

Leprosy and Slavery in Suriname: Godfried Schilling and the Framing of a Racial Pathology in the Eighteenth Century

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Summary. The skin disease *boasie* became a major health problem in the Dutch colony of Suriname from the 1740s–1750s onwards. European doctors attempted to come to a closer understanding of the disease, and established that it was identical to the leprosy of Antiquity and the Middle Ages. The Prussian surgeon and medical doctor Godfried Wilhelm Schilling (c. 1735 – after 1795) played a key role in this process. Schilling tried to give solutions to the medical and public health problems related to the disease. In particular, he had to mediate between the public interests of the colonial authorities, wishing to curb the spread of the disease, and the private interests of the local planter and slave-owning elite, concerned about financial losses. Schilling framed *boasie* as a disease of African origin, with strong racial and sexual overtones. This racial framing contributed to policies of isolation of *boasie* sufferers. The disease was tainted with moral and cultural value judgments, as a health danger brought over by African slaves, threatening the new Caribbean slave societies of the eighteenth centuries and ultimately the Dutch colonial empire itself. This framing of leprosy in racial terms was not a product of nineteenth-century imperialism, Social Darwinism and bacteriology, but of the plantation economy and of a pre-modern medicine.

Keywords: Leprosy; Suriname; Caribbean; medical history; contagious diseases; Schilling

Slaveholders' Knowledge of Leprosy

On 19 August 1755, the Swedish botanist Daniel Rolander was exploring the plants and wildlife near a plantation on the banks of the Perica river in the Dutch colony of Suriname, in the Guianas, when he came across a horrendous sight.¹ He wrote in his journal,

[I] passed a few sylvan huts of blacks, where some sick unfortunates addressed us from afar, warning us not to approach any closer or enter their huts, because they said they were suffering from a contagious disease called 'boise' [*boasie* or *boassie*]. This disease is exanthematic and reminds one in some way of the leprosy of old and elephantism;

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¹Please note that in this paper 'slaveholders' does not only refer to actual owners of slaves, but also to 'many more with a direct or indirect interest in slaveholding through family connections or professional and

business arrangements'. Cf. Elizabeth Fox-Genovese and Eugene D. Genovese, *The Mind of the Master Class: History and Faith in the Southern Slaveholders'*

it feeds upon the joints, and propagates via physical contact. Blacks infested with this disease are automatically relegated to a remote corner of the plantation, where they serve as guards and spend the rest of their time alienated from friends to keep the entire servile throng from contracting it.²

The city physician of the Surinamese capital Paramaribo told Rolander that African slaves had brought the disease over the ocean; from Guinea in West Africa.³ The name *boasie* was supposed to be the name of the place in Africa where the disease had originated from.⁴ By 1755, it was feared that *boasie* would spread to Europe.

Although in the eighteenth-century definition, symptomatology and aetiology of the disease still had to be developed, *boasie* was routinely equated by contemporary physicians with *elephantiasis graecorum* or *lepra arabum*: leprosy (or in Dutch *melaatschheid*), the dreaded disease of the Middle Ages.⁵ In the eighteenth century many doctors and laymen regarded this disease as highly contagious. Healthy persons in Suriname were advised to stay as far away from the sufferers as possible, not to enter their dwellings, not to touch them and not even to breathe the same air.⁶ To many slaveholders, leprosy seemed to endanger the functioning of the Surinamese slave society. Knowledge was needed to counter this perceived threat. A new pathology was constructed and public health measures were taken.

This paper is about this remarkable process, which foreshadowed later medical and political developments around leprosy in colonial empires by more than a century. The paper questions how exactly the new pathology of leprosy was constructed. What factors were influential in its framing, and in particular how did this relate to the development of Suriname as a colony in the eighteenth century? What should be our understanding of the role of the new pathology in devising and implementing health policies? By studying the extant unpublished and published sources on leprosy in Suriname in the eighteenth century, we will come to a closer understanding of the origins and shaping of colonial health policies and of the complex reciprocity between knowledge, attitudes and practices towards leprosy.

A Prussian surgeon played a key role in the construction and implementation of a slaveholders' knowledge of leprosy. Godfried Wilhelm Schilling (c. 1735–after 1795) took up the idea that *boasie* was an African disease threatening the health of Europeans.⁷ In 1769 he wrote that the 'Abyssinians' (by which he meant the black Africans) had brought the disease to America. He saw almost no incidence of *boasie* among the 'Aborigines'

²Daniel Rolander, 'Journal', in Lars Hansen *et al.* (eds), *The Linnaeus Apostles: Global Science and Adventure*, 8 vols, (London: Ik Foundation, 2008) III, Bd. III, 1339. This is the first publication and translation of Rolander's Latin diary since its composition in 1754–1756. The original manuscript is in the Botanical Garden and Museum, Copenhagen, Denmark.

³*Ibid.*, 1483.

⁴This is a rather uncertain etymological conclusion. A Dutch dictionary of 1855 would claim that *boasie* was the name given in Angola to an ulceration that looked like elephantiasis, which makes more sense. L. C. E. E. Fock, *Natuur- en geneeskundig etymologisch woordenboek* (n.p.: J. Noorduy, 1855), 170.

⁵In this paper, 'leprosy' is used to refer to '*boasie*', '*melaatschheid*' and '*elephantiasis graecorum*' interchangeably, as these were understood by eighteenth-century physicians, and not to the current medical understanding of 'Hansen's disease', as leprosy is called today.

⁶Rolander, 'Journal', 1483.

⁷The name Schilling is sometimes spelled as 'Schelling'. But he signed his own name as 'Schilling'. Cf. C. H. Landré, 'Naschrift bij P. Duchassaing, Over de Elephantiasis Arabum in West-Indië', in H. C. Focke, C. H. Landré *et al.* (eds), *West-Indië. Bijdragen tot de bevordering van de kennis der Nederlandsch West-Indische kolonien*, 2 vols (Haarlem: A. C. Kruseman, 1858), II, 224.

(the native Americans), and so believed that the disease had not existed in the Americas before the immigration of African slaves. Europeans who had had physical contact with the Africans were therefore in danger of becoming contaminated as well. Since more and more slaves came to Suriname it was to be expected that the incidence of the disease would increase.⁸

As one of the few physicians in the colony of Suriname, and moreover since he conducted medical examinations of newly arrived slaves, Schilling played an important part in framing health policy measures around boasia in the 1770s–1790s. In the meantime he was also able to profit from his medico-scientific research in Suriname. He is therefore a good example of what I have called the ‘adventurer-scientists’ who were essential in gathering medical and scientific knowledge in tropical and colonial regions.⁹

A closer investigation of Schilling’s work on leprosy, as undertaken in this paper, demonstrates that the need for medical knowledge of the disease was driven by its effect on the slave trade and the slave economy in Suriname. The driving forces and profit motives of the slave economy profoundly shaped the aims, methods and personnel involved in the search for medical knowledge in the tropics. Ultimately profits were at stake if changes in the disease environment were not met by changes in medical practice and health care, for which medical knowledge was needed. As will be shown in this paper, Schilling gave the medico-scientific ‘evidence’ and provided the underpinnings of a public health policy of isolation and segregation that was implemented in Suriname in the decades before 1790. This public health policy was modified but never revoked until after the Second World War.¹⁰ A key role in the development of this policy was Schilling’s formulation of a racial pathology of the disease. To him, racial characteristics were essential to the understanding of the aetiology and epidemiology of leprosy, and important in determining the measures that needed to be taken.

Even by the eighteenth century, leprosy was constructed as a threat to an empire. African slaves were thought to bring the disease across the Atlantic to the Caribbean, where Europeans were then infected. Europeans could then in turn bring leprosy back to Europe, where it had become extinct. To many observers, the health of the Dutch colonial and commercial empire was at stake.¹¹

In the next section of this paper I will situate the case study of leprosy in Suriname in the context of the historiographical discussion on leprosy, race, colonialism and imperialism. In the third section I will discuss leprosy within the context of the Surinamese slave economy. Lastly, in the fourth section, Schilling’s development of medical knowledge will be investigated as a slaveholders’ knowledge of leprosy.

