develop exact methods for predicting and altering environmental conditions, but they did figure out how to conquer some environments and use them to alleviate their own illnesses. In the case of San Diego, the construction of a railroad from Havana to Pinar del Rio in 1860 surely hastened the

414 For historical and theoretical work on black epistemes of knowledge production in Cuba specifically Stephan Palmié, *Wizards and Scientists: Explorations in Afro-Cuban Modernity and Tradition* (Duke, 2002).

colonization of the spring waters, as it included a stop at San Diego. Indeed, San Diego, San Miguel, White Sulphur Springs, and Abita Springs (which is just north of New Orleans) all became popular white health tourist destinations in the late nineteenth century. By then, all that remained of enslaved people’s fugitive therapeutics were the fables of the “innocent,” “simple” and long-dead people who had “accidentally discovered” the healing waters. As such, some aspects of the relationship between medicine and slavery management lived on in white health tourism, particularly in its continual exploitation and colonization of Black medical knowledge. But the central connection between physician medicine and plantation management science – being their focus on productivity – is even more noticeable in the labor regimes that came after slavery.

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416 See the discussion of the railroad’s construction and its economic impact in Aprobación del proyecto de construcción del ferrocarril de La Habana a Pinar del Río. Legajo 198, Exp. 8. Ministerio de Ultramar, Archivo Histórico Nacional de España, Madrid.
Conclusion: The Further Integration of Health and Productivity after Slavery

This dissertation has shown how the development of slavery management, from urban colonial slavery to plantation slavery, shaped the rise of the modern medical profession in Louisiana and Cuba. White male physicians became vital to the maintenance of healthy slave populations under Spanish colonialism during the late eighteenth century, which primed them for a similar relationship with the powerful planter classes who took over the slavery economy during the first half of the nineteenth century. Physicians held on to their claims to medical authority by continuing to delegitimize and subordinate Black hospital workers, nurses, midwives, and “charm doctors.” Although Louisianan and Cuban slave-holders never stopped relying on Black practitioners for medical labor, they became more willing to hire white male physicians to treat enslaved people as they became more convinced that these men possessed the medical knowledge that fit with managerial priorities. This process differed between Louisiana and Cuba due in part to different understandings of race and blackness. But in both places, physicians used their connections to slavery management to close ranks and make their knowledge seem more scientific. Enslaved people challenged managers and physicians by reimagining health and healing in ways that sometimes intersected with environmental elements that neither planters nor physicians could control. But ultimately, enslaved people did not disrupt the hegemony of productivity. It might be argued that this was not their primary goal, anyway.

Managerial and medical thinking about health through the lens of productivity did not end with emancipation and the collapse of racial slavery in Cuba and Louisiana. Neither did the relationship between Black health and disposability towards capital accumulation. These ideas became foundational to the “free” wage labor-based economies that emerged
after slavery. This continuity does not suggest that what came after slavery in Cuba and Louisiana was necessarily “slavery by a different name.” Such a framing is reductive, even in the U.S. where slavery was essentially relegalized as punishment for crime. It fails to acknowledge key differences in materiality, politics, and lived experience, while also diminishing the simple yet crucial fact that anti-Black racism easily survived without slavery. Instead, continuity in this case illustrates that understanding health from the perspective of management had become so culturally entrenched throughout the acceleration of slavery that it could weather major social and economic transitions like emancipation. The ideas discussed in the preceding chapters reemerged in the short term, in both Cuba and Louisiana, in the decades immediately after slavery. Moreover, the naturalization of time-conscious, efficiency-minded, and scientific meanings of productivity into medicine, and into ideas of health and the body generally, has persisted over the long term. This historical process has been particularly evident in the United States, where access to medicine and health care became increasingly tied to employment over the course of the twentieth century. But even in Cuba, where medicine and employment have been largely decoupled since the advent of universal health care in 1961, workplace productivity – which often serves the Cuban state and its interests – has remained an important means of measuring health, racial fitness for labor, and worthiness for medical care.417

Back in nineteenth century Cuba, the abolition of slavery was more gradual than it was in Louisiana. Manumission rates began to increase after 1868 as powerful planters realized that such concessions might be necessary to maintain commodity production as they

