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## **“I Don’t Believe in Doctors Much”: The Social Control of Health Care, Mistrust, and Folk Remedies in the African American Slave Narrative**

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**Abstract:** *The social control of human labor during slavery made it difficult if not nearly impossible for enslaved Africans in the Americas to lead both healthy and fulfilling lives. Forcibly working during such extremely difficult conditions had an enormous and profound effect on the health and well-being of enslaved African Americans in the United States. The current research project will examine the recorded interviews of former slaves collected by the Works Progress Administration during 1936-1938 as a context for the present study. Content analyses of 84 slave narratives were examined in order to capture depictions of health status and subsequent treatment remedies. Results indicated that formerly enslaved African Americans participated in an array of health practices including the elaborate use of herbs, roots, and potent elixirs to prevent and treat illnesses with or without the consent of their owners. Those who did not have access to doctors were often allowed to get treatment from ‘granny doctors’ to get them back on their feet once more. Findings reveal that folk remedies administered by the enslaved (i.e. self-care or slave-prescribed care) were preferred to doctor administered medicines and that there was an inherent mistrust of doctor administered care and doctor-prescribed medicine. After emancipation, health conditions during slavery carried over with little or no recourse due to institutional discrimination and prevalent racial stereotypes which still considered African Americans as inferior to their White counterparts.*

**Key words:** *social control, health care, perceptions, mistrust and slave narratives*

### **1. Introduction**

It is well documented that the institution of slavery significantly impacted the lives and personal agency of the enslaved and their families for successive generations. Slave

owners dictated the diet, health care needs, and medicinal usage of their “property”. In the last fifty years of slavery, the social control of the enslaved became even more marked (Berlin, Favreau, and Miller, 1998) which coincided with the beginnings of modern medicine and the streamlining of medical authority in America (Weitz, 2010). It was also during this time that one of the most publicized slave rebellions in American history took place, the Nat Turner rebellion of 1831 inspired by the independence of Haiti in 1804(Higginson, 1998, Dubois and Garrigus 2006). Despite the enormous social control exercised by American enslavers to keep slavery intact, enslaved African Americans still managed to persevere generation after generation and developed key survival strategies to deal with the confines of slavery.

Although the interrelationship between health and slavery is strong (Washington, 2006; Covey, 2008; Savitt, 1982) it has received little attention from Medical Sociologists, despite a general focus in the field on medicine as social control. Given that modern medicine and the American health care system were directly and indirectly shaped by slavery, the current study seeks to examine the process of social control regarding the health of the enslaved. Using a content analysis of slave narratives collected from formerly enslaved African Americans post emancipation, the current study attempts to further understand sources of health care of the enslaved in a meaningful manner and answer the following questions: 1) What role or roles did those who were enslaved play in their health care during the immediate years before Emancipation (if any)?, 2) In contrast, how was plantation medicine (approved by enslavers and primarily administered by White doctors) understood? and lastly, 3) What were their perceptions of traditional medicines (defined here as medicines, therapies, or health practices that utilized herbs, roots, barks, or plants) used during slavery.

## **2. Brief History of Health Care during Slavery in Colonial America**

The first enslaved Africans were brought to Virginia in 1619, representing the official start of chattel slavery in colonial America that would persist until 1865. For the vast majority of the period of slavery in America, medicine was quite primitive and knowledge of specific diseases and illnesses was severely undeveloped (Washington, 2006). Very few effective treatments existed for the most prevalent diseases, and America lagged behind Europe in terms of embracing public health measures, vaccination programs, scientific medical education and hospitals for many years (Washington, 2006).

In early colonial America, virtually all persons were vulnerable to infectious diseases such as smallpox, cholera, measles, diphtheria, typhoid and cholera. European immigration and the slave trade increasingly brought new groups into contact, and common diseases affected different populations differently. For example, the Europeans brought influenza, tuberculosis, the plague, smallpox, and measles to America which devastated Native American and African populations (Semmes, 1983). Slaves were particularly susceptible to contagious diseases and epidemics spread rapidly through slave quarters. The most common ailments among enslaved populations included dysentery, parasites, trichinosis, hookworms, tapeworms, ague, diphtheria, colic, leg ulcers, inflammation, joint pain, syphilis, gonorrhea and cholera as well as high rates of infant mortality and miscarriages (Savitt, 1978; Kiple and King, 1981). Enslaved African Americans were also more vulnerable to bacterial pneumonia than Whites (Savitt, 1978). Prevention during this time focused on the control of communicable diseases by enacting new laws regarding sanitation and the subsequent quarantine of the ill. Local public health

agencies in the United States existed in a handful of cities dating to the 1700s in order to address environmental factors believed to affect the population’s health (Savitt 1978).

