WE'RE NOT IN CUBA ANYMORE:

NEGOTIATING BIOMEDICINE, RACE, AND *LUCUMÍ* RELIGION

IN SOUTH FLORIDA

A DISSERTATION ABSTRACT

SUBMITTED ON THE SIXTH DAY OF MAY 2022

TO THE DEPARTMENT OF ANTHROPOLOGY

IN PARTIAL FULFILMENT OF THE REQUIRMENTS

OF THE GRADUATE DIVISION OF THE SCHOOL OF LIBERAL ARTS

OF TULANE UNIVERSITY

FOR THE DEGREE

OF

DOCTOR OF PHILOSOPHY

BY

Eugenia Theresa Rainey

Eugenia Theresa Rainey

APROVED: _____

Adeline Masquelier ~~(Chair),~~ Ph.D.

_____

Sabia McCoy-Torres, Ph.D.

_____

Andrew McDowell, Ph.D.

ABSTRACT

This dissertation is about what happened when Afro-Cuban religions were brought to South Florida in the wake of the Cuban Revolution and the implementation of LBJ's "Great Society" initiatives. It charts how in the process of Cuban racialization into the amorphous "Hispanic" category (new at the time), power brokers in the community sought to regain their "white" status but were faced with the challenge of Afro-Cuban religion, a threat to regaining whiteness. As more Cubans immigrated to the area, media coverage of Afro-Cuban religions grew more and more hostile, frightening Cubans in the area. In order to address this complication some managed to reframe Lucumí, arguably the most visible Afro-Cuban religion, through the cultural competency paradigm initiated in the University of Miami, Department of Psychiatry. Afro-Cuban religions were described as a mental health network which helped immigrants manage the stress it took to adjust to life in the United States. For a biomedical audience, it is easy to read this as a temporary issue that would resolve itself. Yet Afro-Cuban religions in general, and Lucumí in particular, are thriving in the area decades later. This success is, in part, because of the religion's historic habitus of being both "seen and unseen" by the Catholic church and colonial authorities in Cuba, a habitus that transfers to biomedical institutions in the US. In the process of reframing Lucumí as a mental health care system practiced by Cubans, and depicting Cubans as white, despite the ethnic diversity of the island, imagery around Lucumí identity shifted: what was considered a "black-African" religion in Cuba, became a "white-Cuban" religion in South Florida. By charting how the effort to make Afro-Cuban religions visible and seen by biomedicine participated in reframing Lucumí identity in the wider social context, while examining how in quotidian experience the micropractices of the religion kept it in a comfortable invisible and unseen space within biomedical institutions, I explore religion as *negotiated* process.

WE'RE NOT IN CUBA ANYMORE:

NEGOTIATING BIOMEDICINE, RACE, AND *LUCUMÍ* RELIGION

IN SOUTH FLORIDA

A DISSERTATION

SUBMITTED ON THE SIXTH DAY OF MAY 2022

TO THE DEPARTMENT OF ANTHROPOLOGY

IN PARTIAL FULFILMENT OF THE REQUIRMENTS

OF THE GRADUATE DIVISION OF THE SCHOOL OF LIBERAL ARTS

OF TULANE UNIVERSITY

FOR THE DEGREE

OF

DOCTOR OF PHILOSOPHY

BY

Eugenia Theresa Rainey

Eugenia Theresa Rainey

APROVED:

Adeline Masquelier ~~(Chair)~~, Ph.D.

Sabia McCoy-Torres, Ph.D.

Andrew McDowell, Ph.D.

Acknowledgements

As I reflect on the years that have built the foundation for this dissertation, I am grateful to have found myself in such a welcoming and supportive environment. I would first like to thank my advisor and chair, Adeline Masquelier, for taking me on as an advisee. Coming to the game as a nontraditional student in the midst of raising four kids, I am sure that there were easier roads she could have taken. Over the past eight years she has provided me with thorough feedback and reflection on my work that has been a gift. In addition I must thank one of my original committee members Allison Truitt who has always had an open door to talk with me, an open eye to read drafts for me, and to share her insight. We didn't make it to the end of the process, but almost, and worth every bit. A hearty thank you to Sabia McCoy-Torres for being on my committee and coming to my aid in her fledgling moments at Tulane. She has provided thoughtful guidance and reflection to me from that point on. For the final member of my committee, Andrew McDowell, though you were the last to arrive, your contribution does not reflect that. Thank you for your pointed detailed feedback, thoughtful conversation, and for being a Foucault hotline. This dissertation has been shaped by all of you and all of you have my sincere gratitude. Any mistakes in this dissertation are my own.

I would also like to thank Bill Balee, Chris Rodning and Judy Maxwell for their assistance in this process. My sincere gratitude goes out to Suzie Chevalier, for providing support and problem solving that I am sure goes beyond my full comprehension. As well as Arachu Castro for being an inspiration and Mohan Ambikaipaker for providing me with inspiration. Also, a hearty thanks to Michele Adams and Carol Reese in the CCC program for the architectural insight. Guadeloupe Garcia for the historical perspective. And Laura Adderley for the opportunity to grasp a slice of the history of healing. I also must thank Marc Perry for his critical and frank assessment of much of the cultural landscape that I now chart. And a great big thank you to Ariana Hernandez-Reguant for being my academic commentator on location in Miami.

My thanks also go out to the classmates that I have been trudging through with for these past eight years. Lauren Dodaro who gave me my first Tulane hug. Borislava "Bobbie" Simova for support in teaching reviews, great conversation, and fun puzzles. Carrie Parris and Erin Patterson for all the writers groups and seasonal mailings. Rachel Horowitz for being a steady presence and good suggestions. Ayo Odiduro for emotional support, thoughtful reflection, and community drums. Jarrette Allen for laughs and tails from the Philippines. Olamide Eniola for the well wishes. Sarah Van Oss, Rachel Witt, John White, Alex Jurado, Rachel Johnson, and Rubén Moralés Forte for raising a glass. Matt Olson for having such an uplifting presence. Daniella Santoro for showing how it is done and being such an admirable and engaging scholar.

In my personal life, I would like to thank my life-line in the mommy carpool circuit, Brenda. Without the space our after school carpool arrangement allowed, I don't know how I would have gotten through grad school. I would also like to thank my long-time friend Cindy who has always been a more than generous presence in my life. Thank you to Gina and Marty, who have had my back and been a welcome part of my life these last twenty five years.

I would also like to thank the person that brought this about in an unexpected way. In the Spring of 2010, I was well into my third trimester with my fourth child. I received a message from a professor, Shannon Lee Dawdy, at the University of Chicago. She was doing research on tourism in New Orleans and wanted to talk with me about the ghost tours I performed. I had not spoken with an anthropologist in years, so I leapt at the opportunity. During our interview I was struck by how much I missed the discipline. While it would be four more years before I began graduate school at Tulane, that meeting set the ball rolling. I would like to thank Shannon for that.

To that end, I would also like to thank my undergraduate advisor Ralph Nicholas. Although it was roughly 15 years between you guiding me through my BA thesis and my starting graduate school, it clearly meant a lot to me. Fifteen years might seem like a long time to ponder a dissertation topic, but I have always found ideas come in their own time. Thank you to Russell Tuttle who remembered me well enough after fifteen years to help me with my application. I am grateful for the education I received at the University of Chicago as an undergraduate, I have no doubt that much of it is embedded in this dissertation.

I am also grateful to my college cohort who keeps the bonds strong. A big thanks to Rita and John, for their solid presence and reliable organization. To Sarah, to Kumie, to Carl, to Kurt, to Brendan, and to Chris for keeping the conversations going and providing me with many wonderful memories, even if I don't actually "remember" all of them.

Finally, I need to thank my family. My parents Carol and Peter Lowe, who have stood by me always, offering whatever support was called for in the moment, and cheering me on to the finish line. To my brother Sangode, for the insight and dedication. To my oldest brother David, for the thought. To my sister-in-law Angela for the salt-room. My nephew Laurencio for the charm. And to my wonderful husband Michael, who has sacrificed so much over these past eight years to see me through this grueling process. There is simply no adequate way to fully capture how much dedication it took, but he has really been my backbone through this whole thing. And to our beautiful children, Rhiannon, Sabah, Anusha, and Perrine. Eight years of your lives has been with mom in grad school, I suspect Anusha doesn't remember a time before and I am confident that Perrine does not. Nonetheless, I could never have done this without you. Each one of you has always been so wonderful, independent, and reliable that I have been able to manage graduate school and being your mom. It might seem like nothing, but it is a great big something.

And finally I must thank my padrino Odun and Oba Ikuro, *ibaé*. Paul & Nina for opening the door to Miami. My madrina, Eshú Alátilégua for all the support over the years and believing in me. Obá "Willie" Ramos for sharing his thoughts. And Obá Ernesto Pichardo for suggesting cultural competency to me in the first place. And last, but certainly not least, all of my *orishas,* and my *egún*, as well as my family in Lucumí.

This research was supported by a generous grant from the Reed Foundation's Ruth Landes Memorial Research Fund, the Tulane School of Liberal Arts Summer Merit Fellowship Award, the Department of Anthropology Graduate Student Fund, the Department of Anthropology COVID-19 Fellowship, and the School of Liberal Arts Dissertation Completion Fellowship.

TABLE OF CONTENTS

Introduction

December 17th is the feast day of San Lazaro, the Catholic saint of the poor and infirmed associated with the Yoruba *orisha* (divinity), Babalú Ayé. On East 4th street in Hialeah, Florida, stands the Rincón de San Lazaro Church with the accompanying *botanica* (occult religious goods store) *y* flower shop across the street. The *botanica* is in an unassuming single story cement building wedged against the sidewalk, characteristic of this working-class town adjacent to glittering Miami. Inside the *botanica* customers are greeted by a fiberglass life-sized statue of the old "African slave" spirit, also referred to as the "old *santero/a*." A common sight in *botanica*s across Hialeah, the old *santero/a* is often depicted as an elderly, slouched Black figure, with grey hair, sporting a straw hat or kerchief, wearing beaded *elekes* (sacred necklaces) and the simple lose white cotton, burlap, or gingham clothing commonly worn in Lucumí ritual. These figures are often understood to embody the spirits of enslaved people who kept various indigenous African religions alive and vibrant in Cuba, despite the brutalities of the Transatlantic slave trade and institutional slavery. Afro-Cuban religions are predominantly associated with the Yoruba, Kongo, and Ewe-Fon of West and Central Africa. In Cuba and the corresponding diaspora, they are known as Lucumí/La Regla de Ocha/Santería, Palo Mayumbe, and Arará. Lucumí is the most widely known of these religions and the subject of this dissertation. In the East 4th Street *botanica*, just beyond the "old *santero*" is a life-sized statue of San Lazaro, one of the most beloved *orisha* of the Lucumí pantheon. Standing

barefoot, an ornate purple brocade cape draped over his shoulders, a dog on either side, covered in sores, he gazes kindly at the customers.

While the *botanica* celebrates the widely popular Babalú Ayé, it must be acknowledged that the *orisha* are part of a divine community, and Babalú Ayé does not walk alone. If you look down, at Babalú Ayé's feet, you will see what appears to be an oddly shaped chunk of cement with cowry shell eyes and mouth, buried in a dish filled with coins, candy, and colorful small toys. He is Elegguá, the *orisha* who opens and closes the paths we take in life, both material and spiritual; nothing happens without him. Elegguá has two companions. Ogún lives in an iron pot nearby filled with railroad spikes, horseshoes, anvils, bellows, and any number of the iron tools and technologies that make civilization possible; he cuts the path through the wilderness. Not far from the iron pot is , Ochossi, the *orisha* of the hunt, who lives in a large earthen dish containing a rack of deer antlers with a stylized bow and arrow mounted on it. These three *orishas* are the warriors people receive as a set early-on in their religious experience to open their pathways and protect them. The warriors keep an eye on all who enter the homes and businesses of Lucumí devotees. Once customers have been inspected by these forces, they must strategically navigate the narrow aisles of the compact *botanica* to pick out the candles, incense, herbs, statues, and other religious materials they may be looking for. The ceiling is just arms-length above their heads. There are buckets of cut flowers everywhere. A glass check-out counter jets out slightly into the center of the small building, beaded jewelry and trinkets sit in the case below while hanging beaded necklaces cover the wall behind. If you look closely, you'll notice a door on the side wall leading into a small room set aside for private use, likely for divinations and religious consultation.

The *botanica* is painted the same royal purple as the loin cloth and cape commonly draped over the statues of San Lazaro, whose shrines grace numerous front yards throughout the town. This is probably to highlight the store's connection to the saint—as well as to the church across the street. A male figure, San Lazaro is usually depicted as white, though I have seen a few brown and black variations, all bearing a resigned expression, a hallo, bandages, and crutches. He is covered in sores that represent diverse contagious diseases, especially those associated with skin lesions, like smallpox and leprosy. As one of the most popular *santos* ("Catholic" saints) in Cuba and Hialeah alike, his feast day draws an enormous crowd for the midnight procession held at the church bearing his name. On that day, the *botanica* is open late so that people can buy the flowers and other accoutrements that they will bring to the church to celebrate.

In 2018, I attended the celebration of San Lazaro's feast day, parking a block or two down from the *botanica* in a residential area. The police had the street blocked off to vehicles to accommodate foot traffic. I was thrilled to have the opportunity to be a pedestrian in a town originally designed for car traffic and factory work, a town that boasted few sidewalks. The grounds of the church, a parking lot and outbuildings, had been transformed for the occasion: huge tents had been set up to accommodate businesses, including a vendor of statuary, and a food truck. Inside the church the change was equally dramatic, all the pews had been removed so people could move freely about the sanctuary. The back wall was covered in heavy plastic and bunches of flowers were propped up against it. As I walked toward the front to hand my bundle of purple flowers to the volunteers in bright yellow tee-shirts, I noticed that they moved quickly taking bundles from people, mostly purple varieties and sunflowers, and stuffed them into the

plastic wall covering hanging behind a larger-than-life-size statue of San Lazaro, two dogs at his feet, encased in Plexiglas. In front of me was a woman walking on her knees, her purple and burlap skirt dragging, her white athletic socks caked in dirt, everything about her presentation in conflict with her well quaffed hair and nails. Two men, one on each side, were assisting her, their arms locked in hers. All around me, I spotted people in the crowd wearing the burlap and purple clothing worn for the rituals of Babalú Ayé. They bought tea candles at the door, then wove their way through the milling crowd, trying to avoid bumping into small dogs on leashes and cradled in people's arms, finally making it to the altar to kneel and pray to San Lazaro for health. For as my *padrino* (godfather) always reminded me, "If you don't have your health, you don't have anything."

Outside, under a tent roughly the width of the church itself, was a stage with a San Lazaro altar and a densely packed audience before it. Many of the people taking up chairs wore the same purple and burlap, or purple and tan, outfits. At eleven pm three people descended the middle aisle and took their places on the stage: two Catholic priests in ornate robes with purple capes and a blond woman in a white robe. As people in the audience held up their cell phones, one of the priests began speaking in Spanish, unexpectedly slowly and deliberately. The other priest swung an aspergillum, sprinkling people with holy water, making his way around the audience. Once he was finished dousing the crowd, he too spoke, but in the fast-passed Cuban Spanish I was accustomed to hearing in Hialeah. After the mass, they turned to walk into the sanctuary. The woman in the white robe, wore platform stiletto heels which made her almost level with a large cockatiel perched on the shoulder of a young girl in ribbons and bobby socks standing

nearby. A classic mariachi band came out to entertain with "Cielito Lindo" and "La Guantanamera," punctuated with shouts of "Oye como va" and "*Viva* San Lazaro!" In the crowd Pomeranians, Chihuahuas, Pit Bulls, Huskies, and a spattering of lap dogs panted and wagged their tails. It is said that when San Lazaro the beggar was laying in the street covered in sores, dogs came and licked them. In Hialeah, and other parts of Latin America, dogs are important participants in the celebration of San Lazaro's feast day.[1]

Soon after the musical interlude it was time for the procession. People poured out of the church and the tent into the street, surrounding a float covered in flowers, a large statue of San Lazaro setting on top of the blossoms. The crowd from the church folded in behind a white van blaring Christmas carols alternated with the music of New Orleans marching bands. Behind the van were four women in elaborate nineteenth century ruffled dresses of shinny purple and burlap trim, their hoop skirts swinging about as they walked. On the back of their dresses were gauzy iridescent capes attached to poles that they manipulated so the capes moved like flowing butterfly wings. On their heads were purple sequence feather headdresses, with strings of lights woven in. The San Lazaro float lumbered behind, the bearers managing the weight of the statue on their shoulders. Two people with bull horns managed traffic at the cross streets and a small blond woman with a third bull horn led the way, singing to Babalú Ayé in the Lucumí language,[2] "BABA S'IRE S'IRE—OBALÚYÉ YÀN FÒ'MO LE—BABA S'IRE S'IRE" (Father does goodness, does goodness—The king lord of the world chooses to scrub the child healthy—Father does goodness, does goodness). Wherever I looked, there were people in wheelchairs, walkers, children in strollers, *iyawos*[3] (newly initiated into Lucumí) dressed in white, with white kerchief's below white hats below white umbrellas. Many people

carried statues of San Lazaro in their arms, including a little boy who held a statue half his size, and all over were people in burlap and purple, many of them barefoot, filling the atmosphere with cigar smoke, engulfing the San Lazaros in the mystical trappings of Lucumí.

On residential streets, people stood in their yards and came out on balconies to watch the procession go by. Some walked a few blocks with the crowd. One of the small two-story cement apartment buildings had an elaborate San Lazaro altar set up just outside one apartment door, shiny purple cloth with a white ruffled border, a statue of San Lazaro standing in the center. After a few blocks the procession stopped to say a prayer to Babalú Ayé, neighbors watching from front steps and through social media aps. When the procession reached the commuter train overpass, I noticed two women ahead of me carrying their Babalú Ayés, in his cowry shell *sopera* (the containers where the sacred *otones,* stones, of *orishas* are housed) hoisted on their shoulders through the crowd. Until then, the few other Black people I had noticed in the crowd were a handful of dark skin-toned women in white dresses and kerchiefs. Those women seemed apart from the crowd in their body language and carriage, and when they passed by me, I overheard them speaking French to one another. The two women carrying their Babalú Ayé *soperas* were more medium skin-toned and from their dress and body language, as well as their Lucumí religious paraphernalia, I took them to be Cuban like the rest of the crowd. I had my Elegguá in a small bag over my shoulder that I keep just for him since he travels with me all the time, but I was shocked to see that they had brought their Babalú Ayés to a crowded public event: he is such a shy, retiring *orisha*. In people's home altars, Babalú Ayé is shrouded in a separate area from the rest of the *orisha*, rarely visible. Should he

arrive to possess a person unexpectedly at an Añá *tambor*,[4] elders will try to stop the possession, running him off least the people in attendance should fall sick from the disease that accompanies him. The presence of this *orisha* at such an event was a new experience for me and I wondered what my late godfather would think. Was this part of the excesses of modern practice? Would the old people not approve? Or was it part of the natural variations embedded in Lucumí which is tailored to accommodate individual devotees?

Back at the church the float was set on a platform on the grounds and people continued to kneel to the statue and pray, sure to touch the hem of the purple cape. Across from the church I saw a man on his knees against a wall, a candle in one hand and another lit on the ground beside him. A young woman sat nearby on the street. As I walked back to my car, I noticed there was a line snaking around the block, people waiting patiently to "touch the hem of his garment."[5] I looked again across the street, the man who previously balanced on his knees was now pacing on the sidewalk, smoking a cigarette.

*****

Since the arrival of enslaved Yoruba people to the island of Cuba during the Transatlantic slave trade, Lucumí religious practice has had to be both seen and unseen. The spatial transition that occurs during the festival, from the institutional built space of the Catholic Church to the non-institutional Lucumí space of the street (and the corresponding transference from San Lazaro to Babalú Ayé), is a common framework in Latin America for Lucumí and a host of other religious traditions subsumed by colonial Catholicism. It is a common framework that has allowed colonized people to address practical and

critical everyday concerns, in this instance, healing. The relationship between the quest for healing and religious devotion is a long and sorted one. This dissertation theorizes one small piece of this history, namely what happened in the late twentieth century when Lucumí practice was transferred to Miami Dade county by Cuban exiles and intersected with a sea change in biomedical discourse in the United States where "culture" was acknowledged as a salient factor in the medical encounter that providers should be sensitive to. When processions pour out of the church onto the street and crowds begin to sing to Babalú Ayé, not only is the presence of Lucumí practice in Hialeah made evident, but the material reality of the spiritual is activated. When people walk on their knees to the Church, covered in caked dirt, they are not only doing penance, but also rendering the *orisha* immanent in the material world through action. Babalú Ayé too wandered in the wilderness, exiled and destitute until he attained salvation. Afro-Cuban religion infuses all layers of the social context in Hialeah, allowing the *orisha* to become immanent in the lives of devotees. In analyzing this slice of religious experience, I explore religion as *negotiated* process.

Immigrants to the US are soon made plainly aware of US racial ideologies through immigration policy, politicians, policing, business, media, education, and pop culture. Yet, immigrant groups are not blank slates; they too emerge with their own histories with which they interpret US ideologies. When waves of Cuban immigrants began arriving in South Florida after the 1959 Revolution, the US set about re-racializing them within the amorphous and marginalized "Hispanic" category, but power-broker Cuban immigrant groups pushed back, seeking to be racialized within the normalized and successful "White" category, as they had been on the island. A major complication in this

effort was Lucumí, a clearly African religion representing an island that was clearly racially diverse. To achieve whiteness in Miami, the religion, and Cuban identity on the whole, had to be reframed. This dissertation does not explain this process in its entirety, but focuses on one element, namely, what happened in the realm of biomedical pedagogy with the creation of the "cultural competency" paradigm. I argue that the hegemony of biomedicine welded through cultural competency education, which trained medical personnel to be sensitive to cultural differences, was an influential factor in the shaping of Lucumí identity and the "diasporic horizon" which Paul C. Johnson argues "guides diasporic religious actors in their efforts to derive ritual efficacy from spatial authenticity" (2007, 174-5). In this dissertation I enter in conversation with both the anthropology of religion and medical anthropology in order to better grasp how a religion often characterized as a product of old-world sensibilities is as much a product of modernity as the institutions, such as biomedicine, often used to mark modernity. Through the cultural competency paradigm implemented to deal with the influx of immigrants in the US, biomedicine participated in the re-racializing of Lucumí from a "Black African" to a "White Cuban" practice in South Florida. By tracing how the use of "culture" to improve healthcare for racial and ethnic minorities inadvertently "whitened" Lucumí, this dissertation participates in anthropological discussions of race and the political economy of racialization, as well as "lived" religion, and place-based medicine.

Lucumí is, in short, the worship of the *orisha*, a pantheon of divinities that originate in Yorubaland which spans current Nigeria, Benin, and Togo. Lucumí also includes respect and honor to the *egún,* a person's ancestors, who must be acknowledged before the *orisha.* It was brought to Cuba during the Transatlantic slave trade and thrust

into a diverse spiritual landscape including the religious traditions of other ethnic groups from west and central Africa, Indigenous traditions from the Americas, as well as occult practices from Europe, in addition to Catholicism. The Church sponsored *cabildos* (fraternal organizations), segregated by ethnic group and dedicated to a specific Catholic saint. The official intention of the Church was to educate members about Catholicism, specifically the saint in question. In practice, the *cabildos* functioned as a perfect place for Afro-Cuban religions to flourish. While there is no official number of *orisha,* people usually claim there are four hundred *and one,* a reminder that it is a multitudinous mystery. Devotees interact with different *orisha* by visiting them in those places where they intersect with the material world, the places sacred to them, like the crossroads for Elegguá or the river for Ochún. A person can also communicate with different *orisha* through the ritual objects that they embody, or during a ritual possession ceremony. A person who has gone through the first ritual of Lucumí, entering the community through receiving *elekes,* can then learn who their tutelary *orisha* is, often colloquially referred to as a person's guardian angel or *santo*. This information may provide some insight into a person's personality but, more importantly, it situates the divine relationships a person has in their life, providing a sense of touch, and a source of guidance. In sum, it gives texture to Lucumí spiritual ontologies. Lucumí is structured to help people follow and manage their unique destiny; it is through living in the world and with other beings, seen and unseen, that the most fully realized self is possible.

Over time it has become clear that the social changes made possible through modernity have not rendered religion irrelevant. As the popularity of San Lazaro feast day celebrations attests, religious practices of all sorts have remained salient in modern

life. The San Lazaro procession is not an anachronism; it is a part of modernity. Illness and the search for healing often lead to the intersection of religion and medicine, highlighting not only how religion remains salient, but also how biomedicine must interact with local religiosities. While we often think of biomedicine as a standardized practice, in fact, the social determinants of health inevitably vary by location, forcing place-based approaches onto biomedicine. The healthcare infrastructure is often where individuals interact with the state and consequently the body becomes a site for gauging political and social legitimacy (Brodwin 1996; Masquelier 2001; Ong 1995; Petryna 2002; Street 2014). To this end, this dissertation seeks to elaborate on the relationship between biomedicine and the social power dynamics faced by Lucumí devotees in South Florida.

Hialeah, the Mariel Boatlift, and the Diasporic Horizon

The feast day of San Lazaro intertwined with devotion to the *orisha* Babalú Ayé highlights the thick presence of Lucumí in Hialeah. Throughout the city, there are numerous Cuban mom-n-pop businesses housed in single-story commercial strips along busy streets, among them are numerous *botanica*s serving the Lucumí community. Some *botanica*s sell strictly religious goods. Others are *botanica* "y" pet shop while yet others are *botanica* "y" hardware, 99-cent store, or flower shop. Their presence in the area facilitates the practice of multiple Afro-Cuban religions which are animistic, reliant upon sacred stones embodying different *orisha*, and consist of numerous rituals, most of which require a great deal of paraphernalia ranging from powders to wooden sticks, to sacrificial animals, and so on. As Martin Holbraad (2012) highlights, much of the work

of Lucumí is seeking ontological truth.[6] The *orisha* are made immanent through religious practice, divination, rituals, and so on: the materials are essential to this process. Most of those who practice Afro-Cuban religions in the area also consider themselves Catholic. Cuba, a Spanish colony for four hundred years, only gained "independence" (though many would argue it was not true independence but transferred to the neo-colonial US) at the end of the Spanish-American War in 1898. In the Spanish colony, Catholicism was state sponsored. Today the sense of a sort of Catholic "inevitability" remains salient. As the celebration of the San Lazaro feast day suggests, for many though certainly not all Cuban Americans living in the Miami area, Afro-Cuban religions, especially Lucumí, are considered another form of Catholic expression.[7] For some in the African American community, this is seen as deference to white colonial European oppression and it is a sore spot in relations between the African American and Cuban American communities of Lucumí devotees. In this respect, the African American position supported being "seen" by the powerful as practicing an African religion, while the Cuban American position supported being seen as Catholic and unseen as practicing an African religion.

Rincón de San Lázaro is named for the church dedicated to San Lazaro in the Rincón suburb of Havana where there is a parallel celebration on the saint's feast day, December 17th. Hialeah, adjacent to Miami, is the focal point of this fieldwork, although, given the spread-out nature of the area, research took place throughout Miami-Dade County. When it was founded in 1925, Hialeah was envisioned as a playground for the wealthy, featuring among other things, the Hialeah Park Racetrack which powerful business leaders and politicians visited. Yet, by the time Cuban exiles began moving in after the 1959 Revolution, it had been refashioned into an industrial working-class white

Anglo-American town populated by World War II veterans benefiting from the GI bill. In particular, it had been redesigned to accommodate factory work. Today the houses are mostly modest one-stories, made of brick or cement block and covered in stucco, as if hunkered down to withstand hurricane force winds. Hialeah Park Racetrack sits overgrown, derelict and empty, while 22 percent of the less than 225,000 residents live below the poverty line (2020 US Census). Since 1983, Latin American immigrants have been in the majority in Hialeah, Miami-Dade's second largest city. By the 2000 census Miami-Dade County was 60 percent Latino, with 600,000 Cubans, the highest concentration of Cubans in the US (Stepick et al. 2003).

Cubans arriving in Miami in the wake of Fidel Castro's rise to power quickly established themselves in business and local politics. At the time, the local Anglo-American power structure expected them to assimilate into the area by learning English and "earning" a place in the white power-structure. Instead, with the generous assistance of benefits from the federal government, Cuban exiles established their own businesses, business organizations, and banks, soon refashioning Miami into the de-facto capital of Latin America (Stepick et al. 2003). In this ethnic enclave it was possible for a person to succeed without learning to speak English. For many in the African American community, Cubans were so uniformly and overtly anti-Black that community leaders preferred to deal with white Americans in negotiations aimed at increasing African American participation in the local economy (Stepick et al 2003, 82). Economically and politically successful in Miami-Dade County, supporting anti-Communist policy and separating themselves from the local African American population as so many immigrant groups before them, even though the many benefits they enjoyed were due to the hard-

earned successes of the Civil Rights movement, white Cubans in Miami felt that they had been accepted in the United States.

This understanding was shaken in 1980 when the third wave of Cubans arrived in Miami with the Mariel Boatlift. Prompted by a downturn in the Cuban economy, numerous Cubans sought asylum at the Peruvian embassy. When Fidel Castro announced that anyone who wanted to leave could, Cubans in Miami began chartering boats to sail to Cuba and retrieve family members. Yet, when the boats arrived at the port of Mariel, they were forced to load numerous "unwanted" others that Castro claimed were criminals or mentally ill. The US backlash was swift. Between April and October of 1980, roughly 125,000 Cuban refugees arrived in Miami (Stepick et al 2003). This wave was the most racially diverse wave of Cuban immigrants to the US, problematizing the white image of Cubans, the Latinx group most likely to identify as white (Aja 2016). Despite the stigma faced by the exiles from the Mariel Boatlift, only a fraction of them stemmed from the prison system. Castro's goal was to portray them as degenerates, but of the 125,000 only 1,800 were convicted felons. Many of those were convicted of political "crimes" to do with activity considered against the Revolution. Still, the stigma and racial bias held toward this black and brown wave (upwards of twenty percent of the group was considered non-white) effectively hurt the prospects of these exiles as the established Cubans in South Florida refused them the benefits of the ethnic enclave that earlier immigrants enjoyed. Many of the exiles were young men without families. Since they were not able to gain sponsors in the US, it was nearly impossible for them to start a new life (see Gosin 2019; Grenier and Moebius 2015).

In the years that followed, Afro-Cuban religious practice became bound up in Cuban identity in Miami in ways it had never been on the island. This moment in history pushed a new "diasporic horizon" onto devotees of Afro-Cuban religions (Johnson 2007). This expression "connotes both a spatial edge of longing or nostalgia and a temporal edge of futurity and desire" (Axel 2004, 27, 40). Among Garifuna immigrants in New York City, Johnson observes that the spatial edge of longing or nostalgia in spiritual ontologies shifts. In Central America that gaze falls to St Vincent, the Caribbean island where the Black Caribs, descendants of enslaved African people and ancestors of the Garifuna people originated. But for immigrants to NYC, over time that gaze shifts away from the Caribbean toward Africa aligning with US racial ideologies as Garifuna people are racialized as Black in the United States, not Hispanic. As African Americans joined the Lucumí community, they sought a focus on Africa, not Cuba. Some Cubans in the US took umbrage, insisting on a Cuban focus, bound up in nostalgia for the island and reflecting the Cuban racialization in the US as Hispanic with a strong nod toward white in the US.

In this way "diasporic horizon" helps to incorporate the longing of Cuban exiles in Miami and their expectation of a quick return to the island into the analysis of what later melts into nostalgia for a past believed to be more authentic as "religious power is acquired through the perceived fidelity of actions done here to the ones done there; there in the direction endowed with 'mythical feeling value'" (Cassirer 1955, 85). In Cuba, Afro-Cuban religions, often referred to simply as *brujeria* or witchcraft, were associated with people of African descent and lower-class European descent people. When mid-twentieth century anthropologists like Fernando Ortiz studied these religions, they did so

as examples of Melville Herskovits's "African retentions" (Herskovits 1941; Ortiz 1947). These religious practices were evidence of strong African influences in Cuba, and though there was undeniable white participation, there was also a great deal of racial bias and stigma directed toward these practices. Many of the white Cuban Americans I have spoken with over the years reference their grandparent's disparaging attitudes toward Lucumí on the island as something that "Black people did." In Miami after 1980, Lucumí became something that "white people do," gaining widespread acceptance.

If we follow Herskovits's concept of "African Retentions," the diasporic horizon of early twentieth century Cuba is on Africa, conceptualizing Afro-Cuban religions as Black and African. In Miami we see that horizon shift with Cuban immigration to the island of Cuba as the "source" of the religion, re-conceptualizing Afro-Cuban religions as white and Cuban. By extension this notion conceptualizes Cuba as a white country, leaving a deep disjuncture, the absence of Black Cubans, a large part of the island's population and without whom the religion would not exist. While there was evidence of Afro-Cuban religious practice from the beginning of the Cuban enclave, it was heightened dramatically, and made visually explicit, especially in relation to animal sacrifice, in the wake of the Mariel Boatlift (Sandoval 2008). News organizations like the *Miami Herald* began to run hostile coverage of Cubans overall, using the spectacle of Afro-Cuban religious practices full of dramatic blood, sticks, and leaves, as a lynchpin. This hostility left established Cuban immigrants fearing for their reputation, the continuation of generous aid from the US government, and at times their physical well-being. Afro-Cuban religious practice had become an American spectacle.

The Origins of the Miami Model of Cultural Competency

As the first and second waves of Cuban immigrants were arriving in Miami-Dade County, the US government was starting an ambitious effort to end poverty and racial injustice. In 1964, President Lyndon Baines Johnson announced his domestic agenda, which was thereafter referred to as the "Great Society." This agenda would fund a set of domestic programs aimed at improving education, urban and rural poverty, transportation, and medical care. US policy makers were experimenting with ways to improve healthcare distribution and outcomes, especially mental healthcare which was very much limited to elite circles. Policy makers and program designers were encouraged to decentralize healthcare and create community health centers tailored to neighborhood ethnic groups, shifting from institutionalism to "short-term stays, outpatient medication, and culturally sensitive and tailored treatment at many community mental health centers" (M. Good, Hannah and Willen 2011, 6). The cultural competency paradigm was created as part of the effort to provide "culturally sensitive and tailored treatment" to marginalized populations. Its goal was to get biomedical providers familiar with cross-cultural narratives to improve communication between providers and patients leading to more successful healthcare outcomes (Castaneda 2010; Leininger 2002). This effort was spearheaded by psychiatry departments but bled into other areas of medicine. As Arthur Kleinman (1988) noted, communication in the medical encounter succeeds when people share cultural idioms and fails when they do not.

Bringing culture into the domain of biomedicine was an important shift in discourse, given the fact that culture is often important to effective clinical treatment (Kleinman and Benson 2006). Unfortunately, there were problems with the fundamental

premises of the original cultural competency paradigm, the most critical of them being that something as complex, nuanced, and fluid as culture could "be reduced to a technical skill for which clinicians [could] be trained to develop expertise" (M. Good 1995). Culture was understood as a set of characteristics that bounded and contained communities possessed. Each culture was isolated from the other, each person a member of one culture as opposed to embedded in multiple ones, and the notion that mental illness expresses itself differently given racial and ethnic groups (M Good, Hannah and Willen 2011). Today, anthropologists have argued that far from mitigating cultural misunderstandings, the cultural competency paradigm deepened them by reducing culture to a laundry list of ethnic stereotypes which fundamentally misunderstand culture and cast it as something that minorities have and healthcare providers lack since they are "modern" (Carpenter-Song et al. 2007; Castaneda 2010; Guarnaccia and Rodriguez 1996; Hirsch 2003; Holmes 2013; Kleinman and Benson 2006; Taylor 2003). The cultural competency model relies on the notion of acculturation which is problematic because: 1) it assumes that everyone is coming from the same space of "foreignness"; 2) it also assumes that people can be reduced to cultural stereotypes; 3) it is reductionist, ignoring the socioeconomic structural factors critical to health and access to healthcare; 4) it further assumes healthcare is necessarily better in the host country than in the immigrant's country of origin; and 5) it ignores life habits in the old country and does not look at a whole life top to bottom. In addition, efforts to be "culturally sensitive" can backfire with healthcare professionals providing incomplete information or inadequate care to patients based on their assumptions about patients' worldview or perceived ethnic background (Castaneda 2010, 13-14; Hunt and de Voogd 2005; van Rynn 2002). Finally,

the concept of culture did not extend to the domain of biomedicine: patients had culture, doctors had science. This dissertation traces the failures of biomedicine's use of culture through an ethnographic focus on the cultural competency model produced to train doctors to be culturally sensitive to Cubans.

The 1960s' programs of the Great Society were intended to educate doctors on the dynamics of different cultures with the expectation that this would lead to more effective doctor/patient interactions at community clinics, eventually ending inequality in healthcare outcomes. Given the number of Cubans in the area, they were considered one of the ethnic groups biomedical practitioners should be familiar with. Medical anthropologists in the Department of Psychiatry at the University of Miami medical school set out to produce the research that would develop into the Miami model of cultural competency. By shinning a light on Afro-Cuban religion as part of the effort to familiarize biomedical practitioners with the cultural idioms salient in the Cuban community, the project contributed to naturalizing Afro-Cuban religious practices as a part of mainstream Cuban identity (Beliso-De Jesus 2015). As such, it gave practitioners of Afro-Cuban religion the tools they needed to carve out a legitimate space for their practices in US society. This dissertation follows religious leaders and allies, such as Oba Ernesto Pichardo who has been active in religious scholarship and activism. When the mayor of Hialeah, in an effort to erase Afro-Cuban religious practice in the Cuban community, led the city council to make animal sacrifice illegal, Pichardo sued, taking the case all the way to the Supreme Court and winning in the 1993 Supreme Court case "The Church of the Lukumí Babalu Ayé v the City of Hialeah." After years of harassment within the Cuban community, and outside of it, including frequent police

action, this was a major victory and Lucumí devotees took a sigh of relief. Thereafter, Pichardo worked for many years to educate future nurses and other healthcare professionals to the world and values of Lucumí, sensitizing them to the needs of Lucumí patients (Pichardo 2017).

The first two waves of Cuban immigrants were mostly white, and quickly adopted anti-Black attitudes, including toward to Afro-Cuban religions. These attitudes fit not only with the white-Anglo[8] power structure of Miami, but also with Cuban racial attitudes on the island and a political narrative that argued the Revolution was fought for Afro-Cuban people. In this narrative, Afro-Cubans were conflated them with communism and blamed for the "loss" of the island. Some Black Cubans migrated to South Florida, but few stayed very long, feeling disenfranchised from the benefits of the ethnic enclave by their white fellow Cubans. Many more were encouraged by US immigration policy to immigrate to urban areas of the northeast (Aja 2016; Hay 2006). Today Cuban identity in Miami-Dade County is largely white, in contrast to Cuban identity in other parts of the US where immigrants settled. The paradoxical popularity of Afro-Cuban religion and its embeddedness in a white Cuban American identity requires a thoughtful examination of the historical and sociocultural factors that contributed to it.

Power in the Creation of Religion

Talal Asad (1993) asks us to consider how power creates religion. Asad's discussion is framed by the history of anthropology and colonialism; he considers it incorrect to portray colonized, subaltern groups as helpless under the weight of colonial forces. Colonized people resist, successfully or not, and their agency is worthy of

anthropological analysis. Adapting to the circumstances in which you find yourself can also be an act of resistance, like an enslaved person dragging their feet in performing tasks for their enslaver. As Michel de Certeau (1984) observes, the colonized "chip away" at the power structure used to control them by using that structure in unsanctioned ways. Folk Catholicism is one illustration of this, as people marginalized by colonialism resist by worshiping an indigenous divinity understood to be disguised as a saint and therefore unrecognizable by the Catholic Church.[9] It is nevertheless important to note that, according to Robert Nodal and Miguel "Willie" Ramos, this is not a matter of disguise but of *ashé*, the power that flows from Olodumare through the orisha and through all things, including images of saints associated with orisha. It is not a matter of Santa Barbara being a false front for Shangó, but Santa Barbara sharing in the *ashé* of Shango (2005). The Catholic power structure is left to see and unsee as it chooses.

But is this "agency" tantamount to "subjectivity"? Asad does not think so. If so, then what does it mean to make your own history (as history is central to the project of Western modernity as Michel-Rolph Trouillot (2003) argues)? Asad does not consider simple adaptation to be a conscious making of history because, in large part, it is instinctual. Yet these acts of instinct are still enormously important. As he notes, "One does not have to subscribe to a full-blown Freudianism to see that instinctive reaction, the docile body, and the unconscious work, in their different ways, more pervasively and continuously than consciousness does. This is part of the reason why an agent's act is more (and less) than her consciousness of it" (1993, 15). The importance of consciousness has been exaggerated by scholars, leading to a dichotomous framework "that takes consent and repression to be two basic conditions of political domination"

(1993, 15). Asad wants us to turn our attention to the "*structures* of possible actions" that are separate from consciousness (1993, 15). Ultimately Asad concludes that an "agent" of history should be addressed independently from a "subject" which we define as having a critical "consciousness of self" that an agent, who is inevitably operating largely instinctually, does not (1993, 16).

Clearly the space between agent and subject leaves a great deal of opportunity for slippage. I would argue that over the course of a day, most of our actions are route, which relies more on instinct than conscious thought, yet bits of conscious thought will enter that process. Those route actions are largely shaped by the "social warrant" in which we live, which George Lipstiz defines as "a widely shared and generally understood definition of what is permitted and forbidden in society" (2006, 454). Our social warrant is often a product of historical and social forces that structure our actions. A notion that is "widely shared and generally understood" must exist within some level of ambiguity. It is in spaces of ambiguity where slippages are possible and where attention to what is "seen" and "unseen" within a sociocultural context is critical According to Asad, colonial powers, far from uniformly enforcing homogeneity, as some scholars have argued, allow for ambiguity. According to Stephen Greenblatt (1980), these powers rely on "improvisation" to maintain power; ambiguity creates the circumstances that allow for improvisation. It was only through improvisation that powers could progress toward the goals that they were invested in. In Western discourse, the West is portrayed as a force of modernity creating change moving forward to an infinite horizon. This identity has relied on the foil of non-western peoples, and practices like Lucumí, as the opposite, either refusing to move forward or worse, moving backwards (1993, 18).

Ambiguity allows for creativity, innovation, and "improvisation," which Greenblatt describes as "the ability both to capitalize on the unforeseen and to transform given materials into one's own scenario" (1980, 225). The late twentieth century in South Florida was a time of intense transformation where the discourse of the West was central to US foreign policy, namely the US government's narrative during the Cold War that it was the promise of a future for all those that abandoned communism for democracy. Cubans who adopted this narrative and left the island for the US were given enormous benefits by the US government, benefits that far exceeded those extended to other Caribbean or Latin American immigrants. The first two waves of Cuban exiles to land in South Florida soon created trade unions and businesses, participated in local government (Stepick et al 2003) and were invested in incorporating the Cuban community into the "mobile powers that have constructed its [the West's] structures, projects, and desires… religion, in its positive and negative senses, is an essential part of that construction" (Asad 1993, 24). It should not come as a surprise that some of those actors functioned on behalf of Lucumí religion, especially when public perception, with the help of local media coverage, began to stigmatize Lucumí (already stigmatized on the island) and conflate it with Cuban identity. Biomedicine is one domain of Western power; it indexes the presence of "modernity." When the discourse of biomedicine adopted the notion that medical care would be improved if providers were "culturally competent" in relation to specific ethnic groups, an opening was created for Lucumí and biomedicine to intersect in this historical moment. The "authoring process" (Asad 1993, 43) of incorporating Lucumí into the Miami model of cultural competency is one of creating meaning, but

what is the relationship between this meaning and the socio-historical experience of those practicing it? And who are the "authors"?

Actors in the Creation of Afro-Cuban Religion

Stephan Palmié (2013) argues that what we refer to today as "Afro-Cuban" religion is not the retentions of a bounded autonomous system, as Melville Herskovits and his generation of scholars conceived it, but in fact a sociohistorical product, the coming together of agendas—religious practitioners and academics—and the exchanges between them. This position highlights the role of individual actors in the creation of the practice of Lucumí today, what I refer to as religion as *negotiated* process. Adeshina, a Yoruba *babaláwo* brought enslaved to Cuba in the nineteenth century, and Fernando Ortiz, a white Cuban scholar who wrote extensively about the island in the first half of the twentieth century, are two such actors that negotiated the creation of what we refer to today as Afro-Cuban religion. In theorizing the sociohistorical construction of Lucumí, Palmié asks that we look at the specific details of the context: "…did their agency set into motion a train of cultural developments we might be better off studying in their proper local and historical contexts rather than referring it to ready-made solutions suggested by the ethnological trait-lists of a time-less "Yoruba culture" sprung from the latter-day anthropological (and native) imagination" (2013, 47)? If we follow Asad's question of how power creates religion and Palmié's argument that sociohistorical actors are central to this creation, then, as Palmié suggests, we must look at the landscape of power in the sociocultural context that these actors negotiated, in colonial Cuba as well as late nineteenth century South Florida.

