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From effluvia to chemicals: techniques of self and somatic ethics in tropical health travel narratives

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ABSTRACT

Recent environmental humanities scholarship has argued that environmental illness memoirs perform important cultural work by recasting health as an environmental issue. In this article, I show how EI autobiography hearkens back to a longer tradition of health travel with deep colonial resonances. I explore such connections by means of a comparative analysis of two health travel narratives: The first, *A winter in the West Indies and Florida*, is an anonymous tract by a self-described 'northern invalid' dealing with his travels to the Caribbean as a remedy for his chronic pulmonary problems during the late 1830s. The second, drawn from a collection by disability activist Aurora Levins Morales, details the author's healing journey to Cuba during the summer of 2009. I argue that, while *A Winter* points forward to modern sociobiology, Levins Morales's narrative should be read as issuing from a biosocial community of EI sufferers. Finally, attending to the continuities and differences between EI autobiographies may deepen current debates on trans-corporeality, which tend to assume a direct relation between non-dualistic epistemologies and somatic ethics. In this sense, the article can be read as a commentary on overly rights-based approaches to illness and Q1 disability in the present biochemical age.

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Arguably one of the most exciting developments in humanities scholarship during the last couple of years has been the convergence of ecocriticism and disability studies. What Ursula Heise (2006) and Lawrence Buell (2001; 2005) at the turn of the twentieth century described as a shift from deep to social ecology in ecocriticism has chimed well with a parallel tendency in disability studies to focus increasingly on rights issues and the social construction of disability. Social ecology involves a heightened interest in questions of environmental justice and the ways in which vulnerable populations are disproportionately exposed to environmental hazards. In turn, the social model of disability draws attention to issues of unequal access and obstacles in the built environment over and against a purely medical approach to impairment. It should therefore not surprise that scholars have attempted to bring these two fields into correlation, as is evident in the work of, among others, Stacy Alaimo (2010), Matthew J. C. Cella (2013), and Elizabeth A. Wheeler (2013). What is inspiring about this coming together of the health and

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environmental humanities is that it forces us to profoundly rethink traditional categories of personhood, the (able) body, materiality, and the environment. As Stacy Alaimo (2010: 2) argues:

> [. . .] thinking across bodies may catalyze the recognition that the environment, which is too often imagined as inert, empty space or as a resource for human use, is, in fact, a world of fleshy beings with their own needs, claims, and actions.

Alaimo's own work on environmental illness epitomises this decentring of traditional subjectivity and broadened understanding of the environment. What is commonly referred to as environmental illness or multiple chemical sensitivity denotes a range of conditions whereby people claim to be sensitive to low-level chemical exposures. This heightened reactiveness to chemicals often impels these afflicted individuals to drastically alter their living situation in order to regain their health to the extent that they might find themselves on the edges of modern society, which they experience as increasingly unliveable. In the medical literature, environmental illness (e.g. Hetherington & Battershill 2013) is generally approached as a psychiatric disorder without a clearly defined toxicological foundation. Contrastively, Alaimo suggests that the testimonies of the environmentally sensitive require us to rethink existing clinical models, which are based on a conception of the body as a bounded organic entity and mechanism-based approaches to disease. In Alaimo's non-dualistic framework, health ceases to be understood in terms of the absence or presence of discrete pathogens and rather comes to be recast in terms of dense correspondences between bodies and the landscape.

Alaimo's reflections on environmental illness clearly betray the influence of the environmental justice movement and the social model of disability. Rather than approaching environmental illness as a purely clinical issue, Alaimo reframes it along the lines of minority rights activism as a political struggle for the recognition of the chemically sensitive. In this way, Alaimo develops what she calls an ethics of trans-corporeality, or an ethics grounded in an understanding of the body as enmeshed in its environment. Approaching environmental illness in this way might be serviceable in destigmatising and mobilising support for a number of contested illnesses still inadequately understood by the medical profession. On the other hand, Alaimo's model displays problems similar to those that have surfaced in discussions on the social model. The disability scholar Tom Shakespeare started out as a proponent of the social model but has recently insisted on its limitations. As he outlines (Shakespeare 2017: 201), by presenting the disabled body as necessarily oppressed by society, the social model engages in circular reasoning that fails to show how oppression takes shape in given constellations: 'the question is not whether disabled people are oppressed in a particular situation, but only the extent to which they are oppressed'. Similar problems, in my view, inhere in Alaimo's ethics of trans-corporeality. By grounding her ethics in distributed embodied experience and investing all research energy in refuting dualisms deemed problematic or unjust, Alaimo stops short of interrogating in what ways environmentally sensitive bodies enter into conflict with their environments.

As a result, the project of 'thinking across bodies' (Alaimo 2010: 2) inevitably runs into contradictions. On the one hand, Alaimo points to the crucial function filled by personal narratives of the environmentally sensitive as a means of validating their predicament in the face of a medical establishment that fails to take them seriously.

On the other hand, these groups' reliance on print, mass, and social media in their struggle for recognition necessarily compromises the narrative of somatic vulnerability and relation. The effectiveness of dissemination media derives from their capacity to transcend local interaction contexts. They spread information globally because they decontextualise it through processes of standardisation and simplification. The new materialist philosophies' programmatic commitment to embodied experience, therefore, is at least partly belied by their reliance on the disembedding mechanisms of modern society. Even while Alaimo's ethics of trans-corporeality ostensibly cuts across the traditional epistemological divisions between body and environment, self and other, or materiality and discourse, it cannot but reinforce such oppositions when defining environmental illness as a protest movement that relies on the media for its agency. Katherine Hayles (2017) has pointed out a similar contradiction at the heart of the new materialist ontologies in general. By suggesting that the category of the human has lost its validity, the new materialisms, Hayles (2017: 66) writes, are effectively caught in 'an unrealistic and ultimately self-defeating enterprise, considering that the success of the decentering project depends precisely on persuading humans of its efficacy'. If the posthuman turn is merely about cancelling out the differences between humans, other species, and the material world, it yields a rather impoverished ethics indeed.