417 For more on the contemporary politics of health, medicine, work, and the state in Cuba see P. Sean Brotherton, Revolutionary Medicine: Health and the Body in Post-Soviet Cuba (Duke, 2012).
engaged in protracted wars of independence against the Spanish Crown, which was no longer content to ignore the problem of slavery. The institution was officially abolished on the island in 1886, but highly exploitative and racialized plantation-based agriculture remained the island’s most important industry until the Cuban Revolution in 1959. Many formerly enslaved plantation workers and their children continued to work on sugar, coffee, and tobacco plantations in the decades after 1886. Most of these people did not have the education, skills, connections, or capital to leave the plantations to find work in the cities. As Rebecca Scott has shown in her comparative study of Cuba and Louisiana after slavery, many formerly enslaved people were still subjected to intense work regimens and plantation surveillance, but some were able to organize their workforces. They demanded access to better working and living conditions, such as the elimination of barrack housing and the return of cabin living arrangements, and thus the return of the small gardens that provided food, medicine, and supplemental income.418 Afro-Cuban workers and thinkers – some of whom had fought on the side of the planters during the wars against Spain – continued to fight for more political and economic power, often critiquing the structural subordination of Afro-Cubans in Cuban society which remained in place even as the island transitioned from Spanish colony to U.S. occupied territory to the independent nation (nevertheless still under U.S. neocolonial control) in 1902. Some nationalist political elites in the new Republic of Cuba sought to blame anti-Black racism in Cuba on the influence of their neocolonial overlord, the United States. They pointed to the political enfranchisement of Afro-Cuban men as a significant victory in the making of a kind of consciously deracialized Cuban

418 Scott, Degrees of Freedom, see esp. 61-93 and 129-153.
national identity that dissolved meaningful differences in citizenship experiences, and arguably enabled the perpetuation of systematic racial discrimination.419

The persistence of racism in Cuba after slavery was, unsurprisingly, especially noticeable in the plantation sphere of production, where some of the ideas, expertise, and technologies made for managing enslaved health clearly survived the transition to free labor. Business and estate records from the Santa Rosalía sugar plantation in Cienfuegos demonstrate a continuous managerial and medical focus on systematically accounting for and controlling the health of their labor force throughout the final decades of slavery and in the decade after abolition. These records show the same tracking of enslaved and free people’s work time and sick time, and the same medical hierarchy where the most authoritative and trustworthy medical knowers were those who knew plantation medicine was about saving time and increasing plantation efficiency, not necessarily healing. The Blanco family, owners of Santa Rosalía, retained the services of white male Havana-educated physicians throughout this period, sometimes hiring full-time physicians for their infirmaries or, when times were leaner, paying for the services of local physicians, some of whom may have been on their plantation tournees. According to Santa Rosalía records, one local physician named Manuel Gonzalez, who had earned his medical degree at the University of Havana, treated sugar laborers at Santa Rosalía off and on between 1870, when many were still enslaved, and 1884, when almost all laborers were free. Plantation records and correspondence do not provide much details about Gonzalez’s practice beyond when he was called to the plantation and the conditions he treated (which included pregnancies, traumatic

injuries, stomach ailments, and skin diseases). However, this information does suggest that Gonzalez had a continuous relationship with Santa Rosalía managers and owners over the years, and that he likely understood their priorities when it came to the health of laborers.\footnote{Notes on Gonzalez’s visits can be found throughout volume 1 of Relaciones nominales, cuentas, inventarios y otro documentos de diversos ingenios. Ingenio Caledonia, Santa Rosalía, Conchita, Reglita, 1860-1897. C. M. Lobo No. 159, BNJM.} The Blancos presumably could not force Dr. Gonzalez or any other white male physician upon workers once they had their freedom, but if these were the most available and trusted medical experts, and/or if their remedies actually seemed to free laborers to be the most efficacious, in spite of connections to management, it is further safe to say that Gonzalez and physicians like him maintained dominance of plantation medicine after slavery.