To conceptualize the choices that Adeshina made as he was forced to refashion his religious traditions and body of knowledge to fit within a new and largely hostile sociocultural context, we must take into account his positionality in nineteenth century Cuba. Made a *babaláwo* in Nigeria, then enslaved, he was part of a large wave of Yoruba people brought to the Americas at the tail end of the Transatlantic slave trade when the *alafin* (king) of Oyo passed away and a power struggle ensued. According to oral history, the respect and admiration he enjoyed was such that when he arrived in Matanzas in the nineteenth century he was immediately recognized and people soon gathered together the money to buy his freedom so that he could continue his religious work. In Cuba, he, like many other Yoruba people, began to identify as Lucumí, from the Yoruba[10]greeting "*oluku mi* "my friend" (Murphy 1988, 27). [11] Lucumí is not an ethnic group in Nigeria, but in Cuba the word took on new meaning. Adeshina is also responsible for the establishment of the influential *Cabildo Lucumí Santa Bárbara* (Ramos 2003). The *cabildo* system in colonial Cuba was a system of fraternal social organizations, divided by ethnic group and language, dedicated to a specific Catholic saint. The goal of the system was to educate enslaved and free people of color about Catholicism by teaching them about specific saints. The ethnic segregation was also intended to maintain separation between groups, to avoid organized rebellion. What it did, in effect, was create the social context for Afro-Cuban religions to flourish.*[12]* Adeshina petitioned the Cuban government for permission to hold a public *tambor* (drum ceremony) to Santa Bárbara, the saint aligned with the *orisha Shango*, patron *orisha* of Oyo, Nigeria. When he petitioned for the right for a public ritual to "Santa Bárbara," he claimed his right as a Lucumí person, a new ethnic identity recognized by the Cuban government (Palmié

2013). The sociocultural context influenced how ethnic identity was conceptualized as well as how religious practice was negotiated.

Fernando Ortiz, who is largely credited with originating Cuban scholarship in Afro-Cuban religions, began his career framing Afro-Cuban religions are inherently criminal, then completely shifted his outlook to sincerely document them ethnographically (Brown 2003, 3). According to Palmié, Ortiz played a central role in the production of Afro-Cuban religions for scholarly analysis. In Ortiz's theory of *transculturation*, he illustrates that cultural influence is not simply a matter of the subordinate group blending into the dominant group— African traditions blending into "superior" European traditions, an effective erasure—but of a blending of cultures from both groups creating a new whole. This theory highlighted his position that *cubanidad,* this ineffable essence of being Cuban, was not "the endpoint but the essence of the processes to be equated with hybridity in the sense of a consummated synthesis. To be Cuban was to be in flux; to share in a condition of instability; to be always on one's way to a novel prediction" (Palmié 2013, 97). This representation of *cubanidad* is beautifully expressed in Lucumí practice by Ortiz's estimation. In Hialeah, this practice has been negotiated once again, not through *cubanidad* but through the lens of US racial ideologies and part of the process of this negotiation occurs within the gaze of biomedicine and the navigation of healing.[13]

Late-Twentieth Century Actors Negotiating Religion

The intersection of biomedicine and Lucumí situates these events squarely in late-twentieth century modernity and renders them distinct from the events Adeshina and

Fernando Ortiz were navigating. In the early twenty-first century transnational identities and the influence of modern technologies like video, the internet, and the ease of international travel have entered into religious discourses and ontologies as well. Aisha Beliso-De Jesus (2015) highlights the complexities of religious networks that span from L.A. to Sweden to Havana to New York to Matanzas and yet at the same time can be said to exist as a unit through the concept of copresences the "spirits, deities (oricha), priests, video technology, and religious travelers that operate in contemporary transnational networks as active spiritual agents" (2015, XIII). Beliso-De Jesus draws "on assemblages (landscapes, diasporas, racial, sexual, and national scapes) to explore the intensities and affective economies of religious feeling through copresences" (2015, 13). Such discussions illustrate the dramatic changes that have occurred in the social contexts where Lucumí exists and the shift in meaningful analysis that follows. While there is certainly a relationship between the "agency" of actors like Adeshina, Ortiz, and Beliso-De Jesus and the "cultural developments" that they navigate and those that this dissertation tackles, the "local and historical contexts" at play in Miami-Dade County in the late twentieth century bear their own unique qualities and actors.

As the Cuban ethnic enclave in Miami-Dade County grew, it was inevitable that medical anthropologists at the University of Miami School of Medicine, in the Department of Psychiatry, would decide that they needed to bring in socio-cultural scholars who could specifically address Cuban cultural idioms specific to the Miami area. These academics would produce ethnographic research, creating scholarly literature to build bodies of knowledge, outreach in the community, and speaking engagements. Central to the Miami model was the "cultural broker," a cultural representative in the

neighborhood clinic to act as a liaison between patient and healthcare provider (Lefly and Bestman 1991; Sandoval and de la Roza 1986). At times this exchange would extend to the "indigenous healer," whom the cultural broker would ask for assistance with a difficult patient, often maneuvering the weight of the spiritual social world to encourage a recalcitrant patient to participate in clinical treatment (Sandoval 1979; Sandoval and de la Roza 1986).

The cultural competency literature developed to educate doctors in Miami also had to manage US racial ideologies which racialized Cubans into the relatively new category "Hispanic" and facilitated the erasure of Afro-Cubans. In the US black people are not seen as Hispanic. In many Latin American countries, with the exception of Cuba and Brazil, black people are present but written out of the national narrative. Yet in the literature, the effort to racialize Cubans as de facto White, by virtue of not being Black is evident, and tenable, especially in the historical moment, in a country built on a racial binary and still messing out what the amorphous category of "Hispanic" meant. While the Cuban population of Miami arguably was white, the population of the island was not.

What especially stands out in the literature on Cubans is the slippage into the term "Hispanic," which is then contrasted strictly with what the authors refer to as "White Americans," "mainstream Americans," and the "White-American middle class" described as: 1) focused on the future (as opposed to "Hispanics" who are focused on the present); 2) mastering nature (while "Hispanics" consider themselves subjugated to nature); 3) individually oriented (versus "Hispanics" family focused); and 4) focused on personal change and betterment (in contrast to personal acceptance and the mitigation of problems in the "Hispanic" community) (Sandoval and LaRoza 1986). The literature almost

completely erases African Americans from the discourse with two exceptions. Sandoval inserted a note about "Santería" not being a messianic movement like "some American Black sects" (1979, 138). This comment was deemed necessary to provide a parallel analysis between an African Diaspora practice in Cuba and an African Diaspora practice in the United States (including followers of Daddy Grace, Father Divine, or Louis Farrakhan). But in doing so, Sandoval also absorbed the Afro-Cuban community into the wider Cuban community, erasing it even as it distanced the Cuban community from the African American community. He also makes one brief mention of the "deculturating" effect of slavery (Sandoval and LaRoza 1986, 178). This contrasts with the endurance of Hispanic culture despite their alienation from the "dominant culture."

This strange disassociation between slavery and "Hispanic" culture overlooks the fact that Lucumí is a system born out of slavery and that it is unsurprising that such a religious system should exist in the Caribbean and Latin America given that a large majority (95%? See Curtin 1978) of those enslaved in the Transatlantic slave trade were brought there as opposed to the US. Why was institutional slavery "deculturating" in the US and not in Latin America? Furthermore, does not the existence of messianic movements among African Americans disprove "deculturation" altogether? Or is culture being treated as something "pure," a "hard" pathological quality requiring uncovering within a racialized group? Rather than the shared knowledge and memory constantly growing and being reproduced in new incarnations through social activity within a community? As to the racial diversity of the Hispanic population (the researchers do acknowledge that the term "Hispanic" is problematic given it reduces a complex diverse group of nations into one homogeneous group), this is described as a "color spectrum,"

the result of a "mixture" of Mediterranean, Indigenous, and African genes, rendering a "highly colorful palette," which is also complicated by socioeconomic differences and by contrasts in rural versus urban backgrounds (Sandoval and LaRoza 1986). This "colorful palette" is consistent with the multiracial, monoethnic ideology of Latin America (Palmié 2013). But it also flattens a highly textured picture, erasing the complex and diverse racial history of Latin America in general and silencing any potential discussion of existing social inequalities in relation to race (Ayorinde 2007; Wade 1995).

The refugee policy of the US government mirrored and was designed to recreate the racial and class dynamics of Cuban society (Aguirre 1976; Dixon 1988) and protected white Cubans from being as harshly racialized as so many other Latinx groups were. Still, this protection was not absolute. Cuban immigrants had accents, many had trouble speaking English. As a consequence, they were associated with people from other parts of Latin America. Alan Aja (2016) argues that to "regain" their whiteness in the US, white Cubans sought to disenfranchise the Afro-Cubans within their Cuban ethnic enclave. Through their performance of whiteness, they effectively illustrated their alignment with US racial ideology as evidenced in social policy and structural inequality. According to Monika Gosin, "attempts by marginalized groups to secure status as *true* Americans can reinscribe white racializing frames" (2019, 13, my emphasis). This strategy is consistent with other immigrant groups struggling to vie for position in the US. Aihwa Ong (2003) argues that much of the "moral" expectations set for immigrants in order to earn a place in the US, the characteristics necessary for belonging, are in fact cultural White Anglo-Saxon Protestant values like autonomy, "freedom loving," hard-working, and law-abiding. I would add to this list, "white models of religiosity" (Pérez

2015, 77). It is also important to keep in mind that Ong's framework, does not address solely White Anglo-Saxon Protestant values, but middle-class urban industrial ones as well: poor white people are not included here. Nonetheless this framework institutionalizes white supremacy and forces immigrant groups to fight amongst one another for success in the US. White Cubans faced the challenge of language and US-style racism; these are challenges faced by many immigrant communities. But these challenges were compounded by the Mariel Boatlift which made clear to US television viewers that Cuba was not in fact a "white" country and Cubans were not "model minorities." The spectacle of Lucumí, a religious practice that was plainly of African descent, further othered Cuban immigrants by tapping into US racial and religious bigotry. In Cuba, Afro-Cuban practices could be better unseen, but in Miami, they could *not* be unseen. Lucumí needed to be reframed to fit the goals of the Cuban population in Miami.

John and Jean Comaroff have observed how in newly immerging marketplaces cultural representatives will mine culture to extract elements that can potentially be commodified, like the Shipibo marketing of traditional art objects from the Peruvian Amazon (2009, 33). For a cultural product to be successfully marketed, it must be not only seen as authentic to the culture but also essentialized to satisfy the demands of the marketplace. These are conflicting demands: authenticity is rarely easily digestible to outsiders. Authenticity cannot be reduced to what Palmié describes as "the ethnological trait-lists of a time-less 'Yoruba [or any other] culture' sprung from the latter-day anthropological (and native) imagination" (2013, 47). The Comaroffs also note that in the current landscape, the "sale of culture has replaced the sale of labor in many places"

(2009, 24). In the wake of neoliberal policies designed to promote privatization and gut social services, culture has become the only thing many marginalized people can sell. "Cultural branding," is essentially using the tools of marketing to authenticate an object or tradition (religious ritual, dance, song, and so on) as belonging to a specific cultural group, an outgrowth of globalization and the transnational flow of markets as well as the ease of tourism. The design of the Miami model of cultural competency and the commodification of Lucumí as a cultural product,[14] and by extension the process of "cultural branding," is a useful analytical framework to grasp the sociohistorical moment where religious identity is refashioned anew. This process encompasses both authenticity and essentialization. In the cultural competency literature Lucumí, referred to as "Santería," is likened to a "sprawling, vital and dynamic mental health care system" which modernity has failed to stamp out due to its "flexibility, eclecticism and heterogeneity…helping ensure functional, dogmatic and ritual changes which enable it to meet the different needs of its many followers" (Sandoval 1979, 137). Authenticity is not in question given the religion's irrefutable connection to the island. Essentializing is largely characteristic of biomedicine's positivist framework.

Yet, there is an inherent conflict in the cognitive framework of cultural competency stemming from the disjuncture between anthropology, a social science with a vested interest in increasing complexity, and the biomedical sciences with a vested interest in reducing complexity in the search for singular solutions (Kleinman and Benson 2006, M. Good 1995). In branding "Santería" as a mental health care system that meets the needs of its followers, it begs the question, how else could the needs of followers be meet? How would a '*true* American' meet those needs? The researchers often refer to the

anxiety created by the doubt and uncertainty of the immigrant experience, anxiety that religious practice, and the social networks embedded in that practice, alleviate. Biomedicine has its own ways to address anxiety. The researchers encourage biomedicine to work with traditional healers and take advantage of opportunities for holistic treatment that engaging with the spiritual worlds of patients provides (Lefley et al. 1998). There is widespread agreement, that the patient whose social world is intact, will have more successful treatment. Yet the researchers openly acknowledge that many biomedical providers are uncomfortable with any discussion of religion and this discomfort is difficult to address (Lefley et al. 1998).

The Comaroffs also hold that once essentialized for the marketplace, that cultural product is returned to the community. Ironically, it becomes the marketplace that determines/reinforces authenticity for the community. "Santería" in Cuba was a marginalized practice, in the late twentieth century in South Florida, in the wake of the Miami model of cultural competency, it becomes a marker of Cuban identity, as highlighted by my opening ethnographic description. When in the mid-twentieth century the African American community took notice of the religion and adopted it to reclaim a distinctly "African" identity, a power struggle soon emerged over who the African American community should look to for religious authority: Cuba or Nigeria (Ayorinde 2007; Hucks 2008; Palmié 199?)? Cubans would claim that they had kept Yoruba practice alive, maintaining a temporal line to the past, keeping an authentic heritage vital in a new world context, despite the challenges of this. Cubans *lived* the religion. Yoruba representatives in Nigeria would claim authority based on ethnic identity, the very ethnic identity that many in the African American community sought to reclaim. For some this

autochthonous claim was paradoxical given the fact that some of the Yoruba representatives had converted to Abrahamic religions.[15] The Cuban claim on authority is rooted in a creole positionality, a *mestizaje* identity whose origins are rooted in the mixture of old-world ethnic identities and new world indigenous ones. Bruno Latour (1993) argues that modern people believe that they have "facts" and nonmodern people have "beliefs." It is in this fundamentally incorrect assessment that the ethos of modernity rests. Likewise, the *mestizaje* identity of Cuba, rests on the idea that there is not similar cultural exchange in "Africa," and if there is, that it is somehow false. "Santería" was very much a *mestizaje* metaphor in religious expression, cultivating a distinct Cuban American identity in South Florida (Ayorinde 2007).

"Lived" Religion, the Cultivation of Doubt, and Subjectivity

How do we manage to live in a world full of doubt and uncertainty? Where does that doubt and uncertainty originate? The Miami model sought to capture the specific nature of the doubt and uncertainty experienced by Cuban immigrants at the time and through the process explain their reliance on Lucumí. In this way the literature served to shape the reality of this experience. When B. Good (1994) theorizes how medical anthropology shapes reality, he notes that much of medical anthropology in the 1970s is premised on the notion that biomedicine is simply superior to other medical systems, and outside of culture, not something for medical anthropologists to study. The perceived role of medical anthropologists at the time was applied, work toward making biomedicine accessible to disenfranchised populations in need. While this was, and is, a noble goal, it did not allow for a great deal of theoretical development to better analyze how "[d]isease

belongs to culture" and how the networks of meaning present within a culture "appear to members of a society simply as part of nature or an invariant of the social world and may therefore be part of hegemonic structures" (B. Good 1994, 53; B. Good and M Good 1981). The influence of hegemony in the immigrant experience of Cubans in South Florida and the identities that would develop from their negotiation with it was not critiqued by the literature.

The cultural competency scholarship produced by the Miami model peddled insistently the challenges of acculturation to life in the United States which instilled constant doubt and uncertainty for Cuban immigrants. These challenges centered on the discomfort experienced by immigrants in a space where people spoke a language they did not understand and shared very different values; where the closeness of Cuban families was constantly portrayed as controlling; where people were not encouraged to accept and love themselves as they were but instead constantly expected to "improve" their character in some way; where patriarchal authority was questioned in the household; where African Americans protested their oppression; where young people protested the obligation to serve their country in Vietnam through military conscription; and where women protested their social status. Having to adapt to a social context so different from Cuba and at times in conflict with the island created a great deal of stress for the average immigrant. Participation in Lucumí helped alleviate the anxiety produced by these levels of stress (Sandoval 1979). Given these issues the Department of Psychiatry felt that some Cuban immigrants must need psychiatric care, and they were confused as to why these patients were not showing up in clinics. Yet Cubans were accustomed to receiving mental health treatment from their general practitioner or social networks—a Lucumí religious

community, for instance. When this reality was represented in the literature, it reduced Lucumí practice to a social network substituting for a behavioral health provider: mental healthcare for poor uneducated people who couldn't afford or did not understand psychiatry.

Mathijs Pelkmans argues that doubt "is ephemeral and unstable, inherently contradictory and active" (2011b, 16). Essentially, it is something wild that must be tamed. A specific agency emerges from this experience. In his ethnography of the relationship between doubt and agency, Nils Bubandt's (2014) argues that witchcraft serves as a tool to tame the "restlessness of doubt," which the promise of the modern world has failed to tame. In effect modernity has not delivered people from the troubles of witchcraft as it promised. Doubt abounds regarding witchcraft, but misfortune persists despite modernity. Witchcraft provides concrete action to address doubt and misfortune: "Focusing on witchcraft as doubt rather than as 'reflection,' 'explanation,' 'meaning,' or 'belief' entails," Bubandt suggests, "a break with an epistemology of presence, in which objects either "are" or "are-not," as well as with the hermeneutic functionalism that attends it. This also means rethinking the relationship between witchcraft and modernity" (2014, 12). While Bubandt is specifically focused on witchcraft and doubt, I believe that in this dissertation the unseen relates to doubt, as doubt, is experienced in large part in the juxtaposition between the seen and the unseen.

Susan Whyte holds that the Nyole of Eastern Uganda in dealing with misfortune do not seek to have their doubts answered, or to have the unseen revealed, but to gain security. This security is sought using every possible resource at hand, from biomedicine, to rituals, to experts of every type available. Misfortune and doubt are unavoidable and

require action acceptable within the scope of social and moral concerns. The experience of misfortune and appropriate reaction to it are mediated through culture as shared knowledge. Misfortune must be spoken of freely to seek solutions, hence "knowledge" is engagement "using social resources and experience to heal with problems and then judging the consequences" (Whyte 1997, 14). As Whyte points out, this approach to misfortune is in keeping with John Dewey's understanding of knowledge, that far from being some truth 'out there' to uncover, knowledge is action and the consequences that flow from it. "[T]he true object of knowledge resides in the consequences of directed action" (Dewey 1984, 157). For Lucumí devotees, as for the Nyole, divination is a critical social resource providing knowledge in the management of misfortune not to provide ready-made solutions, but action that can be carried through, like walking on your knees to the church on the feast day of San Lazaro. With this observation in mind, quotidian "lived" religion, are also experienced through micropractices, those small mundane activities long overlooked in Western scholarship of religion. As Elizabeth Pérez (2013, 2016) argues, in Afro-Atlantic religious practices these acts build up identity, bit by bit: cooking for the *orisha*, arranging food offerings, altars, the stories told during this communal activity, stories of how the *orisha* claimed a devotee, how someone was reprimanded by their spirits when they stepped out of line, or how someone received healing from Babalú Ayé after the simple act of lighting a yellow candle for him on December 17th. These humble exchanges in the piecing together of a religious identity, I argue, provide security and stability. They are the mechanism for building knowledge within a Lucumí social context and mediating the doubt and uncertainty caused by the misfortunes of life. Although the cultural competency paradigm was initially aimed at

unveiling the preserved "truth" of "Santería," it was ultimately more successful at unveiling the gaps in biomedical knowledge and, more generally, the undelivered promises of modernity.

Methodology

Tracing the origins of this research takes me back to the spring of 1992, when I first entered the temple/*ilé* of the man who would become my godfather in Lucumí. I was in high school and living in suburban Maryland at the time. My parents had taken me on a tour to visit colleges in the Chicago area and I was focused on my future education. But as soon as I entered the *ilé* in a repurposed automotive repair shop on the Northside of Chicago, Lucumí became woven into my life's journey. From that point on, it remained an intricate part of my personal life, though I kept it separate from my academic life. By 2001, my godfather had moved his temple to a classic New Orleans nineteenth century townhome, and my husband and our two daughters moved to the city as well. In 2005, he passed away and a month later Katrina hit New Orleans, two seismic shifts in our lives in a brief thirty days. We were displaced to Lafayette, Louisiana, with our, then, three daughters. It would be a year before we were able to return to New Orleans. After roughly eighteen months of aimlessness, we found a new religious home in 2007 in Hialeah, Florida. When I realized that my best path to graduate research was to work within my own religious community, I consulted with members of the *ilé* before beginning the process. In 2014, with their approval, I started my graduate studies.

From my home in New Orleans, I traveled by car to South Florida over spring breaks and summer vacations. As a member of the religious community, much of my

fieldwork was in relation to ritual. Clifford Geertz (1988) suggests that perhaps what makes a quality ethnography is not the sheer amount of data one can provide, but the ability to get across "person-specific" description to the audience, making it clear through narrative that you have in fact "been there." I regularly attended Lucumí rituals, as well as spiritual *missas*, and generally tried to be of use to my godparents. Lucumí involves a great deal of community labor and from my beginnings in the religion, my credibility as a sincere actor has always hinged on my sweat equity. I pluck birds, gut and butcher, cook (though rarely asked to), get supplies, sweep and mop floors and perform whatever menial task I can take care of. Much of my participant observation happened wearing an apron, mop in hand. Lila Abu-Lughod (2000) holds that ethnography should focus on "life as lived" (Paul Reisman 1974) so that we, as ethnographers, are better positioned to grasp the relationships between the structures of life and personal agency. Since I was working in my own community, this is the approach that came naturally to my work, enriched by the "counter discourse" that comes naturally when the community you work with is not distant, but all around. As Abu-Lughod observes, "[w]e know that everyone is different, that people are confused, that life is complicated, emotional and uncertain" (2000, 263). In incorporating my own positionality into this ethnographic work, I draw on Abu-Lugod's "ethnography of the particular," focusing sharply on the geography and temporality central to this ethnography as well as my own lens as a member of the community, both apart (as a Lucumí devotee) and separate (as a resident of New Orleans and a person not of Cuban descent but Cape Verdean and Anglo-American descent).

One of the initial things that I noticed when I began practicing Lucumí in Hialeah was the openness and ease of practice, compared to my previous experiences in Chicago

and New Orleans. Michael Jackson advises us that those insights that emerge as personally useful "may also illuminate the *transpersonal* and *interpersonal* life worlds that one is seeking to understand" (2010, 36). My personal observation of the sheer thickness of practice in the area, did prove to be central to the transpersonal and interpersonal life worlds I sought to best communicate. In Chicago a wiry man wearing a baseball cap, coke-bottle glasses, and a dramatic paunch belly, delivered animals for rituals in a beat-up white van. He made his way down the Northside Chicago alley to the back of the temple, skirting commercial dumpsters along the way. My godfather's godfather brought herbs in from Miami, boarding the plane with a large black garbage bag filled with leaves, flowers, and twigs to make the ritual possible. In New Orleans it was often challenging to find live animals—something that might seem odd, given the city's reputed association with Vodou. Members of the community had to buy them directly from a poultry farm, sometimes in a neighboring state. In Hialeah, on the other hand, not only were there multiple animal and herb delivery services, but you could pop into any number of *botanica*s, pick up a chicken or rooster, and bring it to your godparents' in a paper bag. Others did the same thing so there would be several bags deposited in the driveway, passers-by may see brown-paper grocery bags lined up against the side of the house, flopping around clumsily of their own accord.

In our godfather's house in Chicago, when it came time for an initiation, he set to work designing a singular *ilé*, unique to the person going into it. This sacred space, an elaborate stage where the newly initiated *iyawo* would remain, forbidden to leave the roughly five by ten grass mat for the duration of their *kariocha* initiation, was a source of great pride for my godfather. This was possible because he had been a set designer for

opera productions and an interior decorator, and he had a staff of temple priests to help, one of whom was an adept carpenter. In Hialeah there is a man who comes around to put up the *ilés*. He comes with plastic tubs full of cloth and a staple gun, then sets to work stapling cloth to the walls, putting together a standardized *ilé* appropriate to the specific *orisha*. A week later he comes to collect his fabric. I have seen his handiwork in multiple houses, lending a visual consistency to religious practice, if not a reprieve for those without an artistic bent for set design, or time to dedicate to it.

All of this is possible because there is such a wide audience in South Florida. There are Lucumí practitioners all over Hialeah and the wider Miami area. As you drive through town, because it seems you must drive, you see small grass rooftops peeking over the fences of people's backyards, figures of small Black boys balanced on rooftops, people harvesting plants in median strips, and San Lazaro altars in front yards. When you talk with people at rituals, they inevitably bring up other houses and what they have observed at rituals all over the area. And there are numerous professionals, people who can support themselves as *obá oriatés, iya/babalorishas,* and *babaláwos*. Some still take on other jobs to support themselves, especially young people still building a reputation, but many do not. To put it simply, Miami and its suburbs are a hub of Afro-Cuban practice.

As a Lucumí practitioner and a frequent visitor, I was well positioned to conduct fieldwork in this community. Many in my own *ilé* and within the orbit of my madrina, were enthusiastic about the possibility of discussing their experiences of illness. They were teachers, port office workers, professional ritual cooks, former factory workers, and service workers in tourism. Originally, I planned to focus my dissertation on spatial

theory, which explores the cultural dimensions of space and place. I had hoped to gain access to hospital space and join religious devotees in their visits to the doctor to better understand how the space was embodied. Yet as time went on, the plan no longer became tenable. For many Lucumí practitioners, a trip to the doctor was either unplanned (and I was not appraised of it), or too sensitive. In addition, the large and spread-out nature of the landscape, as well as the dominance of traffic, made the prospect of hospital and doctor visits challenging. My efforts were also stymied when I set out to contact doctors and hospitals. At first it seemed I could leverage my religious connections to make contacts among the medical professionals. However, those efforts were not as successful as I had hoped, although I did manage to make a few connections with medical personnel. My efforts to establish contacts with doctors and social workers in hospitals also failed, leaving me with the impression that they were unfamiliar with the work that ethnographers and other social scientists do. Some cited issues centering on patient confidentiality under HIPPA, while many others simply did not respond to my requests for a meeting. Most of the hospitals in question were corporate for-profit hospitals administered by distant corporate boards which showed little interest in providing service, never mind accommodating a researcher. Disappointed, I reconsidered the goals of my research.

Through my research in medical anthropology and an early interview I had done with Ernesto Pichardo, I was aware of the cultural competency paradigm that had been implemented in Miami to deal with the culture barrier between US medical personnel and Cuban immigrants seeking healthcare. In fact, when I initially interviewed Ernesto Pichardo during a pilot study in 2016, he recommended that I focus on cultural

competency in my dissertation research. At that time, I wanted to focus on space and place in the hospital, so I did not follow-up on his suggestion. Two years later, as I reconsidered my research approach, I realized I was not especially interested in individual health profiles and that medical education and training were likely a better fit for my project. While I agree with Abu-Lughod on the importance of bringing the distinct individuality of participants into ethnography, and I hope that I have done so successfully, the hegemony of biomedicine eclipsed so much of my research that attention to how this system functions beyond individuals was critical to the analysis. I decided to find out how cultural competency training influenced doctors' conceptualizations of the function of Lucumí in relation to patient healthcare outcomes, and how it impacted their relationship with patients. As my interviews progressed, I was dismayed to learn that some of the medical personal I interviewed had no experience with Lucumí devotion among their patients, and some had no idea what it was, even when I offered the term "Santería" instead. While all experience is learning and can contribute to dissertation work, I was prompted to reach out to more people I knew to already be familiar with Lucumí, like those who Rafael Martinez who covered it in coursework and training, and I used snowball sampling to widen my circle of interlocutors.

Fortunately, a thorough focus on cultural competency training proved a more productive direction as medical educators were comfortable with my position as a researcher and interested in the outcome of my research. My participant observation of physicians was limited to an Interdisciplinary Seminar conducted by Rafael Martinez for residents in behavioral health. But I had numerous opportunities to conduct semi-structured interviews with various healthcare educators and healthcare providers:

physicians, nurses, and psychologists. I was also fortunate to interview two of the people who were central participants in the design of the Miami model of cultural competency, Mercedes Cros Sandoval, who was involved in the project from the very beginning, and Rafael Martinez, who began as Sandoval's assistant. By the official conclusion of my fieldwork, I had comparable interview data in both the religious and medical domains with fifty-five total interviews and twenty-seven in the medical domain and twenty-eight in the religious domain, although two interviewees overlapped both domains. All of my interviews were conducted in English, though Spanish words were often peppered throughout.

Structure of the Dissertation

This dissertation is divided into five chapters framed by this introduction and a conclusion. In chapter one I analyze how the cultural competency model became a tool of racialization, creating the image of Cuban immigrants as inevitably white. Then I critique how the multi-racial make-up of the Mariel boatlift disrupted this white image and landed Lucumí practice in the spotlight. The spectacle of Afro-Cuban religion pressured the established Cuban population of Miami to reframe Lucumí to fit into a biomedical framework, consequently "whitening" the perception of Lucumí practice. In chapter two I explore Lucumí practice as it is lived in the everyday and the frameworks of "ordinary ethics" that shape quotidian practice. In chapter three I examine the relationships devotees have with their doctors as those relationships are tested by illness that the doctors cannot cure. Through an exploration of the literature on "knowledge" and "doubt," doctor/patient relationships are illuminated. Chapter four explores the tension

that arises when a divination provides advice that contradicts that of the medical establishment and how that tension is managed by devotees. Anthropology has long theorized the role of divination in various social milieus, through the "restlessness of doubt" and the quotidian experience of divination, this important element of Lucumí practice is examined. Chapter five theorizes the creation of space for Lucumí ritual inside the hospital through engagement with anthropological discussions of contamination and counter-hegemonic practice. The conclusion brings us to the current pedagogy of cultural humility. While this paradigm alleviates some of the problems of "cultural competency," it also enhances the erasure of culture which also holds the potential to undermine healthcare outcomes.

Chapter 1

Lucumí and the Creation of a New Paradigm

On June 10, 1987, the *Miami Herald* published two separate reviews of "The Believers," a film about a Cuban cult, assumed to be Santería, that practices human sacrifice. The film's story-line fit well with the newspaper's depictions of the religion at that time, often portraying it as a bloody cult. In the 1980s many who practiced Lucumí felt targeted by the paper, which seemed to take little interest in the history or substance of the religion outside of the spectacle of animal sacrifice. The coverage from the Spanish language version of the paper, *El Nuevo Herald,* was also negative, but not as obsessed with the 'cult' depictions; Americans often waited in line to see such "bloody cults" depicted in popular horror films. Many in the Cuban community were frightened by this negative coverage, both those that were devotees and those that had nothing to do with it, but felt targeted because of their ethnicity. Often Cubans who claimed no connection to the religion turned on Lucumí, suggesting it was just witchcraft masquerading as religion, or worse, a satanic cult that could spread throughout the United States.[1] These Cubans pushed back against their own community for fear that the *Miami Herald*'s coverage would promote negative stereotypes of them to the American public.

Mercedes Cros Sandoval, a Cuban scholar of "Santería," immigrated to the United States from Spain in 1967. An anthropologist born and educated in Cuba where she received her first PhD, Sandoval received a second doctorate in Spain. Her dissertation was

in “cultural and historical factors of Latin America,” or as she puts it simply, “it’s about Santería.” Considered an expert on the religion, she joined the University of Miami’s Department of Psychiatry’s Health Ecology Project in 1968, as a researcher and eventually a “cultural broker” for the Cuban community. She generally interpreted Lucumí as an example of Cuban culture: “There are so many ingredients to Cuban culture that they melted down.”[2] Sandoval argued that “Santería” was another example of Cuban syncretism and functioned primarily as a means for people to solve problems, in this instance, the challenges that arose from the acculturation process newly immigrated Cubans experienced. For those suffering the fallout of revolution, forced to manage life in exile, the social network that was made available through “Santería” provided necessary support for Cuban immigrants. “This augmented social support function of Santería has expanded into a viable mental health delivery system, which offer[s] social support, counseling, and socialization opportunities to many people who [are] suffering from the many stressors that characterize acculturative, immigration, and de-culturative processes” (Sandoval 2008, 363).

In 1959, Miami was a deep south town with an Anglo-American power base deeply invested in segregation, an African American population woefully disenfranchised as well as Seminole, Ais, Jeaga, Myaimi, Tequesta (confirm) and Jewish populations. The Cuba that the exiles left was not as segregated as the Miami that they arrived in, but it was not the “racial democracy” portrayed by many twentieth century Latin American scholars. Cuba has a large African descent population as well as people of Mayan, Chinese, and European decent. And not unlike the US, racism was prevalent in Cuba’s social hierarchy where Europe and “whiteness” were identified with civilization and

progress, while Africa and "Blackness" were identified with barbarism and backwardness. In their new country, the exiles were not in power, but were subjected to the hostility of the local Anglo-American power structure which racialized them as "Hispanic," an amorphous descriptor. Nonetheless they soon managed to establish themselves, adapting to the local geography of segregation and contributing to it by walling themselves off into an ethnic enclave. In time Cuban exiles were conditioned to think of themselves as competing with African Americans for limited resources, consequently contributing to the disenfranchisement of African Americans in the area.

Concomitantly in the late twentieth century, cultural competency was at the fore of medical anthropology. As a pedagogy designed to develop the cultural awareness of healthcare providers through cross-cultural narratives,[3] cultural competency is based on the expectation that when healthcare providers are familiar with cultural idioms that are different from their own, communication in the medical encounter will be improved as will healthcare outcomes. In the process of designing pedagogy, culture is negotiated and produced. This process provides a window into how a religion emerging out of a historic context where it was seen and unseen is renegotiated in a new context where it cannot be unseen and where biomedicine as hegemonic practice is ascendant. The paradigm participated in the racialization of the Cuban exile community in South Florida, "whitening" not only Cuban identity, but also Lucumí practice, despite its clearly African origin. When we examine religion as *negotiated* process, this is a critical point in the development of Lucumí, when identity politics as realized through biomedicine in the United States comes to alter religious identities.

In the early 1980s, evidence of Lucumí practice began popping up all over Miami, plainly visible and plainly of African origin. White Supremacy, in Anglo and Latin America, rests on the premise of African "backwardness." For Cubans who had been trying to gain power in the area, this was a crisis of reputation which they feared would threaten their position as a 'model minority'; everyday Cubans feared for their well-being. This chapter is about how cultural competency became one tool in the toolbox to reframe Lucumí. I begin with a discussion of the origins of the Miami model of cultural competency. Then I explore understandings of "Santería" embedded in the system, followed by exploration of how the model functioned on the ground. Later I explore where this intersects with the contributions of the religious community. Finally, I examine how this participates in notions of place-based medicine. This discussion contributes to anthropological understandings of the intersection of religion, racialization, and biomedical hegemony. Lucumí shifted from an Afro-Cuban practice presumed to be for nefarious purposes to a Euro-Cuban practice (most of the population looked white) aimed at managing the anxiety and stress caused by acculturation, a reason considered legitimate in the social context. This dissertation is a case study in 1) how immigrant groups are racialized and how biomedicine plays a part in this process and 2) religion as *negotiated* process, as religious identities are recreated in a new social context. "Santería" is the most well-known term for this religion and it is the one used most often in the late twentieth century literature discussed in this chapter. However, the term is considered derogatory within the community today and La Regla de Ochá or Lucumí/Lukumí is preferred. For this reason I will use the term Lucumí, except when I discuss the early literature which makes references to Santería.

The Origin of the Miami Model of Cultural Competency

According to Mary-Jo Delvecchio Good, Seth Donal Hannah, and Sarah S. Willen (2011), the "Great Society" agenda of the 1960s shaped the design of the initial "cultural competency" paradigm, which began in the mental health care field. The government policies and by extension, the research that took place were designed with culture conceptualized as a bounded system. The goal was to reach out to those overlooked by the system and provide them with care. Woven into this effort was a concomitant effort to shift mental health treatment from institutionalization to more intimate, outpatient treatment tailored to cultural concerns and provided at community clinics. In Miami, immigrants from all over the Caribbean converged and the University of Miami began research to understand how to address their mental health concerns along with those of the local African American and elder Anglo-American communities. This effort to bridge the gap between local marginalized groups and mental health practitioners sought to capture the cultural explanatory models of illness, which tap into cultural models that work when patient and practitioner share the same metaphors and not so much when they do not (Kleinman 188, 13). But how did a field like biomedicine, a hegemonic system rooted in the notion of itself as objective and outside of culture, conceptualize the complications involved in representing a racialized, historicized, and politicized object like Lucumí?

The 1971 Health Ecology Project was created by Hazel Weidman and conducted the initial research into the ethnic-health landscape of Miami. Marginalized by capital and institutional structures, people of color in Miami were not inclined to seek out mental

health care through orthodox channels. They distrusted the medical establishment. Weidman, who graduated from Harvard with a doctorate in medical anthropology, was tasked with figuring out why. Five hundred families participated in the study. The sample included African Americans as well as people from the Bahamas, Haiti, Puerto Rico, and Cuba. The project explored the health systems, beliefs, and behaviors of these groups. The goal was to treat serious cases of mental illness in the community. The project's mission was twofold: 1) to create accessible and culturally appropriate care for a wide range of mental health issues; and 2) to "alleviate environmental stressors by helping residents receive their fair share of adaptive resources" (Leafly and Bestman 1991, 477). The three-year-long research study examined cultural variations in the conceptualization, expression, and distribution of mental health issues and concluded that if community health centers were designed along the traditional biomedical lines, that is, if they ignored cultural and environmental factors impacting patients, they would be underutilized and not especially effective. It was necessary to look for culturally specific therapeutic interventions (Leafly and Bestman 1991, 477). Critical to my analysis, is an examination of the first part of this project's mission. How was "culturally appropriate" care determined? The research did not broach historical analysis to examine lack of access to care, as much as focus on ways to increase access within neighborhoods. The lack of analysis of social structure, beyond helping people receive resources, and historical analysis supports the critique of cultural competency models that the "social and political" was eclipsed by the "social psychological" (Minkler et al, 1994).

Founded in 1974 by the National Institute of Health, the University of Miami-Jackson Memorial Community Mental Health Center (CMHC) addressed the mental

health needs of people in marginalized areas of Miami. Based upon the findings of the Health Ecology Project, the CMHA was initially organized to support six different groups: African Americans, elderly Anglo Americans, Bahamians, Puerto Ricans, Haitians, and Cubans. Later, a seventh group, composed of elderly African Americans, was added. Centers were located in neighborhoods dominated by these populations, a reflection of the segregation enforced by the long-time Anglo-American power structure. Each center had two objectives: to engage in social science research and to provide health services. A social science researcher, a part-time psychiatrist and psychologist, a clinical social worker, and three to five paraprofessionals staffed each center. The social scientist and clinicians were to fulfil the role of "cultural brokers." This role, conceived of by Weidman, was to facilitate culturally specific care.

Mercedes Cros Sandoval describes the "cultural broker" as a liaison between the patient and the health-care provider. Cultural brokers were intended to educate mental health staff and medical staff "about culturally appropriate care which was focused on beliefs and practices that might impede or facilitate effective treatment and also adaptive strategies, strengths, and supports within the patients' cultural milieu" (Leafly and Bestman 1991, 480). In this role, they were especially intended to help crisis workers to understand behavior that was culturally appropriate not pathological or psychotic. Extensive data collected on the program found it was effective at promoting full utilization of the facility as well as improving no-show and drop-out rates among patients (Leafly and Bestman 1991).

As the impetus of the program was to address the question of why people were not seeking mental health treatment from biomedical providers despite the significant

"stressors" patients experienced in their lives, the program also focused on providing support to alleviate everyday stressors like finding proper medical care for a sick child or getting food assistance. The programs brought resources into communities as well as strengthened existing resources. To this end, staff also collected surveys to provide the data necessary to support programs requested by the community and to connect consumer groups with appropriate service agencies, informing residents about how those agencies could mitigate neighborhood problems. The CMHC tailored these projects to the specific ethnic community involved and they were "conducted in its own cultural idiom" (Leafly and Bestman 1991, 479). The program was set up to "find" those cultural idioms in a Cuban population going through dramatic change as a new Cuban American identity was being developed. In this instance, Cuban American identity was being produced in a space where, because of immigration patterns developed by US immigration policy, most of the population was white and "whiteness" was valued as a marker of social success—as illustrated by the saying common in Brazil (another Latin American country embedded in the myth of racial democracy) "money whitens." By default the CMHC would end up contributing to this new identity which would emerge out of the Latin American history of "lightening" colliding with the Anglo-American history of the Jim Crow South.

Focusing on "Santería" in Miami

As a clinician, who had worked at the Little Havana clinic at this time, described the environment to me: it was not uncommon to see young kids come into the center all dressed in white with a white "yarmulke"[4] on their head, following their mothers. "We knew they were practicing Afro-Cuban religion, and everyone was very respectful of it."

While teaching at Miami Dade in 1968, Sandoval gained prominence as people in Miami were newly exposed to Santería. Sandoval defended regla de ocha devotees, arguing that "they don't do anything anti-social." As we spoke, she often returned to the issue of animal sacrifice the focal point of the *Miami Herald*'s critical coverage. She did not think animal sacrifice was a reason to demonize people, especially as priests were taught to kill in a merciful manner. The subject of animal sacrifice remains a sore one among Lucumí practitioners, in part due to the *Miami Herald*'s negative coverage of the Cuban immigrant community. In defending the religious practice, she was ultimately speaking up for the Cuban population.

Sandoval's primary observation about Lucumí practice—that it is an important tool to help people manage the stressors of immigration and help them in the transculturation process in the United States—highlights the focus on the *role* of religion in society, its place within culture. This observation is not unique to regla de ocha and the Cuban population, "traditional beliefs" are central to helping immigrants from all over the world in their efforts to transition to a different society (Leafly et al, 1998). Implicit in this observation is the premise that people with "traditional beliefs" must adjust to modernity; they must shed their "traditional beliefs" in order to be absorbed into modern society. "Transitioning" here means subjecting themselves to a power structure that extracts the "truth" out of them. As Foucault (1982) observes, in biomedicine it is understood that the insides of a thing must be "seen" in order to be addressed, the body must be dissected, the psyche must confess, and so on. Sandoval's position on the importance of traditional beliefs in transculturation was highlighted in the wake of the Mariel Boatlift in 1980. According to the press coverage, boats filled up with the

disgruntled and troubled alike were sent off to South Florida. This inadvertently exposed the wider mainstream population of South Florida to Lucumí because the people who arrived were not inclined to hide their religious practice (Sandoval 2008, 2009).

In the Cuba of Sandoval's childhood, Lucumí only existed in small snippets, yet it was embedded in an extensive landscape of occult beliefs and practices. In the small town where Sandoval grew up, there was a lot of *muerteria*, as she describes it: the notion that the dead were present and played a part in everyday life was common knowledge. Trance was accepted as a reality and natural. According to Sandoval, Cubans claim "they don't believe in witchcraft, but they respect it. How can you respect something you don't believe in?" In this instance, the meaning of belief fits with what Janet McIntosh describes as "the post-Enlightenment western ideology[y]" understanding of belief as "the commitment to the truth value of a certain proposition" (2006, 284). In other words, how can Cubans claim that witchcraft is not true, therefore does not exist, yet they respect this non-existent thing. Yet, as McIntosh points out in her work on the contradictory attitudes toward witchcraft and indigenous religions held by white Kenyans, the nagging possibility that the spiritual ontologies of subaltern groups in society may in fact be true, was evident in colonial societies as well. As Peter Pels (1998) argues, colonial-era writing illustrates a great deal of anxiety over the possibility that the 'irrational beliefs' of the colonized, may be real. In the West Indies, Margaret J. Wiener (2003) observes that colonial commentary on the subject is rife with similar contradictions and anxieties. As Sandoval's observations would imply, the tension between "belief" and "respect" regarding spiritual ontologies has not been resolved by modernity.

To figure out how to convince Cubans to utilize mental healthcare facilities in Miami, Weidman sought the assistance of Sandoval, given her Cuban background and expertise in "Santería." The idea that the department of psychiatry was interested in Cuban immigrants was intriguing and Sandoval agreed to meet with them. She had initially looked at "Santería" from a diachronic point of view. The program at the University of Miami was in its incipient form, but it allowed Sandoval to approach her studies from a different point of view, focusing on the practical and everyday function of the religion in the lives of Cuban exiles. She found that Lucumí changed after its devotees arrived in the United States and their needs changed. These observations ultimately led her to conclude that "congruencies" in different cultures were the basis of the transculturation process. When the worldviews of different groups were mapped onto one another, the parallels, the places where the two come together were the characteristics that were maintained and utilized as a tool to manage the trauma of adjusting to a new cultural context (Sandoval 2009). At the time the religious landscape was evolving in Miami. People openly wore the *idé* of Orula (a sacred bracelet worn by devotees to pay homage to Orula and to ward off death). In Cuban neighborhoods, *botanica*s, where devotees could purchase herbs and religious artifacts, were appearing. *Botanica*s were originally a Puerto Rican institution. They were unheard of in Cuba, where people purchased what was needed for religious rituals at the market. Another sign that things were changing was the rise in numbers of white devotees who had joined Lucumí *ilés* (a religious house designated for ritual as well as the social network created through religious initiation itself). According to Sandoval, the religion counted few white practitioners in Cuba when she was growing up. A religion that was originally practiced

on the island predominantly by Black, mixed-race, and lower-class white Cubans had infiltrated the white middle-class among Miami's Cuban immigrant enclave.