Beginning in the 1730s, the nation began to witness the first recognizable seeds of the modern formal health care system, of which discrimination against African Americans fostered unequal care. This discrimination extended to free and enslaved African Americans alike and affected virtually every single social determinant of health and illness (Byrd and Clayton, 1992). Following the lead of several other European nations, the United States developed a network of almshouses to provide care for the “undeserving poor” which included free and enslaved African Americans. These almshouses were the early precursors to today’s underfunded and grossly under-resourced public hospitals (Rosenberg, 1987). Further, medical training in the 1700s included the use of physical bodies for medical education (Fett, 2002; Washington, 2006). The inherent lack of value placed on the lives of enslaved African Americans and their vulnerability meant that their bodies would be utilized most often for medical experimentation, training, and education which became a widespread practice in the United States (Washington, 2006; Fett, 2002).

### **3. Linkage between Poverty and Health in the late 1700’s-mid 1800’s**

Connections between poverty and poor health in the European scientific community did not surface until the late 1700s. Landmark studies include the research of Percivall Pott in 1775 who was able to link the hazardous working conditions of London’s chimney sweepers to an increased rate of scrotal cancer. His discovery helped raise the awareness of not only injurious labor conditions, but also

the importance of bathing (Brown and Thornton, 1957). In 1843, Edwin Chadwick published a ground-breaking report that documented an increased prevalence of disease among manual workers and the poor compared to their wealthier counterparts. He deduced that the unsanitary environment of the poor contributed to their higher rates of disease (Aschengrau and Seage, 2008). The connection between poor social conditions and disease was also observed in the United States during this same time period.

In the early 1800s, scientific ideas on illness and disease began to gain legitimacy with the general public, particularly among the upper class (Weitz, 2010: 108). Germ Theory, or the notion that for every disease there is one specific cause, coincided with the discovery of bacteria and viruses. While this ushered in some general improvements, germ theory had the latent effect of contributing to notions of biologically based differences in susceptibility to sickness. People were considered to be either more susceptible to a disease or illness because they were themselves believed to be inferior or weak since it was assumed that their actions and behaviors left them vulnerable. In a sociological context, this phenomenon is known as victim-blaming which focuses on the symptom and not the cause of the problem. Thus, we see the first examples of connecting illness to individual dysfunction of sorts and creating a split between the “deserving” and “undeserving” sick. Weitz writes that theories of illness that highlight individual “dysfunction” reinforce existing social arrangements and serve to justify the rejection, mistreatment, and negative stereotypes of those who suffer from illness (Weitz, 2010). Furthermore, a current argument against universal health care in the United States is based on the idea that there is a difference between “unfortunate circumstances” and “unfair ones” (Engelhardt, 1986).

One of the major roles of science during slavery was to fundamentally "prove" the racial inferiority of African Americans to Whites, thus, justifying the continuation of slavery (Washington, 2006). Medical journals published reports of experiments performed on the enslaved, withholding treatment to African Americans, unnecessary surgeries, the supposed identification of "Negro diseases," in addition to "evidence" designed to showcase the inferiority of African Americans (Byrd and Clayton, 1992; Washington, 2006). Byrd and Clayton state that the burgeoning medical profession had clearly "adapted the health system to the paradoxes of the new republic's 'peculiar institution' and racial caste system," (1992: 194). Essentially, scientific racism helped fuel the dominance of the medical model and the professionalization of doctors that characterized the institution of slavery. For example, The Jacksonian era (1813-1860) saw an explosive growth in the dominance of the medical profession at the expense of African American health. Following a number of slave rebellions and the Haitian slave revolt, cruel and violent punishments and treatment became even more prevalent. This uptick in extremely violent and inhumane treatment along with the rape, and forced breeding of African American women meant that slaves' illnesses were disproportionately due to trauma, obstetrical complications and gynecological problems (Byrd and Clayton, 1992; David et al, 1976).

During this same time period, the American Medical Association (AMA) was founded in 1847. This professional organization helped consolidate the power of the medical profession firmly in the hands of White males. The continued segregation of medical training and health care delivery was a central issue of the AMA, although a small handful of African-Americans would become formally trained doctors they proved to be the exception (Fontenot, 1994). The AMA would become one of the most powerful and successful opponents of universal health care and progressive health

care legislation, much of which would have benefited Blacks. Organized medicine would prove to be one of the largest hurdles against black health by backing market-based approaches to health care, working to concentrate the medical profession in the hands of the white male class, and being a vocal opponent of national health care plans (Quadagno, 2004). Indeed, although their dominance has declined some in recent years, as a whole, the medical profession remains a key stakeholder in maintaining the current health care system (Timmerman and Oh, 2010).