Just as medical expertise on the plantation had not changed much, neither had managerial methods of accounting for laborer health and illness in terms of time lost. In one account book, which was used to track daily and weekly work activities at Santa Rosalía between March 1893 and April 1899, managers continued to count the number of laborers assigned to each task in the sugar-making process; how much they did each day and each week (e.g. how much cane they cut); and whether or not they had taken any sick days that week. Organizing all of this data in a spreadsheet format, with the names of laborers and their assigned tasks on the Y axis, and the days of the week on the X axis, the managers used the last column, marked “observations,” to note the number of hours or days each worker had lost to sick time, as well as the corresponding reduction in wages needed to cover that loss. One free Black woman named Emilia was out sick during the week of March 19\textsuperscript{th}, 1893, which resulted in two days of lost time and a call to Dr. Gonzalez. The records do not say what Emilia was suffering from, nor whether or not Gonzalez gave Emilia a diagnosis, but
she was back to work the day after seeing him. In theory, Emilia could have refused to see Dr. Gonzalez. She could have refused to return to work if she did not agree that she was healed, or if she decided she did not like the sick time terms that came with her employment. But what she could not challenge was the managerial logic that was still influencing the medical treatment that was available to her at Santa Rosalía. The most significant issue with relation to her illness, as far as those with power were concerned, was the work time it was costing her employer.

Free Black laborers in Louisiana could also, at least in theory, refuse the authority of white doctors in their workplaces, and refuse to agree to sick time policies that they perceived to be unfair. However, convict laborers, who replaced enslaved laborers in many industries in Louisiana and throughout the postbellum South, usually could not do anything of the sort. After the Civil War, many cotton and sugar plantations in Louisiana went under, or voluntarily closed, as planters and their financiers were no longer satisfied with the profits that remained after paying wages. In the first decade after the Civil War, some forfeited plantations were left to decay; some became tourist destinations (first, for health tourism, and more recently, for weddings); and some became convict labor camps. Because slavery and slavery-like working conditions were legal for people detained for or convicted of crimes, and because the incarcerated population of the post-bellum South was disproportionately Black, many historians have argued that convict leasing systems represented one of the clearest continuations of racialized oppression and exploitation after emancipation. Importantly though, historians such as Talitha LeFlouria have cautioned

421 Vol. 1, pg. 6, Ibid.

422 See for example Sarah Haley, No Mercy Here: Gender, Punishment, and the Making of Jim Crow Modernity (UNC, 2016); Mary Ellen Curtin, Black Prisoners and Their World, Alabama, 1865-1900 (University Press of Virginia, 2000); Karin A. Shapiro, A New South Rebellion: The Battle Against Convict Labor in the Tennessee Coalfields, 1871-
against too much blurring of the lines between slave labor and convict labor, pointing out
that the “just like slavery” analysis – though sometimes very apt – can obscure how crucial
convict labor was to the expansion of capitalist industries in the New South.

LeFlouria’s work on Black women convicts in Georgia also illustrates an important
ideological distinction between slavery and convict leasing which resonated in differences in
physician medicine under both systems. Southern slavery – like Cuban slavery – was pro-
natalist when it came to enslaved Black people (though not free Black people). This was
because enslavers viewed enslaved people’s bodies as property, capital, and a source of
productivity, through their physical labor and reproductive labor. Convict leasing was not a
heritable institution and did not require natal reproduction to grow its labor forces. As such,
the lease owners, camp managers, and physicians who profited off of convict leasing saw
medical conditions like pregnancy and childbirth “as threats to economic progress and
productivity,” to use LeFlouria’s words.423 Both enslaved and convict laborers could be
subjected to medical interventions at the hands of hired white male physicians. Under both
systems, Black women were subjected to particularly dangerous and dehumanizing
gynecological experts. But in convict leasing camps, physicians did not have the same
incentives to try to ensure that, for example, convict women had healthy pregnancies and
childbirths. According to LeFlouria, this reflected how convict labor used medical
intervention to “enhance productiveness – but not reproductivity – of female convicts.”424

1896 (UNC, 1998); Matthew J. Mancini, One Dies, Get Another: Convict Leasing in the American South, 1866-1928
(Columbia, SC: University of South Carolina Press, 1996); David M. Oshinsky, "Worse Than Slavery": Parchman


424 Ibid, 14.
This distinction is important, but it also reveals that, under both slavery and convict leasing, physicians were there to protect labor productivity. Although they had different biopolitical readings of the laboring body, it is clear that management and medicine under both economic systems believed that it was possible to interpret the healthiness of an enslaved or a convict laborer through standardized measures of productivity.

