Monstrosity, medicine, and misunderstanding

The infamy and polemics of the twentieth-century literary giant Louis-Ferdinand Céline

Death and suffering can't matter nearly as much as I think they do. Since they are so common, my taking them so seriously must mean that I am insane.

I must try to be saner.

—Louis-Ferdinand Céline, Rigadoon

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Céline, the paradox, the monster, the misunderstood victim; the ferocious French writer of works that were bombastic, burning, bellicose; the anti-Semite, forever scorned by history; the impossible, contradictory, paranoid maniac; one of the most influential authors of the twentieth century. But at the same time the compassionate Céline, obsessed with human anguish and suffering, the physician Dr. Destouches.

The list of literary greats he inspired is remarkable: Günter Grass, William Burroughs, Henry Miller, Samuel Beckett, Norman Mailer, Jack Kerouac, Joseph Heller, Ken Kesey, Philip Roth, and Charles Bukowski, just to name a few. Kurt Vonnegut says of Céline: “Every writer is in his debt, and so is anyone else interested in discussing lives in their entirety. By being so impolite, he demonstrated that perhaps half of all experience, the animal half, had been concealed by good manners. No honest writer or speaker will ever want to be polite again.”

An unlikely figure to emerge as a literary pioneer and an eminent modern influence, Céline, born Louis-Ferdinand Destouches in 1894 in Courbevoie, France, was a practicing
doctor in Paris before publishing his breakthrough masterpiece *Voyage au bout de la nuit* (*Journey to the End of the Night*) in 1932 at the age of thirty-eight.

Most famous for his loosely autobiographical novels *Voyage au bout de la nuit* and *Mort à crédit* (*Death on the Installment Plan*, 1936), widely regarded as two of the twentieth century’s greatest novels, Céline launched pathologically urgent tirades about his wretched childhood in Paris slums, his service during World War I and the horrors he experienced in the trenches, the abysmal African jungle, his travels in America, and finally life in Paris as a failed doctor.

Céline remains elusive, obscure, and in many ways, misunderstood. His writing is distinguished by his use of street slang, his famous “trois points” (three dots), his idiosyncratic style, lexical invention, rhythm and tonality, use of allusion and contrast, and, as Merlin Thomas, author of the biography *Louis-Ferdinand Céline* notes, his interesting “exploitation of what is a relatively rare technical field in literature, that of medicine.”

His writing defined an entirely new literary style in a manner that uniquely captured the vivacity, brutality, and futility of existence, and the human condition therein.

Though an acclaimed writer and influential figure, there are reasons why Céline—“one of the loneliest figures in twentieth-century literature”—is not a more recognizable name: political ones. These reasons, writes Thomas, are “less important than the positive artistic reasons for considering him to be one of the very few great and original writers in twentieth-century France.”

Much is known about the public figure—mostly infamy and scandal—but the personal Céline remains elusive, obscure, and in many ways, misunderstood.

The war wound determined his future

Louis-Ferdinand Destouches was born just outside Paris. His father was a minor functionary in an insurance firm and his mother was a lace maker. The author later took his pseudonym, the name that became so infamous, from his maternal grandmother. By all accounts Louis’s childhood was harmonious and uneventful. He dearly loved his parents, caused no trouble or grief, was courteous and polite, and seemed happy. In his youth, Louis was sent abroad by his parents to both England and Germany for schooling, but he “curtailed formal education” to spend his adolescence as an apprentice in various trades. In 1912, at the age of eighteen, Louis began a three-year enlistment in the Twelfth Cavalry Regiment, and in 1914, marched off into war. Writes Frédéric Vitoux, author of the outstanding biography *Céline*: “The complete Céline . . . Céline the doctor and Céline the writer, was to be born out of this first Apocalypse.”

In October 1914, shortly after the fighting erupted, Louis was wounded in the right arm by a ricocheting bullet: “. . . ban! . . . I was blown away by a shell, blown away! Swept off my feet! . . . a big one, mind you! a ‘107’!” In November, while recovering in a hospital, Louis was commended for bravery and awarded the *médaille militaire*.

The wound left Louis with insomnia, unbearable headaches, and “a continual roaring in his ears” for the remainder of his life. Although he did not receive the singular head wound he later claimed, he undoubtedly endured endless neuralgias and “stabbing, screaming pains, enough to drive him mad;” the etiology of which remains vague, and “variously attributed to abuse of quinine while in the colonies, an ear infection and high blood pressure,” or “a violent blow to the head” from a shell explosion earlier in the war.

After spending time in London, Louis signed a contract in March 1916 with a French lumber company holding rights in Cameroon. Following his year in West Africa, he returned to France on official medical leave with insufferable pain from his war wound, relapsing malarial fever, and chronic parasitic dysentery.

As a little boy, I dreamed of being a doctor, of healing people.

In France, Louis obtained a position with the Rockefeller Foundation, lecturing in rural France as part of an anti-tuberculosis health campaign, and in November 1919 he enrolled in the Rennes Faculty of Sciences. Louis’s medical studies progressed with few difficulties. At the hospital he was noted to manifest “astonishing and indispensable ease for communicating with the patient and winning his or her trust”; further, his peers noted him to be “startlingly curious, versatile, scoffing, rude, inspired, irritable, a great spinner of yarns.”

In 1923, nearing the end of his medical studies, Louis Destouches wrote *The Life and Work of Philippe-Ignace Semmelweis*. This dissertation describes Semmelweis’s 1846 investigations into the terrible mortality rate of women in a Vienna maternity ward. Semmelweis attributed the death rate, as high as twenty five percent, to the contaminated hands of medical students assisting physicians during childbirth. Apparently, the students arrived at the clinic immediately after dissecting corpses riddled with disease. By having the students wash their hands in chloride of lime—and essentially inventing prophylaxis—Semmelweis reduced the mortality rate to practically zero. His peers refused to believe his theories, and
A public health expert with the Rockefeller Foundation

In 1924, now Dr. Destouches, Louis was officially employed by the Rockefeller Foundation, and enlisted with the Health Section of the League of Nations. The experience allowed him to travel extensively, exploring matters of public health and industrial medicine in Switzerland, Italy, England, Canada, the United States, West Africa, and Cuba.

In 1926, Louis made his first literary attempt, writing the play L’Église (The Church). Already anticipating the cynicism and fatality of his later work, he writes: “The truth of the world is death, right? Life is a drunkenness, a lie. It’s fragile, and absolutely necessary.”

In September 1927, Dr. Destouches filed his medical certificate and began work at the Laennec hospital. Later that year he opened an office of General Practice, Childhood Diseases in Clichy. His clients were “queues of poor people, deprived children, cripples of all sorts, old people with no future . . . grappling with sickness.”

Dr. Destouches displayed a special tenderness for society’s undesirable and vulnerable, often providing his medical care without charge.

In 1929, Louis moved into an apartment in Montmarte, “a tight community with a radical political and artistic tradition.” During this time Louis underwent a personality transformation; his American girlfriend Elizabeth Craig recalls: “I often wondered what made him so depressed and depressing . . . It all began when he decided to write this book.”

A novelist as extraordinary as his book

The writing grew and expanded out from the “endless parade of drunks, the goiterous, soldiers, laborers, madmen, sick children—that panoramic human condition observed by Dr. Destouches and to which the writer Céline suddenly gave a language in harmony with his memory, his despair, and his hallucinations.” The novel was completed in April 1932.

Robert Denoël, Céline’s future publisher, remembers their first meeting: “I found myself before a man as extraordinary as his book. He talked to me nearly two hours as a clinician who had done the rounds in life, a man of extreme clear-sightedness, coldly despairing, and yet passionate; cynical but pitiful.”

The initial critical response to Voyage au bout de la nuit was astounding. One reviewer wrote: “A cruel work but one so true, so empathetically painful yet at the same time vibrant, that it will immediately leave its mark, protestations notwithstanding.” Leon Trotsky famously remarked: “Louis-Ferdinand Céline walked into great literature as other people walk into their own house.” The book, truly, was a thundering masterpiece.

Hiding behind his pseudonym, Louis Destouches was quickly discovered, revealing a reluctant, cynical, and indifferent Céline. Following a disappointing near-win of the prestigious Goncourt literary award, Céline continued to experience contempt for “the vulgarity, the crassness, the shamelessness” of public recognition, of literary critics, and of controversy, gossip, scandal, and sensationalism. “The book caused a fuss. It stopped me from doing medicine . . . I miss it, medicine was my vocation. I should never have written.”

Balancing medical trips, his clinic and patients in Clichy, and the literary sensation and disrepute of his novel, Céline toiled away at a second book. He withdrew further from public life, deeper into the private nightmare of his mind. His second novel detailed Céline’s childhood through fantastic satirical exaggeration, with more wild gasps of punctuation and more bombast, and filled plumb-deep with the same scatological rage of Voyage au bout de la nuit. He forbade his mother to read the book, and she obeyed.

On publication of Mort à crédit, Céline was accused of “merely denouncing the poor and disenfranchised” in a “detestable style . . . full of the most vulgar literary methods.” But it proved to be another literary tour de force, and for Nicholas Hewitt, author of The Life of Céline, it is “France’s major fictional contribution to European Modernism.”

The critics were horrified: “Clearly, we are dealing with a maniac.” Savage letters by outraged readers were published: “Céline is darkness, hatred, fury, disgraceful, loathsome cowardice before life, mud, shit . . . When one writes what Céline has written, one does not broadcast it: one commits suicide.”

Predictably, Céline continued to remain and act the pariah: “With ideas, effort, and enthusiasm, I have fed more insatiable cretins, more pathetic paranoiacs, more complex anthropoids than are needed to drive any average monkey to suicide.”
His preference for seclusion, and his delusions of persecution increasingly dominated his life.

In 1936, following his celebrated visit to the Soviet Union, Céline wrote the short anti-Communist pamphlet *Mea culpa* (*My Fault*), a fired-up attack on the U.S.S.R. and communist principles. The harangue was an “enormous success,” and paved the way for his next three published works, a series of political pamphlets in which Céline the stylist, the polemicist, the uncouth sensationalist and satirist, demonstrated the tremendous danger of mixing artistic voice and politick. Nonetheless, he insisted: “I have no ideas, myself! not a one! there’s nothing more vulgar, more common, more disgusting than ideas!”

About *Bagatelles pour un massacre* (*Trifles for a Massacre*, 1937) Vitoux writes: “This confession book, this awful book, would long haunt him like a curse.” The work, framed in conversations between Ferdinand and three friends, serves as a polemic pretext for an invective outburst on the present
state of France, the impending European climate of war, and “a malediction on others . . . the Jews, the communists, the Freemasons, the Russians . . . the entire world.”3

Bagatelles pour un massacre, while a success with the public, was received by the critics with indifference, as if no one knew whether or not Céline could be taken seriously. A French Fascist even remarked that Céline had “become a monomaniac of insult . . . clearly an anarchist.”17

In Céline’s next work, L’École des cadavers (School of Corpses, 1938), he fell into a furious fit of words and ideas bordering on lunacy:

The fuming, destructing Furies of War scoff at your woggish emotings to the ends of hell! your silent, anathematic farting.

You cowardly, shit-scared gropers! I’m enfulminating I admit! I’m moiling! I’m boiling! I’m humbugging my wig! I’m fuguing! I’m shrieking! I’m breathless! I’m belching roiling vapors! I don’t give a fitting fuck anymore!8

In 1939, Céline and his publisher were fined in court for publishing offensive passages. Not long after, L’École des cadavers and Bagatelles pour un massacre were pulled from the shelves. In 1941, Céline published a third and final political diatribe, Les Beaux Draps (The Fine Mess), a pessimistic condemnation of France.

As a result of his polemic writing, Céline became associated with the “most extreme journalists, writers, and pamphleteers”3 of the era. In late 1942, he appeared on a blacklist published by Life and the BBC named him a “collaborating writer.” In the winter of 1943 Céline began to receive death threats in the form of letters and miniature coffins.