#### **4. Health, health care and illness during Slavery**

History and research tell us that slaves suffered from poor health more than Whites and received unequal and inadequate health care (Covey, 2007). The brutal and deplorable conditions of slavery led to poor health, injuries (inflicted and accidental), and untimely death for millions of Africans. At the crux of the issue, was the slave owners' need to coerce as much labor as possible from a slave without causing his/her death or infertility. Slaves were often expected to work regardless of a health condition or illness and White slaveholders dictated the living and work conditions for millions of enslaved Blacks. These conditions promoted or destroyed the health of the slave population. Insufficient diets meant few received proper nutrients, leaving them susceptible to diseases of nutritional deficiencies (Covey, 2008). Living conditions were characterized by poor sanitation, improper ventilation, damp floors and cramped quarters. These factors along with harsh labor conditions, exposure to the elements, and improper personal hygiene resulted in epidemics of typhoid, typhus, measles, mumps and chicken pox among slaves (Gibbs et al, 1980; Savitt, 1978).

In their review of black health from slavery to the current era, Byrd and Clayton’s (1992) findings highlight the importance of locating today’s poor health outcomes in the Black community in the racial historical analysis of health in America. As summarized in their article beginning as early as 1619, historical data shows the existence of a definite pattern of poor health for enslaved Africans due to strenuous workloads, insufficient housing, clothing and food, inadequate sanitation and overexposure to the elements (Byrd and Clayton, 1992). Other studies on slave health have found that enslaved blacks fared worse than their White counterparts (Kiple and King, 1981; Savitt, 1982; Steckel, 1986, Fett, 2002, Shaw, 2003; Covey, 2000). Following Emancipation and the Civil War, poor black health continued into the next century due to poverty, poor living conditions, inadequate sanitation and housing, and persistent racism and racial discrimination.

Utilizing historical records with data on slave height, age, and sex, Margo and Steckel (1982) found a negative association between height and median slave holding. This, they write, is consistent with other findings (Steckel, 1979b) of greater mortality and morbidity, lower quality of diet, and greater intensification of labor on large plantations. Other findings supported that slaves reached adult height earlier and were taller than many of their European counterparts, light-skinned free and enslaved Blacks were taller than darker-skinned Blacks, and that enslaved females were approximately 2.5 years younger at age of first menarche (Margo and Steckel, 1982). More often than not, scholarship on slave nutrition and diet find evidence of deficiencies as the rule (Shaw, 2003; Kiple and King, 1981).

As much as they varied in the treatment of their slaves, slave owners dramatically differed in the measures they took to ensure (or not) the health of their slaves. In general, owners called doctors typically in incidences of life-

threatening illnesses or when epidemics spread through the slave populations (Kiple and King, 1981). However, many plantations had a domestic-based health care manual that advised on health care prevention, treatments, signs and symptoms of diseases and disorders, and when to call a formally-trained doctor (Covey, 2007; Keeney, 1989). Even when not directly involved in the administration of health care, physicians still answered to slave owners' requests and were vital to "slave management," meaning an enslaved person rarely had any say in their own treatment.

Slave owners differed in their allowance of slaves treating slaves and folk remedies. When slaves were used to treat other slaves, this role was usually fulfilled by an older woman commonly referred to as a "granny doctor". In some cases, plantation owners were encouraged to find slave women able to oversee and provide medical care (Covey, 2008; Goodson, 1987). Indeed, some scholars even assert that free and enslaved African-American women were the primary health care providers for the sick and dying in the antebellum South (Covey, 2008). Slaves were frequently allowed to practice in the areas of maternal health and childbirth and many brought knowledge from Africa regarding cesarean sections and midwifery (Semmes, 1983). Savitt (2005) writes that most large Virginia plantations had at least one slave knowledgeable about midwifery practices, who often helped both Black and White women during childbirth. Fontenot (1994:90) also writes that African-American women "dominated" the field of midwifery in the early days of obstetric knowledge in the US. The glaring fact that enslaved persons not only had medical expertise, but could potentially outshine their free White counterparts in health service delivery represents one of the many ironies of the institution of slavery (Washington, 2006).