Another way of articulating this problem is by saying that the new materialisms too easily assume, no doubt partly for rhetorical effect, that a viable ethics flows *naturally* from the questioning of received categories such as nature and the body. Jane Bennett (2010: ix), for instance, legitimises her vital materialism in the following way: 'my hunch is that the image of dead or thoroughly instrumentalized matter feeds human hubris and our earth-destroying fantasies of conquest and consumption'. Even if this 'hunch' is correct, it does not therefore follow that a political ecology of things will automatically foster a less destructive relation to the world. We still need to ask how specific groups, such as the environmentally sensitive, stand to gain from an ethics grounded in a non-dualistic ontology and how that would translate in specific policies and approaches. Programmatically rejecting traditional categories of personhood or the human is hardly a solid foundation for patient and activist groups that are struggling for recognition of their condition, better access to health care, provisions for safe environments, and so forth.

A fruitful way to address such theoretical shortcomings, I believe, is by more insistently historicising phenomena such as multiple chemical sensitivity. As has often been noted, there are striking continuities between today's stories of chemical sensitivity and the kind of health travel narratives that were current before the rise of clinical medicine towards the mid-nineteenth century. In neo-Hippocratic medicine, the permeability of bodies was considered an accepted fact. Health and disease were understood as functions of place. This is evident in the historical literature on climatotherapy, a medical paradigm that proscribed prolonged residences in climates deemed conducive to the recovery of people suffering from chronic afflictions. A historical comparison of the testimonies of today's environmentally ill and their quest for a home free of toxins, mould, or electromagnetic radiation, and the accounts of nineteenth-century invalids seeking out 'smiling' climates for the relief of their symptoms allows us to consider the political valences of various health regimes and to interrogate ethical positions predicated on somatic sensitivity.

In what follows, I will begin by outlining significant shifts in western conceptions of health and the environment since the early 1800s. Of necessity, this will be a very schematic overview and the aim is therefore mainly exploratory and heuristic. In a second step, I will then try to operationalise these insights in a reading of two health travel narratives. The first, entitled *A winter in the West Indies and Florida*, is an anonymous tract, dating from 1839, by a self-described 'northern invalid' dealing with his travels to the Caribbean and Florida as a remedy for his chronic pulmonary problems.[1] The second narrative is drawn from Aurora Levins Morales's collection *Kindling: Writings on the body*, which the author self-published with her own press Palabrera in 2013. In this book, Levins Morales, a Latina feminist author and activist born in Puerto Rico of Jewish parents and now living in a mobile home in the United States, narrates her healing journey to Cuba in the summer of 2009. What motivates the comparison of these otherwise very different texts is that both define bodily health in large measure as a function of the (tropical) landscape. But there are also significant differences, which can be linked to the medical epistemologies against which the authors define their predicament. Analysing these texts is thus an opportunity to pin down the specific rationalities – or what Ludwik Fleck (1979) would have called 'thought styles' – attached to distinct health regimes. I will argue that, where *A winter in the West Indies*, while pointing forward to modern biopolitics, remains largely steeped in a neo-Hippocratic framework designed to demarcate rather than normalise healthy environments, Aurora Levins Morales's book operates within a new health regime derived from biomedicine that fundamentally blurs the boundaries between illness and health.

Rationalities of western health regimes

The environmental historian Linda Nash (2006) has pointed attention to two competing conceptions of the body vying for dominance in western medicine. The first is the modern body of allopathic medicine, which approaches the body as bounded and separate from its environment. In this epistemological framework, the environment has little or no agency in the production of health or illness. Or put differently, health is nothing but the organism's capacity to remain separate from its environment. The second model, by contrast, conceptualises the body as open rather than closed. What Nash calls the 'ecological body' allows for continual exchange between inside and outside. In this framework, health is understood in dynamic terms as a continual process of interchange with the landscape. While clinical medicine would eventually disqualify this holistic model of body–environment interaction, Nash argues that it has never truly disappeared and might now be returning to prominence in view of heightened concerns regarding environmental toxicity and anthropogenic climate change. As Nash notes, current controversies over the environmental causes of multiple chemical sensitivity and related illnesses go back to nineteenth-century anxieties regarding the pathogenic influence of miasmata or effluvia. While Nash does not call for a return to now superseded medical theories of environmental influencing, she (2006: 214) asks us to question the 'sanitary modernity' of modern medicine, which posits an all too strict separation between medical

[1]While the author's gender is not revealed, his male identity can easily be inferred from remarks about the fitness of the West Indies as a resort for 'ladies'.

and environmental concerns. Instead, she pleads for a medical science that highlights our bodies' intimate connections with the environment.

Nash's explorations of the history of body–environment interactions are highly stimulating but fail to outline in detail how current conceptions of personhood and the body differ from those of earlier times. In this respect, Nikolas Rose's (2007) work on the mutations of biopolitics in the age of biomedicine is instructive. Rose takes his departure from Michel Foucault's theory of biopolitics. Foucault's (1973) well-known argument was that the modern conception of the body is intimately tied up with the rise of clinical medicine. The clinical body made it possible for states to develop health policies predicated on the future development of the population in the aggregate. Hence, the age of clinical medicine was also a biopolitical age in which states wielded control over people by invoking the general welfare of the different subpopulations within their territories. As Rose argues, however, the body of the post-World War II period is very different from that of traditional clinical medicine. With the discovery of DNA, we have moved from the molar to the molecular level, which, inevitably, has resulted in a new understanding of the body and of the very meaning of life. What Rose (2007: 44) calls the 'biomedical body' differs from the clinical body in that it is not clearly bounded but subject to the expectation of continual technical alteration. In this new regime, health is no longer comprehended as the absence of disease in the here and now; instead, our understanding of health is largely a product of the promissory culture of the industrial-biomedical complex, which brings the future into the present in unprecedented ways.

