

ACESO

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About the Cover



The Things We Take With Us:

The cover picture depicts a homoeopathic medical kit, circa 1870. In 1874 the Massachusetts Homeopathic Hospital moved into a newly-built Talbot Building in Boston's South End. It later abandoned homeopathic practices, and in 1929 became part of Massachusetts Memorial Hospital. This was eventually merged into the Boston University Medical Center, now part of Boston Medical Center. The Talbot Building now houses the Boston University School of Public Health.

Note the vial of Digitalis in the top left. The drug is an inhibitor of sodium-potassium ATPase extracted from the foxglove plant. Digitalis has been used as a medication to treat congestive heart failure for hundreds of years.

In the past, a doctor's bag provided both the function of a repository of medication and tools, as well as a symbol of the office. In the modern practice of medicine the physician's bag has all but been eliminated from practical use and this symbol of the things carried into practice has disappeared. Yet the thing that each physician carries with them internally remains - their background, biases, experiences, education and more.

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Interested in getting involved with *Aceso*? We are actively looking for new Editors and Graphic Designers to join our staff. We are recruiting for this upcoming semester so spread the word!

Design Editors and graphic designers create the cover, layout the format, and manage the artwork of *Aceso*. This position requires either some art or design experience.

Editors take part in shaping the overall direction of *Aceso* and review the articles submitted by our writers. This position requires the staff member to have excellent writing and strong spelling skills.

If you are interested in applying for one of these positions, please email us at aceso@bu.edu and let us know what position you are applying for.



About Aceso

This journal is named for a Greek goddess Aceso, the daughter of Asclepius and sister of Panacea. Her name comes from the Greek word *akéomai*, which means "to heal." She represented the act of the healing process itself. Unlike the other gods, she personified medicine from the patient's side, a process that involved both the ill and the physician. Rather than a magic cure, personified by Panacea, Aceso was more involved in overall care and the realization that healthcare and well-being took time and the effort of an active process.

Letter from the Editor

The Things We Take With Us:

It is my pleasure to introduce the inaugural issue of *Aceso: Journal of the Boston University School of Medicine Historical Society*. I hope you enjoy this publication as much as the staff, editors, writers, and I had in assembling this journal. I feel obligated though to share a thought on why I felt this journal was necessary.

In a place devoted to the study of 'hard' science, it is not always easy to find interest in the humanities. We are more concerned with the practical, that which is immediately relevant. And we are not wrong to focus on such either. A tremendous amount of knowledge and skill must be transmitted in an efficient manner to train professionals who will be engaged in deadly serious endeavor. Furthermore, the system is designed to self-select for the serious student of physical and biological sciences. Yet, as I have been told time and again, medicine is not a science, it is an art. But what does that mean?

It is said that if you know your enemies and know yourself, you will not be imperiled in a hundred battles; if you do not know your enemies but do know yourself, you will win one and lose one; if you do not know your enemies nor yourself, you will be imperiled in every single battle.

~Sun Tzu

Simply put, science is the accumulation of knowledge, as of yet incomplete. Medicine is the

application of science to diagnose and treat disease. While science remains incomplete there is a demonstrated benefit to the treatment of disease using medicinal science. And while we know much, much also remains unknown. Mechanisms of action that remain elusive, interventions that work but are not perfectly understood, presentations that are obscure, variables that cannot be calculated, differentials that are incorrect, treatments that work for some have no or little effect on others – these complicate the practice of the art.

Thus medicine finds itself in the strange position where one is compelled to act using incomplete information and an imperfect understanding. As Sun Tzu would say, we know ourselves and our enemies' imperfectly and as a result the outcomes are not always guaranteed. What fills the gap in understanding is the physician, the person. What they bring with them to the table is more than just science; it is compassion, reason, emotion, experience, dedication, determination, and so much more that make us human. It is this reason that the humanities should not be neglected. As I make the case that the humanities have gained from science (A Medical History, pg 23), perhaps the science of medicine can also learn from humanities.

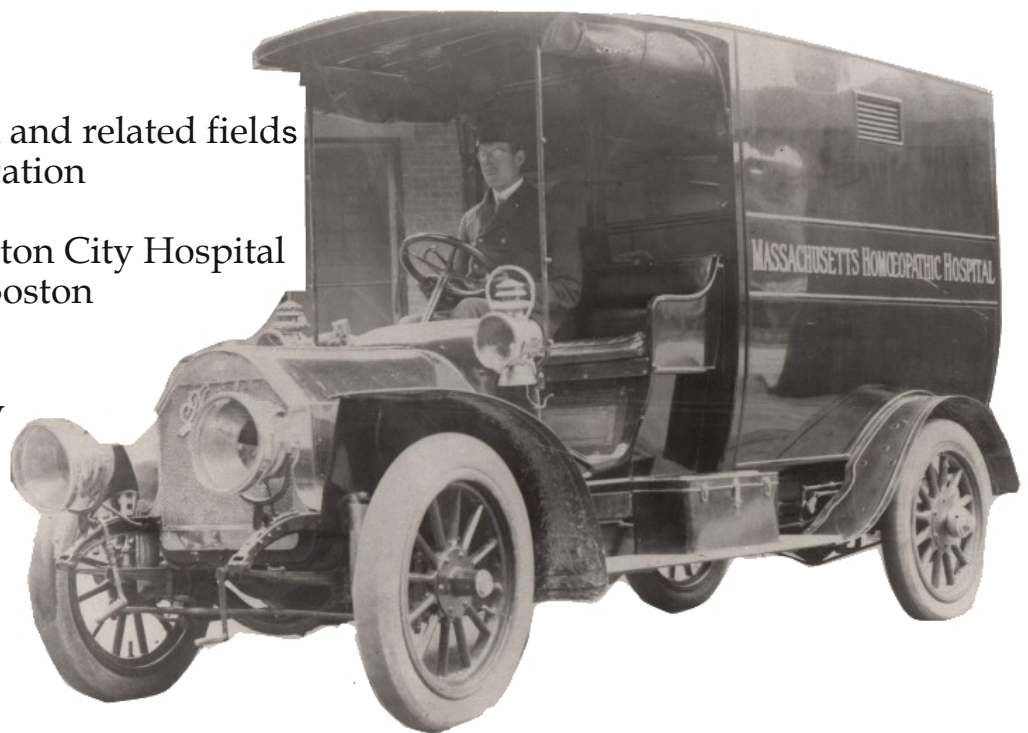
Michael H. Sherman
BUSM Class of 2015

ACESO SUBMISSIONS

Are you interested in History and Medicine?

Aceso: The Journal of the BUSM Historical Society is accepting submissions for next spring's issue. We are looking for contributions in the fields of:

- Medicine in Antiquity
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- History of BUSM
- History of BMC and Boston City Hospital
- History of Medicine in Boston
- Biographical Essays
- Ethics/Editorials
- General Medical History
- Book Reviews



If you have an interest in these topics or a suggestion for another topic and would like to write an article please contact us at: aceso@bu.edu

About the Art

Unless noted, pictures throughout this issue are from the archives of the Alumni Medical Library of Boston University School of Medicine. Special thanks to A'Llyn Ettien for allowing us to access the archives.



Modern Medicine

The Hapsburgs in the Time of Cholera:

The 1873 World's Fair in Vienna

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Historians often ascribe the course of human events to the giants of history, huge personalities like Napoleon, Alexander the Great, and Ghengis Khan. However, history's smallest players – microbes – have had a hand in some of the largest events. From the Plague of Athens to the Black Death to the Spanish Flu, viruses and bacteria have often driven human history. Cholera could also be added to that list, as it had a role in bringing down one of nineteenth century Europe's largest empires.

The Hapsburg Empire experienced a period of slow decline in the late nineteenth century. A Hungarian revolt in 1848, a lost war against Sardinia and France in 1859, and a crushing defeat by Prussia in 1866 were all low points. After defeat in the Austro-Prussian War in 1866 and facing another Hungarian uprising, Austria was forced to accept Hungary on equal footing and formed the Austro-Hungarian Empire in 1867. While many wonder at and study how the Roman Empire could have fallen, Austria-Hungary's "existence into the twentieth century

amazed external observers." [1]

A bright point on the empire's horizon was the 1873 World's Fair, or *Weltausstellung*, which was to be held in Vienna. At that time, the great cities of London and Paris were the only other cities that had held expos, [2] so it was an honor for the capitol of the declining empire to be held in such company. The fair was also a chance for Austria-Hungary to prove that it was still a relevant power, a chance for the empire to show off what it could still do. Emperor Franz Joseph himself, in a speech given on November 5, 1873 at a ceremony for the World's Fair, gave the fair credit for "[raising] the standing and position of the monarchy amongst the league of nations." [3] An uncited *New York Times* correspondent wrote that visitors to the city would "be surprised at its altered look, magnitude, and magnificence," and that "the Viennese [have] disencumbered themselves of former cittyish [sic] and narrow notions and habits." [4] This author's tone and use of the word "surprised" give one the impression that he is challenging the

reader to see for himself the work Austria-Hungary had done to maintain its power and world standing; however, by doing so the author was by necessity confirming that the common belief of the day was that the Hapsburg Empire was one where finding magnificence would be surprising.

Expectations surrounding the fair were high and excitement preceding the event could be found worldwide, even reaching the United States. *New York Times* "special correspondent" H.J.W. began an article about the upcoming event in a gushing manner:

Vienna – the gay and beautiful capital of the Polyglot [sic] empire of Austria, the city of palaces, the refuge of exiled royalty, and the Paris of Germany – promises to be the Mecca during the Summer of 1873, of a pilgrimage grander than that which poured in 1867 from all quarters of the globe to the capital of France.

He would go on to praise the city, the upcoming event, and those planning it for three columns. Ironically, he also noted the city's "practical advantage of springs of pure water everywhere." [5]

Numeric expectations for the fair were high as well. Leading up the

event, Vienna expected twenty million visitors.[6] Contemporaries wrote in 1872 that the 1873 fair was “to be the largest and most important ever held.”[7]

Unfortunately for the Austro-Hungarian Empire, their World’s Fair, preceded by so much hope and expectation, was turned into yet another failure by a fairly unlikely source, especially considering the city’s reported grandeur: an epidemic of cholera. Cholera is caused by some strains of the gram-negative bacteria *V. cholerae* and is spread when one consumes water contaminated by the feces of an infected person, usually via an infected water source. The main symptom of the disease is “peruse watery diarrhea,”[8] which is not only a miserable symptom but also exacerbates the spread of the disease. The disease is capable of causing death by dehydration, and even today in our era of powerful antibiotics rehydration therapy is an effective treatment that allows the patient’s immune system time to fight off the disease on its own.[9] In 1873, treatments for the disease were varied but often included bloodletting or opium.[10]

In describing Vienna’s 1873 cholera outbreak, The *New York Times*’ uncited correspondent begins his article simply by writing, “I fear it must be said at length, with no attempt at disguise, that there is a great deal of cholera in this city.”[11] Perhaps the correspondent was a bit biased by the fact that he himself came down with the disease, and the title of his article being “Vienna Gossip” makes his sources questionable, but he reports hotels where up to forty people died of the disease. He also reports that many visitors to the city fled and that he himself stayed only out of a “sense of duty.”[12] With so many people fleeing the city, the fair could not possibly live up to the expectations set for it, especially concerning numbers of visitors.

A failed World’s Fair might not have been such a blow to the empire if the people of the time had been ignorant as to the cause of the disease. However, Englishman John Snow showed in 1854 that cholera was water-borne, and people of the day knew that the disease was associated with poor water and associated

cholera with dirtiness. Considering cholera’s symptoms and mode of transmission, this association becomes quite understandable. Despite H.J.W.’s assurances of “springs of pure water everywhere,”[13] the *New York Times* correspondent called Vienna “a dirty city at best” and wrote that “the disease mainly attacks the poor in the dirty parts of the city,” although he was convinced that the epidemic was city-wide.[14] These condemnations of the Hapsburg Empire’s capital city were quite a blow, especially considering the praise the city had received leading up to the fair. How could Austrians be “citizens of the world”[15] and their empire be a world power if they could not even maintain a clean water source? If their “abominable” sewers emit a “stench that is sometimes nearly stifling”?[16] The cholera epidemic showed to the world an Austria-Hungary that was backward and incompetent, not one that was modern and formidable.

Even numerically, the 1873 *Weltausstellung* was a failure. Instead of the expected twenty million visitors, only seven million came due to the fear surrounding the cholera epidemic.[17]

The failure of Austria-Hungary’s 1873 World’s Fair was probably not the straw that broke the camel’s back, nor could a successful fair have saved the empire. However, the presence of such a “dirty” disease in a supposedly modern city was certainly a blow to the empire’s reputation, especially when Vienna was promoted before the fair as a city that exemplified the Hapsburgs’ attempts to remain a modern world power. Instead of showing the world a still-relevant empire, the fair’s cholera epidemic revealed that beneath Austria-Hungary’s gilded exterior was a crumbling core. ◆

Notes:

[1] Williamson Jr., Samuel R. *Austria Hungary and the Origins of the First World War*. New York: St. Martin’s Press, 1991.

[2] This is according to the Bureau of International Expositions, which has rules about the length and organization of what can be considered a World’s Fair. Many other events,

regardless of size, styled themselves World’s Fairs before Vienna in 1873 but were smaller and/or shorter. See <<http://www.bie-paris.org/site/en/expos/historical-expos.html>>, <<http://www.bie-paris.org/site/en/main/history.html>>, and <<http://www.bie-paris.org/site/en/main/rules.html>>. Accessed 9 July 2012.

[3] Expo 2000. The Vienna World Exposition 1873. “Comments.” <http://www.expo2000.de/expo2000/geschichte/detail.php?wa_id=4&lang=1&s_typ=14>. Accessed 27 July 2012. Source cited as “Karl Richter, *Die Fortschritte in der Kultur 1873 und 1876*. Prag 1877.”

[4] “Vienna’s Exhibition.” The *New York Times*, 27 Jan 1873. <<http://select.nytimes.com/gst/abstract.html?res=F30E15FF3E5D1A7493C5AB178AD85F478784F9>>. Accessed 27 July 2012.