In 1941, the Nazis confiscated Céline’s bank account in Holland. Céline declared the “collaboration . . . a worthless enterprise,”3 prophesying the Reich’s defeat. In 1942, deeply obsessed with finances, he made an unsuccessful attempt to retrieve his bank savings in Copenhagen. He made another attempt in 1944 as Allied forces and Soviet troops encircled France.

French resistance fighter Pierre Petrovich would later say: “Céline did well to flee Paris at the liberation, not because he had anything to fear from résistants who knew him, but because certain hotheads were capable of anything. Some obscure commando would have unthinkingly shot him down and nobody would have been able to prevent it.”19

Céline’s 1944/45 exodus to Germany and then to Denmark is captured in his literary trilogy D’un château l’autre (Castle to Castle, 1957), Nord (North, 1960), and Rigodon (Rigadoon, 1969). Thomas describes these three novels as “the supreme artistic achievement of Céline . . . an unforgettable impression of the dramatic months before the collapse of Nazi Germany, and also . . . of the way in which the individual is reduced to all kinds of humiliating sycophancy when struggling with mere survival.”20

Céline and his wife Lucette and cat Bérbert remained refugees in Baden-Baden and Berlin for over three months. In late 1944, with permission of German authorities, Céline left for Sigmaringen, a refuge enclave formed to regroup the French government in exile, and the setting of D’un château l’autre.

Surrounded by the French collaborators, Dr. Destouches became the official physician to the French colony, and assumed, under stifling conditions, the medical care of the French refugees. He continued to avoid participation in governmental affairs, declaring openly against the Germans: “all of this propagandist nonsense is disgusting!”20

Post-war chaos—leaving France for Denmark—a collaborator?

Following VE Day in May 1945, Céline, his wife, and his cat—amid the confusion and devastation of a destroyed German nation—left for Denmark. This nightmarish journey is captured in Rigodon. After arriving in German-occupied Copenhagen, Céline remained hidden for nine months in a friend’s apartment. He applied for Danish residency status, and the permits were eventually issued. In France, a warrant of arrest was issued for Céline on the charge of treason.

Meanwhile, the world was slowly beginning to learn about the atrocities, horrors, and heinous repercussions of Hitler’s ideology. Céline later stated: “I knew nothing, absolutely nothing . . . I only learnt about these atrocities after the war. I deplore my ignorance.”21

On December 15, 1945, Danish newspapers revealed Céline’s presence, with front-page headlines loudly proclaiming: “A FRENCH NAZI IS HIDING IN COPENHAGEN—THE WRITER CÉLINE, WHO ESCAPED WITH THE VICIOUS GOVERNMENT.” That night judicial police were sent to arrest Céline and his wife. French authorities demanded his extradition. Thomas writes that Céline had “no significant group of persons to defend him in France: he had deliberately severed all political ties and he had shot and wounded too many sacred cows.”22

The Danish Ministry of Justice found that Céline could not be extradited until an intelligence report became available. Eighteen months of detention followed, an experience that proved to be profoundly destructive to Céline’s withering morale. His wife later noted, “after the prison ordeal, Céline changed entirely.”23

In his public defense, Céline pleaded that “he had never called for anti-Semitic persecution but merely protested
against the actions of certain Semitic clans then pushing France toward war.”  

Céline was finally freed in June 1947. The journey through Germany, the experience of hiding in Denmark, “the arrest, imprisonment and constant fear of extradition to France led to a nervous collapse from which Céline never fully recovered.”  

Four years would elapse before he could return to France. He continued to write while the press continued to badger him.

An immense hatred keeps me alive. I would live a thousand years if I were certain of seeing the whole world croak.  

In France again, Céline enjoyed no influence, and remained a symbol of anti-Semitism. To the intelligentsia, Céline “represented merely a disturbing specimen of populist pre-war literature that had foundered into racism and barbarity.”  

In early 1950, the open opinions of writers, artists, and publishers in France regarding Céline were printed. Marcel Aymé attested: Céline is “the greatest contemporary French writer and perhaps one of the greatest lyric poets we have ever had,” while at the other end of the spectrum, Albert Béguin jibed: “that of Céline, slimy with rabid slobber, is worthy of a servile dog.”  

Céline maintained, time and time again: “I am not a man of messages, I am not a man of ideas, I am a man of style.”  

In 1950, after a lengthy and contentious hearing, years of investigation, police searches of Céline’s apartment, rogatory commissions, and trials in absentia, Céline was sentenced to a year in prison and a fine of 50,000 francs, and was declared a “national disgrace,” with confiscation of his property present and future not exceeding fifty percent. However, after a fitful controversy, Céline was granted amnesty in 1951.

Ruined . . . after trials and persecutions

Céline entered into a life of seclusion, withdrawing into his writing. Literary critic Robert Poulet described him: “a ruined man, morally and materially . . . protected by childish precautions: the appearance of a tramp, a pack of dogs and a barrier of lies.” In 1952, Céline published Féeerie pour une autre (Fable for Another Time), describing “his traumatic experience of arrest, imprisonment, exile, and conviction as a Nazi collaborator.” It was only in 1953 that Céline decided to start practicing medicine again from his home in an attempt “to rejoin the profession that he loved.”  

D’un château l’autre was published in 1957. Although later hailed a literary masterpiece, the book was far from a best seller at the time.

In 1959, Céline, going on 65, gave up his medical practice, and in 1960, Nord was completed. Its publication was followed by little controversy, and the book received some critical acclaim.

Céline now plunged into the writing of what would be his final book: Rigodon. During this time his health continued to deteriorate. He suffered a minor stroke. His wife remembered that “he took barely two years to write Rigodon, he overworked himself, and everything was done, in draft, on the eve of his death, he had just written the last page.”

On Saturday, July 1, 1961, his head hurting him more than usual, and forbidding his wife to call for a doctor (“I want to be left to die quietly” 22), Céline suffered a ruptured intracranial aneurysm, dying shortly thereafter. The press was not informed; only intimate friends were invited to file past his deathbed.

Erected at the site of his grave by his wife, a vault reads:

Louis-Ferdinand
Céline
Doctor L.-F. Destouches


As Céline had written some thirty years earlier: “The truth of this world is death.”

A substantial volume of writing attempts to explain and understand the regrettable political aspects of Céline’s life. Although Céline’s political pamphlets were highly pitched, bursting with “deliberate exaggerations” and “in all probability [of] no influence,” Céline was a notorious political symbol, and an author of disturbing anti-Semitic invective.

His earlier books contain no note of anti-Semitism. Not one Jewish character appears in Mort à crédit or Voyage au bout de la nuit. In Mort à crédit, Céline ridicules his father as a “grotesque and vociferous anti-Semitic loser . . . winded by his own pathetic grudges.” A number of theories seek to explain Céline’s sudden and unexpected racist stance, including early childhood influences, as well as personal humiliations, rejections, suspicions, and conspiracies, and finally an over-bearing sense of pacifism: “Anything rather than war!”

Vitoux writes: the “hatreds, which [Céline] nurtured and developed with such intolerable energy, were, I repeat, fictitious hatreds to him, solitary and rhetorical hatreds, neither real nor personalized.” Nonetheless, the hatreds were sinister, irresponsible, and inflammatory in the pre-war climate. Unfortunately, Céline was “in tune with the times. France, in the main, was anti-Semitic.”

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Despite later allegations, Céline was politically isolated, a member of “no committee and no administration” and “never provided assistance, either by report, advice, or information, to the German ambassador, let alone the Gestapo.”

Thomas states: Céline “was, in fact, politically very ignorant . . . and very naive.”

Throughout his career, Céline “wrote not of reality but of the hallucinations provoked by reality.” Likewise, his pre-war ranting reflected the unrest and violence of his milieu, the frustration of inevitable war, as well his isolation, feelings of persecution and disgust with politics.

. . . all I had to do was to remain what I am and keep my trap shut. Guilty of the sin of pride is what I was, I admit, through vanity and stupidity.2p24

A respected physician? Or paranoid, scatalogical writer?

Céline was an immensely talented and influential writer, but his position in literary history remains precarious.

A complex dichotomy of personality is notable throughout Céline’s career: Dr. Destouches is irreplaceable, and Céline, the writer, is a phantom, a figment of literary creation. Céline would maintain until his death that he was a physician foremost, and a writer secondarily.

Vitoux writes that Céline “looked down upon the world from the heights of his insatiable and sometimes remote need, eager to understand, to know, to deliver a diagnosis on everything. Certainly, a clinical diagnosis, that of the doctor . . . but a writer’s diagnosis too.”

Is Céline the author incompatible with Destouches the doctor? There is no doubt that Destouches witnessed an unbearable amount of suffering, in some of its highest pitches, during his life. There is also no doubt that he experienced profound frustration and loss as a witness to this suffering.

Two truths appear evident: first, Céline the terrifying literary genius was a figure of great controversy; and second, he was largely misunderstood, in that he was also a physician, a compassionate soul, exquisitely anxious and sensitive, brutalized by existence, the world, and himself.

Céline was obsessed with human misery and death, and with the fleetingness, futility, and absurdity of the human condition. Perhaps he understood the irreducible drama of basic struggle, of life versus death, the simplistic ethos of all medicine, the shameless honesty of life stripped down to its brutal core, in the way that all doctors must. If he did, he did so with flair, with literature so provocative, so inimitable, so tumultuous and forceful, that it can only be recognized as art, a stark portrait of the beauty of humanity.

As the character Bardamu says in Voyage au bout de la nuit: “Maybe that’s what we’re looking for all through life, just this, the greatest possible sorrow so we can become ourselves before dying.”

Acknowledgment
Edited by Matthew C. Crawford.

References

The Pharos/Spring 2009 21


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Illustration by Laura Aitken

All us travelers in the dark
Thank you for your tiny spark.
Twinkle, Twinkle Little Star

A speck of a beating heart
In a gaping blackness of the Universe.
Tears of joy stream down her face
And for the first time I see light
In her tired eyes.
So fragile, she wipes a tear.
And is it even real?
It is, I smile and nod.
And from that moment on
Oppressive silence of an empty nursery
With curtains drawn and toys unplayed
Is in the past, a memory . . .
She finally will be a mother.

Katerina Pavenski, MD, FRCPC

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Illustration by Laura Aitken
A cold crisp glass of Cava while watching the bullfights. Absinthe, emerald green poured over sugar, shared between young lovers. And cocktails—before reading, before dining, before dancing, before everything. Scenes from Hemingway are inexorably bound to drinking, so it is no surprise that his work may inform us on the topic of alcoholism. The pages of his fiction are figuratively soaked in booze and, in many cases, probably literally as well. The descriptions of distinct and complex alcohol-related behaviors range from abstention to healthy social imbibing to pathologic, chronic, and relapsing alcoholism. Hemingway describes the disease with such vividness and clarity that medical professionals might benefit from studying the models presented in his novels. The author once remarked, “I’m trying in all my stories to get the feeling of the actual life across—not just to depict life—or to criticize it—but to actually make it alive. So that when you have read something by me you actually experience the thing.” He succeeds, and his pen strokes illustrate both the full-blown end-stage alcoholic and early alcoholism, as well as the many gradations between the alcohol abusive problem drinker and the alcohol dependent. His works capture the diverse symptoms and complications of pathologic drinking, going beyond the pathology well known to medical students: neuropathy, cirrhosis, encephalopathy, delirium tremens, etc. These organic consequences of alcoholism, while medically important, are dangerously late manifestations of the disease. Hemingway conveys the subtle and sometimes not so subtle nuances of the alcoholic, including but not limited to comorbid psychopathology, personality changes, “craving,” isolation, obsessive thinking, and compulsive behavior.

Another compelling reason to regard Hemingway’s fiction as a potent source for understanding alcoholism is the concept of “autopathography” put forth by Dr. Stephen Moran, which describes “a type of literature in which the author’s illness is the primary lens through which the narrative is filtered.”

Papa pours a shot...