In Louisiana, the influence of slavery management was especially clear in physician medical care for convict laborers at the Louisiana State Penitentiary, also known as Angola Prison or “the Farm.” This prison opened in 1870 on former plantation land in West Feliciana Parish that had once belonged to Joseph Acklen, the well-known planter and managerial thinker, and his wife, Adelicia Acklen. In 1870, the state of Louisiana, which still had little infrastructure, money, or power to administer the post-Reconstruction economy, awarded former Confederate Major Samuel L. James the lease to operate the State Penitentiary. This lease also gave James the privilege of profiting off of the labor of inmates, who were legally sanctioned for forced labor. Inmates produced cotton and sugar, among other commodities, and were even housed in old slave barracks. Today, Angola inmates make clothes for L Brands, which owns The Limited, Victoria’s Secret, and Bath and Body Works, among others. Set on nearly 8,000 acres of land, with more than 6,000 inmates (4,400 currently serving life sentences without parole), it is one of the largest maximum-security prisons in the United States. Throughout its history, the prison has been notorious for its violence and brutal working and living conditions.425

The physicians in charge of medical care at the Louisiana State Penitentiary in the postbellum period wanted to get sick and injured convict laborers back to work quickly, and they believed that more work was one of the best treatments. Recent scholarship on prisons, asylums, and unfree labor in postbellum Louisiana has shed some light on these physicians and their role in facilitating the new carceral-based economic regime. William Horne has shown how New Orleans doctors Yves LeMonnier and Stanford E. Chaillé, both of whom became prominent physicians and medical thinkers under slavery, used medical knowledge about the racialized Black body that was once used to justify slave labor to explain why Black prisoners and Black people deemed “mentally unsound” were suited to hard labor with minimal time for rest and recovery. LeMonnier and Chaillé worked for the city of New Orleans after the Civil War, serving as medical experts in criminal cases where the accused often ended up in either an asylum or the State Penitentiary. Both men also served as top physicians for the convict leasing system, overseeing the work of doctors and nurses who ran the hospital at Louisiana State Penitentiary. They instructed their subordinates to focus their efforts on prisoners who were good workers and to not to waste precious resources and time on those who were often sick or injured. They also stressed that keeping convict laborers at work, as much as was possible, would be the most beneficial intervention for their health.426 Although continuity of managerial ideas of enslaved health is not Horne’s focus, his sources demonstrate that leading New Orleans-based physicians were still using productivity as a lens for understanding Black convicts’ health and worthiness for medical

care. Just as they had been when the prison was a slave plantation, physicians’ medical interventions were all chiefly aimed not at healing, but at maximizing the amount of time prisoners spent working.

Moving from the immediate aftermath of slavery to the present, we can see how the relationship between medicine and slavery management haunts health surveillance in the American workplace. In a certain sense, we are all productivity minders now. The COVID-19 pandemic has triggered a widespread shift from collective workplaces to digital-dependent, work-from-home workplaces. With this change, and the related pandemic-induced explosion of telemedicine, many professionals are now subjected to intensive productivity monitoring and regular health screening requirements. Key stroke tracking software, webcams, and required reporting of symptoms, test results, and vaccination status help employers see their laborers, control their habits, and manage their health within the comfort of their own homes. Of course, such workplace surveillance technologies are hardly new for wage workers, who are often timed while serving customers, stocking shelves, or hauling parcels; gig workers, who rely on smartphone apps to access employment; and other “essential” workers, such as health care workers and teachers, whose bodies are essentially disposable to capitalist economic continuity, “unprecedented times” or not.