[5] H.J.W. “The Vienna Exposition.” The *New York Times*, 28 April 1872. <<http://select.nytimes.com/gst/abstract.html?res=FB0A1EF73C5D1A7493CAAB178FD85F468784F9>>. Accessed 27 July 2012.

[6] Expo 2000. The Vienna World Exposition 1873. “A Mixed Result: The End and Repercussions of the Exposition.” <http://www.expo2000.de/expo2000/geschichte/detail.php?wa_id=4&lang=1&s_typ=15>. Accessed 27 July 2012.

[7] Van Buren, Thomas B. “World’s Fair at Vienna, Commencing May 1, 1873.” The *New York Times*, 16 July 1872. <<http://query.nytimes.com/gst/abstract.html?res=F30B17FD355C1A7493C4A8178CD85F468784F9>>. Accessed 27 July 2012.

[8] Mekalanos, John Joseph. *Epidemiological and Molecular Aspects on Cholera*. New York: Springer New York, 2011. P. 98. http://dx.doi.org/10.1007/978-1-60327-265-0_6. Accessed 11 Aug 2012.

[9] *Ibid*, p3.

[10] Harvard University Library Open Collections Program. “Cholera Epidemics in the Nineteenth Century.” *Contagion: Historical Views of Diseases and Epidemics*. <http://ocp.hul.harvard.edu/contagion/cholera.html>>. Accessed 11 Aug 2012.

[11] “Vienna Gossip.” The *New York Times*, 2 Sept 1873. <<http://select.nytimes.com/gst/abstract.html?res=FA071EF63D59117B93C0A91782D85F478784F9>>. Accessed 27 July 2012.

[12] *Ibid*.

[13] J.W. “The Vienna Exposition.”

[14] *Ibid*.

[15] “Vienna’s Exhibition.”

[16] “Vienna Gossip.”

[17] “A Mixed Result: The End and Repercussions of the Exposition.”

Modern Medicine

The Making of a Public Health Campaign: Public Perception in Shaping London's Sanitation Reform

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By the turn-of-the-century, London was well-known for its unsightly, epidemic-causing slums. Newspapers richly depicted the emerging public health issue: inhabitants lived in vicinity of miasmatic cesspools, helpless families cramped into confining two-bedroom houses, and children wailing in the corners of poorly ventilated rooms. By around 1900, there was clear popular support from experts and city inhabitants alike to clean slums in order to eliminate disease and raise the standard of living for the working poor. London's sanitary movement could be traced back decades earlier with the "Chadwick Reports" of 1842 and John Snow's study of cholera.[1] Years later, Richardson's "Hygeia: a City of Health" in 1875 and Howard's "Garden Cities of To-morrow" in 1902 were examples of proposals to assuage the growing problem by building new communities in order to eliminate illness and set new standards for urban health.[2] However, it is impossible to study a public health movement without studying how the public interpreted germs as a danger—particularly, how the public perception of and motivation to eliminate germs helped drive urban health reforms. Was health reform truly based on science

accumulation or underlying social insecurities? A closer look at public opinion of London's inhabitants during the late 19th century reveals that London's inhabitants were a vital catalyst in the city's sanitation reform.

London's public health campaign was an eye-catching health communication tactic driven by vivid, journalistic depictions. Rather than inform, these descriptions of germs instilled fear; no one was safe from the unpredictable and omnipresent bacteria. In depicting germs, one journalist in an 1895 Harper's Weekly article invoked public panic, warning that "starvation is the only remedy against the introduction of germs rid the food; and even that heroic measure would avail little, since many germs float in the air and are inhaled, or are blown against our bodies by the winds. Whatever measures we resort to we cannot possibly evade these subtle enemies." [3] The vivid and personifying language of germs during the late nineteenth century also helped legitimize the public health threat. Those who read them did not just read reports; they read plotlines that were "embellished with colorful imagery that an educated lay person could understand." [4] Germs did not just move, they "lurk", "float," and "scatter." They do not simply grow, but "multiply," "poison," and become

"the seeds of disease." [5] Creative licensing reached the masses more effectively, but speculation soon turned to facts, and consequently, facts turned into public fear. [6]

The case for germs and slum sanitation became even more urgent because germs challenged a mother's role, which according to Ellen Ross in "Love and Toil" was multifaceted responsibility that included mothers acting as family nurses.[7] According to Adelaide Nutting in a 1904 article, "There is nothing concerning our homes so trivial that it may be safely left to chance." However, germs challenged Nutting's claim because they were out of a mother's control. "Housing of the poor, and their lives and occupations and troubles are beyond our power," she continues.[8] During the late 19th century, children's health was not only the mother's responsibility; her children's health was a reflection on how good of a mother she was. When appearance was priority, a sick child reflected poorly on the mother. Middle-class mothers themselves looked down on working class mothers whose children, for example, failed school health inspections.[9] Sanitation reform became more compelling than ever for mothers not only for their children's sake, but for their own reputations.

Although germs stressed working class inferiority to the middle class, many of London's middle class inhabitants during the 19th century believed that cleaning up the slums was a way to carry out philanthropic reform. Unclean slums indicated the failure of urban planning and city leadership. To many, sanitation reform became a moral obligation to help the poor.[10] Much public health literature of the 1880s and 1890s had progressive reform attitudes, such as Dr. Cameron's address in the *British Medical Journal* titled "Sanitary Progress in the Last Twenty-Five Years and in the Next." Unlike other public health experts, Dr. Cameron provoked readers to sympathize, not blame. To some, public health acted as an extension of the tradition of middle class goodwill rather than condemnation.

Public health knowledge alone could not have impacted the sanitary movement without the emotional responses of the public health danger. Even today, in the age of autism scares, social stigma of HIV/AIDS, and a panacea of food safety, London's example is not a far-

fetched phenomenon. The sanitation reform of the late 19th century is important to study from the perspective of inhabitants because it sheds light on the catalyst of the public health movement and the potential energy of popular voice. Oftentimes, an iron curtain divides what public health experts know and what the public understands. Scientists may research and experts may teach, but a large part of public health is when people, not just doctors, understand their own risks. Rosenstock's Health Belief Model can explain the pattern—when the individual perceives threat and vulnerability, they are more likely to adopt a change.[11] On the other hand, oftentimes what the public believes is not always true. Germs did not easily spread through air, just like vaccines do not necessarily cause autism. Strong public health narratives have enormous power to reform; but one cannot simply ignore that narratives, fact or fiction, can be believable enough to accept when they are interesting enough to hear. ◆

[1] Stephanie True Peters, *Cholera: Curse of the Nineteenth Century* (Marshall Cavendish, 2004).

[2] Benjamin Ward Richardson, *Hygeia, a City of Health* (General Books LLC, 2010); Sir Ebenezer Howard, *Garden Cities of Tomorrow* (Forgotten Books, 1946).

[3] W. Bengoughs, "The Evasion of Germs," *Harper's Weekly*, 1895.

[4] *Ibid*, 38.

[5] W. Bengoughs, "The Evasion of Germs," *Harper's Weekly*, 1895. J. S Billings, "Germs of Disease," *New York Times*, 1885. Adelaide Nutting, "Home and Its Relation to the Prevention of Disease." *American Journal of Nursing* 4: (1904), accessed on November 11, 2011. <http://www.jstor.org/stable/3401626>

[6] Nancy Tomes, *The Gospel of Germs: Men, Women, and the Microbe in American Life* (Cambridge, MA: Harvard UP, 1998), 56.

[7] Ross. *Love and Toil: Motherhood in Outcast London, 1870-1918*, 196.

[8] Adelaide Nutting, "Home and Its Relation to the Prevention of Disease," 922.

[9] Ross. *Love and Toil: Motherhood in Outcast London, 1870-1918*, 210.

[10] Platt, *Shock Cities: the Environmental Transformation and Reform of Manchester and Chicago*, 308.

[11] Nancy K. Janz and Marshall H. Becker, "The Health Belief Model: A Decade Later," *Health Education & Behavior* 11, no. 1 (March 1, 1984): 1-47.

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Bengoughs, W. "The Evasion of Germs." *Harper's Weekly* [New York] 29 June 1895. *Handbook of Psychiatric Measures* (CD-ROM) About Mugar Workstation *Harper's Weekly* (1857-1912). Web. 26 Nov. 2011.

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Modern Medicine

What War is Good For:

The United States and the Cuban Health Revolution

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In 2001, Fidel Castro met with members from the US Congressional Black Caucus to discuss Cuba's financing of US citizens to receive full paid scholarships to attend medical school at Cuba's Latin American Medical School. In exchange for their training the graduates had to promise to return to the US to serve the poor in their communities for at least five years. Scholarships were divided amongst three underrepresented US minorities: blacks, Hispanics, and Native Americans.

The offer was symbolic of Cuba's commitment to the poor. The offer

provided Cuba with a platform to advertise its medical sophistication while simultaneously criticizing the US government for its indifference towards serving its own poor populations. Not surprisingly, this program was received in the US with mixed reactions. The Bush administration tightened the US embargo in 2004. Eighty US citizens were studying medicine in Cuba when they were informed to leave. The Bush administration ultimately exempted the medical students from the new travel restrictions after sustained pressure from the Congressional Black Caucus.[1]

More broadly, the medical school program highlights two ingredients which define Cuban health: commitment to the poor and its often complicated relationship to the United States. History reveals these ingredients are rooted in the same

historical event. The interplay between these two parts helps demonstrate US-Cuba relations to be rooted in part from an American effort to maintain adequate public health in Cuba, and a Cuban effort to prove the strength of their public health system to the US. Conventional wisdom states that the Cuban commitment to healthcare began as a Castro-backed revolutionary initiative. This narrative is only partially correct. The Castro regime has expanded the scope of medicine in Cuba and has incorporated it as part of its arsenal of international diplomacy. However, it is incorrect to state the 1959 regime deserves all of the credit for the Cuban health care system. While Cuban healthcare is often painted as a utopian dream of the revolutionary guard, it has in fact been born out of pragmatic survival.

The Latin American Medical

School was not limited to Cubans and Americans, however. Founded in 1998 to train students from poor Latin American and African communities, the school confers degrees in medicine, dentistry, nursing, and health technology. Cuba's commitment to train foreign doctors has been steadily increasing. In 2006 there were 10,661 students at the university, 10,084 of them in medicine. This represents a three fold increase since 2002.[2]

Instead of being content with these numbers, Cuba has reached agreements with Venezuela to establish a second Latin American Medical School (ELAM) to train 100,000 physicians over ten years at no cost in exchange for work in developing nations. The scope of the program promises to make a significant impact on poor populations in developing nations.

In many ways post-revolutionary Cuba was victim to its own success. Life expectancy increased and infant mortalities dropped. By the 1990s the economy could not keep up. The graying of the population increased pension costs. The government kept spending on healthcare while overall GDP declined. The government did so to "shield the most vulnerable population from the worst effects of the crisis." [3]

As the healthcare system grew so did its personnel. Physicians continued to be trained while their need decreased on the island. Cuba was left with a choice: to pursue healthcare on par with the best of Latin America despite incredible costs, or cut spending and turn off a system which created an abundance of physicians and medical researchers pursuing cutting-edge research and manufacturing medicine for the Cuban people. Cuba rejected these options and pursued its own course. Cuba relied on outside firms, relationships within Latin America, the pursuit of Western dollars through medical tourism, and deploying doctors around the world on disaster relief missions. In short, Cuba looked to outside dollars to finance the continuity of strong domestic healthcare. In doing so, Cuba may have jeopardized some of its core principles from the Revolution. A lone bastion of socialism, Cuba increasingly relied on the world market to finance

its world renowned medical system.

Some have attributed the financial troubles of Cuban healthcare to the declining revolutionary passion on the island. While it is difficult for any nation to remain committed to a revolution when a regime remains in power for half a century, Cuba has nevertheless remained consistent to its principles of helping those who can help themselves the least. Not only does Cuba help its own, it also uses its physicians abroad as part of an effort in global diplomacy. Cuba has been able to offer a low price for these services while still making a profit because the government pays physicians similarly to other workers, significantly less than other Latin American nations pay physicians they employ. As a consequence, Bolivian and Venezuelan medical associations have protested the presence of Cuban doctors because they provide competition. Meanwhile, the Bolivian and Venezuelan governments, the purchasers of Cuba's services, welcome the Cubans largely because they provide care to segments of society neglected by a country's medical establishment.[4]

The success of Cuban public health has not been without paradoxes. While a large educated class has enabled Cuba to reach its healthcare objectives, it has also helped create an overeducated society without being an economically prosperous state. The professional classes were overrepresented. Cuba's efforts in medical diplomacy and medical research are partly explained because of the nation's surplus of doctors. Many physicians who began their studies in the 1970s are now in positions of power, which testifies to the collective status of physicians in society.[5]

It appears Cuba has sacrificed considerable time and capital to achieve its level of healthcare. And not only that, it has gone the extra effort to demonstrate to the US and the world its accomplishments in patient care through efforts in global diplomacy. If the goal were simply national pride, the government would be content doing nothing more, as the public health service has overwhelming national support. However, in its sustained international campaign promoting the efficiencies of Cuban healthcare, one is left to wonder if

there are any additional political pressures that would cause the Cuban government to promote its achievements internationally. Sending physicians to Venezuela can be justified by noting the close political alliance of two isolated, socialist governments in the same hemisphere. Sending physicians to the US, a longtime political foe? Less so, at first glance.

The promotion of a healthy Cuba became an early *cause célèbre* for Cuban sovereignty. Cuban gained its independence from the US in 1902. The independence, however, was limited by the Platt Amendment to the Cuban constitution. One of the conditions to the US imposed Platt Amendment, instituted in 1903 and left in the constitution until 1934, gave the US discretion to reoccupy Cuba if the Cuban government failed to control disease.[6] From its beginnings, the health of the island was linked with its independence. Article V states:

That the government of Cuba will execute, and, as far as necessary, extend, the plans already devised or other plans to be mutually agreed upon, for the sanitation of the cities of the island, to the end that a recurrence of epidemic and infectious diseases may be prevented, thereby assuring protection to the people and commerce of Cuba, as well as to the commerce of the southern ports of the United States and the people residing therein.