Photo by Tore Johnson/Pix Inc./Time Life Pictures/Getty Images.
Because Hemingway was himself an alcoholic who never conquered denial, his writings are all the more convincing on the subject. If his purpose in *For Whom the Bell Tolls* was to give the reader, in Aristotlean terms, a poetic understanding of the human condition, he was uniquely well equipped to do so with regard to addiction. In dramatic irony, the disease about which Hemingway so adeptly wrote was not recognized by his own alcoholic mind, and ultimately played a role in his suicide.

*For Whom the Bell Tolls* focuses on three characters—Robert Jordan, Pablo, and Pablo's wife Pilar—who are avatars of the three common types of alcohol user: abusive, dependent, and healthy. In addition to providing a tripartite model for ethanol-related behavior, *For Whom the Bell Tolls* marks a literary departure of the author: “Instead of omission, of suggestiveness by implication, Hemingway adds and becomes explicit, pausing to develop the many facets of a situation or a personality. . . . He has devoted nearly five hundred pages to seventy hours of action.” The wealth of detail is ideal for examining character pathology.

Pablo: Drinking his way through *For Whom the Bell Tolls*

The year is 1937 and the Spanish Civil War is raging. Robert Jordan, rugged, handsome, and equipped with two packs of explosives, finds himself in the picturesque mountains of central Spain behind enemy lines, charged with assisting the International Brigade in its fight against Franco and the Fascists. An American college professor turned anti-fascist dynamiter, his primary task is to destroy a bridge near Segovia. We are introduced to Robert as he surveys the target bridge. During his reconnaissance, Robert meets Pablo, the leader of a guerilla unit harbored in the same mountains.

Pablo cuts a formidable figure, rough and tough talking, perched on his stolen steed with a carbine rifle over his shoulder. He is proud and authoritative, and from the remarks of his compatriots it appears that his braggadocio was earned through bravery and valiant if violent deeds—“Pablo . . . has killed more people than cholera . . . more than the bubonic plague.” It also seems, however, that something has changed in the past several months. Pablo has become muy flojo—very flaccid—according to Anselmo, an older
gentleman who has agreed to help Robert explode the bridge. Anselmo explicitly remarks that Pablo drinks too much. In his drinking Pablo has become sad and desperate, preferring the company of his horses to humans. Living in a fantasy world, he seems fixated on finding an escape from the seeming dead end of war and life as a fugitive. Robert can see Pablo’s sadness, and thinks, “That sadness is bad. That’s the sadness they get before they quit or before they betray. That is the sadness that comes before the sell-out."  

Pablo’s condition reeks of late-stage alcoholism. Throughout the rest of the novel we will see him display six of the seven DSM-IV criteria for substance dependence: tolerance, withdrawal, increased intake, excessive time devoted to the substance, major activities given up because of substance use, continued use despite consequences, and failed attempts to abstain. Three of these are required for diagnosis; Pablo never tries to abstain. In chapter 14, when Robert returns in the afternoon to the guerrillo camp, he finds Pablo thoroughly intoxicated.

“I have been drinking all day waiting for the snow.”

“... I am drunk,” Pablo said with dignity. “To drink is nothing. It is to be drunk that is important. Estoy muy borracho.”

Here Pablo displays knowledge of his increased tolerance and obsession with drinking, a self diagnosis. In this chapter he also displays the Jekyll-and-Hyde personality changes not mentioned in the DSM-IV but common in alcoholics. When drunk the alcoholic is prone to drastic mood swings. Pablo, for instance, is combative with Robert, accusing him of being Scottish and wearing kilts. He proposes a snowball fight and eventually provokes the gypsy Agustin, who strikes him repeatedly in the face. Unconvinced his drinking is the cause of any of his problems, Pablo simply remarks, “‘An intelligent man is sometimes forced to be drunk to spend his time with fools.’”

The dipsomaniac is a genuine monomaniac, with alcohol being a powerful object of desire, hatred, and many of the alcoholic’s thoughts. Pablo’s monomania is especially evident during one encounter with Robert. Each man has a cup of wine, but Pablo’s eyes

were looking at the wine bowl as though he had never seen one before... Pablo looked from the wine bowl to Anselmo’s face as he drank and then he looked back at the wine bowl.  

“Listen, Inglés,” Pablo spoke directly to the wine bowl.  

“...I have admired thy judgment much today, Inglés,” Pablo told the wine bowl.”

Alcohol has become the center of his life.

By and about Gregory Miday

Raised in beautiful Cincinnati by a brilliant psychiatrist and an astute epidemiologist—my mother and father—I have always had an interest in understanding mental illness and the societal impact of psychiatric disorders. While my primary passion is for internal medicine, I have not wanted to neglect my other passions: art, history, literature, and music. My bachelor’s degree from Northwestern University is in Art History.

Throughout medical school I made a point to continue reading nonmedical literature for both pleasure and intellectual fulfillment. I have known people who struggled with substance disorders, and the idea for this essay struck suddenly while reading Hemingway’s oeuvre.

I am an intern at Washington University in St. Louis in Internal Medicine. I plan to continue to explore the connections between the humanities and medicine. The key will be finding the time to do so!

The alcoholic can be a powerful leader

Pablo’s position as group leader is no contradiction. Early ethanol abusers may possess an “alcoholic charm” that makes them attractive members of society. This has been viewed as a true compensatory reaction by the ill person to mask the disease. For example early-stage alcoholics are on average better dressed and groomed than nonalcoholics. Also, in another type of subconscious autoregulation, the alcoholic may display a high degree of egoism. It is hypothesized that this develops as the alcoholic realizes he no longer has control over his drinking. This powerlessness over alcohol manifests itself as a desire to have control in other arenas. The combination of charisma and drive for ego satisfaction (derived from the acquisition of sex, money, power, respect, etc.) often places alcoholics in “egocentric” positions and occupations. Thus alcoholics are often writers, actors, politicians (with an estimated prevalence of thirty percent compared to ten percent in the general U.S. population), and, in this case, de facto commanders of guerrilla factions. The deceptive compensation can sometimes last decades,
Drinking in earnest

but will eventually fall apart assuming the drinker does not quit drinking or go into spontaneous remission. As the disease progresses, the alcoholic neglects his health and appearance, develops bizarre personality traits, and is frequently inebriated at inappropriate times. As with Pablo, the untreated severe alcoholic tends to become antisocial, losing his own self-respect and the esteem of his peers. The late-stage exhausted, or “bottom,” alcoholic demonstrates intense emotional reactions to alcohol, including, according to Dr. Jorge Valles: moodiness, irritability, impatience, excessive sensitivity, intolerance, compulsiveness, procrastination, suspiciousness, jealousy, remorsefulness, irresponsibility, hostility, loneliness, deceptiveness, and confusion. Watch as Pablo pathetically caresses a horse in a drunken stupor, whispering sweet nothings, “Thou lovely white-faced big beauty. . . . Thou dost not insult nor lie nor not understand. Thou, oh, thee, oh my good big little pony.” Listen as Pablo’s wife reprimands, “Borracho!” the colorfully loaded term for “drunkard” in Spanish, then verbally castrates him in front of his new guest and declares herself the true leader. Feel what Pilar means when she describes her husband awaking in sobs, “as though there is an animal inside that is shaking him,” and finally states, “But now he is finished. The plug has been drawn and the wine has all run out of the skin.”

The rate and quantity of consumption in this scene are characteristic of someone who may have a drinking problem. In addition, when Robert steps outside the cave, he notes that he is surprisingly clear despite the alcohol. Increased tolerance and adaptive changes such that one may not feel or appear intoxicated after six quick drinks are also signs of a possible alcohol problem. It is important to distinguish the person with alcohol abuse from the alcoholic. While addiction runs on a continuum and should be considered on an individual basis, science has shown that alcohol abusers and alcoholics are usually distinct entities. The first will have some problems due to drinking. He will have guilt and will have suffered adverse consequences from alcohol use but will not demonstrate physiologic withdrawal upon abstaining. Nor will he have the same degree of cravings and obsessive thinking and compulsive behavior that the alcoholic experiences. While his life is not centered about procuring and ingesting alcohol, and he may be normal in all other facets of life, he has a pathologic relationship to alcohol. Even if he continues to drink heavily, however, he probably will not become an alcoholic. The

A drinking problem? Or just a man who likes drinking?

Let us now focus on protagonist Robert Jordan. Upon first meeting Pablo’s troops and accompanying them to their cave hideaway, a large wineskin is produced and drink offered: “Robert Jordan drank it slowly, feeling it spread warmly through his tiredness.” He then drinks another cup of wine with dinner. After dinner, he dips for a third cup. There is an attractive young woman in the cave, Maria, recently orphaned and brutalized by the facissimos and saved by Pablo’s group. Robert has felt a “thickness” in his throat since laying eyes on her, and it is noted that this feeling remains despite the third cup of wine. While some healthy alcohol users will have a drink to boost confidence and lower inhibitions, the deliberate and mindful attempt to self-medicate by using alcohol as an anxiolytic is a characteristic of problem drinking. Robert later drinks a fourth cup of wine. When he asks about a fifth cup Pablo denies him, claiming the wine is near finished (we later find this is not true but another instance of alcoholic mendacity to keep more for oneself). In response Robert asks for a cup of water instead. But not to worry, Robert has no intention of quitting so early. He empties half the water and then withdraws a flask from his belt, from which he slowly pours absinthe, mixing it with the water. A gypsy queries, “What drink is that?” Replies Robert, “A medicine . . . It cures everything. If you have anything wrong this will cure it.” As he drinks he experiences a pleasant feeling of euphoric recall, picturing a beautiful Parisian evening as “he tasted that opaque, bitter, tongue-numbing, brain-warming, stomach-warming, idea-changing liquid alchemy.” After he finishes his second absinthe, “making a warm, small, fumerescent, wet, chemical-change-producing heat in him,” he passes his cup for more vino. That makes six drinks, not that anybody’s counting.
best evidence for the differentiation comes from adoption studies. One sibling of alcoholic parentage adopted by a non-alcoholic family has the same risk of becoming alcoholic as a sibling (about twenty percent) reared in the alcoholic home. Children of nonalcoholics adopted by alcoholic families have a significantly higher chance of being abusive drinkers, but not of becoming alcoholic. The implication is that alcoholism is a disease with strong genetic origins, while problem drinking may be mostly determined by environmental factors.8

The likely ethanol-abusive Robert Jordan drinks more or less continuously throughout the rest of the novel. On day two, when he visits El Sordo, another guerilla leader nearby, the two talk over several whiskies. It is not yet noon. Morning drinking, especially after a previous night of drinking, can be repugnant to healthy drinkers, but welcomed by problem drinkers and alcoholics as the best cure for a hangover and morning jitters. Later, as Pilar is getting to know Robert and inquiring about his interests, she states, “‘You like to drink, I know. I have seen.” He responds, “‘Yes. Very much. But not to interfere with my work!’” A problem drinker’s problem is almost invariably evident to others before it is self-evident. A moment of clarity for Robert, when he surely realizes his reliance on alcohol, comes towards the end of the novel as he lies on the ground wounded, anticipating what will likely be his own death.

Then he remembered that he had the small flask in his hip pocket and he thought, I’ll take a good spot of the giant killer . . . But the flask was not there when he felt for it. Then he felt that much more alone because he knew there was not going to be even that. I guess I’d counted on that, he said.9p67

In contradistinction to Robert and Pablo, Pilar exemplifies the normal, healthy drinker. In the initial scene at the cave, when Robert offers her a cup of wine, she declines, “‘Not until dinner,’ she said. ‘It gives me heartburn.’” The next morning, when offered whiskey: “‘I don’t want any,’ Pilar said and covered her glass with her hand.” Then, offered wine instead, she answers, “‘No. Water.’” Pilar does enjoy a glass of wine with food, and in her stories she reminisces on the delight of a cold beer in the afternoon, but during the novel she never has more than two drinks at a time and possesses the ability to take it or leave it without much thought or worry, the hallmark of the normal drinker.