Rose's biomedical body resembles Nash's ecological body in the sense that it is conceived as a permeable entity rather than an organic unity. In this sense, Nash is justified in arguing that the ecological body has never truly disappeared and is now emerging more visibly as a result of the transformation of our relation to the environment. But there are also significant differences between the ecological and biomedical body. The former still worked largely in the service of the hygienist policies of disciplinary societies, as is evident, for instance, in colonial medicine's concern with protecting the coloniser's body against the noxious influences of colonial environments. In the post-clinical regime, by contrast, expertise and power are distributed in more complex ways. While state authorities definitely still have a role to play, they now have to compete with other actors, including pharmaceutical companies, ethical committees, the mass media, and patient groups, all of which claim certain forms of bioethical authority. While medical knowledge formation has of course always been messy, Rose's argument is that the possibilities for contestation and conflict have increased dramatically as a result of advances in genetic research, the pervasiveness of risk factor analysis, and so forth. Charles Rosenberg (2003) made a similar point when arguing that we have entered an age of chronic disease, in which the line between being at risk and being ill has become tenuous and conflicts over what counts as a disease have multiplied. This also means that what counts as a healthy or toxic environment is less easily localisable than was the case, for instance, in nineteenth-century medical geography. Just as symptomless ills multiply, so every place seems to be a potential toxic waste site.

It is inevitable that this new context generates new practices and conceptions of personhood. Drawing on Paul Rabinow (1996), Rose suggests that we are witnessing the emergence of new 'biosocial' communities coagulating around specific genetic conditions or susceptibilities in today's society. I find Rose's work on the new vital politics of

biomedicine highly stimulating as it allows us to isolate distinctive techniques of self-presentation attached to different health regimes. Rose distinguishes three such regimes: if nineteenth-century health policies were focused on the containment of diseases and epidemics, then the twentieth-century shifted the focus to inheritable properties and the reproduction of specific populations; what Rose calls 'molecular biopolitics' in the present century, finally, aims not so much to preselect fit populations as to engineer and enhance their vital capacities. It is a politics, not of health, or inheritance, but of risk, or of 'life itself'. To be sure, as Rose acknowledges, this model is highly schematic. Like Foucault's three epistemes, it squeezes complex historical developments into a simple triad. Social theorists have a predilection for such tripartite models. What I find attractive about Rose's approach, however, is that it constitutes a serious attempt to extend Foucault's insights on the age of the clinic to illuminate ongoing developments in biomedicine. As such, Rose offers a useful corrective to overly ideological pronouncements regarding our 'posthuman' future. One shortcoming of new materialist studies of contested illnesses, I believe, is that they fail to account for the power structures informing the new, biomedical regime. By reproducing patients' claims to somatic exclusivity, this scholarship glosses over (whether or not deliberately) the fact that life at the submicroscopic level is not knowable directly through the senses. It can only be accessed indirectly through advanced machines and computers operated by research teams in laboratories. What we know about this laboratory work, moreover, is communicated to us through the media, which preselect what counts as newsworthy. To a considerable extent, as Rose insists, who controls these scientific resources and media apparatuses also controls what counts as life and health in today's society.

Patient organisations and action groups, while they often maintain a conflictual relationship with the medical establishment, do possess considerable clout in directing attention and funding to specific illnesses and conditions. The autosomatographical testimonies such communities produce play a non-negligible part in the social construction of disease. These narratives display something of the 'suspended agency' that according to Sianne Ngai (2004: 33) animates late capitalist artistic expression. Arguing that the individuals producing such narratives, often with the help of participatory media and production platforms, are entirely at the mercy of a medical system that does not recognise their symptoms strikes me as a misguided, or at least partial interpretation. Moreover, if the biomedical regime indeed creates new identities that are open and fluid rather than closed and discrete, it is nevertheless noteworthy that it has given rise to an apparently ceaseless stream of personal narratives, in a wide variety of formats, challenging the traditional amanuensis as a diagnostic tool. The bounded ego is not abandoned, but embraced with unprecedented vigour. This paradox deserves to be unpacked carefully. A historical comparison of health travel narratives spanning the three regimes outlined by Rose – which I refer to for brevity as the hygienist or sanitationist, clinical, and biomedical regimes – can help to foreground such power dynamics.

Tropical health travel in the age of climatotherapy

A winter in the West Indies was published at a time when the Caribbean was increasingly promoted as a health resort for invalids, particularly for northerners suffering from chronic pulmonary afflictions. This trend in health tourism coincided with a period when the

southern slave states were eyeing the Caribbean, and particularly Cuba, the most profitable Caribbean island after the Haitian Revolution, as a potential colony of the United States. Insofar as it stresses the curative potential of tropical climates in general and that of Cuba in particular, *A winter in the West Indies* reflects these diverse, and often conflicting, interests and aspirations. This shines through in the formal organisation of the work, which can be read as part personal narrative, part advice manual for invalids, part natural history, and part political pamphlet. The book displays the restless quality that has often been attributed (Abbott 1988) to the autobiographical genre in general. This restlessness is also evident in the physical trajectory of the author, who traverses the Caribbean in the winter months of 1838/9. The curative potential of mobility is a central topos of the literature of invalidism, which for this reason can be said to exhibit something of the episodic structure of the picturesque novel. The invalid's insatiable desire for new scenery was a frequent object of satire, as shows for instance in Tobias Smollett's *The expedition of Humphrey Clinker* (1771) or Anna Brownell Jameson's *Diary of an ennuyée* (1826), a fictitious memoir of an invalid in search of '[c]ontinual motion, continual activity, continual novelty' (Jameson 1826: 3). While *A winter in the West Indies* lacks this satirical dimension, it displays the edginess that runs through the culture of invalidism. In spite of his severe health problems, the narrator travels almost 5000 miles in just a few months, journeying from New York to the Danish West Indies, over Cuba, to Florida, from where he returns by steamboat and overland by stage coach and rail back to the north.