Both lay folk healers and folk medicine in general were pivotal to the slave population's struggle for health and well-

being. A complex array of herbs, roots, foods, and elixirs to prevent and treat illnesses were often used. As a result, a dual system developed in which some slaves received treatment from both Whites (i.e. Doctor, mistress, enslaver) and Blacks (i.e. granny doctor). Fontenot (1994) writes that deficient medical care directly enabled the survival of African-American folk medicine. African slaves integrated knowledge of indigenous plants and herbs from Native Americans into their own practices. A variety of indigenous African plants, roots, and herbs made their way to the New World intentionally and unintentionally via the transatlantic slave trade (Fett, 2002). Many were successfully cultivated by slaves for food or medicinal purposes, thus keeping an array of native African health practices alive in the New World. The use of herbal remedies was not exclusive to Blacks and historical documents show that Whites often appropriated African cures (Fett, 2002). However, it was also just as common for 'slave medicine' to be shunned as less advanced than doctor prescribed medicines. Many owners banned the practice outright. For some slaves, health care became a form of Black independence and resistance against the institution of slavery and White supremacy. On many plantations, Black home remedies circulated secretly through the slave quarters as slaves treated other slaves (Savitt, 2005).

## **5. Methodology**

The data for this study comes from slave narratives obtained by the Works Progress Administration's Federal Writers' Project (WPA) between the years of 1936 and 1938. In order to examine the interrelationship between slavery, medicine, and health care we explore the role played by slaves and doctors during slavery as well as slaves' perceptions of medicine. Using relevant key word searches, 84 interviews conducted with former slaves were analyzed and coded for common themes and patterns.

The WPA sponsored interviews in seventeen states and the subsequent documents have been housed in the Library of Congress since 1939 (Berlin, Favreau, and Miller, 1998). In these narratives, former slaves recount their experiences in slavery and the political, economic, and social constraints imposed on them. As historical documents, these narratives offer a means to examine the evolution of racism and White Supremacy in the South during slavery and beyond (Andrews, nd). The WPA's ex-slave narratives have been used by sociologists, historians, anthropologists, and human ecologists with great success (Shaw, 2003). For historians in particular, Stephanie Shaw writes that the use of these narratives facilitated a "paradigm shift in the scholarly discourse ... made it possible to rewrite part of the history of the antebellum South from the perspective of the slave" (2003: 624).

Narratives came from Norman Yetman's (2000) anthology of WPA interviews, Voices From Slavery: 100 Authentic Slave Narratives. Yetman used the following criterion to select these narratives: previously unpublished, the subjects had to be at least 13 or in adolescence by the time of Emancipation, and interviews were at least three typed pages in length (Yetman, 2000). In order to augment Yetman's book, three additional volumes of slave narratives were read: South Carolina, Volume II with 68 contributors; Alabama, Volume I with 129 contributors; and Texas, Volume III with 77 contributors. As regional variation is not a variable of interest, these volumes were admittedly selected based on convenience and availability. Yetman's anthology and these three sources gave us an initial sample of 374 slave narratives which became 371 once duplicate passages were eliminated.

The decision was made to exclude information on injuries and health care related to punishment and abuse. Although

violence and brutality color slavery, many of the narratives detail punishments that happened to neighboring slaves or that they “heard about.” This is likely due to the tendency of some respondents to downplay their own cruel treatment and discuss abuse in the context of what happened to other slaves (Berlin, Favreau, and Miller, 1998). These were also not considered “organic” illnesses and may better be served in research centered around punishment.

## **6. Results**

Each interview in the sample was read and coded for information relating to health care, illness, disease and medicine (both traditional and modern forms) in slavery times. Many interviewees did not address these topics and these narratives were removed from the sample, resulting in a final sample of 96 individual slave narratives that discussed health care, illness, disease and medicine in the context of slavery. Next, we reread these narratives to identify themes and patterns regarding our research questions. Relevant passages were pulled and a chart was created for the coding process. Some passages were quite long with detailed information on more than one topic (i.e. the primary health care provider, herbs that were used, and midwives) whereas others consisted of only one or two lines. These passages will be referred to as “cases” for the remainder of this study.

The first key word that was coded for was the source of health care or health care provider. In 84 of the 96 cases, specific mention was made of treatment and health care from a “granny doctor<sup>1</sup>”, slaves, the master or missus, or a doctor (in the Western sense). In three cases, the source of health care could not be determined and these were coded as such. Approximately 25% of these cases inferred that slaves or a granny doctor were the sole source of health care, which is similar to the number of cases in which a doctor or the

owner was the only provider at 22% and 16% respectively. Almost 24 of the 84 cases indicated that care came from more than one source. When health care was received by more than one source, slaves were active in their health care (i.e. treatment or prevention) in over half the cases (54%). Table 1 below provides more information on health care providers in this sample.