Article V originated from a yellow-fever outbreak during the Spanish-American war. Eighty percent of US troops came down with the disease during the occupation from 1898-1902. The US put significant political pressure on Cuba to contain the disease to protect its economic interests. The Havana Sanitation Department was responsible for reducing deaths from yellow fever, from an average of 706 deaths from 1868-1898 to none in 1902.[7] A focus on preventive medicine would become a hallmark of revolutionary public health policies. Still, the question remains in a larger sense: was the 1959 revolution responsible for the revolution in health care?

The 1959 revolution was responsible for a new direction in Cuban politics. Castro's commitment to socialism meant health care for Cubans at no cost. Family and primary care was emphasized. In 1974

a program was created along these lines called “medicine in the community”. Health-care workers lived in their patients’ communities and were distributed equally through the population.[8] The revolution was credited with providing equal access to health care. Conventional wisdom holds the 1959 revolution provided health care to poor rural workers who did not have access to medical treatment. Cuba’s nationalized public health system accomplished much within its first decade, including preventive measures and containing infectious disease: “these efforts paid off in changes in major health indicators, reductions in infectious diseases, and improved hygienic and environmental conditions”.[9] Improvements in infrastructure included new and renovated facilities, increased hospital beds, *etc.* Furthermore, secondary care was organized through a system of polyclinics in the 1970s. Polyclinics consisted of teams of specialists from a variety of fields such as internal medicine, ophthalmology, cardiology, and psychiatry.[10] At the beginning there were not enough trained specialists, so polyclinics acted as teaching centers and were staffed largely by residents.[11]

The Castro narrative was enhanced by the image of doctors fleeing the island. 3000 physicians fled the island by the mid-1960s out of the 6300 doctors in 1959.[12] There was one medical school and university hospital on the eve of the revolution. Richard Cooper *et al.* assert these institutions existed alongside “a dominant private sector and a rudimentary public system”.[13]

There has been a marked difference in the numbers of health professionals since the revolution. Current literature indicates there are 31,000 family physicians with an overall doctor/population ratio of 1:170.[14] The government’s emphasis on education and producing doctors provides imagery of an egalitarian, modern state. Many have assumed the public health successes were due to a post-revolutionary commitment to education for all as well as the state’s financial and political support for training doctors and improving medical facilities. The literature disputes these assumptions. Under new leadership, the revolution

continued public health policies began decades earlier. The revolutionary government’s first priorities revealed a commitment to build upon pre-revolutionary health structures, albeit with a socialist twist.

The revolutionary state enacted basic preventative measures. These improvements dealt with sanitation, immunization, containing and treating infectious disease, and expanding medical care to rural areas.[15]

The 1959 Cuban revolutionaries’ dramatic rise to power, subsequent public health initiatives, and a commitment to international medical diplomacy, biotechnology, and basic science research—even in the face of economic downturn—tend to overlook the formation of the Cuban health infrastructure begun after the first US occupation following the Spanish-American war. Provisions in the Platt Amendment forced the strengthening of Cuban health care through improved infrastructure and helped shape the direction of health policy because the Platt Amendment linked expansive public health with nationalist passions for independence.

Cuba has not always been admired for its public health.[16] Article V of the Platt Amendment profoundly guided public policy to the extent that it prompted Havana to enforce nationwide standards in sanitation: “[Article V] obliged the Cuban government to maintain closer surveillance over the country’s sanitary conditions than that maintained by the governments of other countries at similar levels of socioeconomic development early in the century”.[17] Article V gave the US the right to intervene in Cuba should there be another outbreak of disease. Article V implicitly refers to the yellow fever and malaria epidemics on the island, which were responsible for 90 percent of US casualties in the 1898 military intervention.[18]

The overall Cuban health was poor enough that at the annual meeting of the American Public Health Association in 1889, Benjamin Lee argued sanitary conditions were so poor that the US public health interests “demanded its

In other words, the US imposed public health on the Cubans.

annexation”[19] Smith concluded the flow of people between Havana and the US would lead to transmittance of the prevailing diseases on the island, which included leprosy, if no steps to

eradicate these diseases were taken. Lee’s solution entailed a unified public health strategy which began with sewer and drainage systems to help eradicate germs from the city. Lee

also mentioned the possible detriment to US trade should there be an outbreak: “A single widespread epidemic of yellow-fever would cost the United States more in money, to say nothing of the grief and misery it would entail, than the purchase-money of Cuba.” Also: “The introduction of yellow-fever into the United States, through both legitimate and illegal trade, must be of frequent occurrence, so long as this condition of things continues.”[20] Lee’s analysis proved prescient. Less than ten years after Lee presented his paper the US invaded Cuba, although for economic interests, not public health interests. The rest of the Platt Amendment largely dealt with US economic interests and helped secure foreign investment since the US could exercise control over the Cuban government.[21]

In other words, the US imposed public health on the Cubans. The US military did not take action itself; it left that to the Cuban government. It was the Cubans who were responsible for enacting health measures onto Cuban society. To counter the sanitation problem Benjamin Lee mentioned, the Administrator of Sanitation, William Gorgas, implemented a strategy based on a Cuban physician’s hypothesis that mosquitoes were responsible for spreading yellow fever. This was the first instance where mosquitoes were linked with the disease, and is significant in how the medical community worked with the government to implement novel strategies to eradicate disease. Gorgas isolated yellow fever by draining cesspools, ponds, ditches, and fumigated houses. In Havana, the yellow fever mortality rate was 706 per year 1868-1898, 310 in 1900, and 0 by 1902.[22]

The second US occupation 1906-1909 led to the formation of the

Department of Public Health, the world's first national health ministry.[23] The health ministry was designed to appropriate funds through the country's 124 municipalities. This organization allowed funds to reach outside Havana to be used for basic sanitation improvements. Another aspect of the arrangement allowed Havana to collect data through daily reports received from municipal sanitation departments. Any spikes in morbidity and mortality raised immediate concern in Havana and physicians were dispatched to the appropriate municipalities to investigate and treat local health problems. This nationwide system designed to improve local conditions was unparalleled in Latin America. Despite concern over the ministry's judiciousness in appropriating funds, it nonetheless provided results in reducing mortalities.[24]

By the 1950s 7.5 percent of government spending went to public health, although much of this money was not directed to the people. Health services, doctors, and nurses were still concentrated in Havana. Still, a health system was in place to treat the rural poor which was independent from the private and contributory health industries of the upper-middle and land-owning peninsular classes. McGuire and Frankel note how these services played a crucial role in expanding access to the masses: "This access, we believe, goes some way towards explaining why pre-1959 Cuba became Latin America's unlikely champion of premature mortality decline".[25]

Health reforms originated from the US occupation and because the US sought to protect its economic interests. The Platt Amendment put these interests into writing. When the Platt Amendment was abolished from the Cuban constitution in 1934, the US economic interests still remained. The occupation set a precedent linking widespread public health with Cuban independence.

The Cuban economy relied on sugar exports during the first half of

the 20th century. Economic monoculture contributed to a degree of prosperity at the beginning of the century and also created an economy dependent on fluctuating prices on the world market. The second quarter of the century was marked with economic stagnation as a result.[26]

Economic monoculture also meant a large fraction of the workforce was employed in the labor intensive sugar industry. More than half of agricultural laborers worked in sugar mills, which concentrated the rural population around the mills. [27] By law, large plantations were staffed with on-site physicians to treat injuries arising from their dangerous working conditions. Some mills recognized their interests in keeping workers safe and also subsidized the cost of additional physicians, nurses, medicine, and hospitalization.[28] By the 1940s agricultural companies began deducting 1-2 percent from workers' salaries to provide health care services. These funds allowed sugar companies to pay for medical staff, the construction of facilities—and in some instances hospitals—on-site at the sugar mills.

Labor unions increasingly played a role in politics from the 1940s to 1960. Labor unions represented 14 percent of the population in 1946 and 60 percent in 1960.[29] These figures lent Cuba to having one of the most powerful labor movements in Latin America. Unlike the rest of Latin America, the strong labor movement correlates with the rapid decline in mortality. The statistics show mortality declined most rapidly post-World War II until 1960, faster than in any Latin American country, at a time when the Cuban labor movement was most unionized. The expansion of health care to the rural poor bucked trends in Argentina, Brazil, and Chile where corporatist-minded governments enacted urban and sector-based health care policies. The key difference in Cuba was the unionists and the rural poor were largely one in the same. Cuba developed a system of providing access to the rural poor even though

only a fraction of workers were unionized, and also despite a relatively high Gini coefficient and economic stagnation.[30] Labor unions were remarkably successful in the Cuban case, and the revolutionary government used the lessons from this period to make access more equal to the rural workers. The government protected the citizenry similarly during the 1990s when Soviet subsidies ended and the economy collapsed.

The literature does not discuss the causal link between expansive health care and Cuban independence. Overall there is a deficiency in the literature of how Cuba has accomplished what it has. Dresang *et al.* write: "there has been remarkably little scholarship evaluating how Cuba's successes have been achieved, let alone sustained during a period of extreme economic difficulty".[31]

The peculiarities of the Cuban experience have been attributed in part to the failed war of independence. Cuba was the only Latin American nation to have lost its war of independence. Additionally, the struggle was against two colonial powers, Spain and the US. These factors helped cultivate a strong Cuban nationalist impulse towards independence and help explain the nature of the 1959 revolution. The development of health infrastructure can not be attributed to any single factor. Even so, if the US were to have never intervened in Cuba, the status of Cuban health care would be a mystery.

The US presence had been so strong and deeply felt by the Cuban people that it would be difficult to imagine an alternate universe where the US never intervened. The difficulties of this hypothetical scenario reveal Cuban resentment after the occupation as an underlying catalyst for the development of health policies. The health revolution did not begin with the 1959 revolution, it began with the US occupation following the Spanish-American war. The 1959 revolution marked a continuation of health policies modified to adapt to socialist principles and a US embargo. Should Castro's death change the political landscape and improve US-Cuban relations, the direction of Cuba's public health will be closely watched. ◆

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Notes:

- [1] DeWayne Wickham, "Powell Prescribes Cuba travel waiver for U.S. Medical Students," *USA Today*, July 7 2004.
- [2] Julie Feinsilver, "Cuban Medical Diplomacy: When the Left Has Got It Right," *Foreign Affairs en Español* 6 (Octubre-Diciembre 2006): 81-94.
- [3] *Ibid.*
- [4] *Ibid.*
- [5] *Ibid.*
- [6] James W. McGuire and Laura B. Frankel, "Mortality Decline in Cuba, 1900-1959: Patterns, Comparisons, and Causes," *Latin American Research Review* 40 (June 2005): 106.
- [7] *Ibid.*
- [8] Margaret Gilpin, "Update: Cuba: On the Road to a Family Medicine Nation," *Journal of Public Health Policy* 12 (Spring 1991): 87.
- [9] *Ibid.*
- [10] Lee T. Dresand et al., "Family Medicine in Cuba: Community-Oriented Primary Care and Complementary and Alternative Medicine" *Journal of the American Board of Family Practice* 18 (August 2005): 298-9.
- [11] Gilpin, "Update: Cuba: On the Road to a Family Medicine Nation," .
- [12] Richard S Cooper et al., "Health in Cuba," *International Journal of Epidemiology* 35 (August 2006): 818.
- [13] *Ibid.*
- [14] *Ibid.*
- [15] *Ibid.*
- [16] George Davey Smith, "Mensuration, Mendel, and a 19th century public health justification for US imperialism," *International Journal of Epidemiology* 35 (August 2006): 811
- [17] Sergio Diaz-Briquets, *The Health Revolution in Cuba*, (Austin: University of Texas Press). 1978, p36.
- [18] Smith, "Mensuration, Mendel, and a 19th century public health justification for US imperialism," 811.
- [19] *Ibid.*; Benjamin Lee, "Do the sanitary interests of the United States demand the annexation of Cuba?" *Public Health Papers and reports Vol XV*. Presented at the 17th Annual meeting of the American Public Health Association. Brooklyn, NY, 22-25 October 1889. Concord, NH: Republican Press Association, 1890.
- [20] Smith, "Mensuration, Mendel, and a 19th century public health justification for US imperialism," 812.
- [21] Diaz-Briquets, *The Health Revolution in Cuba*, 36.
- [22] McGuire and Frankel, "Mortality Decline in Cuba, 1900-1959: Patterns, Comparisons, and Causes," 106.
- [23] Diaz-Barquets, *The Health Revolution in Cuba*, 36; McGuire and Frankel, "Mortality Decline in Cuba, 1900-1959: Patterns, Comparisons, and Causes," 103.
- [24] Diaz-Barquets, *The Health Revolution in Cuba*, 36.
- [25] McGuire and Frankel, *Mortality Decline in Cuba, 1900-1959: Patterns, Comparisons, and Causes*, 103-4.
- [26] Diaz-Barquets, *The Health Revolution in Cuba*, 37.
- [27] McGuire and Frankel, "Mortality Decline in Cuba, 1900-1959: Patterns, Comparisons, and Causes," 107.
- [28] *Ibid.*
- [29] *Ibid.*
- [30] *Ibid.*
- [31] Dresang et al., "Family Medicine in Cuba," 299.

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Feature Article

A Psychiatrist Looks at Mary Lincoln

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*In addition to full time practice, Dr. Brust is an independent historian, specializing in 19th century popular prints and photographs, occasionally crossing over into medical topics including Mary Lincoln. He has written over forty journal articles, several book chapters, and is a coauthor of the book *Where Custer Fell, Photographs of the Little Bighorn Battlefield Then and Now* (University of Oklahoma Press, 2005). Since 1995, Dr. Brust has been acquiring and donating historical artifacts relating to BUSM and the Boston City Hospital,*

*This essay first appeared in the book *The Mary Lincoln Enigma, Historians on America's Most Controversial First Lady* (Southern Illinois University Press, 2012).*

I have practiced psychiatry full time for over forty years. That is my profession and main role—what I do most and know best. My interest in historical research and writing grew out of collecting nineteenth-century prints and photographs. These are my leisure activities, and for a long time I went out of my way never to mix vocation and avocation. For example, when asked by research colleagues at the Little Bighorn Battlefield for my psychological analysis of George Armstrong Custer, I would find a way to politely decline.