Following Steve Kroll-Smith and H. Hugh Floyd (1997), Stacy Alaimo (2010: 130) has suggested that the memoirs of the chemically reactive can be approached as a 'practical epistemology':

> The person with MCS may be understood as a sort of scientist, actively seeking knowledge about material agencies, and, simultaneously, as the instrument that registers those agencies.

A comparable practical epistemology seems to underlie *A winter in the West Indies*. As the author insists (Invalid 1839: vii; italics in text), while pulmonary diseases account for about one-fourth of all deaths in the United States, physicians have only a dim sense of the ways in which such conditions can be treated by means of a change of climate: '*no healthy man can be a competent judge of such matters*'. While he declares that invalids are often too weak to undertake such an investigation themselves, the author takes this role upon himself, invoking his 'peculiar sensitiveness' (xi) as a benchmark for his comparison of the healthful nature of various tropical resorts. It is by virtue of his heightened susceptibility to climatic influences that the author can claim a form of what Paula Moya (2002) has called 'epistemic privilege' in the context of minority rights. The northern invalid grounds his authorial voice in his somatic experience and a conception of the body as highly susceptible to variations in temperature, humidity, altitude, and other environmental influences. At a time when meteorological instruments were not as reliable as today and not yet fully standardised, the invalid's body functioned to differentiate between noxious and wholesome landscapes.

Which landscapes proved most suitable for the environmentally sensitive of the nineteenth-century? The author's conclusion seems unequivocal: the ideal climate should display an even temperature, is to be devoid of sudden variations and extremes, and should boast a dry and pure air. On this ground, he insists (Invalid 1839: 21), the tropics are to be preferred over any other destination, including the southern states (most of which

he considers unhealthy) and the Mediterranean (deemed too far away for most American invalids):

> It is only between the Tropics that the requisite uniformity of temperature can be found. The West India Islands are the most accessible to us on account of proximity, and are, in many other respects, the best resort on earth for those afflicted with chronic disease.

This appraisal of the tropics as a preferential destination for invalids is significant insofar as it inverts an age-old assumption, going back to ancient Greek climate theory, that they are pathogenic. 'Beyond the tropics', Aristotle states in his *Metereologica* (1952: 31), 'no one can live: for there the shade would not fall to the north, whereas the earth is known to be uninhabitable before the sun is in the zenith or the shade is thrown to the south'. Even if travellers soon discovered that the tropics were inhabited, the idea that advanced societies could not develop there due to the harsh climate persisted up until well into the early modern period, which significantly shaped routes of empire and trade (Wey Gómez 2008). In this framework, the tropics counted as an 'anti-landscape' in David Nye's (2014) sense of a non-sustainable, unliveable environment.[2]

A winter in the West Indies refigures this anti-landscape as a life-giving one by pointing to the author's remarkable recovery to health in the tropics. After having unsuccessfully tried several climate cures on the American mainland, the northern invalid embarks on a journey to the Caribbean 'as a last experiment' (Invalid 1839: 28) for relieving his chronic symptoms. As he recounts (31), the restorative influence of the tropical climate makes itself felt with wonderful force as early as a few days into the sea voyage:

> After four days of fair wind, but rough sea, during which I was unable to leave my berth, I crawled, for I was unable to walk, to the deck, and stretched myself at full length in a sunshine as cheering as the smiles of friendship. We had now passed the Gulf Stream, and saw no more of cold weather. My improvement, in spite of continued sea-sickness, was truly surprising – far beyond my most ardent anticipations. The pains about the spine and chest, the stricture of the lungs, catarrhal and asthmatic symptoms, all subsided; and long before eating anything I could walk the deck without pain, and respire the pure air with perfect ease.

The doctrine of the open body, as a system of continual flow of airs and fluids, can hardly be rendered more graphically than in the image of the northern invalid prostrated on the ship's deck and visibly regaining his strength under the suns' rays. The cultural mutation of the tropics from a pathogenic into a regenerative landscape, which prefigures the rise of the Caribbean tourist industry, can be read in terms of a specific thought style associated with neo-Hippocratism and the field of medical geography, which defines health in dynamic terms as a state of harmony with the landscape.

But, as the northern invalid discovers soon after his arrival in the Danish West Indies, by no means all tropical locales are equally healthy. In fact, there is great variation, not just between the islands themselves but also between different places on a given island, or even between different accommodations in the same locale. The invalid explains these differences partly in terms of seasonal variations as well as geodetic and geographical features (elevation, exposure to wind, proximity to the sea, etc.). But other, less clearly definable characteristics prove no less important. They include the availability and state of infrastructure, the fertility of the soil, food and fresh produce, opportunities for diversion,

[2]For a discussion of Nye's anti-landscape, see Mitchell's contribution in this issue.

the political and legal system, and the manners of the population. This complex of factors, as the author asserts, might account for why certain places are considered unwholesome in spite of their advantageous location. Thus, while Cuba is presented as a perfect resort for invalids, Jamaica receives a negative rating (Invalid 1839: 173) even though the island is 'without a single cause of unhealthiness of the climate'. What defines Jamaica as unhealthy is the insecurity following the abolition of slavery, which, as the author insists (1839: 174), has been 'highly disastrous of the interests of the country'. No longer relying on evidence derived from his 'peculiar sensitivity', the northern invalid (1839: 175) here rehearses the typical arguments by which the southern planter class defended the institution of slavery, namely that the freed slaves are 'an insolent, indolent, and, in all respects worthless class of people' who will not work in a warm climate unless forced to do so.