**Table 1: Source of Health Care for Slaves**

Category	Count	Valid Percent
<b>Doctor only</b>	<b>N=18</b>	<b>21.9%</b>
<b>Master or Missus only</b>	<b>N = 13</b>	<b>15.9%</b>
<b>Slaves only</b>	<b>N=11</b>	<b>13.4%</b>
<b>Slaves and Doctor</b>	<b>N=9</b>	<b>10.9%</b>
<b>Granny only</b>	<b>N=9</b>	<b>10.9%</b>
<b>Granny and Doctor</b>	<b>N=7</b>	<b>8.5%</b>
<b>Missus/Master and Doctor</b>	<b>N=5</b>	<b>6.1%</b>
<b>Midwife</b>	<b>N=5</b>	<b>6.1%</b>
<b>Missus/Master and slaves</b>	<b>N=3</b>	<b>3.7%</b>
<b>Master is a Doctor and treats his slaves</b>	<b>N=3</b>	<b>3.7%</b>
<b>Missus/Master, slaves and doctor</b>	<b>N=1</b>	<b>1.2%</b>
<b>Total</b>	<b>N=84</b>	<b>100%</b>

*Research Question 1: 1) What role or roles did those who were enslaved play in their health care during the immediate years before Emancipation (if any)?*

When discussing the role played by slaves or a granny doctor in health care, participants had generally positive perceptions and memories of this treatment. In no place where slaves discussed providing their own health care, did an interviewee express dissatisfaction with this care, inferred that it was inferior to Owner-prescribed medicine or doctors, or suggest that it was insufficient to meet their needs. Everett Ingram (age unknown) of Alabama stated,

*“Gran’mammy was a great doctor; useta give us turpentine an’ castor oil an’ Jerusalem oak fer worms. She’s give us all kinds of tea, too. I ‘members dat gran’mammy was also a midwife.”*

Distinctions were often made between midwives and other types of health care providers. Of the ten cases where midwifery or labor assistance was directly mentioned, seven were granny doctors, two were the Missus, and the other could not be determined. This seems to support literature that childbirth and midwifery is an area of medicine in which slaves routinely participated. It is also suggestive that the formerly enslaved had many different skill sets that were either developed or heightened out of necessity and circumstance. Philip Evans, age 85 of South Carolina remembers one eventful day,

*“I help to bring my brother Richard, us calls him Dick, into de world. Dat is, when mammy got in de pains, I run for de old granny on de place to come right away. Us both run all de way back. Good us did, for dat boy come right away.”*

And Carrie Pollard of Alabama who was a free “mulatto” woman recalls family stories,

*“Aunt Cynthy was a good midwife, so a white lady sent fer her to come to Sumterville, Alabama to nuss her an’ she went ...”*

Evidence of training was relayed in a few passages, whereby traditional medical knowledge was passed down through generations. In one case, Gus Feaster (age 97) of South Carolina recalls that many granny doctors actively studied to learn their craft,

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*“On all de plantations dar was old womens, too old to do any work and dey would take and study what to do fer de ailments of grown folks and lil’ chilluns...”*

It was also noticed that many of the terminologies used to refer to Black health care practitioners (granny, aunt, and gran’mammy) corresponded to fictive kin designations. The excerpt from Gus Feaster was an exception since he used the term “old womens”. It would be interesting to note whether the name the health care provider was called had any bearing on how the care was received by the recipient. Given the context, perhaps the race of the provider was more important than the name the provider was called.

Of the 40 cases in which slaves were not involved in their own health care, only three of these stories discussed being forbidden to treat themselves. These results seem to counter some scholars’ assertion that this was a frequent occurrence. George Kye, age 110 of Oklahoma says,

*“Old Master wouldn’t let us take her medicine, and he got all our medicine in Van Buren when we was sick. But I wore a buckeye (\*believed to prevent diseases and illnesses) on my neck just the same.”*

***Research Question 2: In contrast, how was plantation medicine (approved by enslavers and administered by White doctors) understood?***

In the instances where more than one source provided health care, a type of triage system seems to have been in place in which minor ailments and everyday illnesses were dealt with on the plantation, but a doctor would be called for serious situations. Some quotes support the assumption that enslavers were motivated to call a doctor only when they perceived the situation to be life threatening. Former slave, Charles Hayes (age unknown) of Alabama explains,