And then along came Mary.

Settling down to lunch one day in June of 2006, I opened and was quickly drawn to an article titled “The Madness of Mary Lincoln.”[1] I read it twice before I got up from the table. Most people in this country are familiar with Mary Todd Lincoln but know only a tiny bit about her. I was no different. But suddenly I was reading vivid, detailed descriptions of symptoms and situations very familiar to me as a practicing psychiatrist. Mary Lincoln had a

significant psychiatric illness, most likely bipolar disorder. She required hospitalization and improved while she was there. For me there was no “controversy” about her condition and need for treatment. Everyone could understand that aspect of Mrs. Lincoln if her story were told with proper psychiatric perspective, which, it occurred to me, I might help provide. The author of the article, Jason Emerson, was working on a book on this topic. Overcoming my own resistance to mixing psychiatry with historical research, I contacted Jason, who accepted my offer to assist. [2]

Any attempt to study Mary Lincoln from a psychiatric point of view must include an examination of general attitudes and perceptions regarding mental illness, both past and present. Psychiatry has always been viewed differently from other medical specialties. The brain is both more complex and less accessible than other organs of the body; its workings more mysterious and difficult to understand. The symptoms associated with conditions classed as “mental” illnesses are more personal and emotional, affecting essential aspects

of an individual’s identity and personality. If the heart beats irregularly or blood sugar is elevated, we can usually be objective. But that is more difficult when thoughts and feelings become abnormal.

The earliest explanations of mental illness were supernatural, with madness seen as a punishment from the gods or possession by demons. People so afflicted became the province of the clergy, with uncertain benefit and occasional excesses like executions for witchcraft. Later views would see mental illness as unbalanced bodily “humours,” an excess of passion or failure of reason.[3] But into the twentieth century, each evolving theory provided little in the way of improved treatment, yet still left a stigma on those seen as suffering from “madness” or “insanity” or whatever word was being used to connote serious mental illness. Such individuals were not fully accepted. Regardless of their social class, if they had significant psychiatric illness, they would be viewed as being “different from” or “less than” others—even a president’s wife or widow. This

stigma against mental illness was powerful and pervasive in Mary Lincoln's time and sadly continues into the present. As a psychiatrist, I see it every day, and it must be kept in mind whenever the psychiatric aspects of Mrs. Lincoln are discussed.

Also important in the history of mental illness in general, and the story of Mary Lincoln in particular, are asylums for the care of the insane. "Asylum" means a place of protection and refuge, and such facilities should have provided acceptance and support, though in the early days they often fell short. Asylums began to proliferate in the late eighteenth century, with a renewed effort to be therapeutic and to alleviate or even cure mental illness. As the nineteenth century progressed, however, such care was not to be the case for the vast majority of patients because public facilities became so overfilled and physically taxed they could be little more than warehouses.[4]

Of course there were private sanitariums that were not overcrowded and could be beneficial, such as Bellevue Place in Batavia, Illinois, where Mrs. Lincoln was sent in 1875. Living in comfortable quarters in a beautiful rural setting, she received special attention from the superintendent and his family, and the most humane treatment.[5] So it was not the actual events of her four months at Bellevue Place that were so repugnant to her, to some of her family and friends, and to her "supporters" both then and now. It was the symbolism of it, because one remanded to any asylum was branded as "mad" or "insane" and hence stigmatized in a way so awful that over one hundred and thirty years later there are many who still argue that it never should have happened. This dramatic impact of her hospitalization is further verified by the frequent use of the term "insanity episode" to describe it. If Mary Lincoln was "insane" (that is, psychiatrically ill) in 1875, then she was also ill at other times, and we should speak of "insanity episodes." But all focus seems to be on the one that led to hospitalization. How ironic that the place meant to be helpful and accepting, which might have countered stigma, ended up increasing it.

What are we speaking of
ACESO

when we refer to serious and stigmatizing illnesses known by such words as "madness," "insanity," "craziness," or "derangement"? None of these terms are still used in psychiatry or medicine, though all remain in our language, loaded with negative connotation. The modern word that most closely corresponds to these older ones is "psychotic," which means unable, at times, to tell what is real from what is not. Such patients might have delusions (fixed beliefs in things that are impossible, or known to be untrue by all other observers) or hallucinations (sensations seeming to be external but actually arising in the individual's own brain, such as hearing voices when no one is talking, or seeing things that are not there). Those suffering from delusions and hallucinations are certain they are true and will not accept any logical alternative explanation. Also included among the more serious psychiatric conditions are two severe disorders of mood. One is the extreme sadness of depression so profound that the person is rendered unable to function, or possibly driven to suicide. The other mood disorder is a manic state, with emotions often being euphoric, accompanied by excitement or agitation that impairs activities and interactions, and likewise makes normal function impossible. Both severe depression and mania are often accompanied by delusions. Manic patients are often paranoid (as Mary Lincoln was at times)[6] and can show a full range of psychotic symptoms. Even patients in the depressed state can have delusions, usually negative towards themselves. They may believe that they have done something wrong, have a deadly illness, or, in Mrs. Lincoln's case, that she was impoverished.[7] These, then, were the conditions whose sufferers were most stigmatized, and most likely to end up in asylums where they were tended to by the psychiatrists of that era who were known as "alienists." [8]

Of course there were more minor psychiatric ailments such as anxiety and depression that was not disabling. In the nineteenth century, these might be classed as "nerves" or "nervous illness." They were seen as physical or medical conditions and not nearly as stigmatized as psychotic illnesses. Since those afflicted were not sick enough to require

institutionalization, they were not treated by the asylum-based psychiatric profession,[9] but by general medical doctors or neurologists. An informal distinction has existed through the ages separating serious forms of mental illness from their less dramatic and disabling counterparts. Simply put, it was better to suffer from "nerves" than "madness" or "insanity."

Where does Mary Lincoln fit in this psychiatric spectrum? Other qualified physician-writers have tried to diagnose Mrs. Lincoln with varied conclusions. Their work is well thought out and generally accurate, though often not providing a complete understanding of all facets of her psychiatric symptoms.

W. A. Evans, MD, assisted by five psychiatrists, published a book in 1932 titled *Mrs. Abraham Lincoln: A Study of Her Personality and Her Influence on Lincoln*. [10] His goal was a "study of her personality," a term he defined broadly to include not only her basic traits, but also intelligence, emotions, physical characteristics, and illnesses. His work contained fascinating biographical information on Mrs. Lincoln, and an interesting discussion of her medical conditions. But as a psychiatric study of Mary Lincoln, it is handicapped by several factors. Terminology has changed so much in the years since Evans wrote this book that it is hard to correlate his wording to modern psychiatric thought. More importantly, though he acknowledged that delusions and hallucinations were prominent in Mary Lincoln's illness, he explained them away as being either near-normal or associated with her Spiritualism. Finally, in his efforts to "understand Mrs. Lincoln and be just to her," he seemed to go out of his way to defend rather than diagnose her. Dr. Evans's emphasis on Mrs. Lincoln's psychological and emotional state is laudable, but his study fails to deal fully with the seriousness of her most severe psychiatric symptoms.

In January 1941, Dr. James A. Brussel, then an army psychiatrist who would later gain fame for his use of psychiatric profiling to solve criminal cases, published a study of Mary Lincoln. [11] Using the evidence available to him, Brussel did not find a major psychiatric diagnosis such as manic-depressive illness or

schizophrenia. He concluded that Mrs. Lincoln suffered from migraine, which explained her seeming psychiatric symptoms, including visual hallucinations and certain delusions. Migraine can cause visual abnormalities that include seeing colors and patterns. While these have sometimes been called hallucinations, they are vague in form, and those experiencing them know they are inside their own brain. The visual hallucinations of psychotic illness are very different, with specific objects "seen" and firmly believed to exist in the external world. In day-to-day practice, psychiatrists and neurologists have no problem differentiating one from the other. Certain of Mrs. Lincoln's apparent delusions have likewise been attributed to migraine. She told Dr. Willis Danforth that wires and springs were being pulled out of her head and eyes, and some have taken these statements as figurative descriptions of migraine headache pain. But she attributed them to an "Indian spirit" who was also removing her scalp and bones from her face.[12] In full context these sound like literal beliefs that were delusional. Migraine cannot explain the full range of Mary Lincoln's psychiatric symptoms.

In 1966, UCLA psychiatrist John Suarez, MD, published a case history of Mary Lincoln.[13] He focused on Mary's early personality traits, and the dynamics of her relationships with family members throughout her life. He wisely expressed trepidation at the prospect of establishing a firm psychiatric diagnosis. He concluded that as a result of the repeated stresses in her life, Mrs. Lincoln developed a "paranoid psychosis . . . that had manic, schizophrenic and involuntional features." He also noted that the depressions she suffered when she lost her sons and husband were "clearly pathological in severity and duration." All told, Suarez's description of an illness that was at times psychotic, at times manic, and at times severely depressed is consistent with current concepts of bipolar disorder. Also noteworthy in Dr. Suarez's study are his observations that Mary Lincoln's commitment was necessary, and her hospitalization helpful.

In a 1999 article, physicians Norbert Hirschhorn and Robert G. ACESO

Feldman presented and studied a most important primary source document—the report of a medical examination of Mrs. Lincoln by four prominent physicians conducted in New York City on January 1, 1882, and subsequently submitted to Congress in support of her request for an increase in her pension. It was preserved in the Congressional Record.[14] In a careful study of the 1882 report, Hirschhorn and Feldman concluded that Mary Lincoln had *tabes dorsalis*, which is a complex of symptoms affecting certain nerves in the body. It can be caused by a number of different illnesses. By that late stage of her life, Mrs. Lincoln had many medical complaints, among them various pains, difficulty walking, and disturbances of vision, all of which could be caused by *tabes dorsalis*.

Hirschhorn and Feldman's conclusion that Mary Lincoln had *tabes dorsalis* is astute but raises some interesting and potentially troubling questions. What illness caused this syndrome in Mrs. Lincoln? There was a school of thought in the nineteenth century that *tabes dorsalis* could be caused by certain spinal injuries. By the 1880s, support for that etiology was fading, but Mrs. Lincoln had been involved in a carriage accident in 1863 and reported having hurt her back in two separate falls in France in 1879 and 1880,[15] so the 1882 evaluators favored injury to her spine as the cause. In doing so, they skirted around the ever-increasing awareness that *tabes dorsalis* was more frequently associated with late stage syphilis. Given the fact that the 1882 medical report was intended to support a petition for an increase in Mary Lincoln's pension, and no definitive test for syphilis existed as yet, it is not surprising that the examining physicians leaned away from that diagnosis.

The possibility that Mrs. Lincoln had syphilis presented Hirschhorn and Feldman with a dilemma similar to that faced by the 1882 examiners, but by the time they were writing in 1999, other causes of *tabes dorsalis* had been identified. The most notable of these is diabetes, and they settled on that as the cause. I agree with them and find no strong evidence that Mary Lincoln had syphilis, though at least one modern

author, Deborah Hayden, is convinced that she did, as was William Herndon in the 1860s.[16]

Hirschhorn and Feldman made a good case that Mary Lincoln had *tabes dorsalis*, but the more important question for this study is whether that condition, be it from diabetes or syphilis, could account for her psychiatric symptoms. These authors were mindful of the difficulties of establishing a psychiatric diagnosis from the historical record alone but did state that symptoms of *tabes dorsalis* were "misinterpreted as madness" in Mrs. Lincoln. A specific point was made of a feature of *tabes dorsalis* known as Argyll Robertson pupils, in which the pupil of the eye no longer constricts in response to bright light.[17] Hirschhorn and Feldman offered this as an explanation of Mary Lincoln's tendency to stay in a darkened room using only candlelight in the final years of her life. Finally, they added that the more bizarre symptoms seen prior to Mrs. Lincoln's 1875 commitment may have had their roots in a posttraumatic stress disorder (PTSD) triggered by the tenth anniversary of President Lincoln's death.

As excellent as the Hirschhorn and Feldman study is, I doubt that *tabes dorsalis* could account for the full picture of Mary Lincoln's psychiatric symptoms. It would not cause her paranoid delusions, auditory hallucinations, or delusions of poverty. And patients with Argyll Robertson pupils, even if sensitive to bright sunlight, can come out of their darkened rooms at night, which Mary Lincoln did not, making it more likely that she chose isolation because she was depressed. As to the possibility of posttraumatic stress disorder, given the awful events of April 14, 1865, it was likely present to some degree, but the key element in a formal diagnosis of that condition is the persistent reexperiencing of the traumatic event, which is not described in the historical record of Mrs. Lincoln's symptoms. Moreover, delusions and hallucinations are not usually part of PTSD.[18]

If we can establish a diagnosis for Mary Lincoln, it might help us to understand her, but is it even possible to do so for someone who lived so far in the past? We might look first at how we diagnose people in the present.

Historically, medical diagnosis was completely “clinical”—based solely on direct and personal interaction between the doctor and the patient and their family. The physician would talk to the patient, obtain a description and history of the illness and symptoms, physically examine the person, and then, if possible, corroborate or augment that information with family or other observers. Most fields of medicine have benefitted from impressive advances in diagnostic technology through the twentieth and into the twenty-first century. We now have sophisticated analysis of blood and bodily fluids, ever sharper pictures obtained by X-ray and other imaging techniques, and even direct visualization of internal body spaces with scopes and catheters. But the brain yields up its secrets much more grudgingly. Though there has been progress, such technologies have not yet proved applicable to psychiatric diagnosis, which continues to be almost completely clinical. Without a major boost in diagnostic acumen from laboratory and imaging, we still rely on talking to, interacting with, and observing people. This has helped to keep psychiatry a truly interpersonal discipline but has left it vulnerable to criticism that it is somehow not the equal of other medical fields and, therefore, more readily undervalued or ignored.