Such passages bring out the complex links between the nineteenth-century culture of invalidism, colonialism, and industrial slavery. To a large extent, the health travel industry relied on the infrastructure of the plantation system. Several of the packet lines that transported invalids to and from the Caribbean were run by plantation owners, who often also exploited the resorts for invalids on the islands. In fact, some of the sugar and coffee estates were owned by self-described invalids. *A winter in the West Indies* (Invalid 1839: 184) qualifies Cuba as the best destination for invalids not only because it possesses a standing army 'kept always ready to put down the first efforts at insurrection', but also because of its centrality to the West Indian plantation economy. As the author insists, the low property taxes, designed to stimulate foreign investments in the plantations, contribute significantly to the wholesomeness of the Cuban climate. The imbrications of medical, aesthetic, and economic registers are evident in the following passage:

> Nothing can be more beautiful than a coffee estate, or furnish a more neat pleasant business, for a gentleman who wishes to live at his ease, in a fine climate, and with a home that will supply every luxury of life. If gentlemen who have the means, instead of going to the West Indies for a single winter, when they find pulmonary complaints approaching, and then returning to the north, where the summers are almost as bad for the lungs as the winters, move to Cuba at once, they would stand a much better chance of ultimate recovery; and, at all events, contribute greatly to their own happiness during the residue of their lives. (Invalid 1839: 181)

This quotation reveals that the transformation of the tropics from a sickly to a healthy place was driven as much by the West Indian plantation economy as by its curative effects. In fact, the tropical climate was considered regenerative only for a specific class of people, namely gentleman-invalids possessing a 'peculiar sensitivity' associated with the ills of modern society. For all other classes of people, including not just the slaves but also the creole population, whom the author regards as equally lazy and devoid of American-style industry, the tropical climate actually exerts a negative influence on the moral, mental, and physical constitution. The classical idea of the tropics as an anti-landscape is thus not so much abandoned in *A winter in the West Indies* as refigured with the apparent aim to ideologically cement nineteenth-century power hierarchies in the Atlantic space. If Aristotle believed that only Greece could build expansive empires by virtue of its temperate climate in between the extremes of heat and cold, *A winter in the West* Indies projects a comparable valuation order in which the tropics continue to function as a climatically determined zone

suited for colonisation and exploitation. In this framework, it is no longer the temperate Mediterranean from which higher civilisation radiates but the American Northeast, which, while endowed with a harsh and extreme climate, epitomises American enterprise.

In passing, the northern invalid inserts a muffled plea for Cuban annexation. 'If Cuba belonged to our Government', he asserts (1839: 105), 'its population would double in two years, and quadruple in less than five, for no place on earth enjoys a finer climate than some parts of it, or greater natural resources'. This statement is remarkable not only for underscoring the involvement of the northern health travel industry in the circum-Caribbean slave economy, but also because it appears to announce a transition to a new kind of vital politics that would come to predominate with the rise of clinical medicine. By linking Cuba's gentle climate to population increase, the narrative here moves away from a sanitationist politics of health focused on differentiating between life-sustaining and life-destroying landscapes, or genial and not so genial climates, and towards a new vital politics predicated on the reproduction and management of populations. The author is of course primarily concerned with a future population of American citizens in Cuba, who would display the perfect mix between industry and physical health. What is to happen to the bodies of the local inhabitants, the slaves, and the indigenous groups, remains significantly unspoken in this narrative. The shift from a politics of health towards one of inheritance suggests that the different regimes are not neatly demarcated, but intersect in complex ways. My main aim with the example of *A winter in the West Indies*, however, has been to show that we should be careful with arguments that self-evidently ground a progressive ethics in a non-dualist, trans-corporeal epistemology. As the above reveals, a conception of the open body is not of itself an antidote against, and may sometimes even further 'human hubris and earth-destroying fantasies of conquest and consumption'. This is not to deny the relevance of the new ontologies, but rather to indicate that a sustained inquiry into body–environment interactions in our biomedical age should go beyond programmatic calls for an anti-anthropomorphic epistemology. It should also ask which bodies are affected and how this process takes shape.

Environmental illness narratives in the biomedical regime

The last decade or so has witnessed a deluge of narratives by, about, and for people suffering from environmental illnesses. It is virtually impossible to keep track of the personal narratives by people outing themselves as suffering from one or several environmentally induced chronic afflictions. Podcasts, blogs, vlogs, posts in online fora, along with conventional published memoirs, chronicle individuals' experiences with a variety of medically unexplained or difficult to treat illnesses, such as chronic fatigue syndrome (Rehmeyer 2017), mould illness (Brooklyn 2017), chronic Lyme disease (Feinberg 2011; Khakpour 2018), and several other poorly defined conditions. Most of these autosomatographies linger on the social obstacles the afflicted are faced with, in the form of indifferent bureaucracies and insurance companies, non-responsive medical doctors, predatory alternative medicine practitioners, and well-meaning but non-comprehending friends and family. Countless self-help books, often with a confessional component, offer holistic healing solutions for a whole range of afflictions attributed to environmental toxins or infectious agents. Many of them promise to give visibility to otherwise invisible diseases, as the following sample of recent titles might indicate: *You*

Don't Look Sick! Living Well with Chronic Invisible Illness (Selak & Overman 2012), *Young, Sick, and Invisible: A Sceptic's Journey with Chronic Illness* (Bula 2016), *Invisible: How Young Women with Serious Health Issues Navigate Work, Relationships, and the Pressure to Seem Just Fine* (Hirsch 2018), *Surviving and Thriving with an Invisible Chronic Illness* (Jacqueline 2018).