*"Us useta to have all sorts of cures for de sick people, f'instance, us used de Jerusalem weed cooked wid molasses into a candy for to give to de chilluns to get rid of worms.... Horehouse, dat growed wild in Clarke County, was used for colds. Mullen tea was used for colds an' swollen j'intis. Den dere was de live everlastin' tea dat was also good for colds and horse mint tea dat was good for de chill an' fevers. Co'se, Mistis, us niggers had a regular fambly doctah dat 'tended to us when we was sho 'nough down right sick, but dese remedies I's tellin you 'bout us used when warn't nothin' much ailing us. It was always good to de owner's interest, Mistis, to have de niggers in a good healthy condition."*

Callie Williams (approximately 75 years of age) of Alabama's recollections include care from three different sources,

*"Two things dey (\*the slaves) really loved to eat was 'possum and fish. Dey'd eat and eat 'till dey'd get sick and den dey'd have to boil up a dose of Boneset tea to work 'em out. If dat didn't make 'em feel better, dey's go to Marster. He always kept calomel, bluemass, and quinine on hand. If de got too bad off sick, den marster would call de doctor."*

Sometimes the only reason a doctor was involved in the treating of slaves was because the master or owner was himself a doctor. Not only does this information help illustrate the complicated relationship between slaves, owners, and doctors that helped shape the current institution of medicine, but the critical fact that medical doctors also owned slaves. Lucindia Washington, age 80, of Alabama says,

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*“When we got sick f’um eatin’ too much or somp’n, Massa Jim Godfrey was a doctor an he’d ten’ to us. Den when new nigger babies came, nine little black bugs was tied up in rags ‘roun’ dere necks for to make de babies teeth easy.”*

Regarding cases where care was received by a doctor, in 10 out of the 42 cases (23.8%) slaves openly mentioned negative experiences. Although ethical codes of medicine and health care existed in the mid-1850s, most White doctors did not apply these standards to Blacks or the poor (Weitz, 2010) and this is evident in our sample. These experiences consisted of three instances where medicine was physically forced down a slave’s throat, an illegal autopsy on a stolen slave child’s body, inadequate or insufficient medicine or pills, and experimental medicine. Some in the latter two categories reflect the state of medical knowledge and slaves differed in their opinion towards the beneficial nature of this care, yet, it still stands that slaves were used in an experimental and unethical manner. In the case of Thomas Goodwater, approximately 82 years of age of South Carolina one encounter with a doctor left him blind:

*“Dere was a fambly doctor on de plantation name James Hibbins. My eye use to run water a lot an’ he take out my eye an’ couldn’ put it bac kin, dats why I am blin’ now. He as ma an’ pa not to say anything ‘bout it cus he’s lost his job an’ hab his license take ‘way. So ma an’ pa even didn’ say anything even to Mr. Winning as to the truth of my blindness.”*

Julia Brown, age 85 of Georgia, also reported on the ineffective care provided by doctors by stating,

*“Doctors weren’t so plentiful then. They’d go round in buggies and on hosses. Them that rode on a hoss had saddle pockets just filled with little bottles and lots*

*of them. He’d try one medicine and if it didn’t do no good he’d try another until it did do good...”*

Henry Barnes, age 79, of Mobile, Alabama provides interesting insight in to what constituted a “good” doctor at that time:

*“Ole Marster allus tuk good keer of he slaves, ‘caze when dey got sick, he hab de doctor, jes lak when de white folks get sick. One o’ Marse John’s boys, Marse Bennie, was a good doctor, an’ he was a good doctor, cep’n’ he gin us bad med’cin’, but he cured you.”*

Morris Sheppard, age 85 of Oklahoma had a similar experience:

*“...De hog killing mean we get lots of spareribs and chitlings, and somebody always gets sick eating too much of dat fresh pork. I also pick a passel of muscadines for Old Master and he make up sour wine and dat helps out when we get the bowel complaint from eating dat fresh pork. If somebody bad sick he get de doctor right quick, and he don’t let no Negros mess around with no poultices and teas and things like cupping-horns neither!”*

**Research Question 3: What were slaves’ perceptions of “modern” medicine versus traditional herbs and natural remedies?**

Herbs, roots, barks, plants, or natural remedies were discussed in some form or fashion of health care in 48 different slave narratives. Many of the longest passages were those in which a participant listed a number of different herbal remedies for all sorts of ailments. Examples of illnesses that were treated by herbal and traditional remedies in this sample included: worms, colic, stomach pains, fever, chills and fever. Herbs, roots, and plants were

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also used to prevent illnesses, with Asafetida worn around the neck being the most often mentioned in 14 different narratives. Perhaps the most important result is that in none of these narratives discussed herbal remedies in a disparaging or negative manner. In other words, these remedies and the associated knowledge were overall highly regarded, believed to be successful, and posited to be better than modern medicine. Furthermore, all of the instances in which a formerly enslaved person remarked that he/she believed slaves were “not as sick back then” discussed herbal remedies.