If psychiatric diagnosis requires direct contact and observation, how do we attempt it on someone who has been dead for over a century? We could only do so with great trepidation. We cannot conduct a psychiatric interview on Mrs. Lincoln, and there is no one alive who can describe her to us from personal observation. But we are not totally without information. Mary Lincoln was a person of interest and at times controversy as a president’s wife and widow, and more was written about her than would be the case for most nineteenth-century Americans. And we have the additional benefit of surviving medical records.[19] We must be aware of the limitations of such a backward-look diagnosis, but we do have some information to base it on.

In an earlier essay[20] I discussed the multiaxial diagnostic system currently used in psychiatry, ACESO

which considers factors such as personality traits, coexisting medical illnesses, and psychosocial stressors. These are of great significance in the complex case of Mary Lincoln, especially the multiple losses she endured. But they engender far less controversy, so I will not repeat that discussion here. It has become clear to me that when psychiatry is considered in regard to Mrs. Lincoln, the debate centers on whether or not she had a major mental illness that included psychotic thinking (delusions and hallucinations) and potentially dangerous behaviors—the kind of disorder that would necessitate psychiatric hospitalization for her own safety. Do we have evidence for such a condition?

There can be no question that Mary Lincoln suffered from depression, which she acknowledged herself, speaking of April as her “season of sadness.” Other observers who noted her depression made no mention of it being limited only to a certain month, so likely it could occur at any time of the year. One of her closest family members, sister Elizabeth Edwards, with whom she lived at various times, said of Mary, “it is impossible to prevent frequent reactions to extreme sadness.” Two of her physicians also observed depression. Dr. Willis Danforth, who treated her in 1873, described “melancholia” as one of her symptoms, and Dr. Louis Sayre, who usually emphasized her physical symptoms, said that Mrs. Lincoln was suffering from “great mental depression” upon her return from France to the United States in October (not April) of 1880.[21] Discussions of Mary Lincoln’s mental health often center on grief, and depression is expected after a loss, of course. But the severity and duration of her symptoms following President Lincoln’s assassination and the deaths of sons Eddie (1850), Willie (1862), and Tad (1871) exceeded the usual grief reaction.[22] Also of note is her tendency to stay in darkened rooms in the later years of her life, which was more likely a sign of depression than the product of any abnormality of her eyes. The next important consideration is whether Mary Lincoln was at times psychotic, that is suffering from delusions and hallucinations. The presence of psychosis greatly increases

the severity of an illness, the potential for dangerous behavior, and the need for intervention. The earliest documentation of such symptoms in Mrs. Lincoln was in 1863, even before her husband’s assassination. Her half sister Emilie Todd Helm noted in her diary that Mary spoke of nighttime visits from her son Willie, who had died the year before. Mary’s descriptions were vivid and detailed: “He lives[,] Emily. . . . [H]e comes to me every night and stands at the foot of my bed. . . . [L]ittle Eddie is sometimes with him and twice he has come with our brother Alec.” She not only “saw” Willie, she also “heard” him (“he tells me he loves his Uncle Alec and is with him most of the time”). And all of this was related to Mrs. Helm with “eyes [that] were wide and shining.”[23] While it may be tempting to dismiss these visions as dreams, or as fantasies fueled by Spiritualism, the repetitive and dramatic nature of these symptoms, and Mary Lincoln’s unquestioning belief in them, make it far more likely that they were hallucinations.

Psychotic symptoms would be described again in Mrs. Lincoln even before the remarkable events of 1875. According to family friend Isaac N. Arnold, from the time of Tad’s death in 1871, Mrs. Lincoln “had various hallucinations.” During the same period of time her personal nurse stated that Mary “had strange delusions,” including a preference for candles since she believed gas to be the invention of the devil. By 1873, Mary was telling her physician, Dr. Willis Danforth, that an Indian spirit was removing her scalp and the bones of her face, and pulling wires out of her eyes and steel springs out of her head. Dr. Danforth concluded these symptoms “were indications of mental disturbance.”[24]

The psychotic symptoms described in 1875 that led to Mary Lincoln’s commitment were even more dramatic. She rushed from Florida to Chicago based on the delusional belief that her son Robert was gravely ill. She spoke of a “wandering Jew” who had stolen her pocketbook on the train. She thought the city of Chicago was on fire, heard “strange sounds,” and feared that she was in danger from a man who was “going to molest her.” She was described by hotel employees as

“excited, agitated, restless and nervous,” and “complain[ing] frequently that people were speaking to her through the wall.” She told Dr. Danforth that she had been poisoned on the train from Florida. All told, the evidence that Mary Lincoln suffered from psychotic symptoms seems clear, particularly during her 1875 episode.[25]

Mrs. Lincoln’s episodes of significant depression accompanied by psychosis would be sufficient evidence of a major psychiatric illness, which in current terminology would be called major depressive disorder with psychotic features.[26] But there were other symptoms as well. Prominent in the story of Mrs. Lincoln was her extravagant spending of money, often on unnecessary items. Her sister Elizabeth Edwards noted Mary’s spending habits, telling Robert that “it has always been a prominent trait in her character to accumulate large amounts of clothing.” At her commitment hearing in 1875, five Chicago merchants testified that Mrs. Lincoln, in the weeks since her arrival from Florida, was making large and “reckless” purchases—hundreds of dollars worth of lace curtains, watches, jewelry, soaps, and perfumes—all items she had little or no use for as she was living in a hotel and always dressed in mourning black without jewelry.[27] Spending of this kind is a symptom not usually associated with depression, but rather with what we now refer to as mania or a manic state. If Mary Lincoln experienced manic episodes, our diagnostic speculation turns in an important new direction, toward what for years was known as manic-depressive illness but is now called bipolar disorder, a condition characterized by episodes that can take two distinct forms, sometimes manic and at other times depressed, though there can even be a mixture of the two.[28] Mary Lincoln was depressed at times, but did she have evidence of sustained spells of any other abnormal or troubling mood? The official diagnostic criteria for a manic episode require a “distinct period of elevated, expansive or irritable mood lasting at least a week.” There is little in the historical record to support sustained elevated or expansive mood in Mrs. Lincoln, but irritable spells would not be hard to imagine.

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Mood abnormality, by itself, is not enough to diagnose a manic state, so even if we accept sustained irritability, other symptoms would be required. One, “engaging in unrestricted buying sprees,” is well documented in Mary Lincoln, and a case can be made that she showed another symptom of mania, “inflated self esteem or grandiosity.” Benjamin French, commissioner of public buildings, referred to Mrs. Lincoln as “The Queen,” and a number of people felt she acted as if she were royalty.[29] Other symptoms of a manic state include decreased need for sleep, being more talkative than usual, racing thoughts, and distractibility. We have no specific descriptions of these in Mrs. Lincoln; they may have been present, but no firsthand account has survived that might prove it. These are things we would ask her about if we could, but of course we cannot, and not surprisingly, any attempt to diagnose her by strict current criteria will fall short. But still, there are many interesting diagnostic signs worth considering.

For example, another characteristic of bipolar disorder is that it tends to be intermittent rather than chronic, at least until its late stages. The episodes, whether manic or depressed, occur on a periodic basis, perhaps with a regular cycle, but then remit, leaving the affected individual relatively normal until the next spell. Mary Lincoln seemed fine at times, and even her son Robert noted that her episodes tended to “blow over.”[30] As mentioned, she herself saw her depressions as cyclical, coming in April, which she referred to as “my season of sadness.” April, of course, was the anniversary of President Lincoln’s assassination, and near in the calendar to the February deaths of sons Willie (1850) and Eddie (1862). Though we know she was likely depressed at other times as well, her self-described cycle also points toward bipolar disorder.

So we have evidence of depression, mania, and psychosis, of a relapsing-remitting course, and even of a regular cycle. All of this is consistent with bipolar disorder. Another factor we look for is a family history of the illness. Mary Lincoln’s full sister, Elizabeth Edwards, once again proves to be a helpful informant, by revealing that her

daughter Julia (Mary’s niece) first showed signs of “insanity” at age thirteen, and “at the birth of each child, the same symptoms were shown, and severely felt.”[31] Since the niece’s symptoms were described as “insanity,” they must have been severe. The picture described sounds consistent with full-blown postpartum psychosis, rather than milder postpartum depression, and women with such episodes in their childbearing years often turn out to be bipolar with spells of illness later in life.[32] The likelihood that niece Julia Edwards Baker suffered from bipolar disorder is strengthened by knowledge that she engaged in “risqué” behavior in 1864 and was involved in a scandal in 1872.[33] While details are not known, it seems quite possible these events involved sexual indiscretion, and hypersexual behavior is another sign of a manic state.

There is further evidence of serious psychiatric illness in Mary Lincoln’s family. One of Mary’s brothers, Dr. George Todd, was “given to moods of deep melancholy,” while another brother, Levi Owen Todd, died in an insane asylum. Also institutionalized were niece Mattie Todd and a grandniece (the daughter of Mary’s nephew Albert Edwards). Another grandniece, Nellie Canfield, committed suicide, and fourteen members of her family were said to have been in asylums.[34] Together, these cases point toward an inheritable, biological component to Mary Lincoln’s mental illness.

Bipolar disorder has a high suicide rate, and Mary Lincoln tried to ingest a lethal dose of laudanum the day after her commitment hearing. Like so many aspects of this story, those who wish to minimize her psychiatric illness can speculate that she was not seriously trying to kill herself. But a well-researched and thought-out study by physician Norbert Hirschhorn has shown that this was, indeed, a serious attempt to end her life.[35]

As I have acknowledged, I cannot “prove” that Mary Lincoln had bipolar disorder, but for all of the reasons presented, I think it quite possible that she did. If accurate, what can that tell us about her? First, it shows us she had an illness. One of the most extreme criticisms occasionally

leveled at psychiatry is that mental illness does not really exist, but is just a construct of society to deal with individuality or deviance, or an invention of psychiatrists to insure their influence and income.[36] But the illness we now call bipolar disorder has been described for some twenty-five hundred years. Though given different names through the ages, there is evidence of a consistent clinical entity whose essential features have been described similarly for centuries. It is not unique to a certain individual or specific period of time.[37] Given this historical stability, it is a "real" illness.

Establishing a diagnosis can tell us something about the cause of that illness. Those interested in Mary Lincoln, and horrified by the stigma of major mental illness, have tried to "defend" her from such a diagnosis. This is still the case in the twenty-first century as it was in the nineteenth. But in defending Mary Lincoln, they overlook a factor that might place her symptoms in a more favorable light. Based on emerging scientific knowledge of the chemicals that mediate brain function, research studies that reveal evidence of an inherited pattern to major psychiatric illnesses, and the development of medications that can enter the brain and improve psychiatric symptoms, these psychotic illnesses are now thought to be based in brain chemistry, not personal weakness or failure. Though episodes may be precipitated or worsened by unhappy life events, they will not occur at all unless the individual has the necessary biological and biochemical vulnerability. And internal shifts in brain chemistry in those with such biologically based susceptibility can even cause illness at times when there has been no unusual stress or unhappiness in their lives, leaving others puzzled about why they got sick for "no reason." Since these physical and chemical factors in the brain are beyond conscious control, the affected individual can neither cause nor cure the symptoms themselves, and the episodes of illness are not the person's "fault." So to say that Mary Lincoln or anyone else demonstrated abnormalities of thought, mood, or behavior brought on by such illness is not a personal criticism but a blameless explanation.

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Finally, a diagnosis tells us something about the expected course or prognosis of that illness. As noted, bipolar disorder can completely remit, even for extended periods of time, though other episodes will eventually follow. This is a more favorable outlook than many other major psychiatric conditions, which can become chronic. Sadly, though, bipolar disorder tends to worsen over time, the episodes becoming more frequent and more severe, even to the point of no longer fully remitting. This seems to have been the case for Mrs. Lincoln in the last two years of her life.

If we acknowledge the severity of Mrs. Lincoln's symptoms at the time of her commitment in 1875, we can see a major level of psychiatric illness. Her delusions and hallucinations caused erratic, irrational, and potentially dangerous behavior. Fearing she had been robbed on the train to Chicago, and thinking she was in danger from one or more "strangers," she felt a need to protect her money by carrying thousands of dollars in cash and bonds in her pockets, making her a target for anyone wishing to rob her. She believed the city was on fire, which led to fears that she might jump from a window. Hospitalization was necessary to protect her from these frightened responses to her delusions and hallucinations. Yet despite the fact that acceptance of her condition helps explain much of her behavior in a way that does not leave her personally blameworthy, and even though she actually improved at Bellevue Place once she finally got there, the stigma is so strong that some simply do not want to see her as having had a psychiatric illness, and seek another explanation.

One such alternative view is that Mary Lincoln had no significant mental illness at all but was simply the victim of her powerful and unfeeling son Robert and others, operating in a male-dominated society, who wished her out of the way in order to stifle her assertiveness, silence her outspoken nature, or steal her money. Jean H. Baker, in *Mary Todd Lincoln: A Biography* (1987) was a prominent proponent of this viewpoint.[38] Though there are ample firsthand descriptions of Mary Lincoln's psychotic symptoms at the time of her commitment in 1875, Baker declares

them unreliable, the products of Robert Lincoln's influence and money. She says: "Robert carefully organized his case, rounding up doctors, hotel maids, waiters and store clerks to testify against her," tipped "the small time merchants . . . two weeks' wages," and paid "fifty dollars apiece" to the doctors who "were [his] friends and would say what he directed." [39] So in a few sentences written over one hundred years later, multiple statements and descriptions, many given under oath, are dismissed despite the fact that not a single one was ever recanted or proved false.