⁸Godefredus Wilhelmus Schilling, ‘Dissertatio medica inauguralis de lepra’ (MD thesis, University of Utrecht, 1769); Schilling, *Verhandeling over de melaatsheid* (Utrecht: J.C. ten Bosch, 1771).

⁹For the adventurer-scientists in the Dutch tropical Atlantic, see Stephen Snelders, *Vrijbuiters van de heelkunde. Op zoek naar medische kennis in de tropen 1600–1800* (Amsterdam: Atlas, 2012).

¹⁰Cf. Wim Hoogbergen and Hans Ramsøedh (eds), ‘Leprosy in Suriname’, *OSO*, 2003, 22, 1–123; Henk Menke, Stephen Snelders and Toine Pieters,

‘Omgang met lepra in ‘de West’ in de negentiende eeuw. Tegendraadse maar betekenisvolle geluiden vanuit Suriname’, *Studium* 2009, 2, 65–77.

¹¹For example, forty years after Rolander, another visitor to Suriname, the Dutch physician Pieter van Woensel, expressed similar fears that contagion of Europeans by Africans would bring leprosy back to Europe. Pieter van Woensel, ‘West-Indische fragmenten’ [1796] in: André Hanou, ed., *De lantaarn* (Amsterdam: Athenaeum-Polak & Van Gennep, 2002), 51–2.

Leprosy, Race, Imperialism and Slavery

From a historiographical perspective, the eighteenth-century development of a racial pathology of leprosy and isolation policies in Suriname is remarkable. 'Leprosy as a danger to the empire' is mostly associated with the end of the nineteenth century, the Age of Imperialism and the onset of scientific racism and Social Darwinism.¹² At that time leprosy came to be regarded as an 'imperial disease' moving throughout the European colonial empires through migration of people and circulation of goods and affecting white people in the process. In 1989 Zachary Gussow concluded in his study of American leprosy politics in an international context:

... by the nineteenth century [leprosy] had reappeared and by the end of the century had caused Western nations to panic. During the period of nineteenth-century imperialism, the disease was discovered to be hyperendemic in those parts of the world that western nations were annexing and colonizing. The discovery of leprosy in the colonial world, and the excitement in the 1860s generated by the announcement of an epidemic in Hawaii, revived Western concerns about a disease that otherwise remained but a memory.¹³

Gussow relates the 'rediscovery' and renewed fears of leprosy to anxieties about Chinese immigration and the endangerment of 'American-ness'. Leprosy came to be regarded as a disease of racially 'inferior' people. According to Gussow, the association of the rediscovered leprosy with biblical and medieval leprosy led to the stigmatization and isolation of leprosy sufferers and to segregation policies.

Since Gussow's study, other historians have further explored leprosy in the contexts of imperialism, the rise of Social Darwinism and of the development of the new scientific theories of bacteriology.¹⁴ Some of these studies have given special attention to the role of missionary societies in dealing with leprosy in the colonial world since the religious revival of the 1860s.¹⁵ Leprosy has also been situated in the context of the construction of national identities in the era of imperialism.¹⁶ Even where a more long-term perspective is taken, the period between the 1860s and 1880s has been regarded as essential in the construction of leprosy as a danger to the empire.¹⁷

¹² Alison Bashford, *Imperial Hygiene: A Critical History of Colonialism, Nationalism and Public Health* (Basingstoke: Palgrave Macmillan, 2004), 81–93. *Leprosy, an Imperial Danger*, is the title of a book by Henry Wright (London: Churchill, 1889).

¹³ Zachary Gussow, *Leprosy, Racism, and Public Health: Social Policy in Chronic Disease Control* (Boulder: Westview Press, 1989), 19.

¹⁴ Essential studies that should be mentioned are Megan Vaughan, *Curing their Ills: Colonial Power and African Illness* (Cambridge: Polity Press, 1991), esp. pp. 77–99; Jane Buckingham, *Leprosy in Colonial South India: Medicine and Confinement* (Basingstoke: Palgrave, 2002); Jo Robertson, 'Leprosy and the elusive *M. Leprosae*: Colonial and imperial medical exchanges in the nineteenth century', *Manguinhos* 2003, 10, suppl.1, 13–40; Warwick Anderson, *Colonial Pathologies: American Tropical Medicine, Race and Hygiene in*

the Philippines (Durham: Duke University Press, 2006), esp. pp. 161–75; Rod Edmond, *Leprosy and Empire: A Medical and Cultural History* (Cambridge: Cambridge University Press, 2006); Jo Robertson, 'The Leprosy Asylum in India, 1886–1947', *Journal for the History of Medicine and Allied Sciences*, 2009, 64, 474–517. For other relevant studies cf. Bashford, *Imperial Hygiene*, 81–114.

¹⁵ Cf. Michael Worboys, 'The Colonial World as Mission and Mandate: Leprosy and Empire, 1900–1940', *Osiris*, 2000, 15, 207–18.

¹⁶ D. Obregon, 'Building National Medicine: Leprosy and Power in Colombia, 1870–1910', *Social History of Medicine*, 2002, 15, 89–108; Angela Ki Che Leung, *Leprosy in China: A History* (Columbia University Press, 2008).

¹⁷ E.g. Buckingham, *Leprosy in Colonial South India*.

By this time, the Caribbean had become of minor importance in the colonial and imperial projects of the European nations. However, the first constructions of leprosy as a danger to white dominance brought over by an 'inferior' race of people and a disease similar or identical to biblical and medieval leprosy, started from the eighteenth-century Caribbean history. Authors like Gussow and Edmond do point out that leprosy became a concern in the West Indies at the end of the eighteenth century, but then quickly move on.¹⁸ The history of leprosy in the eighteenth- and early nineteenth-century Caribbean has been insufficiently explored. This paper attempts to undertake that exploration.

Race is a key issue in this history. According to the historiography of colonial medicine, racism was on the increase after c. 1800. To Mark Harrison this increase was connected to the changing history of slavery. Attacks on the slave trade led to a 'hardening of slavery' in the colonies. European rulers emphasised their supposed fundamental biological difference with the Africans.¹⁹ Although the emphasis on racial difference may have hardened in the course of the nineteenth century, according to Harrison, race held central place in the medicine in the 'hot climates' in the early part of that century.²⁰ Of course the idea of a fundamental difference between races was not new in a colonial context. Alfred Crosby in his seminal work on *The Columbian Exchange* wrote that, from the very first, discoverers of the New World wondered about the differences between the European newcomers and indigenous inhabitants. Some Europeans entertained the notion of 'multiple creations': God may have created different worlds, the Old and the New. To the eighteenth-century French naturalist Buffon it was clear that American Indians were in all respects inferior to Europeans. It had also become recognised that since the Conquest diseases that had been prevalent among the inhabitants of one part of the world had started to plague the inhabitants of other parts.²¹ Kenneth Kiple and Richard Sheridan have described in more detail the epidemiological transitions and the changing disease environment in the Caribbean in the eighteenth century, changes related to the forced migration of Africans to the New World. Yellow fever, filariasis, malaria and yaws were some of the diseases that became rampant on Caribbean islands and threatened the success of European military operations.²² 'Faced with numerous diseases that were indigenous to Africa ... attention [of European doctors] was directed to the differences between Africans and Europeans with respect to resistance and susceptibility to various diseases', Sheridan writes.²³ The changing

¹⁸Gussow, *Leprosy, Racism, and Public Health*, 44–5; Edmond, *Leprosy and Empire*, 24–9.

¹⁹Mark Harrison, 'The Tender Frame of Man: Disease, Climate, and Racial Differences in India and the West Indies', *Bulletin of the History of Medicine*, 1996, 70, 68–93.

²⁰Mark Harrison, *Medicine in an Age of Commerce and Empire: Britain and Its Tropical Colonies 1660–1830* (Oxford: Oxford University Press, 2010), 287.