**Alcoholism—Genetic pathways in the brain**

The “Big Book” of Alcoholics Anonymous describes alcohol as “cunning, baffling, powerful!” and from both a medical and lay perspective it is. One of the most fascinating aspects of the drug—the crux of the reason why Pablo, Pilar, and Robert are so different—is that alcohol is selectively addicting. In the United States, about nine percent of people who drink will become problem drinkers, with a smaller subset of those becoming alcoholic. The alcoholic who never takes a first drink will never suffer from the disease! Ethanol affects almost all people similarly in its initial stages. It is first a stimulant—people become talkative and carefree. People drink for this initial favorable response. These universal reactions are not limited to humans, and as Anselmo points out in chapter 3: “The gypsies believe the bear to be a brother to man because he has the same body beneath his hide, because he drinks beer.”9p40 Alcohol is later a sedative, but subsequent reactions vary greatly, and are different among different types of alcohol users. Normal, healthy drinkers will experience adverse affects after several drinks, including sedation and sometimes nausea and unease. They will naturally slow down or stop ingesting, hence Pilar’s heartburn. Alcoholics also metabolize alcohol differently, and their central nervous system responses, especially processes in the deep, primitive brain structures, are also different, though this is still not well understood. With ingestion of one-half to an ounce of alcohol, both alcoholics and nonalcoholics experience not only “euphoria, relaxation, and [a sense of] well being,” but also improved “concentration, memory, attention span, [and] creative thinking.”11p52 These improvements quickly disappear in the nonalcoholic as blood...
alcohol levels rise, but they are persistent in the alcoholic up to much higher levels of ethanol intake.\textsuperscript{11} Most importantly, alcoholics, despite signals indicating they should cease drinking, lack the ability to do so. It is this lack of control, and the inherent unpredictability of whether they will drink to intoxication, that most specialists believe to be the \textit{sine qua non} of alcoholism.\textsuperscript{10} The abusive drinker reacts similarly to the alcoholic in many ways, and will binge drink, but will never experience total loss of control over drinking. It is impossible to separate the abusive drinker from the early alcoholic. In \textit{For Whom the Bell Tolls}, Robert Jordan is a problem drinker, but one cannot say whether or not he will develop alcoholism.

The purging of the fascists from Avila, a story within a story told by Pilar, provides the most poignant and deeply affecting passage in the novel. Alcohol plays a prominent role in the drama and deserves special attention. The narrative describes the storming of Avila by Pablo’s guerilla force. After executing the fascist soldiers, the fascist civilians are collected from around the city and packed into the town hall, the \textit{Ayuntamiento}. A line of townspeople forms, making an aisle from the building to the edge of a high cliff. One by one the fascists are forced to walk the line, where they are brutally clubbed and finally flung over the precipice. The killing of each fascist is described in detail, and in the lines of the townspeople we see anger, fear, guilt, pride, and, not to be ignored, a lot of drunkenness. As the scene unfolds, Hemingway uses a musical, sonatesque composition of melody, harmony, and counterpoint. Resounding through the drama is the major key of death and reprisal, the vertically melodic crescendo of each killing, and the harmonic minor key composed of the quotidian aspects of the scene strung together compositionally by the alcohol that saturates the crowd.\textsuperscript{12} Pilar says at first only a few townspeople are drunk, the “useless characters who would have been drunk at any time.”\textsuperscript{sp104} As tension builds, they begin

“... handing around bottles of anis and cognac that they had looted from the bar of the club of the fascists, drinking them down like wine... Those who did not drink from the bottles of liquor were drinking from leather wineskins that were passed about.”\textsuperscript{sp115}

After the first fascist is flung to his death by a hesitant crowd the alcohol and strong emotions begin to affect the people in the lines. When Don Guillermo is brought out pleading for mercy he is struck on the head and rolls about

“...while the drunkards beat him and one drunkard jumped on top of him, astride his shoulders, and beat him with a bottle.”\textsuperscript{sp118}

Pilar observes,

“Two men had fallen down and lay on their backs in the middle of the square and were passing a bottle back and forth between them. One would take a drink and then shout, ‘\textit{Viva la Anarquia}!’ lying on his back and shouting as though he were a madman...”\textsuperscript{sp120}

“A peasant who had left the lines and now stood in the shade of the arcade looked at them in disgust and said, ‘They should shout, ‘Long live drunkenness.’ That’s all they believe in.’”\textsuperscript{sp122–23}

Pilar, having dealt with an alcoholic husband, is bitter but also wise. She recognizes the ability of alcohol to foment mob behavior and to cause normally sane and sensitive people to commit heinous acts. While watching the commotion a man presses against her,

“His breath on my neck smelled like the smell of the mob, sour, like vomit on paving stones and the smell of drunkenness...”

“As I watched, this man turned away from the crowd and went and sat down and drank from a bottle and then, while he was sitting down, he saw Don Anastasio, who was still lying face down on the stones, but much trampled now, and the drunkard got up and went over to Don Anastasio and leaned over and poured out of the bottle onto the head of Don Anastasio and onto his clothes, and then he took a matchbox out of his pocket and lit several matches, trying to make a fire with Don Anastasio. But the wind was blowing hard now and it blew the matches out and after a little the big drunkard sat there by Don Anastasio, shaking his head and drinking out of the bottle and every once in a while, leaning over and patting Don Anastasio on the shoulders of his dead body.”\textsuperscript{sp122–23}

Pilar has at once illustrated both “alcoholic insanity” and the existential futility that seems to plague the alcoholic. As her story draws to an end and the last of the fascists are killed, Pilar concludes, “‘It would have been better for the town if they had thrown over twenty or thirty of the drunkards... and if we ever have another revolution I believe they should be destroyed at the start.’”\textsuperscript{sp127}

There is much disagreement regarding diagnosis and treatment of alcoholism (and addiction in general), and science has yet to elucidate many aspects of this complicated condition. In Great Britain, the concept of alcoholism as a disease is less widely accepted.\textsuperscript{13} But Ernest Hemingway, a highly intelligent drinker given to solipsistic reverie in his writing, unwittingly unravels some of the mysteries of alcohol use and abuse in this novel. By separating out the three most common types of drinkers, who comprise the majority of the adult U.S. population, he provides us with entertaining and informational guides to recognizing and characterizing ethanol behavior. Alcoholism is a unique disease with broad consequences not
just for the alcoholic, but for family, friends, and society at large. The indirect victims of this disease are often hurt and angry, and rightly so. The most powerful condemnation of alcoholism in this novel comes from the afflicted wife Pilar, who acidly exclaims:

"Of all men the drunkard is the foulest. The thief when he is not stealing is like another. The extortioner does not practice in the home. The murderer when he is at home can wash his hands. But the drunkard stinks and vomits in his own bed and dissolves his organs in alcohol."  

**Alcoholics: Often not recognized and inadequately managed**

But the real outrage of alcoholism, and a heavy burden on the medical profession, is that it is under-recognized, under-researched, and under-treated. Statistics tell the story: A recent study of over 40,000 subjects representative of the U.S. population demonstrated a lifetime prevalence of alcohol abuse of 17.8 percent and alcohol dependence of 3.8 percent. Less than a quarter of those with alcohol dependence received any treatment at all. Unlike in the days of the Spanish Civil War, there now exist FDA-approved drugs for the treatment of alcoholism. Other pharmaceuticals are in the pipeline, and successful rehabilitation therapies ranging from psychotherapy to twelve-step programs abound. Hopefully, by taking a multidisciplinary approach that may even include looking to American literature, the problem may be investigated more thoroughly and better addressed. The next time you read a novel, or examine a new patient, keep a vigilant eye for the alcoholic, because his disease is deadly but treatable, and he needs your help.

**References**


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The cat drinks water...
Photo by Tore Johnson/PIx Inc./Time Life Pictures/Getty Images.
Marat’s Terror

When the prominent French revolutionary Joseph-Emmanuel Sieyes was asked what role he had during the French Revolution, he responded “J’ai vecu.” (“I survived.”) Thousands could not make that claim during the tumultuous decade from 1789 through 1799. The period was marked by fear, intrigue, and violence, and no life more closely paralleled the revolution than that of Jean-Paul Marat. During a decade of hostility he was L’Ami du Peuple (The Friend of the People), and even as his cries of Liberté, égalité, fraternité! rang through the streets of Paris, Marat’s assassination in 1793 showed that history is less a triumph of ideology than a series of tragic human atrocities.

Marat, in his own time, was known as a madman, a fanatical demagogue, and the murderer of thousands. A mysterious skin disease earned him the stigma of a leper, but he is also remembered as a doctor, a frustrated scientist, and the subject of the period’s most memorable painting. The scene of his death in 1793 was immortalized in Jacques-Louis David’s masterpiece Death of Marat. The indelible depiction shows a Christ-like Marat lying dead in his bath, the evidence of his murder in plain view. Upon its completion, the painting was carried through the streets of Paris in tribute and Marat was worshipped as a god.

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Johannes Kepler contended that the seat of the soul was in the meninges: an examination of the soul in terms of anatomy and medicine, and a new treatise entitled "A Philosophical Essay on Man," which was followed the next year by a larger treatise entitled "A Letter to the Christian People." The work was a curious exercise, with each page filled with a single word: "A." The essay was dismissed as nothing more than a clever trick, and the author was left to ponder the meaning of his own work.

The spirit of the eighteenth century, which was dominated by the Enlightenment, sought to bring about a revolution in thought and society. The Industrial Revolution of the late eighteenth century brought progress and change, but also brought about new challenges and problems. The French Revolution, which began in 1789, was a response to these challenges, and it was a time of great upheaval and change.

Marat was a leading figure in the French Revolution. He was a physician and philosopher, known for his radical ideas and his role in the early days of the Revolution. He was also a victim of the Revolution, as he was stabbed to death in his home in 1793.

The events surrounding Marat's death were a source of fascination for the people of France. They were shocked and saddened by his death, and they sought to understand the circumstances surrounding it. The events of the French Revolution were a turning point in history, and they continue to be studied and debated to this day.

Despite the challenges of the eighteenth century, the Enlightenment was a time of great promise and potential. It was a time when people sought to understand the world around them, and to use that understanding to improve their lives. The French Revolution was a response to those challenges, and it was a time of great change and transformation.
Marat’s daily rants against the aristocracy earned him the disdain of the privileged and the adoration of the poor. “To pretend to please everyone is mad,” he wrote. His allegiances to the Jacobins were well known. He hated the monarchy, and his rhetoric against the throne galvanized the rebellion.

In the years following the storming of the Bastille in 1789, anarchy descended on Paris. With the deposition and capture of Louis XVI in 1792, the notion of a constitutional monarchy was quickly abandoned and the hope of a republic spread through Paris. During this unstable time, the balance of power shifted from the failed Legislative Assembly to the Paris Commune, a body composed not of politicians, but of the working class. Many of the delegates were members of France’s most unpredictable faction, the “sans-culottes.” The term meant “without culottes,” the knee breeches worn by the privileged. The Paris Commune wielded merciless authority and had no more vocal leader than Jean-Paul Marat.

1792—Purge of counterrevolutionaries by the Paris Commune

The revolutionary government survived an early threat in September 1792. With the Prussian army marching on Paris, and faced with insurrection at home by those loyal to the imprisoned king, the Commune sought to rid the city of any trace of “counterrevolution.” Thousands of the accused were arrested, imprisoned, and beheaded on charges of rebellion during the bloody September Massacres. Others were set free, only to be raped, castrated, or disemboweled at the hands of mob violence. Hearts were ripped from the chests of men and eaten. The head of Princesse de Lambelle, the maid of honor to Marie Antoinette, was placed on a pike and paraded beneath the temple fortress where the royal family was held captive. Blame for these atrocities rested with no single man, but reputation placed the crimes at the feet of Marat.