The plight of people suffering from contested or undefined chronic illnesses, however, has also been picked by mainstream media. Testimonies have appeared in serious magazines such as *The New Yorker* (O'Rourke 2013) and *Harper's* (Jamison 2013). Work by documentary photographers, such as Thilde Jensen's *The Canaries* (2013), which calls to mind Rhonda Zwillinger's pathbreaking photo collection *The Dispossessed* (1998) as analysed by Alaimo (2009), has visualised the suffering and isolation of the chemically sensitive in gripping ways. Streaming platforms, reaching millions of viewers worldwide, feature an array of films, documentaries, and docuseries on this topic, including, for instance, Andy Abrahams Wilson's *Under Our Skin* (2008) and its sequel *Emergence* (2014), both about the Lyme controversy, Sini Anderson's *The Punk Singer* (2013), equally on Lyme, Jennifer Brea's *Unrest* (2017), a testimony of chronic fatigue syndrome, Susan Abod's *Homesick: Living with Multiple Chemical Sensitivities* (2013), Drew Xanthopoulos's *The Sensitives* (2017), a self-published documentary by diet guru Dave Asprey entitled *Moldy* (2017), and Ben Bloodwell and Bryan Donnell's controversial Netflix series *Afflicted* (2018). Fictional representations of the environmentally afflicted, finally, have been woven into TV series such as, for instance, Vince Gilligan and Peter Gould's *Better Call Saul* (2015–present), which features a character suffering from electromagnetic hypersensitivity. The list is of course non-exhaustive, but it does mark a trend in the genre of self-writing.

In his discussion of biosociality, Paul Rabinow (1996: 101) noted that:

> [there is] a large historical step indeed from the rich web of social and personal significations that Western culture inscribed in tuberculosis to the inclusive grid of the welfare state, which has yet to inspire much poetry or yield a celebrated bildungsroman.

Rabinow here has in mind the romantic literature on TB as well as canonical novels such as Thomas Mann's *The Magic Mountain* (1927), as famously analysed in Susan Sontag's essay 'Illness as Metaphor' (1990). While Rabinow might be correct in suggesting that the new illnesses of the biomedical age have not yet produced a novel of the standing of *The Magic Mountain*, the recent outpouring of EI memoirs clearly suggests that they have started to amass their own web of significations. Interestingly, Alaimo (2010: 132) suggests that MCS autobiographies display the typical structure of a bildungsroman, revolving as they do around a central tension between the perspective of naïve youth and the knowing adult. But Alaimo also indicates that they do not construct a coherent identity in the same way as other bildungsromans. As Alaimo suggests, they are 'strangely material, with solvents and elastic as the antagonists which, ultimately, permeate the self'. While I do not entirely agree with Alaimo's conclusions for reasons that will be made explicit below, she deserves praise for taking self-narratives of idiopathic environmental illnesses seriously and identifying new identity formations centring around the issue of generalised chemical harm. In their activist embrace of contested illnesses categories, these new identities have started to transform what Talcott Parsons (1951) called the 'sick role' in modern medicine.

The outpouring of narratives on environmental illness displays properties similar to those of the late twentieth-century toxic discourses analysed by Lawrence Buell (2001) in *Writing for an Endangered World*. As Buell argued in this book, which was instrumental in the opening up of ecocriticism towards environmental justice concerns, the literature of toxicity exhibits many of the topoi of earlier environmental writing, derived among other things from the gothic and the pastoral modes. But, as Buell usefully outlines, the literature of toxicity also departs from this tradition, most crucially in the ways, it imagines the victims of toxic waste. Contrary to earlier environmental narratives, which through their didacticism and reliance on scientific expertise often reinstall the social divisions that they promise to overcome, contemporary toxic discourses allow victims of toxic waste, Buell (2001: 44) claims, 'to reverse roles and claim authority'. Possibly as a result of the proliferation of media outlets and the emergence of new forms of biosociality as described above, the tendency towards increased victim agency has become even more pronounced in early twenty-first-century environmental illness narratives. The toxic narratives analysed by Buell still largely frame environmental illness as a symptom of suburban malaise (Todd Haynes's *Safe* [1995]), the postmodern society of the spectacle (Don DeLillo's *White Noise* [1985]) or the nuclear fallout of the Cold War (Terry Tempest Williams's *Refuge* [1991]).What, in contrast, unifies recent environmental illness narratives in spite of their remarkable variety is their strong fixation on the perspective of the sufferer. In them, we can witness the alignment of environmentalist and disability rights discourses that up until quite recently remained largely separate.

Aurora Levins Morales's *Kindling* (exemplifies this development in interesting ways. Levins Morales started out as a Latina feminist activist author in the 1970s, when she contributed to such collections as *This Bridge Called My Back* (1981), edited byGloría Anzaldúa and Cherríe Moraga. Levins Morales's activism during this period was internationalist, anti-racist, and feminist, but she did not yet openly self-identify as a person suffering from chronic environmental illness. In *Medicine Stories* (1998; revised edition in 2019), a book that grew out of her graduate research, Levins Morales starts to connect her personal childhood traumas resulting from patriarchal culture to histories of racism, colonialism, and environmental destruction in Puerto Rican society, but still without embedding these reflections in a disability justice framework. This kind of fusion of environmental and health activism only manifests itself fully in Levins Morales's more recent writings produced after the turn of the century. Thomas Couser has noted that the boom of illness memoirs in the latter half of the twentieth century is inseparable from the civil rights movements taking shape during the same period (Couser 2016). The coalition between health and environmental activism in early twenty-first-century illness narratives can be read as an offshoot of this focus on illness as a rights issue which focuses specifically on body–environment relations in a toxic world. As the case of Levins Morales might serve to illustrate, this new epistemic framework hearkens back to earlier discourses that constructed chronic invalidism as an identity position during the pre-clinical health regime.