²¹Alfred W. Crosby, Jr., *The Columbian Exchange: Biological and Cultural Consequences of 1492* (Westport: Greenwood, 1972), 4–31.

²²Kenneth F. Kiple, *The Caribbean Slave: A Biological History* (Cambridge: Cambridge University Press, 1984); Richard B. Sheridan, *Doctors and Slaves: A Medical and Demographic History of Slavery in the*

British West Indies, 1680–1834 (Cambridge: Cambridge University Press, 1985). Cf. also Kenneth F. Kiple and Kriemhild Coneé Ornelas, 'Race, War and Tropical Medicine in the Eighteenth-Century Caribbean', in David Arnold (ed.), *Warm Climates and Western Medicine: The Emergence of Tropical Medicine, 1500–1900* (Amsterdam: Rodopi, 1996), 65–79; Jeremy Handler, 'Diseases and Medical Disabilities of Enslaved Barbadians, from the Seventeenth Century to around 1838', *The Journal of Caribbean History*, 2006, 1–38, 177–214; J. R. McNeill, *Mosquito Empires: Ecology and War in the Greater Caribbean, 1629–1914* (Cambridge: Cambridge University Press, 2010).

²³Sheridan, *Doctors and Slaves*, 18.

disease–environment and the close proximity to slaves of African descent prompted inquiries into the health and disease of the non-white population in the Caribbean much earlier than in Asia.²⁴

By the late eighteenth century, what Londa Schiebinger has called the ‘anatomy of difference’ between races was widely debated among the scientists and savants of Europe. Explanations for these ‘differences’ ranged between environmentalism and hereditarianism, including combinations of both.²⁵ While in Europe this was more of a theoretical concern, in the colonies the question of why and to what extent different races were prey to different diseases was of an eminently practical concern. As Sean Quinlan writes in his study of the French colonies, doctors in the colonies had to find an explanation for the ‘selective nature of disease’ as they observed that Africans and Europeans, ‘responded quite differently to the exigencies of the Caribbean tropics ... In contrast to physicians in Europe (who emphasized differences of class) colonial doctors frequently laid stress on biological differences of a racial type.’²⁶

According to Quinlan, it was a French physician, Pierre Barrère, who in 1741 was one of the first to identify a ‘morbid otherness’ among the African population. To Barrère, who had spent five years working in Cayenne—the French colony neighbouring Suriname—Africans were a source of pollution for Europeans.²⁷ The ultimate distinction between the races was located in the amount of self-control a male European could exert, in order to regulate his functioning in accordance with the environment. ‘In a sense, the diseased body became the ultimate signifier of not just the pathological milieu but the total lack of physical self-control exercised by the European individual’, writes Quinlan.²⁸ Differences in ‘passions of the mind’ were used as an explanation for racial differences in disease patterns. We will see similar ideas at work in the case of Schilling.

Luke Demaitre, in his study of leprosy in pre-modern European medicine, concludes that pre-modern physicians primarily tended to look at the disease from a medico-scientific perspective (more in particular, humoral pathology) rather than from a moralistic or biblical perspective.²⁹ In eighteenth-century Suriname, however, as we will see, the supposed African connections of the disease brought moralistic notions within the medico-scientific perspective of doctors such as Schilling.

Eighteenth-century colonial medicine in the Caribbean remains to be more fully explored, and not just in relation to leprosy.³⁰ Existing studies of Dutch colonial medicine in general tend to focus on the East Indies. Colonial medicine in the Dutch West Indies has received

²⁴Cf. Michael Worboys, ‘Tropical Diseases’, in W. F. Bynum and Roy Porter (eds), *Companion Encyclopedia of the History of Medicine*, Vol. II (London: Routledge, 1993), 517, on India: ‘In fact, colonialism had little or no knowledge of health and disease amongst indigenous peoples.’

²⁵Londa Schiebinger, ‘The Anatomy of Difference: Race and Sex in Eighteenth-Century Science’, *Eighteenth-Century Studies* 1989/1990, 23, 387–405.

²⁶Sean Quinlan, ‘Colonial Encounters: Colonial Bodies, Hygiene and Abolitionist Policies in Eighteenth-

Century France’, *History Workshop Journal* 1996, 42, 107.

²⁷*Ibid.*, 112–13.

²⁸*Ibid.*, 120. According to male European savants female Europeans lacked of course the self-control of the male, as did Africans. Cf. Schiebinger, ‘Anatomy of Difference’.

²⁹Luke Demaitre, *Leprosy in Premodern Medicine: A Malady of the Whole Body* (Baltimore: The Johns Hopkins University Press, 2007).

³⁰Significant contributions are Sheridan, *Doctors and Slaves*; Handler, ‘Diseases and Medical Disabilities’.

little attention of scholars.³¹ Leprosy in the Surinamese plantations of the eighteenth century is mentioned only in the contexts of general overviews of diseases.³² Historians interested in the global circulation of medical knowledge have accorded limited significance to the Dutch Caribbean.³³

One difficulty in the historical exploration of pre-modern colonial medicine lies in the exact meanings of terms when they occur in eighteenth-century sources. When historians of colonial medicine have been inclined to attempt to translate the diagnoses and symptoms given in the sources into modern medical terms, they have run into difficulties. At worst, this can lead to an anachronistic perspective of pre-modern colonial medicine.³⁴ Furthermore, there is a lack of explorations of the position of African and other non-European health practices in the Caribbean slave societies. Significant exceptions are the work of Karol Weaver on eighteenth-century Haiti (Saint Domingue) and of Pablo Gómez on the Spanish Caribbean.³⁵ They remind us that the practices and experiences of Africans were at the centre and not on the periphery of the Caribbean health systems and beliefs. As we will see in this paper, Schilling had to deal with these beliefs and practices in Suriname.

By studying debates and practices around boasie in Suriname we gain more insight into how diseases were dealt with in the eighteenth-century Caribbean, into the role of ideas about racial difference in these dealings, and into the contribution of medicine to the management of the labouring slave population.

Leprosy in the Surinamese Slave Society

The English had ceded Suriname to the Dutch in 1667. At that time only a little more than a thousand people lived in the colony, seven hundred of whom were slaves. The colony came under the control of a private company, the Society of Suriname, comprised of members of the Dutch West India Company (WIC), the city of Amsterdam and private investors. Since then the Dutch had created a wealthy plantation economy based on African slave labour. By 1754 there were almost 1,500 Europeans and more than 33,000 slaves in Suriname. In 1783 the population had grown further to over 2,000 Europeans and more than 50,000 slaves, as well as approximately 500 free people of mixed African and European descent.³⁶

³¹Cf. Leo van Bergen and Stephen Snelders (eds), 'Van piratendokters tot wetenschappelijke instituten. Drie eeuwen Nederlandse en Belgische tropische geneeskunde', *Studium*, 2009, 2, 53–129.

³²Gert Oostindie, *Roosenburg en Mon Bijou. Twee Surinaamse plantages, 1720–1870* (Dordrecht: Fortis, 1989); Rudi Otto Beeldsnijder, "'Om werk van jullie te hebben" Plantageslaven in Suriname', 1730–1750 (unpublished PhD thesis, Leiden University, 1994).

³³E.g. Harold J. Cook, *Matters of Exchange: Commerce, Medicine, and Science in the Dutch Golden Age* (New Haven: Yale University Press, 2007).

³⁴As in McNeill, *Mosquito Empires*.

³⁵Karol K. Weaver, *Medical Revolutionaries: The Enslaved Healers of Eighteenth-Century Saint Domingue* (Urbana: University of Illinois Press, 2006); Pablo Fernando Gómez Zuluaga, 'Bodies of Encounter: Health, Illness and Death in the Early Modern

African-Spanish Caribbean' (PhD thesis, Vanderbilt University, Nashville, 2010).