When Sandoval initially arranged to set Weidman up with contacts in the Lucumí community, there was no funding to start a large project. Within a year, however, funding had been secured to conduct research into "minority care," and the University of Miami was seeking "minority experts" for the research team, so Sandoval was asked to join the project. The specific question which troubled the biomedical establishment and which Sandoval was well positioned to address was why Cubans did not come to the department of psychiatry for mental health care. Sandoval argued that in Cuba, people received "that sort of care" from their general practitioner. In Cuba the biomedical infrastructure did not provide medical doctors with the level of compensation and admiration US-based doctors enjoyed. While medical doctors were relatively well compensated and well respected, the business motivations embedded in the US system were not a part of the Cuban one, even before the Revolution. When Sandoval was brought on, the initial project was not focused on mental health-seeking behavior, but on drug use, a sliver in the larger picture of mental health. It would not be until after Sandoval had invested time into researching and writing about drug access and use in gay nightclubs in Miami during the 1970s that the research shifted to how to manage and incorporate culture into the delivery of mental health care services to marginalized groups in Miami.

As a "cultural broker," Sandoval acted as a mediator between patients and the psychiatry department, focusing on spiritual matters in particular. According to her, the community really appreciated it. She visited the homes of *santero/as* and introduced herself as an anthropologist, going on to explain to them that a given patient was one of

his/her godchildren and maybe the patient did not want to take the medicine prescribed. Sandoval would suggest that if the *santero/a* told the patient that Sango (the orisha of masculinity, thunder, authority, and kingship) wanted the person to take the meds, then the problem would be solved. This is not unlike medical doctors I have spoken with about their interactions with patients in Abrahamic religions. Many have told me that they are not believers but encourage resistant patients to frame medical treatment as sanctioned by God, for example, so that God will work through the doctor. During our interview, Sandoval insisted that *santeros* were happy to follow her suggestions because "*santeros*, like everyone else, want success." The critical difference here is that Lucumí has a divination system with its own internal structure that does not allow for idle suggestions. There is no divination system present in Abrahamic religions. *Santero/as* were a resource in the community that Sandoval was able to access to strengthen the community mental health program. This position solidified Sandoval's place as a scholar of regla de ocha. She went on to write about characteristics of "Hispanic patients" that the biomedical practitioners should consider in their diagnoses and treatments, and she received numerous invitations to lecture about Hispanic patients, on the whole, and regla de ocha patients, in particular.

The Expansion to Lectures and Trainings

In the late 1970s Rafael Martinez was working at the University of Miami as a research assistant for Weidman, Leafly, and Sandoval, whom he described as pioneers in sensitivity training for medical practitioners. When the steady influx of Cuban immigrants escalated to a sudden wave during the Mariel boatlift, the team was already

prepared to train the first responders so they would know how to address new cultural challenges. The police and human service workers needed to be trained in all aspects of culture ranging from family to domestic violence to language to religion. The team was perfectly positioned to provide this sort of training when it was most needed. When a slow trickle of Haitian immigrants emerged, the team trained those who would be addressing the basic needs of these populations. Building off this experience, Martinez went on to get a Master's in psycho-cultural approaches to healing. In time he was called upon to use his psycho-cultural background to conduct training programs for the police and the biomedical infrastructure.[5]

Martinez argued that his aim was to develop awareness in the professionals he trained so that they would not mistake the cultural for the pathological. This is not to say that he was not aware that some people suffer from mental illness. But he wanted medical practitioners to not make the mistake of labeling something that was culturally appropriate as a mental health problem.[6] To start, he addressed the issue of cultural relativity to get the audience to appreciate that there are different ways of interpreting the world. The goal of medicine and psychology is to heal the patient and reinsert them into society. During training sessions, Martinez makes it clear that his aim is not to convert anyone but to inform the trainees about religions that are practiced in the area.[7] Inevitably people come to him afterward with comments like "oh, that's why my grandmother gave me such and such to carry for protection." If they do not draw from their own life stories, they share stories from colleagues who practice regla de ocha or another religion.[8] All of these stories are anecdotal, yet they are also resonate with one another. Martinez maintains that over the past thirty years there has been enough education, programming

on Spanish television, presentations, newspaper articles, and so on, to shift the landscape. He also notes that the internet provides a great deal of information for medical practitioners to deal with things on a case-by-case basis.[9] The make-up of Martinez's audiences is very diverse. While many in his audiences are supportive, there are some individuals who object to being educated about African Diaspora religions, which they refer as "devil stuff." Nevertheless, Martinez's interactions with medical practitioners were positive on the whole. His proudest experience was when an *iyawo* (a newly initiated preist/ess who must dress completely in white for the following year) approached him after a presentation at a hospital and expressed his appreciation for the way Martinez had described and explained Lucumí. Roughly a year later, Martinez ran into the man again, no longer in his *iyawo* year, when Martinez returned to the hospital for another presentation, this time about Vodou.

Religious Leader Educator

Paul Brodwin (1996), Adeline Masquelier (2001) Alice Street (2014) and Warwick Anderson (2006) point out that the hospital/biomedicine often manifests as a representative of political power and the state.[1] Ernesto Pichardo was also building a reputation in the Lucumí community at the same time as Sandoval and Martinez, but his was as an *oba oriaté*, a ritual expert called upon to lead important religious rituals and divinations. Like Sandoval, Pichardo found it important that the religious community be seen by the biomedical infrastructure, but he was and is an insider in the religious

[1] Given the power of private corporations in the US at this time, the metaphor still stands despite the fact that the US system is based on privatized healthcare.

community, while Sandoval remained on the outside. Pichardo and Sandoval were both motivated to help the community as it faced overwhelmingly negative ethnic and national sentiment, yet Sandoval's motivation largely ended there, while Pichardo was also fighting for the right to freely practice Lucumí in the United States without being harassed and intimidated by the police, the media, and the authorities, a common occurrence before his successful SCOTUS case. Pichardo was fighting the state for civil rights, and, in the instances discussed here, the hospital was a proxy for the US establishment. This setting is also where questions of the "deservingness" of a population are played out on the bodies of sick religious devotees.

According to Pichardo, going to the hospital was stressful for Cuban immigrants not only because of the suffering and uncertainty produced by illness but also because of the stark differences that existed between the Cuban and the American experience of healthcare. In Cuba the entire family would be expected to stay with the patient during a hospital visit. In the US a patient's family was allowed only limited access to a loved one who was hospitalized. Hospital staff there were often hostile and aggressive with patients when they asked them to remove their *ilekes* and *ides*, which they took to be jewelry. They perceived patients who refused to remove them as "difficult." Pichardo argues the stress many immigrants experienced when faced with an illness was compounded by the fact that they did not speak English well, the credentials they had earned in Cuba were not recognized in the United States,[10] and they were now working jobs they never imagined they would have to work. Pichardo familiarized himself with the lengthy and complex administrative process that took place when people checked into the hospital. It seemed clear to him that some outreach may help staff to better appreciate the patient's

needs, especially when that patient was a Cuban immigrant with a poor command of English.

During training sessions, Pichardo began by focusing on the *ilekes* and *ides* worn by devotees, as these were generally the most prominent thing that hospital staff would see. (*Ilekes* are beaded necklaces designed for specific *orisha* and sacred to them. *Ides* are beaded bracelets, also specific to an *orisha* and sacred to them. In general, a devotee may have many *ilekes,* but likely only 1-3 *ides*.) The items held an important religious significance, he explained, especially the *Orula ide* that wards off death. Before digital cameras and laptops, Pichardo brought boxes filled with *ilekes* to training sessions. Using them as props, he described the process that religious devotees go through when faced with a health crisis. The first step is to obtain a divination from the patient's godparent. A divination provides a "spiritual diagnosis" regarding the illness and lets the patient know what rituals need to be done to aid the healing process. It is often possible to perform these rituals at home, yet circumstances may dictate that they be performed at the bedside of a hospitalized patient. When Pichardo started training medical professionals, cleansing rituals were being performed clandestinely in hospitals. Items needed for spiritual cleansings, such as raw meat, eggs, fruit, pieces of coconut, or live pigeons, would be sneaked into the patient's hospital room. Pichardo argued that since Lucumí is a religion like any other, performing spiritual cleansings in hospital should not be illegal. Nor should people be stigmatized when they did so. According to Pichardo, after talking to hospitals directly for a while, they voluntarily made changes.

In this time frame, Pichardo also met an anthropologist at Florida International University who, in turn, introduced him to other scholars. These scholars invited him to

their classes so he could give talks about Lucumí and "break down the walls," academically speaking, regarding the religion. Simultaneously he was starting out as an *oba oriete* and he found numerous inaccuracies in the literature about the religion, much of it coming from practitioners who did not trust the academics they were interacting with and mislead them. As the issues with the Lucumí literature became clear to Pichardo, he sought to clarify the record through his own writing, websites, speaking engagements and work with academics.

By Pichardo's account, somewhere along the line biomedicine lost track of the human element of healing and anthropology stepped in to remind them of the cultural elements involved, helping to nudge them back to the human element central to healing. While he was participating in efforts to educate and inform the biomedical establishment, the door opened for him to educate people about the religion more accurately, shifting Lucumí representation in the US and solidifying its identity as a legitimate religion. He ultimately became an activist for religious freedom for the Lucumí community.

Much like Martinez, Pichardo focuses on the importance of getting students to appreciate that they have a worldview, but that it is not the only worldview possible. There are other options for how to interpret the world around them. Still Pichardo stresses the need to "know your limits," for as he put it, he's never seen an *orisha* mount and perform open heart surgery. On the other hand, he has a lot of advice about which doctor a person should request when they need open-heart surgery. Like Martinez, he has seen things change over the decades in the make-up of his audiences. Now people often introduce themselves to him as *santeros* after he speaks to a classroom. When he first began his talks, that did not happen.

Place-based Biomedicine

While it is easy to think of biomedicine as a one-size fits all paradigm, it has to function in a place-specific manner. In part, this is because the social determinants of health vary from location to location as the social contexts and dynamics change; Lucumí in South Florida is one illustration of a social dynamic that is both time and location specific. Yet it is also true that the infrastructure of the location, as well as the history, has an impact. How different populations are conditioned to interact with the state is often reflected in how they interact with the biomedical infrastructure. Alice Street (2103) argues that within this interaction different patient and staff subjectivities are created. One illustration of this is in the Philippines under the US, where, according to Warwick Anderson (2006), Filipinos' experience of hygiene was also an experience of empire and race.

This realization of a place-based identity shaped by interactions with the biomedical infrastructure is also evident among Lucumí devotees beyond biomedicine. As Cubans immigrated to the US, the religious community and religious practice shifted to fit the socio-cultural context. Steven Gregory found that the impact of the African American community on Lucumí in New York/New Jersey is one of Lucumí flowing past ethnic/racial boundaries to promote change in "cultural" and "political" consciousness (1989, 292). This consciousness included more open expression of religious practice, shifting representation. While New York/New Jersey were more racially diverse than South Florida, the sentiment of religious freedom was consistent, as Pichardo puts it, "We're not in Cuba anymore, guys, we don't have to hide."

In South Florida, the Cuban immigrant population was substantial and with strong support from the US government, it developed into an immigrant enclave which was constantly absorbing newcomers. According to Michelle Hay, this enclave supported a US specific "Cuban ethnic group formation and identity" (Hay 2006, 111-12). A person who enters and remains in this immigrant enclave can easily never need to speak English, a stark contrast to Cuban immigration in other parts of the US. Many scholars argue that within immigrant enclaves, often the social stratification and marginalization that exists in the home country is recreated in an enclave (Aja 20016; Gosin 2019). Many of the Afro-Cubans who have immigrated to the US have settled in areas outside of South Florida, because as some put it, it is "…easier to be a black man in American than among white Cubans" (Hay 2006, 129). Those Afro-Cubans who do stay in the enclave are encouraged to identify as "Cuban" or even as "white" (by conflating being Cuban with being white)—not "Black." They are discouraged from bringing up issues of race, which is seen as divisive, as is illustrated in common refrains like "We like *our* Blacks," which implies that they do not openly express troublesome grievances in the way African Americans are assumed to. Embedded in these attitudes is the understanding that, to maintain the favor and support of the US government as a "model minority," Cubans must be seen as "white." This is illustrated in the work of Hay, who interviewed a Black Cuban woman employed by the Cuban American National Foundation in the late 1980s. The woman was hired to work behind the scenes on account of her "perfect" English but was specifically forbidden to be seen on camera representing the foundation. When, because of unforeseen circumstances, she was forced to go before the media, the chairman immediately fired her, insisting that "When people in Washington, state and

local politics see a black face, they associate it with poverty, welfare, crime and the message that they're conveying loses power. Their color becomes the message" (2006, 245). The chairman feared the sudden visibility of her race would undermine the foundation's goals of projecting an image of Cuban Americans that white Americans could embrace. In South Florida the enclave has allowed Cubans to achieve success in the US by protecting themselves in the face of Anglo-American racism while reinforcing the "othering" of African Americans. In this social dynamic, the visibility of Lucumí, a religion that is clearly of African origin, was bound to create a crisis that the Cuban community had to address.

In his study of the modalities of religion in the current transnational moment, Thomas Csordas (2009) finds that religion spreads through multiple modalities. The traditional assumption that religion spreads through powerful actors like colonialism, Empire, and missionaries, limits the spread of religion to a select few. But, in fact, Csordas finds that the spread of religion is not limited to the interests of Empires. Today, Yoruba religion is spreading to populations outside of its prior spaces in Nigeria, Brazil, and Cuba through more modest modalities. He refers to this expansion as occuring "from the margins in" (2009: page). In this analysis, religion moves like water, filling up whatever channels and interstices are available. In examining how religion is reimagined as it flows through these channels, it is critical to keep in mind that religion provides a framework for engaging with the world. It must be functional and meet the needs of devotees. In this instance, regla de ocha actors seek ways to be incorporated into medical infrastructure in the United States. True, this is not an effort to "spread" the religious practice, but it is an effort to make the religious practice functional in a new context,

which facilitates practice. It also legitimates the religion in a new space, in this case, the United States. While the US prides itself on a history of "religious freedom," it has had very limited exposure to African Diaspora religious practices when compared to countries south of it. Latin America was a place that openly rejected religious freedom, while deliberately looking the other way in the practice of regla de ocha and other African Diaspora religious practices. Historically, Catholicism, as an institution, was structured to accommodate indigenous practices within it. Latin America has a long rich history of "Folk Catholicism."[11] Regla de ocha developed within a Catholic context in Cuba under the Spanish where the Church and the State were joined. Religious practice in this modality had no language of "civil rights." In the South Florida context, embedded in the US rhetoric of human rights and religious freedom, the regla de ocha community experienced the spread of "civil rights" on a religious scale quite different than what had existed in Cuba.

Stephan Palmié (2013) points out that historically the agents facilitating the reproduction of regla de ocha were likewise facilitating their social and political goals/needs. Consequently, the political is embedded in the origins of the religion:

> To this end (a shared conceptual infrastructure that would support the production of those social objects we now recognize as Yoruba or lukumí identities) they deployed cultural resources at their disposal in the service of their social and political goals. They did so under historically specific conditions, in historically divergent ways, and with no foreknowledge whatsoever of the future implications of their agency (2013, 45).

It is worth noting that while this is certainly a fair reading of this instance and regla de ocha history, I would argue that it is a common reality among religions. As religions are used by human beings, who must always navigate the current political context, this sort of maneuvering is always necessary. That said, Palmié's observation that Afro-Cuban

religion is as much a product of anthropology as it is a product of historical circumstances is thought provoking. The actors responsible for the design of the "Miami model" had real concerns about how the depiction of "Santería" in the media would affect the political goals of the community as well as how individual devotees may be mistreated within the medical encounter, due to cultural misunderstandings. It is impossible to separate this reality from the way that Lucumí was depicted for a biomedical audience. In this instance of the design of the "Miami model," we are afforded further insight into how anthropology works to shape the objects that it studies, how it shaped regla de ocha, its functionality, and its representation in South Florida.

The issue of regla de ocha representation within the biomedical infrastructure and by extension the wider society is critical to examine. What does Lucumí representation look like in this context? When Lucumí first gained large-scale visibility in South Florida, animal sacrifice was central to the media's demonization of the religion. This is low-hanging fruit, in the US where people are largely disconnected from food production and rarely see an animal butchered despite the frequent consumption of meat. Actors like Sandoval, Martinez, and Pichardo complicated Lucumí representation in South Florida, providing information and images outside of the salacious news coverage of the *Miami Herald*. As Palmié suggests, these factors shape Lucumí as a cultural object. This interaction also shapes biomedicine as a cultural object which is an arm of hegemony seeking to identify a marginalized community.

These social shifts in representation also impact Lucumí subjectivity. As Palmié points out, in nineteenth century Cuba, one of the founders of regla de ocha in Cuba, Adeshina, petitioned the colonial government for recognition based on a *lukumí* identity

(2013). This is a reminder that while the discipline of anthropology may have moved beyond conceptualizing cultural groups as bounded, government institutions, and policy makers, as well as regular people, have been using this lens for hundreds of years. Another reason the notion of bounded cultural groups has yet to fade is that it seems to have salience in addressing serious issues in the overall society that fall along bounded lines, be they gender, race or ethnicity lines. Biomedicine produces unequal outcomes along all of these lines. When we trouble the narrative of biomedicine as "objective science" and instead think of it as an extension of an unequal society and an arm of power, it is to find that health outcomes are also unequal. Within the specific landscape of the Cuban ethnic enclave in South Florida, Lucumí subjectivity must navigate yet another unequal social context, South Florida. As Alisha Beliso-De Jesús argues, "Santería is not an exemplary site of decolonization, nor even an example of pure resistance; rather, these attempts (whether successful or incomplete) to constitute embodied subjecthood emerge in the very nexus of abject power" (2015, 144). In designing the Miami model of cultural competency to alleviate the stigma of Lucumí practice and present a Cuban *beuna presencia* to the "abject power" of the state embodied in biomedicine, the architect of this new paradigm unwittingly reinforced the notion that Lucumí was a part of a newly racialized Cuban identity.[12]

"Cultural Brokers"

Medical anthropology in the 1970s primarily focused on improving health outcomes for third world societies (B. Good 1994, 4), in time extending to marginalized populations in Miami. The "cultural broker" of the Miami model was a position intended to educate

biomedical practitioners about different cultural groups. This education was meant to be twofold: 1) to make sure biomedical practitioners could distinguish between behaviors that were culturally appropriate and those which were symptomatic of illness and 2) to make biomedical practitioners aware of concepts embedded in the cultural milieu, and members of the cultural group, that could be resources in healing. The program, in line with the focus of early medical anthropology, did not seek to develop a better theoretical understanding of the power dynamics embedded in biomedicine nor the social relationships critical to healthcare outcomes. My goal here is to look beyond improvements in "no-shows" and "drop-out-rates" and examine how this specific interpretation of experience impacted representation, as well as the regla de ocha subjectivities shaped by the "cultural brokers" in what came to be known as the Miami model.

Science is rooted in the presumption that the language it uses describes the world, rather than interprets it (B. Good 1994). In efforts to explain the practice of Lucumí to biomedical practitioners it had to be wedged into a small box, broken down into simple, easily digestible pieces that lacked the nuance and complexity of the realities that religious practitioners confront on a regular basis. There was also a tension for Cubans in Miami that was not so much an issue for Cubans *in* Cuba. In Kenya, McIntosh observes that historically, the justification for colonialism rested on the notion that the "natives" were irrational and required the guiding hand of the colonial power to manage their resources. At the turn of the twenty-first century, the descendants of white colonials cannot ideologically justify their advantage nor their presence in Africa, so despite their overt resistance to it, the trope of the "rational European" keeps seeping into their

discourse—a trope that relies on a social separation between Black and white Kenyans. Yet, around indigenous African spiritual ontologies there is a blurring of social and racial lines. Younger white Kenyans often seek justification for their presence in Africa by touting their 'closeness' to the continent, this often is expressed through a connection with African spiritual ontologies. In a Cuba with understood socioeconomic divisions, Lucumí had a place among Afro-Cubans and poor Euro-Cubans. In Florida those lines were blurred, and the religion was gaining a following across socioeconomic lines among primarily white Cubans, also, like white Kenyans, out of place and needing something to build up a new identity. Jacques Derrida (1993) describes such an experience as an "aporia" which Nils Bubandt likens to "a fracture in space-time itself before which the subject's own identity begins to dissolve" (2014, 6). While the negative media attention given to Lucumí was taken as a direct assault on Cuban presence in the US, it became possible to use this moment to build Cuban American identity and focus on the presence of one qualities espoused by US ideology: self-improvement.

Sandoval was a part of what we might call, following AbdouMaliq Simone (2004), the biomedical infrastructure. This infrastructure historically operated based on the notion that the language it uses describes the "natural" world and that, as scientific knowledge moves forward like a great machine, it unveils the "truth" of the natural world "out there." This value system puts a great deal of power and moral weight onto the language employed by biomedicine. In fact, B. Good argues that scientific language does not produce "truths" about the natural world that can be separated from culture. Scientific language "is a rich *cultural language*, linked to a highly specialized version of reality and system of social relations, and when employed in medical care, it joins deep moral

concerns with its more obvious technical functions" (1994, 5). A fundamental issue woven into the moral concerns that complicate scientific language, especially in terms of biomedicine, is that the biological sciences hold a philosophical position as a tool of modern society, delivering both "reason" and "salvation" (B. Good 1994). The juxtaposition between culture and science embedded in the effort to design the "Miami model" is a classic premise in anthropology and one that B. Good begs us to problematize. The first element to tackle in this process, according to B. Good, is to examine the anthropological use of the key analytic term "belief."

In mainstream US culture today, the term "belief," when it appears in a religious context, is an assertion of positionality: "I am a Christian. I believe in God." The implication is that, in saying this, *I assert that God exists*. It is a simple statement on the face of it, but as Tanya Luhrmann (2013) points out, for many churchgoers, not nearly to the point. In fact, Luhrmann argues, many people do not go to Church because they believe in God; they believe in God because they go to Church. For the Evangelicals that Luhrmann works with, the concept of "belief" is used more as it was used prior to the Enlightenment, not a statement of certainty about the existence of God, but as a pledge to serve God despite uncertainty of God's existence. Wilfred Cantwell Smith (date of publication) sheds light on this tension, explaining that the meaning of the term has shifted over the centuries. Prior to the Enlightenment, belief first referred to the practice of pledging loyalty to a person or idea, later it came to imply the person uttering it was sincere and trustworthy. By the Enlightenment, it had come to mean an assertion or opinion or proposition. In the 19th century belief implies doubt, but by the 20th century in

many circles, in anthropology especially, it implied an error in thinking or a fabrication (B. Good 1994, 16-17).

Historically, anthropologists have not really examined their use of the concept, and this, B. Good argues, has led to a great deal of misunderstanding. For the most part, the term "belief" in anthropology "does indeed connote error or falsehood, although it is seldom explicitly asserted" (B. Good 1994, 17). A classic example is the "belief" in witchcraft, as exemplified in Sandoval's comment that, Cubans say "they don't believe in witchcraft, but they respect it. How can you respect something you don't believe in?" The remark highlights the tension between Lucumí devotees in South Florida and the biomedical infrastructure. Sandoval implies that belief can be equated to a lack of rationality, arguing that you respect a non-existent thing; her position in the biomedical infrastructure requires her to account for this "irrational belief" to that infrastructure and tease out a way that healthcare providers can use this "irrational belief" to provide the "salvation" that biomedicine offers. Yet, this understanding of belief is untroubled, it is taken at face value to mean *these actors take for reality something that cannot be deduced or proven as factual, they are wrong.* Is this truly what is happening? Or might we take this statement of "respect" for witchcraft without "belief" in it, to mean something like: *I do not wish tragedy on anyone, nor do I deliberately act to cause it for anyone, but I do not doubt that others may wish and act to cause tragedy in my life, and their ill intent can influence my life.* In other words, *I have not pledged myself to it, but based on the inexplicable tragedies I have seen, it may well be real.*

As B. Good holds, historically, the word "belief" has functioned as an 'odd-job' word. In discourse on witchcraft, and other spiritual ontologies, anthropological discourse

has often relied on ‘belief’ to explain its cultural salience. The notion that a given group of people ‘believe’ in witchcraft, meaning, they hold it to be a true reality—There are real ‘witches’ and they perform real actions, witchcraft—has been the premise of most scholarship. Bubandt (2014) takes an alternate position, and rather than argue people ‘believe’ in witchcraft, he argues that when faced with the possibility of witchcraft, one is compelled to act. Most people have their doubts that such things really exist, but the fact that they might, keeps you up at night and forces you to take whatever action you have at your disposal, that is, when you are suffering. “[W]itchcraft—in Buli and possibly elsewhere—is an aporia in Derrida’s sense. It is “an interminable experience” intimately entangled with the problem and impossibility of identity, with the discomfort of a subjectivity that is disarmed and delivered unto the other as well as with the dangers of the other within oneself…[it] exposes naked identity and makes its maintenance as a safe interior space impossible” (2014, 6-7). Modern subjectivity, as Bruno Latour (1993) argues, is often fashioned upon the foil of ‘primitive subjectivity’: modern subjects have facts, non-modern subjects have beliefs. Modern subjects believe deeply in this. But, Bubandt suggests, those non-modern people are just as interested in facts, and are just as inclined to doubt ‘belief,’ in fact, probably less inclined toward blind belief that modern subjects. To be a modern subject, you are supposed to give up your ‘beliefs’ for ‘facts’ and in return you get all the wonders of modernity, only, as Bubandt points out, for many, those *wonders* never materialized.

The misunderstanding in approaches to “belief” are compounded when mapped against the framework of the biological sciences. Rather than examine how anthropology has interpreted “belief,” the discipline has leaned on biological sciences, especially the

medical sciences, to handle the issue of "irrational beliefs" (B. Good 1994, 21). The notion of culture as a system of beliefs—without examining the term itself—has done a disservice to anthropological research.

> Given the semantics of the term, that is the *meaning* "belief" had taken on by the late nineteenth century and continues to have in the twentieth century, the analysis of culture as belief thus both reflected and helped reproduce an underlying epistemology and a prevailing structure of power relations. (B. Good 1994, 21)

The power relations referred to by B. Good are embedded in the Miami model. One of the central problems in seeing the biological sciences as a machine rolling ahead, unveiling the natural world as it goes, is that the picture is more complex and nuanced than that. One of the major functions of religion is to manage other elements of the picture that relate to vulnerability and ambiguity—the shadows and grey areas embedded in a complex, nuanced picture. For the populations the Miami model sought to serve, these elements of life were prominent and shifting. As Sandoval states plainly when describing how people felt when the media was using Lucumí to demonize the Cuban population, *people were scared*. In her research on witchcraft in rural France, Jeanne Favret-Saada (1989) found that when one asks the direct question— *do you believe in witches?*— the conversation goes nowhere. Those living in rural France knew they would be mocked in an "objective" discussion into the existence of witches. When Favret-Saada began to experience inexplicable misfortune and clear vulnerability in her own life, the people started to open up to her. It was not a question of "belief," it was a question of how to protect yourself from harm. Likewise, when Mary Steedly (1993) began her research in Sumatra with the Karobatak people, she translated a common question she was asked to mean "do you believe in spirits?" Only months later did she realize that this was not what people were asking. Rather they wanted to know: What was her

relationship with spirits? How did she interact with them? No one was uncertain as to the spirits' existence, nor did they expect her to be either.

These examples illustrate a disjunction in interpretations of the world. While B. Good focuses on modern society leaning on science to settle the issue of "irrational belief," there is an additional layer to consider, that has to do with Abrahamic religions. As Christopher Kavanagh asserts, the central characteristics of Abrahamic religions are "endorsement of professed beliefs, regular participation in religious services, hierarchical institutions and exclusive membership" (2016). In line with Lorand Matory (2005), I would add a focus on eschatology and monotheism to this list of characteristics. Science, like Abrahamic religions, expects the "endorsement of professed beliefs," "exclusive membership" and monotheism, and singular answers to complex questions—in addition, a distaste for ambiguity. Kavanagh's research focuses on Japan: a nation arguably situated firmly in "modern society," but not part of the Abrahamic fold. In Japan few people profess religious "belief" or identify as "religious." In fact most people engage with multiple religions, Shintoism and Buddhism being the most popular among them. It is common for families to maintain multiple altars at home and attend rituals officiated by priests at community Shinto and Buddhist shrines. A foreign scholar visiting Kavanagh from the West was taken aback by people's engagement with multiple religion and quizzed a Japanese man about it, asking him which altar he believed in? Flummoxed, the man responded that he believed in neither, then, pausing, decided he believed in both. The question was not relevant: he had never considered it.

In this example, two divergent worldviews collide. One is held by the Western scholar who interprets belief not as a falsehood, as anthropologists so often do, but rather

as a commitment to a professed belief in a religion one holds exclusive membership in. From this perspective, practicing two religions is tantamount to falsehood. The other is held by the Japanese scholar who does not hold to the notion of exclusive membership or the need to profess belief in one specific religion, both altars are central parts of his life as a Japanese person. I would argue this falls under the issue of "irrational belief" that B. Good refers to, but unlike many of the instances he highlights, science is not leaned upon to settle the matter. Granted, health is not part of the irrational belief cited here. Still, it stands that the scientific thought associated with modern society that B. Good refers to is embedded in the same mind-set that Abrahamic religions are. This is not disputed by B. Good who argues,

> For fundamentalist Christians, salvation is often seen to follow from belief, and mission work is conceived as an effort to convince the natives to give up false beliefs and take up a set of beliefs that will produce a new life and ultimate salvation. Ironically, quite a-religious scientists and policy makers see a similar benefit from correct belief. (1994, 7)

Arguably, the critical factor is that, unlike the Cuban population the Miami model was aimed at, the Japanese living in their own country are not a vulnerable population. In that respect, whatever the Japanese "believe" does not have to be explained or defended to biomedical practitioners because Shintoism and Buddhism are not competing for space with biomedicine in their social imaginary. In this example, Kavanagh is not attempting to design culturally specific care for the Japanese, still his observations of the use of the term belief are helpful. Let us return to the goal of the "cultural broker" to provide culturally specific care for Cuban immigrants in general and Lucumí devotees in particular.

As previously mentioned, one of the key characteristics of Abrahamic religions is a concern with eschatology, while Lucumí, much like Shintoism and numerous other religious systems, is primarily concerned with the here and now. Divination is a central component of religious practice for those who are intimately involved in Lucumí as well as those who are on the periphery of this religious community. It is a direct way that people ask for help in life and receive direct answers, as well as specific actions or rituals that people can perform to be successful. Sandoval argues that magic rituals are performed to "obtain the attention of someone else's spouse, conducted to cause illness in an oppressive boss, or carried out to bring harm to the enemy of a client is perceived as protective rather than aggressive in nature" (2008, 359). The examples chosen here play into the stigma borne by Afro-Cuban religion, implying that rather than a fully realized religion, it is simply intended to satisfy selfish want. While certainly some people may have these motivations, people also worry about keeping their home from being bought out from under them ensuring a safe voyage, finding the best doctor to go to for an illness, or pursuing the right career.[2] The salient questions are: what circumstances must people contend with? What do they use magic for?

A common criticism of religions focused on the "here and now" is that they are opportunistic, and by extension, amoral. Rather than providing the Durkheimian "social glue" that keeps people together, they nurture "selfish" projects. Sandoval makes it clear that this is her position when she claims to have commonly visited the *iles* of santero/as to request that they "tell so-n-so that Sango wants him to take his medicine." Divination

[2] In Florida, it is common for a company (?) to pay a delinquent tax bill and take possession of a home. This is a frequent threat to older people who have paid off their mortgage, but may experience a delay in their ability to pay an annual tax bill.

is a complex and extensive system that people take years to master. In daily life, diviners must maintain not only the integrity of their divination instruments but their own integrity as well. To suggest that an anthropologist at the door can simply instruct a diviner to ignore the divining instrument to suit the interests and expectations of healthcare providers, reflects a deep cynicism. In addition, this position also supports the premise that the expectations of the biomedical system are more important than the integrity of the cultural system. It aligns with the interpretation of "belief" as an error in thinking and in judgement, based on the notion of "belief" in divination is foolish since the system can be easily manipulated.

Finally, B. Good notes that the notion that what people "truly think" about a subject can be deduced through anthropological analysis is a false premise. Anthropologists know that "all discourse is pragmatically located in social relationships, that all assertions about illness experience are located in linguistic practices and most typically embedded in narratives about life and suffering" (B. Good 1994, 23-24). One of the goals of the "culture broker" is to make healthcare providers aware of behaviors that they may be unfamiliar with but are culturally appropriate for the patient. In part, this helps providers better understand the "narratives of life" patients are using. Yet the essentialist's goal of getting to what patients "truly think" is still woven into the "cultural broker" design. The design refers to behaviors, such as trance possession, spiritual cleansing, witchcraft, and references to spirits as a part of everyday life, that are "culturally appropriate." Though the implication that they cannot be proven, so cannot be "true," mingles with the notion that something with such extensive cultural salience cannot be completely untrue. When I asked Penelope, a psychologist who grew up in

rural Cuba and immigrated to the US as an adolescent, about the value of understanding a patient's religious experience, she hypothesized about a mental health patient approaching her in passing and telling her that someone has done *brujeria* (witchcraft) against him. A healthcare provider unfamiliar with this may simply dismiss the comment, she stressed. But with training they may be more open to engaging the patient about his experience. Perhaps the patient had a small disagreement with one of the nurses, later that nurse ate lunch, tossed the remains into a paper bag, which she threw in the trash as the patient was passing by. Paper bags are sometimes used as a part of ritual. A patient coming from a social context where witchcraft is culturally salient would likely interpret this action as a sign that the nurse has done *brujeria* against them. To be effective, healthcare providers must be able to understand patients' concerns and address them accordingly.

The "cultural broker" also provided access to individuals in the community that could be of assistance in treating patients. This could be an important part of treatment. Penelope has once been part of a team treating a mentally ill patient experiencing conflict between the religion practiced by his family and his own interest in Vodou. To address this tension, she suggested bringing in a member of the religious community to talk with the patient. She was met with resistance, when other team members cited the patient's overall incoherence and dismissed the therapeutic value of Vodou altogether. She prevailed and a Vodou priest was brought in to talk with the patient. The case turned out to be a success as the integration of Vodou "opened up" the patient to treatment. These anecdotes illustrate that while the Miami model no longer exists, the tasks of the "cultural broker" are still being employed. Yet it is also critical to note that overall, healthcare

practitioners I spoke with did not have many patients who were devotees of Lucumí or Vodou to their knowledge. If religion came up, most of the patients in the mental health care system referenced mainstream Abrahamic religions.

Conclusion

The creation of the Miami model of cultural competency provides insight into one of Asad's (1993) basic questions, how does power create religion? One way to address this question is to examine religion as *negotiated* process. Initially, the expectation of cultural competency was to *reveal* patient's cultural milieu to healthcare providers with the understanding that it was the primary roadblock to getting Cuban patients to seek psychiatric care. In hindsight, it was not in fact a reveal but a shift in Lucumí representation and by extension, subjectivity. In this way the cultural competency paradigm facilitated a racialized reproduction of Cuban identity that Lucumí became bound up in given its exotic and stigmatized visibility intersecting with the collision of conflicting Latin American and Anglo-American racial ideologies, and the common understanding immigrants absorb that to be successful in the US you must be white or "lighten" yourself as much as possible. While Asad argues that "religious discourse in the political area is seen as a disguise for political power" (1993, 29), in this instance, religion in the biomedical domain became part of an effort to leverage political power. Lucumí was an element of Cuban culture that white Americans could not look away from or un-see. I do not want to suggest that the Miami model sanitized or sugar-coated Lucumí in order to make it palatable to the Euro-American power structure. Instead it seems that two things occurred: the ethnic enclave became so large and entrenched that

Anglo-American stigma was diminished within that space; and neoliberal policy restructured biomedicine shifting individuals seeking healthcare from *patients* that had to do what they were told, to *customers* that had to be satisfied least they take their business elsewhere. As one of my interlocutors, Bartolomé, who has been a Lucumí devotee and a registered nurse for over thirty years, told me, attitudes changed dramatically since he first entered the medical field. “If you watch any [old] movie, the nurse image that you see will be an old lady, *really mean* and she’ll say, “Sit there! Don’t move!” A lot of people were like that [when I began nursing]. I still remember those times.” Today providers’ approach to patients is much more accommodating. As he put it, “So now it’s, what do you need? ‘Three roosters and a chicken, we’ll have it!’” The Lucumí community adapted within the power structure in which it found itself, and while it did not fully gain power, the actions of academics and religious leaders have significantly contributed to the reshaping the sociocultural landscape and power dynamics of South Florida.

Chapter 2

Ethics and Everyday "Lived" Religion

In a busy *casa-templo* (house temple), a person is often pulled in multiple directions. One afternoon, after a long morning of ritual production—*Mina* had made two of the *orisha Inlé*, the divine doctor, who governs health—there were people, unrelated to those receiving the *orisha*, waiting outside to consult the oracle. Mina had to set down preparation of the *ashes* (sacrificial food offerings) for *Inlé*, the culinary part of the ritual, to attend to the people waiting. Since these were regular visitors who often required an extended amount of time, she asked me to plate the offerings for *Inlé*, telling me that they had to be delicate and beautiful, much like offerings for Ochún, the goddess of sweetness, honey, love, all those things that instill passion for living and in this way keep life going. Plating ritual food offerings is a small task, but one where attention to sacred alignment is important; the numbers, colors, and character of the *orisha* represented must be aligned. Yet, beyond that, this is an opportunity for the person performing the labor to express personal artistry and character and to unmask the magical in the mundane, thereby opening the door for a devotee to be seen by that *orisha*, via material effort.

This chapter explores how both *micropractices* and other aspects of quotidian religious devotion build conceptual religious worlds and ethical identities. For Lucumí devotees, religious practice incorporates numerous micropractices—ranging from fumbling through proper greetings, such as tapping right shoulders then left before

embracing, to the quick spiritual cleansing through passing a ritual offering over the body—which serve to inculcate individuals into a religious framework and assist in binding members to the social group (Pérez 2016, 49). Many of these micropractices are rooted in the understood "desire" of the *orisha*, sometimes gastronomical, others audio, or visual, still other desires come in the form of attention to health and illness. This chapter is constructed on the understanding that human beings are fundamentally ethical; for any given situation they make decisions based on what they deem the "right" choice (Lambek 2010; Keane 2016). Through micropractices ethical identities are constructed within the religious community: ethical identities that flow into the medical encounter.

In terms of semantic productivity, the mundane is profound. For this reason, many anthropologists who wish to explore ethics argue that it should emerge out of an analysis of everyday human engagement, of what we call the ordinary. In this chapter, I argue that the ethics of Lucumí can be understood through micropractices and everyday practice which reflects the importance of alignment with the *orisha* and effort in simple tasks that are premised on an understanding that the world is diverse and multifaceted, all things in it having a role to play, and all things having an influence on one another. Through an analysis of micropractices and the mundane within religious practice, meaningful worlds are built which provide devotees with a framework to make meaning out of illness. You rarely hear "Why me?" in social discourse. Anthropological discussion of 'ordinary' everyday ethics and the building of meaningful worlds provides a useful framework to shape this discussion. Michael Lambek argues that "ethics can be found not only in the balance between continuity and innovation but in the movement or tension between the ostensible (explicit…) and the tacit (implicit…) and between the application of criteria

and the recognition of their limits" (2010, 28). To this end, this chapter begins with an account of the *anniversaerio,* or sacred birthday, the date of an *olorisha's* initiation then continues to explore the micropractices embedded in these events. Then the discussion shifts to the discussion of the *ori,* "inner head," and its positionality in these micropractices. It is through the *ori* that micropractices can hit their mark. Then the chapter shifts to examine how micropractices and quotidian devotion as shaped by the *itá* of initiation [lifetime reading done as part of *kariocha* initiation] engage with anthropological discussions of everyday ethics. Finally, expanding into ethical applications beyond the world of the living.

An anthropology of ethics must be embedded in how people make immediate choices and rationalize these decisions within a given social context. According to Mary Douglas, the implicit "furnishes the stable background on which more coherent meanings are based" (1999, 3). Within a social context, implicit meanings often relate to the social cosmology which dictates this "background" knowledge. The implicit is the lynchpin of most human discourse and reason, which is choreographed around reinforcing social truths without ever making these truths explicit.

The *Anniversaerio*

One day, while I was visiting my *Mina*, she turned and said to me "I have to go throw coco for my goddaughter, Katarina. You remember her, the little Ochossi?" I did remember her. She was just a teenager really, but a very serious one, she had decided she needed to 'make ocha' that is, be initiated into Lucumí. To that end, she worked tirelessly at odd jobs to save the debt. It was no small feat, Ochossi is one of the costliest initiations

to hold, owing to the additional rituals (and exotic "extras" required) that must be performed. Birthing a new initiate of Ochossi, the mild-mannered, quiet god of the hunt takes more than the standard seven days, as the addition rituals must be done in proper order prior to the beginning of the initiation.

In Miami, to "make ocha," or "make *santo*," refers to the standard *kariocha* initiation, a ritual process likely modeled after kingly initiations in Oyo, the center of early nineteenth century Yoruba civilization.[1] It is a seven day ritual where the initiate is isolated in a small sacred space in a *casa-templo*, their tutelary *orisha* is ritually 'seated' on their head, a set of the pillar *orisha*—Obatalá, Ochún, Yemayá, and Shangó (for some initiations other *orisha* may be added)— is made for them, and they receive their *itá*, an oracle intended to provide lifetime advice. Each new *olorisha* is born from an elder one, who is referred to colloquially as their godmother or godfather. The person designated *oyebona* is the primary assistant of the godparent, performing much of the labor critical to the creation of a new initiate. As George Brandon (1993) observed, this ritual family structure is likely modeled after that of the Catholic godparent system. After the initial seven-day ritual, the individual, now an *iyawo*, or 'bride' of their tutelary *orisha*, regardless of the gender associated with that *orisha* or the initiate, the person must wear white and avoid social activity for the following year. On the one-year anniversary, they generally have a celebration where they set up a *trono* (translation) for their *orisha* to set in, covered in fruit and or food offerings. It is after this time, and not before, that the new initiate can begin to participate as a priest/ess in Lucumí ritual.

"I just have to get a few things together first." Mina was always pulled in multiple directions and, consequently, you could be sure that celebrations and other events she

organized would rarely start on time. She had numerous godchildren to tend to and the needs of godchildren, as well as her grandchildren, can be endless. The first time I heard her say, "I have to throw coco for my godchild," I was flummoxed. Baba, my original (deceased) godfather, avoided leaving his home. He would generally attend a godchild's first birthday, the event that effectively marked the conclusion of the year in white. All of us were expected to set up a throne for our newly graduated *orisha*, the more elaborate the staging the better. We draped the room with cloth suspended from the ceiling and set the *soperas* of each *orisha* at the appropriate height and position, relative to the other *orisha* and the attendees, adding plenty of fresh flowers. Each *orisha* would be crowned with the appropriate fruit in the appropriate number, or alternatively the fruit may be laid out between the audience and the *orisha* mixed in with the candies sprinkled over the warriors set on the ground. The *soperas* would be covered in *paños* (an elaborate cloth) or they may be crowned with different food, such as petit fours for Ochún and white bread for Obatalá. There were also the four puddings for the four pillar *orisha*s: rice pudding with golden raisins dusted with cinnamon for Obatalá; rich buttery-colored caramel flan for Ochún; hearty cornmeal pudding with dark raisins dusted with nutmeg for Shangó; and sweet dark sticky coconut pudding for Yemayá. In addition, a meal would be provided for all participants. Lunch was expected. Usually a simple roast chicken with black beans and white rice. Everyone with an *itá* had been given a list of foods to avoid, but almost no one was told not to eat chicken.

Baba and his entourage of temple priests would come to your house and visit, socializing until a fair number of people had arrived. Once there were enough witnesses, he would throw *obi* [coconut oracle] for each of your *orisha* to see if they were satisfied

with your offerings.[2] *Orisha* who expressed displeasure would have their offerings supplemented. Did Elegguá want a spray of rum? Did Ochún want a dish of honey? Did Shangó want to keep his bananas until they turned black? He would also ask if the fruit was to be shared with the people in attendance, for good luck. Usually that was the case, and you spent the latter half of the party making sure that no one left without a bag of fruit and candy. After that first year, there was no expectation of another visit from Baba, unless you were having an elaborate event for a "big" birthday, generally one that fell on the sacred number of your tutelary *orisha*.

When my godmother first asked if I remembered Katarina, I did, but I was pretty sure she had been initiated for two or three years, nowhere near time for a "big" celebration. It would be another few weeks before I realized that it was commonplace for Mina to go to all of her local godchildren's homes, on the anniversary of their initiation, to act as the intermediary between them and their *orisha*. This form of engagement with the *orisha* is relatively humble and modest, yet it gives us a useful framework for examining the role of ritual engagement in the Lucumí community.

Birthdays and Micropractices

While the celebration of a sacred birthday is not significant on a grand scale, embedded in it are the many of the *micropractices* that Pérez (2016) stresses are fundamental to religious identity as they build it up "bit by bit." Micropractices are those "routine and intimate sequences of operations that can be broken down into more minute unites of activity" (2016, 9). While to the outsider these small exchanges may seem inconsequential, Pérez argues that, in fact, they "hold the chief ingredients for the

survival of Black Atlantic religions because they develop the faculties, sentiments, and expertise indispensable for their viability and spread" (2016, 11). These small "bits" are critical to how religious conceptual worlds are built and how moral and ethical communities set limits on practice. The birthday celebration is a space for community socializing, a ritual that is more focused on the casual consumption of food and conversation, than the many rituals of production that the community engages in. The *obí* divination also gives shape and meaning not only to the moment, but to the religious practice as a whole, it takes the existence and "desire" of the *orisha* for granted and the officiating presence of the godparent honors and reinforces their position in the community. According to Pérez, "Overtime micropractices instill a palpable sense of the spirits' reality—including the unapologetic urgency of their desires—while inculcating obedience to the religious leadership of a tradition" (2016,7).