Baker's other focus is on her perception of the unfairness of Mary Lincoln's insanity trial. I would agree that an open trial before a jury is an awkward way to rule on commitment, and the very use of the terms "trial" and "verdict" add a very negative slant to what is meant to ultimately be a helpful process. It is doubtful that a private person like Robert Lincoln would have chosen that route if he had any other choice. But it was an improvement over the ultrasexist Illinois system it replaced,[40] and the proceedings were conducted under the rules set forth by law. The all-male nature of the proceeding does not automatically invalidate the findings, any more than Robert Lincoln's supposed wealth proves that he bribed all the witnesses. And in further regard to this notion that it was sexism and not psychosis that caused Mrs. Lincoln to be committed to Bellevue Place, it is interesting to note how many of the witnesses who left descriptions of her psychiatric symptoms were women, including close relatives such as sister Elizabeth Edwards and half sister Emilie Todd Helm, who could not have been controlled by Robert. Even Myra Bradwell, Mary Lincoln's chief defender, told Mary's psychiatrist Dr. R. J. Patterson "that she had no doubt that Mrs. Lincoln was insane and had been for some time"; she simply doubted the need to keep her in an asylum.[41]

Feminist concerns that Mary Lincoln's troubled circumstances may have been gender related are understandable. She was of symbolic importance as the widow of a revered and martyred president, and as a high-profile woman in an age when women were not usually in the public

eye. Robert Lincoln was concerned about family legacy and may have been worried about the view others had of his mother's behavior. The sexist nature of society at that time might have judged Mary more harshly because she was a woman, and given Robert more power because he was a man. The possibility of mistreatment based on gender, combined with the stigma against mental illness, could create a blind spot in which psychiatry would be rejected as a form of sexist oppression. This should not be the case. Sexism and psychiatric illness can coexist; they are not mutually exclusive. If the true goal of historical inquiry is to understand multifaceted situations as fully as possible, then the psychiatric component should be included as one piece among others that can provide a more complete understanding of this complex figure.

There are other alternative explanations sometimes offered to explain Mary Lincoln's psychiatric symptoms, but they may be difficult to evaluate for those without a background in the mental health professions. Many people have no experience with serious or psychotic-level mental illness at all and may never have seen a person suffering from such a condition. It is good for them, of course, if mental illness has never touched their friends or loved ones, but this lack of familiarity is a definite handicap in understanding the realities of evaluating and dealing with psychiatric illness—then or now. Without knowledge of the full range of psychiatric illnesses, it is hard to know how they differ in their causes and symptoms. For example, Mary Lincoln's mental or emotional difficulties are usually attributed to grief. She was cruelly aggrieved by the death of three of her four sons, and the assassination of her husband as he sat by her side.

But grief alone, either at the time or anniversary of a loss, causes a different symptom picture. Though it creates great sadness, it would not cause the delusions and hallucinations she suffered in 1875 and other times.

Other explanations have been put forth to account for Mrs. Lincoln's 1875 illness. One is migraine, but as discussed earlier in this essay, that condition cannot fully account for her psychiatric symptoms. Another

sometimes offered is misuse of chloral hydrate or some other sedative substance.[42] Chloral hydrate is not without potential for danger or abuse, but here too, the symptom picture is wrong. If overused, chloral hydrate would cause excessive sedation or sleepiness, not excitement or agitation, and not delusions or hallucinations. If a person were addicted to chloral hydrate or a similar compound, then stopped it suddenly, there could be withdrawal symptoms, including a brief delirium with visual hallucinations, but it would run its course in days and not last from March to May as Mrs. Lincoln's symptoms did in 1875. And it is unlikely she was misusing chloral hydrate at the time of her hospitalization, as her medical records at Bellevue Place make no note of any withdrawal after she arrived.[43] So most likely the psychotic illness she suffered from in 1875 was just that, a psychotic illness akin to the ones we continue to see in psychiatry today.

All of this might be relatively clear, but sadly, the stigma surrounding mental illness skews the viewpoint of many observers. Both in the past and in the present, it creates a crucial dilemma—does one accept the illness and fight the stigma, or so fear the stigma that they deny the illness? I see this with patients and their families all the time, and I fear that some who study Mary Lincoln feel it as well. So perhaps a closer look is in order. Stigma means a mark of shame, but where or what is that shame as regards psychiatric illness? This stigma is not the product of rational thought, but rather arises from misunderstanding and fear, which we should be able to counter. I offer interesting points of view on denial of illness and undeserved stigma from two women who have achieved admirably despite suffering from and requiring treatment for major psychiatric illness.

The first is Elyn R. Saks, a professor of law at the University of Southern California, who, by her own acknowledgment, suffers from schizophrenia, which is definitely a major psychiatric illness. In a thoughtful essay in the *American Journal of Psychiatry*, she discussed how, for many years, she denied her illness. She alternately tried to convince herself that "everyone's

mind contained the same chaos, violence, confusion and scary beliefs that mine did," or that she really was not mentally ill, or that she, herself, simply chose to have the symptoms. With treatment she came to accept her mental illness. And, her most important observation: "with this acceptance, paradoxically, my illness came to define me much less." [44]

The second is actress Carrie Fisher, widely known in our popular culture for her portrayal of Princess Leia in the *Star Wars* movies. She openly discussed her bipolar disorder in a recent autobiography, which she ended with some very straightforward remarks about her condition and reactions to it: "One of the things that baffles me . . . is how there can be so much lingering stigma with regards to mental illness, specifically bipolar disorder. In my opinion, living with manic depression takes a tremendous amount of balls. Not unlike a tour of duty in Afghanistan (though the bombs and bullets, in this case, come from inside). At times, being bipolar can be an all-consuming challenge, requiring a lot of stamina and even more courage, so if you're living with this illness and functioning at all, it's something to be proud of, not ashamed of." [45]

Their message is clear—failing to accept the reality of illness is neither helpful nor wise. In most fields of medicine, people would readily acknowledge the need to recognize and treat diabetes, or high blood pressure, or a lump in the breast. The same should be true in psychiatry. It is unnecessary to avoid Mrs. Lincoln's psychiatric symptoms. We can better honor her for bearing the burdens she faced if we fully acknowledge those burdens, including her psychiatric illness.

There is one final factor of absolutely overriding importance that must be kept in mind when evaluating the events leading to Mary Lincoln's hospitalization. When someone becomes severely ill, as Mrs. Lincoln did in 1875, something has to be done. That is the bottom line, then or now. No matter how disinclined such a person or their family might be to turn to psychiatry, they have a crisis and must seek help from a professional person who knows what to do. Until such an unhappy moment arises in any of our lives, it is easy to think that

it never will. But if your mother had terrifying paranoid delusions, heard frightening voices, and reacted in ways that put her in danger, you would have little choice but to turn to the psychiatric profession. That is what happened to Robert Lincoln's mother in 1875 and he had no choice either. ◆

Notes:

[1] Jason Emerson, "The Madness of Mary Lincoln," *American Heritage* 57, no. 3 (June/July 2006): 56–65.

[2] Jason Emerson, *The Madness of Mary Lincoln* (Carbondale: Southern Illinois University Press, 2007). I served as psychiatric consultant for this book and contributed an essay that appeared as an appendix titled "The Psychiatric Illness of Mary Lincoln," 185–90.

[3] On societal views of mental illness, see Roy Porter, *Madness: A Brief History* (Oxford: Oxford University Press, 2002).

[4] On asylums see Edward Shorter, *A History of Psychiatry* (New York: John Wiley and Sons, 1997), 4–22, 33–68.

[5] Mark E. Neely Jr., and R. Gerald McMurtry, *The Insanity File: The Case of Mary Todd Lincoln* (Carbondale: Southern Illinois University Press, 1986), 38–39; Emerson, *The Madness of Mary Lincoln*, 71–72.

[6] Neely, *Insanity File*, 6–8, 11–12; Emerson, *The Madness of Mary Lincoln*, 40, 44, 46.

[7] Emerson, *The Madness of Mary Lincoln*, 23, 28–29, 45.

[8] The term "psychiatry" dates to the early nineteenth century but was not frequently used in the United States until the twentieth century. Before that, those who treated the mentally ill often referred to themselves as "alienists" because they treated mental alienation. See Shorter, *A History of Psychiatry*, 17. For ease of understanding, I will use the terms psychiatry and psychiatrists throughout this essay.

[9] The degree to which psychiatrists in the United States in the nineteenth century were asylum based is reflected in the name chosen for their first professional organization, the Association of Medical Superintendents of American Institutions for the Insane, founded in 1844. This became the American Psychiatric Association in 1921.

[10] W. A. Evans, *Mrs. Abraham Lincoln: A Study of Her Personality and Her Influence on Lincoln* (New York: Alfred A. Knopf, 1932). This book was reprinted in 2010 by Southern Illinois University Press with an informative foreword by Jason Emerson.

[11] James A. Brussel, "Mary Todd Lincoln: A Psychiatric Study," *Psychiatric Quarterly* 15, supplement 1 (January 1941): 7–26.

[12] Neely, *Insanity File*, 11; Emerson, *The*

Madness of Mary Lincoln, 40.

[13] John M. Suarez, "Mary Todd Lincoln: A Case Study," *American Journal of Psychiatry* 122, no. 7 (January 1966): 816–19.

[14] Norbert Hirschhorn and Robert G. Feldman, "Mary Lincoln's Final Illness: A Medical and Historical Reappraisal," *Journal of the History of Medicine and Allied Sciences* 54, no. 4 (October 1999): 511–42.

[15] Emerson, *The Madness of Mary Lincoln*, 16, 129.

[16] *Ibid.*, 230 n. 75 contains a summary of published thought on the possibility that Mary Lincoln had syphilis.

[17] In the normal eye, the pupil will constrict in response to bright light (sometimes called the light reflex), or when focusing on a near object (also known as accommodation). Argyll Robertson pupils no longer constrict in response to light but still react to accommodation. This symptom was named for Scottish ophthalmologist Douglas Argyll Robertson (1837–1909), who described it in 1869.

[18] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., text revision (Washington, DC: American Psychiatric Association, 2000), 463–68, hereafter cited as DSM-IV-TR.

[19] Rodney Ross, "Mary Todd Lincoln: Patient at Bellevue Place, Batavia," *Journal of the Illinois State Historical Society* 63, no. 1 (Spring 1970): 5–34 contains a transcription of Mrs. Lincoln's daily patient notes while at Bellevue Place, and Hirschhorn and Feldman, "Mary Lincoln's Final Illness," contains the 1882 medical evaluation submitted to Congress.

[20] Brust, "The Psychiatric Illness of Mary Lincoln," 185–86.

[21] Emerson, *The Madness of Mary Lincoln*, 40, 103, 129, 174.

[22] DSM-IV-TR, 740–41.

[23] Katherine Helm, *The True Story of Mary, Wife of Lincoln* (New York: Harper and Brothers, 1928), 227. "Uncle Alec" was Mary's youngest half brother, Lieutenant Alexander H. Todd, who was killed while serving with Confederate forces at Baton Rouge, Louisiana, in August of 1862; see Stephen Berry, *House of Abraham: Lincoln, and the Todds; A Family Divided by War* (Boston: Houghton-Mifflin, 2007), 126–28.

[24] Neely, *Insanity File*, 6, 11; Emerson, *The Madness of Mary Lincoln*, 33, 40.

[25] Emerson, *The Madness of Mary Lincoln*, 44–46 gives a good description of Mary Lincoln's symptoms between March and May of 1875.

[26] DSM-IV-TR, 349–56.

[27] Neely, *Insanity File*, 15–16; Emerson, *The Madness of Mary Lincoln*, 24, 45–46.

[28] DSM-IV-TR, 357–62. The terms manic depressive illness and bipolar disorder had not yet come into use during Mary Lincoln's

lifetime, but for ease of understanding, I will use them.

[29] Emerson, *The Madness of Mary Lincoln*, 25.

[30] *Ibid.*, 46.

[31] *Ibid.*, 101.

[32] DSM-IV-TR, 422–23.

[33] Michael Burlingame, *Abraham Lincoln: A Life* (Baltimore: Johns Hopkins University Press, 2008), unedited manuscript on the Knox College website <<http://www.knox.edu/Academics/Distinctive-Programs/Lincoln-Studies-Center/Burlingame-Abraham-Lincoln-A-Life.html>>, 538–39, accessed August 5, 2010.

[34] *Ibid.*, 535–40.

[35] Neely, *Insanity File*, 34–35; Emerson, *The Madness of Mary Lincoln*, 67–70; Norbert Hirschhorn, "Mary Lincoln's 'Suicide Attempt': A Physician Reconsiders the Evidence," *Lincoln Herald* 104, no. 3 (Fall 2003): 94–98. Laudanum is a liquid medication containing various forms of opium. Like other narcotics, it is usually taken to relieve pain, but since an overdose can cause fatal suppression of breathing, laudanum ingestion was a frequent method of suicide in the nineteenth century.

[36] Shorter, *A History of Psychiatry*, 274–77.

[37] For a good review of the history of manic-depressive illness/bipolar disorder, see Frederick K. Goodwin and Kay Redfield Jamison, *Manic-Depressive Illness* (New York: Oxford University Press, 1990), 56–61, 70.

[38] Jean H. Baker, *Mary Todd Lincoln: A Biography* (New York: W. W. Norton, 1987).

[39] *Ibid.*, 317–18, 323–24.

[40] Neely, *Insanity File*, 19–21; Emerson, *The Madness of Mary Lincoln*, 55–56.

[41] Ross, "Mary Todd Lincoln: Patient at Bellevue Place," 32, quote from patient record entry for August 6, 1875.

[42] Baker, *Mary Todd Lincoln: A Biography*, 324, 331, 345; and Catherine Clinton, *Mrs. Lincoln: A Life* (New York: HarperCollins, 2009), 300, 304–5. Chloral hydrate was the first sedative synthesized in the laboratory (1832) and was used extensively in psychiatry beginning in the late 1860s. Though it has largely been replaced by other agents, it remains available today and I still prescribe it on rare occasion. See Louis S. Goodman and Alfred Gilman, *The Pharmacological Basis of Therapeutics*, 3rd ed. (New York: MacMillan, 1965), 131–34; and Shorter, *A History of Psychiatry*, 198–99.

[43] Ross, "Mary Todd Lincoln: Patient at Bellevue Place," 26–34.