³⁶Beeldsnijder, "'Om werk van jullie te hebben'", 264–6; B. van der Oudermeulen, 'lets tot voordeel der deelgenooten van de Oost-Indische Compagnie en tot nut van ieder ingezetenen van dit gemenebest kan strekken', in Dirk van Hogendorp (ed.), *Stukken, raakende den tegenwoordige toestand der Bataafsche bezittingen in Oost-Indië en de handel op derzelve* (The Hague: J.C. Leeuwesteyn, 1801), 327–8. Beeldsnijder is probably right to assume that '1738' in the memoir of Van der Oudermeulen is a typographical error and should be read as '1783'. In the census Europeans are described as 'blanken' ('whites'). Schilling calls them Europeans. For the sake of consistency and clarity I will use 'Europeans' for all whites, including those born in Suriname (who were called 'Creoles' at the time). To avoid confusion I will use

Since 95 per cent of the population was of African descent, it is unsurprising that most boasia sufferers were Africans. Based on that evidence, Europeans drew the conclusion that boasia had come to the New World from Africa. This might have been a general opinion in the West Indies: a closer systematic study of other European sources, including English, French and Danish ones, would reveal whether and at what time similar notions were held by other Europeans in the Caribbean.

Ideas about the African connections of boasia were related to more general ideas of possible racial differences in susceptibility to disease— notions which doctors and surgeons in the Dutch West Indies shared with those from the French and British West Indies. For instance in 1721, Laurens Horst, a physician on the island of Curacao and superintendent of the slave depot there, tried unsuccessfully to use these so-called differences as an argument against his dismissal by the directors of the WIC. Curacao had become less important as a transit harbour in the slave trade and profits were falling. The directors of the WIC wished to cut expenses and decided to replace the doctor with a less expensive surgeon. Horst countered that this was a waste of human capital, since he now had more than 20 years of experience with diseases among different population groups. Most importantly, he claimed, he had much experience with the ‘totally different’ character of European and African diseases, on which he even planned to write a book. He argued that this knowledge should remain available to the commissioner for the slave trade.³⁷

Despite this, the doctor was dismissed and nothing was heard again of his planned book on racial differences. Others, however, independently developed similar ideas. In 1745 Laurens Storm van 's-Gravesande, the governor of the Dutch colony of Essequibo (to the west of Suriname and now part of the Republic of Guyana) wrote in a report on an outbreak of smallpox in his fortress: ‘... I found it very noteworthy that among both my children and others in the colony no one who was born in Europe was so affected [as] the natives of these countries.’³⁸ Half a century later the German physician Ernst Karl Rodschied, who practised in Essequibo in the 1790s, found that classical European medicine could not be used in the treatment of African slaves without making modifications. According to Rodschied, Africans had brought ‘strange’ diseases from Africa, and their constitution was quite different from that of the Europeans due to their different customs and habits. Moreover, because of the difference in skin colour, ‘Hippocratic semiotics’, the recognition and interpretation of physical signs and characteristics as learned by European doctors had to be modified. Rodschied, who apparently had only had limited contact with Africans, thought that the slaves had few passions, did not mind being slaves, and were really only interested in keeping themselves alive and (when male) in sexual contact with women. The passions of the mind that according to pre-modern medicine exercised an important influence on health—the German physician thought—radically differed between Africans and Europeans.³⁹

the word ‘Africans’ for slaves and freemen of African descent. Schilling calls them ‘Ethiopians’ or ‘Abyssinians’, which they were not.

³⁷Laurens Horst to West India Company, February 1721, Nr. 576, Tweede West-Indische Compagnie Archive, National Archive, The Hague, The Netherlands.

³⁸Laurens Storm van 's-Gravesande to the Chamber of Zeeland of the West India Company, February 1745,

CRO 116/29, Colonial Record Office, The National Archives, Kew. My translation.

³⁹Ernst Karl Rodschied, *Medizinische und Chirurgische Bemerkungen über das Klima, die Lebensweise und Krankheiten der Einwohner der Holländischen Kolonie Rio Essequibo* (Frankfurt: Jaegerschen Buchhandlung, 1796), 126–38.

Europeans considered skin diseases such as boasie and yaws as especially repugnant examples of contagious diseases with African connections. But boasie could and did affect Europeans as well. Both this and the increasing incidence among Africans became visible to observers in the 1740s and 1750s, resulting in a number of public health measures. In 1728, following an edict of the governor, slaves with yaws or other potentially contagious diseases were prohibited from travelling on public roads under penalty of a fine for their master. The governor was particularly concerned about the danger of contamination of white children.⁴⁰ The edict of 1728 did not specifically mention boasie or leprosy. It is also remarkable that inventories of plantations hardly mentioned boasie at all between 1730 and 1750. In a sample of 2,062 slaves on 18 plantations, 346 were reported sick. Only one of them was described as having boasie. But in general the descriptions of all the sick slaves are so vague that this gives us little information: 23 per cent had *zweren* (ulcers), 8 per cent *zwellingen* ('swellings'), and 20 per cent had no description other than 'sick', 'decrepit', etc.⁴¹

A new edict of 1761, which essentially was a revised version of the 1728 edict, did specifically mention boasie.⁴² This attests to the increase in visibility of the disease in the intermediate three decades. By the 1750s one European doctor spoke of an epidemic. Philippe Fermin, a Berlin-born descendant of French Protestant refugees, practised from 1754 to 1762 in Suriname. He believed that boasie was highly contagious: 'elle le deviendroit sans les precautions convenables' ('the disease will be contracted if no decent precautions are taken').⁴³ According to Fermin most sufferers were slaves, but there were a few European patients as well.⁴⁴ Unfortunately we do not have more detailed descriptions of these European sufferers, but the edict of 1761 shows that the colonial government of Suriname had become convinced that boasie was threatening Europeans as well as Africans.

Though the edict of 1761 prohibited slaves with signs of boasie from travelling by public roads, it did not stop them entirely from doing so. Slave owners continued to send afflicted slaves to the shops of surgeons in the city of Paramaribo. A new edict was therefore issued in 1764, prohibiting the treatment of slaves in the city. Surgeons would have to travel to the plantations to attend the slaves.⁴⁵

The health management around boasie was part of a broader attempt of the colonial government to gain more control over health care in Suriname. Like all Caribbean colonies, Suriname was continuously plagued by various kinds of diseases thought to be contagious: different kinds of 'fevers', smallpox, dysentery and so forth. In 1766 the government put medical practitioners in Suriname under closer scrutiny. They now had to show qualifications

⁴⁰Plakkaat, Bescherming tegen besmettelijke ziekten', 30 November 1728, in J. Th. de Smidt (ed.), *Plakkatien, ordonnantiën en andere wetten, uitgevaardigd in Suriname 1667–1816* (Amsterdam: Emmering, 1973), 395–6. Our present medical knowledge holds that yaws can be transmitted through physical contact, for example when children play together. We have to keep in mind, however, that for eighteenth-century observers the differentiation between different diseases with effects on the skin would not have been as clear.

⁴¹Beeldsnijder, "'Om werk van jullie te hebben'", 198, 203.

⁴²Plakkaat, Voorschriften in verband met besmettelijke ziekten van slaven', 4 February 1761, in De Smidt (ed.), *Plakkatien*, 707–8.

⁴³Philippe Fermin, *Traité des maladies les plus frequenter à Surinam, et des remedes les plus propres à les guérir* (Maastricht; Jacques Lekens, 1764), 127.

⁴⁴*Ibid.*, 127.