On the surface, the interactions of the people and the *orisha* may appear casual, but the effort put into the *ilé* is a central part of the practice of Lucumí, an activity that binds devotees back[3] to their religious lineages. Ricky, a *santero* I spoke with, who had also started his religious life in Chicago, remarked that, unlike his experience in Chicago, in Miami he found that many people helped with preparations, especially if it was a person's first *anniversario*. Elders in the house would help them with the cooking and preparing the *trono*. These *tronos* would also highlight the royal iconography embedded in Lucumí practice. As David Brown explains, "Come festival time, the tureens, or *soperas*, received royal honors; they could be enthroned upon plaster Corinthian columns; draped with dazzling satin, lame, chiffon and lace, and presented with mounds of fruit and masses of flowers" (2003, 2). Much of this royal iconography draws on the

images of European colonial royalty so common in the Cuban practice of Lucumí, while in fewer instances the iconography is intertwined with West African royal ascetics.

When we arrived at the home Katarina shared with her parents, Mina and I were met with a *trono* that was both familiar and strange to me. Miami is a hub of Lucumí practice in the United States. You can get just about anything you need and you have your pick of ritual experts, as well as a *trono* designer who will arrive at your door with a plastic tub filled with yards of beautiful cloth—chiffon, silk brocade, satin, lame—riddled with holes from tugging it down from ceilings and walls where it has been attached with a staple gun. He knows how each *orishá's ilé* is put together, the appropriate colors, designs, and symbolic accessories. To the traditional elements he adds his own signature style of tight straight folds and layers of elaborate cloth set on a diagonal culminating in rosettes. In Chicago, Baba designed all of the *ilés* himself, this was one of his signatures. Each *ilé* was original and unique, while each did include the required ritual symbolism and was thematically appropriate to the *orisha* in question, his *ilés* were more akin to opera sets. When it came to a godchild's birthday, they designed their own *ilé,* observing the order and height each *orisha* should be at. Katarina, or her parents, had hired this popular *trono* designer for her birthday celebration and I was struck by the codifying effect of this ascetic.

The *trono* took up nearly a quarter of the large rectangular living room, roughly the same size as an initiation *ilé*.[4] The walls and ceiling were covered in his signature strips of folded straight cloth, set at a diagonal against the wall, climbing up to cover the ceiling, the lighting in the room was dimmed and the *trono* was backlit to complete the dramatic effect. Her numerous *orisha* were set up on pedestals, her Obatalá towered over

everyone, as is standard for the king of the gods, but her tutelary *orisha* Ochossi was most prominent and when we sat down on the low set couch, we had to look up to admire his brass bowl crowned in antlers. I leaned over to Mina and said, "I didn't know your *ilé*-guy did birthdays."

We sat for some time, chatting with the visitors. This was clearly a social event for Katarina's family, lots of people came and went. A number of them were *babaláwos*, so I followed Mina in leaning down before each with one hand, touching my fingertips to the floor, and reciting the prayer in honor of the *orisha* of divination, *Orunmila*. There was fruit piled up in front of the *ilé* and we had to walk gingerly around it to salute Ochossi, Mina on her stomach and myself on each hip.[5] I shook his rattle to thank him for the opportunity to visit and to ask his blessings on the house, then I carefully leaned over to place a money offering in a *jicara*[6] (gourd bowl) lined with silky blue and yellow cloth.

After an hour or so of visiting, it seemed enough people had arrived to do the divination. Katarina brought Mina a plate of five round pieces of coconut with a small *jicara* of water balanced on a stand in the middle. Someone stood by and shook the rattle, or other percussion instrument appropriate to each *orisha* as she went through addressing each one, reciting her *mojuba*[7] and tossing the pieces of coconut to the ground to observe the pattern that fell. She gave *obi* to all in the *trono*, starting with Elegguá and ending with Ochossi. It was a lengthy process and when it was finally over, Katarina's elderly grand aunt came out with a homemade flan. We each ate a slice then began our good-byes. Katarina asked if we wanted to stay, they were roasting a whole pig in the back

yard. It seemed the party was just getting started, but there were more godchildren and grandchildren to attend to, so we said our good-byes.

The Head

Selena, who often wore a pair of reading glasses not realizing there was a pair on her head, had been friends with Mina long before she was initiated into Mina's house. Every year, she got a rogation on her *anniversario*. A rogation is a cleansing ritual for the head, to lift negative spiritual influences from it and provide clarity of thought or emotion. This cleansing ritual is relatively modest within the body of Lucumí ritual, while it must be done by an *olorisha*, it does not require a ritual expert, in fact, it is a task often delegated to an assistant. Still, it is a commonplace illustration of the significance of the head in Lucumí cosmology and likely relates to the Yoruba concept of *orí* the 'inner head' which guides a person's destiny and shapes their character. The physical head represents the *orí* but they are not the same. In Nigeria and in Brazilian *Candomblé* there are more complex and involved rituals for the *ori.* According to Miguel "Willie" Ramos (email message March 7, 2022) the Yoruba concept of *ori* is present, but dissipated in Cuban Lucumí. While Selena was intent to have a rogation every year to mark her *anniversario* this is not standard practice within the community.

Although attention to the head is not elaborated on within the Lucumí community in general, if one asks, a member of the community will venture a response. If that member of the community is a respected elder, or a ritual expert, then their response will be granted more respect. Nonetheless, the significance of the head serves as the 'background' against which much of the ritual unfolds. Through the body of ritual, the

importance of the head is referenced. The person who constantly bumps their head is told to receive a rogation or perform another ritual cleansing to mitigate the spiritual damage that extends from the physical. Even minimal head bumping is either interpreted as causing spiritual damage or caused by spiritual troubles. The *orí* is central to a person's success in life (Makinde 1984). The rogation ritual is performed either specifically to fortify the head to make good decisions in life, or as part of an extensive web of ritual ultimately expected to keep the person on a positive and productive path in life.

Ethics and Everyday Devotions

Lambek argues that an anthropological analysis of ethics must be approached through the lens of the social. Racial ideologies are at the heart of the social in the US. Ethics exists in the space between the explicit and the implicit, be that space full of tension, or simply movement (2010, 28). In this dissertation it is fair to parallel the explicit and the implicit with the seen and the unseen. Fundamental to finding the ethical is the examination of people's criteria in evaluating what is ethical and the recognition of "their limits" (Lambek 2010, 28). The critical elements of the ethics of everyday life are activity, practice, and judgement—rather than rule and obligation (Lambek 2010, 28). The ontological premises upon which activity, practice, and judgement are based within the Lucumí context is what needs fleshing out here. In the case of Lucumí this is split between people, *egún*[8], and *orisha* through ritual and divination. There is a constant need to "check-in" with your *egún* and your *orisha* to evaluate your position in the spiritual and material worlds: the birthday celebration is one consistent way to do that. As Ricky puts it "Spiritual communion with your source of strength" is a central part of the

anniversario. He goes on to say that "we tend to think of our relationship with them not their relationship with us…But they kind of want to see us on our anniversary too. It's communion." Not everyone celebrates their *anniversario* with a professional *trono,* this is expensive and not always available. Some people prepare their own throne and may embellish it with *addimus,* food prepared specifically for the *orisha,* rather than fruits. In addition, the *anniversario* is a time when *orisha* are rearranged. I attended one of Selena's celebrations and all her *orisha* were arranged on pillars and small tables in front of the china cabinet where they were kept. The balance between movement and stability, hot and cold, is a common theme in Lucumí practice. To get your *orisha* going, to make things happen in your life, it is considered important to move them from their everyday position, usually set in the background, on a shelf or cabinet away from daily activity, and set them in the foreground where it is clear that your intention is for them to act on your behalf.

According to Lambek, judgement as process is "prospective… immediate… and retrospective" (2010, 43). In that prospective stage we are evaluating the proper way to live. On the third day of the seven-day *kariosha* initiation ritual the *obá oriaté* performs an *itá* generally referred to as a lifetime divination, a person's "book."[9] In the *itá* each of the *orisha* that the person receives during the initiation has the chance to speak through the *Diloggun* oracle (the cowry shell divination system read by *olorishas,* in the case of an *itá* it must be read by an *oba oriaté*). The book is meant to guide the novice on proper behavior based on the individual signs that come up. As Holbraad explains, it is "not so much people who make divination as divination makes people" (2012, 85). By extension, divination builds moral imaginaries allowing people to see a life that the advice given in

the *itá* is meant to create. As Richard Werbner (2017) argues, divination allows for "reflexivity, for heightened consciousness" which also serves in the "unmasking the hidden in everyday life." There are two hundred and fifty signs and each has multiple qualifiers before it is complete, given this level of complexity each initiate's "book" is singular to them. The *itá* is central to Lucumí subjectivity as "how the self is incited or invited to become a moral subject" (Das 2015, 135). Mina once told me that it was very important to her to have her own children initiated at a young age in order to have that book as guidance in how best to raise them. Needless to say, there is plenty of debate in the community about what age is best to put a child through the rigorous ritual, if at all. Nonetheless, the centrality of the *itá* as prospective in evaluating proper behavior for a person is widely agreed upon. According to Mina, the person that has their book, and lives their life accordingly, is able to be the best version of themselves. In other words, their moral imaginary becomes personalized within them.

Often, much of the information contained in the *itá* are prescriptions and proscriptions for the novice, some of which is considered "common sense." Yet when this "common sense" comes during such a significant divination, it is foregrounded. During one *itá* I attended, the new initiate was told to be careful not to leave her drink unattended in public. This is good advice to anyone, but in this context the implication was that at some time in this person's life, they *will* cross paths with someone who will poison that unattended drink, rather than that they *may* cross paths with such a person. Or, alternatively, it may be a warning that the new initiate is too trusting overall and needs to be more suspicious of people's intentions. This advice, given in the context of the *itá*, provides license to the new initiate to take these precautions. Ritual establishes a

new set of criteria, according to Lambek. When a person publicly commits to a ritual and follows through with it, they make a public commitment to a new set of criteria. With this public commitment the person is able to alleviate a private sense of ambiguity or obscurity in their life through the "public clarity" of the ritual and the set of criteria that accompany it (2010, 46). For example, when a person goes through the *kariosha* and receives their "book," that new criteria is laid out. Whatever insecurity or ambiguity the new initiate may feel about leaving an unattended drink in public, she has been given the "public clarity" which necessitates that act as ethical behavior based on a ritual commitment. In other words, she does not need to feel embarrassed or apologetic for protecting her drinks in the future.

Lambek describes the "immediate" stage of judgment in terms of action, "doing the right thing, drawing on what is at hand, jumping in" (2010, 43). Much of the advice given in the *itá,* involves rituals to perform in the event of acute need—for instance, "If a time comes in your life of grave difficulty, do this specific ritual and a solution will reveal itself." While other advice relates to how to manage the framework of life, like what rituals should be done regularly to keep peace in your household. For parents this guidance is often used for childrearing. I once attended a ritual for the *egún*[10] at a home north of Fort Lauderdale. The ritual was for a ten-year-old girl. Unlike urgent rituals designed to remedy a specific problem, this was a ritual that was called for in her "book" and intended to promote her stability. Her parents were hoping that she would be admitted to a special academic program in the local school district. If she was admitted, then her educational opportunities would be expanded. They felt that it was best to complete all the rituals called for in her *itá,* in hopes of laying the best foundation for her.

There was no expectation that were these rituals left undone any immediate harm would come to her, Still, it was understood that she would not gain the "firm" character that her parents hoped would ideally come to define her; in effect the ritual would "make" her, as Holbraad suggests. That firm character they expected would help her at a critical point in her schooling when she had the opportunity to enter the program. We managed to complete the ritual just in time for mother and daughter to make it in time to gymnastics, another activity the parents felt would help develop their daughter's "firm" character.

In the final stage of exercising judgement, a person is "retrospective" on what has been done (Lambek 2010, 43). Often this reflection involves forgiveness. In some instances, this retrospective step can be obscure, especially in a "spiritual" context. Lucumí ritual strives for affirmation, every step involving divination to confirm that that step has been done correctly. This is in large part what assures that a ritual is "done right" and meets the community's public standards for propriety. Yet, embedded in this constant "check-in" is the potential for doing the ritual incorrectly and the concern that a wrong move will cause a negative outcome. Always looming in this context is human fallibility: the potential that the person doing the divination will utter the prayer incorrectly, that they may ask the wrong question, or that they may misinterpret the signs all together. In still other instances, what is occurring on a spiritual level may be opaque to a devotee, and it is not until a divination, or other spiritual activity that this obscurity is revealed.

Maggie spent her childhood in a small town in Cuba. She and other children would visit religious events to get sweets and fruits. At no point in Cuba did she have any interest in Lucumí, and after she moved to the US as a teenager, she remained indifferent. As she put it,

> I wasn't interested in the religion until I was like forty-two years old. My husband's cousin, she did *santo*. And she invited us to the *missas* and we started going. And [my husband], he never believed in nothing. He said he believed in Saint Dollar. But that was a religion that kind of interested him, and we got involved and that's when I realized that—all my life I been spiritual, I put out a glass of water with the Virgin and ice in the doorways, I didn't know why I did it, I just did it because I thought it was good. And then I found out that it comes in the family. My grandmother was a spirit host, she pass the spirit, my mother pretty much also but she denied it always, in the chain it was my turn.

For some devotees, the prospect of having spiritual problems that are unclear until visiting a diviner motivate constant *ebo* (ritual sacrifice).[11] In fact Diane, a woman who had been initiated in Miami in the late 1980s, and later initiated one of her children in Miami and the other in Cuba, informed me that she was constantly performing *ebos* for her *orisha*. She suffered from numerous health problems and felt she needed to be vigilant in her spiritual practice. The *babaláwo* that she consulted regularly told her, "If I needed to make a living, I could never make a living off of you because you don't need any big jobs." When I asked what he meant by this, she said "I cleanse myself every day. I'm clean." Another long-time initiate, Loupe, was initiated as a teenager. She spent many years feeling ambivalent about her *orisha* and not utilizing her talents as a medium. After a series of car accidents roughly fifteen years before, she found herself facing life in a wheelchair. She went to a diviner and was able to perform an *ebo* to prevent this, but she also had to "work the religion," as she put it, use her talents as a medium by attending spiritual masses. Every time I visited Loupe's home, her *orisha* were topped with offerings. During one visit her *orisha*s were all topped with cakes, Ochún with a yellow-cake jellyroll topped with capuchinos (cone-shaped sponge cakes soaked in anisette syrup).[12] The first time I visited she was preparing *harina* for Shango. After years of skirting religious engagement, skeptical of its role in her life, Loupe changed her

position. Holbraad argues that there is "a general notion that all human experiences are in one way or the other under the sway of the *orisha*s" (2012, 98). In divination, questions of truth should not be equated with questions of *actuality* or fact—reified concepts—but rather of representation. Within this space representation relates to *possibilities* and *necessity*, two concepts that allow for doubt, as Loupe's years of avoidance illustrate. Yet after Loupe experienced a series of accidents, the pull of necessity (avoiding the wheelchair) and possibility (she had also left a stressful and dangerous job to pursue a teaching career) laid out in divination motivated her to actualize these representations, ultimately changing the facts/ "truth" of her life. As she put it, "Some people believe, but we don't believe, we know it exists. And I think in *santo, egún*, they move mountains and they don't ask a lot from us. People think you have to do a lot, but no. I'm making some *harina* now, for Shangó, hell I put it to everyone."

These "retrospective" micropractices, in part, constantly reproduce *orisha* and in this way render them a reality. Elizabeth Pérez posits that it is in feeding and talking about the *orisha*, they become "real to others" (2016, 8). Given that it is often in retrospect that we search for meaning and evaluate, or at times create, the ethical dimensions of an event, or in other instances, an entire life, I would argue this is the time when our ethical framework is consciously being built, a critical layer of identity, "bit by bit." Yet not only does it reproduce the *orisha*, it is the *orisha* in action. Every day that Loupe wakes up not in crippling pain, the long shadow of the wheelchair invading her consciousness, her *orisha* are active in her life. Every time Diane consults the *babaláwo* and he informs her that her signs reflect her constant cleansing, her *orisha* are active in

her life. As they both reflect on "what was done" the affirmation is evident and the ethical framework is set, the proper way to live, at least within this realm of life.

Truthfulness and Ethics

The approach here assumes that ethics is "basic to the human condition" (Lambek 2010, 2), something that need not be thought of in isolation, but rather integrated into the everyday. In essence, to be human is to weigh the "right thing to do" in any given situation. But what of the context of the everyday? "Criteria define context of action" and the context can be changed and by extension the criteria (2010, 44). The criteria also define truth and falsehood. Yet "truth" is made messy by "alternatives." In this respect "the "lie" is a subspecies of the alternative" (2010, 46). Ritual produces certainty as it "assur[es] the truthfulness of any given utterance or set of propositions…they render such acts of commitment difficult…to take back" (2010, 47). So now that we have gotten from judgment to criteria to truth, Lambek posits that "[t]ruthfulness and committing to specific ways of doing or being are fundamentally ethical matters" (2010, 47). Still, at this point I think it important to examine the concept of truth and how "truthfulness is conceptualized (an issue I return to in chapter four). While in some context "truth" refers to a simple revelation of material reality, something "seen," in divination and Spiritism, often understandings of "truth" relate to unseen spiritual influences that create material reality, including the "truth" of a person, in other words, the best version of themselves.

Webb Keane argues that "[t]o be ethical is to be invested in a way of life and to live up to some vision of what a good person ought to be" (2016: 22). In Lucumí part of that "vision of what a good person ought to be" is evident in how an individual relates to

a deceased loved one and the material manifestations that follow. Mina's husband Poppi passed away during one of my short visits to South Florida. Months later I returned to Miami and she relayed to me the many miracles that she and others associated with him. She said that people called her every other day with a report. A serious storm had blown through since I had been there last, during which a large branch had broken off a tree and gotten stuck on Mina's roof. As I wrote in my fieldnotes:

> ...a large tree branch fell onto an electric wire in her backyard and there was no way for the electric company to get into the space with their large equipment to cut the branch and free the wire without electrocuting an employee. This went on for a few days, the branch hanging over the rooftop of the outside kitchen and so on. So she was really concerned, had no insurance and told [her husband] "Babe, I don't know what we're gonna do." She even moved her above ground pool so they [the electric company] could get in but by that point she was off their list. The next morning she gets up and goes outside and the branch is standing up on the ground. Nothing has been moved from the roof (as would have been if the branch had slid off the roof) it was just up on its side, erect on the ground, the wire untouched. No one ever lost power. Everyone said it was Abreu, Enrique's [a godchild] hair stood up on his arms.

Part of what surprised Mina about Poppi's many "miracles" was that, as she said, it usually took a spirit about a year before it could perform miracles. The fact that Poppi was able to so soon after passing was a testament to his *aché* as an *oba orieaté* and his good character as a person.

Poppi's miracles fortified Mina's ethical identity. The drive to tend to the needs of godchildren was a part of her understandings of ethical behavior, a constant, fundamental to what she considered her responsibilities as a Mina: her "vision of what a good person ought to be." Efforts to differentiate ethical behavior from other species of human behavior often hinges on the issue of motivation with the understanding that what is "ethical" cannot be done to attain a goal, or with the expectation of some sort of result. While anthropologists tend to problematize this understanding of ethics by effectively

spreading it out over the bread of everyday life (Lambek 2010; Keane 2016), the notion of motivation is still a salient one. Pérez (2011) argues that in the African American Lucumí community the spiritual *missa* serves to reach back to the past and render it salient in the present in a way that serves to maintain devotees' ethical framework; the motivation in religious work is to fortify an ethical identity. The effect is often one of creating a 'dividual' merging into a personal and social history that is altered by this merging. Mina's strength lay in her integrity in being attentive to the religious needs of her godchildren. According to Ricky, this sort of action was, in many respects, what maintains the religious family, and by extension, negligence of this sort of action was a sign of disinterest in the religious unity on the part of the *iyalosha* or *babalosha*. It was also an illustration of how Mina in part functioned on a dividual level within the religious family. As she and her late husband were professionals in Lucumí, making their living through providing religious services, this merging was central to her own ethical framework and central to success. In turn, the behavior of godchildren was also crucial to maintaining this religious family network. In having Mina over to give *coco* for an *anniversario*, that godchild was also fulfilling a "vision of what a good [godchild] ought to be." When I asked Mina what were her expectations of observing the *anniversario,* her response was, some years you are able to do it, some years life is too busy and you miss one. The *orisha* understand. In this way what is ethical in everyday life is a reflection of what is ethical in the world beyond everyday life.

Conclusion

According to Lambek, ritual creates truth in that it commits us to a specific way of doing things. The *itá* commits the *olorisha* to a way of doing things. The attention the godparent gives to the reading and explaining of the *itá,* after it has been divined, can often be as spiritually intense as the original experience of divination. Mina took great care in explaining a person's signs to them and reflecting on each. If, by chance, she had the same sign in her *itá* that was all the more cause to feel bound to the house. Werbner argues that for us to analyze the creation of the moral subject, we must look, not strictly at the interior world, but at what happens beyond the self, at "the pursuit of well-being in the world, not to focus narrowly on the inner thought of an individual but on relations between the self and others in social interaction" and also to realize that "the reflection almost always has to be understood in the light of engagement with ambivalence, conflict, and contradiction" (2017, 82).

Yet, within this context it is incorrect to suggest the choice is between what is truthful and what is false or a lie; instead it is the choice between various alternatives, the ritual serving as a public declaration of which alternative has been chosen. It is *truth* expressed through *action*. According to Rappaport (1999) one of the fundamental problems for human beings is recognizing the "lie." Yet, in this discussion Lambek describes the "lie" as "a subspecies of alternative." We make allowances in our judgements of people by taking into consideration *their* truths, as Webb Keane describes explaining marriage customs in the US to a woman in Indonesia. The lack of customary exchange of elaborate gifts in the US initially offended her, then she rationalized this with the understanding that this was the custom in the US. In effect, we come to the

conclusion that ethical behavior is not based on a universal but what is appropriate in a given social context: the social context that a person is embedded in, and consequently committed to, should dictate their understanding of "what a good person ought to be."

A frequent topic of conversation is the person who rejects the advice given to them in divination and the consequences that follow. Sabrina, who had been initiated to Yemayá shortly after the 1993 Supreme Court decision legalizing Lucumí, a cause of great celebration at her ceremony, often expressed frustration with a close friend who, by her account, suffered needlessly. Her friend had been advised in divination to receive her warriors and get them for her young daughter as well. But her friend constantly bemoaned that she did not have the money and therefore could not hold the rituals, even though they required minimal expenses. When we spoke, Sabrina told me that her friend was currently on an expensive vacation with her daughter. The two of them had been in five or six car accidents, and her friend's divorce from the child's father had resulted in joint custody when her friend failed, reportedly through her own negligence, to secure full custody. Rather than follow through in receiving the warriors, the friend insisted the car she had had the accidents with had "bad juju" and bought a new car. Meanwhile she called Sabrina every day to complain about the state of her life, asking her advice on what to do. Sabrina reminded her of what was undone; every so often her friend brought over a few dollars to be put toward her warriors.

When Sabrina shared this story at a table of *olorishas,* reactions were mixed. Though everyone agreed on what the friend should do, and that her constant complaints must be tiresome, Sabrina's aunt reminded her that the friend lacked the religious network that Sabrina enjoyed. The friend only knew one *olorisha,* Sabrina, so it was

understandable that she was uncertain about how to proceed. An uncle seconded this, stating plainly "She just doesn't believe. That's all." As Keane observes, our understanding of ethical behavior is rooted in a social context, one that we are committed too and consequently committed to following through on what a "good person ought to be." By the reasoning of Sabrina's aunt and uncle, her friend was not embedded in the same social context, so she was not confident enough to take the actions sanctioned within that social context. Yet, by Sabrina's assessment, the friend's behavior did not met her criteria of a "good person," worse yet, they were minimal and tepid, a reflection of her trepidation about divination and Lucumí which explained the abysmal state of her life.

One of the fundamental "truths" of Lucumí practice that is implicit, as Douglas describes as part of the 'background' of the social discourse that shapes social context, is that a person can and should *act*. When faced with hardship, it is a person's responsibility to consult an oracle, or to review their *itá,* or to see a Spiritist, or, at the very least, to pray for a lucid dream (spirit communication), in order to gain insight and clarity into the spiritual forces influencing the situation and how they can mitigate or manage these influences. Given this social context, ethical behavior when a person is ill, necessitates learning what role the spiritual is playing in this misfortune. When a person is prompted to as "Why me?" the spirit world is always prepared to answer, not only "Why?" but "What can be done?"

Chapter 3

When the Doctor Doesn't Know:

Managing Uncertainty through Lucumí

I have a doctor who is a *santero*. My *madrina* gave him his *santo*. I prefer that one, because he'll say, "Why don't you ask Obatalá and come back in a few days?" I really prefer that one. Because regardless, he knows I'm going to do it.
—*Diana*

It was not unusual to hear about *olorishas* in biomedicine like Diana's doctor. In South Florida, the interface of biomedicine and Lucumí is rich. This context allows us to examine, following Susan Levine, how these two paradigms of healing, can co-exist and in fact "be linked *usefully* in both knowledge and practice" (2012, 3). Bartolomé, whom you may recall from chapter one, often used the mediumnity he had developed in his religious practice to guide his work in the hospital. He once had a patient with a persistent inflection, who had been on antibiotics for months. After unsuccessfully draining the infection, a doctor in the hospital where Bartolomé worked had surgically opened her from tailbone to groin, cleaning down to the bone, to clear out the infection, unsuccessfully. She no longer remembered how long she had been on antibiotics. The surgeon wanted to try again when Bartolomé met her**.** Bartolomé asked the woman not to go forward with the surgery but to let him dress her wound and give it some time. She came back to him repeatedly for a month and a half, after which the wound had healed to a small opening. Delighted, the doctor called for another surgery to close it, Bartolomé

begged her not to let the surgeon touch her, but instead continue to let him treat the wound. In the end, the wound completely healed without additional surgical intervention. "And even to this day when I move to another hospital and I see her, she says 'that's the nurse that was able to heal me,' so that kept me going in the nursing area." The uncertainty produced when clinical interventions do not unfold as predicted often leads devotees, and at times healthcare providers, to seek out solutions from Lucumí.

In this chapter, I argue that despite the advances of biomedicine the complexity, and tenacity, of some illness overwhelms the system—uncertainty remains a salient factor in the healing process—forcing biomedical practitioners to acknowledge and at times engage domains outside of biomedicine, in this instance, the domain of Lucumí. Through engaging with anthropological critiques of knowledge and uncertainty, I illustrate that Lucumí can be used to address the ambiguity inherent in healing. While the anecdote above is not an instance of the building of a body of religious knowledge but rather competing clinical interventions, it illustrates how some illness overwhelms the system of modern medicine: healing is an art. Art draws inspiration from all corners. In other chapters my discussion veers to patient subjectivity, but this chapter incorporates physician subjectivity as interpreted by the patient. In this chapter, I contribute to a discussion of the challenges faced by doctor's when their training is at odds with the illness that they are tasked with treating, consequently undermining their sense of competency as a physician. The fact that the work done in hospitals on a global scale goes far beyond what is revealed through pathology, clinical experience, and medical research, is not new. Many scholars discuss the necessity for improvisation within biomedicine (Gawande 2003; Livingston 2012; Street 2014; Wendland 2010). How this

affects physician subjectivity has been examined on a global scale by Byron Good (1995) and Arthur Kleinman (1988) in the United States, Alice Street (2014) in Papua New Guinea, Claire Wendland (2010) in Malawi, and Kaja Finkler (1991) in Mexico, to name a few. Here I examine Lucumí devotees' interpretation of how physicians improvise and how their subjectivity is affected by the difficulties posed by some patient illnesses.

Historically, the relationship between modern medicine and religion has been fraught with contradictions. On the one hand, since the beginning of the Enlightenment there has been conflict between religion and modern physical science. The understanding that modern science provides truth through concrete fact, while religion provides unverifiable promises, has dominated the discourse. On the other hand, modern medicine has served as a tool of colonial powers to spread the influence of Christianity, as well as a tool for missionaries to attract converts. During my fieldwork some healthcare providers were uncomfortable in discussing matters relating to religion, but whether this was because they did not feel they had been properly trained in it, because they were not religious themselves, or because they were uncertain of my positionality regarding religion, I am not sure. What I focus on in the discussion that follows are those instances where devotees shared with me examples of their doctors—stumped with a diagnosis or unsuccessful clinical treatment—turning over the reins to Lucumí. This seepage between biomedicine and religious practice is what this chapter examines.

The experience of illness and expectations of healing are different for patients than for physicians. As Finkler (1991) highlights, patients do not experience illness only as physical pathogen, but through their social worlds. Illness experience is social (also see B. Good and M. Good 1981). And yet, as Fiona Ross points out "…so little is known

of how people make sense of daily life in the face of illness, or about its impact on accustomed modes of sociality and ordinary modes of relating" (2010, 169). Classically, this understanding of illness did not extend to the pedagogy of modern medicine. According to Byron Good (1995), biomedical training is characterized by a juxtaposition of competence and care. The former is understood as the domain of scientific training provided in medical school and the latter is perceived to be an innate personal quality that training cannot address. In biomedicine, competence is expected to bear more weight and ultimately to lead to unambiguous outcomes. Competence in modern medicine is evaluated based on a physician's ability to effectively draw from the toolbox of scientific knowledge, and their technological ability to peer into the inside of patients, to "see" disease and injury up close, be that through x-rays, ultrasounds, surgery, and so on.

But what happens when that competence does not lead to a reliable diagnosis or effective clinical treatment? What happens when doctors cannot properly "see" patients? What happens when religion is used as an outside resource, another toolbox, in the diagnosis or treatment of disease? This chapter begins to address these questions through an examination of anthropological theory on bodies of knowledge, followed by a discussion of uncertainty. With a firm grasp of these concepts, I move on to examine explanatory models of illness and clinical treatment in relation to doctors and followed by an exploration of how Lucumí devotees have interpreted doctor subjectivity when menaced by biomedical uncertainty. Then the discussion shifts to devotee experiences of physicians "giving up" exhausted in their attempts to cure, directing patients to spiritual solutions. Finally, the chapter concludes with physicians in the face of mystery, subjectivity in the reflection of miracle cures. In this approach, this chapter contributes to

anthropological discussions of knowledge and uncertainty, as well as explorations of physician subjectivity. In the process of developing biomedical competency, medical students are developing "reorganized personal boundaries" no longer expected to simply relate to the sick person as one individual would relate to another or engage with the patient's illness experience outside of pathology (B. Good and M. Good 1993, 102). But what happens when medicine's mediation of the biological sciences and that of human suffering, fails? In the cases discussed in this chapter, healthcare providers, having exhausted their competence to treat a specific illness, shift their gaze to the Lucumí body of knowledge for answers.

The Intersection of Bodies of Knowledge

In the first half of the twentieth century, the study of knowledge was often rooted in the objectivist concept of knowledge "as the truth about the world waiting to be discovered," commonplace in western discourse (Lambek 1993, 8). John Dewey (1984) describes this as the "spectator theory of knowledge," a modality which approaches uncertainty through 'thought' or 'being' which assumes some transcendent certain reality beyond quotidian experience. Susan Whyte argues that in Uganda this "recognizes order, examining reality in terms of given antecedent truths. It sees intellectual and spiritual concerns as separate from and superior to the practical ones of health, wealth, and the control of the conditions of life" (1997, 19). In Mayotte, Michael Lambek argues that this concept of knowledge is often used in 'self-definition' as well as the "construction of social relationships" and as a way to legitimate personhood (1993, 11).

Byron Good and Mary-Jo Del Vecchio Good share similar observations about the epistemology and semantics of the biomedical model which understands diseases to be "universal biological or psychophysiological entities, resulting from somatic lesions or dysfunctions" (1981, 180). This assumed universality of biological meaning extends also to 'the empiricist theory of language' which holds that the meaning of words/utterances represent the empirical, matter of fact reality of the world—not a cultural interpretation of the world (Harrison 1972). In these models, knowledge, especially scientific knowledge is conceptualized as a singular reified 'truth,' be it the truth of the physical world, or the truth of descriptive language. It sets up a dichotomy between truth and culture; relegating culture to the false since it is not universal. I would argue that these notions of knowledge bear the palimpsest of a monotheistic Abrahamic framework, as science is characterized as the seeker of a universal truth that is "out there," or rather "up there," and must reject messy individual experience in order to pinpoint that universal truth.[1] Or, as Stephen Toulmin described it "In his view, the scientist must approach the observed facts of Nature in a simple, unprejudiced frame of mind, and those facts would then 'speaks[sic] for themselves'…the history of scientific thought was a record of good, rational empiricists seeking to follow this rule, in the face of interference from bad, irrational theologians and metaphysicians" (1977, 150-51). This approach to knowledge, undermines our ability to engage in cross-cultural analysis and draw meaning from "*experienced illness realities"* to better expand medical knowledge and discourse (B. Good and M. Good 1981, 187, italics in original).

The notion of knowledge as singular truth awaiting discovery conditions the seeker to focus on gaining certainty in one specific dimension of the issue at hand,

rendering other aspects invisible. As Ann H. Kelly, Javier Lezaun, Ilana Löwy, Gustavo Corrêa Matta, Carolina de Oliveira Nogueira, and Elaine Teixeira Rabello (2020) point out in reference to the Zika crisis in Brazil, "the revelatory power of medical crises is concentrated on specific dimensions of the problem at the expense of others" (2020, 9). As different elements of the healthcare infrastructure, the WHO, the local public health authorities, and clinical actors, sought to address the Zika crisis the WHO focused on what they did not know about the connection between Zika and microcephaly. Once the WHO felt this "specific ignorance" had been addressed, the emergency ban on Zika was lifted, yet the numerous other questions scientists had about the virus, which reflected a lack of familiarity with related issues and troubled public health and clinical authorities, were left unresolved. The "known unknowns" the realities of human experience that those in power will not name are a window into the power dynamics within a social context. As Paul Geissler (2013) observes in public health settings in various parts of Africa, where doctors, researchers, and public health professionals from different parts of the globe interact with local professionals, staff, and patients the "known unknowns" often relate to socioeconomic inequalities between these actors. Geissler suggests that in part, this unknowing contributes to the veneer of equality, which some in the environment appreciate as a welcome contrast to the theatre of inequality at the heart of colonialism. In this way collaborative research can continue in the expectation that equality in the future is possible through visualization in the present. Yet, Geissler also notes that this silence denies the ability to speak to the human experience of inequality and the opportunity to negotiate improved conditions. I would argue that this unknowing also does the social work necessary to maintain the premise that scientific knowledge is

a-contextual. To render the inequalities of the context visible, hence knowable, would be to acknowledge that the body of knowledge created by scientists is not a representation of empirical observation but the product of hermeneutic endeavor.

Late twentieth century scholars, including all those cited in the previous paragraph, argue that the concept of objectivist knowledge is generally flawed. Though Lambek does not vehemently object to this concept of objectivist knowledge fundamentally, he does remind us that culture is best understood through action, and that "knowledge can only be understood in the context of practice (and vice versa)" (1993, 14). Similarly, Dewey and Whyte suggest that knowledge is rooted in action and consequence as experienced in the here and now. What Dewey describes as the 'doing' and 'action' modality of addressing uncertainty. To Whyte, this approach to gaining knowledge engages "the apparent, the particular, the empirical, the changing, perishable, contingent, and chancy. Practice looks to the consequences of commitment and action. The key words are belief and intelligent inquiry, rather than knowledge and reasoned recognition of existing order" (1997, 19). This is why in Uganda, for the Noyole she works with, knowledge is born of communal engagement and the 'trying out' of possible solutions. One does not hide misfortune, but rather, shares it publicly where members of the community can provide suggestions, "using social resources and experience to heal with problems and then judging the consequences" (1997, 14). Often this public sharing of misfortune is couched in the practice of divination where many suggestions to 'try out' are made. Within this social context diviners do not hesitate to recommend alternative healing systems to clients if those of the diviner do not provide relief. In such a rich environment, the challenge for those suffering misfortune is often deciding between the

systems that are available. Dewey argues that the quest for certainty is folly, while Whyte suggests that certainty is not what the Noyole seek when they engage a diviner. What they seek instead is security in an uncertain world. They draw on the toolboxes available to them to seek this security and would be remiss not to try out all the tools available. Similarly, B. Good and M. Good suggest a "meaning-centered approach to the analysis of [what Everett Mendelsohn 1977 describes as] the 'social construction of scientific knowledge'" (178). As they argue, it is a misrepresentation of medicine to reduce the process of healing to a simple matter of matching symptoms with universal somatic referents assumed to be immediate. Semantics are always a determinant factor in that equation, and those semantics are developed within cultural contexts which demand the attention of medical anthropologists and other scholars concerned with the art of healing. In order to grasp how knowledge functions in the Lucumí community, we must examine what actions people "try out" in the face of adversity.

Uncertainty in Biomedicine

In the nineteenth century, the concept of "subjectivity" was used as a foil to the concept of "objectivity" offered by a scientific worldview. This reflected an implied conflict between the "lie" of subjective experience versus the "truth" of real observable facts, somehow outside of experience. Within colonial contexts, and the like, the implication is that the "subjective" point of view falls to the colonized, while the "objective" point of view is that of the colonizer. Take the "subjective" belief in spontaneous generation, the belief that living organisms arose spontaneously, which was overtaken by the "objective" fact of biogenesis, that living things are reproduced by other living things. Subjectivity,

according to João Biehl, Byron Good, and Arthur Kleinman is “a synonym for inner life processes and affective states” (2007, 6). Yet subjectivity is, by nature, fractured, as each individual has multiple roles in life, for example, a person is a physician to their patients, a child to their parents, and a spouse to their partner. For each role the same individual will employ different inner life processes and experience different affective states. While doctors are expected to function within a domain dictated by ‘real observable facts,’ they, nonetheless, are affected by their own experience. As Jean Langford (2013) and Sharon Kaufman (2005) observe, doctors who must advise families on the terminal diagnosis of a loved one, often hedge due to their own uncertainty and experience with “miraculous recoveries” (Kaufman 2005, 123).

Uncertainty is central to these challenges to the authority of biomedicine; uncertainty not only in diagnosis, but also in the “meaning” of the diagnosis and the clinical treatment that must follow, as well as the moral implications for the physician, the patient and the patient’s family. As Susan Whyte illustrates, uncertainty and “trying out” responses to it are as much about social relationships and moral concerns as specific problems (1997, 3). Whyte focuses on ways to take appropriate action in the face of uncertainty, action that is socially and morally shaped by the shared values of the community. She borrows from the school of pragmatism, in this analysis, readily exploring when those actions fail and the ambiguity that follows. Uncertainty often follows when a cure to illness cannot be realized. Modern medicine is a central actor in this context as many of its promises have not materialized in the life experiences of many in Uganda. When modern medicine cannot provide certainty, its authority suffers as patients and their families feel insecure. The impetus of physicians to allow for space

between strictly scientific "truth" and *hope* in cases where uncertainty extends to physicians as well as patients highlights the complexities in physician subjectivity in the management of uncertainty.

Scholars such as Clifford Geertz (1973, 1983) and Byron Good and Mary-Jo Del Vecchio Good (2004) illustrate how people inhabit distinct sensory worlds which are accessed through "a set of embodied practices" within a "behavioral environment" shaped by culture. This way of experiencing the world shapes individuals, the agents in the "making and remaking of culture" (Biehl, Good, and Kleinman 2007, 8). This chapter addresses the question of how these "modes of subjectivity intertwine with particular configurations of…medical institutions" (2007, 8). Given that current anthropological scholarship approaches "the subject and subjectivity not as original forms but as dynamically formed and transformed entities," the process of becoming a 'professional' physician is a process of adding a new subjectivity which is separate from personal inner subjectivity (2007, 10). Arjun Appadurai (date) argues that much of the transformation of subjectivity in a swiftly moving modern world is impacted by the manner in which those modern influences like media and migration strike imagination. While medicine is sometimes discussed by anthropologists in isolation for analytical purposes, scholars like Kleinman, B. Good and M. Good, Street, and Finkler remind us that medicine is in fact an extension of the wider social world in which it is practiced. The social world of Hialeah was greatly influenced by Cuban immigration. An immigrant enclave by the late twentieth century, the area shifted from English speaking to Spanish, and the sociocultural space was altered through media, consumption, entertainment, and so on, to suit Cuban immigrants, having a profound influence on the shape of imagination in the

area. Bartolomé observed these shifts firsthand at hospitals with primarily Spanish speaking patients:

> … things have changed a lot, because some of the practitioners, even from other religions, it's not that they [healthcare providers] approve the practice, but I guess that a lot of nurses and doctors and psychiatrists, and things like that, they are convinced that "Maybe, if I cannot help you we can try a different approach." So sometimes they leave it open to the patient to come and say well, maybe you should be looking at something else because there is not much that I can do for you. People I see now in Miami…a lot of the population that I have taken care of are Hispanic… the English speaking they have more interaction with the culture. So they make comments like "What you really need is an *ebó* [sacrificial ritual], you need a *santero* to take care of you, because I cannot help you." In the 1980s never, nobody would make that comment.

Over the course of Miami's history into the present it has experienced large influxes of immigrants from the Caribbean. Much of the current influx of immigrants coming to the area are from Latin America, adding to the diverse cultural influences in this extension of the Caribbean and Latin America that exists in the United States.

In the process of medical training a new subjectivity is being created for physicians, a subjectivity meant to situate authority in newly emerging physicians. As B. Good and M. Good point out, medical school reconstitutes students providing them with distinct "forms of reasoning" about the new world they are learning, the medical world (1993, 84). This new subjectivity is developed through biomedical training which is understood as: 1) primarily scientific in nature, as opposed to social, to be a physician is to wear the mantel of modern science; 2) the medical "gaze" is on the human body, entrance into the subjectivity of physician is realized through physical entrance into the human body; and 3) learned through case studies where individuals are center stage and the social circumstances that surround them fade upstage (B. Good and M. Good 1993, 89-90). The "patient" within this framework is human, but a human distinct from the

everyday human interactions students are accustomed to prior to medical school. Medical students learn to take in the person as the object of the medical gaze through interacting with the human body as a cadaver in anatomy lab, as well as through learning the "language of medicine," describing the object of the medical gaze in mushrooming minute details as biochemistry and the microscope allow them to go ever deeper into the mechanisms of the body and the illnesses that plague it (1993, 94-100). Their ability to master the human body as the object of the medical gaze and diagnose what ails it is how their "competence" is illustrated. Competence is also illustrated through the habitus of professionalism, but as many critics of biomedicine argue, the process of cultivating professionalism is one of diminishing humanity, an effect which is likely systemic to medical education. In other instances, the institutional structure of medical facilities may undermine a physician's ability to provide humane care (Kleinman 1988, 223).

Critics of biomedicine often point out its tendency toward reductionism which likens the human body to a machine and illness/disease(?) a breakdown of some mechanism within it. The reification of the domain of "scientific facts" set up in opposition to "human values" hampers the doctor's ability to manage the socio-psychological factors that may be relevant to diagnosis and/or clinical treatment (B. Good and M. Good 1993, 91; Kleinman 1988). Still, over the course of time in the healthcare profession, the "reorganized personal boundaries" learned (102) are tested. Sometimes what doctors "see" with the biomedical technology available does not result in healing. When scientific technology makes *some* things knowable, but not all, this leads to what Rayna Rapp describes as "uneven seepages" in biomedicine's ability to transform biological bodies in meaningful ways (1999, 303). In these instances, a patient's

experience with biomedicine can leave them and their physician with uncertainty about the illness, modern medicine and/or the competency of the healthcare provider themselves, leading to insecurity for all those involved.

In bioethics, subjectivity is reliant on individual autonomy. To this end, patients are expected to process "truth" in the guise of biomedical diagnosis and reveal their subjective truth in disclosing how they feel about this. That is, the patient is expected to accept a given diagnosis, "your ankle is broken," and respond, "I'm angry that something so minor as tripping off a curb, turned out to cause such a serious injury." The power of biomedicine is often exercised by opening up the individual: either physically, as in the case of surgery or autopsy (Foucault 1994), or psychologically, as in an individual's subjectivity (Arney and Bergen 1984). Michel Foucault (1982; Langford 2013,115) considers this form of power an extension of "pastoral power" in Christianity when ministers intent on parishioner salvation encouraged confession to get at their inner lives in order to guide them to it. Over time this impetus to dig into the interior lives of lay people became "an individualizing 'tactic'" highlighting truth as something deeply embedded in an individual that must be sought out through "truth-telling" which assumes an objective truth that can be reified and the medical "gaze" can take-in. It is yet another reminder that there is no room in biomedicine for uncertainty, since the biomedical body of knowledge is built on the premise that it reveals empirical reality allowing for diagnosis through matching symptoms and immediate somatic causes. Within this understanding certainty should always be achievable. Yet, somatic causes are not always immediate, and symptoms are realized through semantics not a-contextual stimuli. Uncertainty persists, and in biomedicine it is sometimes necessary for physicians to

persist in treatment despite the fact of uncertainty. As the doctors at the resource-poor hospital in New Guinea where Street conducted fieldwork commonly observe, “we are acting blind” (Street 2014, 111). In the context of Street’s work, it is when uncertainty overwhelms and doctor’s must treat patients “blind” that “networks of collaboration to expand through the production of uncertainty and the making of “modest” experts (De Laet and Mol 2000) who are visibly dependent on their relationships with other actors” (Street 2014, 111-12). Uncertainty in the medical encounter and clinical treatment, as well as the ambiguity that flows from it, must be taken into account as we seek to examine the subjectivity of physicians.