For example, the collection and analysis of employee health data has been a flash point issue in recent teacher’s strikes. In February 2018, public school teachers in West Virginia walked off the job in an attempt to address rampant underfunding of schools, low pay, and high health insurance costs. With regard to health insurance, chief complaints were ever-climbing premiums and widening gaps in coverage, but the strikers decided to act when
they did after the state employee’s insurance agency proposed a “solution” to high
premiums, which was to require that teachers wear fitness tracking devices, like FitBits. The
idea was that these devices would provide the agency with continuous streams of
individualized health data that could be used to identify teachers who were not getting
enough physical activity. The agency assumed that these people would be less healthy and
therefore more likely to need medical care in the future. Teachers who refused to comply
with fitness tracking, or those who did but failed to reach the target number of steps and
accelerated heart rates, would then be charged an individual deductible increase of $500,
rather than increasing costs for everyone across the board.427 To the teachers, it was an
obvious attempt to shift the financial burden of care on to the people who likely needed care
the most, while also dividing labor along the lines of health.

This incident may seem particularly invasive and dystopic, but the agency’s logic was
hardly exceptional. Their views were very much in line with the business of employer-based
medical care in the U.S., where employers, insurers, and physicians assume that employees
will abuse health benefits and threaten the accumulation of work time without proper
managerial and medical surveillance. One need only look at the ways that insurance

427 For the fitness tracking requirement and its associated “penalties” see the West Virginia Public Employee
Insurance Agency’s open enrollment information packet for 2019. West Virginia Public Employee Insurance
West Virginia Teachers Strike Shows That Winning Big Requires Creating a Crisis,” The Nation. Published
virginia-teachers-strike-shows-that-winning-big-requires-creating-a-crisis/; Jess Bidgood, “I Live Paycheck to
Paycheck’: A West Virginia Teacher Explains Why She’s on Strike,” The New York Times. Published March 1,
strike.html.
companies, health benefits research organizations, and occupational physicians have focused on detecting “fraudulent” medical claims and minimizing lost productivity.

With the purchase of some group health insurance plans, Cigna Health and Life Insurance Company provides employers with “Leave Solutions®,” which is an administrative suite of consulting services, reporting technologies, and “fraud prevention monitoring” that promises to “effectively manage” employee sick time, family medical leave, and disability leave “to help keep workforce productivity and costs on track” and encourage “shorter durations of absence.”\textsuperscript{428} Similarly, Integrated Benefits Institute, a large not-for-profit organization devoted to “health and productivity research,” has produced studies on the loss of “work time” to employee illness. One study found that “depression costs [employers] about $232,000 in excess healthcare treatments and lost work time for every 1,000 employees.”\textsuperscript{429} The same thinking can be found in the pages of the \textit{Journal of the American Medical Association}, one of the most prestigious medical journals in the United States. A recent study of a “workplace wellness program” at “a large US warehouse retail company” found that the program “resulted in significantly greater rates of positive self-reported health behaviors,” but “no significant differences” in “health care spending and utilization.” For the study authors, this meant that the workplace wellness program was ineffective because, even though it may have helped employees feel better overall, it did not curb the use of sick time and other health benefits. As they explained, these “findings may temper expectations about the financial return on investment that wellness programs can

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deliver in the short term.” In all three of these examples, “health services” analytical tools and medical research that supposedly improve “employee health” are in fact primarily concerned with increasing workforce productivity and reducing employee “utilization” of health care.

This analysis is not meant to suggest that we can draw a straight line between nineteenth century slavery and twenty-first century capitalism. Neither I am arguing that planter meanings of sick time are the only historically consequential interpretation of the concept. (After all, enslaved people had their own ideas of sick time which may have been more important to them.) Rather, I am contending that the relationship between medicine and slavery management is an important example of a core logic of management under capitalism, which is that the health of laborers can and should be steered towards productivity. Racial slavery is the most extreme example of this managerial reasoning, and that extremity helped to define what came after it. Moreover, the reverberations of managerial meanings of enslaved health in the present should encourage us to seriously consider why the link between health and productivity has seemed obvious to us, or even natural. Why do doctors take a patient’s time out of work into consideration when determining the severity of illness? Why does a doctor’s note prove that someone is worthy of missing school or work? Why do we assume that productive people are healthy people?