[44] Elyn Saks, JD, "Some Thoughts on Denial of Mental Illness," *American Journal of Psychiatry* 166, no. 9 (September 2009): 972–73. On schizophrenia, see DSM-IV-TR, 297–317.

[45] Carrie Fisher, *Wishful Drinking* (New York: Simon and Schuster, 2008), 159.

Ancient World

A Medical History: Thucydides and Historiography

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Thucydides stands unique in Western history as one who concerned himself with the diseases and ills of the state, empowered by his empirical scientific study of both history and political science. *The History of the Peloponnesian War* chronicles the war in all its detail of slaughter and politics, from the council debates of Athens and Sparta to the battlefields of Greece. Thucydides work is astounding in its historical method

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that approaches modernity in its scope. Similarly, his political insights are acute and cutting. Yet one must wonder where this historiography came from. To read *The History of the Peloponnesian War*, one cannot help but be amazed by Thucydides' almost modern day methodology. The answer to this may rest in the very heart of the scientific and intellectual revolution of Greece prior to the outbreak of the Peloponnesian War. The prosperity and economic boom of pre-war Athens was unprecedented in the history of Greece at that time. One

of the greatest was Hippocrates whose treatise on medicine was considered so authoritative it was used for thousands of years. Perhaps there is a connection between Hippocrates' revolutionary theories of the body and Thucydides' theories regarding the study of the body politic. Thus, to look for a cause of Thucydides' methodology, it behooves one to first look at his writings and then at the intellectual environment in which he created them.

Born to a mid-rank Athenian noble family in Thrace during the golden age of Athens, Thucydides

lived in the very heart of history. Aeschylus, Sophocles, and Aristophanes composed major works of drama. Hippocrates of Cos was born around 460 BCE and began his school of medicine in Athens, which led to the composition of the body of works known as the *Hippocratic Corpus*. The city-states of Greece prospered in the peace before the war. Mines there in the Thrace mountains provided Thucydides with a sufficient income to be financially independent. Best estimates place his birth around 460 BCE. He himself claims, "I lived through the whole of [The Peloponnesian War], being of an age to understand what was happening." [1] He was also of the age to hold the position of *stratagos*, or general, at the Battle of Amphipolis. It seems that he began his major work, *The History of the Peloponnesian War*, during the war and finished after it concluded. For failure to prevent the fall of Amphipolis, Thucydides was exiled from Athens and probably did not return until the end of the war. Thucydides himself believed this put him in a position to record the war from the perspective of both combatants. "I saw what was being done on both sides...because of my exile, and this leisure gave me rather exceptional facilities for looking into things." [2] Note the word 'leisure', for we shall return to it. Thucydides' exile took place in 424 BCE, about a decade into the war. This left him twenty years in exile till the defeat of Athens in 404 BCE. He died in Athens soon after his return to the city, though the date is not known. [3]

The *History of the Peloponnesian War*, has become one of the foundations of Western history and thought. Thucydides writes with a candor and insight that strikes the modern reader. The modernity of Thucydides' methods as well as his political, military, and economic acumen is astonishing. Incredibly, in some cases he is almost prophetic in his predictions [4]. Yet what is perhaps most astounding is that Thucydides is writing with almost no historical tradition to speak of. It is as if, *deus ex machina*, Thucydides one day invented a historical method comparable to our ACESO

modern tradition. The amount of squeamishness on the part of modern historians when it comes to Thucydides is prodigious. Perhaps one explanation for this is that his work defies conventional definitions. In addition, one gets the impression that Thucydides' self-awareness seems to spook modern historians in a way that affects their opinion. As well they should, because Thucydides' methods are eerily similar to our own.

"My work is not a piece of writing designed to meet the taste of an immediate public, but was done to last forever"

Early in his writings he enters into a discussion of his historical methods. It is these passages that stand out immediately from the rest of his work as something unique. However, his own discussions of his methods are spread out over several chapters and are only briefly treated here. First Thucydides speaks of his inadequate historical tradition, "In investigating past history, and in forming the conclusions which I have formed, it must be admitted that one cannot rely on the every detail which has come down to us by way of tradition." [5] Yet Thucydides is able to draw conclusions from his study and he openly mocks any predecessors who have come before him,

It is better evidence than that of the poets, who exaggerates the importance of their themes, or of the prose chroniclers, who are less interested in telling the truth than in catching the attention of their public, whose authorities cannot be checked, and whose subject-matter, owing to the passage of time, is mostly lost in the unreliable streams of mythology. We may claim instead to have only the plainest evidence and to have reached conclusions which are reasonably accurate, considering that we have been dealing with ancient history. [6]

Indeed, immediately preceding this passage Thucydides criticizes Herodotus' inaccuracies. However it is important to note that he does not mention him by name, perhaps out of deference to him. Even with all this, Thucydides is not only aware of his limitations, but is able to nonetheless attempt to piece the parts of history together. It is this calm, self-supposed superiority that will later prompt Cochrane to formulate his view of

Thucydides the 'scientist'. [7]

And with regard to my factual reporting of the events of the war I have made it a principal not to write down the first story that came my way, and not even to be guided by my own general impressions; either I was present myself at the events which I have described or else I heard of them from eye-witnesses whose reports I have checked with as much thoroughness as possible. Not that even so the truth was easy to discover: different eye-witnesses give different accounts of the same events, speaking out of partiality for one side or the other or else from imperfect memories. [8]

His claim to a critical treatment of sources is impressive, for it may be the first conscious example of this in western tradition. With actual historical fact Thucydides is able to be more 'scientific' in his history. Good data will lead to good theories, so accurate reports are needed. Thucydides is also acutely aware of what he is writing, and knows that its reception may be mixed compared to the other works of his day,

And it may well be that my history will seem less easy to read because the absence in it of a romantic element. It will be enough for me, however, if these words of mine are judged useful by those who want to understand clearly the events which happened in the past and which (human nature being what it is) will, at some time or other be repeated in the future. My work is not a piece of writing designed to meet the taste of an immediate public, but was done to last forever. [9]

Yet Thucydides is the calm, self-assured historian, able to commend his work to eternity for its historical significance, a work of monumental effort to define and describe a pan-Hellenic war that lasted decades and shook the foundation of Greek society.

Thucydides realism is also of part of his modernity and originality. Of the many examples of Thucydides' realist approach to politics and history the most striking is his analysis of the cause of the Peloponnesian War. Steven Forde describes realism in part as, "skepticism regarding the applicability of ethical norms to international politics." [10] Thucydides has that in spades,

War began when the Athenians and the Peloponnesians broke the Thirty Years Truce...As to the reasons why they broke the truce, I propose first to

give an account of the causes of complaint which they had against each other and of the specific instances where their interests clashed...But the real reason for the war is, in my opinion, most likely to be disguised by such an argument. What made war inevitable was the growth of Athenian power and fear which this caused in Sparta. As for the reasons for breaking the truce and the declaring war which were openly expressed by each side, they are as follows.[11]

The “causes of complaint” spoke of here are the trumped up charges that Athens and Sparta levied against each other. This interpretation cuts to the heart of the matter with ease and simplicity. Thucydides brushes aside the doublespeak of the political posturing between Athens and Sparta and shows the reader the real reason that war is waged: power, and fear that its accumulation creates.

Beyond an examination of Thucydides’ methods and morals, it is equally important to examine how he conceived of these notions. The theories proposed by historians on this issue and debates they cause are legion. No one theory can explain all that there is to Thucydides, there is one that draws several well founded conclusions. In *Thucydides and the Science of History*, Cochrane notes a fascinating parallel between Thucydides and Hippocrates. It is Cochrane’s contention that Thucydides was aware of Hippocrates and his inquiries into a scientific approach to medicine, and that Thucydides borrowed those methods and applied them to history. It is this concept of himself a scientist and his scientific approach to history that gave Thucydides the “calm assurance with which he commends his *Histories* to the world as a possession forever.”[12]

Cochran relates Hippocrates to Thucydides in several ways. First is Thucydides’ and Hippocrates’ secularism.[13] Also, Cochrane indicates that Thucydides borrows medicine’s ability to predict the progress of an illness as a way to predict history from a study of the past.[14] However there is one glaring example that Thucydides himself gives in his account of the plague in Athens. In a work where Thucydides is overly careful not to stray off topic, in Book II there is long discussion of the plague and its effects. In fact, Thucydides’ describes the symptoms of the plague in a very clinical

manner.[15] It seems strange that Thucydides could almost exactly emulate the Hippocratic method[16] of cataloging and codifying disease.

Cochrane’s theory is a fascinating way of explaining the methods of Thucydides. It seems a poignant note that “Almost simultaneously with the birth of natural science...the new critical history came into being.”[17] One cannot help but be struck by the compelling idea that the study of science gave Thucydides the breadth of tradition to turn history into science. Out of a tradition of poets and literary histories, Thucydides was born in a golden age of prosperity and intellectual development. He lived to witness the chaos of a Greece torn apart by years of war and massive loss of life, a war spread across the Aegean and Adriatic seas, a war of Greek against Greek. Thucydides emerged from this with a revolution in thinking, perhaps influenced by the scientific and medical revolution that flourished in Greece of his youth. ◆

Notes:

[1]Thucydides. *The History of the Peloponnesian War*. Translated by Rex Warner. London: Penguin Publishing, 1972, Book V:26.

[2]Thucydides, Book V:26.

[3] Specific dates are taken from M.I. Finley’s introductory essay to the Rex Warner translation.

[4] Specifically the case in point is Thucydides’ discussion of the archeological records of Athens and Sparta. See Book I:10. There is something so spectacular about this that it begs to be mentioned here. This is the fate of the ruins of Athens and Sparta in modernity. Thucydides speculates on how future generations would view the power of Athens and Sparta based solely on the ruins that they would leave behind. This vision is almost prophetic in its accuracy today in regards to the importance attributed to the ruins of Athens and the neglect of the ruins of Sparta as a sight of historical interest.

For his proto-archeology in the burial

sites on the island of Delos, see Book I:8.

[5] Thucydides, Book I:20.

[6]Thucydides, Book I:21.

[7]Cochrane, Charles. *Thucydides and the Science of History*. London: Oxford University Press, 1929.

[8]Thucydides, Book I:22.

[9]Thucydides, Book I:22.

[10]Forde, Steven. “Varieties of Realism: Thucydides and Machiavelli”. *The Journal of Politics*. Vol. 54, No. 2 (May, 1992), pg. 373.

[11] Thucydides, Book I:23.

[12]Cochrane, pg. 2.

[13] Cochrane, pg. 17.

[14]Cochrane, pg. 8.

[15] Cochrane, pg. 12.

[16]Cochrane, pg. 27.

[17]Holborn, Hajo. “Greek and Modern Concepts of History”. *Journal of the History of Ideas*. Vol. 10, No. 1 (Jan., 1949), pg. 3.

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Ethics

“Our Message is Unequivocal”: The Stake of Physician Advocacy in Reproductive Health

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*For the sake of their patients and the profession of medicine,
physicians will have to pay more attention to politics.*

- George Annas (2007;2207)

*Politicians were not elected to, nor should they, legislate the practice of
medicine or dictate the parameters of the doctor-patient relationship.*

Our message to politicians is unequivocal: Get out of our exam rooms.

- Dr. James T. Breenan, President of ACOG[1] (2012)

We, as future physicians, are walking into the practice of medicine at a particularly contentious time, especially for those with an interest in reproductive health. From proposed cuts to Planned Parenthood and Title X clinics to the controversial (and now deferred) Virginia bill requiring transvaginal ultrasounds prior to elective terminations[2], and suits from the Catholic Church against the proposed federal mandate ensuring contraceptive coverage under health insurance policies, the past year in reproductive health has been fraught with controversy and complex challenges (Gold 2011; New York Times 2012; Vogel 2012; McDonnell 2012; Goodstein 2012). Complicating the field further are the loopholes

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present in the recent Supreme Court upholding of the Affordable Care Act (Liptak 2012), allowing states to opt out of expanding their Medicaid programs (*ibid.*), and President Obama’s executive order assigning the Hyde Amendment[3] to this piece of legislation (Annas 2010). I bring up these recent developments in reproductive health to set the stage for describing the female body in politics today - its biological, social, and sexual functioning, especially in the context of abortion - and how governmental regulations and court decisions ascribe (or rather, inscribe) a particularly patriarchal and oppressive structure to the everyday actions of women.

Medicine cannot and will not be practiced in a biological vacuum; life seeps into the seemingly sterile boundaries of our clinics, emergency rooms, and operating tables. Understanding these new developments in healthcare, therefore,

must take into account how such actions impact the everyday lives of our patients. Using theory from fields such as medical anthropology and public health can unveil the historical, political, social, economic, and gendered biases present in current debates surrounding reproductive health, and can ultimately demonstrate how we can change the way these issues are presented, discussed, and ultimately regulated on a grand scale. The current legislative challenges in reproductive healthcare policy structure an economy of medical regulation, impacting how physicians will or will not be able to provide adequate and necessary care for our patients. The elements of this overemphasis on sexual and reproductive control of bodies, specifically female bodies, find its nidus in those most vulnerable in the structure of inequality present in healthcare today: low-income, minority women. The arguments presented in this essay are not new, but I feel that the challenges to

medical students and physicians are, especially in the context of the implications for our political action and the consequences of our potential inaction.