Marat’s newspaper—its appeal to the poor commoners

Marat’s influence began simply. In early September 1789, he initiated publication of a newspaper that became his signature in Paris, L’Ami du Peuple. It was here, among the common soldiers of the French Revolution, that he finally found the acceptance he sought. The paper was controversial from its first issue, marrying philosophical and political doctrine with violence, suspicion, and conspiracy. Marat openly denounced France’s most prominent men as traitors based on presumption:

In order to judge men, you always need proof positive, clear, and precise. For me, their inaction or their silence on great occasions is sufficient. In order to believe in a conspiracy, you demand judicial evidence; for me, it is enough to see the general course of events, the relationships between enemies of liberty, the comings and goings of certain agents of power.

Not surprisingly, Marat found himself with few political allies. Attempts were made to weaken his influence by the circulation of false L’Ami with exaggerated diatribes and bloodthirsty language. Ironically, Marat attacked these spurious writings as being too tame to be his own.

Cut off the thumbs of the aristocrats who conspire against you, split the tongues of the priests who have preached servitude.

To secure the public tranquility two hundred thousand heads should be cut off.

This rhetoric did not go unnoticed, and Marat fled to London. His subsequent return to Paris found four journals in circulation claiming to be his L’Ami. Undeterred, Marat wrote “I warn honest men not to play with the ‘People’s Friend,’ any more, as he is never likely to be their dupe.”

Marat’s blistering, pruritic, painful skin disease—what was it?

I saw him at one time address himself to Louvet; and, in doing so, he attempted to lay his hand on Louvet’s shoulder, who instantly started back with looks of aversion, as one would do from the touch of a noxious reptile, exclaiming, “Ne me touchez pas!” (“Don’t touch me!”)

—John Moore

Marat’s journalism was a clandestine affair. Though he was well known throughout France, the location of his publishing house changed often and was kept secret from his political enemies. Several times he was forced to abandon his publication for fear of arrest. He
once reportedly avoided capture by hiding in the famously filthy sewers of Paris, an event recorded in Victor Hugo's *Les Miserables* as Jean Valjean's "descen[t] into the sewer is to enter the grave . . . in which we find vestiges of all the cataclysms from the shell-fish of the deluge down to the rag of Marat." Speculators have often assumed an infectious etiology, the result of his escape through the sewers. Marat, however, first noted the skin condition in 1788, two years before his flight. Others argue that this event never occurred and that Marat simply hid in the attic of his friend. Thus, while his experience with the miasmas of Paris might have aggravated his condition, it cannot be assumed that the primary etiology was infectious.

In an attempt to alienate him from mounting public support, Marat's opponents claimed he suffered from either leprosy or syphilis. These diagnoses are, however, inconsistent with his symptoms. The lesions of leprosy are patches of diminished sensation accompanied by peripheral neuropathies. Furthermore, while little is known about the epidemiology of leprosy during this period, an examination of some five thousand skulls in Paris's eighteenth-century catacombs, France's largest mass grave at the time, reported no skulls with lepromatous bony changes. This finding suggests that the prevalence was sufficiently low to consider the diagnosis rare. Little in this description suggests secondary syphilis, either, which classically presents as a transient, nonpruritic rash, involving the palms and soles.

Several historians have assumed he suffered from scabies. Indeed scabies does itch. This, however, was one of the few infections for which accurate diagnosis and treatment was available at the time, and it is unlikely that Marat, a physician, would have allowed that disease to progress.

Psoriasis and seborrheic dermatitis have been the most consistently offered diagnoses. While certainly not the classic presentation of either, both are known to affect the groin. At least one investigator offers the diagnosis of dermatitis herpetiformis, a cutaneous manifestation of gluten-sensitive enteropathy. The role of bread in revolutionary France bears mentioning, as the rising cost of grain was, in many ways, the inciting event of the peasant uprising. History remembers, perhaps incorrectly, Marie Antoinette's infamous response to the lack of bread with the famous reply, "Let them eat cake."

The diagnosis of hidradenitis suppurativa (HS) neatly accounts for Marat's symptoms and should be added to the possible differential diagnoses. HS is an occlusive disease of the follicles classically located in the groin and axilla. In males, it commonly arises during early adulthood, and pruritus may be an early symptom. HS has a highly variable course, but abscess formation and draining sinus tracts are the norm. The lesions are often secondarily infected. If untreated, the disease can become quite debilitating, and patients may find themselves unable to walk or sit comfortably.

A complex psychiatric illness that fueled Marat's revolutionary fervor

Some argue that investigation should focus on Marat's psychiatric state. Dermatological manifestations of psychiatric disturbances are well documented. Moreover, psychiatric medications have been used in the treatment of dermatosis resistant to conventional treatment. Often, an inciting event leads to repetitive scratching and, later, excoriations and infection. These pruritic areas are generally located on accessible areas such as forearms, face, and back.

Although Marat was regarded as insane, few attempts have been made to diagnose the psychiatric disturbance of a man who loved "carnage like a vulture." Marat's grandiosity and sleep disturbance suggest a manic state and there appears to be an element of psychomotor agitation:

In speaking in society he always appeared much agitated, and almost invariably ended the expression of a sentiment by a movement of his foot, which he thrust rapidly forward, stamping with it at the same time on the ground, and then rising on tiptoe.

Though Marat was known to spend much time confined to his house, no specific periods of depression are recorded. Ironically, he was among the first proponents of electroconvulsive therapy for treatment of a host of conditions ranging from edema to eczema, and lead poisoning to paralysis. His preference for solitude also typifies the diagnosis of schizophrenia, most likely paranoid type. Supporting such a conclusion is Marat's well-documented disheveled appearance. One historian considered the man "a Caesar draped in rags." We have, however, no clear evidence of hallucinations or severe thought disturbance. A diagnosis of delusional disorder best accounts for his supposed persecution, as Marat's thoughts reflect a fixed false belief in the absence of frank psychosis. Marat also displays several traits of the cluster A personality disorders, and a diagnosis of paranoid personality disorder is most appropriate.

Hated by many, a set up for assassination—Charlotte Corday, come forth!
The name of Marat dishonors your race. He was a ferocious beast, who was about to devour the remains of France by the fire of civil war.

—Charlotte Corday at trial

As his skin condition worsened, Marat continued writing at a furious pace. He published a second journal, *Junius François*, in addition to numerous pamphlets. In 1792 he was elected as the people's representative to the National Convention, the first legislative body of the newly formed Republic of France. He quickly learned that his friends were few as he addressed the Convention after his election: “'In this Assembly I have a large number of Personal Enemies.'” The assembly cried back “'All of us, all of us!'”

As his status increased, so too did his denunciations. They seemed almost random, and his most consistent position was hypervigilance. Though Marat seemed to hate any man in a position of prominence, his ire was most consistently aimed at those in the Gironndin party, the ruling majority in the National Convention. They had initially enjoyed the backing of the people, but in the mood of the times, today’s radicals were tomorrow’s moderates. The Girondins had exhausted their support on a failed war against Prussia and the party's reluctance to bring Louis XVI to trial. Inspired by Marat, the commoners of Paris had no such reservations, and their voices would not be denied—Louis was guillotined in 1793. In an effort to silence Marat, the Gironndin-led Tribunal arrested him on the charge of inciting to rebellion. After his acquittal, he led the Convention to overthrow the Gironndin leadership, in favor of the more radical Jacobin rule. It was a period of soaring rhetoric and rule by an iron fist, but the Jacobins held the promise of economic stability. The Girondins fled death, and many sought refuge in the northern city of Caen.

Marat’s medical condition kept him confined to his baths but did not prevent him from working on a small table improvised from an upturned wooden box. On the twelfth of July, 1793, the painter Jacques-Louis David visited Marat beside his tub to wish him a rapid recovery. He admired Marat, even if he did not fully understand him, and he held that the only true martyrs were revolutionary ones. Unknowingly, he was about to get his most famous subject.

The next day a young woman claiming to be from Caen appeared at 30 Rue des Cordeliers and sought an audience with Marat. He refused her on two occasions but relented when she returned a few hours later, claiming to be in possession of the names of Girondin sympathizers. The woman was Charlotte Corday, a passionate admirer of the Gironndin party and, though she had traveled from Caen, she had not come to betray her fellow patriots. When she began to recount to him the names of the traitors, Marat replied, “'Good, in a few days I will have them all guillotined!'”

In an instant she leaned over the man, pulled a knife out from the top of her dress, and plunged it down hard into the Marat’s right chest. The knife pierced “between the first and second rib, traversing the upper part of the right lung as well as the aorta, and going into the left clavicle.” He called for help but any aid was in vain.

Corday did not attempt escape. Expecting her arrest, she carried her certificate of baptism and a letter to the nation of France explaining her actions. At trial she calmly defended her actions, “I knew he was perverting France. I killed one man to save a hundred thousand.”

Four days later she was guillotined. Immediately upon decapitation, one of the executioner’s assistants—a man hired for the day named Legros—is said to have lifted her head from the basket and slapped it on the cheek.

The responsibility of vengeance fell to Jacques-Louis David, rightly regarded as the greatest neoclassical painter in France. A Jacobin member of the National Convention, David had voted for the death of the king, an odd career move since Louis XVI had commissioned his most famous work to date *The Oath of the Horatii*. The work had earned him a reputation for capturing the revolutionary spirit, and his depiction of *The Death of Marat* is a lesson in propaganda.

David sought to portray Marat as a revolutionary martyr, painting him in a pose much like that of Christ in Michelangelo’s *Pieta* and Caravaggio’s *Deposition of the Cross*. So striking was this similarity that the work would later be known as “David’s Pieta.” The wound in Marat’s side and the linen clothes are clear references to Christ, as is the simple wooden desk which recollects the cross.

Marat himself is idealized in the painting. His skin is fair. He appears peaceful, perhaps even smiling. The instrument of
Marat's terror
death lies harmlessly on the floor. The simple composition and subtle color forces the viewer to pity the man. The neutral space above the scene is too conspicuous to be incidental. Occupying nearly half the canvas, the space leaves the viewer feeling somber and oppressed. In his left hand, Marat holds the treasonous letter with which Corday gained her meeting; in his right, the pen with which he was to record the names of the traitors. On his desk lies an assignat, a banknote issued by the revolutionary government and Marat’s instructions for it to be given to a widow with five children whose husband had died for the revolutionary cause.

Marat has largely been overshadowed by other infamous names of the French Revolution, among them Marie Antoinette, Danton, and Robespierre. The man who brought an end to the Revolution, Napoleon Bonaparte, captured the period best: “Vanity made the French Revolution; liberty was only the pretext.”17

Jean-Paul Marat was no exception. Violent, unstable, and loud, his life typified the times. He was insane, and all of France with him. His uncompromising opposition to the throne made him both a hero and a villain. Perhaps what endeared Marat to ordinary men and women of France was that he truly wrote as a friend of the people, elevating Parisian concerns above the rancor of public debate and power plays. Marat summarized his own legacy in an address to the National Convention:

My ideas, however revolting they might appear, tended only to the public good, for no person was ever more fond than myself of order, and the reign of just laws. If your ideas are not sufficiently elevated to enable you to understand me, the worse for you.18p39

In April 1941 Adolf Hitler issued a declaration that he intended to celebrate the New Year in the palace of the tsar in Leningrad, Russia. Thus began a bloody 900-day siege on the city, which ended with the death of more than one and a half million Soviet citizens. The port of Leningrad was defended by the Russian battleship Marat. Originally named the Petropavlovsk, the ship was renamed during the Russian revolution. In the battle, German Stutka pilots sank Marat. The vessel lay wounded in shallow water while retaining many of her guns. In the years that followed, the ship sustained the most brutal siege in the war but continued to serve as an all-important Russian battery to withstand the German assault. Mortally wounded, the Marat refused to be silenced and defended the homes of those left in Leningrad from the fear of Nazi oppression. Like its namesake, the battleship continued to spew venom from a tub.