J.A. English-Lueck, an anthropologist of work under late capitalism, has argued that technologically intensive “integration of workplace productivity and personal health” is a defining feature of the twenty-first century neoliberal workplace. To be sure, the digital

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production landscape of late capitalism has rendered older mechanisms of labor control obsolete. Managers, owners, insurers, and physicians have been forced to develop new ways of monitoring and interpreting the health of the laboring body when they can no longer watch it moving about the field, the shop floor, or the office. According to English-Lueck, one distinctive feature of neoliberal management has been the shifting of responsibility for health surveillance onto workers themselves, requiring them to not just report on their own health but also to be more “present” in and “mindful” of their bodies as they work. More than just human resources platitudes intended to simulate care and compassion, the expectation is that workers will “check in” with their bodies so they can recognize when they need to take a break, or a sick day. Such strategies supposedly protect workers from becoming overwhelmed by work, but another goal is that workers will self-identify as sick sooner, when their sickness can be mitigated through sick time, instead of later, when it might spiral into larger issue that costs comparatively more work time.

If we have all been made aware that our health impacts our productivity, and that we are responsible for mitigating that impact, it may be because this has remained a sound management practice since it was implemented under slavery. The amalgamation of bodily health and workplace productivity; the idea that worker health can be improved at work and through work; and the belief that sick time can manage health and productivity can all be found in the medical administration of slaves. As this dissertation has shown, there is a deep past that helps to explain why many people feel compelled to keep up with the compression of time under late capitalism, even if it makes them sick. There are also historical reasons for

why we feel deeply alienated when our employers, political leaders, and society at large demand that we take off our masks, get back to the office, and continue to be productive in the midst of a global pandemic. Part of the reason why this feels so wretched to us and so harmful to our well-being – in addition to the implicit requirement to accept that some people must die so that profits flow and assets appreciate – is because it is historically linked to the violence of enslavement.

Perhaps the wretchedness is especially palpable to some Black people, who might see how the expectation of productivity is still a key feature of blackness. In the fall of 2021, I taught one Black student who had noticed this. During that semester, the first “in-person” semester at Yale since the spring of 2020, I served as a teaching fellow for a course on the history of science and biomedicine as told through the works of science fiction author Michael Crichton. For the semester-long term project, we asked students to identify a “felt difficulty” that they were currently experiencing and to think about the kinds of medical and scientific knowledge that were wrapped up in that difficulty. In keeping with the science fiction spirit of the course, we asked them to not just to analyze the problem and identify its stakeholders, but also to imagine a future world where their felt difficulties did not exist. We asked them, what things would you change if you have all the power to do so?

Understandably, many students wrote about their anxieties related to attending college during a pandemic and their frustration with Yale and governmental institutions which seemed to care more about profits than their safety. However, several students wrote about their struggles with what they called the “cult of productivity,” “workaholicism,” and “hustle culture” at Yale and in wider American society.
When describing her experiences with the “cult of productivity,” my student wrote that she could not be sure if this “cult” made her feel horrible because it was intrinsically horrible for everyone who encountered it, or if she was especially affected because her worth as a Black woman is based on what she “will do,” with her intelligence; as a student at an elite university; with networking and job opportunities; and with all the social capital that comes with being someone who has been seemingly destined to succeed since she was very young. “I feel like a robot,” she wrote, “I’m always grinding, just doing the work I know I need to do.” She felt that other people interpret her productivity as a sign that she is physically and mentally well. She also wondered if the assumption that she “will do” something would be as ubiquitous if she was not Black. She explained how the “what will you do?” question felt like it was actually a different question, which was “how are you going to pay us back for what we’ve given you?” In her experience, others felt entitled to answer on that question because, as a Black woman, she was not supposed to have any of her economic and social privilege unless she did something meaningful with it. Something productive.

My student was right on both counts. The tie between health and productivity is intrinsically violent, exploitative, and traumatizing, but it is perhaps especially so for Black people because it was made for them. We are all productive minders now, but there are some people who will never be fully trusted to mind themselves.
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