⁴⁵'Notifikatie, Het verplegen van slaven in chirurgijns-winkels', 22 February 1764, in De Smidt (ed.), *Plakkatien*, 780–1.

or pass an examination before being allowed to set up medical practice. It would take another 15 years, until 1781, before a board of supervisors, the Collegium Medicum, was instituted. Modelled on the health care system of the city of Amsterdam, the Collegium Medicum regulated the activities of doctors, surgeons and pharmacists, and advised the colonial government on health matters.⁴⁶

In the meantime, no apparent progress was made in the fight against boasia. This was for the most part related to the paradoxical status of boasia sufferers. Most of the visible sufferers were Africans, who were supposed to be kept out of sight, if not isolated. The Scottish-Dutch mercenary John Gabriel Stedman wrote that in the 1770s the sufferers were segregated from other slaves and isolated in the plantations.⁴⁷ But to their owners these sufferers were commodities expected to bring in profits. This should be taken literally: it was not until 1828 that slaves in Suriname were legally regarded as persons instead of as commodities. In health issues as well as other matters they were completely subordinate to the demands and economics of the slave system.

By the 1770s there were around 400 plantations in Suriname cultivating and exporting sugar, coffee, tobacco, cacao and dyewood; an exponential growth compared to the previous century. African slaves were needed to sustain this growth. But they did not bear the working conditions in the plantations well. The annual mortality rate was high, estimated to be at least 40 per 1,000 slaves.⁴⁸ At the same time, the import of new slaves was limited. In this context, we should re-read the passage in Rolander's diary quoted at the start of this paper: 'Blacks infested with this disease [boasia] are automatically relegated to a remote corner of the plantation', he wrote, adding, 'where they serve as guards and spend the rest of their time alienated from friends to keep the entire servile throng from contracting it.'⁴⁹ The plantation owners did not want to relinquish the usefulness of their human commodities by sending them out of sight. The owners intended their slaves to keep performing some sort of physical labour, even when afflicted with a horrid disease. They did not openly resist the new public health measures, but often chose to ignore them. From this perspective, it is significant that the edict of 1761 attempted to encourage slave owners to keep their leprous slaves off the public roads (whereas Europeans could stay in their own homes to receive treatment), but that the edict of 1764 shows that this had not had the required effect. Either the owners disregarded the edict and sent their slaves on the roads anyway, or the slaves acted on their own and travelled for the purposes of trade and personal visits. The sanctions on these activities—fines for the owners—were not strictly enforced. As usual, private interests prevailed over public-spirited motives.⁵⁰

The financial costs of the incidence and treatment of boasia among slaves could be quite high. Slaves could be expensive and were not always easy to come by, especially when highly qualified. Prices and estimated worth varied widely. The figures that are available for the

⁴⁶Geert-Jaap Hallewas, 'De gezondheidszorg in Suriname' (unpublished PhD thesis, Groningen University, 1981), 55.

⁴⁷John Gabriel, Stedman, *Narrative of a five years' expedition against the Revolted Negroes of Surinam, in Guiana and the Wild Coast of South America from*

the year 1772 to 1777, 2 vols (London: J. Johnson & J. Edwards, 1796), II, 275.

⁴⁸Cf. Hans Buddingh', *Geschiedenis van Suriname* (Utrecht: het Spectrum, 1995), 84.

⁴⁹Rolander, 'Journal', 1339.

⁵⁰Of course, these public-spirited motives had themselves racial and discriminatory connotations.

plantation of Roosenburg vary from a thousand guilders or more for a highly qualified slave such as a carpenter or a 'dresiman' or 'dressy negro' (a black surgeon) to a hundred guilders for a healthy female house slave.⁵¹ But regardless of the financial value of the slaves, the costs of medical treatment of a black patient by a white surgeon or doctor were quite high: in the 1780s it was around fifty guilders.⁵²

Slave traders and owners, therefore, did not hesitate to try to sell off slaves with signs of boasis and disguise any visible symptoms. For buyers it was not easy to recognise signs of the disease in its earlier stages. In 1780, the governor of Suriname issued a new edict explicitly prohibiting the sale of leprous (and mentally ill) slaves, a step he would not have needed to take if this had not been common practice.⁵³ Ten years later, in 1790, the colonial government issued even stricter measures. Every slave owner was now compelled to report possible leprosy cases among his slaves to the board of medical supervisors, the Collegium Medicum. If the doctors and surgeons of this supervising institution found a slave afflicted with leprosy, the sufferer had to move to a special colony for leprosy sufferers.⁵⁴ This colony was called Voorzorg ('Prevention') and was founded on an uncultivated bank of the Saramacca River. On 21 December 1791, the first group of seven leprosy sufferers were deported to this colony.⁵⁵ In practice, Voorzorg was nothing more than an isolation place controlled by the military, without any medical supervision. Shortly after the foundation of Voorzorg, the Dutch ship's doctor, social critic and an occasional secret agent, Pieter van Woensel, visited the settlement. By then Voorzorg was expanding. Van Woensel noted about 140 sufferers, some of them also afflicted with venereal diseases. He left with the impression that the goal of the establishment was to isolate, not to cure the sufferers, in an attempt to prevent further contagion of the population.⁵⁶

Little else is known about Voorzorg. When the first supervisor arrived in 1795, the colony had about 200 inhabitants. Their number expanded to 300 in 1797, 400 in 1808, 500 in 1812.⁵⁷ We have one other eyewitness account, dated 30 years after the visit of Van Woensel. In 1824 the Dutch Catholic priest Joannes Willemsen came to Voorzorg. With some difficulties, Willemsen received permission from the commander of the military post, situated opposite the settlement on the other bank of the river, to enter the establishment. This permission was denied to the priest's African servants.⁵⁸ Voorzorg seems to have been more or less a colony within the colony of Suriname, kept isolated by the 30 soldiers of the military post and possibly with a high degree of self-sufficiency. Unlike later leprosy asylums there was neither medical nor religious supervision and disciplining of the sufferers.

As per the edict of 1790, not only slaves were sent to Voorzorg, but free Africans and mulattos (of mixed European and African descent) as well. Europeans were allowed to

⁵¹Oostindie, *Roosenburg en Mon Bijou*, 106–7.

⁵²Johann Friedrich Ludwig, *Neueste Nachrichten von Surinam* (Jena: Akademischen Buchhandlung, 1789), 165.

⁵³'Notifikatie, Zieke of krankzinnige slaven mogen niet worden verkocht', 10 February 1780, in De Smidt (ed.), *Plakaten*, 971–2.

⁵⁴'Plakkaat, Voorzorgsmaatregelen tegen melaatsheid', 28 May/4 June 1790, in De Smidt (ed.), *Plakaten*, 1144–7.

⁵⁵A. Bosser, *Beknopte geschiedenis der katholieke missie in Suriname* (Gulpen: H. Alberts, 1884) 177–8; Report Commissie van Geneeskundig Onderzoek en Toevoorzigt, 22 January 1847, *Nieuw Praktisch Tijdschrift voor de Geneeskunde in al haren omvang*, 1849, 1, 556.

⁵⁶Van Woensel, 'West-Indische fragmenten', 52.

⁵⁷'Report Commissie van Geneeskundig Onderzoek en Toevoorzigt', 556.

⁵⁸Bosser, *Beknopte geschiedenis*, 170–2.

stay in isolation on their plantation or in their home town. It is intriguing that Van Woensel did encounter one European in Voorzorg, a Dutchman. Unfortunately he does not tell us more about him.⁵⁹

In 1791, the government tried to prevent the import of new slaves with boasie. Captains of slave ships had to pay a hundred guilders fine for each slave diagnosed with boasie at the medical examination of the human cargo, held on arrival in Suriname. The slave should then be sent to Voorzorg. But the edict of 1791 crossed the interests of the powerful commercial companies that ran the slave trade, as it meant an increase in the costs of new slaves from Africa. As early as 1792, the fine was revoked.⁶⁰

An astute observer, Van Woensel was sceptical about the efficacy of the anti-boasie measures. He wrote that the attempts of the colonial government to prohibit the sale of slaves without proper medical examination were in vain.⁶¹ The interests of the local elite, the plantation and slave owners, did not always coincide with those of the colonial state, represented by the governor appointed by the Society of Suriname that owned the colony. There were continuous tensions between the two parties. The rich planters and merchants of the colony were expected to make financial contributions to the colonial state, but they were seldom content with government policies.⁶² In the case of boasie, the contribution of physicians to the control of the disease was hindered by these conflicts of interest among the slaveholders. But at the same time, the medical contribution reflected a commonality of fears, prejudices and interests lying beneath the conflicts between colonial elite and colonial government, as will be evident in the analysis of Schilling and his framing of a racial pathology.