Acknowledgment
This paper would not have been possible without the guidance of Dr. J. David Woodard, professor of Modern and Classical Political Thought and the Strom Thurmond Chair of Political Science at Clemson University. Dr. Woodard’s insight into the French Revolution was as invaluable as his assistance in editing this paper.

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Marat’s terror

Charlotte Corday being led to the guillotine. © Bettmann/CORBIS.

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Improving the Conditions of Confinement

End-of-life care in prison

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Prison populations throughout the United States are growing rapidly: in the 1990s, they increased an average of 6.5 percent per year. With an estimated seven million people in the correctional system, prisons have become some of the largest health care providers in the nation. The need for quality end-of-life care has become more apparent as the number of older inmates and those suffering from chronic illness has increased; there are, however, several unique barriers to providing such care to an incarcerated population.

While inmates are guaranteed a basic level of health care under the Eighth Amendment and Due Process Clause, they have restricted access to information, limited mobility, and little freedom to choose their health care coverage. They are dependent on an institutional system for health care needs, and timely access to treatment can be difficult to obtain given restrictions on inmate and staff movement. Furthermore, adequate health care facilities, equipment, and personnel may be difficult to find in some jurisdictions.

In addition to the practical, institutional, and legal barriers to providing and improving end-of-life care for prisoners, efforts to develop hospice and palliative care services for the incarcerated may lack public support. While courts have generally confirmed that incarceration itself, not substandard health care, is the intended punishment for criminal acts, and the National Commission on Correctional Health Care has published clinical guidelines adapted from the recommendations of the National Hospice and Palliative Care Organization and advocates for high quality care, there is little published literature describing public attitudes toward inmates and the health care provided to them. Anecdotal evidence suggests that end-of-life care for terminally-ill prisoners is a low priority for most. One 1997 survey evaluated the attitudes of correctional nurses toward their inmate-patients, and found that they maintain negative attitudes in spite of their professional duty to provide care and irrespective of patient background and status. Societal and professional inattention, indifference, and negativity thus apparently remain significant obstacles to providing adequate palliative care to prisoners.

The penitentiary—designed to correct moral deficiencies

Before the invention of the penitentiary in Europe and the United States around the turn of the nineteenth century, criminal offenders in the Western world were punished swiftly and physically. The pain and the public humiliation endured were often brutal, but few offenders were held for extended periods; those imprisoned for any length of time were usually hostages held for ransom or political purposes. Other punishments included torture, execution, disfigurement and release, or banishment.

With the advent of the penitentiary, punishment of
offenders assumed a higher purpose: rehabilitation. Religious instruction during extended periods of incarceration, reinforced through manual labor and enforced by threat of punishment, was expected to correct the supposed moral deficiencies of the convicted offender and to rehabilitate him for re-entry into the community. The penitentiary was also thought to protect the public from the threat of dangerous persons and to deter prisoners from re-offending.

Imprisonment today purports to serve a variety of purposes: to punish, to protect the public from dangerous individuals, to deter criminals from re-offending, to control ordinary members of society, and to reform or rehabilitate criminals for re-entry into the community. The broad range of aims impedes the development of a prison medical service. Medical professionals are generally unable to identify clearly with or contribute toward prisons’ custodial, rehabilitative, or punitive goals. The imperatives of the medical profession—to treat illness, manage chronic conditions, alleviate pain or discomfort, and prevent death—are not directly compatible with the primary functions of prisons, and may in fact be disruptive to their operation. Medical concerns must be subordinated to the greater concerns of the physical restraint of the prisoner and the security of prison staff; thus the ability of health professionals to serve their patients is hindered. For a variety of reasons, including the challenges of working with the prison population, the location of penitentiaries in remote communities, relatively poor remuneration, and the apparent tension between the goals of the penal system and those of the medical profession, prison medical services may have great difficulty recruiting and retaining quality personnel.

Until the 1970s, most jails and prisons in the United States offered little or no medical care, and any care delivered was poor compared to that in the general community. Many within the penal system considered attention to health needs a privilege that could be given or withheld depending on an inmate’s behavior rather than a basic right of confinement to which all prisoners were entitled.

The courts generally left administrative decisions regarding the care and treatment of inmates to prison officials. With the exception of the Eighth Amendment’s prohibition of “cruel and unusual punishment,” nothing in the Constitution applies directly to the protection of prisoners while in the custody of the state. The “hands-off doctrine” established in the 1866 case of Pervear v. Massachusetts permitted states to operate their prison systems as they saw fit.

The Attica prison riot in September 1971 catalyzed the prison reform movement. Inmates at Attica, a facility designed to house 1,200 prisoners but holding more than twice that number, erupted into violence on the morning of September 9, taking more than forty people hostage to protest officer brutality and a lack of basic services such as sanitation, nutritious food, and adequate health care. The prisoners’ demands for federal takeover of the prison, better conditions, amnesty for crimes committed during the revolt, and the removal of the prison’s superintendent were made public in a statement criticizing the “unmitigated oppression wrought by the racist administrative network of this prison” and the “ruthless brutalization and disregard for the lives of the prisoners here and throughout the United States.” After negotiations failed, New York Governor Nelson Rockefeller ordered the Commissioner of Correctional Services, Russell Oswald, to take the prison

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*The American Medical Association (AMA) explicitly forbids physicians from participating in legally authorized executions, including the selection of injection sites for execution by lethal injection, starting intravenous lines, prescribing, administering, or supervising the use of lethal drugs, monitoring vital signs (on-site or remotely), and declaring death. For a detailed discussion, see reference 8.
back by force. In the end, thirty-nine people (ten hostages and twenty-nine inmates) were killed and many more wounded by gunfire from state troopers and prison guards.

In the aftermath, federal courts began to overcome their reluctance to intervene in matters of prison administration, issuing a number of rulings affirming inmates’ rights to certain basic needs. The case that marked the beginning of the reversal of the hands-off doctrine with respect to inmates’ rights to adequate health care was *Newman v. Alabama*. In October 1972, a federal district court found Alabama’s entire state correctional system to be in violation of inmates’ constitutional right to be free of cruel and unusual punishment by failing to provide them with adequate and sufficient medical care:

If the State furnishes its prisoners with reasonably adequate food, clothing, shelter, sanitation, medical care, and personal safety, so as to avoid the imposition of cruel and unusual punishment, that ends its obligations under Amendment Eight.\(^{11}\)

**The legal imperative (1972) to provide inmates with good medical care**

While *Newman* is frequently cited in support of the argument that inmates have no right to rehabilitation or educational programs beyond simply providing access, the case recognized at least a legal imperative to provide appropriate health care to prisoners. It established the right to basic medical care and recognized conditions it deemed constitutionally impermissible, including the use of unlicensed caregivers and instances of neglect and abuse. The 1976 landmark case *Estelle v. Gamble* established the “deliberate indifference” standard with respect to intentional delays of access to medical care and treatment:

> deliberate indifference to serious medical needs of prisoners constitutes the “unnecessary and wanton infliction of pain” ... proscribed by the Eighth Amendment. This is true whether the indifference is manifested by prison doctors in their response to the prisoner’s needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed.\(^{2}\)

The judicial activism of the 1970s was accompanied by social activism by professional organizations including the American Bar Association (ABA) and the American Medical Association (AMA). The ABA worked to clarify inmate rights and improve conditions of confinement, while the AMA developed a set of standards to govern health care delivery within the penal system and a voluntary accreditation system. The AMA’s “Jail Project” evolved into the National Commission on Correctional Health Care (NCCHC), which, along with the American Correctional Association (ACA) and the Joint Commission on Accreditation of Health Care Organizations, offers accreditation of correctional health systems. The ACA’s Task Force on Health Care in Corrections mandates that the health services provided within prisons “reflect contemporary standards for health care.”\(^{3}\) Similarly, the National Commission on Institutions and Alternatives stipulates that prison health care systems provide a standard of care equivalent to that generally available in the community in which the penitentiary is located, while recognizing that the health needs of prisoners may be distinct from those of the general population. However, end-of-life care has not yet been specifically addressed by the ACA or the other committees issuing guidelines for the provision of health care within the penal system.

**First day of incarceration—thorough medical screening**

All but the smallest jails and prisons have some type of health care delivery system in place, the range and quality of services varying widely depending on the jurisdiction. Most inmates enter the penal system through a county jail, where they may receive a health screening at the time of intake, a more thorough physical exam in the following days, and have their acute health needs addressed.

Following transfer to a state prison system, inmates enter...
Improving the conditions of confinement

a reception and diagnostic facility where within a few hours of admission they are interviewed about their medical history and current health needs, receive screening for tuberculosis, mental illness, mental retardation, and substance abuse, and follow-up treatment is scheduled. Within the first two weeks of detainment, inmates receive a more detailed routine health appraisal, including an extensive health history, vital signs, routine laboratory testing for communicable diseases, and a physical exam performed by a physician or other midlevel practitioner.

Basic ambulatory health services are generally available on-site, and most prisons have arrangements with another prison in the system or community health care providers for diagnostic and/or specialty services. Inpatient care for the acutely mentally ill usually occurs in a specially designated prison within the state system or in a state-operated mental hospital in the community. With the exception of the Federal Bureau of Prisons and a few of the larger state systems, few prisons operate their own acute care hospitals; arrangements for acute care are generally made with the nearest community hospital. Nearly all prison systems have at least one facility that provides diagnostic and/or specialty care that may not be available in most prisons. Palliative and hospice care, when available, is often delivered in such regional medical facilities.

Access and quality of prison health care—great variability

It is difficult to generalize about the quality of health care in prisons, as some systems may provide better care than others. When there is a disparity of care in population subgroups of the community—as may be the case in many communities in the United States—the aim of equality of care may be complicated by the question of the choice of reference.13 Prison administrators and health care professionals may interpret the “adequate minimum standard” of health care in a variety of ways such that the quality of health care differs widely among institutions.

Access to care also varies among prison systems. Minimum security institutions may have walk-in clinics, while most other prisons use some type of written request service, such as a sign-up sheet in the cell block or a written “sick-call” form. While for many imprisonment represents the first time in an inmate’s life he or she has had consistent access to health care, prison security remains of paramount importance and may hinder prompt medical attention. Additionally, a disproportionately high number of inmates have limited literacy skills, which may make it difficult for them to fill out request forms, resulting in delays, misunderstanding, frustration, and poorer health outcomes.

Inmate access to the Internet is severely restricted. Prisoners’ autonomy may also be affected by more subtle forms of constraint, as an inmate’s physical health can be a factor in the duration or the conditions of confinement. A prisoner may, for example, consent to a surgical procedure to gain time in the hospital or infirmary and away from the cell block, or accept an anti-androgen or anti-psychotic medication in the hope of qualifying for parole. While physicians customarily take nonmedical factors into consideration in assessing a patient’s competence to grant informed consent, those in correctional institutions should not participate in such subtle constraints on the patient’s already limited autonomy.

Death in prison—linked to graying of prisoners

The U.S. Justice Department’s Bureau of Justice Statistics reports that 12,129 inmates died while in custody from 2001 through 2004, an annual mortality rate of 250 deaths per 100,000 inmates. Eighty-nine percent of all inmate deaths were attributed to medical conditions, eight percent were due to suicide or homicide, and the remainder were attributed to alcohol or drug intoxication or accidental injury. Half of all inmate deaths resulted from heart disease (twenty-seven percent) or cancer (twenty-three percent); liver diseases, including cirrhosis, accounted for more than ten percent of inmate deaths, followed by AIDS-related causes (seven percent).14

The trend towards longer sentences, limits on judicial discretion in sentencing and releases, the proliferation of “three strikes and you’re out” laws, determinate sentences, and mandatory minimums have all contributed towards the “graying” of prison populations. Prisoners also tend to be physiologically older than their years imply, as low socioeconomic status, prior lack of access to medical and dental care, chronic addictions, and the trauma of extended incarceration may create as much as a ten-year aging differential.15 Despite lower arrest rates among the elderly, the number of inmates aged fifty-five and older increased from approximately forty thousand in 2001 to more than eighty thousand in 2006. Many of these prisoners suffer from multiple medical problems, including kidney failure, diabetes, cancer, heart disease, dementia, and other degenerative diseases common among geriatric patients and in long-term care facilities. Older inmates may also be vulnerable to predatory abuse and find it difficult to mix with younger inmates.