William Henry Towns of Alabama, who was age 7 at the start of the Civil War recalls:

*“Slaves never got sick much, but when dey did dey got de bes’. Dere was always an nurse on de farm, and when slave got sick dey was righ’ dere to give dem treatments. Back in dose days dey used all sorts of roots and herbs for medicine. Peach tree leaves was one of de mos’ of en. Sassafrass was anudder what was used of en; hit was used mostly in de spring made in tea. Asafetida was anudder what was use to keep you from havin’ asma. Hit was wore ‘round de neck in a lil bag...”*

Ferebe Rogers, believed to be over 100 years old of Georgia told the interviewer:

*“Course dey had doctors in dem days, but we mostly used homemade medicines. I don’t believe in doctors much now. We used sage tea, ginger tea, rosemary tea – all good for colds and other ailments, too.”*

Julia Brown, age 85 of Georgia said:

*“We used herbs a lot in those days...We didn’t need many doctors then for we didn’t have so much sickness in them days, and naturally they didn’t die so fast. Folks lived a long time. They used a lot of peach tree leaves too, for fever, an when the stomach got upset we’d crush the leaves, pour water over the, and wouldn’t let them drink any other kind of water till they was better. I still believes in them old homemade medicines, too, and I don’t believe in so many doctors.”*

Representing the longest passage on herbal remedies, Gus Smith, age 92, of Missouri, provides a wealth of information including an occurrence where a slave’s knowledge and expertise was so highly regarded that they provided care for Whites as well.

*“There was not many good doctors in those days, but my grandfather was an old fashioned herb doctor. I remember him well... everybody know him in dat country and he doctored among white people, one of de best doctors of his kind. He went over thirty miles around to people who sent for him. He was seldom at home. Lots of cases dat other doctors gave up, he went and raised him. He could cure anything...”*

A few Owners and Doctors also used herbal remedies instead of “modern medicine.” Hector Goldbold’s, age 87, of South Carolina interview, discussed plant doctors,

*“Sho, dey had doctors in dat dey en time. Had plant doctors dat go from one plantation to another en doctor de peoples. Dr. Monroe was one of dem doctor bout here en dere ain’ never been no better cures nowher’ den dem plant cures was.”*

And George Taylor (age unknown) of Alabama says,

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*“I also ‘members de ole time remedies dat dey used in de old days. Dey used red oak bark for fever an’ colds, an’ den dere was hoarhound, an’ black snake root dat de ol’ Marster put whiskey on. Ol’ marster made his own whiskey. An’ oh! Yes, de calomus growed in de woods whar de lived. I never seed dem send to no store for medicine. I never hyeard ob no hoodoo stuff, ‘till I was grown, an’ anudder thing folks didn’t die of lack dey do now.”*

In addition, we can also glean from this case above that slaves made clear distinctions between herbal remedies and hoodoo, voodoo, or conjuring. This was expressed in 8/95 cases and whereas herbal and homemade medicines were widely embraced, feelings towards “voodoo” and voodoo practitioners were usually negative. Annie Stanton, age 84, of Oklahoma declared:

*“I’se neber hyeard of no hoodoo stuff ‘til in late years, dey’s mo’ ob dat foolishness now dan I’se ebber hyeard of in may life.... Us had tuh make our own medicine. When de babies had de colic us wud tie soot up in a rag an’ boil it, and den gib dem de water, an’ tuh ease de prickly heat us used cotton wood powdered up fine, and fo’ de yellow thrash us would boil de sheep trash an’ gib de tea.”*

Patsy Moses, age 74, from Texas describes the difference in terms of casting spells:

*“De conjure doctor, old Dr. Jones, walk ‘bout in de black coat like a preacher, and wear sideburns and used roots and sich for medicine. He larnt ‘bout dem in de piney woods from he old granny. He did’t’ case spells like do voodoo doctors, but uses roots for smallpox, and ride of bacon for mumps and sheep-wool tea for whoopin’ cough ...”*