Schilling and the Knowledge and Treatment of Leprosy

Medical expertise was a key part of slave labour management, including dealing with boasie. Doctors and surgeons had defined the disease as a contagious threat and identified it with leprosy. Doctors and surgeons had to identify the sufferers of the disease in order to isolate them from society. This, rather than treatment, was their main task. Specialised medical knowledge was needed to perform this task, in which Godfried Schilling played a key role.

Very little is known about Schilling's early life. He was born in the German town of Prignitz in Brandenburg, not far from Berlin, but the exact year of his birth is unknown. One biographical lexicon situates it around 1730, but this seems to be a wild guess.⁶³ The German traveller Johann Friedrich Ludwig who met Schilling in Paramaribo in the second half of the 1780s described him as an 'old man'. This suggests that Schilling was at least

⁵⁹Van Woensel, 'West-Indische fragmenten', 52.

⁶⁰'Publikatie, Voorzorgsmaatregelen tegen melaatsheid', 20/27 May 1791, in De Smidt (ed.), *Plakaten*, 1159–60; 'Publikatie, Voorzorgsmaatregelen tegen melaatsheid', 29 February 1792, in *ibid.*, 1167–8.

⁶¹Van Woensel, 'West-Indische fragmenten', 51.

⁶²Cf. Buddingh', *Geschiedenis*, 35–50; J. Marten W. Schalkwijk, *The Colonial State in the Caribbean: Structural Analysis and Changing Elite Networks in Suriname, 1650–1920* (The Hague: Amrit, 2011).

⁶³G. A. Lindeboom, *Dutch Medical Biography: A Biographical Dictionary of Dutch physicians and surgeons 1475–1975* (Amsterdam: Rodopi, 1984), 1751. Lindeboom's most important source is August Hirsch (ed.), *Biographisches Lexikon der hervorragenden Aerzte aller Zeiten und Völker*, 5 vols (Vienna: Urban & Schwarzenberg, 1887) V, 224. This lexicon, however, only claims that Schilling was born 'in the beginning of the eighteenth century'.

50 years of age by then.⁶⁴ Since he was still working in Suriname in 1795, it seems likely that he was born in the 1730s.⁶⁵

Schilling was trained as a surgeon before travelling to Suriname. Most probably, he apprenticed with a master-surgeon in his youth and, after receiving some sort of certificate of proficiency, went on his *Wanderjahre*, travelling through the world and gaining experience. In the Dutch Republic he took a ship to Suriname. We know he went there as a surgeon, although it is not clear if he was ship's surgeon for one of the trading companies (perhaps on a slaver) or was already in the service of the Society of Suriname. In his treatise on leprosy, he refers to his observations in both the 'hot' and the 'cold' regions of America, suggesting that he spent time in both North and South America.⁶⁶

A career like Schilling's was far from unusual. Germans comprised a significant part of the medical personnel (and indeed all other personnel) of Dutch trading companies such as the WIC or the VOC (East India Company).⁶⁷ Like them, Schilling went overseas in search of a career. But unlike most of them, he continued his career there. After his initial voyage to Suriname, Schilling first went back to the Netherlands. He wrote about his observations and thoughts on leprosy in an MD thesis, for which he received a medical doctorate at the University of Utrecht in 1769. At the same time he wrote a treatise on yaws. Both treatises were translated from Latin into Dutch and then published in the Dutch Republic.⁶⁸

It is significant that Schilling's treatises in Latin on diseases that were hardly known in the Dutch Republic itself were translated into Dutch for a more general readership. It is especially significant that his treatise on yaws, a disease which in Suriname was even more widespread among slaves than boasio, was published in the town of Middelburg. Middelburg, in the maritime province of Zeeland, was home to the largest Dutch slave-trading company of the eighteenth century: the MCC (Middelburgsche Commercie Compagnie). The publication of Schilling's treatises in Dutch can be explained by the fact that one of the problems faced by the slave-traders and especially the surgeons of the MCC was that, when buying slaves in Africa, they were often deceived by the slave merchants, who would disguise symptoms of illness as well as the age of their human merchandise.⁶⁹ Thus knowledge of these 'exotic' diseases was vital within the Republic itself.

Through his treatises on leprosy and yaws, Schilling established himself as a leading authority on health and illness among African slaves. It is therefore not surprising that in the 1770s we find him back in Suriname, probably as a physician at the military hospital in Paramaribo that was opened in 1760.⁷⁰ In 1789, he is mentioned as a doctor of medicine

⁶⁴Ludwig, *Neueste Nachrichten*, 164.

⁶⁵Cf. Piet Emmer, *De Nederlandse slavenhandel 1500–1850* (Amsterdam: De Arbeiderspers, 2003), 133–5.

⁶⁶Schilling, *Verhandeling over de melaatsheid*, 1.

⁶⁷Cf. Roelof van Gelder, *Het Oost-Indisch avontuur. Duitsers in dienst van de VOC (1600–1800)* (Nijmegen: SUN, 1997).

⁶⁸Schilling, 'Dissertatio'; Schilling, *Diatribe de morbo in Europa pene ignoto, quem America vocant Jaws* (Utrecht: J.C. ten Bosch, 1770); Schilling, *Geneeskundige verhandeling van eene in Europa byna onbekende ziekte, bij de Amerikanen JAWS genoemd*

(Middelburg: Christiaan Bohemer, 1770); Schilling, *Verhandeling over de melaatsheid*.

⁶⁹This problem is discussed in David Henry Gallandat, *Noodige onderrigtingen voor de slaafhandelaren* (Middelburg: Pieter Gilissen, 1769). Gallandat, a Swiss surgeon who had served on slavers of the MCC, published this study around the same time as Schilling's treatises were published.

⁷⁰J. Karbaat, '200 jaar militair hospitaal in Paramaribo (1760–1960)', *Nederlands Militair Geneeskundig Tijdschrift* 1960, 13, 355–64; E. van der Kuyp, 'Sri-naamse medische en paramedische kroniek 1494–1899', *Surinaams Medisch Bulletin* 1985, 9, 18.

at the hospital.⁷¹ According to the traveller Ludwig, at the end of the 1780s Schilling was the president of the Collegium Medicum, the medical supervisory board of Suriname. He lived opposite the hospital and had an extensive private practice.⁷² Schilling is an example of the European ‘adventurer-scientists’ who gathered extensive knowledge on diseases in the tropics.⁷³ In Europe, ‘armchair botanists’ were very interested in obtaining information from Suriname and other colonies, although they did not often prefer to go there themselves.⁷⁴ Trained academics such as Rolander, who did venture out to the tropics, often lacked the stamina and the spirit of adventure needed for their stay. Rolander disliked Suriname to the extreme. In his journal he wrote how he resented the behaviour of the Europeans from the colonies, how he resented the treatment of the slaves and how he could not stand the heat and the insects and fell ill.

