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The Etiology of Music: Frederic Chopin and the Consumptive Ideal

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**The Etiology of Music:
Frédéric Chopin and the Consumptive Ideal**

by
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A thesis submitted to the Department of Music at Trinity
University in partial fulfillment of the requirements for
graduation with departmental honors.

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Abstract.

Although disease, in many ways, helped shape the life of Polish pianist and composer Frédéric Chopin (1810-1849), its social implications have rarely been examined in biographical studies on the composer's life. In this study, the medical literature on tuberculosis disease (formerly known as consumption) from the 19th century was examined for its significance in influencing public perceptions of the innovative musician during his lifetime. It was found that Chopin's 19th-century profile as a effeminate pianist and composer may have been at least partially established through his embodiment of the 19th-century consumptive ideal.

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For Dr. Carl Leafstedt.

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Introduction.

Medical history has often been neglected in Chopin studies. This seems surprising. Admittedly, mention is generally made of Chopin's constant battle with illness, and the image of Chopin as a suffering artist also appears to be quite strong in western classical music history. But for a composer whose life was, in many ways, *shaped* by disease, it seems important for any Chopin biography to take the image of the suffering artist one step further and examine how both disease and societal perceptions of disease may have influenced both the pianist/composer's acceptance into the elite circles of Paris and his own personal choices in composition and style.

For this reason, I have chosen to take in hand the music and life of Frédéric Chopin, a most beloved 19th-century figure, to examine closely the twists and turns that disease, namely tuberculosis, may have caused for him, both personally and socially, while living in Paris.

The essay has been divided into three chapters. I begin in Chapter 1 with an examination of Chopin's life. The primary purpose of this chapter is simply to prove that a very basic connection between Chopin and tuberculosis existed in the 19th century. In order to establish this relation, I have included information about Chopin's physicians and their various diagnoses, treatment plans, and comments. Excerpts from letters written by Chopin and his contemporaries, reviews of his concerts, and anecdotal stories also have been compiled in order to understand how his illnesses were being interpreted in society, and particular attention has been paid to connections between the physical repercussions of disease and frailty and Chopin's compositional and playing style. Niecks' biography was particularly helpful in locating comments made specifically in the

19th century, since the author so thoroughly recorded direct quotes, reviews, and anecdotal stories from Chopin's contemporaries in his book. An alternative hypothesis from modern medicine, namely cystic fibrosis, is also considered.

Upon establishing the underlying connection between tuberculosis and Chopin, I continue in Chapter 2 with a medical and historical exploration of the disease. Beginning with an outline of tuberculosis as it is understood today, I then attempt to lay out the medical literature on consumption from the 19th century. I primarily focus on the writings from France; however, treatment and theories from Italy, Spain, and England, have also been noted. Barnes' book on the social views of consumption in 19th-century France was especially useful in writing this chapter.

Chapter 3 can best be described as the crux of the essay; Chapter 1 and 2 unite here, as the influences of medical literature on the 19th-century perceptions of Chopin are examined. The writings of Laënnec, as well as the articles by Benoiston, Lombard, and P.C.A. Louis from Chapter 2 are further explored for their correlations to the life of Chopin. Of particular note in this chapter are the connections between gender-associated biases in the consumption literature with the music of Chopin. The C# minor nocturne from Op. 27 has also been examined as part of the analysis.

Researching Chopin from the perspective of both a medical and music historian has led me to conclude that medical literature is, indeed, relevant to the study of Chopin in music history. As noted in Chapter 3, Chopin's physically diminutive frame and his tendency to compose music that was both revolutionary and effeminate lent themselves well to interpretations of the romanticized medical literature on consumption. And

ultimately, it appears that Chopin, a prominent figure from music history, may have actually represented a sort of 19th-century “poster-child” for consumption.

Chapter 1: *Defining the Obscure: Was Chopin consumptive?*

Before examining the repercussions of disease in the life of Polish composer and pianist Frédéric Chopin (1810-1849), it is necessary to clarify which disease the composer was assumed to suffer from during the 19th century. Biographies and articles often state or imply tuberculosis disease (otherwise known as consumption) as the source of Chopin's constant health problems. However, the reasons *behind* such assumptions are rarely thoroughly addressed. Admittedly, physicians have returned to Chopin's medical history to reassess the validity of Chopin's assumed diagnosis of tuberculosis with their advanced understanding of the human body. But because their analysis relies on knowledge from the present day, their conclusions tell us nothing about whether Chopin really was or was not thought to be suffering from consumption during the 19th century.

In order to understand Chopin's health as it was understood during his life, a close review of his illness utilizing letters and observations by both Chopin and his contemporaries is needed. Only then can we declare with any degree of certainty that Chopin was, in fact, thought to suffer from consumption during the 19th century. Such a task is undertaken in this first chapter, as the medical history of Chopin is examined in an attempt to evaluate the assumed link between composer and consumption, the most dreaded of all deadly diseases.