The administrative obstacles to effecting compassionate release
Many Departments of Corrections (DOCs) have some mechanism for compassionate release to permit a terminally-ill inmate, whose condition is found to preclude his or her posing a threat to society, to die at home or in a noncorrectional facility. In general, the prisoner or an advocate (in some cases, the prisoner’s physician) submits a request for release, then the physician works with the DOC, the district attorney, and a judge to document the medical case and to argue for medical parole. In practice, however, the eligibility criteria in some jurisdictions are so restrictive or the bureaucratic process is so protracted that it is seldom successfully used. The vast majority of prisoners requesting release die before the process is completed. One commentator notes,

The mechanisms for compassionate release of terminally ill prisoners now operating in the United States are many and varied. These mechanisms share some common features, and they certainly exist with a common purpose. It is unfortunate, therefore, that many of the compassionate release programs are inefficient in accomplishing these laudable humanitarian goals. It is of even greater concern that some jurisdictions and the federal system are essentially devoid of compassionate release mechanisms. The creation of systems that operate expeditiously and fairly is essential for success in the endeavor to extend humanitarian assistance even to those we have imprisoned.16p153

The difficulty of navigating these programs leads to lack of use. Steps to improve use could include early identification of potential candidates, creation of a mechanism for family members to request consideration, appointment of an advocate for each applicant, and an appeal procedure for prisoners and their families. It is important to note, however, that not all inmates have friends or family members, and not all friends or family members are willing or able to assume the responsibility of caring for the terminally-ill inmate after release. However, once paroled, an inmate is eligible for Medicare or Medicaid on the same basis as the general population, and patient advocates could help to ensure continuity of insurance coverage and facilitate transfer to a long-term care institution if no one can assume responsibility for care.

Obstacles to the effective implementation of prison hospice programs include institutional policies that frequently limit physicians’ power to prescribe narcotics to prisoners, specify limits on family visitation, and prohibit visits from other inmates when a patient is in the infirmary. While inmate “nurses” were once common in prison infirmaries, ACA guidelines state that inmates may not provide “direct patient care” to other inmates.17 While this may be variously interpreted, institutional policies often prohibit inmates from serving as volunteers or workers in any caregiving capacity. Prison hospice programs thus have difficulty finding, training, and employing hospice volunteers, and are hemmed by restrictions on inmate and staff movement, limited access to urgent care facilities, and limited patient autonomy, with DOC policies sometimes restricting the use of do-not-resuscitate orders and advance medical directives. Furthermore, prison administrators and correctional officers concerned with liability issues may be apprehensive about permitting inmates to die in their facilities, while inmates, who may distrust the administration and the health care delivery system, may be concerned that they are being coerced to accept “comfort care” in lieu of more costly treatment.

Fortunately, palliative care and hospice programs are becoming more common in prison systems: the most recent U.S.-Canadian survey data available, for 2001, shows that hospice programs existed in twenty-five of the forty-nine jurisdictions surveyed. Twenty-two prison systems operate hospice programs as part of the services offered in their infirmaries; five are freestanding hospice units. Prison systems are free to determine which palliative services will be provided and how, as long as they abide by the judicial rubric of compatibility with the community standard of care.
Proposals to improve end-of-life care and expand hospice programs for prisoners are typically met with little enthusiasm from members of the general public, who may be deeply ambivalent about supporting such programs when to them it seems criminal offenders are hardly the most deserving of scarce health care resources. The perception that offenders do not deserve special health care services persists, particularly when persons in the general population do not have access to similar levels of health care. Dubler notes,

It would be difficult, if not impossible, for any one correctional facility, acting on its own initiative, to implement the number and quality of changes needed for humane care. If end-of-life care is offered in the facility, public perception and legislative oversight are likely to charge "coddling," and if prisoners are given compassionate release, these same critics are likely to decry a “danger to the public.” The disregard for well-being that has led many systems to end education programs (the only intervention correlated with decreased recidivism rates) is unlikely to risk disapprobation of government and populace.15p154–55

Arguments for improvement in conditions of confinement often begin with a consideration of the value of a person. In our society, many believe that we are to treat others as we wish to be treated, and that treatment is not contingent—at least theoretically—on a person’s social status, economic worth, criminal record, or other subjective criteria. A person’s value is based on something innate, some particular characteristic of human beings, such that a person matters as an end in and of himself. Respect for the notion of human dignity may entail acting on an individual’s behalf even when we do not believe that such an individual deserves the benefit of our actions. Indeed, codes of professional ethics charge physicians and other health care providers with delivering care to all in need, regardless of ethnicity, gender, ability to pay, social status, or other arbitrary measures such as personal merit, contribution and/or harm to society, and socioeconomic worth.

In addition to the ethical imperative to provide adequate health care to criminal offenders, there exists a legal imperative to do so as well. By virtue of incarceration, the state interferes with the ability of the inmate to provide for certain of his or her basic needs and is therefore obliged to provide for them. The U.S. Supreme Court elaborated on the State’s obligation toward its wards in its 1989 decision DeShaney v. Winnebago County Social Services Department:

when the State by the affirmative exercise of its power so restrains an individual’s liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs—e.g. food, clothing, shelter, medical care, and reasonable safety—it transgresses the substantive limits on state action set by the Eighth Amendment and the Due Process Clause. The affirmative duty to protect arises not from the State’s knowledge of the individual’s predicament or from its expressions of intent to help him, but from the limitation which it has imposed on his freedom to act of its own behalf.18

Prisoners are dependent upon the correctional system to provide them with the medical services they are unable to access independently as a consequence of their status.
In the years since Estelle, other cases have added substantive content to the requirement for adequate health care in prisons. Courts have developed requirements for the provision of psychiatric care, special medications or diets, inmate hospitalization, and qualified health care professionals. These rulings are reflected in the standards of responsible professional practice for correctional health services promulgated by the NCCHC and the ACA. End-of-life care has not yet been addressed specifically by the courts or any of the professional organizations responsible for prison health care services accreditation. While community health care standards apply to hospice and palliative care in prisons as they do to other types of medical care, there are significant disparities in access to and quality of end-of-life care in the general community as well, which may make it difficult to develop and implement hospice programs in the correctional setting.

The editorial board of The Lancet notes:

There is little popular support for most programs to improve the conditions of confinement for our nation’s prisoners, particularly when the public perceives that its tax dollars are supporting services for inmates that many in the community lack.

The health care needs of the burgeoning older inmate population present an occasion to discuss the barriers to improving access to and the quality of care at the end of life. Society has an ethical imperative to provide proper end-of-life care. Inmates, no less than other persons, should have access to appropriate diagnostic and treatment interventions. Regular evaluation of correctional health care services by a mandatory national quality assurance program may be the first step in ensuring that prison health care services are consistent with community health standards. State legislatures and the Federal Bureau of Prisons must develop rational and effective criteria for compassionate release programs with adequate medical discharge planning so that inmates will not have to die in prison.

Palliative and hospice care should be provided in prisons for those ineligible for medical parole. This may require a number of interventions, including educating correctional and medical personnel to regard terminally-ill inmates as patients approaching the end of life rather than as individuals for whom suffering and dying are appropriate punishments, adequately stocking prison infirmaries and drug formularies to provide appropriate analgesia, relaxing institutional visiting rules to allow dying inmates more visits from friends, family members, and social support services, and revising informed consent standards and restrictions on the use of do-not-resuscitate orders and other advance directives.

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There have been many campaigns for lifestyle changes that lead to better health. Examples include the “5 A Day” campaign to increase fruit and vegetable intake, the “VERB” campaign to increase physical activity, and the “truth” campaign for smoking cessation. Such changes demonstrably decrease the risk of chronic diseases such as cardiovascular disease, diabetes, obesity, and some cancers. Health care providers therefore aggressively encourage patients to make these changes in their own lifestyles, but any noncompliance with these recommendations is often attributed to apathy. Although patient motivation is important, the ability to comply with these recommendations is also limited by access to the means to fulfill them.¹ All patients do not have equal access to the basic requirements for healthy living; the resources available in the immediate environment dictate a person’s potential for health. Minorities and the urban poor have a disadvantage in their pursuit of health. Many studies show that low-income and predominantly minority neighborhoods are less likely to have grocery stores that sell high-quality foods, and are less likely to have safe places for exercise.¹⁻⁸ These neighborhoods also have more fast food outlets and liquor stores, as well as more advertising for soda, candy, tobacco products, and alcohol than do wealthier neighborhoods.²,⁴,⁵,⁹⁻¹¹ Minorities and the poor also seem to have worsening health, particularly of chronic “lifestyle” diseases.¹⁻⁵,¹¹⁻¹³ Thus, a major contributor to differences in health among income groups may be the inequities in the local environment, particularly the food environment.

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Good reviews for the supermarket

Supermarkets that are part of regional or national chains have more high-quality foods, including more fruits, vegetables, and low-fat items, than nonchain supermarkets or smaller, independent grocers.\(^2\)\textsuperscript{3,4,7,12,14,15} Compliance with healthy diet recommendations seems to depend on the availability of markets offering wide selections of quality foods.\(^3,6,9,14\) Allen Cheadle and his coworkers found that increased selection of low-fat and high-fiber foods in local supermarkets was associated with healthier diets among those living nearby.\(^16\) Kimberly Morland and colleagues showed that people who live near supermarkets eat more fruit and vegetables and less fat.\(^9\)

The higher-quality foods offered by supermarkets are less likely to be available in low-income and predominantly minority neighborhoods because these neighborhoods have fewer chain supermarkets.\(^2\)\textsuperscript{5–7} A 2007 study shows that predominantly African American neighborhoods have about half the number of supermarkets that exist in those that are mostly white;\(^3\) while a 1999 study in the Minneapolis-St. Paul area found that eighty-nine percent of chain supermarkets were located in areas with poverty rates of less than ten percent.\(^7\) Low-income neighborhoods are also more likely to have smaller, independently-owned grocery stores and convenience stores that do not offer the same selection of healthy items that larger supermarkets do. A study published in 2006 showed that, while low-income neighborhoods have four times as many food outlets as do wealthier neighborhoods, including independent grocery stores and convenience stores, they have only half as many supermarkets, and fewer produce markets, bakeries, and other specialty markets.\(^5\)

Flight of the chains from poor urban areas

Supermarkets are now scarce in poor and minority neighborhoods, after deserting these areas in the 1960s and 1970s as they followed the middle-class population exodus to the suburbs.\(^13,17\) This was compounded in the 1980s by the increasing competition among supermarket chains, with subsequent buyouts and mergers leaving larger, but fewer, players.\(^1,17\) Supermarket chains found business easier in suburban locations, where there was more space for growth and less crime; urban areas were left with few stores of their own. As this trend progressed into the 1990s, it became known as “supermarket redlining,” mirroring the practices of the banking and insurance industries, which denied services or increased charges to minorities and the poor.\(^1\) Many factors, including higher land values, labor and utility costs, less available space for store expansion, low profit margins on perishable food items, and increased crime, are cited as reasons that supermarkets have stayed away from the inner cities.\(^1,17\) Many feel, however, that, as with other forms of redlining, the supermarket industry’s abandonment of the inner city is based on stereotypes.\(^1,17\) A 1992 Newsweek article quoted an executive of a Pittsburgh economic development group as saying that the perception that poor people “all rob and steal” hinders many chain supermarkets from pursuing opportunities in the inner city.\(^17\) Regardless of whether such assumptions are widespread, few supermarkets have moved back to the inner cities.\(^1,17\)

Supermarkets in poor and minority neighborhoods—even those that are part of a regional or national chain—may still be less likely to have healthy selections than their counterparts in predominantly white suburbs.\(^14\) Because supermarkets average less than one percent net profit on sales,\(^1,17\) they do not carry food items that are unlikely to sell well. It is often argued that store selection reflects consumer demand.\(^3,18\) Perhaps the residents of poor and minority communities are simply not as interested in fruits, vegetables, and low-fat items. Available studies evaluating store selection do not show whether supply is influenced by demand. Many studies show, however, that dietary choices—both good and bad—are influenced by supply.\(^5,6,9,14,16\) When more produce is available in a community, more fruit and vegetables are consumed.\(^5,14\) Alcohol use
follows a similar trend. Thus, grocers are in a position to change the eating habits of their local communities.