Explanatory Models of Illness and Clinical Treatment

On some level, medical knowledge is rooted in the “personal knowledge” of the healthcare provider (B. Good and M. Good 1993, 84). In Mexico, Finkler argues that “diagnoses are usually influenced more by the physicians’ personal inclinations and experience and less by patients’ presenting complaints (1991, 95). These diagnoses are based upon a doctor-patient interaction where doctors have been trained to listen for data considered relevant to a medical diagnosis, but not to hear the patient’s personal narrative, less the doctor’s diagnosis be muddled by the patient’s incoherent complaints. Finkler likens this interaction to the unfolding of a stage drama, observing that much of the doctor’s professional identity is dictated by this staging of the doctor-patient interaction. In some ways the doctor’s professional identity is vulnerable in this setting should they be tempted by the patient’s narrative to veer from the biomedical model of disease. This staging of the doctor patient interaction only allows for “revelations related

to the physical body, to "objective phenomena," and to a stereotypic social map on which the physician situates the patient" (1991, 124). Although doctors follow a medical script that renders the patient's illness generic and explicable, placing it within a limited set of known psychological problems, they are nevertheless often uncertain of their diagnosis. In contrast, Finkler observes that patients are generally very certain of their experience of illness, though they do not know how to alleviate it. In Papua New Guinea, Street finds that physicians have not been completely conditioned to the human distance that critics of medical training claim it produces. In the Madang hospital physicians must work to cultivate distance and detachment, for fear that too much eye-contact or conversation with a patient will lead to the obligations that personal relationships in that social context involve, like money or special treatment from the doctor. If the patient's condition worsens it may be considered a sign that the doctor is unhappy with the patient (2014, 159). The potential for interpersonal fallout created when physicians do not properly master distance and detachment creates a great deal of stress on physician subjectivity.

Treating chronically ill patients is difficult, even for the most experienced physicians. Patients expect to get well, and physicians may be unable to provide the healing that people expect. This is true in well-resourced hospitals, where various treatment plans may be attempted before a successful one is found, and it is even more so in under-resourced hospitals, where treatment plans are limited. This means that what is considered success must be recalibrated based on the context. "The frustration of trying multiple treatment plans without obtaining the desired results tires the practitioner as much as the patient. The very sense of compulsive responsibility essential to the care of acute illness and the emergency exacerbation of chronic disorder may, over the long

course, create chronic irritability and numbing exhaustion. Repeated treatment failure tests the physician's sense of competence, until over time and with enough cases his sense of confidence is menaced" (Kleinman 1988, 225). What follows examines such circumstances, where physicians sought outside resources for patients because they have exhausted their own repertoire. In the immigrant enclave of South Florida, those outside resources include a wealth of occult beliefs and practices brought to the area from the Caribbean and Latin America.

Menaced Doctors and Lucumí Answers

Back in the 1980s, AJ was experiencing fatigue and widespread pain all over his body. "I went to this doctor, and he runs all these tests, and he tells me, 'Look, I can't figure out what is wrong with you, all these tests don't say anything. Are you a spiritual person?' And he gives me the name and number of this guy he wanted me to go see." AJ had grown up with Lucumí and Spiritism, but this was not the response he expected from his long-term doctor. While at first, he was unsure of how to react and frustrated by the absence of a diagnosis, he was impressed with his doctor's openness to alternative therapies. The phone number was for a spiritist who held regular spiritual masses during which he mounted a number of different spirits. The masses were held every Tuesday evening in a small annex off the man's house, complete with a bathroom and kitchenette. As AJ's remembers, the spiritist's wife did not share his devotions, but she nevertheless consented to his holding mass on the premises. "But, as a joke, I used to call it a 'dry mass' because there was no water, no cologne, just a cross he would use and pray." Upon the advice of his doctors, AJ soon visited the spiritist, accompanied by his *iyalorisha* and

a friend. All three witnessed as the medium successively mounting the various spirits in his *cordón espiritual*, before being possessed by a different spirit, an outsider:

> I sit down, we're all praying, and I hear my name being screamed [*inaudible*] and he calls me up. So his guide leaves and another one comes in just like that, crying, and I think it must be my father, because he always comes in like that, crying. So I'm thinking it's my father and I go up and he shakes my hands and says, in Spanish, "What have I done to you?" and, the way, the tongue, my father never spoke that way.

The "outsider" spirit was one of AJ's personal spirits whom he had unfairly blamed for his illness. After giving AJ a firm talking to, the spirit agreed to help him find a treatment. The next day AJ's boss proceeded to tell him about the debilitating symptoms (a sense of fatigue, generalized pain, and so on) she was experiencing. When she suggested he must think she was crazy, he responded that, on the contrary, he had been suffering from the same symptoms but the doctor he was seeing could not help him. She, happily, had just found a doctor who could treat her so she passed on the information to AJ. Biomedicine was just beginning to acknowledge the existence of fibromyalgia. "Today they sell pills for it—Lyrica! Take it! But back then no one knew anything about it," AJ told me.

I should note that AJ's doctor did not seem to be in doubt that he was ill, or that his illness could be managed, somehow. But despite all the medical technology at his disposal and the biomedical body of knowledge, he could not provide AJ with a diagnosis, or treatment. It is not just in poorly sourced medical facilities in places like PNG where, in the absence of a diagnosis, physicians must "giv[e] up control," and resist the impetus to assert "given" professional authority over patients and local understandings of illness, in as well, when faced with the inability to diagnose and treat

illness, sometimes physicians give up control and authority to local alternatives (Street 2014, 106). AJ's doctor gave up "control" of the illness by directing AJ to the Spiritism which the doctor, likely, had a level of familiarity with as it is widely practiced in the area. It stands to reason that the doctor already had experience with the spiritist's ability to access solutions that the doctor could not; consequently, he approached this dilemma much like Whyte describes diviners in Uganda suggesting clients pursue alternative solutions if the one's recommended in divination were not successful. Biomedical knowledge of fibromyalgia at the time was embryonic. Unable to properly diagnose AJ, his doctor was forced to accept the "contingency of biomedical knowledge" and give up control of the illness, even as he acknowledged its presence. Yet ultimately AJ found a biomedicine solution, but not through the original biomedical practitioner—the successful biomedical solution was mitigated through the spiritist. In his recollections of the doctor, AJ was overflowing with respect and admiration and referred to him as a medium: "He has passed away now. One of the most beautiful human beings I have ever known, and he was a doctor, a scientist, and he sent me to a spiritist."

*****

Mina, who was initiated before having children, was told in her *itá* that she would have to do many *ebós* to avoid losing a child. When she was pregnant with her oldest son, she never felt any movement so she "lived for doctor visits" during which she could hear the fetal heartbeat. Other mothers would ask her what is was like to feel the baby move inside her and Mina, embarrassed, would pretend to feel the baby move. Her son was born with severe kidney disease.

> I was a C-section, he would always cry, this desperate cry, every single day ALL day long.[…] We'd get things for colic, boil onions, we'd get him this thing

> called gripe, anise seeds. Every home remedy we could think of.[…] He got his *elekes* when he was a week old, he was baptized in the hospital because they didn't think he would make it. Then, afterwards, he got his *mano* of *orula* when he was 3 months old.[…] He goes to the hospital, I take him because he has this low-grade fever all the time. The doctor tells me: "Oh, you, young mothers, you freak out over everything. He doesn't have anything." And I thought, "I'm a nurse, I have dealt with babies before."
>
> What happened was I woke up in the middle of the night to the smell of urine and I had him in a basinet by the bed and I checked his diaper and it looked like coffee grounds.[…] The doctor told me that he was going to run all these tests, but he didn't run it STAT. (What is that?) If you don't do that, it is three days versus an hour. I took it upstairs and asked the girl to run it STAT and she said, "I would lose my job." I said, "please, for the love of my son." She said, "you don't understand, I can't." And I saw that she had an Ochún *ide* on, [meaning she was an *olorisha,* child of Ochún] so I said, "look, my son is very sick, the santos told me my son is very sick." And she said, "it's going to cost me my job, but I believe you, I'm going to do it."

An hour and fifteen minutes later the doctor called Mina back, noting that he had forgotten to mark the test STAT. But things worked out because there was a mix-up in the lab and her tests had been marked STAT anyway. Then he told her, "You have to go right away to Miami Children's, your son is very sick."

Mina and her husband consulted the oracle and were told things were in the doctors' hands. Their son was diagnosed with *glomernulonephritis,* an inflammation of the filters in the kidneys. For months he was in and out of hospitals, receiving various treatments:

> At that point they […] put this tube through the penis with a little umbrella and when they pull it out it pulls out all the excess meat. There is a narrowing of the urethra. When they do it on a man, it is horrible, they can't pee for days. Can you imagine when they do it on a baby?[...] He suffered with that for month and months, he was in and out of hospitals. Finally he was close to 11 months old and this Jewish doctor takes us into his office and asks: "Do you believe in faith healers?" And I remember looking at my husband and thinking, "is this doctor insane?" And I say, "I don't know what you mean." And he says, "I am telling you, that the last thing in our lives that we lose is faith." He goes on to say that the medical field has done everything that it knows how to do to at this point, in order to help our son; they cannot do anything more. There are other options out there and [you] need to find a lot of faith and seek out something, some faith healer. So

> I look at my husband, I still get the chills, thinking about it. My husband says, I'm going to look at him [perform a divination]. So he does and the signs say that he needs to be initiated then. So we initiate him then.

In this instance, the diagnosis is never called into question, there is no failure in the physician's ability to see into the human body to reveal the sickness. But the lengthy clinical treatment did not cure the patient. In Papua New Guinea, physicians who are unable to treat patients refer them back to their villages, claiming "'this is not sickness for hospital medicine,' the clear implication being that it must therefore be 'village sickness'…even as doctors refute the very existence of [village sickness] and insis[t] that 'all sickness is biological'" (Street 2014, 159). In Mina's experience the doctors had exhausted all that they knew to do. Based on Mina's surprise at the doctor telling her to take her son to a faith healer, we can surmise that this was the only time religion had been broached in the course of her son's treatment. Yet, the doctor's reference to faith healers and the acknowledgement of "other options" that include faith, suggest that, as Langford (2013) and Kaufman (2005) observe, the doctor had some experience with "miraculous recoveries."

In the first two years that followed his initiation, Mina's son was fine. Then the symptoms reappeared: he was unable to urinate, suffered from nose bleeds, and had bags under his eyes. Mina took him to various doctors who suspected he may have leukemia. She tried to schedule a visit with a particular nephrologist, but he would not see her son.

> [My son] had been sick for so long. So this woman calls me up and says, "I really want a reading." And I tell her I can't do it, but I will make her an appointment with my husband. She says, "well, I really want it to be you." I tell her, "With me I can't, I have a lot of work." So she says, "I'll call back." This goes on for weeks, I tell her nicely, I tell her rudely, I tell her in English, I tell her in Spanish.[…] Finally, I get so frustrated.[…] I tell her, "Look, I have a very sick son." She asks, "with what? His kidneys. Why don't you see him with Dr. P?" "I have been trying but he won't see new patients, he's retiring." "I'm his secretary. Can you be here

> at 2:00 today, and read me tomorrow?" Oh my God! All this time he's been sending me the answer and I've been too blind to hear it. He sent me a rowboat, a helicopter, a car. She says, "I'll see you today and you put me down for tomorrow at whatever time is convenient for you."
>
> So I take him to Dr. P and he is looking at the paperwork and looking at [my son], and back and forth and [my son] climbing up the chair and down the chair and the doctor looks so confused. Finally he says to me, "when did they give you this kind of diagnosis?" And I say, "well it's all there in the records." And he says, "yeah, but I look at this diagnosis and I look at this kid and they don't match." This child with this paperwork and this disease should have a belly like he's nine months pregnant, should have bags under his eyes from the inability to eliminate fluids and poisons and be sitting on a chair waiting to die. Yet you have a normal little boy. Why do you have him dressed in white?" I say, "I dress him in white because I think it's purer." He said, "you did this because you think its purer or because it's what you believe in?" I said, "it's what I believe in." He says, "you initiated this boy in *santo*?" And I said, "yes, you know about that?" He said, "I know about that, I haven't done it, but I've seen miracles." He says, "okay, I can't help him because I don't know how to do what he needs, but I will send you to the person that does."

*****

In both cases, the patients were healed through a combination of the biomedical and the spiritual. In AJ's case and Mina's second example the illness narrative goes from the biomedical domain to the spiritual and back to the biomedical; when the illness narrative pivots back to the biomedical it is successful because the spiritual has directed the patient to the "right" biomedical provider. On other words, in both AJ and Mina's case, they rely on the spiritual to direct them to the right doctor, the one who can heal them.

Arthur Kleinman suggests that it is through the explanatory models of illness that the meaning of symptoms is reflected. These descriptions of pain and discomfort "tap into cultural models that work when patient and practitioner share the metaphors and not so much when they don't" (1988, 13). Here, biomedical practitioners and patients do share some metaphors, that is, the idea that spirituality is an appropriate alternative when biomedicine has not produced the results people need. I think it is also important to note

that in both cases, it is the doctors, not the patients, who bring up spirituality as an alternative treatment method. The frustration of AJ's doctor with his inability to reach an evidence-based biomedical diagnosis and the exhaustion felt by Mina's son's first doctor after the clinical treatment proved unsuccessful menaced their subjectivity to the point that that they had to refer patients to spiritual resources to seek healing. I have no way of knowing on what basis these doctors suspected that their patients enjoyed a spiritual life. What is clear is that the patients were so embedded in the spiritual domain that they were able to pivot to such treatment.

As Amélie Oksenberg Rorty points out, the themes that have emerged out of discussions of patient subjectivity in medical anthropology hinge on patient autonomy and how patient investment in the process of clinical treatment relies on the value placed on patient narratives (2007, 48). Are these examples illustrations of doctors turning over the entire process to patients "fully invested" in the process, and taking patient autonomy to another level entirely? Or perhaps doctors are not so much expressing support for patient autonomy as the need to engage a different explanatory model, given the failure of the biomedical one in these instances?

When Biomedicine Looks to Spirits for Help

Bartholomé, a long-time RN and *olorisha*, has noticed a great deal of change in biomedicine and Lucumí over the years. Many practices once considered outlandish by biomedicine, such as meditation and aroma therapy, are experiencing growing acceptance. Within the Hispanic community he has also noticed more openness to Afro-Cuban religions, with many people getting initiated for their health when they have not

found a cure through biomedicine. Bartolomé observes that nowadays, if the doctor cannot produce a diagnosis for them, patients may be told they should go to the witch doctor. "But we are still in the realm of witch doctor practices," he notes. When I asked whether nurses referred patients to alternative healing, he specified, "only doctors." Nurses, he thought, may be relieved to hear a doctor mention it, and be supportive, but if the doctor said nothing, they would be too afraid that a patient would take the advice the wrong way and tell the doctor, in Bartolomé's words, "The nurse thinks I'm crazy and there is nothing wrong with me."

Despite his misgivings, Bartolomé had taken the initiative to suggest alternative paths to healing on two occasions when he felt confident the patients were not going to get relief from clinical treatment:

> One time, there was this family, they were all white. I said, how may I help you? With Cubans it is very common, if your child is sick, everyone will come, the aunts and uncles, grandmothers, it's a crowd not just the mom and dad, you know. I remember, when I go in, I thought, oh this is strange this young white guy, I think 19-20… [His dad] said it was hard to explain, sometimes he's totally normal and then suddenly he will start acting strange and we can't understand what is going on with him. We don't understand, he may be having seizures or something. Okay. And I'm talking to him and all the sudden I feel this funny feeling. Then all on top of the stretcher and I'm feeling it and all of the sudden there is this "NO! (a kissing sound over and over, clapping)" Getting into a trance. You see that's what's going on. I was like, he's going into a trance. "Okay, you know I am talking to you, this is not your moment to come here and get into this body. We'll deal with you later. Because we're in a hospital." And boom, it's gone. Everyone is like, who is this nurse? I said "Ma'am, don't be surprised if everything that they test is negative. I think that eventually you should be seeking alternatives." But they don't get it, the tests were negative, they need to send him to the neurologist. I said, "no I think you need to send him to a grandmother in Cuba." Then they seemed to get the hint.

Whether or not the family went on to seek spiritual help, we do not know. But in this example the condition was not a medical one, it was a spiritual one. It is because of the "distinct sensory world" Bartolomé inhabited, shaped by the "embodied practices" of an

olorisha experienced in Spiritism that he was able to identify the trance and communicate with the spirit, successfully instructing it to leave (B. Good and M. Good 2004). Bartolomé did not let his subordinate position within the hospital completely dictate what he should do, though the hierarchy of the medical institution is evident as he doesn't explicitly state his diagnosis, opting instead to recommend that the young man's family seek a "grandmother in Cuba" for help. As a senior nurse who could not be easily fired, he was not totally powerless. Moreover, based on his religious experience, he was quite certain he was witnessing possession trance. Here the "fractured" quality of subjectivity is highlighted, most of us "wear different hats" in life; Bartolomé's subjectivity as an *olorisha* should not be equated with his subjectivity as a RN, or the other aspects of his subjectivity like co-worker, neighbor, and so on. This quality is implied when the subject and subjectivity is understood not as original, but dynamic and transformable in nature (Biehl, Good, and Kleinman 2007, 10). Yet, this contrast does not undermine Bartolomé's "belief" in modern medicine. In this instance he was faced with an illness that he was confident scientific technology would be unable to "see" in order to transform the boy's biological body in a meaningful way revealing an "uneven seepage" between the domain of biomedicine and the spirit world (Rapp 1999, 303).

Nonetheless, in other instances he's not so much stepped outside the domain of biomedicine as used spiritual guidance to exercise his effectiveness within the domain of biomedicine.

> I've had a lot of beautiful experiences as a nurse, spiritual experiences. I could not tell you the patients, they changed my perspective. For example… I remember in Hialeah hospital when I walked into this room, there was a big, huge fat lady, she was Black, she could barely see because she had cataracts, basically legally blind. She was considered a "difficult" patient. She had a colostomy bag that was detaching all the time. She was there because she had an infection because it was

> always leaking so it was burning her skin. And I walk into the room, and she says "Oh my God, in the name of Jesus, I can feel the presence of Jesus when you walk in. I *know* you're going to help me because I feel the presence of Jesus when you walk in." I said, I am going to help you, don't worry. Because sometimes you have to be a little bit creative with patients. And it became like a common thing with patients, that they say, I just feel better when this guy walks into the room. They can feel the energy.

This example highlights when the subjectivity of the healthcare provider is not dominated by a ridged biomedical point of view, though it may be guided by one. Unlike the first example from Bartolomé, there was no uncertainty in the patient's diagnosis, it was her treatment that was unsuccessful. Why did the hospital classify her as a "difficult patient" Was this due to her size? Her blindness? Her race? Did she have a disagreement with the staff in an already racially charged social context? Or a combination of these things?

Given the strong anti-Black sentiment that pervades the Cuban immigrant enclave of South Florida, racial bias is not out of the question. What is clear, is that when Bartolomé walked into the room, she put her trust into him based not on "belief" in modern medicine but a belief in "Jesus," citing Bartolomé as somehow tapping into the power the patient associated with Christianity. This is not the "truth-telling" Foucault refers to when he mentions biomedical expectations that a patient "confess" their feelings about a diagnosis, yet it does reflect the "pastoral power" in Christianity Foucault identifies as central to modern medicine's impetus to get at the "inner lives" of patients and guide them in treatment. The need to expose the corporeal or psychological "insides" of the patient in order to treat them is arguably one of the central notions of modern medicine that carries over to much of US mainstream culture. When Bartolomé entered the room, the woman exposed her spiritual insides to him in the expectation that this would allow, or implore, him to heal her.

*****

Laila, who suffers from numerous illnesses, has been with her general practitioner for roughly twenty years, and they have gotten to know each other well. The doctor trains medical students and Laila says she can tell when her doctor is in what she describes as a precocious mood because the doctor sends medical students to interview Laila without telling them anything, just to see if they can grasp just how complicated Laila's medical history is. Given the difficulty of diagnosing her, the doctor has become open to recommendations from Laila's *orisha*. At one point Laila had a flare-up of a combination of symptoms. Since her bloodwork showed her as extremely anemic, she was treated for anemia. But when the treatment did not provide relief, Laila consulted an oracle. According to the oracle, the doctors were not looking in the right place.

> So, I kind of had to say, bite the bullet, and I went back to my doctor, and I said, "Look, this is my problem" I was very forthcoming. I explained to her what the situation was that I had seen myself (done a reading)…I told her, they are talking about tumors, they are talking about things on my insides. Is there any possible way that we could do a scan or something? She said, "Well anemia doesn't scan, but what are your symptoms again?" And she did notice that in one of my blood works that my pituitary gland was off [very slightly] and some of my hormones [too]. So she said, "Let's see how your adrenal is." So, they did an ultrasound and saw a marking and that led to an MRI. And they found my tumor. So everything correlated.

I asked Laila: "So when you talked to her and told her this, did she have any commentary?" She responded:

> After she found out it was one of the "Ah-ha" moments. She was like, "wow, you know that's not a bad thing to have." You know, she's Hindu and she said to me "You got to believe. It's interesting that your religion brought you to this. You know at the end of the day we all believe in something and in that something is where we discover ourselves." And I said, "exactly, exactly." So each time, if I feel something weird or whatever, she'll ask me "have you seen yourself, is there something I should know?"

In Laila's case, her physician has managed the "sense of compulsive responsibility" physicians may feel when treating chronic patients differently than relenting to the "chronic irritability and numbing exhaustion" that Kleinman refers to when he describes the crisis of physician subjectivity suffered by doctor's unable to address the chronic illness of suffering patients (1988, 225). The physician has mitigated the potentially debilitating frustration of unsuccessful treatment with the addition of Lucumí divination. Because the advice given in divination was borne out through scientific technology which made Laila's tumor visible and ultimately yielded a correct diagnosis and a successful clinical treatment, the doctor's sense of competence was not menaced. The information that Laila provides to her doctor based on Lucumí divination must always be backed up through the doctor's body of knowledge, medical technology. In part because both Laila and her physician want that confirmation, they both believe in modern medicine. Moreover they both know that for the health insurance to cover the costs of clinical treatment, it must receive the "truth" delivered by biomedical technology. These practical concerns provide boundaries that comfort both parties.

Respect at Arm's Length

Not all physicians have found common ground with Lucumí explanatory models but some nevertheless acknowledge that biomedicine does not invariably provide a solution to illness. Nancy, a statuesque older woman with shinny long grey hair, thought she had become initiated to acquire the strength to parent her oldest son when he was at risk of going to prison, but from the moment she left the *ilé,* following the initiation, she had been awash in health problems. For several years she spent much of her time in the

hospital or the doctor's office when she was not having *ebo* after *ebo* performed by *babaláwos* and *oba orietés*. One of her most challenging health problems was the blockage of her entire portal venous system, which brings blood from the intestines to the liver.

> First they thought I had an autoimmune problem where my own blood would clog and coagulate. Then they thought maybe I had a cancer hidden somewhere and clogging things. Nothing, after all these tests, they had no idea why my portal veins clogged… The first three years I had all these times that I should have died. The pneumonia was only a month, the portal vein and pituitary were both nine months. What ended up happening was my portal veins developed these tiny little capillaries around them and the blood was able to flow. So the block is there and it's surrounded by these tiny little capillaries. So mind you, I don't digest like you do, but it is enough to keep me alive. So I go to my oncologist every six months and she's like, I don't even want to touch you. You're that 2 percent anomaly that I don't have any explanation for. Just keep doing what you're doing… they are just amazed, and they know it was not do to anything they did because they didn't know what to do. Just pain killers, a lot of codeine, a lot of blood thinners.

In Nancy's case, there is no uncertainty in her diagnosis. Medical technology was able to "see" her insides and properly diagnose the blockage of her portal vein system. Yet the only clinical treatment available to clear the blockage was a high-risk procedure (which I discuss in greater detail in chapter four). In this instance the uncertainty lay in whether or not to proceed with surgery. Nancy's physician had categorized her as one of the "miraculous recoveries" that Langford and Kaufman argue motivate physicians to hedge when informing patients of a terminal diagnosis. Her doctor was well aware of the limits of clinical treatment available to address Nancy's condition and had accepted the fact that this issue was one of those cases that she could not treat, irrespective of her professional competency. In this instance, the humanity that many medical anthropologists argue is lacking in much of modern medicine is, in contrast, well-realized by Nancy's physician.

Conclusion

Despite the advances of modern medicine, uncertainty remains a salient factor in biomedical diagnosis and clinical treatment, even in the well-resourced parts of the United States. When a physician's sense of competency is menaced due to uncertainty, some in South Florida recommend patients seek out spiritual assistance for possible diagnosis and/or healing. If that patient is a Lucumí devotee, they have a wealth of resources available to them. For some Lucumí devotees, their illness narrative went from a physician unable to come up with answers, to a diviner who directed them to the physician who could provide the answers. In other instances, Lucumí provides the healing that biomedicine cannot. In yet other instances, Lucumí practice facilitates effective biomedical treatment, with divination providing directives to the physician seeking a diagnosis, as was the case of Laila, or Lucumí practitioners intervening into the diagnostic process, as when Bartolomé tapped into his experience as an *olorisha*.

These examples highlight the "uneven seepages" present in modern medicine. In some respect, these instances push back against the "reorganized personal boundaries" that medical students are expected to develop during their medical training. Yet, it is understandable that over the course of their careers, physicians will, on occasion, struggle with these boundaries, especially when the competence expected of them and the system to which they are attached falters. In part this discursive gap in the theorizing of modern medical providers is a gap between the pedagogical "bubble" of the medical school classroom, textbooks, and case studies, versus the lived experience of the biomedical provider who is faced with the reality that much of what they contend with in treating illness goes beyond the visible pathologies of biological bodies. It is important that

ethnography complicate physician subjectivity, especially in relation to location. As Street and Whyte (2009) argue, this is the power of ethnography "its capacity to locate universalizing projects such as biomedicine within their situated practices" (Street 2014, 30).

The universalizing efforts of biomedical institutions run up against complications in some ways similar to those experienced by the Church and by colonial powers—the inability to exercise total control. Janet McIntosh (2006) observes that in the instance of the British in Kenya, the official discourse was premised on the superiority, rationality, and overall competence of the colonial administration, while British subjects living in Kenya constantly questioned their competence and ability to do what the colonial government expected. The competence of colonial powers was not taken for granted by those actually tasked with enacting that competence. Comparatively, Asad (1993) argues that, in fact, these powers have always relied on a certain level of ambiguity in order to retain power. There are parallels between healthcare providers' relationships to Lucumí devotees as described in this chapter, and the relationship of Lucumí and the Church, as highlighted in the San Lazaro procession described in the introduction. The passing off of a symbol of healing from an institution of power to the marginalized, the seen to the unseen.

The ambiguity that Asad refers to is in large part a nod to imagination which hegemony needs to control, yet must not appear to, least the spell of this naturalization of power evaporate. Still, within these larger hegemonic institutions, like the hospital, are human beings, like physicians, working to heal other human beings, like patients. In these

instances the relationship between the reality of uncertainty, the task of competence, and the ambiguity of imagination can become hopelessly intertwined in projects of healing.

Chapter 4

When the Spirits Say No

In 2007, when I first began traveling to Miami, Mina's husband, Popi, introduced me to Enrique. Enrique was an older man from the Dominican Republic, with milk chocolate skin, a quick friendly smile, and thick course hands from having spent much of his adult life working in the construction industry. He had a house on the canal that he had built himself and was very religious. His devotion went back many years, starting when Enrique came to Popi for advice. A good friend wanted Enrique to invest in a housing development. Developers had convinced the friend that the investment would pay off exponentially and surely make them all rich. But there was a steep price-tag , that would have taken up most of the money Enrique had worked for over the years. The prospect of riches was appealing, but Enrique wanted to be sure things would work out, so he asked Popi to consult the oracle. The answer came: Enrique should not invest or he would lose what he put in. This was not what Enrique had hoped for, but begrudgingly, he complied. His friend invested in the housing development and as it ran its course, the project failed and everyone involved lost their money. Had he dismissed the oracle's advice, Enrique would now be penniless. Grateful to have been saved from possible ruin, he built Mina and Popi a carport and roof for an outside kitchen where much of the ritual cooking is now done.

Divination is a fundamental part of Lucumí practice. It is the interface between devotees and the *orisha,* as well as various other spirits that may be influencing a person's life, where the expert diviner gains insight from the invisible world about forces at play in the material world of the client, in the present, past, and future. At times, devotees will consult an oracle to address a question they have, but also simply to "check-in" with the *orisha* to receive general advice, for example at the new year or the anniversary of a person's *kariocha*. Oracles provide advice and actions tailored to the person's individual circumstances. While Lucumí practice often supports biomedicine, in this chapter, I explore the tension created for patients when divination advises against a specific biomedical treatment. These are not instances of everyday healthcare treatment, but instances when devotees suffer from acute illnesses and the advice of their doctors seems dubious or potentially risky. I argue that divination provides Lucumí devotees with the ontological adjustment to oppose the hegemonic authority of doctors in times of uncertainty by providing insight into-their health situation. This insight ontologically shifts their perspective, allowing for the confidence necessary to buck the medical system. Through fleshing out the role of divination in facilitating ontological transformation and analyzing how skepticism influences decision making, this analysis contributes to broader anthropological discussion of the ontology of divination.

In past anthropological scholarship refusing medical treatment in such circumstances may be read as a case of "irrational belief" so often perplexing researchers who studied "non-modern" people. The doctor, as a representative of secular modernity, provides rational facts, and the devotee rejects them based on "belief" in a dubious system. The promise of modernity was that science would address all human dilemmas.

E.E. Evans-Pritchard, in his study of Azande witchcraft argued that the people themselves were, in fact, rational, but trapped by their "irrational belief" in oracles. Oracles among the Azande, according to Evans-Pritchard, and among the Kalabari, according to Robin Horton (1967a, 1967b), amounted to flawed science. If the Azande were not trapped by the yolk of belief, they would test their oracles by asking them concrete temporal questions, such as "Will I kill a bushbuck if I go hunting tomorrow," and it would soon become clear that their oracles were false (1989 [1937], 160). However, Evans-Pritchard goes on to point out that oracles are not used to gain that sort of information. Oracles are used by average men (as opposed to nobles who use them in criminal proceedings) for guidance: should I marry a certain person? Should I build a house in a certain area? Since one cannot do two things at once, there is no way to test the validity of the oracle. Evans-Pritchard, in his preoccupation with disproving oracles, does not lead us to believe that his peers used the scientific method to determine who to marry or where to live either, but perhaps they, like the Azande, asked advice of a trusted source on these matters? Yet Evans-Pritchard's observations are telling. People use oracles for insight on their situation that is otherwise hidden from them, and to identify the ritual steps required to shift the situation to their benefit.

Rosalind Shaw (1985) argues that the purpose of divination for the Temne of Sierra Leone is not to provide an explanation for misfortune and a stereo-typed means to address it [via the idiom of witchcraft], as Evans-Pritchard argues, nor is it a form of "social redress" as Victor Turner (1975) suggests, especially given that in plenty of instances, divination creates more strife than it quells (De Boeck and Devish 1994). The purpose of divination is to facilitate ontological change through the negotiation of

meanings and categorizations. Shaw faults the functionalist approaches of these scholars for their reductionist approach to actors who are little more than "passive ciphers" operating mindlessly within cultural systems (1985, 297). Shaw supports an "interactive approach" where agency, personal interest, and strategy are taken into account. "This process of the construction of 'the reality of the situation' via strategy and interaction is, I have argued, central to divination. It should not, however, be assumed that the participants in divination who negotiate interpretations which serve their interests do not experience these interpretations as 'reality'" (1985, 298). In the process of divination, people experience those negotiations of the reality of their situation ontologically, in effect it is a process of shifting from the ontological chaos created by a given situation to ontological order (also see Lienhardt 1961). This chapter examines first, how divination is incorporated into Lucumí practice, followed by a discussion of how oracles influence Lucumí subjectivities. Then I explore how the meaning of illness is conceptualized through relationships with the *orisha,* which flows into an examination of *itás* and chronic illness experience. Next, is a discussion of how the spiritual intersects with biomedical diagnosis followed by spiritual diagnosis and healing. Finally, I examine what happens when biomedical treatment is refused and replaced by the spiritual. Even for the most regimented person, illness can inflict chaos on personal ontology in profound ways that necessitate transformation.

Divination in Lucumí

As illustrated by Diana Espírito-Santo, types of divination are either inspirational, such as when a message comes upon someone through dreams or visions, or, in contrast, the

product of training such as astrology. While a person can be technically trained in a divination system, a certain level of spiritual skill or mediumnity, is still important. Historically and globally, divination is used for "diagnostic, forecasting and interventionist," proposes (Espírito-Santo 2019). In the Lucumí community in South Florida, many people also practice Spiritism. For example, a person may attend spiritual masses, *missas*, where a *boveda* of seven, or alternately nine, glasses of water are arranged either in a circle or V-shape on a table covered in a white tablecloth. Cut flowers and cologne will also be on the table. A group of people, generally lead by an experienced medium, will cleanse themselves spiritually with the cologne, say prayers and meditate to communicate with the deceased. Some will have spirit guides that they regularly interact with, while other spirits may simply wander in to communicate. In the process people may become possessed by spirits, or they may simply hear, see, or otherwise sense them. The spirits who come will give advice to alleviate any number of issues experienced by people in the room or those close to them. While spirit mediums work to develop this skill, they do not have to go through formal ritual to be sanctified to attend a *missa*. Spiritism falls more to the inspirational, and within the community it is valued, but not given the weight of Lucumí oracles.

Oracles in Lucumí that are commonly used by *olorishas* are *obi* divination and *Diloggún* and *Ifá*. Obí divination is performed by praying over four pieces of coconut then tossing them to the ground to see what pattern falls. *Obi* divination is generally used to get confirmation that an offering has been accepted or that a ritual has been performed correctly. When people seek more specific, nuanced advice, they refer to the Diloggún oracle. This requires a complex skill set and a set of sacred tools which only those having

undergone full *kariocha* initiation can access. Diloggún divination is performed with sixteen cowry shells. For the cowry shells to embody the *orisha* they must first be flattened on one side, then ritually sanctified with animal blood and other sacrifices. When a person wishes to consult such an oracle, the priest prays over the shells and throws them twice, counting the shells with their 'mouths' open to speak. There are two hundred and fifty-six signs that can fall. A set of numbers is an *odu*, or divination sign, which aligns to a series of verses specific and unique to that *odu*. According to William Bascom (1980) it is impossible to confirm the exact number of verses, although during his research in Nigeria each sign was said to contain sixteen verses, over four thousand in total. Verses include a proverb and often a folktale or myth to explain its meaning. During my research, some diviners recited the entire set, while others used their mediumnity to focus on the one set that was relevant to the issue at hand. Generally, a consultant did not ask their question first, the expectation was that one of the verses would address the problem at hand, which at times was different than the problem they originally sought to address.

According to Cuban tradition *olorisha* who are heterosexually identified males and have never been possessed by a spirit may be called by divination to pass to *Ifá* and become *babaláwos*, the priests of *Orula/Orunmila* the *orisha* of divination. Today some houses are changing this to include homosexually identified men and women (a source of tension in the community that this dissertation will not be able to cover). Rather than cowry shells, *Ifa* is read on a diving try with a sacred powder, *aché Orula*, through the *ikins*, (palm nuts), or the *opele* divining chain. In this form of divination the *orisha* speak through *Orula*. *Babaláwos* are specialists in divination, while the average *olorisha* is not

and may never read their own shells. Which form of divination a person consults varies by person. Some rely on consulting the *Diloggún* of a godparent, or other experienced *olorisha* diviner, while others will rely on a *Babaláwo*.

According to Bascom (1980), in Cuba cowry divination was widely popular throughout the island, perhaps because women and homosexually identified men could perform this type of divination. The inequality embedded in *Ifá* tradition is likely part of the controversy. I have never heard an *olorisha* criticize *Orula*, the *orisha* of divination who owns *Ifá*, but I have heard many criticize his priests, the *babaláwos*. Although this criticism may or may not mean the person does not consult *Ifá.* Some will criticize *babaláwos* in general, but still feel more comfortable within that system, or consult strictly the *babaláwo* they trust.[1] In my experience a trusted diviner of either fold has the most weight in the community and devotees often have a long-term relationship with one that they consult regularly.

Given the frequency with which devotees engage with divination, it should come as no surprise that at times they question the conclusions of a divination. In the mid-twentieth century, scholars, like Evans-Pritchard, felt that this should be proof that oracles were false, and pondered over "irrational belief" in them. Yet if fallibility is part of a system, why would it be the downfall of that system? As Martin Holbraad (2012) argues, the question that anthropologists should pursue is what oracles really *are*, not why people believe in them. Oracles are not considered infallible, but when people suspect a reading is either slightly inaccurate or completely wrong, they fault the diviner—maybe the person is simply distracted by their own problems or they are incompetent—not the system of divination itself (Holbraad 2012). In this respect, people

approach divination much like they approach healthcare. If a treatment they undergo does not work, they generally assume the medical practitioner is at fault, or there has been a mistake made in a laboratory or with a machine. They do not lose faith in modern medicine. Lucumí devotees are invested in both and seek insight from both systems.

Oracular Subjectivity (Agency, Personal Interest, Strategy?)

People don't typically consult an oracle when facing a minor illness or an illness that is easily treatable with home remedies or the medication prescribed by a biomedical practitioner. When told they require a more invasive clinical treatment, on the other hand, they are more likely to seek advice from divination to determine whether they should go ahead with the procedure, especially when uncertain. According to J. Omosade Awolalu, divination provides insight into those unseen forces influencing people's lives, what those forces are planning and how one gain their favor, generally through sacrifice (1996, 121). A psychologist I spoke with, who had spent years working in family interventions on the part of the state, commented that the few "s*anteros*" she had interacted with seemed skeptical of her advice on child-rearing and interpersonal relationships, leading her to the conclusion that they believed they had access to other insight. The overlapping subjectivities produced by having access to the guidance of Afro-Cuban divination within the wider US culture in South Florida is central to this dissertation, and specifically to this chapter. How does having access to insight that mainstream healthcare providers do not have and the mainstream system does not acknowledge impact the development of devotee's patient subjectivity? Some scholars find that in postcolonial contexts the way people talk about "traditional" systems positions them within the society: skepticism

positions one as a participant in modernity (see Langwick 2008 and Pigg 1996 for further discussion). But as Stacey Pigg (1996) aptly points out, these "traditional" systems are as much embedded in modernity as biomedical systems. Lucumí serves as a marker of identity for many of Cuban descent, but it does not function as a juxtaposition to modernity. Rather it is an effective tool to realize the aspirations of modern citizens in an information age.

Divination serves as additional information from unseen forces outside the sphere of biomedical practitioners. In this respect the "doing" of divination "positions" the self within the religious landscapes of South Florida (Comaroff 1985; Pigg 1996). It is also worth noting that divination generally occurs within the community, semi-privately, and to this extent is within the domain of the secret. Historically there is power and protection associated with this secrecy as it was necessary to shield Afro-Cuban religious practices from the Church and the State of Cuba, yet this same secrecy made Lucumí the object of accusations of criminality, both in early twentieth century Cuba and late twentieth century Miami (Beliso-De Jesús 2015, 62; Wirtz 2007). These two systems of healing bear certain parallels. Biomedical diagnosis is also information that is provided in a semi-private context as well. Although physicians have a great deal of respect today, this is relatively new dating to the early twentieth century. Prior to that time, there was a great deal of suspicion of doctors. Is this a reminder of modern medicine's insistence that patients, including those with access to oracles, must "act" on behalf of their own healing? Or is this an extension of the emphasis within the biomedical system to focus on the autonomy of individual patients over the integrity of the medical system?

The Lucumí construction of patient subjectivity is in marked contrast to the traditional biomedical construction of patient subjectivity where the patient is generally processed as the center of illness, the "stage" where illness takes place (as discussed at length in B. Good 1994 and Foucault 1972). Generally, there can only be one illness dealt with at a time, only one story-line in the theater. In this way, the patient's ability to be an active participant in healing is hampered. Patients are expected to participate in healing through compliance to clinical treatment, not refusal based on oracular insight. These conflicting subjectivities, doctor and patient, highlight a gap in framework: biomedicine focused strictly on singular forms of illness in the present versus Lucumí focused on myriad factors participating in illness the past, present, future, body, and spirit. This gap is illustrated by C. Nadia Seremetakis's argument that "[l]inear, compartmentalized time advanced by modernity precludes any interpenetration of the present and the future" (2009, 339). In modernity the present is impermeable. In Lucumí the insight offered by oracles pulls insight from the past, present, and future, as well as the material and spiritual worlds in order to provide advice. Often when people seek divination to confirm or deny a medical procedure, it is specifically because they doubt the biomedical "cure" and suspect that the doctors are "missing something" in the treatment they are prescribing. For many, Lucumí practice offers more in-depth and accurate ways of "seeing" patient illness, making divination a "messy variable" (Kleinman 1988) in the medical encounter. This is not to imply that devotees do not appreciate biomedical ways of seeing or think that divination is a substitute for it. The point is that divination encompasses the sphere of biomedicine as well as the cosmology of Lucumí allowing them to complement one another rather than setting them up in an oppositional duality.

Kleinman (1988) argues that there are two basic questions when someone is ill, "why me" and "what can be done?" Biomedicine is singularly focused on the latter, while divination addresses both. The presence of divination in health seeking behaviors among Lucumí devotees complicates the three themes prevalent in medical anthropology's explorations of subjectivity according to Rorty (2007): 1) the overall value of patient narratives to doctors' work; 2) getting patients invested in treatment and the process of treatment; 3) feeding into medical ethicists attachment to patient autonomy, especially in questions of life and death. The element of divination complicates notions of patient autonomy but highlights a focus on the "particularity of experience" and the intersubjectivity of that experience.

Divination is a "messy variable" in health seeking behaviors. According to Bruno Latour (2005), the reason for scholar's basic misunderstanding of divination is that religious "talk" is not to relay facts, but to create transformation. Latour specifies that he is referring directly to Christianity, as that is what he is familiar with. When he refers to religious "talk," he is considering gospels, sermons and so on. If we understand Lucumí divination as another sort of religious "talk" intended to create transformation, then its role in healing becomes all the more nuanced. If a person goes to a diviner simply to learn the "truth" of their health situation, the diviner is little more than a sort of spiritual x-ray. Yet that is not an adequate analysis of the role of divination in this context. Holbraad (2012) argues that, in fact, people do not simply assume oracles are true, they are understood to be "indubitable truth." In the act of divination the diviner is not pulling back a curtain, so to speak, but is in fact calling a divinity in the immaterial world down to the material world to speak directly to the client through the *odu*, divinatory verses,

tied to a series of *patakí* (myths).[2] Holbraad describes this in the *Ifá* cosmology as "a relationship of continuity between the realms one would heuristically describe as transcendent and immanent"—the diviner uses divination to "elicit [the transcendent] into immanence" (2012: 147). While in this chapter I am looking at not only *Ifá,* but *Diloggún, obi,* Spiritism, and "hunches," I would argue that in all these instances, Holbraad's observation that divination elicits the transcendent momentarily into immanence still stands. As he argues, what the oracle does is make connections between individual events and the *odu,* revealing relationships which had not previously been understood. Consequently, divination is one modality of transformation that religious practice offers. In the analysis that follows, I am in alignment with Holbraad's observation. As we shall see, divinations are assumed to be "indubitable truth," reliable enough to justify refusing clinical treatment. In this way patient subjectivity among Lucumí devotees is very much a product of modernity, the result of processing a great deal of information from multiple domains and weighing it to produce an effective ontology leading to action.

Working Out Meaning and the Nature of Illness Through Relationships with the *Orisha*

A few years back, Ida's doctor told her she needed a hysterectomy. "The biopsy wasn't negative, but it wasn't positive either, so he thought it was best. He just wanted to cut me. I told madrina, I don't trust this doctor." The hysterectomy was supposed to be done the day after Ida's sacred birthday, the anniversary of her *kariocha* initiation. During a birthday celebration people often present offerings to their *orisha* and an *obi* divination is

performed to ask if the offerings are accepted and if the *olorisha* receives the blessings of their *orisha* over the coming year. At this birthday, Ida requested that her madrina, Mina, ask Ida's tutelary *orisha*, Yemayá, if she should receive a second opinion on her hysterectomy. Mina asked the question, threw *obí*, and got confirmation: Yemayá replied "yes, get the second opinion." Ida said that usually, she just follows the doctor's advice, no questions asked, but this time, she just had a bad feeling about it. She had canceled the surgery a couple of days before her birthday celebration, yet she was still feeling anxious. "This was a very good doctor. When I called to cancel, he was pissed. He said, 'You probably have cancer,' and I said, 'Well, I guess I'm going to die of cancer.'" Ida saw another gynecologist who performed a second series of cancer screenings on her uterus. It was not easy, but Ida managed to cover the additional fees on her limited salary as a public school teacher. The second doctor told her there was no need for a hysterectomy: she did not have cancer.

Ida's story illustrates how divination is sought out when there is uncertainty. Patients, or their families, are not confident that the medical procedures proscribed are appropriate for them. Holbraad (2012) argues that divinatory rituals deal in the truth of the individual. Here Holbraad is pushing back on prior anthropological studies of divination largely intended to debunk it, rather than gaining a better understanding of the role it plays in people's lives. He suggests that many scholars have based their work on an unexamined notion of truth altogether, one assumed to refer to truth as understood by the natural sciences and consistent with the process of unveiling the workings of the natural world: truth is a cold hard fact waiting to be discovered. In contrast, the "truth" of divination reveals the connections relevant to the problem a person faces. Holbraad

argues that diviners bring an ontological understanding of truth to consultation. In other words, the connections in question are between elements of the *Ifá* cosmology. In this way, I would argue, divination expands that cosmology, as the inner workings of it are revealed to devotees through the ontology transformed by divination. But how is the individual, or the individual's situation "transformed" by divination?