Levins Morales's *Kindling* (2019) presents itself as a hybrid narrative, containing confessional writings culled from her blog, poetry, occasional pieces revealing her involvement in the disability arts movement, and manifesto-like declarations on the rights of the environmentally sensitive as well as pronouncements on health care reform under the Obama administration. The memoir even extends beyond the covers of the book itself

when we are referred to Levins Morales's (2013) website for 'updates on Aurora's condition, or to donate to her health care fund'. In this way, the reader is interpellated as a potential fellow sufferer in an emergent biosocial community who not only might profit from the author's advocacy but is also urged to contribute materially to her 'ongoing survival' by financing her medical expenses: 'May my truth stand beside yours', Levins Morales (2013: iv) states in the introduction, 'and do its part in the task of saving us all'. In similar fashion as nineteenth-century invalids, therefore, Levins Morales elides the patient role of modern medicine. She is at once a victim of an unresponsive healthcare system and an active champion of the cause of the environmentally sensitive. This dynamic is evident in Levins Morales's diary of her journey to a Cuban treatment facility she undertook in the summer of 2009 after suffering what she describes as a stroke that confined her to a wheelchair. During her time in Cuba, Levins Morales not only undergoes a treatment that will eventually allow her to walk again but also intervenes actively in the host society by developing plans for performance arts projects, by monitoring political developments in Latin America (notably the coup in Honduras), and by visiting various organisations and institutes concerned with the disabled as well as the LBGTQ community.

This paradoxical combination of victimhood and activism is reminiscent of the northern invalid's active prospecting for Caribbean health resorts described above. One way of making sense of Levins Morales's narrative, therefore, might be by arguing that it functions to relocalize conceptions of health and illness by drawing renewed attention to the density of relations between the body to the landscape that have become largely obscured in our sanitary modernity. From the vantage point of allopathic medicine, Levins Morales's self-presentation appears highly contradictory and shifty. While rejecting the personal responsibility rhetoric of the American for-profit medical care system, she (2013: 63) emphasises the healing power of 'emotional work'. Further, while insisting that what she refers to as the 'medico-industrial complex' is failing the chronically afflicted, she repeatedly appeals to scientific advances, alongside alternative remedies, to validate her truth claims (6).[3] Rather than identifying a specific pathogenic cause, however, she attributes her plight to multiple, mutually reinforcing factors, from a genetic liver disease making her unusually vulnerable to even small doses of environmental toxins, to pesticide exposure during her childhood in Puerto Rico, to sexual and psychological abuse in grade school, to environmentally caused epilepsy, diabetes, and fibromyalgia, and chronic Lyme disease contracted in the American Northeast. Even while Levins Morales invokes medical explanations at the genetic-molecular level that have only emerged during the biomedical regime, her spatially specific and multifactorial understanding of health resonates in tangible ways with the nineteenth-century culture of invalidism.

This is of course not to suggest that Levins Morales deliberately modelled her memoir onto the autosomatography of nineteenth-century climatotherapy, but rather that narratives like hers are infused with some of the generic structures through which such therapeutic self-writing historically found expression. Like the author of *A winter in the West Indies*, Levins Morales attaches conflicting valuations to the American tropics. On the one hand, she pictures Cuba as a place of regeneration where the 'wonderful climate of

[3]Levins Morales's father, Richard Levins, was an ecologist who researched genetic diversity in Puerto Rico. It is therefore not surprising that her work is infused with the language of genetics.

open affection' (2013: 154) – which here might denote both the socialist medical system and the balmy tropical atmosphere – works to relieve her diffuse symptoms. But, on the other hand, Levins Morales's narrative equally taps the ancient topos of the tropics as a place of degeneration. This is already evident in her construction of her childhood years in Puerto Rico, which exposed her to both actual toxins (a consequence of the off shoring of unsustainable industrial agriculture following the American ban on chemical pesticides during the 1970s) and the 'toxicity of heterosexism' in Latinx culture (Levins Morales 2013: 4). But in Cuba, too, Levins Morales lingers on the pathogenic qualities of the climate when insisting on the debilitating influence of the oppressive summer heat and the risk of attracting tropical and other ailments as a result of the unhealthy food and poor hygienic conditions. Levins Morales intersperses her diary entries with comments about the unreliable wireless network, the lack of toilet paper and soap, and the failing air conditioning system. When a full septic tank makes the toilet in her room overflow, she is assigned another room only to discover that it 'is moldy, and so is each of the other available rooms' (2013: 129). She eventually decides to stay in her room while using a bathroom at the other end of the building that is unoccupied because of a broken air conditioner. In spite of its remedial properties, apparently, the tropical environment presents particular hazards for the chemically reactive.

Homi Bhabha's (1994) key contribution to cultural theory has been to show that ambivalence and hybridity constitute crucial ingredients of colonial discourse. The contradictory valuations of the tropics in Levins Morales's memoir, while it invites decolonial readings, can equally be interpreted as functional in hiding and sustaining (neo-)colonial power structures.[4] As Levins Morales (2013) herself notes, the health facility where she was in rehab is largely reserved for foreign patients who have the means to pay for such treatment. While it might benefit the Cuban economy, this sort of tropical health tourism inevitably reinforces disparities of wealth between privileged outside patients and the Cuban population. Levins Morales (2013: 123) does show some awareness of her complicity in such inequities, for instance when she notes that the price of lunch in a 'reasonably priced place with delicious food' in Old Havana 'turns out to be more than a month's salary in Moneda National' for local Cubans. At another point, she indicates doing 'our part for the current energy conservation campaign' by using a fan in her room rather than two air conditioners. During the day, moreover, she makes this fan available to the personnel in the kitchen, who 'are visibly wilting' (126). Overall, however, Levins Morales's narrative is too focused on her body's symbiotic relation with the tropical environment to truly register the ways in which her personal healing journey can be read as an effect of colonial impositions. One might even hypothesise that the surface rhetoric of connection with the landscape functions to prevent her from establishing such connections. This is not to deny the pertinence of Levins Morales's critique of the American health care system and of allopathic medicine in general, but rather that such a critique might very well co-exist with colonial practices.