A common theme that became evident is that a handful of respondents (approximately 8 cases) make references to being healthier before modern interventions. Jacob Branch of Houston Texas, age 86 said,

*“Us sure in good health dem days. Iffen a cullud man weak dey move de muscles in he arms, bleed him, and give him plenty bacon and corn bread, and he git so strong he could life a log. Dey didn’t go in for cuttin’ like dey do now. Dey got herbs out de woods, blue moss, and quinine and calome<sup>l</sup>. I think people just die under pills, now. Old lady Field she made medicine with snakeroot and larkspur and marshroot and redroot.”*

## **7. Discussion**

From these narratives alone it is difficult to assume that slaves were denied health care or the right to practice health care, which is a common theme in literature on slavery and health. However, this does not invalidate previous claims, but, rather illustrates the complexity of reconstructing health and health care during this pivotal time in American history. Based on the interviews in this sample, we found that a doctor in the Western sense was involved in more than half of the health care received by slaves. The formerly enslaved varied in their perceptions of doctor care. Many actively engaged in practices believed to prevent disease and illnesses even when a doctor was routinely called for slaves. While motivations were unclear, it could indicate a lack of faith or fear in the doctor’s ability to cure sickness, the importance of staying healthy for various reasons, or a combination.

We also found substantial evidence of slaves’ pivotal role in their own health care and the health care of other slaves,

which echoes established findings in the literature. However, from the context of a health care system undergoing qualitative change, the contributors were only involved in their health care half of the time which could indicate several things. In light of the little evidence that suggests that slaves were forbidden to practice medicine, it is possible that this near 50-50 split reflects a society transitioning to modern medicine. Regarding preference for traditional over modern medicine, a reasonably significant percentage of former slaves in this sample voiced a clear preference for herbal remedies and mistrust of modern medicine.

This study is not without its flaws, namely in its small sample, lack of generalizability, and coding bias. In addition, we cannot assume what it is not stated in the narratives and must take the narratives at face value. Likewise, it is possible that we can learn something from the omission of health information in so many of the narratives. Future research should incorporate information on a slave's general treatment (i.e. housing, clothing, diet) to see if there is a relationship between "better treatment" and the provision of health care. This study contributes to our understanding of how modern medicine was perceived by slaves and the integral role they played through exercising their personal agency.

The limitations of the slave narratives are widely discussed in the literature (Blassingame, 1975; Escott, 1979; Yetman, 1967; Yetman, 1984; Shaw, 2003). One limitation is the context of race relations in the Great Depression because the majority of the interviewers were White. These men and women came to the project with their own personal biases and feelings towards slavery and their contributors, African American ex-slaves. Scholars agree that many respondents were unwilling to recall painful memories, answer truthfully about their brutal ordeals, or freely express their feelings to White interviewers (Escott, 1979; Yetman, 1967; Berlin,

Favreau, and Miller, 1998). A second limitation of the narratives is the likelihood of recall bias because respondents were remembering events that happened some 60 or 70 years ago and most were quite elderly (Yetman, 1967). In addition, interviewers edited narratives in accordance with their own biases (Blassingame, 1975).

Despite the limitations, the narratives are regarded as invaluable windows into the past and are valid sources for uncovering life under slavery (Shaw, 2003; Yetman, 1967; Yetman, 1984; Savitt, 1982). Narratives reveal the social complexities during slavery, the civil war, and after emancipation. While some slaves had access to doctors, others used ‘granny doctors’ to prescribe herbal remedies during slavery. After emancipation, health conditions during slavery carried over with little or no recourse due to an inability to afford medical care in a highly racially polarized American society.

The current study attempts to shed light on the fact that enslaved African Americans used their own personal agency to not only treat themselves but their fellow enslaved comrades. It is also suggestive that the roots of medical mistrust in the African American community most likely started with the unequal and inadequate medical treatment they encountered during slavery, an institution lasting some 246 years and even after its dissolution was firmly planted in the American psyche and infrastructure for future generations.

## **8. Notes**

1. This includes male “granny doctors” as well. This category was separated from slaves, as these granny doctors were usually more knowledgeable than other slaves, or were appointed as the health care provider by the owner. In some

cases, the sole job of this person was to act as a nurse or doctor for other slaves.

2. It must be noted that blue moss is most likely “blue mass” which was a commonly used medicine that contained mercury. Calomel also contained mercury and had been used since the 1600s (George Urdang, "The Early Chemical and Pharmaceutical History of Calomel," *Chymia*, 1 (1948): 93-108. Haynes, *American Chemical Industry*, 212-213.

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