In the Lucumí cosmology, people are understood to be interacting with any number of *orisha*, *egún*[3] (spirits of the dead) and their own destiny[4], as well as the comings and goings of the material world, at all times. These material and immaterial forces are constantly coming together and pulling apart impacting everything in the flow of life. Divination is understood to be a means of communicating directly with the *orisha* and gaining insight into the flow of those material and immaterial forces. While *olorishas*[5] have their own *orishas*[6] at home and can always talk to them, as well as do an *obí* divination to ask questions, this is not comparable to *Ifá* or *Diloggun* divination. *Obí* divination is generally just to initiate yes/no responses and does not provide a sign—an *odu* linked to a series of divination verses—to be interpreted by a diviner. In addition, during *Ifá* and *Diloggun* divination, questions are generally not asked until after the sign has been read and interpreted. If the sign speaks directly to the problem that is brought to the oracle, it is understood to confirm the prominence of that problem. If the sign does not address the problem, the person can still ask the oracle the question, provided it is still relevant after the sign has been interpreted. Plenty of divinations are initiated without a specific question in mind. In such cases, devotees visit the oracle of their religious house to maintain communication with the *orisha* and to make sure that they are "on track" spiritually. Palmié (2002) argues that divination is an inherently historical exercise in that

the divination verses speak to history, a mythological body of knowledge relating to the *orisha*. The diviner's task is to find how this history relates to the client's situation to resolve it. In this way, throughout a devotee's life, meaning is built through the framework of the oracle.

To be "on track" spiritually is also to address health and how to be proactive with it. Health maintenance is something that divination is often used for. As Mina, an experienced, longtime *iyalorisha*, explained to me, sometimes a person is unable to articulate their symptoms and is advised in a divination session to ask their attending physician to test for a specific sickness. This may include situations where the symptoms exhibited by the patient do not match those associated with that sickness and the patient must ask their physician to test for it anyway. In the interpretation of divination verses, cosmological connections can be established, and divination can tell the client what to ask medical professionals about. Doctors, Kleinman (1988) argues, are often trained to think of their job as dealing with "disease problems" while ignoring the fuller picture of "illness," that holistic experience of patient and family. Diagnosis is one of the most important, and most difficult responsibilities of a doctor, in part because it requires clear communication between doctors and patients. Different divination signs speak to difference spheres of illness—blood, circulatory system, digestive, and so on—and where those illnesses steam from: poor health choices, spiritual transgression, witchcraft, or unavoidable destiny. Over the course of modernity these religious forms of thought and practice have been used as a foil to enhance the "rationality" of Western practices (Palmié 2002, 28). I doubt that Kleinman has divination in mind when speaking of the holistic experience of illness. Yet, if we are to get a more holistic understanding of

rationality, we will have to go beyond the misguided notion that the specific idiom of "rationality" that the academy has been working with is not a human universal, but a culturally specific idiom that is reliant on a thin and constantly unfolding cosmology of the "natural world" coupled with a persistent monotheistic palimpsest.

The people that I worked with are often engaged with new age and eastern philosophies prominent in the mainstream. A notion of "energy," the movement and manipulation of an ill-defined force comes up often.[7] According to Laila, whom you may recall from chapter 3, divination provides guidance in how to "tune" your energy. She moves her long straight black hair from one shoulder to another as we talk, "I think that *orishas* work more with tuning in your energy, tuning in your mental status. *Orisha* have a better grasp of that. I think that when you hear the words of your *orishas* speaking to you it gives you a different look at what is ailing you, what you think is ailing you." George Brandon (2012) argues that part of the role of divination is helping people to be proactive in their healthcare treatment. Yet this active engagement with treatment goes both ways, either supporting treatment, or stopping it all together. In this respect divination has a concrete role in transformations in devotee health and well-being. Notice Laila's choice of words, referring to literally *hearing* the "words of your *orisha*s." During divination the *orisha* are understood to be present in a tactile way that is *more* than happens in the everyday life of an *olorisha*. As Holbraad puts it "…the deities *are* transcendent most of the time, so that the diviners' powers are necessary in order to *elicit* them into immanence" (2012, 147, emphasis in the original).

This immanence also allows for direct maneuvering of obligations on the part of devotees. Spiritual instruction provided in divination often serves as a platform for

negotiating with the *orisha* and/or the *egún*. According to Loupe, everything that she agrees to do spiritually comes with some caveat. When told in divination to perform as a spirit medium regularly, she agreed, given that the *orisha* help her get a job that allows her the time off. Spiritual negotiation is critical to Lucumí and indexes the pragmatism of religious practice and ideology. For many devotees asserting this form of agency is perfectly aligned with active religious devotion.

Itás in the Experience of Chronic Illness

When people undergo religious initiation, they receive a lifetime divination, an *itan*, often with health advice. Each *odu* corresponds to a different system in the body and patients are given advice to follow, such as what to eat, and what illness or disease to be on the lookout for. The *itá* goes well beyond the average reading, where the advice given is generally understood to be relevant for 3-4 weeks. *Itá*s are for life as this is, for many, likely the one and only time that all their *orisha* will speak directly to them. In the average reading the diviner's Elegguá speaks. Elegguá is the *orisha* who is always first as he makes communication possible, and people like to joke that he never stops talking.

While all *olorishas* have an *itá,* people's understandings of what their different *odu* mean varies greatly. The *odu* in an *itá* may speak to the past, the present, or the future. For many people, the most important things to remember are what they should not do. Chrissy, a red headed woman under five feet tall, was told not to take pharmaceuticals unless she had exhausted all other options. She was advised to treat illnesses with natural remedies and spiritual rituals and resort to mainstream drug regimens only when these options had been exhausted.

> Chrissy: I was living in Georgia and I was literally sick with sinus problems for the two years I was living there.
> Eugenia: What were you reacting to?
> Chrissy: Amoxicillin. Any type of drug to try to take away whatever I had because we were trying to figure out what I had. I was constantly sick. Every couple of weeks I would go in because I was sick. I would be okay for a while. One day I would wake up and my tongue or throat would be swollen.

Chrissy managed to move past her two-year-long illness by moving back to Florida near her religious family and by following the religious advice she had been given. When we spoke, she was relatively healthy. Yet she still found the advice followed her. Just weeks before the interview, she had tried to take an over-the-counter nasal spray for her allergies. Not long after, she found it caused discoloration under her eyes and stopped taking it.

Mina, who had been initiated close to four decades before, had signs for thyroid problems in her *itá*. It did not seem relevant to her until she was diagnosed with Graves' disease, an immune system disorder that results in the overproduction of thyroid hormones. Lucumí devotees who are given signs for an illness do not expect to avoid the condition altogether. But they understand that the *ebos* they are required to do will enable them to manage those illnesses.

> So I was diagnosed last year with Graves' disease, and it was in my *itá* that I had done all of them [*ebos*]. If you look at the *eboses*, half the time you wonder what one thing has to do with another. What does going to a graveyard and cleaning a tomb have to do with my thyroid? But they are connected somehow because you do the *ebos* and everything works out.

The understanding is that your religious signs are all interwoven with your health profile and, by extension, the best health you are going to achieve is embedded in the Lucumí cosmology. While in the 'linear, compartmentalized time' of modernity, cleaning a tomb and the thyroid are not connected, in the oracular domain that does observe non-linear

connections in alternate temporalities, they are (Seremetakis 2009). A person's *itá* provides a guidebook to managing the individual's best life within that cosmology. The seemingly disconnected things—the thyroid and cleaning a tomb—illustrate the objective of divination, to master how these transcendent forces can be catalyzed to achieve immanent ends. Everyone's *itá* is singular to them; it is understood to provide information, some of it hidden, about yourself. Other information provided in the *itá* may be public knowledge or self-evident, but this is not a disappointment, it is a confirmation. Any doubts that the person may have had are washed away.

Diagnosis and Spiritual Blocks

One of the primary challenges of biomedicine is diagnosing illness. In the Lucumí cosmos, diagnosis can be disrupted when the patient or the clinician has a spiritual block, that is to say that either the patient's spirits or the doctor's spirits are preventing an accurate diagnosis. Recall that Ida did not ask her Yemayá if she had been "misdiagnosed," but rather if she "should" get a second opinion. Ida was plagued with what Pelkmans (2011) describes as "the restlessness of doubt," an overwhelming sense of uncertainty that overwhelms one's capacity to make decisions, and she managed it through divination. When I interviewed Ida, she did not have a lot of experience with illness or seeking advice from doctors. Laila, on the other hand, suffered from chronic illness and had a long-term close relationship with her general practitioner. A few years back, she was suffering from a battery of symptoms that prompted her doctor to order a series of tests for fibromyalgia. After undergoing the tests, she consulted a diviner and the *orisha* said that the doctor was on the wrong track.

> A while back they thought that I had fibromyalgia and I'm going for all these tests and everything. Finally, I'm like, I need to go get a reading, and pretty much, my ocha said you don't have fibromyalgia. They said you are overworked, you are stressed out, that's it. Sure enough, I started getting my chiropractic treatments regularly and taking more time for me. I accepted less work. And it happened. My body just started healing itself. It went through that process and that's it. I was looking at all those medications they give you for fibromyalgia and anti-depressants and all that, ugh, I didn't want that.

Perhaps overwhelmed by other concerns, Laila had initially accepted her doctor's diagnosis of fibromyalgia. When Laila had some time to reflect on what the diagnosis would mean in her life, however, she sought out divination to gain insight into this chaotic health crisis and find ways to deal with her symptoms that would have fewer side effects than the burdensome treatment for fibromyalgia. In effect shifting her situation from one of illness and chaos to health and material order.

Bartolomé in his many years as a long-term practitioner and registered nurse had experienced misdiagnoses first-hand in his profession. He told me that he generally tried to keep his spiritual impressions to himself. In a hospital, things can get hectic physically as well as spiritually, as patients are understood to have spirits with them and individuals who die unexpectedly in the hospital often end up stuck there, both types of spirits can create confusion. At one point he came into work on the night shift and his coworkers warned him to provide extra care to one of the patients as her daughter was an RN at another local hospital. After Bartolomé went in to see the patient, the two of them chatted. He learned that things were looking good, her tests were negative, and her daughter was on the way to pick her up. "But there was that inner voice, usually it's there," he just felt that something was not right in the diagnosis. When the woman's daughter arrived, he told her about his misgivings:

> The daughter came in, and I said are you her daughter? "Yeah." I understand that you're a nurse at Jackson. She said, yes, I said, you know when you're a nurse, sometimes you develop that a sixth sense, an inner voice, when things don't look right. She said [angrily], "what do you mean by that? What are you talking about? The doctor said that everything was negative!" I said, "look, I'm talking to you as a nurse, this is your mom, as a human being. If this were my mom, I'm asking you please, take her to a surgeon, don't wait until next week unless you take her to a surgeon." "But why?" […] I said, "look, I'm just letting you know this."

Bartolomé discharged the patient and continued with his shift feeling that the daughter had completely dismissed him. Months later, when he arrived for his shift, he was told a woman was looking for him. When he saw her, he had no memory of her at all. "She says, 'you don't remember me?' And I say 'no.' 'Because my mother was here and you told me to take her to surgery [….]'" Slowly his memory came back as she told him her mother had been released on a Friday. Since she (the daughter) was going back to work two days later, she brought her mother with her to the hospital. A surgeon examined her mother, after which she was immediately taken to surgery. The surgeon drained a liter of pus and removed a tumor the size of an avocado from her abdomen. She said "the only reason that I'm here is that the surgeon told me, begged me, whoever told you to come to surgery you need to go back to that person and say thank you to that person, they saved your mother's life."

In this instance, Bartolomé went with a "hunch" he had about the condition of a patient. What blocked the attending physician from "seeing" the sickness in his patient's abdomen? Was the block a spiritual one on the patient's side? Was it on the biomedical practitioner's side? Was it not spiritually related at all, but simple material incompetence? If this had been an instance of a *Diloggún* or *Ifá* divination, more insight would have been revealed through the *odu.* Bartolomé did not weigh in on the cause of the misinformation, but as a long-time nurse and a long-time *olorisha*, he had a great deal of

experience and trust in his own vision, enough to share it with another nurse and in such a way that that person could not ignore it.

Laila and Bartolomé each acted on a feeling that something was wrong with the diagnosis that had been made by a physician. While Laila received clarification for her hunch that she did not have fibromyalgia by seeking divination and the success she experienced in following the advice she was given, Bartolomé found out his instinct was right when a surgeon at another hospital made sure he was thanked for saving a woman who has been misdiagnosed. In both instances doubt motivates action. In Laila's case her management of doubt through the insight of divination is in keeping with her positionality as a Lucumí devotee, as doubt is often managed through the mat. But the daughter of Bartolomé's patient is another case in point, why did she take his advice when she seemed hostile to it initially? According to Pelkmans doubt produces restlessness which forces agency. Whether or not she wanted to hear what Bartolomé said, his words instilled "the restlessness of doubt" in her and as an RN in a hospital her agency was put to action. Ultimately, he got the confirmation that his spiritual "hunch" was correct, and the original misdiagnosis was corrected.

Spiritual Diagnosis and Healing in Lieu of Biomedicine

The truth unveiled by divination does not typically contradict a physician's recommendation to their patient, especially when the patient suffers from an acute illness, although at times the *orisha*, or the *egún*, may offer alternatives to the solutions offered by biomedicine. Milly, who has been an initiated devotee of Yemayá for nearly four decades, was healthy until she was diagnosed with kidney cancer. Since that time, she has

been in and out of doctor's offices and hospitals. A few days before we spoke, she started suffering from pain she did not consider serious enough to warrant a visit to the emergency room, but she nevertheless contacted her doctor. The doctor had a few suggestions to alleviate the pain, but none of them worked:

> So I asked Yemayá [presumably through *obi* divination] if I should go to the hospital, she said no. So I needed to cleanse myself with the *otanes* of all of my *orisha* and put an *addimu* to all of them. Even in pain I did it. The next day I didn't have pain […] It took all day, with the pain. I had some ochas in the room that I had put in my mother's room. I had to do a lot of stuff, it was 'til like 10:00 at night. But I said, they told me to do this, they are going to give me the strength to do this … I did a meat for Agau… For Sango I did *harina* with *quimbombo*, for Ochún I did a custard, Obatalá I did *ñamé* (starchy root vegetable) cone, Oya I did *tore*, it's like a French toast that you do and I put sprinkles of different colors, and for Yemayá I did the coconut pudding with the *melao* (cane syrup), and for Ogún and Ochossi I did a *bonyato* baked (Caribbean sweet potato) in the oven, for Ochossi I put some anise on it—but just plain—Elegguá I put three pieces of guava [paste] because I couldn't think of anything else. And the next day I felt much better. But I had to do all of that before I could go to the doctor's office. So today I have to ask if I can take it away or anything. It's been like a week and I go to the doctor's in two days. What do I do with it, where does it have to go?

Faced with pain and uncertainty, Milly asked her Yemayá for advice and was told, very clearly, not to seek out immediate biomedical help, but instead give a ritual offering to all of her *orisha*. This required a day of rearranging, cooking, and spiritual cleansings during which all the *orisha* agreed to remove her pain in exchange for the sustenance they received. A day of labor for a healthy person leaves one exhausted, a day of labor for an someone suffering from pain and long-term illness compounds this. Yet, Milly found the strength to do what was required and she reaped the rewards of her labor in the form of improved health.

In managing chronic illness, patients often must decide if a visit to the emergency room is in order. Given the emotional burden and financial strain of emergency room visits, compounded with the overall burden and costs of chronic illness, this dilemma is

not to be taken lightly. As Kleinman points out, patients interpret illness through the lens of culture as well as personal experience. “The experience of chronic illness provides personal training in both ways [exaggeration and minimization] of responding to symptoms” (Kleinman 1988, 59). In this instance, through divination Milly was able to minimize symptoms by addressing the question of “what can be done?” in the moment. Here, the symptom was temporarily taken entirely out of the hands of biomedicine.

Kleinman makes a distinction between patients suffering with chronic illness and those suffering with chronic pain. Arguably, Milly’s experience was one of chronic illness. Loupe, on the other hand, had experience with chronic pain resulting from injury.

> I’ve had two separate accidents in cars. And I don’t have bumper accidents where your bumper gets cracked. No, it’s major accidents. I was on I-95, it was rainy, and someone hit me and I ran into six other cars, my car got hit from each side, and almost went over the bridge. I got two herniated disks from that. But I got better with some physical therapy, everything was okay. Then about seven years ago, I was […] driving back from a *missa* and someone ran the red light making a left from the right-hand lane. I got another four herniated disks. So I have six total.

Between these two major car accidents, Loupe suffered from terrible back pain that made it difficult to get out of bed. For an entire year, she contemplated back surgery, while her wife had to push her out of bed every day. Loupe refused pain killers and suffered through. One doctor told her that she needed an operation to either align or pad her herniated disks, she was not sure, but he made it clear that without the operation, she would be in pain for the rest of her life. She got a second opinion from another specialist who also wanted to operate on her but added that the operation may not be successful. “You have to sign this paper because you could end up in a wheelchair. I said ‘no, wait! Wait! Wait!’ Because he wanted to operate the *next week*.” Desperate, Loupe called on her tutelary *orisha*, Obatalá, to ask if she should get the surgery.

> [Obatalá] said no, you cannot have the operation. And he gave me a bunch of *obras* to do, a bunch of *ebos*… And so when he came down he told me he didn't want me to do any operations, he wanted me to work the religion and to work spiritually. Because for many years I didn't work the religion. It has only been, maybe fifteen years that I've been working the religion. The rest I did not work the religion. (And did you have signs that you should work the religion before?) Oh, from day one! From day one I was told to work the religion. But I would always, 'yeah yeah yeah.' So then I said, you know what, I work weather they pay me or not, I don't care. I'll work all the *missas* and all the *santos*, so long as I'm not in school—you know, there are always clauses with me. But really, after that *obra*, I felt like something was lifted from me and I don't feel any pain. My back is still crooked. Because my doctor sent me to a chiropractor and he said, 'wow, how do you walk?' I said, 'ocha.' He said, 'hey, if it works for you.'

In this instance, unlike the experiences of Ida and Bartolomé, Loupe did not doubt her diagnosis, but she was not confident about the clinical treatments prescribed by her doctors. The fear that the back surgery proposed would not be an effective solution and could even cause worse harm led her to question the authority of her doctors. In effect, the doubts expressed by everyone in this chapter (except Milly), lead them to push-back against the authority of biomedicine. In Ida's case she relied more on her own intuition, canceling surgery before confirmation from divination. Also in Ida's case, the reasons given for the surgery were completely false, she was not sick. Loupe, on the other hand, did not doubt that her injuries and chronic pain were real, and she did not doubt that the specialists she saw were diagnosing her properly and applying their training appropriately. Still, she wanted to avoid surgery and consulting with her Obatalá gave her the confidence to refuse the clinical treatment offered by biomedical authorities. Loupe had another source of information, another authority to rely on, much like the patients mentioned by the former psychologist for the state of Florida observed (see above, this chapter).

For some practitioners in the US, memories from Cuba feed their doubts about unquestioned faith in biomedical treatment. A.J., a well-built man of modest height in his mid to late fifties, who is often mistaken for Anglo, grew up in Cuba in a well-off family accustomed to being surrounded by Afro-Cuban servants. When he was a young child and his family still lived in Cuba, A.J.'s parents had nothing to do with Lucumí, but his grandmother and some of her extended family did. As best he could guess, her knowledge and familiarity came from the Afro-Cubans who worked for the family and lived in their small town. When he was growing up, if "You wanted to do Santería you just went to the other side of the train tracks." Overall, he described himself as a sickly child, and his grandmother used Lucumí practice to save him on more than one occasion. He did not remember specific divination guidance that his grandmother received, but he did remember his gratitude for her help in "saving him" from potentially dangerous medical procedures.

> When I was eight, I used to get these sharp headaches… like electro shots, it was very painful. I was a sick child. So they took me to the doctor, and they wanted to do brain surgery on me, 1968. My grandmother on my father's side, at the time said, "no way." I remember holding on to her skirt at the time saying, 'You are my savior.' He was a Hindu doctor, I remember him, he had the turban. So he was very impressive to look at. He wasn't what I was used to. So he said "oh, he needs this surgery" and my grandmother said, "okay, sure." I remember there was a river, this place they used to take me. And I would go and sit there as a kid and pray to the rocks at the river. And my grandmother said "no" [to the doctor] and she took me back to the santero and those pains went away… whatever ritual that he did got that hex off me. It's like an electric shock, have you ever been shocked by electricity? [. . .] Think of that multiple times a thousand, I would feel that right here (pointing to his head) for a few seconds. It was so painful. And psychiatrist saw me, psychologists saw me. I remember being in a room playing video games because that was fun. A neurologist, and that was the one who wanted to do the brain surgery. They didn't have MRIs back then, I think he just wanted to open me up to see what was going on. I was the guinea pig. Thank God, I had my grandmother in my life, otherwise I would have had scares on my face.

While this incident happened over fifty years ago and is but an old memory for A.J., the success of his treatment bolsters support for spiritual diagnosis and healing, especially when contrasted with the ominous suggestion of the doctor wanting to "open me up," as he puts it. This confidence would play out in his adulthood as years later he sought out spiritual healing for other illnesses and was eventually initiated into Lucumí in Miami.

Outright Refusal

In some instances, an *orisha* will refuse a surgery and not offer a ritual to replace it. In the case of people suffering multiple illnesses with likely future illnesses, sometimes it seems that the oracle is simply refusing because the surgery is too dangerous for that individual, given the overall forces at play in their life. Diana suffered with high blood pressure. When her grandmother was alive, she would prepare an herbal remedy which kept Diana's blood pressure under control without medication. But her grandmother did not pass down the recipe and now Diana takes multiple pharmaceuticals to control her blood pressure, at times it is still unsuccessful. A few years back she asked an oracle if she could have a gastric bypass surgery. The oracle advised against it and her blood pressure problems got worse. In our interview it seemed she considered the increase in her blood pressure to be the reason that the divination advised against the surgery. The increase in blood pressure was inevitable and if she had the surgery she would be in a worse position. As an alternative to the gastric bypass surgery, she has a gastric sleeve.

Loupe's mother had been sick her entire life. Born with an enlarged heart, she suffered a lifetime of health complications from twisted veins to fibromyalgia to arthritis to a bad knee. Loupe's mother was an avid spiritist and had many clients. As Loupe

described it, her mother would heal people with the water from her spirit altar. For Loupe's mother Lucumí was very much second to her work in Spiritism, but not in matters of illness. She was initiated to Ochún for her health, and she reverently followed the *orisha's* instructions when it came to clinical treatments.

> …she had a bum knee that she couldn't operate so her knee was bone on bone, she suffered so much on that knee. But she couldn't operate because she would have passed away. (Oh, did the *santo* say not to operate?) yeah, with my mother, if the *santo* said no, it was no. It didn't matter what the doctor said, if the doctor was god herself, the *santo* said no, my mother wasn't doing it.

As Bronislaw Malinowski observed, the more vulnerable a situation the more people rely on ritual magic. Given the overall vulnerability of Loupe's mother, and the number of clinical procedures that she went through in her lifetime, it is not a surprise that she would rely so heavily on spiritual guidance for her health. Historically anthropology has struggled with how to manage the persistence of "irrational belief." Palmié argues science and other indices of modernity retrospectively create the concept of "irrational belief" to delegitimize magic, witchcraft, religion and the like (2002, 28). Modernity has defined itself in contrast to the "irrational belief" it created. In a similar vein, Bruno Latour points out that to become modern people have to trade in "belief" for "fact." Latour goes on to highlight the obsession with "belief" embedded in nonbelief: "moderns need to believe in the belief of the other to maintain their own account of themselves as nonbelievers. Moderns 'believe in belief in order to understand others'" (2010, 7). In other words, modernity is defined largely by what it lacks, more so than by its qualities (Gilroy 1992; Comaroff and Comaroff 1993; Felski 1995). But while modernity performs summersaults of reason in trying to support the belief that it lacks belief, where does this leave Loupe's chronically ill mother? While many would refer to her as "deeply

believing" in her religion, is that all there is to it? In fact much of her life was spent surrounded by doctors who expected her to die, and she did not. As a "deeply" religious woman she lived much longer than her doctors ever thought possible. Unless you argue that she only "believed" she was alive, it is a "fact" that she was not dead. Certainly it was not a fact that could be recreated in a laboratory on a large scale, but it was the fact relevant to her vulnerable life. In this respect, her life choices, namely her reliance on the words of her *orisha* were not based on belief but on fact. That is, the truth of her *orisha* found routine confirmation in the fact that, by remaining alive, she continually proved her doctors wrong.

Nancy, a retired elementary teacher had been initiated less than ten years when we first spoke. Prior to her initiation she was relatively healthy, but since the moment she left the ritual she had been sick. She liked to question why she got initiated at all, jokingly, but then she would clarify that really, all that illness was always just around the corner, the reason she was not dead is that she *was* just leaving her initiation. Over the next few years she was in and out of the hospital. When we spoke, she told me that a few years before she was attending a tambour for her tutelary *orisha*, Shango, shortly after leaving the hospital for a brain hemorrhage. For some time before, she had been suffering with pain that she took to be from her uterus, but trips to the gynecologist did not reveal anything wrong.

> …all Sango says to me is "Ogunda meji" [an *odu*]. This doesn't sound good, I don't want to know what it is. And my godmother said to me, "It's talking about illness. You already know, he talks about that, but he's here to save you. Let's see what it is, go to the doctor." So I'm helping clean up after the *tambor* and having these pains in my stomach. I had already been getting them and been to the gynecologist, but they couldn't find anything because they were looking from the uterus down. So I faint, and they take me to the hospital, portal vein thrombosis. All the veins going to the heart were blocked.

Nancy's true condition was accidentally detected. The technician was checking the lungs for pneumonia when she tripped and the scanner moved down. There was a dark mass and the technician had no idea what it was. Nancy's portal vein system was completely blocked. She had to be transferred to another hospital.

> They didn't even know how I was alive and functioning with all of these clogged. How was I functioning like a normal human being? That's when the doctor says to my children and my godmother, there was this surgery that was first performed … in 1995, I was in another hospital and they transferred me… It has only been performed once and it is completely different than any of the normal surgeries. Because you're thinking why can't they just put in a stint, like a vein or an artery, but no, here you have to go through the jugular and then through the liver to get to the portal system. That is only to unclog one vein. When you puncture the liver it's all blood, right now we are giving you medication to unclog blood. We might unclog one, but we can't tell you that you won't bleed to death after the one. We can't tell you to do it or not do it. The decision has to be yours.

At this point Nancy was in the hospital and incapacitated. Her *madrina* and her children consulted her tutelary *orisha*. Shango forbid the surgery as too risky. Nancy found out when she woke up in the hospital that Shango had refused medical treatment.

> And my kids are like, what, we going to let her sit there and die? And my godmother is like, if she does the surgery she's going to die. It says right in her *itá*, intestinal issues, stomach and blood. So if Shango is saying no, he's going to find a way. So all they could do is give me blood thinners and keep me in the hospital until the pain subsided. I was in the hospital for three weeks. First, they were working on easing the pain. Then how much they could thin the blood so that it could pass through. When I was released, they were in a conundrum because the portal vein thrombosis required me to have two shots a day of blood thinners and the hemorrhage required I have no blood thinners or I would bleed out. So they don't do the surgery. Everyone is like, what are we going to do with her? Even me, I wake up and I'm like, what? There's no surgery? The doctor is looking at me like, how long are you going to live? Got to have faith in my saints.

Every three weeks, Nancy would return to the hospital for an ultrasound and, according to her, the technician would ask what hospital room she was in. Proudly, Nancy would clarify that she was not in the hospital but had driven herself for the visit and ask was the

blockage still there? She insisted to the technician that she felt fine. Shortly after getting out of the hospital, she had done an *ebó* with her *padrino* of *Ifa* and she had not had any pain since. She attributed her survival to tiny capillaries that had formed in her system to allow for just enough blood flow to maintain her system. Her life was filled with constant precautions to protect her digestion, but she managed to stay alive and out of the hospital.

Many people refer to themselves as having "faith" or "deeply believing," but I would argue that perhaps these really are not the right words for these examples. The fact that they did not die when all the biomedical advice said they should, is hard to ignore. What people often referred to in interviews was *pruebas* (proofs) in Lucumí or ancillary religions that were followed by anecdotes of rituals which lead to miraculous cures or the possession of a complete stranger who then reveals intimate personal details of your life that occurred in private and you had not told anyone about. I would also argue that these stories illustrate the inherent "doubt" in the system. In part, doubt is inevitable, an inescapable human quality. But it is likewise true that Lucumí is still a marginalized religion that faces constant stigma, even in South Florida where it has relative visibility. Devotees still need to be able to provide rational for their decision making.

Conclusion

Where there is tension and things get "messy" is often where meaning is being produced. When a sick patient has to tell a doctor, *no*, refusing clinical treatment, it takes a great deal of fortitude. Most of the Lucumí devotees I spoke to would not describe themselves as formidable on their own, but their *orisha* are often described as such. In this respect, divination transforms these everyday people into formidable actors, through rendering the

orisha immanent in their lives. This is not to say that devotees do not doubt oracles, at times they do. In most cases, blame for a questionable reading falls on the diviner, but it is also important to keep in mind that the *orisha* are not thought of as omnificent or omnipotent and spirits especially are not. But in the overall picture, the *orisha* and the spirits are more likely to see more than the individuals involved.

Devotees trust the system when their experience and investment with the system has proven, over years, to be effective. Within the system of Lucumí, agency and decision making is often shaped by the *odu,* even when it isn't. By this I refer to a common understanding in the community, that if a person follows their *itá* and maintains their alignment with the *orisha*, they should not need to constantly seek out the advice of oracles. A life well lived should not fall into such disarray that constant advice is necessary. But for every *devotee* I spoke with, all bets were off when it came to serious illness. Consultations with oracles were all the more critical in these times. In this respect the trust that people put into divination was rooted in long-term experience with these oracles. Divination served to transform *olorishas* into patients strong enough to push back against biomedical providers when patients were in doubt of the clinical treatments they prescribed.

The experience of everyday "lived" religion builds ethical worlds upon the bedrock of reliable relationships with the *orisha*. Divination is the interface that makes these worlds possible. I often asked my interlocutors why they were devotees? Why did they participate? And a common response was that they had seen so many *pruebas*. It's my position that while for the outsider these "proofs" are little more than dramatic stories, for the person experiencing those proofs first-hand, they create ontological

change over time. Whyte (1997) argues that in employing divination in times of misfortune what people seek is not so much to end uncertainty, but to find security and ways to take socially sanctioned action to address misfortune. Richard Rorty argues that our problem solving is always based on the ideas we are exposed to in our social worlds (1991, 166). Years of building a relationship with the *orisha* through devotion, divination, cooking, and simply praying "to the rocks at the river" make it seamless that in cases of medical uncertainty a person would seek out security by leaning on that relationship for strength and insight.

Chapter 5

Pigeons at the Bedside:

Negotiations Around Ritual Space in the Hospital

I was in the medical field for twenty years. The last place you want to go to is a hospital. You're going to go in with a cold and leave with pneumonia. There are so many germs and bacteria I really don't think that going in with a pigeon and letting it go outside is really going to cause malaria, or anything else. But we're in a country where everything is ruled. We have rules and regulations that you have to follow, but our religion has one thing and that is that we believe in saving lives until the very end… if that person is in the hospital and there is that one percent chance that cleansing them with that pigeon is going to save their life, I can guarantee you that there will be an olosha walking in with a pigeon and trying to save that person's life… while the community is around you and seeing that you have that 1 percent chance, we are going to come together and we are going to try to pull you out.
—*Laila*

Contamination is fundamentally a crossing of boundaries. In the hospital there is constant attention to sterilization in the expectation of fulfilling the promise of health by creating a barrier between patients and pathogens. In the practice of Lucumí and Spiritism there is constant attention to cultivating healthy productive relationships with the spirit world in part to avoid the infiltration of negative spirits which can hamper an individual's success in their personal life and potentially their health. For religious devotees who end up in the hospital, the potential for spiritual "contamination" is high as the hospital is not only full of biological germs, but it is also bound to be filled with "confused" or "negative" spirits, and any other invisible entity attracted to desperation and physical weakness. Spiritual contamination for a sick person in the hospital bears the potential for physical fallout.

To deal with spiritual afflictions, people must create space within biomedical infrastructure to execute magical rituals, to engage the unseen. Rituals, generally prescribed in divination, often involve passing objects over the body then disposing of them properly to remove unwanted forces and strengthen the patient's own spirits so they can withstand clinical treatment. The creation of ritual space within the hospital is not institutionally sanctioned, despite the relative visibility of Lucumí in South Florida. Chaplains I spoke with had limited interaction with Lucumí devotees. Lisa Stevenson (2011) observes that for chaplains to fit into the biomedical infrastructure they must conform to it, and in this way end up both religious and areligious, a sort of placeholder for the notion of religion or spirituality. While pastoral services may be *relatively* secular, the palimpsest of Judeo-Christian religion remains. In fact, Jean Langford observes, much of the organization and expectations of hospitals are—rooted in "covertly Christian (largely Protestant) eschatologies…" (2013, 12). Devotees may be inclined to conflate pastoral services with mainstream religions, the heirs of colonialism, and, consequently, avoid them.

In this chapter, I argue that the creation of ritual space in the hospital is a counter-hegemonic practice that maps onto the history of counter-hegemonic practices of Lucumí devotees in Cuba. Embedded in this practice is a layer of urgency created by illness, a variation on this history. Through analyzing how ritual space is created in light of Lucumí concepts of contamination, this essay contributes to a broader anthropological conversation about the nature of hegemony and counter-hegemony, and the space where they intersect. First, I begin with a description of Lucumí cosmology, then I explore quotidian understandings of what these rituals *do.* Finally, I breakdown the different ways

that ritual space is created. Most of the creation of ritual space takes place at what I will refer to as the "language-level," what illocutionary products practitioners engage in order to remove hospital staff from the area; the "secret-level," when practitioners strategically avoid contact with hospital staff, waiting until the patient is unattended to perform a ritual; and the "familiarity-level," when ritual space is created through the mutual understanding of hospital staff and practitioners. Still, in all of these instances the goal of practitioners is to perform rituals inconspicuously, avoiding the gaze of mainstream biomedicine; an institution historically used by colonial powers as an indexer of the "progress" they had to offer colonized populations. The pragmatic creation of temporal ritual space[1] is arguably one illustration of the fluidity of religious practice and its ability to address the quotidian needs of patients[2] without calling institutional attention to itself; an approach that fits within the historically subaltern positionality from which Lucumí emerges.

Lucumí Cosmology and Contamination

For most people, the experience of being admitted to the hospital is wrought with uncertainty and concern. Among Cuban American practitioners of Lucumí and Spiritism[3] in South Florida, this anxiety is often mitigated through a body of magical ritual rooted in the African Diaspora. It is widely understood in Lucumí cosmology[4] that the path to health and well-being requires alignment with *Olodumare,* creator of all things; the *orisha,* divinities or "saints"[5] created to look after creation; and *egún,* spirits of the deceased who play an active role in a person's life.[6] In the material world invisible entities constantly interact in people's lives, yet so do any number of opposing forces that

can disrupt this balance: our own willfulness, spirits who are "confused" or "negative," witchcraft, or the material demands of daily life. The role of ritual magic—be it bringing seven pieces of fruit to the ocean for the *orisha* Yemayá in exchange for a successful job interview or lighting a candle and talking to your deceased aunt so she stops keeping you up at night—is to have the desired *effect* upon the material world through this alignment. When someone ends up in the hospital, it may be on account of their own lack of spiritual care, but for others, illness is simply a part of life's journey.

Lucumí practice is fluid and pragmatic: it is religious work to be done. This is in part due to historical circumstances from which it arose; in colonial Cuba people of African descent often used this resource to weather their marginalized position, for healing, for community organizing, and, for some, to build cultural capital.[7] It is natural that a subaltern communal religious practice that developed in a colonial setting would have to be both seen and unseen. Yet, Lucumí cosmology also lends itself to temporal inconspicuous ritual practice, as a lot of ritual magic is done with modest everyday items. The use of ritual to reinforce boundaries between human and spirit space is a through line in many religions, as it is understood that chaos ensues when boundaries are muddled. Masquelier (2001b) observes that in rural Niger *'yan bori* practitioners blame negligence of boundaries between the human space of the "village" and spirit space of the "bush" for the intrusion of disease. Through ritual, spiritual boundaries between the literal village and space beyond it is reinforced. While large-scale ritual is intended to reinforce long-term boundaries, the porous quality of these boundaries is illustrated by frequent intrusion of spirits into the village to possess the living. Yet with proper boundaries in place, these spirit intrusions can serve to reinforce social bonds (Masquelier 2001b). In

South Florida hospital ritual space is temporal, yet the reinforcement of social bonds through ritual is still evident.

For patients, illness is generally first recognized as a disruption of normalcy. This is in contrast to disease, according to Arthur Kleinman, which can be defined and described through the physical science of biomedicine. In that illness is not "normal," for this analysis it can be conceptualized as "contamination," something from the outside that has entered the patient's body and requires spiritual removal (Kleinman 1988). When Victor Turner analyzed Ndembu ritual, he noted that a recurrent theme was "to make visible" or "to reveal" (1967, 48). In the case of Ndembu affliction, what must be revealed is the specific spirit that is upset and how it can be appeased. In Lucumí the theme "to make visible" is often present in concerns over the doctor's ability to "see" the patient. Hospital cleansings generally remove the *osogbos* that come up in divination. In Lucumí cosmology an *osogbo* is anything in life that undermines the balance of an individual: premature death, illness, material obstacles, the wickedness of others, and so on (Obá Ernesto Pichardo, personal communication to author, October 21, 2021). Devotees describe cleansings as: 1) "removing" a foreign spiritual force causing a disruption of normalcy; 2) removing relatively undefined spiritual "gunk" picked up in the course of daily life: or 3) strengthening the patient's own spirits and/or *egún*. These obstacles prevent doctors from properly "seeing" the patient's disease. In this respect hospital rituals veer from Turner's frame. When practitioners remove spiritual "gunk" it is not considered "a spirit" to appease, but a vague spiritual negative "energy" to remove.

Lucumí devotees are well aware of the limits of all things, religious and medical specifically. Spiritual work, articulated through this pragmatic lens, is seen in hospital

ritual as a helpmate to clinical treatment. As Evans-Pritchard (1989) observes among the Azande, ritual provides a way to "act" on the world when other possibilities are expended. While magical ritual by design operates outside of the material world, often the goal of the magical ritual is quite practical (Tambiah 1985). In this way, these "small events," as I call the hospital rituals to highlight their quasi-invisibility, follow George Brandon's argument that ritual functions to "motivate" and "engage" patients in the healing process (2012). The patient is already seriously ill and embedded within the domain of biomedicine. At this point the role of spiritual work is to protect the patient from receiving a misdiagnosis, incorrect treatment, or ineffective treatment, as well as to avoid the sort of complications that can arise during anesthesia. Similar to what Masquelier observes among *bori* practitioners in Niger, the spirit is understood to the leave the body during periods of unconsciousness, allowing for foreign spirits to enter it. In Lucumí, the artificial unconsciousness brought on by anesthesia, coupled with the spiritual "busyness" of the hospital, leaves a person especially vulnerable. In fact, some devotees have divination signs that instruct them not to enter hospitals, as they are like sponges that will end up collecting the negative energy in one area of the hospital and taking it to another, making a sickly patient worse off than they already were. In addition, devotees fear they could be stigmatized by hospital staff should their religious affiliation become known.

Rational for Hospital Rituals

Woven into the act of ritual is sacrifice. As George Brandon explains, the English term "sacrifice" is from the Latin "to make holy" or "to make sacred," which emphasizes the

distinction between the sacred and profane. While the Lucumí system is attentive to this distinction, the Lucumí word for sacrifice is *ebo*, "to do" or "the thing done." Jean Comaroff describes ritual in the Tswana context as a means to forcefully act upon the world, *tirelo*, "work" (1985, 84). In South Florida, I have heard the word *trabaja* (work) used alternatively with *ebo*. There are standard *ebo* in the process of initiating an *olorisha* or sanctifying and maintaining the sacred implements of the *orisha*. But in addition, there are an infinite number of *ebo* that may be called for in divination to help a devotee overcome problems, such as their health. While some scholars limit sacrifices to material items placed on an altar, Brandon takes a broader view as there are plenty of ritual prescriptions that do not involve material items and altars. An *ebo* can be speaking to an *orisha* or an *egún* to ask for help with a coworker or placing a curtain of okra over a doorway to ward off witchcraft: actions, things *done* to achieve a goal. Brandon defines an *ebo* as "a religious act consisting of ritual procedures for establishing communication with spiritual or superhuman beings in order to modify the condition of the persons on whose behalf it is performed or of objects with which they are concerned. These goals are accomplished through the mediation of a victim or victims—objects or beings that are necessarily consecrated and then destroyed (or considered destroyed) in the course of the rite" (Brandon 1991, 125).

For many Lucumí devotees, conducting an *ebo* in the hospital is necessary given the constant potential for accidents to occur. As anthropologists since Malinowski have observed, the more uncertain the situation, the more likely people are to use magic in hopes of mitigating the potential for undesired outcomes. In the case of illness that

uncertainty is all the more acute. Maggie, an older *iyalorisha* with wavy black hair, retired from the freight industry, explains:

> You have an operation, you cleanse yourself before you go in for the operation. To make sure that everything comes out, so there is no accident. Because some people die in an operation. My niece came over on Saturday because she has an operation on Thursday. I look at her [that is, I perform a divination] and tell her to do a few things. You have to do it because you want it to be good with the saint,[8] with the *egún*, so it's going to be fine.

What most people fear are medical complications due to human error, but they also fear oversight, such as when hospital staff do not factor in a patient's multiple existing conditions. Maggie explained that her niece was having surgery for a hernia, but she also had many open sores due to psoriasis. The ritual Maggie performed was to make sure the hernia surgery was successful, and that the psoriasis did not create secondary issues. Biomedicine has a reputation for singular focus, to the detriment of all else. Ritual can serve multiple functions: sometimes it is understood to ensure the success of clinical treatment, and at other times to replace the procedure altogether. But for devotees with genetic predispositions to disease, religious intervention is often seen as unlikely to help. Maggie's brother had been diagnosed with pancreatic cancer and given that their father died of cancer as well, she did not think that there was a religious remedy for his condition.

When asked what the reasoning behind hospital ritual was, Maggie spoke of "avoiding accidents," but for others it was more a matter of the management of "energy." Laila is a mother of two who is often hired as an *alashé* (devotee who prepares sacred food offered to the *orisha*, the *egún*, and the priests) for ceremonies, a form of labor that requires extensive knowledge of sacrificial *ashes* (preparation of sacrificial animals for each *orisha*). In addition to her professional religious work, she also has a reputation as a

reliable *olorisha* for assistance, often volunteering to cleanse people in the hospital. She explained to me that devotees should know that in times of need their religious community would assist them with these "small events" that could have profound effects on their health. Laila considered hospital rituals a way to "call up energy" to save a person's life.

> When you cleanse somebody, you are taking away the negativity that may be working against the medical part. And after you take that away, the doctors can help them better because there is nothing crashing into what they are trying to do. Sometimes people pick up bad energies along the way.

The notion that the world is flowing with energies, some of them negative or detrimental, and that a person can "pick up" those energies in passing is fundamental to Lucumí cosmology.[9] In Senegal, Katie Kilroy-Marac observes that the "spectral landscape… is crowded with beings and nonbeing alike…." from "wild" spirits, to domesticated ones, to witches, to *jinn*, to winds, to "strange entities that can catch you when you are walking alone at night" (2019, 34). In this respect the spirit world is understood as potentially dangerous and chaotic, not unlike the "bush" in Niger described by Masquelier, or the "wild" illustrated by Comaroff, space that "lacked closure or stable classification… the realm of spirits, plants, and animals of unruly potential, … [that] provided the vital ingredients for transforming the status quo…" (Comaroff 1985, 80). Lucumí practice organizes the spirit world, cultivating relationships with a body of *orisha* and *egún* that protect devotees from dangers both physical and spiritual.

While the picking up of "bad" or "negative" energies can occur in everyday life, in a hospital the energy is concentrated and, potentially, all the more desperate. In Lucumí spirits are not generally referred to as "wild" as are other spirits in other contexts, but they are seen as potentially imbalanced, undeveloped, or "dark." In conversation,

mediums often used the term "energy" to encompass undefined deceased spirits, those they cannot "see" clearly; at times this lack of "visual" clarity is understood to reflect a lack of development on the spirits part (although it could also be on the medium's part). This raw "energy" is not necessarily intentionally negative, but likely "confused" due to a sudden shift of perception from embodied to disembodied, or resentful due to sudden death, painful illness, and so on. For energy presumed to be "confused" often simple cleansing rituals are sufficient. Mina, who has been an *iyalorisha* and a successful spiritist for decades, also says that most rituals are to remove the "negativity" attached to the patient, negative energies that may have been building up for years, working against clinical treatment. When a person is cleansed with a pigeon, the bird takes up that negativity, once set free outside the hospital it flies away and the negativity is released as its wings flap. One of the most important elements of an *ebo* is how it is completed, where ritual remains are deposited, or in the pigeon's case, the spiritual negativity. Once that negativity is removed, the biomedical clinician is better able to "see" the patient's illness and render treatment.