Economic necessity: underfunding food budgets

Residents of poor and predominantly minority neighborhoods not only have less healthy food available, they may also pay more for it. Supermarkets tend to have lower prices than local independent grocery stores and convenience stores, with savings ranging from two to forty-nine percent. In addition to more buying power, supermarkets also offer lower prices by selling more types of products, including cheaper store brand and generic items, as well as more economically sized items. The lack of supermarkets in poor and minority communities means that people there are less likely to benefit from such cost savings. Even in inner city neighborhoods that have supermarkets, smaller stores, higher operating costs, and limited competition lead to higher prices than exist in their suburban counterparts.

Because food is essential and the prices for staples are largely constant, it is no surprise that low-income households spend a significantly greater proportion of their income on food than do wealthier households. A 1992 United States Department of Agriculture study shows that the poorest twenty percent of the country (average income of $6,669) spent $1,249 per capita per year on food, compared to $1,997 for the wealthiest twenty percent (average income of $77,311). Nevertheless, concern exists about how much this cost disparity is influenced by the higher prices that low-income families face. While some argue that such studies are difficult to interpret due to differences in food choices among the two groups, many researchers have found that low-income households adapt to higher prices by replacing fruits, vegetables, and dairy products with meats and simple carbohydrates. Although poor families are likely to pay higher prices for comparable items, they also spend less per unit on food than wealthier families by buying more bargain items, store label and generic products, bulk items, and even lower quality food. Some researchers believe that food item selection does more to lower the cost of food than grocery store type and location do to raise food expenditures, but it is important to remember that cost plays a significant role in dietary choices. People eat what they can afford to eat. It may be possible to adjust the cost data for bargain, generic, and bulk item purchases, but it is much more difficult to assess sacrifices in quality. What is clear is that low-income families spend disproportionately more on comparable food and must make sacrifices to be able to buy what they need.

A proliferation of unhealthy food options

Poor and minority communities not only have fewer, yet more expensive, food options, they also are bombarded with poor nutritional alternatives, such as fast food restaurants, which are more widespread in poorer and minority neighborhoods. LaVonna Lewis and her colleagues found that 25.6 percent of restaurants in largely African American neighborhoods in South Los Angeles were fast food outlets, compared to 11 percent of restaurants in a comparison area of largely white neighborhoods. This study...
also found that restaurants in the black neighborhoods were more likely to promote unhealthy food options than restaurants in the white neighborhoods, which were more likely to advertise their healthy menu options, offer foods prepared by healthier methods (i.e., broiled instead of fried), and identify these healthy options on their menus and provide nutritional information.

**What can be done?**

Improving the health of a poor or minority community can be catalyzed by improving access to good food, a project that should be a community effort. Food availability studies provide the basic accessibility information, and community-based participatory research—defined as health promotion research that allows community members to be involved in decisions that affect them—is effective in building bonds between researchers and residents, which help efforts to force change. The collaboration of community groups, local governments, city planners, supermarket officials, and, perhaps, health professionals, in developing customized solutions is the best way to ensure success. Neighborhood organizations all over the nation have succeeded in getting better food in their communities:

- New Community Corporation, a nonprofit community development organization in Newark, New Jersey, worked to bring a supermarket back to Newark after a study it commissioned in 1980 showed that over ninety percent of residents of the Central Ward left the city to shop for groceries. The organization's founder, William J. Linder, began discussions with Supermarket General, the parent company of Pathmark, to bring the supermarket to his community. After ten years of planning, securing land, and obtaining financing, New Community, in a joint venture with Supermarket General, brought a 47,000-square foot Pathmark supermarket to the Central Ward. Not only has this venture allowed Central Ward residents to shop for better foods more conveniently, it also created jobs for local residents, while the joint venture has reinvested a portion of its revenue in other New Community programs.

  - In the 1980s and early 1990s, the city of Rochester, New York, experienced a huge decline in the number of its supermarkets. When the low-income community of Upper Falls lost its only grocery store, a community partnership called Partners for Food began to lobby for new supermarkets in the area. With widespread support, including from Rochester's mayor, the group negotiated with Buffalo-based chain Tops to bring four new stores to the city, including one to Upper Falls. The city contributed public money to the cause, allowing residents to purchase quality food items in their own neighborhoods again.

- In South Los Angeles, community group African Americans Building a Legacy of Health (AABLH) collaborates with faculty from local universities and the county health department to change the nutrition and exercise factors that lead to cardiovascular disease and diabetes. Working with the Community Health Councils, AABLH conducted a store shelf survey that led to a Neighborhood Food Watch (NFW). AABLH holds local grocers accountable to Standards of Quality, including providing top-quality fruit and vegetable selections, supplying fresh meat (including lean meat containing less than three grams of fat per ounce), and offering nonfat and low-fat dairy products. The organization also encourages community members to patronize only grocers who have signed the Standards of Quality agreement and display the NFW decal in their store window.

These examples show that neighborhoods, with the help of advocates in government, academia, health care, and other sectors, can work to bring healthier food back to their communities.

Poor and minority communities suffer from unequal access to the nutritious food options necessary for health. Health care professionals must understand this disparity. We must be willing to discuss food availability with our patients, and work with them to make changes in their communities.

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The author’s e-mail address is: muyibat.adelani@gmail.com.
Autumn’s darkness descends in this season of their lives.
My patients brace for winter—the chill of cancer snaps the night.
I observe in slow motion, these lives that cycle by,
And I am weathered by their struggle as they fight to stay alive.
After work I sometimes weep at the suffering I’ve seen,
Trapped somewhere between my weakness and the beauty of intimacy.
I ask myself each night, “Should I leave or should I stay?”
Knowing self-preservation begs us to look the other away.
But I take off my white coat, hold their hands and let them cry.
We talk of futures, passions, families—whatever wakes them up inside.
They’re so much stronger than they seem, these patients who inspire,
With vivacious human spirit adding kindle to the fire.
Together we warm up winter; hope’s ember sparks the night,
And I’m humbled by these lions, their courage and their might.
Promises of spring gently bear them through the cold,
As seeds of love are planted for what the future holds.
For her it’s walls of cards, all begging her to stay.
For him, walking laps helps push the pain away.
For her, it’s a quilt, sewn with a sister’s love.
For him, it’s peace in the spirit that’s above.
For her, she holds on to touch her baby’s hands.
For him, it’s pure stubbornness that makes him take a stand.
Green sprouts of love grow from roots that anchor lives,
Giving hope to those who live and peace for those who die.
We may use labs and research to calculate their chances,
Yet some defy the odds giving medicine its magic.
Books can only teach us the science of human art,
But experience will show you, hope sets patients apart.
I relish in these gifts, the observance of these lives,
And I take note of seeds that help my patients fight.

Leah Gilbert

Ms. Gilbert is a fourth-year medical student and candidate for a master’s of public health in Maternal and Child Health at the University of North Carolina at Chapel Hill. This poem won honorable mention in the 2008 Pharos Poetry Competition. Ms. Gilbert’s address is: 159 Springberry Lane, Chapel Hill, North Carolina 27517. E-mail: leah_gilbert@med.unc.edu.
Day in a Golden Year

NPR’s her friend
She still knows her grandchildren
But not her zip code

He toasts her bagel
Fries his eggs and checks their pills
Life post Katrina

Unfamiliar rooms
Both are depressed, yet muster
Smiles when visited

Yummy Nguyen

Mr. Nguyen is an ensign in the U.S. Navy and a first-year medical student at the Uniformed Services University of the Health Sciences in Bethesda, Maryland. This poem won an honorable mention in the 2008 Pharos Poetry Competition. Mr. Nguyen’s address is: 13303 Dovedale Way, Apartment M, Germantown, Maryland 20876. E-mail: yummydkny@yahoo.com.
Symmetry

Everywhere, I look for that perfect, lost shape—Dalí’s mustache, the Joker’s feline grin, the letter v, a streetlamp fountaining into two globes. A vase with winged arms, the caduceus’ twin snakes, an archer’s bow, the Libra scales, a crucified body.

The doctor says: One ovary is all you’ll need. Just wait. But my mother (fertile well past fifty—A good sign for you) brings a mirror to what I must sooner face, already on my body: a listing column of vertebrae, mismatched breasts, unpaired feet, a greener left eye.

Paula Brady

Ms. Brady is a first-year medical student at the Columbia University College of Physicians and Surgeons. This poem won second prize in the 2008 Pharos Poetry Competition. Ms. Brady’s address is: 66 Riverside Lane, Riverside, Connecticut 06878. E-mail: pcbl2112@cumc.columbia.edu.
My Eye Doctor

Today my ophthalmologist, who has been happily married to another woman for a decade, looked more deeply into my eyes than any of my lovers has ever looked. First, he oiled the keyhole of my eye until it grew so large that he could tumble right through it. He landed—plop!—in one of the trapdoored cellars of my face. Then, armed with candlestick

and with monocle, he scrutinized that chamber's contents until my retina burned more hotly than the proverbial virgin's blushing face. Laid bare for him to see were the diaphanous garments worn by my sylphlike blood, the trailing translucent gowns whose trains lay all tangled together in a nexus of scarlet threads. And he saw the alabaster cup and saucer from which I sipped Perception, and he approved their shape and size.—

Today, I said, my ophthalmologist looked in my eyes more deeply than any lover. But, unlike a lover, he looked in them one-by-one, just as a shrewd prison-guard would separate two prisoners whom he suspected of being in cahoots so that he could interrogate them more fruitfully. And if you'd asked him later that morning, after he'd stared into my eyes so long and hard, “Can you recall what color those eyes were, or what expression was in them?” he'd have been unable. His motivations were nobler than love, and much more stable.

Jenna Le

Ms. Le is a member of the Class of 2010 at Columbia University College of Physicians and Surgeons. This poem won first prize in the 2008 Pharos Poetry Competition. Ms. Le’s address is: 630 W. 168th Street, P&S Mailbox #418, New York, New York 10032. E-mail: jnl2105@columbia.edu.
She wouldn’t hear the words, yet
Rivers appeared on parched creeks,
Traversing the hills and valleys of her face,
Leaving behind a desert, more barren.

She shivered now, in the silence
Of his permanent absence,
Praying anxiously that he did not suffer,
That his last moments held some element of peace.

Her mind willed itself to Kashmir,
To the soaring Chinar trees
Beneath which they first faced each other,
Memorizing details while sipping juice.

Please consider, she vaguely heard
The doctor say, stepping back.
This compelled her thoughts back to the blank white room as
She considered, questioned and contemplated.

Does the essence of a tree
Remain when it is fallen?
If then, its leaves are shorn and branches severed?

Her eyes moved past the hallway.
Outside she saw the sidewalk
Glistening in the onerous summer sun
Beside the small patch of yellow yarrow.

From the mud grows the lotus;
From the ashes rises the grass;
From neat, sliced logs comes the warmth of the fire.

She turned to the doctor.
Yes, she said, I will.

Radhika Sreeraman

Ms. Sreeraman is a member of the Class of 2011 at the University of California, Davis, School of Medicine. This poem won third prize in the 2008 Pharos Poetry Competition. Ms. Sreeraman’s address is: 4601 V Street, Sacramento, California 95817. E-mail: radhika.sreeraman@ucdmc.ucdavis.edu.

Illustration by Laura Aitken