‘Adventurer-scientists’ who travelled in the colonies, thus had to possess specific qualities in order to succeed in gathering medical knowledge in the tropics.⁷⁵ Not only were they required to have an eye for useful knowledge and be capable of making exact observations, they also had to be able to function under difficult conditions: unusual weather, stress and a general climate of violence and war. The word ‘adventurer’ is used in its seventeenth- or eighteenth-century spirit. In eighteenth-century Dutch, an *avonturier* (‘adventurer’) was a fortune-seeker venturing into the unknown. It is precisely because Schilling had the qualities of such an adventurer that he was as a scientist better qualified for research in Suriname than someone like Rolander. As an adventurer Schilling turned out to be quite successful too. Ludwig estimated that, by the end of the 1780s, the doctor had a yearly income of between five and six thousand guilders.⁷⁶

Schilling’s qualities as an adventurer helped him to make the scientific observations that were published in his treatises. One of the problems for Schilling in his analysis of boasie was that the European medical authors who had written about leprosy since Antiquity—Leviticus, Celsus, Avicenna, Hildanus and others—had described its symptoms in different ways. Moreover, the terminology was rather confused. Leprosy was called *lepra arabum*, or *elephantiasis graecorum*, while *lepra graecorum* was used to designate more elephantiasis-like afflictions of the legs.⁷⁷ Schilling decided that boasie was some kind of *melaetschheid* (the Dutch word for leprosy) or *lepra arabum* because of its two characteristic signs: changes in skin colour on the parts of the body that were affected by the disease and anaesthesia or insensitivity of those parts. He believed that the disease was contagious, just like European leprosy. How did this contagion spread? Schilling was convinced that leprosy could not occur without the presence of a ‘special substance’; ‘a certain poison’ that could

⁷¹ *Surinaamsche Almanach, op het jaar onzer Heere Jesu Christi Anno 1789* (Paramaribo: W.H. Poppelman, 1789), 21.

⁷² Ludwig, *Neueste Nachrichten*, 164.

⁷³ Cf. Snelders, *Vrijbuiters van de heekunde*.

⁷⁴ Frans A. Stafleu, *Linnaeus and the Linnaeans. The Spreading of their Ideas in Systematic Botany, 1735–1769* (Utrecht: Oosthoek, 1971).

⁷⁵ Snelders, *Vrijbuiters van de heekunde*. Cf. also Stephen Snelders, ‘Kapers van kennis’. De rol van een boekaniersgeleerde in de circulatie van kennis

over ziekten en geneesmiddelen in de tropen’, *Studium*, 2009, 2, 55–64.

⁷⁶ Ludwig, *Neueste Nachrichten*, 165, claims that this was the normal income of a surgeon in Suriname. Schilling would have earned at least that amount, probably more. Compare the costs of slaves and medical treatments in Suriname at that time, above in the section ‘Leprosy in the Surinamese Slave Society’.

⁷⁷ On writings of leprosy by medical authors: Schilling, *Verhandeling*, 4; cf. Demaitre, *Leprosy in Premodern Medicine*.

become virulent when the climate or diet had weakened a person's constitution. Schilling conceived the effects of the leprosy poison in the framework of pre-modern classical medicine. By eating poorly digestible food the *chyle* in the body—the substance that according to Galen transformed food into blood—became tough, thick and sour. The thick, sour *chyle* was thought to produce thickened blood, which resulted in thickened glands and nerves and stifled physical sensations. The body became, as it were, prepared or predisposed for the disease. The abnormal thickening of the fluids prevented their healthy evaporation from the body. If the weakened body was then contaminated with the contagious leprosy poison, it contracted the disease. The body could, however, be strong enough to withstand the poison. Or, if the first signs of the disease manifested themselves, one could stop the progress of the disease for 10–20 years by adopting a healthier diet and lifestyle.

Since Schilling believed that the incidence of leprosy was greater in Suriname and in the Caribbean islands than in North America, he stressed the importance of dietary and environmental factors in the aetiology of the disease. In the Caribbean, he believed, the normal diet, the air, and the (bad) quality of the drinking water were very much similar to that in Africa, but different from those in the colder regions of the north. In the hot climates, the diet—which included fat, rotten meat and fish and bad water—caused the disease. The hot air aggravated problems with the evaporation of bodily fluids. The leprosy poison itself spread through physical contact: by sexual intercourse, or by contact with the exudations of ulcers and wounds.⁷⁸ In his medical practice, whenever possible, Schilling ordered the clothes of those people who were suspected to have died from boasio to be burnt to prevent further contagion.⁷⁹

Schilling emphatically claimed that Africans were the carriers of the disease. In doing so, he justified the edicts of 1780, 1790 and 1791 that attempted to control the slave trade and to isolate the sufferers. Schilling felt that whenever Europeans had physical contact with Africans, they were in danger of catching the contagion. Europeans were especially at risk if they had not adopted a healthy diet and adjusted to the hot climate. Measures had to be taken to prevent their contact with leprosy sufferers. There were distinct moral connotations inherent in this view. African leprosy sufferers contracted the disease because of their susceptibility: they lacked the self-control and level of civilization needed to withstand the leprosy poison. Europeans were at risk in Surinamese society due to its close contacts between slaveholders and slaves. This risk was not only physical, but moral as well. At first, glance it seems that Schilling put the blame entirely on the Africans. However, the moral nature of his diagnosis of leprosy did not spare the resident Europeans either. This was not because they had instituted the slave trade and therefore were responsible for bringing the Africans and the disease to America (a critical opinion put forward by Van Woensel), but because Schilling felt Europeans had difficulties in controlling their sexual urges.⁸⁰ According to him, the hot air of the tropics made Europeans lecherous. In North America, where the air was colder and where there were relatively more European women and less slave women

⁷⁸Schilling, *Verhandeling*, 4–40.

⁷⁹Charles Louis Drogat Landré, 'De besmettelijkheid der lepra arabum, bewezen door de geschiedenis dezer ziekte in Suriname' (Utrecht: J.L. Beijers, 1867), 13.

⁸⁰'A poet would say: to avenge themselves for the injustice done to them by us, the Negroes—or rather the Surinamese—have given us this legacy [of leprosy] [my translation]'. Van Woensel, 'West-Indische fragmenten', 51.

than in Suriname, intercourse between white men and African women did not occur as frequently. When it occurred in North America, it was more out of European curiosity than from 'necessity', Schilling claimed. According to him Africans were also beset by *geilheid* ('lewdness'). And the more that Suriname was besieged by lust, the more the leprosy contagion would spread from slave to master.⁸¹ Van Woensel agreed with Schilling in this regard. According to him it was customary for white men to have black concubines, who had given the Europeans the legacy of leprosy.⁸²

In Schilling's view, unhealthy and unclean living stimulated the spread of leprosy. We can infer that in this perspective the European male became threatened by leprosy the moment he lost his self-control. Not only did he stoop to the level of a race that was held to be inferior, he was also feminized, since self-control was held to be a typical male characteristic.⁸³ In this way medical, social and moral degeneration went together and endangered European dominance in a society largely consisting of Africans.

These racial and sexual aspects made it problematic to control the disease. Schilling therefore suggested that it was essential to make a thorough medical examination of slaves before they were allowed into the houses of the owners.⁸⁴ However, early detection of the disease itself proved to be difficult. Fermin had found it problematic to recognise the disease in an early phase, claiming that the symptoms (the discoloured spots) were very similar to those of ringworm (a fungal infection of the skin).⁸⁵ To Schilling, the issue was further complicated as the semiotics of European medicine had to be differentiated according to race. The spots that were an early sign of leprosy were either red tending to a rather bleak colour, or white tending to blue, yellow and red. In white people white spots were hard to discern; in black people the same held for red spots.

Apart from this there was the problem of stigma attached to *boasie* or leprosy. Schilling found that people with signs of *boasie* would often not go to a physician, out of either ignorance or shame. They would hide the signs under their clothes or pretend to feel pain despite their loss of sensation, when undergoing medical examinations—especially Europeans. Schilling therefore advised the examination to be done when the patient was asleep, putting a needle or a knife in the suspect spots or even scorching them with fire.⁸⁶ He might have learnt the trick with the needle or knife from Fermin, whose treatise on Surinamese diseases had been published in 1764. Fermin himself claimed to have learnt it from an 'old Negress', showing that European doctors did try to make use of African ideas and practices.⁸⁷ They also tried to find out about African therapeutic methods. Slaveholders' medical knowledge to some extent made use of slave medical knowledge. One of the problems for

⁸¹Schilling, *Verhandeling*, 29–32. On sexual relations in Suriname cf. Buddingh', *Geschiedenis*, 65–9. Cf. also Ronald Hyam, *Empire and Sexuality: The British Experience* (Manchester: Manchester University Press, 1990), 92–3: 'In the eighteenth century, the West Indies do seem to have been a kind of sexual paradise for young European men: it was almost customary for white men of every social rank (but equally of the lower classes) to sleep with black women.' And cf. Weaver, *Medical Revolutionaries*, 18: 'According to many

Enlightenment thinkers, the heat of the tropical sun intensified the sexual longings of the region's inhabitants.'