Many hospital rituals involve the pigeon, which is considered to have a pure and giving character. Illness is understood to be "hot" and must therefore be brought it into balance by a "cooling" process.[10] This means that if a person is cleansed with a pigeon, it is released to fly away, in the process releasing negativity and "cooling" the situation. Alternatively, often stationary objects, such as bread, fruit, coconut, meat, whole fish and eggs, are prescribed for cleansings. *Orisha* all have a favorite food, so the item selected to cleanse a person is likely to relate to the *orisha* who speaks in divination to promise assistance and alternately to the patient's tutelary *orisha*. Bringing bread, fruit, coconut,

and eggs in a hospital does not raise eyebrows, but it is more challenging to smuggle in meat, fish, and live birds. Fish, in particular, elicits numerous complaints, as the smell gets overwhelming and is difficult to hide. Pigeons are difficult to handle, especially if, at the moment they are released outside, they fly back into the hospital over people's head.

One final issue to consider when a patient is admitted to the hospital is anesthesia. According to Loupe, a gregarious rotund middle-aged *olorisha* with close cropped grey hair, during this process the body is a vacant vessel. The spirit is absent whilst in a place where there are numerous disembodied confused spirits wandering the corridors, looking for a place to land after death. If the body is not protected another spirit can essentially leap into the patient's body quite easily.[11] When the patient's spirit returns this other spirit can disrupt the patient's life in any number of ways, not necessary intentionally. I once attended a *missa* at Mina's and there was a woman there who had gone in for surgery and just hadn't been "right" ever since. The diagnosis from the mediums was an older man who had passed in the hospital where she was treated. His spirit had taken an easy opportunity to occupy her body. Ever since the surgery she had been unable to finish anything she started. Mina has a spirit guide who is known for convincing uninvited spirits to follow him and willingly leave their hosts, as opposed to using spiritual force. During that *missa*, everyone watched as Mina's spirit guide possessed her and removed the spirit troubling this woman, the two spinning around in circles, forehead to forehead, much to the woman's gratitude.

In Lucumí cosmology, *egún* is often used to refer to the dead in general, but each person is understood to have their personal *cordon espiritual,* a number of spirits, some blood-relatives, some not, whose existence is woven into every individual. Given the

taken-for-granted notion that the visible world of the living and the invisible world of spirits are interconnected, it follows that *egún* who are not self-aware can harm a person. Cosmologies, according to Stanley Tambiah, are "frameworks of concepts and relations which treat the universe or cosmos as an ordered system, describing it in terms of space, time, matter, and motion and peopling it with gods, humans, animals, spirits, demons and the like. Cosmologies consist usually of accounts of the creation and generation of the existing order of phenomena, explain their character and their place and function in the scheme" (Tambiah 1985, 3). Part of the effectiveness of Mina's spirit guide is that he helps lost *egún* to become self-aware and, by extension, realize that their actions are not necessary or beneficial. As Tambiah argues, cosmologies "…are thought as well as lived. They are not only contemplated but also translated into practices. They are designs for living" (1985, 4). Living with one's personal *egún* facilitates clarity in life and health, while living with disconnected *egún,* clouds a person's consciousness, making it difficult to function and difficult for biomedical providers to properly "see" them.

Hospital Ritual Space

Pierre Bourdieu argues that "linguistic exchanges—are also relations of symbolic power in which the power relations between speakers or their respective groups are actualized" (1991, 37). While Bourdieu is focused on examining power through speech, he also makes room in his analysis for silence. In the case of creating ritual space in the hospital, power relations embedded in this exchange are also realized through the choice of silence or, in practice, secrecy. Most hospital rituals take place relatively quickly. Space to perform rituals is created through explicit speech, asking a nurse to leave for five

minutes, while in other cases space is created clandestinely, waiting till "the coast is clear." Complications can arise when hospital rooms are not private, as is often the case according to my collaborators. Still, rituals go forward, as the primary concern is to look after the health of the patient.

Talking Space

According to Bourdieu, to understand language usage you must understand the social context, the power dynamics at play, and history of the group to grasp the language act taking place. In the production of ritual space in the hospital through language usage—what I am referring to here as "talking space"—the actors are often nurses or other hospital staff, the patient, and devotees assisting the patient. Biomedicine is an indexer of modernity: the power inherent in biomedicine as a system and the individual actors that enact the system are central features of this context. In contrast to the weight of biomedicine are devotees of a historically stigmatized, underground religion. While devotees in South Florida today are predominately of Euro-Cuban descent and have diverse economic backgrounds, many of those who participated in this research grew up in an environment where Santería was for "*putas* and *cabrones*," highlighting racial and class bias in Cuba. The "social deviance" associated with religious practice was generally portrayed as one of people who were guided strictly by unrestrained desire, often for wealth or lovers. These depictions are classic tropes, suggesting non-mainstream religious practices are a tool to undermine society, unraveling the system by achieving socially sanctioned goals through socially unsanctioned means. While Lucumí has become more widely accepted over the last four decades that stigma still has currency.

Devotees that I spoke with either used speech to *deflect* anticipated stigma, or to *lean-in* to social deviance stigma to create space using their social characterizations, producing linguistic products that in their decoding implied the stigma historically attached to Lucumí could be transferred to hospital staff.

Maggie had little experience with hospital rituals. She was fortunate in that she, her family, and her godchildren had been healthy; at least until her husband went on dialysis, but fortunately his treatment did not involve hospitalization. Mina, on the other hand, had been called upon to perform a number of hospital rituals as an *iyalorisha*: "Usually I just tell them we're going to pray over the person give us a minute, and they leave right away." This request serves to *deflect* stigma as prayer is generally conflated with mainstream religion. Devotees are often aware of their religious rights, especially after the well-publicized 1993 SCOTUS case "Church of the Lukumi Babalu Aye v the City of Hialeah," which legalized animal sacrifice and legally recognized Lucumí as a religion. Many have mentioned this case during conversation in relation to their right to practice. Still, while legal precedent allows for Lucumí ritual, it does not prevent side-long looks or reproachful tones from staff. When explaining his understanding of the circulation of "discourses," Bourdieu says "…the form and the context of a discourse depend on the relation between a habitus (which is itself the product of sanctions on a market with a given level of tension), and a market defined by a level of tension which is more or less heightened hence by the severity of the sanctions it inflicts on those who pay insufficient attention to 'correctness' and to 'the imposition of form' which formal usage presupposes" (1991, 79). Silent sanctions introduce stress and tension into an uncertain situation.[12] Yet Mina had a formative experience prior to the court case, before she was

initiated into Lucumí; one which may well have shaped her approach to creating ritual space in the hospital for the people she is asked to help today. As a young woman, she trained to become a nurse. Once, as a student, she was taking care of a very sick man:

> I was with him all day long, all the time. A stage 4 lung cancer [she gave more medical description that I am not familiar with] really at the end of his days, maybe a week left. That night, 8:30-9:00… At that time, I didn't know what I was seeing. And at that time Santería was a taboo religion, they would come in and take all your animals away and take you to jail. It was like that. So, this lady comes in, this Black lady, he was a Black man. So, she comes to me and says, "look, I need to do something religious to my husband and so I need you all to get out so I can work." And I told her "really, what are you going to do?" She said, "it's my religion." So my mother was into Santería, it wasn't like I didn't know about it. But they walked in, I didn't see anything, I didn't watch what they did. I was scared to death that I was going to get in trouble. Because I believed in it, but I didn't know what I was believing. When I came back, she said, "don't touch anything, just leave everything as it is," and they would come pick it up in the morning. She'd left at the head of his bed there was a *palangana* [an enamel bowl][13] with something in it and at the foot of the bed was a glass with things in it and there was little feathers, and white powder but no blood. The next day the man was up, he was sitting, he'd come out of his coma and was with me for another three days and then left the hospital. He got out of his death bed.

Many people I spoke to described staff as nervous or fearful when faced with ritual in delicate situations, much like Mina experienced. Still, it is often the respect, or legal obligation, of staff which marks the creation of ritual space. Some of this may be due to stigma around Lucumí, yet equal or more of it is due to familiarity with practice.

Familiarity can breed respect, or hostility. Not all of the "talking spaces" are the result of polite interactions, some exchanges are bristly, and the threat of spiritual fallout is used. When necessary, devotees will *lean-in* to historic stigma in order to create ritual space. These illocutionary acts are arguably being incorporated into the core-ritual act itself, not to say the ritual would not go on as planned if the practitioner created space through deflection, but that the illocutionary act with its warning and play into historic stigma heightens the intensity of core-ritual. Loupe, who served for many years as her

family's go-to person for hospital rituals, once had a minor altercation with a nurse when she performed a spiritual cleansing for her mother:

> …I told the nurse, look, I'm cleaning her spiritually. And the nurse got all huffy, "you can't do that in here." And I say, "Well I'm going to do it, so you are either going to be here in the presence of it or leave." I guess they are scared of me, I don't know.

Whether the nurse was concerned about "negative energy" attached to her, or fearful of stigmatized religion, she left the room without further altercation.

The beginning of life can be an especially precarious time for infants, especially those born sickly or premature. Diana, an *olorisha* who told me that she got involved with Lucumí decades before hoping it would help her get married and conceive a child, after much effort she eventually managed to carry a pregnancy to term and when she finally had her oldest son, he was very sick:

> … he spent fifty-four days in the ICU, he was very critical. And my godfather brought two pigeons, his tobacco and herbs into the ICU. And he told the girl "If you're going to call security, remember, I'm a *babaláwo*, first, and give me five minutes. And I know you're name because it's on your nametag." The girl said, "It's time for me to go on break." And left. This was twenty-one years ago… He [her son] was only a month old, he was out in three days. He [her godfather] did everything, he didn't do much smoke, just pretending to do it, because he didn't want the smoke alarms to go off. But he *limpiezia* [cleansed] [14] with the pigeon and the smoke and the herbs, he opened the incubator and touched him. He did everything he had to do. And the girl is outside turning all kinds of colors because, I don't think it was the Santería but that she was afraid someone else would come and she left her post. The machines were going off. He finished up, put everything in a bag and walked out the door. She looked at him and said "my break was so good, how was yours?" But she didn't go anywhere she was just standing by the door.

Bourdieu observes that "The sense of the value of one's own linguistic products is a fundamental dimension of the sense of knowing the place which one occupies in the social space" (1991, 82). When Diana's *padrino* in Ifá announces himself warning the nurse, he is playing into the understanding that this magic can be used against her: "If

you're going to call security, remember, I'm a *babaláwo*, first, and give me five minutes. And I know you're name because it's on your nametag." In this instance, it seems the nurse was familiar with the system as she made sense of the term *babaláwo* and ultimately participated, albeit clandestinely, in referring to her "break" as they left. I asked Diana if her *babaláwo* had gotten much push back, and she said yes. It was over twenty years ago and things were not as open as they are now. Still, Diana and others needed help from him and he made sure they received it. She had called him to many hospitals in the area, and push back or not, he went forward to complete his ritual work. Generally, the fear of resistance to spiritual work is not a deterrent, within reason. The understanding is that if spirit does not want you to perform a ritual, some block with prevent it. So long as you show up and proceed sincerely, with the cosmos and some charisma on your side, you will complete the ritual and the patient will soon be out of the hospital.

Secret Space

For those that had a lot of experience performing hospital rituals, creating space through language-usage, "talking space," was a last resort. More often people waited for an unattended moment to perform a ritual. The ideal situation was when a patient was fortunate enough to have a private room. The fact that *olorishas* are inclined to avoid interactions with staff is an illustration of power relations between devotees and the biomedical infrastructure. Recall, that for much of its history in Cuba, Lucumí was dismissed as *brujería,* or witchcraft, of specifically African origin. At the turn of the twentieth century, Cuba[15] was embedded in the rhetoric that all things Black and African

were “backwards” and “primitive.” Concomitantly, the modern biomedical facility was emerging, serving in large part as a symbol of Modernity that was simultaneously associated with European colonialism and “whiteness.” The need to create “secret space” indexes this history.

Milly and Teetee had a number of experiences with secret hospital rituals. Milly is a woman in her sixties who shuffles carefully when she walks. I asked if she had run into any problems with staff when performing rituals. “No, I guess when you are doing spiritual things, they make the people go away.” Her mother, Teetee, who now gets around with a walker, is well known in the community for years when she rented her house for seven-day *kariocha* initiations, taking care of many *iyawos,*[16] and practicing as a *alashé*. Milly was relatively healthy, until diagnosed with kidney cancer a few years before. While successful, her treatment undermined her mobility and led to secondary problems. At one point she found herself in the hospital for her pancreas, gall bladder, and other “stuff inside” her. While at this point, she was not a stranger to hospital stays, this issue dragged on.

> Usually when I have anything at the hospital it’s like three days and I’m out. But this was going on. So my mother had a vision that I should cleanse myself with a white pigeon and let it lose. So my son, he’s not that into the religion… And he’s really into the animals, he doesn’t like the killing. So I have his ocha here, he respects it. So when he heard he said, “I’ll do it.” And he went and got the white pigeon. I got inside the bathtub inside the hospital, and he cleansed me with the pigeon, he even got goose bumps and everything, he put it inside a big purse that we had, and he took it outside and let it lose. My mom might have put it in her coat, she brought it in. The next day I was out of the hospital.

In this instance the cleansing was based on Teetee’s “vision.” But Teetee has been called upon many times to perform hospital rituals based on divinations. According to Milly

they have plenty of family and friends, not part of the Lucumí community, but "respectful," calling for help in emergency.

> She [Teetee] cleansed somebody that his stomach was very swollen, and she cleansed him with the insides of an animal. When [s]he got into the door of the room, because his wife was in some religion or Christian or something, so she said, "oh Jesus is going to heal me [him]." So she [Teetee] said, "okay, I won't do anything then." He said "no, no, no, do it anyway." She had it in a plastic bag, they had done something with Orula first, whatever they prepared. She was the one who brought everything. The next day the doctor said, "What happened here, that you don't have anything anymore?" (So she had gone to Orula on his behalf?) Yeah, Orula was the one who sent her to do it. We knew him from New York for a long time. His sister-in-law or someone in the family had called her [Teetee] to help him.

I was not sure if the extended family asked Teetee to consult a *babaláwo,* or if they asked her for general religious "help." Still, ritual based on *Ifá* divination is in contrast to ritual based on a "vision." More weight is placed on formal divination a person must be trained for, while years of experience or the character of a person also affects the situation. Teetee has many years of initiation, and experience, giving weight and authority to her "visions." Milly says that another time the family had contacted her on behalf of an attempted suicide. The patient was in a hospital bed with "all these tubes and everything in her." Teetee and her late son performed a bedside cleansing with a pigeon, her son "cleaning all the feathers and everything." The next day the woman left the hospital. So Milly says that every time her mother "has gone to the hospital to cleanse somebody, the next day they are out."[17]

While Mina usually had relative success simply telling hospital staff, "Please give us a moment to pray," it is not always possible to seamlessly navigate hospital space. A few years back her niece's new baby was ill in the NICU. The baby's intestines were paralyzed, and the doctors were worried she would lose them. Mina's husband performed

a divination where Elegguá spoke agreeing to help the infant in exchange for the payment of a baby goat, its intestines were to be used for a spiritual cleansing:

> … I put [the intestines] in a zip lock bag and went to the hospital. My niece tells the people in the NICU, I just want to come in a for a moment, I want my aunt to see the baby. We waited for the nurse to turn around. I went like this all over the baby, and then like this all over the baby's clothes [passing the bag over]. And then I told my niece goodbye and that was it. That was a big one. Because in the NICU, you have to be very careful, babies can get real bad infections. But I never took anything out of the plastic bag. I just left it in that. Now she's great. She's about eight years old, great personality.

In classical magical terms, this ritual follows James Frazer's (1890) "law of similarity," whatever problems burdening the infant's intestinal tract transferred to those of the sacrificial baby goat. But while many rituals described so far are relatively generic in removing negative energy, this one was specific. Elegguá, the *orisha* who is always first in ritual as he opens the doors of divine communication, the *orisha* who is often depicted as a child himself, stood up to help the infant, to accept the sacrifice, and to make the transfer. Any other *orisha* could have spoken in divination and offered any number of *ebo* in order to heal the infant. Or, divination could have given the painful message, that there was nothing to do for the baby girl, much as Mina and her husband wanted to help. There are times when death is unavoidable, no ritual will prevent it.

In Mina's case she and her niece had a moment when the nurse "turned around." But sometimes the opportunity does not present itself. At birth, Loupe's mother's heart was too big for her chest. Throughout her life, she suffered numerous health problems and was in and out of the hospital. Her mother was an active spiritist and an *olorisha*. Over the years Loupe had been to her mother's hospital bed with countless cleansings: bread, eggs, meat, coconut, a whole fish. The most challenging was the pigeon. Her mother was in the ICU and Loupe had to sign to visit. As she did, she saw there were

cameras monitoring the room. Loupe knew her cleansing ritual would be seen by the entire staff. Undaunted, she went in with the pigeon, telling her mother "I'm here to save your life, mom, because you have *eku* [death] on top of you." She passed the pigeon over her mother and released it out the front door. "The nurse was LOOKING at me when I left. I didn't care. Everyone was looking at me." The tension in this moment and side-long glances are part of "the modalities of silent practices" difficult to dismiss given their insinuating nature (Bourdieu 1991, 51). Loupe's failed attempt at creating a "secret ritual space" is part of the habitus developed by santeros given Lucumí's history, "through suggestions inscribed in the most apparently insignificant aspects of the things, situations and practices of everyday life" (Bourdieu 1991, 51).

This incidence is a reminder of the familiarity of Lucumí in the area. For some staff, Loupe's unexpected behavior may have been their first experience, but likely not their last. The familiarity of religious practice is also a factor in the creation of space. Hospital staff are likely to flex clinical ontologies to accommodate religious practitioners. As Stacey Langwick observes, biomedical practice is structured to make bodies visible long enough for clinical interventions, yet for nurses, clinical work tends to cultivate "skills to discern afflictions or aspects of affliction that might best be treated by one form of therapy or another" (2008, 429). In this instance, staff seem conditioned to appreciate the need for religious practitioners to perform rituals designed to facilitate positive patient health outcomes.

Familiarity and Space: Looking the Other Way

A lot of sociocultural work occurs in grey spaces between official rules and practical guidelines. Lucumí is not the only religion practiced in the area, and *olorishas* are not the only religious actors seeking to help family and friends. When I asked doctors about "Santería" practice, they were often blank for a moment, then shifted to Vodou and the Haitian patient population; some were unaware these were two autonomous religious systems and populations. In fact, when I asked devotees about their hospital experiences, *nurses* were the lynchpin of narratives. At most hospitals in Hialeah, and Jackson Memorial (a public teaching hospital in Miami), it is ambiguous how "secret" these spaces are, given the frequency of Lucumí practice in the area and number of stories people shared about performing rituals in the local hospitals. Teetee, who had been creating these spaces for the longest time, said that today a lot of "religious people" work in the hospital. When I visited one local hospital, I saw staff wearing *elekés*[18] as they pushed IV carts around. At another hospital, the security guard wanding me asked about my "santo," and told me about his, after he noticed my sacred *elekés* and *idés*. Diana, who suffers with chronic illness, says that when she visits the ER, 70 percent of people are wearing an *idé*.[19] She often wears an elaborate one that staff remark on and ask where she bought it. While anecdotes, these bits reflect a comfort level around religious identification in biomedical institutions in the area.

Laila, who like Diana suffered from chronic illness, at one point took her mother to a local hospital. Despite extensive experience with illness and religious practice, she forgot everything in her anxiety over her mother's condition:

> …my mother ended up in the hospital a while back and the nurse asked me "have you had her cleansed yet?" And I was like "No, I haven't done anything yet." And

> she was like "Well, is she initiated?" I go "yeah," and she says "Well, maybe you should have her seen. While she's in here"…Words of a stranger and you never think about it. You're just worried about getting her fixed and getting her home.

Similar exchanges have been observed by Langwick in conversations between nurses and patients regarding the relationship between traditional medicine and clinical therapies in Tanzania. While Langwick's observations are more nuanced than Laila's direct exchange, the intersectionality "reveal[s] a more fluid, flexible, and evolving picture of the relationship…" between clinical treatment and religious practice in the area (2008, 430). It is important to note, Laila's exchange happened at a hospital in Hialeah, many people that I interviewed felt when a patient entered an Anglo hospital outside of the area, potential to bring religious practice into the hospital space was seriously hampered, but not impossible.

The boundaries of hospital-familiarity are in part marked by the front desk. Diana had a lot of conflict in evaluating the local hospitals. She appreciated the hospitals in Hialeah because the staff spoke Spanish and she knew how to make herself visible to them as a religious actor. When she checked in she made sure to identify herself as a "santera" and she found that this "gets a lot of respect." The openness she felt in Hialeah did not follow her. Once, checking into a hospital just over the county line, she marked "other" on the admissions form. A priest arrived at her room and nurses asked if she wanted to talk to him, when Diana asked why a priest had been sent to her room, the nurse replied, "Well, you put 'other'." In Central Florida she felt particularly pressured by staff, though in no specific way: "They want to see if you can be Baptist, or something." It was understood among devotees that hospitals in other parts of the US would be either hostile or indifferent. As one man put it, "If you were in Peoria, Illinois,

they would cut off your beads" referring to the *elekés*, sacred bead necklaces, worn by Lucumí devotees. This was not to say that something like that couldn't happen in South Florida, he insisted, but that you could make your case for keeping your beads on.

While people appreciated the respect their religion was granted in the area, a few were unsatisfied with overall care. Diana, who had been in and out of hospitals for her adult life, told me she felt she got better medical care at an Anglo hospital. Once in Hialeah, she was put in a room with inadequate air conditioning after a surgery when her blood pressure was dangerously high. None of the staff would address her problem with the temperature. Mina had similar complaints with the administration of one of the local hospitals. She had taken her husband because he was unable to urinate and the person who admitted him marked the wrong thing on his form. As a result, he suffered numerous medical complications, despite Mina informing every staff person who entered the room that he had not urinated in days. In contrast, Loupe and Laila seemed satisfied with healthcare they had received in the same area hospitals. While people seemed to have differing opinions about hospitals in Hialeah, everyone had a high opinion of one English-speaking hospital in the southern metropolitan area.[20]

Practical Results

While there is an overall "weight" to spending time in the hospital, the ritual that follows will vary. Some of the rituals people discussed with me were based on the "vision" or "hunch" of an *olorisha*, many more were based on a *Diloggún* or *Ifá* divination.[21] Within the realm of divination, some cleansings were more general, making sure that no potential negative energy attached to the patient during a hospital stay. As mentioned

earlier, standard items used for spiritual cleansings were bread, fruit, eggs, meat, and whole fish. Many people I spoke to had brought pigeons for cleansings. In most of the cases that I have discussed, the patient was an *olorisha* and there was little mention of mitigating circumstances, no religious devotions that had not been completed, no spiritual transgressions to speak of. The magical ritual was performed in a contained hospital space. In most of the cases here the patient was seriously ill but expected to recover. But in some other cases patients had potentially deadly illnesses and magical rituals were performed in and around the hospital to facilitate their clinical treatment, or in other cases, to override failed clinical treatment.

Nancy was told in her *itá*[22] that she would find herself on the operating table. From the moment she left the *ilé*,[23] she was seriously ill. Over the course of the next few years, she was in and out of hospitals. At one point she suffered a brain hemorrhage when she was already taking blood thinners for another illness. Her *babaláwo* performed rituals in and out of the hospital to keep her alive and able-bodied; most she did not remember. Still, she was relieved to be released from the hospital with her sight and hearing intact, however her balance was off. Once she got home, her *babaláwo* continued to perform rituals for her and eventually she fully recovered from the brain hemorrhage.

No one would claim ritual cleansing, or other magical work, is always successful, but often enough, it is. As Tambiah points out "ritual acts have consequences and effect changes; they structure situations…in terms of convention and normative judgement, and as solutions to existential problems and intellectual puzzles" (1985, 355). He reacts harshly to suggestions that magical rituals should be measured within a positivist framework. Devotees accept that biomedicine has value and is worth engaging with,

while accepting its fallibility—or the fallibility of biomedical providers who cannot reasonably be disentangled from it. Magical ritual allows people to *act* on illness and prop up biomedicine when it flounders. As Tambiah further notes:

> …I must also go on to say that insofar as magical rites try to effect a transfer, they are often geared to achieving practical results—such as cure of disease or production of a fine harvest—as much as they are geared to effecting social results. Although we should not judge their [magical rituals] *raison d'être* in terms of applied science, we should however recognize that many (but not all) magical rites are elaborated and utilized precisely in those circumstances where non-Western man has not achieved that special kind of "advanced" scientific knowledge which can control and act upon reality to an extent that reaches beyond the realm of his own practical knowledge. (1985, 83-84)

For most of the people who participated in this research, the effectiveness of hospital rituals was borne out by results: people well-enough to leave the hospital. In most cases ritual is credited with provided the necessary spiritual force, or clarity to pinpoint the correct diagnosis to make clinical treatment successful.

Conclusion

Lucumí ritual is what the patient, and their family can do, a means to act within the realm of illness, outside of biomedicine. These acts are considered spiritually necessary and complementary to biomedicine but assumed to be outside the realm of modern medical sympathies. In this way biomedicine maps onto the Catholic church, serving as a stand-in for colonial dominance that Lucumí must "work-around" in order to survive. And much like the Catholic church, biomedicine has its rituals as well, sartorially in its white coats symbolizing purity and hygiene, as well as its protocols in patient check-ins. These rituals support the framework of biomedical hegemony, a framework similar to what religious devotees have been working around for centuries.

In the creation of the ritual space where the *ebo* can take place, managing the spiritual chaos of the hospital and mitigating the potential for spiritual contamination to undermine healthcare outcomes is the primary objective. These are the actions that people can take in vulnerable and uncertain circumstances. While these rituals are "small events," they not only reinforce social bonds, but can often have a profound effect upon those suffering with illness, heightening their visibility to healthcare practitioners, and fortifying their ability to heal. Through a ritual presence that is both seen and unseen, devotees perform acts embedded in the historical Afro-Cuban religious framework, the complex cosmology of Lucumí, and 21st century expectations of care, patient autonomy and visibility in biomedical institutions.

Conclusion

In the epilogue of *The Cooking of History*, Stephan Palmié observes that "ethnographic things lead social lives as they circulate along—and at times across—pathways of praxis and discourse contingently shaped by the intersecting biographies and utterances of those who jointly bring them into being" (2013, 257). When I first read this comment, I quickly recorded it in my notes. Library shelves are filled with compelling literature about Lucumí, its history, art, music, dance, and divination as well as its place in immigrant experience and identity politics. I wanted to bring biomedicine into the conversation and Palmié's judicious observation crystalized for me how I might do that. As I started conceptualizing my doctoral project, my question became: in the "social lives" of things that "circulate along," what is the relationship between Lucumí and biomedicine in South Florida after the Cuban Revolution? To grasp this relationship, I directed my attention to the power dynamics between Lucumí and modern medicine, two "ethnographic things" that have very different histories and sociocultural contexts.

The experience of modern medicine goes beyond simple matters of diagnosis and treatment. Modern medicine requires the infrastructure of modern empires. Consequently, it is where communities experience "the taken-for granted… natural and received shape of the world…" as a given hegemonic power has designed it (Comaroff and Comaroff 1991, 23). Biomedicine is often bound up in colonial projects where the delivery of biomedicine cannot be disentangled from political efforts (Arnold 1986; Street 2014; Tilley 2011; Vaughan 1991). While the current South Florida context is not a colonial

one, the framework of the colonial project lingers in institutional expectations of categorizing immigrant populations along racial lines embedded in the "historically situated cultural field" of the United States (Comaroff and Comaroff 1991, 23). This "field" is constructed along a racial binary and new immigrant identities are structured through this framework. The biomedical institution is one space where society marks bodies for deservingness (M. Good et al. 2003). When immigrant groups enter the US and seek to gain the status "deserving of citizenship," petitioning biomedical institutions is one way to do that. As new immigrant groups are racialized in the US system, those racial designations have implications for the way that, in the words of Monika Gosin, they "often reinscribe white racializing frames" (2019, 13). The Miami model of cultural competency attempted to reinscribe whiteness onto Cuban immigrants at a time when they were becoming established in South Florida. This framing was used to neutralize the stigma attached to Afro-Cuban religions and make Lucumí acceptable in mainstream US society. But what do these efforts mean to the practice of Afro-Cuban religions and the quotidian experience of devotees?

When I first began to explore the cultural competency paradigm in my dissertation work, many *olorishas* I spoke with were glad to hear that doctors, nurses, and hospital administrators were learning about culture in general, and religion in particular. The notion of being "seen" in society, and more specifically, being seen by medical practitioners and receiving improved healthcare, was heartening. For devotees of a religion that so many found so very beautiful, being finally able to share the beauty of that experience was good news. Yet, at the same time, while *olorishas* expressed the desire to be seen, when it came to the characteristic actions of the seen, like opening up to

healthcare providers without fear of stigma, confidence faltered. This conflict between the aspirational expectation of being seen and the immediate desire to be unseen speaks to the uncanny power of hegemony to get people to police themselves in service to power. Michel Foucault (1994) observed that not long into the existence of the modern hospital, the institution took over the role of the Church in the management of birth and death. The fact that people were born and died within the walls of the hospital came to be seen as "natural." My own observation of the Cuban American encounter with US biomedical institutions in South Florida flows from Foucault's. In Cuba, devotees of Afro-Cuban religions were habituated to being seen and unseen in the society. The Church was aware that Afro-Cuban religious practices and devotion were present in *cabildos* (fraternal societies dedicated to a specific saint) but it looked the other way in hopes that, over-time, people would abandon them for "true" Catholicism. Habituation to being seen and unseen by powerful institutions did not evaporate with immigration to the US or cultural competency efforts.

There is also another critical factor in relation to the "seen" and the "unseen," building bodies of knowledge. The management of spiritual ontologies is embedded in the realm of the "unseen," building bodies of knowledge based on ontological experiences and consequences. Religious ritual in Lucumí is central to organizing the invisible forces at play in devotees' lives. Modern medicine is highly invested in the "seen." It builds bodies of empirical knowledge based on probing the unknown, opening up bodies, either through surgery, or technology like x-rays, blood-tests, samples of bloodily fluids under microscopes, and the like. What is "discovered" through this "seeing" is at the heart of the medical gaze. Modern medicine is not invested in "seeing"

everything, only things that can be empirically validated and ultimately formulated in the language of biological pathology (like tumors, blood clots, and so on). Health problems that cannot be empirically verified are tuned out or, alternately, redirected to spaces like Lucumí.

Many patients I spoke to wanted to be seen by physicians, for to be visible to biomedicine was understood to be less-stigmatizing than having to hide or constantly explain yourself to a new audience. For each new audience member a person must articulate a legible explanation of themselves. The further from the mainstream a patient is, the more distance they must traverse every time they are forced to come up with an explanation for themselves, or of their religious experience. Yet, despite concerted efforts to promote discussions of culture in the hospital (via the Miami model of cultural competency, for instance), with the exception of psychologists, many of the medical practitioners I met did not actually see Lucumí at all. Medical school administrators were fuzzy on any mention of religion in the curriculum and nursing school instructors were similarly uncertain of any discussion of the topic. There had been one instructor who worked tirelessly to educate students at various institutions around the city, but she had passed away just prior to my fieldwork, and there was no one to replace her. There was one other educator teaching future healthcare providers about religion, but he was spread thin at his institution. He seemed very alone, and very poorly compensated, for training healthcare providers about Afro-Cuban religions in the metropolitan area.

It seems that the efforts of the latter half of the twentieth century to make healthcare providers "competent" in bounded cultural groups has faded, rightly so, into cultivating a more tacit sense of "difference." I once interviewed an administrator at a

local medical school who was kind enough to talk to me at length about the curriculum students followed. As we sat at a round table together, his yellow *guayabera* glowing in the sunshine, he articulated how important it was to the school to make sure students were focused on cultural diversity and more specifically on the make-up of the local population. From the beginning of their education, students were well-versed in the social determinants of health and learned, in part, through case studies chosen to reflect the diversity of individual illness experiences. In fact, woven into the system was hands-on training at the neighborhood level to make sure that students got to work with a diverse set of patients and that they had opportunities to meet these patients in their own neighborhoods. Students were encouraged to experience the area, visit grocery stores, navigate sidewalks, gauge how patients moved through their daily lives in the space. This curriculum design seemed to make for a robust medical education. Over the course of our conversation, I kept probing my interlocutor for specific information on the case studies. What did "diversity" actually look like? He spoke mainly of food and family power dynamics—relatively safe topics for an administrator reluctant to address issues that might prove controversial. As a student of religion, I was looking for information on how religious beliefs or ontologies may be woven into a diverse body of patient case studies. He consistently avoided the topic of religion. When I pointed this out, his response was a shrug. He wasn't a religious person, he said, so he was probably just blind to the place of religious experience in illness.

The designers of the Miami model of cultural competency often found that healthcare providers were uncomfortable discussing religion. Healthcare providers I met who were comfortable engaging with the topic, most of whom worked in the field of

psychology, noted similar observations about their fellow healthcare providers, including psychiatrists. This reluctance may in part be understandable in a society which sees itself as secular, but I think this goes deeper in that it reflects an understanding that religion and biomedicine are dogmas, and therefore any discussion of religion is a set up for battle, in the classic "religion vs science" format. Those comfortable enough to discuss religion tended to approach it through a comparison of different bodies of knowledge: they saw religion as one among multiple frameworks for translating life experiences. In the classic cultural competency paradigm, which still has echoes in some areas of the present system, there was a tendency to present voyeuristic details concerning the practice of regla de ocha, images of doorways covered in blood and crosses of white powder, animals bleeding out over *soperas* on bright white tile floors. Images were met with brief explanation, given the timeframe, but perhaps not quite enough time for deeper understanding. Lucumí practitioners have struggled to avoid being relegated to the exotic in the mainstream US. Grasping Lucumí as a complex nuanced body of knowledge and a framework for translating life experiences is a task that mainstream medical education seems ill equipped for.

One answer to the dilemma of cultural competency is "cultural humility." This system focuses on physician subjectivity; rather than offering "competence" in different "cultures," it offers guidance in humility and asking questions of patients to draw out their illness experience. Medical schools in the area have latched on to cultural humility as a way to smooth out the rough, prickly features of the cultural competency model, namely its tendency to fizzle into stereotypes, bullet pointed in palm-sized reference guides nestled in the breast-pockets of button down shirts beside mechanical pencils. In

stark contrast to the "mastery" cultural competency promotes, one of the central positions of cultural humility training is that doctors should feel comfortable with "not knowing." The guiding assumption is that doctors have some notion of what they don't know—that they see enough of the picture to know where the gaps of the unseen lie. Advocates of cultural humility argue that the model shifts the focus of medical education to the particulars of patient experience by encouraging providers to talk with patients. Providers are shown they too have their own culture and that the built-in assumptions they share about the way the world works impact the medical encounter.

While these are important issues for healthcare providers to explore, I fear that engaging in cultural humility makes it too easy to conclude that, in the words of a physician I spoke with, "religious people all believe in the same way— *basically*," resulting once more in a de facto erasure of minority religions like Lucumí. The attention devotees give to building ethical worlds through relationships with their *orisha*, the resources they have at their disposal when a doctor is unable to heal them, the challenges they face when their spirits disagree with biomedicine, and the effort they put into making ritual space in the hospital to manage spiritual ontologies fall beyond the purview of cultural humility proper. This potentially leaves a large gap for a Lucumí devotee to manage when communicating their patient narrative to a healthcare provider. Given the abbreviated time available to doctors meeting with patients and the multiple stresses that come with illness, cultural humility also leaves a great deal to be desired. Ultimately some middle ground is in order. Physicians need not be experts in the variety and diversity of human religious experience, but having some grounding in the variety of

spiritual ontologies people experience will shorten the distance patients must traverse in order to be seen.

Glossary of terms

(All terms from Lucumí language unless specified as Spanish)

Addimú: food offerings to a given *orisha*

Alashé: a person who is a cook for rituals, requiring a specific body of knowledge

Añá: *orisha* of the sacred drum

Ashés: portions of sacrificial animals cooked for the *orisha* who received the offering

Ashé/aché: the power that flows from Olodumare through all of creation, the power to bring things to fruition, to make things happen

Babaláwo: divination priest of Orula/Orunmila the *orisha* of divination

Babalú Ayé (San Lazaro): orisha of communicable diseases, especially of the skin, like small pox, leprosy, and AIDS (saint of the poor and infirmed)

Botanica: retail store providing religious goods

Boveda: alter for missa with 7 (or alternately 9) clear glasses of water and candles

Casa-templo: Spanish term for house-temple where rituals are performed, generally encompasses the members of a religious family, all those initiated by a given *iyalorisha* or *babalorisha*

Diloggún: cowry shell divination performed by *olorisha* with sixteen sacred cowry shells thrown twice to reveal one of 256 *odu* signs which are interpreted by the diviner to situate the consultant and address any potential questions they have

Ebó: ritual sacrifice, anything from words, to effort, flowers, food, candles, blood, or a sacred drumming ceremony, generally a response to divination.

Egún: ancestral spirits of a person's religious family and blood relatives

Elegguá: the orisha who opens the door to all things, including communication with the other orisha, one of the three warriors, but also apart as he is in all places at all times and aware of everything that happens

Eleke: sacred beaded necklace specific to an *orisha*

Idé: beaded bracelet sacred to a given *orisha*

Ilé: house; can refer to a casas-templo, religious family, and the sacred space where the initiate sits during the seven-days cloistered for initiation, (in this case also referred to by the Spanish *trono*)

Ifá: divination system of Orula used by his priests *babaláwos,* performed with *ikin* (palm kernels) or *opelé* (divining chain) on a divining tray covered in sacred powder

Iré: to be in a state of balance or luck, in divination

Itá: major divination performed by *oriaté* on the *estera* (grass mat) as part of *kariocha* initiation where lifetime proscriptions and prescriptions are assigned to *olorisha*, may be performed by during other major rituals

Iyalorisha/Babalorisha (iyalosha/babalosha): *olorisha* who has initiated or "made" other *olorisha* through *kariocha* initiation

Iyawo: A person newly initiated into Lucumí who must wear white and avoid social interaction for a year after.

Jicara: Spanish term for gourd, a vessel used in religious ritual

Kariocha: initiation where tutelary *orisha* is "seated" on the head of the initiate

Lucumí/Lukumí: refers to the religion derived from the Yoruba and/or to the language spoken during ritual, a version of Yoruba language that is highly influenced by Spanish pronunciations and does not fully align with present day Yoruba conventions

Madrina: Spanish term for godmother, here referring to one in Lucumí

Mojuba: prayer paying homage to Olodumare, *egún*, elders, and *orisha*, precedes all ritual

Missa: spiritual mass or séance to communicate with ancestors and other spirits that wish to communicate, primarily from the European occult tradition made popular by Allen Kardec

Oba Oriaté/ Oriaté: ritual expert priest required in order to perform specific rituals including *kariocha* initiation

Obatalá: elder orisha of creation, calm, white cloth, the color white, cotton, mountain tops, wisdom, and intellect

Obi: coconut, divination performed with four pieces of coconut providing yes/no answers

Ochossi: the orisha of the hunt who is elusive and mystical, aware of how to find the hidden

Ocha: often used to refer to the Lucumí religion, *kariocha* initiation, or *orisha* that can be "seated" through initiation

Ochún: orisha of the river, sweetness, honey, the color yellow, fertility, and all that gives people the passion for living

Odu: divination signs in *Ifá* and *Diloggún* each containing a series of *patakí*, advice, proverbs, and ebó to resolve issues at hand

Ogún: orisha of iron, railroads, metal, and technology, he builds the road or cuts the path for others to follow

Olorisha/olosha: person who "has" *orisha*

Orí: "inner head" located in the physical head, refers to destiny and character a person is born with

Orisha: the divinities of the Lucumí pantheon created by Olodumare to be responsible for various aspects of the natural world and human experience

Osogbo: to be in a state of misfortune, imbalance in divination

Otones: sacred stones understood to embody given *orisha*

Oyebona: person who is the primary assistant of *iyalorisha* or *babalorisha* during initiation

Padrino: Spanish term for godfather, here referring to one in Lucumí

Paños: Spanish term for elaborate piece of cloth used to veil *soperas*, decorate an *ilé,* or used by an *orisha* in possession

Patakí: myths, allegories, legends relating to the *orisha*

Pruebas: Spanish term for proofs, used to refer to inexplicable experiences considered proof of the *orishas'* presence

Santera/o: Spanish colloquial term for a devotee of "Santería," often used in Miami area

Shangó/Changó: the orisha of kingship, masculinity, authority, thunder, storms, the drum, dance and the color red

Sopera: Spanish term for soup tureen, generally refers to any vessel used to house an *orisha*

Tambor: Spanish term for drum to call an *orisha* “down” in possession, or simply to honor an *orisha*

Trono: Spanish term for throne, refers to an *ilé* for an *orisha*, generally for an initiation or tambor

Yemayá: the orisha of the sea and all that it contains, the color blue, motherhood, and social bonds

Bibliography

Abu-Lughod, Lila. 2000. “Locating Ethnography.” *Ethnography* 1, no. 2: 261–67.

Aguirre, Benigno E. 1994. "Cuban mass migration and the social construction of deviants." *Bulletin of Latin American Research* 13, no. 2: 155-183.

Aja, Alan A. 2016. *Miami’s Forgotten Cubans: Race, Racialization and the Miami Afro-Cuban Experience.* New York: Palgrave Macmillan.

Anderson, Warwick. 2006. *Colonial Pathologies*. Durham, NC: Duke University Press.

Apter, Andrew. 1991.*“Herskovits’ Heritage: Rethinking Syncretism in the African Diaspora.” Diaspora* 1, no. 3: 235-260.

Aranda, Elizabeth, Rosa E. Chang, and Elena Sabogal. 2015. "Racializing Miami: Immigrant Latinos and Colorblind Racism in the Global City." In *How the United States Racializes Latinos: White Hegemony and Its Consequences*, edited by José A. Cobas, Jorge Duany, and Joe R. Feagin, 149-165. Boulder, CO: Paradigm Publishers.

Arney, William Ray, and Bernard J. Bergen. 1984. *Medicine and the Management of Living: Taming the Last Great Beast*. Chicago, IL: University of Chicago Press.

Arnold, David. 1986. "Cholera and Colonialism in British India.*" Past & Present* 113:118-51.

Asad, Talal. 1993. *Genealogies of Religion: Discipline and Reasons of Power in Christianity and Islam*. Baltimore: The Johns Hopkins University Press.

Awolalu, Omosade J. 1996. *Yoruba Beliefs & Sacrificial Rites.* New York: Athelia Heritage Press.

Axel, Brian Keith. 2004. "The Context of Diaspora." *Cultural Anthropology* 19, no. 1: 26-60.

Ayorinde, Christine. 2007. "Writing out Africa? Racial Politics and the Cuban Regla de Ocha." In *The African Diaspora and the Study of Religion*, edited by Theodore Louis Trost, 151-166. New York: Palgrave Macmillan.

Baro, Sarahi Regla Lim. 1998. *Santeria as religion: A Content Analysis of the" Miami Herald" and " El Nuevo Herald"*. Master’s thesis, Boston College.

Bascom, William. 1980. *Sixteen Cowries: Yoruba Divination from Africa to the New World*. Bloomington: Indiana University Press.

Beliso-De Jesus, Aisha. 2015. *Electric Santería: Racial and Sexual Assemblages of Transnational Religion*. New York: Columbia University Press.

Biehl, Joao, Byron Good, and Arthur Kleinman. 2007. "Introduction." In *Subjectivity: Ethnographic Investigations,* edited by Joao Biehl, Byron Good, and Arthur Kleinman, 1-23. Berkeley: University of California Press.

Boedecker, Hal. "Santería Adds Twist to *Believers,*" *Miami Herald,* movie review, June 10, 1987.

Bourdieu, Pierre. 1991. *Language and Symbolic Power*. Cambridge, MA.: Harvard University Press.

Bourgois, Philippe. 1995. *In Search of Respect: Selling Crack in El Barrio*. 2nd ed. Cambridge, UK: Cambridge University Press.

Brandon, George. 1991. "Sacrificial Practices in Santería, an African-Cuban Religion in the United States." In *Africanisms in American Culture*, edited by Joseph E. Holloway, 119-147. Bloomington: Indiana University Press.

_____. 1993. *Santeria from Africa to the New World: The Dead Sell Memories*. Blacks in the Diaspora. Bloomington: Indiana University Press.

_____. 2012. "Lucumi Divination, the Mythic World and the Management of Misfortune." *Anthropologica (New Series)* 54, no. 2: 167–88.

Brodwin, Paul. 1996. *Medicine and Morality in Haiti: The Contest for Healing Power.* Cambridge, MA: University of Cambridge Press.

Brown, David H. 2003. *Santería Enthroned: Art, Ritual, and Innovation in an Afro-Cuban Religion*. London: Routledge.

Bubandt, Niles. 2014. *The Empty Seashell: Witchcraft and doubt on an Indonesian Island.* Ithaca, NY: Cornell University Press.

Carpenter-Song, Elizabeth A., Megan Nordquest Schwallie, and Jeffrey Longhofer. 2007. Cultural Competence Reexamined: Critique and Directions for the Future. *Psychiatric Services* 58:1362–1365.

Cassirer, Ernst. 1955. *The Philosophy of Symbolic Forms, Volume Two: Mythical Thought.* New Haven: Yale University Press.

Castaneda, Heide. 2010. "Im/migration and Health: Conceptual, Methodological and Theoretical Propositions for Applied Anthropology." *NAPA Bulletin* 34:6-27.