As a result, Levins Morales's healing journey abounds with ambivalences. In several respects, the narrative of her Cuban 'restoration' follows the bildungsroman pattern or that of pastoral betrayal as identified by Buell: 'I have been chronically ill for most of my life', Levins Morales (2013: ii) states early on, 'though I didn't know it'. This suggests a clean

[4]For a reading of Kindling as a decolonial text, see Tai 2020.

break between a before and an after. During her Cuban residence, Levins Morales conscientiously marks key stages in her recovery process. 'This morning I walked 1300 meters!' she exclaims mid-way during the treatment (2013: 130). But even while she eventually ends up waltzing around the room during her final day at the health centre, the idea of a complete recovery appears as a continually receding horizon. Even during the treatment, moments of progress are instantly counterweighed with setbacks. Immediately after her triumphant 1300 metres walk, for instance, Levins Morales (2013: 130) injures her right foot and notes worriedly: 'I clearly have some sort of autoimmune condition, even if they don't yet know what it is'. The moment of enlightenment is still present here, but is projected into an indefinite future. Upon her return to the United States, Levins Morales (2013: 145) visits a Whole Foods store, where she experiences a new crisis moment: 'I feel sick, and dizzy and start sobbing right there in the aisle'. It is not so clear, however, what occasions this breakdown in Levins Morales's inverted captivity narrative. While she claims that the sight of 'an obscene overabundance of food' fills her with 'loathing for the blockade', she does not elaborate on what an end to the embargo would mean for the pastoral Cuban landscape where she sought refuge from the sickening influence of capitalism. Environmental health, therefore, seems less easily localisable than the narrative structure of the Cuba journey suggests. Arguably, it is such tensions that afford the fashionable disease of today much of their appeal.[5]

Conclusion

Although I have glossed over many interesting aspects of Levins Morales's narrative, my primary aim in the above has been to show that it is issued at least in part from an established tradition of health travel. Placing recent environmental illness narratives in such a tradition allows us to visualise the complex ways in which health discourse intersects with geopolitical arrangements. Historically, the conception of the body as a fluid entity has often served to reinforce, rather than counteract, colonial formations. This is an important observation, since recent medical humanities scholarship, in attempting to redefine the patient role and accord more agency to the chronically afflicted, tends to equate the ill body with the postcolony. Thus, in his influential *The wounded story teller*, Arthur Frank (2013: 10) argues that modern medicine 'claimed the body of its patient as its territory' in the same way as colonialism 'took over geographic areas'. Even if they should be read as loose analogies, such statements in my view obstruct a clearer articulation of the relation between non-dualistic ontologies and actual health practices and the modes of self-presentation attached to them. What the comparison between the two, otherwise very dissimilar tutor texts in this article brings out is that, contrary to what Alaimo and others suggest, a life-sustaining ethics does not necessarily emerge spontaneously from a receptive attitude towards the environment.

But the differences between the two narratives are no less revealing. Levins Morales's Cuban narrative is not merely a return to an earlier, ecological understanding of the body somehow forgotten by modern science. While identifying as a chronic invalid whose social standing depends on his 'peculiar sensitivity', the author of *A winter in the West Indies* had no word for disability, which only emerged during the latter half of the twentieth century in the

[5] I derive the phrase 'fashionable diseases' from Wood's seminal 1973 essay on nineteenth-century American women invalids.

context of modern labour relations and performance measures. Drawing on Robert Castel's work (1981), Paul Rabinow (1996: 100) has argued that the distinction between handicap and disease catalysed a new understanding of health, which shifted the focus away from therapeutics and towards risk prevention, and which promoted the idea of 'working on oneself in continuous fashion'. Insofar as it frames life as such as disabling, Levins Morales's memoir can be regarded as an extreme manifestation of this trend towards generalised risk and self-surveillance. I conclude by inserting the following vignette, posted on the author's blog in April 2010 and not included in *Kindling*, which might illustrate not only the open-endedness of Levins Morales's (2010) life story but also the serial symptomatology that accompanies the emergent identity formations taking shape in our biomedical age:

> After my return from Cuba in September, 2009, I enjoyed excellent health for several months, but was then exposed to a toxic level of mold in my apartment and became very ill. In April I was diagnosed with diabetes. In May it was a genetic liver condition, in June I learned I had antibodies to every single mold I was tested for, in July I tested positive for chronic Lyme disease and in August I found out I also have Bartonella, another tick-borne disease. In late June I had to leave my apartment practically overnight because I could no longer breathe there. I spent the summer camped out in various living rooms and offices while I tried to find that was chemically safe for me – free of natural gas, mold, carpets, new paint, smokers, scented laundry products, etc. In September I finally found a room in a house that's mostly OK for me.

In its skittishness and brevity – each month appears to bring a new diagnosis and a sudden insight into a defining chronic condition – this quotation reads as a condensed expression of the distinctive soteriology of the afflicted communities to which Levins Morales's memoir speaks. It articulates a vital politics commensurate with the new age of chronic illness: a politics of suspended agency, of continual motion and never-complete 'restoration', of 'mostly OK'.

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