History and the "Vulnerable Woman"

According to George Annas, with the passage of *Roe v. Wade* (1973) and *Doe v. Bolton* (1973), the physician-patient relationship, in regard to abortion, was supported by the right to privacy (2007;2201). However, with the Supreme Court upholding of the Hyde Amendment in *Harris v. McRae* (1980), the court shifted its methodology of discussion, focusing on agency, rather than privacy:

The court ruled [...] that "a woman's freedom of choice [does not carry] with it a constitutional entitlement to the financial resources to avail herself of the full range of protected choices." [...] According to the Court, because the government did not cause women to be poor, it is not obligated to level the playing field for poor women: "Although government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those not of its own creation, and indigency falls within the latter category" (Boonstra 2007;13)

The emphasis placed on individual liberty, especially in regard to socioeconomic inequality, paved the way for further court rulings that chose to highlight the individual woman herself, rather than the relationship between a physician and a patient. For example, with *Planned Parenthood v. Casey* (1992), the notion of "personal liberty," rather than privacy, was invoked to demonstrate that "undue burdens" could not be implemented to coerce or limit the exercise of this freedom. The shift in thinking of the Supreme Court - from concepts of privacy to individual choice - and the abdication of governmental responsibility for individual poverty provide a scenario in which structural vulnerability comes to the foreground in reproductive health politics (see Quesada, Hart, & Bourgois 2011 & Green 2011) and the limits of agency become justification for governmental inaction.[4]

Ultimately, through these Supreme Court rulings, the caricature of a woman - here, I refer to her as the "vulnerable woman" - is introduced into the political foreground of ACESO

abortion politics.[5] This presupposed being is described in further rulings made by the Supreme Court in *Rust v. Sullivan* (1991)[6] and invoked in Justice Ruth Bader Ginsburg's dissenting opinion in *Gonzales v. Carhart*:

The majority [ruling] seeks to bolster its conclusion by describing pregnant women as in a fragile emotional state that physicians may take advantage of by withholding information about abortion procedures. Justice Ginsburg concludes that the majority's solution to this hypothetical problem is to deprive women of the right to make an autonomous choice, even at the expense of their safety." She continues, "This way of thinking [that men must protect women by restricting their choices] reflects ancient notions about women's place in the family and under the Constitution - ideas that have long since been discredited" (Annas 2007;2205)

A startling, disillusioning picture of the vulnerable woman is beginning to form. Governmental inaction secondary to female autonomy and despite structural inequality, described in *Harris v. McRae* and *Planned Parenthood v. Casey*, is contrasted with the "fragile, emotional woman," easily coerced, in the dissenting opinion of Justice Ginsburg in *Gonzales v. Carhart* and rulings like *Rust v. Sullivan*. In both respects, the vulnerable woman is described both with and without autonomy, in poverty and absent of it, able to speak and mute.[7] As she exists, the vulnerable woman simultaneously offers a wish fulfillment of a masculine government protecting the bodies of weak women from undue violation (i.e. abortion) and an image of female independence tainted with the double-edged sword of social, political, and economic inequality.[8]

Biopolitics, the Limits of Agency, and Physician Action: What Should We Do?

As medical students and future physicians, why should we even care about something as theoretical as the vulnerable woman? How will this help us provide care? I urge us to consider this anthropological and philosophical understanding in light of recent court cases and legislation - starting with *Gonzales v. Carhart* at the federal level and continuing to the recent debates in Virginia over the role of

transvaginal ultrasound in elective pregnancy terminations and questions of personhood in Alabama (William 2012). These acts are, in effect, dictating what physicians can and cannot provide to their patients. The physician-patient relationship, enshrined under the right to privacy via *Roe v. Wade*, is slowly being eroded away by individuals invoking the concept of the vulnerable woman as justification for regulating the therapeutic relationship. The woman as a self-made victim, unable to speak for herself, easily manipulated, but able to make her own decisions, must be protected; even further, her body - her ability to reproduce - must be regulated. Biopolitics - or what philosopher Michel Foucault describes as the "subjugation of bodies" (Foucault 1978;140) via techniques of power exercised through institutions like the legislature, prisons, or the hospital/clinic - are the meeting ground where physicians and politicians clash. In this circumstance, the tension is not merely regarding the autonomy of physicians to practice in the best interests of their patients or the invasion of the clinic by morally-inspired or non-medically indicated procedures, but also in regards to the use of a violently misogynistic and non-representative image of womanhood and autonomy to justify such claims.[9]

I do not want to use this forum to promote a pro-choice or pro-life discussion. I, instead, want to pose a question to our fellow medical students and physicians on either side of this broad, undefined line: although the discussions regarding abortion are important to the future of medicine in this country, does the reliance on the vulnerable woman and the missing discourse on the role of inequality in constricting agency mean that we, as people on both sides of this debate, effectively leave those most hurt by the current struggle - low-income, minority women - out of the picture? Moreover, does this action constitute passive acceptance of a misogynistic portrayal of women, especially poor and minority women?

I turn here to facts: almost half of pregnancies in the United States are unintended, with four out of ten poor women lacking insurance coverage.

Moreover, disparities in contraceptive usage are exacerbated by socioeconomic status and “race”[10]:

Over the course of a year, 28% of poor women at risk of unintended pregnancy experience one or more gaps of at least one month in their contraceptive use, compared with 19% of more affluent women; 30% of black women and Latinas at risk experience such a gap in contraceptive use, compared with 19% of white women (Gold et al. 2009;10)

This discourse, though advocated on the legislative and national level by groups like Planned Parenthood and the Guttmacher Institute, does not figure into many public debates we as a country have about reproductive health. Beyond the moral quandaries surrounding abortion, one thing is made clear: women, especially those who are poor and are of minority status, have little stake in this political game (Annas & Mariner 2011;1590). Moreover, because of the zone of silence surrounding these individuals, the injection of the vulnerable woman into the political schema does not allow for a meaningful or socially relevant discussion of those who will feel the brunt of future legislation. Agency and socioeconomics are left solely out of the question in these regards. Moreover, the vulnerable woman is used as a justification for legislation that negatively impacts the physician-patient relationship, introducing unwanted governmental influence into the physician decision-making process. It’s time, to quote Brennan, to tell politicians to “get out of our exam rooms.”

So what do we do as future physicians? Beyond echoing Annas in the epigraph, the role of witnessing and advocacy have a clear role in bringing alive and challenging the current analyses of this crucial question. Gruen and colleagues note that physician advocacy “[...] bridge[s] the gap between rhetoric and reality—the rhetoric of social responsibility espoused in aspirational statements of professionalism and the realities of medical practice and the mechanisms by which social factors affect the health and care of patients” (2004;98). Moreover, our proximity to suffering and inequality, along with an important public role, makes physicians and students, “natural advocates.” Witnessing inequality, to ACESO

quote J.M. Coetzee, is to “suffer the shame of it” (Coetzee 1980;136). The role of students and physicians in this context goes beyond advocating for or against abortion, but in affirming that, yes, socioeconomic inequality has a huge role to play in agency and access to reproductive health services and yes, our patients have their own opinions and desires regarding their pregnancies that are supported, not coerced, by their physicians. Our action undoes the shame Coetzee ascribes to our witnessing; our advocacy helps to build solidarity and confidence with our patients so that we as a community can speak up and out about suffering and inequality. The voices of our patients at Boston Medical Center, individuals who are predominantly low-income and minority, can reclaim the vulnerable woman, giving her a voice that was once silenced by oppressive sociopolitical machinations. We as future physicians should, regardless of our moral or ethical views, support and empower our patients, whether through their own advocacy or our own, to have a stake in sexual and reproductive health. Without witnessing or advocacy on our part, the dialogue on reproductive health in America will continue to misrepresent and exclude the lives of the women we seek to empower and treat. ◆

Notes:

[1] American College of Obstetrics and Gynecology.

[2] See Annas 2007 for an eerie prediction of this bill in the wake of the Supreme Court upholding of the “partial-birth abortion” ban in *Gonzales v. Carhart*.

[3] According to George Annas, the Hyde Amendment is a “[...] a long-standing prohibition against the use of federal funds for abortions, except in cases of rape, incest, or risk to the life of the pregnant woman” (Annas 2010;e56(1)). Initially attached to Medicaid reforms in the mid-1970’s by Representative Henry Hyde (R-IL), the amendment underwent challenge in the Supreme Court (*Harris v. McRae*), and was ultimately upheld, with attachment to multiple iterations of Medicaid revisions (Boonstra 2007).

[4] It is important to note that theories of

structural vulnerability and violence, described eloquently by individuals like Philippe Bourgois, Paul Farmer, and Nancy Scheper-Hughes, are rooted in analyses of governmental policy and routinization of “everyday violence” (Scheper-Hughes 1992). The fact that the Supreme Court did not describe the role of *Plessy v. Ferguson*, state-sponsored Jim Crow laws, and the government-supported creation of the inner-city ghetto speaks to a particular analysis of American history regarding governmental (a)responsibility in the “racially”-targeted creation of poverty (see Wacquant 2000).

[5] Here, I invoke the concept of the “abducted woman” described by Veena Das in her description of how patriarchy became enshrined in the national image of India via rape and violence during the partition of Pakistan and India in 1947 (see Das 2007).

[6] This Supreme Court case upheld a Department of Health and Human Services regulation that stipulated that individuals receiving Title X funds could not counsel patients regarding abortion (see Fitzpatrick 1992). This so-called “gag rule” was suspended by President Clinton in 1993 and formally repealed in 2000 (Guttmacher Institute 2000).

[7] Recent hearings in the House Committee on Oversight & Government Reform regarding contraceptive coverage were marred with controversy when it was revealed that the first round of witnesses were composed of no women, and the only woman invited to testify was subsequently rebuked for “not being qualified” (Flock 2012; Zornik 2012). Silencing of women’s voices, therefore, bleeds into the concept of the vulnerable woman on a national scale.

[8] These images are reminiscent of the universal images associated with the hyperghetto, or an “ethnoracial space of enclosure” for African-Americans, linking the modern urban ghetto with the prison-industrial complex (see Wacquant 2012). The image of the teenage welfare mother – “dark-skinned, urban, and undeserving” (*ibid* 2002) – is a major image that helped to contribute to the gutting of social safety net in 1996 with the passage of the Personal Responsibility and Work Opportunity Act (see Wacquant 2010; Viladrich 2012).

[9] In his critique of Foucault, Fassin describes how biopolitics and governmentality, or the rationalization of a form of ruling, allow for a “homogenization of lives” (Fassin 2009;54). In this vein, the image of the vulnerable woman becomes a universal caricature in the debates surrounding “the sort of life which is defended today” (*ibid*;52) i.e. the sociopolitical “legitimacy” given to certain dialogues regarding reproductive health on the national and local levels – what Fassin describes as “biolegitimacy.” These anthropological concepts

must be reconciled with clinical and biomedical arguments supporting reproductive health, as they have a major impact on how healthcare is conceptualized by groups impacting policy, access, and regulation of health services (see Willen 2012 for a further discussion of health-related “deservingness”).

[10] “Poor” is defined as having a family income less than 100% of the federal poverty level (approx. 17,600 USD in 2008 for a family of 3) (Gold et al. 2009;10).

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Book Review

Rabies, a Virus to Remember

Rabid: A Cultural History of the World's Most Diabolical Virus

By Bill Wasik and Monica Murphy, New York: Viking, 2012.

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For most of us, rabies is rarely a topic of conversation. It may cross our minds once every few years when the dogs are due for their shots, but in the wealthier countries, it is no longer a disease that motivates terror or even much interest. In *Rabid: A Cultural History of the World's Most Diabolical Virus*, *Wired* magazine editor Wasik and veterinarian Murphy remind us how much of an impact rabies has had on our past, from human-animal relationships to international relations. Though the book is marketed to a general audience, the level of detail suggests the potential for scholarly use; citations are not found in-text, they can be located in an extensive notes section at the end.

Rabies is intertwined with human history in general and the history of medicine in particular. Because it was once so pervasive, rabies was consistently considered by healers over time, and by following this path, it is possible to trace the evolving concepts of disease and medicine. Readers can laugh at some the preposterous-sounding treatments prescribed in ancient and medieval times: the application of the semi-plucked anus of a live rooster, for example, is no longer considered a promising way to “suck forth the poison.” The paradigmatic triumph of germ theory unfolds when Louis Pasteur selected rabies for the focus of one of his earliest vaccine efforts, forever changing the power of this pathogen in our world. This effort also lead to a new understanding of an unseen entity called the “virus.”

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Though much of the sociological scrutiny found in contemporary historical scholarship is absent here, the narrative nevertheless provides an engaging entree into the worlds of history and microbiology.

One of the most fascinating chapters of this book suggests a connection between the history of rabies and the folkloric concepts of vampires and werewolves, still omnipresent in the popular consciousness and especially in teen literature today. Indeed, some of the distinctive symptoms of rabies do call to mind the unsanitized versions of these terrifying figures: mouth foaming, vocalizations that sound like howling, priapism, and uncontrollable ejaculation. Hydrophobia, or the body's rejection of water through convulsions and terror, is almost impossible to fathom from the comfort of the modern, industrialized world. The authors make a good case for the persistence of these themes as a legacy of rabies and other diseases that originated in animal hosts: “The animal infection – the zoonotic idea – is mankind's original horror, and its etiology traces back inevitably to the rabies virus.”[1]

The intersection of rabies and present-day medicine and biotechnology is also a fascinating theme within this book. For example, in the final chapter, the authors outline a technological project that uses genetic material from the rabies virus as part of an engineered vehicle for biomedical treatments. Because of its ability to cross the blood-brain barrier, the once lethal power of rabies is now being “enslaved” in the name of

science. This development is both promising and disconcerting. The authors continue their imagery of the diabolical in entitling this chapter “The Devil, Leashed.” One must wonder if human triumph is indeed the end of the story.

Unlike the eradicated threat of smallpox, rabies still claims victims in the world today. Classified as a Neglected Tropical Disease (NTD), rabies still kills over 55,000 people per year globally[2]. In areas where the vaccine is unavailable and unaffordable, the virus remains almost 100% fatal. After reading this book, it is now impossible to forget how much pain and horror accompanies each of these deaths. It is also essential that we not become too *blasé* about infections of the past, because they have an uncanny way of returning to the present. For example, it was once widely held that science had triumphed over tuberculosis, but it has shown a dangerous and persistent resurgence in the era of HIV, its rebirth also bringing drug resistance. An understanding of rabies helps us to understand the ways in which pathogens, animals, and humans have been intertwined throughout history, and remain intertwined today. ◆

Notes:

[1] Bill Wasik and Monica Murphy. *Rabid: A Cultural History of the World's Most Diabolical Virus*. New York: Viking, 2012.

[2] www.who.int/mediacentre/factsheets/fs099/en