Comaroff, Jean. 1985. *Body of Power Spirit of Resistance: The Culture and History of a South African People*. Chicago: University of Chicago Press.

Comaroff, Jean, and John L. Comaroff. 1991. *Of Revelation and Revolution, volume 1: Christianity, Colonialism, and Consciousness in South Africa*. Vol. 1. Chicago: University of Chicago Press.

Comaroff, John L. and Jean Comaroff. 1993. "Introduction." In *Modernity and Its Malcontents,* edited by John Comaroff and Jean Comaroff, xi-xxxvii. Chicago: University of Chicago Press.

_____. 2009. *Ethnicity, Inc.* Chicago: University of Chicago Press.

Csordas, Thomas J. 2009. "Introduction: Modalities of Transnational Transcendence." In *Transnational Transcendence: Essays on Religion and Globalization,* edited by Thomas Csordas, 1-29. Berkely: University of California Press.

Curtin, Philip D. 1969. *The Atlantic Slave Trade: A Census*. Madison: University of Wisconsin Press.

Daniel, Yvonne. 2005. *Dancing Wisdom: Embodied Knowledge in Haitian Vodou, Cuban Yoruba, and Bahian Candomblé*. Urbana: University of Illinois Press.

Das, Veena. 2015. "Ordinary Ethics." In *A Companion to Moral Anthropology*, edited by Didier Fassin, 133-149. Cambridge, UK: Cambridge University Press.

De Boeck, Filip and René Devisch 1994. Ndembu, Luunda and Yaka divination compared: from representation and social engineering to embodiment and worldmaking. *Journal of Religion in Africa* 24, no.2: 98-133.

De Certeau, Michel. 1984. *The Practice of Everyday Life*. Translated by Steven Rendall. Berkeley: University of California Press.

De Laet, Marianne, and Annemarie Mol. 2000. "The Zimbabwe bush pump: Mechanics of a fluid technology." *Social Studies of Science* 30, no. 2: 225-263.

Derrida, Jacques. 1993. *Aporias*. Stanford, CA: Stanford University Press.

Dewey, John. 1984. "The Quest for Certainty." In *John Dewey: The Later Works, 1925-1953. Vol 4: 1929,* edited by Jo Ann Boydston. Carbondale, IL: University of Southern Illinois Press.

Dixon, Heriberto. 1988. "The Cuban-American Counterpoint: Black Cubans in the United States." *Dialectical Anthropology* 13, no. 3: 227-239.

Douglas, Mary. 1999. *Implicit Meanings: Selected Essays in Anthropology*. London: Routledge.

Espírito Santo, Diana. 2019. "Divination." In *The Cambridge Encyclopedia of Anthropology*, edited by Felix Stein. Online: http://doi.org/10.29164/19divination

Evans-Pritchard, Edward Evan. 1989 [1937]. *Witchcraft, Oracles, and Magic Among the Azande*. Vol. 12. Oxford: Clarendon Press.

Eyman, Scott. "'Believers' Do Their Voodoo Well," *Miami Herald,* movie review, June 10, 1987.

Favret-Saada, Jeanne. 1989. "Unbewitching as Therapy." *American Ethnologist* 16, no. 1: 40-56.

Felski, Rita. 1995. *The Gender of Modernity.* Cambridge, MA: Harvard University Press.

Finkler, Kaja. 2019. *Physicians at Work, Patients in Pain: Biomedical Practice and Patient Response in Mexico*. London: Routledge.

Foucault, Michel. 1972. *The Archeology of Knowledge.* Translated by A.M. Sheridan Smith. New York: Harper and Row.

_____. 1982. "The Subject and Power." *Critical Inquiry* 8, no. 4: 777-795.

_____. 1994. *The Birth of the Clinic an Archaeology of Medical Perception.* Translated by A.M. Sheridan Smith. New York: Vintage Books.

Frazer, James G. 1890. *The Golden Bough: A Study in Comparative Religion*. 1st edition. 2 vols. London: Macmillan.

Gawande, Atul. 2003. *Complications: A Surgeon's Notes on an Imperfect Science.* New York: Picador.

Geissler, P. Wenzel. 2013. "Public secrets in public health: Knowing not to know while making scientific knowledge." *American Ethnologist* 40, no. 1: 13-34.

Geertz, Clifford. 1973. *The Interpretation of Cultures*. Vol. 5019. New York: Basic books.

_____. 1983. *Local Knowledge: Further Essays in Interpretive Anthropology*. New York: Basic books.

_____ . 1988. *Works and Lives: The Anthropologist as Author*. Stanford, CA: Stanford University Press.

Gilroy, Paul. 1992. *The Black Atlantic: Modernity and Double Consciousness*: Cambridge, MA: Harvard University Press.

Good, Byron. 1994. *Medicine, Rationality, and Experience.* New York: Cambridge University Press.

Good, Byron J., and Mary-Jo DelVecchio Good. 1981. "The Semantics of Medical Discourse." In *Sciences and Cultures. Sociology of the Sciences a Yearbook*, vol 5, edited by E. Mendelsohn and Y. Elkana. Dordrecht: Springer.

_____. 1993. "'Learning medicine.' the Construction of Medical Knowledge at Harvard Medicine School." In *Knowledge, Power, and Practice*, edited by S. Lindenbaum & M. Lock, 81-107. Berkeley: University of California Press..

_____. 2004. "On the 'Subject' of Culture Subjectivity and Cultural Phenomenology." In *Clifford Geertz by His Colleagues,* edited by Richard Shweder and Byron Good. Chicago: University of Chicago Press.

Good, Mary-Jo DelVecchio. 1995. *American Medicine: The Quest for Competence*. Berkeley: University of California Press.

Good, Mary-Jo DelVecchio, Cara James, Byron J. Good, and Anne E. Becker. 2003. "The Culture of Medicine and Racial, Ethnic, and Class Disparities in Healthcare." In *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, edited by Brian D. Smedley, Adrienne Y Stith, and Alan R. Nelson. Washington, D.C.: National Academies Press.

Good, Mary-Jo DelVecchio, with Seth Donal Hannah and Sarah S. Willen. 2011. "Shattering Culture: An Introduction." In *Shattering Culture: American Medicine Responds to Cultural Diversity*, edited by Mary-Jo DelVecchio Good, Sarah S Willen, Seth Donal Hannah, Ken Vickery, and Laurence Taeseng Park, 1-30. New York: Russel Sage Foundation.

Gosin, Monika. 2019. *The Racial Politics of Division: Interethnic Struggles from Legitimacy in Multicultural Miami.* Ithaca: Cornell University Press.

Greenblatt, Stephen. 1980. *Renaissance Self-fashioning.* Chicago: University of Chicago Press

Guarnaccia, Peter J., and Orlando Rodriguez. 1996. "Concepts of Culture and their Role in the Development of Culturally Competent Mental Health Services." *Hispanic Journal of Behavioral Sciences* 18(4):419–443.

Gregory, Steven. 1989. "Afro-Caribbean Religions in New York City: The Case of Santería". *Center for Migration Studies* 7, no. 1: 287–304.

Grenier, Guillermo J and Corinna J. Moebius. 2015. *A History of Little Havana*. Charleston, SC: The History Press.

Harrison, Bernard. 1972. *Meaning and Structure: An Essay in the Philosophy of Language*. New York: Harper and Row

Hay, Michelle. 2006. "Social and Economic Adjustment of Afro-Cubans in the United States: Racial and Ethnic Considerations." PhD diss., City University of New York. ProQuest Information and Learning Company.

Herskovits, Melville Jean. 1941. *The Myth of the Negro Past*. New York: Harper & Brothers.

Hirsch, Jennifer S. 2003. "Migrants and Health Research: Confronting Cultural Appropriateness" In *American Arrivals: Anthropology Engages the New Immigration*, edited by Nancy Foner, 229-257. Santa Fe, NM: School of American Research Press.

Holbraad, Martin. 2012. *Truth in Motion: The Recursive Anthropology of Cuban Divination*. Chicago: University of Chicago Press.

Holmes, Seth 2007 "'Oaxacans Like to Work Bent Over': The Naturalization of Social Suffering among Berry Farm Workers." *International Migration* 45(3): 39–68.

_____. 2013. *Fresh Fruit, Broken Bodies: Migrant Farmworkers in the United States*. Berkley: University of California Press.

Horton, Robin. 1967a. "African Traditional Thought and Western Science. Part I: From Tradition to Science." *Africa: Journal of the International African Institute* 37, no.1: 50-71.

_____. 1967b. "African Traditional Thought and Western Science." *Africa: Journal of the International African Institute* 37, no. 2: 155-187.

Hucks, Tracey E. 2008. "From Cuban Santeria to African Yoruba: Evolutions in African American Orisha History, 1959-1970." In *Òrìşà Devotion as World Religion: The Globalization of Yorùbá Religious Culture,* edited by Jacob Kẹhinde Olupona, Terry Rey, and Terry S. Reynolds, 355-371. Madison: University of Wisconsin Press.

Hunt, Linda M., and Katherine B. de Voogd 2005 "Clinical Myths of the Cultural Other: Implications for Latino Patient Care." *Academic Medicine* 80 no.10: 918–924.

Jackson, Michael. 2010. "From Anxiety to Method in Anthropological Fieldwork." *Emotions in the Field: The Psychology and Anthropology of Fieldwork Experience*, edited by Davies, James, and Dimitrina Spencer, 35-54. Stanford, CA: Stanford University Press.

Johnson, Paul Christopher. 2007. "On Leaving and Joining Africanness through Religion: The 'Black Caribs' Across Multiple Diasporic Horizons." *Journal of Religion in Africa* 37, no. 2: 174-211.

Kaufman, Sharon. 2005. *And a Time to Die: How American Hospitals Shape the End of Life*. New York: Simon and Schuster.

Kavanagh, Christopher, "Religion without Belief," *Aeon* 15 September, 2016. https://aeon.co/essays/can-religion-be-based-on-ritual-practice-without-belief

Keane, Webb. 2016. *Ethical Life: Its Natural and Social Histories*. Princeton, NJ: Princeton University Press.

Kelly, Ann H., Javier Lezaun, Ilana Löwy, Gustavo Corrêa Matta, Carolina de Oliveira Nogueira, and Elaine Teixeira Rabello. 2020. "Uncertainty in Times of Medical Emergency: Knowledge Gaps and Structural Ignorance During the Brazilian Zika Crisis." *Social Science & Medicine* 246: 112787.

Kilroy-Marac, Katie. 2019. *An Impossible Inheritance: Postcolonial Psychiatry and the Work of Memory in a West African Clinic*. Berkeley: University of California Press.

Kleinman, Arthur. 1988. *The Illness Narratives: Suffering, Healing, and the Human Condition*. New York: Basic Books.

Kleinman A, and Benson P. 2006. "Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It." *PLoS Med* 3, no.10: e294. https://doi.org/10.1371/journal.pmed.0030294

Langford, Jean M. 2013. *Consoling Ghosts: Stories of Medicine and Mourning from Southeast Asians in Exile*. Minneapolis: University of Minnesota Press.

Langwick, Stacey A. 2008. "Articulate(d) Bodies: Traditional Medicine in a Tanzanian Hospital," *American Ethnologist* 35, no. 3 (July): 428-439.

Lambek, Michael. 1993. *Knowledge and Practice in Mayotte: Local Discourses of Islam, Sorcery and Spirit Possession*. Toronto: University of Toronto Press.

_____ . 2010. *Ordinary Ethics: Anthropology, Language, and Action*. New York: Fordham University Press.

Latour, Bruno. 1993. *We Have Never Been Modern*. Translated by Catherine Porter. London: Prentice-Hall.

_____. 2005. "'Thou Shall Not Freeze-Frame,' or, How Not to Understand the Science and Religion Debate." In *Science, Religion, and the Human Experience,* edited by James D. Proctor, 27-48. Oxford: Oxford University Press.

Lefley, Harriet P and Evalina W Bestman. 1991. "Public Academic Linkages for Culturally Sensitive Community Mental Health." *Community Mental Health Journal* 27, no. 6: 473-488.

Lefley, Harriet P, Mercedes Cros Sandoval, and Claude Charles. 1998. "Traditional Healing Systems in a Multicultural Setting." *Clinical Methods in Transcultural Psychiatry* 1st ed., edited by Okpaku, Samuel O., 88-110. Washington, D.C.: American Psychiatric Press.

Leininger, Madeleine. 2002. *Transcultural Nursing: Concepts, Theories, Research, and Practice*. New York: McGraw-Hill.

Levine, Susan. 2012. *Medicine and the Politics of Knowledge*. Cape Town, South Africa: HSRC Press.

Lienhardt, Godfrey. 1961. *Divinity and Experience: The Religion of the Dinka*. Oxford: Clarendon Press.

Lindenbaum, Shirley, and Margaret M. Lock, eds. 1993. *Knowledge, Power, and Practice: the Anthropology of Medicine and Everyday Life*. Vol. 36. Berkley: University of California Press.

Lipsitz, George. 2006. "Learning from New Orleans: The Social Warrant of Hostile Privatism and Competitive Consumer Citizenship." *Cultural Anthropology* 21, no. 3: 451-468.

Livingston, Julie. 2012. *Improvising Medicine: An African Oncology Ward in an Emerging Cancer Epidemic*. Durhman, NC: Duke University Press.

Luhrmann, Tonya M. "Belief is the Least Part of Faith," *New York Times*, Opinion, May 30, 2013. https://www.nytimes.com/2013/05/30/opinion/luhrmann-belief-is-the-least-part-of-faith.html

Makinde, M. Akin. 1984. "An African Concept of Human Personality: The Yoruba Example." *Ultimate Reality and Meaning* 7, no. 3: 189-200.

Mason, Michael Atwood. 1994. "'I Bow My Head to the Ground': The Creation of Bodily Experience in a Cuban American Santería Initiation." *The Journal of American Folklore* 107 no. 423: 23-39.

Masquelier, Adeline. 2001. “Behind the Dispensary’s Prosperous Façade, Imagining the State in Rural Niger.” *Public Culture* 13, no. 2: 267-291.

_____. 2001b. *Prayer Has Spoiled Everything*. Durham, NC: Duke University Press.

Matory, James Lorand. 2005. *Black Atlantic Religion : Tradition, Transnationalism, and Matriarchy in the Afro-Brazilian Candomblé*. Princeton, NJ: Princeton University Press.

McIntosh, Janet. 2006. "'Going Bush': Black Magic, White Ambivalence and Boundaries of Belief in Postcolonial Kenya." *Journal of Religion in Africa* 36, no. 3-4: 254-295.

Mendelsohn, Everett. 1977. "The Social Construction of Scientific Knowledge." In *The Social Production of Scientific Knowledge*, edited by Everett Mendelsohn, Peter Weingart, and Richard Whitley, 3-26. Dordrecht: Springer.

Metzl, Johnathan and Helena Hansen. 2014. “Structural Competency: Theorizing a New Medical Engagement with Stigma and Inequality.” *Social Science and Medicine* 103:126-133.

Minkler, Meredith, Steven P. Wallace, and Marian McDonald. 1994. "The Political Economy of Health: A Useful Theoretical Tool for Health Education Practice." *International Quarterly of Community Health Education* 15, no. 2: 111-125.

Murphy, Joseph M. 1993 [1988] *Santeria: African Spirits in America*. Boston: Beacon Press.

Nodal, Roberto, and M. W. Ramos. 2005. "Let the Power Flow: Ebó as a Healing Mechanism in Lukumí Orisha Worship." *Fragments of Bone—Neo-African Religions in a New World*, edited by Patrick Bellegarde-Smith,167-186. Urbana: University of Illinois Press.

Ong, Aihwa. 1995. “Making the Biopolitical Subject: Cambodian Immigrants, Refewgee Medicine, and Cultural Citizenship in California.” *Social Science and Medicine* 40, no. 9: 1243-57.

_____. 2003. *Buddha Is Hiding*. Berkley: University of California Press.

Ortiz, Fernando. 1947. *Cuban Counterpoint; Tobacco and Sugar*. New York: A.A. Knopf.

Palmié, Stephan. 1995. “Against Syncretism: Africanizing and Cubanizing Discourses in North American Òrìsà Worship.” In *Counterworks: Managing Diverse Knowledge*, edited by Richard Fardon, 74-107. London: Routledge.

_____. 2002. *Wizards & Scientists*: *Explorations in Afro-Cuban Modernity and Tradition*. Durham, NC: Duke University Press.

_____. 2013. *The Cooking of History: How Not to Study Afro-Cuban Religion*. Chicago: University of Chicago Press.

Pelkmans, Mathijs. 2011. “Outline for an Ethnography of Doubt.” In *Ethnographies of Doubt: Faith and Uncertainty in Contemporary Societies*, edited by M. Pelkmans, 1-42. London: Tauris Academic Studies.

Pels, Peter. 1998. “The Magic of Africa: Reflections on a Western Commonplace.” *African Studies Review* 41, no. 3: 193-209.

Pérez, Elizabeth. 2011. “Spiritist Mediumship as Historical Mediation: African American Pasts, Black Ancestral Presence, and Afro-Cuban Religion.” *Journal of Religion in Africa* 41: 330-365.

_____. 2013. "Willful Spirits and Weakened Flesh: Historicizing the Initiation Narrative in Afro-Cuban Religions." *Journal of Africana Religions* 1, no. 2: 151-193.

_____. 2015. "Working Roots and Conjuring Traditions: Relocating Black ‘Cults and Sects’ in African-American Religious History." In *Esotericism in African American Religious Experience: “There is a Mystery…,”* edited by Stephen Finley, Margarita Guillory, and Hugh Page Jr, 69-85. Brill.

_____. 2016. *Religion in the Kitchen*. New York: New York University Press.

Pérez, Lisandro. 2009. "Racialization Among Cubans and Cuban Americans." In *How the United States Racializes Latinos: White Hegemony and Its Consequences*, edited by José A. Cobas, Jorge Duany, and Joe R. Feagin, 134-148. Boulder, CO: Paradigm Publishers.

Petryna, Adriana. 2002. *Life Exposed : Biological Citizens after Chernobyl*. Princeton, NJ: Princeton University Press.

Pichardo, Oba Ernesto. 2017. “On Being a Lukumi Patient.” *Cuba Counterpoints: Public Scholarship about a Changing Cuba*, edited by Ariana Hernandez-Reguant.

Pigg, Stacy Leigh. 1996. "The Credible and the Credulous: The Question of" Villagers' Beliefs" in Nepal." *Cultural Anthropology* 11, no. 2: 160-201.

Povinelli, Elizabeth A. 2002. *The Cunning of Recognition*. Durham, NC: Duke University Press.

Ramos, Miguel W. 2003. "La División de la Habana: Territorial Conflict and Cultural Hegemony in the Followers of Oyo Lukumí religion, 1850s–1920s." *Cuban Studies*: 38-70.

Rapp, Rayna. 1999. *Testing Women, Testing the Fetus: The Social Impact of Amniocentesis in America*. London: Routledge.

Rappaport, Roy. 1999. *Ritual and Religion in the Making of Humanity.* Cambridge: Cambridge University Press.

Riesman, Paul. 1974. *Freedom in Fulani Social Life.* Chicago: University of Chicago Press.

Rorty, Amélie Oksenberg. 2007. "The Vanishing Subject: The Many Faces of Subjectivity." In *Subjectivity: Ethnographic Investigations,* edited by Joao Biehl, Byron Good, and Arthur Kleinman, 34-51. Berkeley, CA: University of California Press.

Rorty, Richard. 1991 [1982]. *Consequences of Pragmatism*. New York: Harverster Wheatsheaf.

Ross, Fiona. 2010. *Rawlife, New Hope.* Cape Town, South Africa: UCT Press.

Sandoval, Mercedes C. 1979. "Santeria as a Mental Healthcare System: An Historical Overview." *Social Science and Medicine* 13B: 137-151.

_____. 2008. "Twenty-first Century." In *Òrìşà Devotion as World Religion: The Globalization of Yorùbá Religious Culture,* edited by Jacob Kẹhinde Olupona, Terry Rey, and Terry S. Reynolds, 355-371. Madison, WI: University of Wisconsin Press.

_____. 2009. *Worldview, the Orichas, and Santería: African to Cuba and Beyond.* Gainesville, FL: University of Florida Press.

Sandoval, Mercedes C and Maria C de la Roza. 1986. "A Cultural Perspective for Serving the Hispanic Client" in *Cross-cultural Training for Mental Health Professionals*, edited by Harriet P. Lefley, and Paul Pedersen. Springfield, IL: C Thomas.

Seremetakis, Nadia. 2009. "Divination, Media and the Networked Body of Modernity." *American Ethnologist* 36, no. 2: 337-50.

Shaw, Rosalind. 1985. "Gender and the Structuring of Reality in Temne Divination: An Interactive Study." *Africa* 55, no. 3: 286-303.

Simone, AbdouMaliq. 2004. “People as Infrastructure: Intersecting Fragments in Johannesburg.” *Public Culture* 16, no. 3: 407-429.

Soto, Ana Rodriguez. “*San Lazaro* Gets His Dog Back: New Image in Hialeah Church Recognizes ancient popular devotion to beggar in parable.” *Florida Catholic Newspaper*. November 26, 2013. https://www.miamiarch.org/CatholicDiocese.php?op=Article_13111722143628

Steedly, Mary Margaret. 1993. *Hanging Without A Rope: Narrative Experience in Colonial and Neocolonial Karoland.* Princeton: Princeton University Press.

Stepick, Alex, Guillermo Grenier, Max Castro, and Marvin Dunn. 2003. *This Land Is Our Land Immigrants and Power in Miami*. Berkeley: University of California Press.

Stevenson, Lisa. 2011. "Praying Along: Interfaith Chaplaincy and the Politics of Translation.” In *Shattering Culture: American Medicine Responds to Cultural Diversity*, edited by Mary-Jo Delvecchio Good, Sarah S Willen, Seth Donal Hannah, Ken Vickery, and Laurence Taeseng Park, 94-111. New York: Russel Sage Foundation.

Street, Alice. 2014. *Biomedicine in an Unstable Place: Infrastructure and Personhood in a Papua New Guinean Hospital*. Durham, NC: Duke University Press.

Tambiah, Stanley Jeyaraja. 1985. *Culture, Thought, and Social Action*. Cambridge, MA: Harvard University Press.

Taylor, Janelle S. 2003. “The Story Catches You and You Fall Down: “Tragedy, Ethnography, and “Cultural Competence.” *Medical Anthropology Quarterly* 17, no. 2: 159-181.

Tilley, Helen. 2011. *Africa as a Living Laboratory: Empire, Development and the Problem of Scientific Knowledge, 1870-1950*. Chicago: University of Chicago Press.

Toulmin, Stephen. 1977. “From Form to Function: Philosophy and History of Science in the 1950’s and Now.” *Daedalus* 1: 143-162.

Turner, Victor. 1967. *The Forest of Symbols: Aspects of Ndembu Ritual*. Ithaca and London: Cornell University Press.

Trouillot, Michel-Rolph. 2015. *Silencing the Past: Power and the Production of History*. Boston: Beacon Press.

van Ryn, Michelle 2002 “Research on the Provider Contribution to Race/Ethnicity Disparities in Medical Care.” *Medical Care* 40, no. 1:I140–I151.

Vaughan, Megan. 1991. *Curing their Ills: Colonial Power and African Illness*. Stanford, CA: Stanford University Press.

Wade, Peter. 1993. "Blackness and Race Mixture: The Dynamics of Racial Identity in Colombia." Baltimore: Johns Hopkins University Press.

Werbner, Richard. 2017. "The Poetics of Wisdom Divination: Renewing the Moral Imagination." *Journal of the Royal Anthropological Institute* 23, no. 1: 81-102.

Wendland, Claire L. 2010. *A Heart for the Work: Journeys through an African Medical School*. Chicago: University of Chicago Press.

Weiner, Margaret J. 2003. “Hidden Forces: Colonialism and the Politics of Magic in the Netherlands Indies.” In *Magic and Modernity: Interfaces of Revelation and Concealment*, edited by Birgit Meyer and Peter Pels. Stanford, CA: Stanford University Press.

Whyte, Susan Reynolds. 1997. *Questioning Misfortune: The Pragmatics of Uncertainty in Eastern Uganda*. Vol. 4. Cambridge: Cambridge University Press.

Willen, Sarah S., and Elizabeth Carpenter-Song. 2013. "Cultural Competence in Action: “Lifting the hood” on Four Case Studies in Medical Education." *Culture, Medicine, and Psychiatry* 37, no. 2: 241-252.

Wirtz, Kristina. 2007. *Ritual, Discourse, and Community in Cuban Santería: Speaking a Sacred World.* Gainesville, FL: University Press of Florida.

Endnotes

Introduction

[1] In the beginning of the twentieth century the Church in Cuba held two separate images of San Lazaro: one a friend of Jesus who he raised from the dead, often depicted as a bishop; the other a beggar laying on the street outside the door of a rich man, hoping for the crumbs from his table. The latter is laying in the street, dogs licking his sores. The rich man is damned for not taking care of the beggar who goes to heaven. The Church sought to promote the veneration of the bishop and removed images of the beggar. In 2013 the Church in Hialeah replaced images of the beggar. It stands to reason that the participation of dogs in the feast day expresses community support for the veneration of the beggar (see Soto, Ana Rodriguez. "*San Lazaro* Gets His Dog Back" 2013).

[2] Lucumí refers to the religion and to the language used in religious ritual which has been highly influenced by Spanish pronunciation and conventions. While the language comes from the Yoruba language, it is not easily understood by Yoruba speakers in Nigeria today.

[3] A person newly initiated into Lucumí who must wear white and avoid social interaction for a year after. Whether or not a religious procession is considered inappropriate for an *iyawo* will vary based on the person responsible for their initiation.

[4] *Añá* is the divinity of the drum. Sacred drums to call down *orisha* to possess a mount embody *Añá* and the drummer who play them are initiated to this orisha.

[5] A small homage to the gospel song made famous by Sam Cooke.

[6] Holbraad's work is focused on addressing anthropological understandings of "truth" through an analysis of *Ifá* divination. This form of divination is performed by *babaláwos* using the palm nuts or divining chain of *Orunmila* the *orisha* of divination. *Olorishas*, that is people initiated into Lucumí*,* perform divination with sacred cowry shells. Without digressing into a lengthy discussion of the nuances and distinctions between these too systems, I would like to focus on Holbraad's observation that in performing *Ifá* divination we should understand that "truth" is not a static object being revealed, but in fact it is being transformed as the *orisha* are called to the mat. "The divinities, in other words, do not travel across ontological distances. They are themselves distances of ontological travel" (2012, 146). In this process the *orisha* "Rather than representing the world, the oracle transforms it by interfering with its very meaning—an ontological rather than an epistemic operation" (2012, xviii). While Holbraad doesn't focus on the materials involved, it follows that in order to transform the *material* world, materiality is necessary.

[7] In some literature African Diaspora religion in the Americas where devotees also identify as Catholic are referred to as examples of syncretism. I will not refer to them as such in this dissertation as there is a lot of debate about the use of this term. Stephan Palmié (1995) points out that in religious rituals Catholic imagery is superficial and does not impact a fundamentally African-derived practice in meaningful ways. Andrew Apter (1991) argues that Yoruba religion is by nature inclusive and adaptive. George Brandon (1993) does not consider syncretism an adequate framework to understand the religion, stating that it is more of "an intersystem or cultural continuum" All these scholars highlight the implications of the term "syncretism" which is premised on the notion of two independent bounded cultural systems that come into contact. The subaltern one borrows from the dominate one rendering the subaltern one less "pure," and overall "lesser" than the dominate one. The political implications are evident in the rejection of

syncretism by religious leaders like Mãe Stella of Ilê Axé Opô Afonjá one of the most influential houses of Candomblé in Brazil, who argues that her practice is authentically African. She also rejects the borrowing from Indigenous Amazonian groups that is common in Afro-Brazilian practices. Her house is built on the mountain of purity. A similar ethos is expressed in some African American Traditional Yoruba religious groups (for further discussion see Tracy Hucks, "From Cuban Santería to African Yorùbá: Evolutions in African American Orisa History 1959-1970). For my part, I agree with these scholars in that the practice is fundamentally African given that, in my own experience having practiced in a house with no Catholic trappings and then changing to practice in a house where Catholic sentiment is fluid, removing the Catholic elements of religious practice does not fundamentally change the ritual: I have never, remotely, identified as Catholic. Yet, in Hialeah most of my informants sincerely consider their religious expression connected to Catholicism and it is not my place to challenge that experience. Ultimately Brandon's 'cultural continuum' framework and Apter's Yoruba hermeneutic are most useful in approaching this topic. Religion is a product of society, and as society changes, so does religion. The practice of Lucumí in Cuba is a product of the intersection of Yoruba and most recently, Cuban history, as the practice of Catholicism is a product of the internal and external dynamics of its history. Both of these religions have borrowed copiously over the course of their histories and will continue to do so as is the nature of religion. But the purpose of this dissertation is not to debate the meaning or value of the term syncretism.

[8] Throughout this dissertation I use variations on the term "Anglo-American" in part because it is often used in the community, and also because it serves as a contrast to Latin American. I also use the term "white" and "black" when they fit the context.

[9] Folk Catholicism is often described as local or indigenous expressions of Catholicism, which often involve incorporating "folk beliefs" into Catholic practice. While some describe "Santería" as an example of Folk Catholicism, for many Lucumí devotees this is not an adequate framework to understand their religious lives, though for some peripheral casual participants this argument may hold. This dissertation does not focus on casual participation.

[10] When discussing the Yoruba language, it is also important to keep in mind that what we know today as one Yoruba language is a recent creation. Yorubaland was originally made up of various groups with different dialects of the language. When Nigeria became a British colony and missionary activity increased there was an effort to create a single language through the creation of a Yoruba dictionary and a translation of the bible. The dialect that became standard language was that of the town of Oyo. Incidentally, it is also the Oyo style of religious initiation, the *kariocha* initiation for the kings of Oyo, that became the dominate form of religious initiation in Lucumí. (For further reading see Palmié 2013)

[11] You may ask, why not identify as "Yoruba" in the first place, but, like the language, there was not a unified "Yoruba" identity at that time. People identified with the specific place that they were from. A unified "Yoruba" identity is a product of British colonialism, much like a single Yoruba language. While Asad is certainly correct is asserting that power, in this case colonial power, benefited from ambiguity, hence encouraging it at times, when it came to some elements of colonial administration, the British did attempt to enforce homogeneity in order to more easily extract resources from colonized people.

[12] On the feast day of the saint that the Cabildo was dedicate to, it was expected to celebrate and parade an image of that saint in the street. Given that the people involved were all from the same ethnic group with religious traditions that likely varied from location to location, but were similar and eventually combined into a single amalgamation in this new context. Groups made sure to have a statue of their patron saint prominent, but priests rarely visited more than once a year. Otherwise the group was free to socialize, offer aide to one another in times of need, and continue religious worship. The Catholic church was generally aware of this and attitudes toward it varied. But for much of Cuban history, the Catholic church's approach was one of a sort of teared conversion, believing that people allowed to continue their traditional religious practices alongside Catholicism would eventually, overtime, fully convert. (For further reading, see George Brandon, *Santería from Africa to the New World: The Dead Sell Memories,* 1993)

[13] Adeshina-ibaé and Fernando Ortiz- ibaé by no means exhaust the list of historical actors who have influenced what we know today as Lucumí. José Aponte-ibaé, Timotea "Latuan" Albear- ibaé, Ñá Rosalía

Abreú "Efunshé Warikondó"-ibaé, Ma Monserrate "Apóto" González "Obá Tero-ibaé, Lydia Caberra-ibaé, William Bascom-ibaé, are just some of the people who have participated in this religious production.

[14] There is a conversation to be had regarding commodification in Lucumí practice. Not only is commodification a common criticism from outsiders unfamiliar with the materiality of a religious practice made up of rituals that require a certain level of goods in order to achieve. But within the community many frequently express concern that there are many dishonest religious brokers "out there" that undermine the reputation of Lucumí. They lament that when you go to a *tambour* these days the mount does not know your age in the religion. A mount is a person possessed by an *orisha*, this requires a person be initiated and trained as a mount. That *orisha* is expected to interact with all in attendance, especially elders, and salute those older in initiation to the person who it mounted. When a mount does not properly salute those older than them, they are considered a fraud. I have heard people in Miami say that they do not trust the mounts today, twenty years ago a mount could tell you "what was in your purse," but today they only talk to their friends and do not salute their elders. People also express trepidation about professional mounts as they are paid to be possessed, a system that some feel encourages fraudulent possession. Nonetheless, in a religious practice that has a significant service component, from ritual experts, diviners, cooks, butchers, *botanica* proprietors, to professional musicians, it follows that a mount should be compensated for the service that they provide. As to dishonest religious brokers, I had only heard people express concern about them up until my fieldwork, but during my fieldwork I actually crossed paths with a 'genuine' fraud. That experience will be covered in work outside of this dissertation. As to marketplace commodification in Lucumí, that is not within the scope of this dissertation.

[15] For more discussion of the intersection of identity politics, racial ideologies, and discourse on religious authority see George Brandon, *Santería from Africa to the New World: The Dead Sell Memories*; Tracy Hucks "From Cuban Santería to African Yorùbá: Evolutions in African American Orisha History 1959-197; Stephan Palmié Against Syncretism: Africanizing and Cubanizing Discourses in North American orisa_worship. In Richard Fardon (ed.) *Counterworks: Managing Diverse Knowledge*; and Stephan Palmié, *The Cooking of History.*

Chapter 1

[1] For more see Sarahi Regla Lim Baro 1998 *Santeria as religion: A content analysis of the" Miami Herald" and" El Nuevo Herald"*

[2] Presumably this is an allusion to Fernando Ortiz's famous discussion of his concept of "transculturation," comparing Cuban culture to ajiaco stew, a combination of different local ingredients, constantly stirred as new ingredients are added, cooked down so that all the flavors blend but each bite has its own characteristic, different qualities and the top and bottom of the stew yet artfully woven together and experienced.

[3] "Cultural competency" began in the 1960/70s (?) and has changed over the years as problems with the paradigm have come to light. This dissertation will provide further critic along those lines. Today some scholars refer to it as an "umbrella" term encompassing "cultural sensitivity" and "cultural humility" and other efforts to bridge cultural differences in medicine, as well as other disciplines and professional domains. Still other scholars recommend that the paradigm be replaced with "Structural Competency" (Metzl, Johnathan and Helena Hansen. 2014. "Structural Competency: Theorizing a new medical engagement with stigma and inequality." *Social Science and Medicine* 103:126-133). For the trajectory of this dissertation I will be discussing cultural competency throughout and in the conclusion, elaborate on the pedagogical shift to "cultural humility" that is relevant in South Florida today.

[4] This is an incorrect description on the part of the interlocutor. Regla de ocha devotees do not wear Jewish yarmulke, but they do cover their heads often. There is not a proscribed head covering specific to the community. That said, it is not unusual for *santeros* to wear tight caps that resemble a yarmulke.

[5] Martinez also mentioned a nurse/anthropologist at the University of Miami who did similar work. I am guessing this is Ida Trafalgar, who sadly passed away before I was able to meet her.

[6] The labeling of certain behaviors as "culturally appropriate," will be explored later in this chapter as the issue of "irrational belief" is addressed.
[7] I believe the impetus to state this explicitly is a reflection of the hegemony of Abrahamic religions and their focus on proselytizing and conversion, with the exception of Judaism. This is not a characteristic of regla de ocha or any other African Diaspora religion that I am familiar with.
[8] During my fieldwork, most biomedical practitioners had stories about Jehovah Witnesses or Vodou.
[9] The internet as a source is something to respond to at greater length. It is important to elaborate on this.
[10] The US government did acknowledge some Cuban credentials as part of the suit of benefits extended to Cuban immigrants after the 1959 Revolution. These benefits far exceeded those provided to any other immigrant group from Latin America. Though I do not know what percentage of immigrants were able to transfer their credentials to the US or how long that process took. The benefits extended to Cuban immigrants did begin to wane after the first two waves of immigration (see Alan Aja 2016).
[11] Folk Catholicism generally refers to religious practices not taught or sanctioned by the Catholic Church which generally reflects practices embedded in an indigenous religious context that have been imbued with Catholic trappings.
[12] *Buena presencia* literally means "good appearance" but it is used throughout Latin America in employment advertisements to let potential employees know that only the white, or light-skinned need apply.

Chapter 2

[1] More about the development of initiation in Cuba, as Ramos illustrates….
[2] *Obi* is the coconut and a divinity which embodies one form of divination in Lukumí tradition. A form of divination which is often used to ask the *orisha* questions.
[3] "The word "religion" in contemporary English is derived from the Latin, *religare*, meaning "to bind back," "retie," "bond," or "fasten," and it is the human world that is fastened to the spiritual world in my three examples of African American ritual practice" (Daniel 2005, 2).
[4] The anniversario ilé has to accommodate all of the olosha's *orisha*, whereas an ilé for an initiation also has to accommodate the initiate themselves, consequently, it is usually a bit bigger.
[5] Religious salutes are by the "gender" (a term used loosely) of the *orisha*, not the devotee. Devotees of "male" *orisha* salute on their stomachs while devotees of "female" *orisha* salute on the left hip then switch to the right.
[6] A jicara is a dried gourd bowl that is commonly used in religious rituals
[7] The mojuba is a prayer recited before any divination to pay homage to the *egún* (spirits of the dead) of the religious lineage, the personal lineage of the person the ritual is performed for and the *orisha*.
[8] The spirits of the deceased who are connected to the individual, often ancestors, but not always.
[9] *Kariosha* is the term for the formal initiation of a new Lukumí priest/ess where the person is "crowned" with their tutelary *orisha*.
[10] Egún refers to spirits of the dead that influence a devotees life and must be satisfied in order to proceed with ritual for the *orisha*.
[11] Ebo is a term for ritual sacrifice in Lukumí. According to George Brandon, it is "derived from Lucumí, literally, "to do" or "the thing done." As a concept *ebo* includes offerings, sacrifices, and purification without distinction" (1991, 124).
[12] A capuchino is a small cone shaped sponge cake soaked in anise syrup. The name is said to come from the hoods worn by capuchin monks.

Chapter 3

[1] Lerond Matory (2005) describes colonialism similarly.

Chapter 4

[1] The controversy around divination is relatively absent in the literature which takes *Ifá* to be the authority throughout the Lucumí community. This has not been my experience.
[2] Patakí, as used in Afro-Cuban divination are myths used to explain divinatory signs.
[3] The term egún generally refers to spirits of the deceased, often blood relatives, but not necessarily. This is in contrast to *ara orun* which are more the ambient dead, the "people of heaven" (see Murphy 1988).
[4] In Yorubaland, and Brazil to a certain extent, the concept of *ori* is very prominent, and an animistic *ori* will be made and worshipped like an *orisha*. The *ori* is sometimes described as the "inner head" and is said to be located in the head, but it goes far beyond simply the capacity to think. I can best describe it as a source of destiny, character, and integrity. One can have a good *ori* and a worthless body and still have a very successful life in the end. While the person who appears to "have it all" may end up in the gutter because of a poor *ori* (for further readings see M. Akin Makinde 1984. "An African concept of human personality: The Yoruba example." *Ultimate Reality and Meaning* 7(3): 189-200 and Michael Atwood Mason. 1994. ""I Bow My Head to the Ground": The Creation of Bodily Experience in a Cuban American Santería Initiation." *The Journal of American Folklore* 107 (423): 23-39). In Lucumí thus concept is present in ritual and divination, like when a diviner asks if a person's osobgo is because of their own head. But this concept is not so present as to have a sacred altar to it like the *orisha*.
[5] *Olorishas* are people who have been through a *kariocha* initiation and have their own set of orisha, generally in a home altar.
[6] *Orisha*, in this context, refers to the animistic articles "charged" with each *orisha*. My godfather like to refer to your *orisha* as a "telephone line" to them.
[7] I would like to differentiate the concept of "energy" from that of "aché." For the most part, when people use the term energy it relates to a sort of new-age concept attempting to articulate an invisible force present in the material world to contrast the physical body. At other times it may refer to invisible powers, spirits of the dead who do not have clearly defined personalities, (see chapter 5 on hospital rituals). Aché, in contrast, is a religious term specific to Lucumí that I would describe as the power to make things/ideas/rituals/spirit manifest in the world. It is also used to refer to specific religious substances, depending on the context.

Chapter 5

[1] A number of scholars have observed that globalization has driven the production of portal practices within world religions (see Kamari Maxine Clarke, *Mapping Yorùbá Networks: Power and Agency in the Making of Transnational Communities* (New York: Duke University Press, 2004), and Thomas Csordas, ed., *Transnational Transcendence: essays on religion and globalization* (Berkley: University of California Press, 2009). While the creation of temporal ritual space in this context may be an illustration of this in the general sense, this paper does not delve into theories of globalization.

[2] As Stanley Tambiah (1985) points out, magic is generally geared toward addressing practical problems like finding a cure for the sick, when biomedicine has not done so.
[3] Many practitioners of Lucumí are also Spiritist and at times the line between the two can become blurry. However, it is important to realize that Spiritism is a separate tradition from Lucumí, a tradition of European, not African, origin. There are Spirits who do not practice Lucumí and Lucumí devotees who do not practice Spiritism. All of the Lucumí devotees who participated in this research practiced both traditions fluidly.
[4] Cosmologies, according to Stanley Tambiah, are "frameworks of concepts and relations which treat the universe or cosmos as an ordered system, describing it in terms of space, time, matter, and motion and peopling it with gods, humans, animals, spirits, demons and the like. Cosmologies consist usually of accounts of the creation and generation of the existing order of phenomena, explain their character and their place and function in the scheme" (1985, 3).

[5] In South Florida Lucumí is generally interwoven with Catholicism, although the degree to which this is the case in practice various greatly. Still, colloquially the *orisha* are often referred to as saints, and the religion as santo.
[6] Some of the *orisha* are merged with deified ancestors, still, they should not be confused with *egún* who are not deified.
[7] For more discussion on the history of Lucumí practice and the historical actors involved see George Brandon, *Santeria, From Africa to the New World: The Dead Sell Memories* (Bloomington: University of Indiana Press, 1993), and Miguel W. Ramos, "La División de La Habana: Territorial Conflict and Cultural Hegemony in the Followers of Oyo Lukumí Religion, 1850s-1920s." *Cuban Studies* 34 (2003): 38–70.
[8] Many people use the term "saint" interchangeably with "*orisha*."
[9] In this element of the cosmology, the boundaries between Lucumí and Spiritism bleed into one another. In many houses both Lucumí and Spiritism are practiced, but they are not synonymous religious systems. Still, most of the participants in this research practiced both and did not always make a distinction between the two.
[10] Blood sacrifice is understood to "heat" up a situation allowing for movement, but not likely to provide the clarity
made possible by "cooling."

[11] Some spiritists argue this can also happen when a person is conscious, if the person is close to someone who has experienced a violent or sudden death, while others argue this can happen anytime a person sleeps, the problem with anesthesia is your surroundings and the artificial depth of the "sleep".
[12] On this, Bourdieu says, "There is every reason to think that the factors which are most influential in the formation of the habitus are transmitted without passing through language and consciousness, but through suggestions inscribed in the more apparently insignificant aspects of the things, situations and practices of everyday life. Thus the modalities of practices, the ways of looking, sitting, standing, keeping silent, or even of speaking ('reproachful looks' or 'tones', 'disapproving glances' and so on) are full of injunctions that are powerful and hard to resist precisely because they are silent and insidious, insistent and insinuating" (1991, 51).
[13] This is a bowl commonly used in religious practice
[14]*Limpieza* is the Spanish for cleansing.
[15] Cuba was not alone in this. All over Latin and Anglo America, governments were participating in any number of programs to destroy the influence of African and Indigenous cultures, from Eugenics and forced serializations, to Indian schools to "Kill the Indian. Save the man," to policies to increase European immigration.
[16] An *iyawo* is a new initiate, who has gone through the seven-day *kariocha*, and must wear all white for the following year, observing numerous behavioral restrictions. For the first seven days they cannot leave a small space, even to us the restroom, without an older initiate to accompany them.
[17] In this chapter I will not get too much into the classic question of the "efficacy of rituals," as I have focused instead on the creation of space. That said, I think for many people they have seen enough success with hospital rituals to consider them worth doing.
[18] *Elekés* are the sacred beaded necklaces worn in Lucumí and receiving them is akin to a baptism, and the first step in entering religious practice.
[19] This is a beaded bracelet to signify an *orisha*. Many people wear green and yellow ones for Orula. This is based on a *Patakí* (*lukumí* myth) where death agrees not to take a person early so long as the person is wearing the idé of Orula the *orisha* of divination.
[20] The hospitals people had mixed opinions of were for-profit hospitals owned by a single corporation while the one hospital that people always referred to favorably was a non-profit hospital.
[21] Diloggún divination is performed with sacred cowry shells by an *olorisha*. *Ifá* divination is performed by a babaláwo.
[22] An *itan* is a divination performed on the third day of the seven-day initiation. It is considered the *olorisha*'s "sacred book," containing advice for the rest of their life.

[23] The *ilé* is the sacred space where new initiates are made. The term is also used to refer to the literal space where an *olorisha* performs religious ritual (often part of their home) and, more abstractly, to refer to the religious family.

Biography

Eugenia Rainey moved to New Orleans from Chicago in 2001 with her husband and, then, two very young children. Since then, she and her husband have raised four children in New Orleans. Prior to Katrina, she began working as a ghost tour guide in New Orleans' historic French Quarter. Post Katrina, in 2007, she pursued an M.F.A. in Creative Writing from the University of Nebraska at Omaha which lead her to teach composition at Delgado Community College in New Orleans for roughly six years. In 2014 she began her graduate work at Tulane.