⁸²Van Woensel, 'West-Indische fragmenten', 51.

⁸³Cf. Schiebinger, 'Anatomy of Difference'; Quinian, 'Colonial Encounters'.

⁸⁴Schilling, *Verhandeling*, 79.

⁸⁵Fermin, *Traité*, 128.

⁸⁶Schilling, *Verhandeling*, 11.

⁸⁷Fermin, *Traité*, 128.

the European doctors was how to get hold of this knowledge, which was hard to achieve, since slaves were not very open towards their masters.⁸⁸

The basic principle behind Schilling's therapeutic recommendations was for the physician to assist nature in curing the disease by prescribing a healthy lifestyle to his patients. Fermin was of the opinion that boasia was 'absolutely incurable'.⁸⁹ Schilling thought otherwise. According to him, the first step in the therapeutic process was the prescription of a diet of bread, vegetables and juices, with only a sparing use of dairy products. When the body of the patient had been strengthened through this diet, the physician would then try to get the leprosy poison out of the body. He would need to purge the body by prescribing lukewarm baths, fumes and walking exercise. The physician should administer sarsaparilla and kina to make the body sweat and treat the skin with balsams. In this way, Schilling claimed, the disease could be cured in half a year.⁹⁰ Other observers in Suriname were less optimistic. The plantation manager Anthony Blom observed in the 1780s that the body parts of his leprous slaves rotted and the patient died. According to Blom the physicians had no cure.⁹¹ Van Woensel was sceptical of Schilling's medicines, although he was convinced that sweating was the best way of dealing with the disease. According to him, the plantation slaves who worked in heated attics to dry the coffee beans and sweated profusely were cured of skin diseases.⁹² Other observers differentiated between several types of leprosy. It was believed that 'dry' boasia could be healed, not 'wet' boasia.⁹³

Of course, most slaves did not receive the extensive treatments that Schilling had prescribed. On the plantations they were segregated in separate huts and they mostly continued to work until the signs of the disease became too severe. Then they were left to their fate.⁹⁴ Often treatment was administered by African healers, who were an important provider of slave health care on the plantations which lacked trained doctors. On the one hand, Schilling found it beneath his dignity to investigate these healers' methods—or at least he claimed so. On the other, he was curious. He gave one example of what these so-called 'uncivilized people' could achieve with 'a superficial and erroneous medicine'. Schilling bought a 'secret cure for leprosy' from a female African healer. Her method was not unlike Schilling's own. She purged her patients with plant medicine, had them exercised, treated their spots with herbs and had them healed in three or four months.⁹⁵

Schilling framed boasia as a disease tainted with negative connotations, as being of African origin, caused by unhealthy living conditions and related to disreputable sexual moralities. He adapted classical medical concepts, such as the influence of the passions, the weather and diet on health and disease, to the physical and social conditions of the slave societies of the Caribbean and came up with a racial pathology of leprosy. In this pathology, medical, moral and political views were intertwined. Africans were seen as the source of the danger of contagion, had to be controlled and, when necessary, isolated. Europeans had to exercise control over both their subjects and themselves. Contracting boasia was not a

⁸⁸Cf. Gomez, 'Bodies of Encounter'; Snelders, *Vrijbuiters van de heilkunde*, 166–82.

⁸⁹Fermin, *Traité*, 127.

⁹⁰Schilling, *Verhandeling*, 53–73.

⁹¹Anthony Blom, *Verhandeling over de landbouw in de colonie Suriname* (Amsterdam: J.W. Smit, 1787), 341–343.

⁹²Van Woensel, 'West-Indische fragmenten', 52–3.

⁹³Hartsinck, J.J., *Beschrijving van Guiana of de Wilde Kust, in Zuid-Amerika*, 2 vols (Amsterdam: Gerrit Tienlenburg, 1770), II, 914–15.

⁹⁴Stedman, *Narrative*, II, 275.

⁹⁵Schilling, *Verhandeling*, 73–8.

purely physiological process: as was common in the perception of diseases in pre-modern medicine, the 'passions of the mind' were of decisive importance. And precisely these passions were the difference between superior and inferior: between slave owner and slave. In short, the consequence of Schilling's pathology was that the contagion of boasie was a threat to the difference between master and servant, undermining the very essence and foundation of the slave society. But the adaptation of classical medicine to tropical slave societies also offered promising perspectives on prevention and treatment. Contagion could be fought by keeping the Europeans physically and morally strong and the African sufferers isolated, and disease could be conquered by returning strength to the diseased by purging, exercise and a correct lifestyle. In his view, Schilling's pathology not only revealed the threat to the slave society, but also the methods to stop and conquer this threat.

Conclusions

We do not have the sources to ascertain the views of eighteenth-century Africans in Suriname on boasie. To what extent did they share European ideas on the contagiousness of the disease and support the isolation policy? Policy decisions were, of course, made by the owners, but slaves still acted of their own and could travel public roads to and from Paramaribo even when having signs of the disease.

Slave knowledge and perceptions of leprosy in this time are largely unknown.⁹⁶ A closer study of Schilling has revealed much about slaveholders' knowledge, however. From the slaveholders' perspective, boasie was a disease of inferior people (slaves), and methods of detection of the disease and isolation of the sufferers were devised in order to manage slave labour and cut economic losses. Between 1760 and 1790 these methods were developed in Suriname, laying the foundation for a policy of segregation that continued until after the Second World War.

The need for medical knowledge of the disease was driven by its effect on the slave trade and slave economy in Suriname. The perceived financial and economic costs of an epidemic were one of the factors that drove developments, as was the perceived threat to white Europeans. Fears for this threat from Africa were translated into Schilling's framing of a racial pathology. Although framed as a racial pathology, Boasie was not a disease only Africans could contract—which made it a far bigger threat than mere financial and economic losses. Europeans could also develop boasie after being overcome by the tropical environment. This happened when they weakened, when they lost the essential quality of self-control, and were not careful about their diet or had sexual relations with African women.

The case of boasie in Suriname demonstrates why racial differences became increasingly important in health policies and medical thought in the eighteenth-century West Indies and their consequences. But how much did Europeans really fear this threat? To devise a public health policy was one thing, to implement it was another. The colonial government might have wished to eradicate the danger of contagion of boasie, but for the colonial elite, other interests were also at play. As long as the diseased slaves could still undertake physical

⁹⁶Nineteenth-century sources are more abundant and give us some more insights into the reactions of slaves on boasie and isolation policies. They seem to confirm the hypothesis of a relatively large measure

of self-agency among the slaves. I am currently working on these sources in the context of the research project 'Leprosy and Empire' (see Funding note).

labour, plantation owners would send them to work in remote corners of their plantations or try to sell them to unsuspecting buyers, disguising the symptoms of the disease. The colonial government attempted to fine the trading companies for bringing slaves with boasis from Africa, but the decree had to be revoked. The new racial pathology of leprosy laid the foundation for strict isolation policies concerning Africans, but its implementation remained a problem because of conflicting interests between the colonial state and the colonial elite.

In the eighteenth century a new moral framing of leprosy connected the disease to a race that was considered to be inferior. In this framing it was considered dangerous to have physical, let alone sexual relations with the inferior race. Contrary to what some historians have supposed, this process of racialising and sexualising leprosy was not primarily caused by the rise of imperialism or by the development of new theories of bacteriology and Social Darwinism in the later nineteenth century. Of course, a racial framing of leprosy has occurred at different times in different periods. In the second half of the nineteenth century it was adapted to other societies that came under imperial control. But the initial view of leprosy as a disease of the morally and racially inferior had its roots in the slave societies of the Caribbean.

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