Frédéric Chopin was born on February 22, 1810, in Zelazowa-Wola, a village near Warsaw, Poland. Nothing from his early years suggests that he was unusually unhealthy; he suffered and survived the usual childhood ailments without problems.

His youngest sister Emilia, on the other hand, developed consumption at a young age. As her condition worsened, the family physician recommended taking a "cure" in

Bad Reinerz (today's Duszniki).¹ Though a nontubercular, Chopin accompanied Emilia to this spa and underwent some of the spa procedures, namely the drinking of whey and water from the spa spring, with his sister. As Chopin mentioned in a letter to his friend, Jan Bialoblocki, Emilia was also subjected to “the bloodletting, which was done once, twice, innumerable leeches, vesicle-producing plasters, mustard plasters, and herbs, adventures over adventures. During this whole period of time, she did not eat and was so run down that one could hardly recognize her, and only slowly did she somewhat recuperate.”² Unfortunately, Emilia died in April of 1827 at the age of fourteen from the disease. Chopin, at only seventeen years of age, had thus witnessed a family member die of an illness then deemed to be consumption. Years later, his father, Nicholas, would also die of tuberculosis, or, at the very least, of a heart and chest complaint.

Although Chopin generally appeared to be healthy, he was, it seems, still a fragile child. Indeed, this “delicate” health was most likely the reason that Chopin was sent to Reinerz alongside his younger sister. In his biography of Chopin, Niecks comments on a passage about Chopin's early health found in Karasowski's recount of Chopin's life:

Indeed, in Karasowski's narrative there are not wanting indications that the health of Chopin cannot have been very vigorous, nor his strength have amounted to much; for in one place we read that the youth was no friend of long excursions on foot, and in another place, that his parents sent him to Reinerz and some years afterwards to Vienna, because they thought his studies had affected his health, and that rest and change of air and scene would restore his strength. Further, we are told that his mother and sisters never tired of recommending him to wrap up carefully in cold and wet weather and that, like a good son and brother, he followed their advice. Lastly, he objected to smoking.³

¹ Franken, *Diseases of Famous Composers*, 174.

² Bloodletting was a practice invented by Broussais (1772-1838) that tried to remove disease-causing materials from the body by drainage of blood. See Franken, *Diseases of Famous Composers*, 177.

³ Niecks, *Frederick Chopin, Vol. I*, 64.

Nevertheless, in 1829 and 1830, upon finishing his schooling in Warsaw the year before, Chopin decided to travel. He visited Vienna in 1829, but had returned to Warsaw by way of Prague, Dresden, and Breslau by September of that year.⁴ Niecks notes that Stephen Heller, who had met Chopin during his brief return to Warsaw in 1830, had mentioned that the musician/composer was “then in delicate health, thin and with sunken cheeks, and that the people of Warsaw said that he could not live long, but would, like so many geniuses, die young.”⁵ It thus seems that even the early Chopin, though overall a happy and healthy individual, was physically weak and delicate enough for outside individuals to take notice.

In November of 1830, Chopin left Warsaw once again and traveled via Vienna, Munich, and Stuttgart to Paris, the city where he would remain for the rest of his life. While in Vienna, Chopin met Beethoven’s former physician, Dr. Malfatti, who wrote him letters of recommendation to give to some of the important musical figures in Paris. Chopin seems to have been in good health during this visit to Vienna; no records of treatment by Dr. Malfatti have been preserved, suggesting that the relationship between the doctor and musician was simply one of friendship. And indeed, Chopin wrote to his family in May of 1831 that his health was holding up:

I am very brisk, and feel that good health is the best comfort in misfortune. Perhaps Malfatti’s soups have strengthened me so much that I feel better than I ever did...⁶

Chopin officially arrived in Paris in September of 1831. There, with the help of the Italian Ferdinand Paër (for whom Dr. Malfatti had written Chopin a letter of

⁴ Niecks, *Frederick Chopin, Vol. I*, 93.

⁵ Niecks, *Frederick Chopin, Vol. I*, 64-65.

⁶ Niecks, *Frederick Chopin, Vol. I*, 174.

recommendation), Chopin was introduced to the musical elite, namely Rossini, Cherubini, Bellini, Berlioz, and Liszt, and heartily welcomed into the salons.⁷ Due perhaps to his polished, aristocratic manners, he was, within a year, mixing with the elite of Parisian society. Although somewhat fearful of performing in public, Chopin also began playing piano regularly in the salons and eventually began earning his income through teaching and his compositions.

Chopin's health during these early years in Paris seems to have been trouble-free. Again, no records indicate that he was at any time noticeably weaker than usual. Chopin himself supposedly remarked to his good friend, the cellist Franchomme, in September of 1832 that "people feel that I gained weight and that I look healthy."⁸ Franken also notes in his summation of Chopin's illness that his friends found him to be in excellent health, with composer and violinist Orłowski noting to his relatives in 1834 that Chopin was healthy and strong and that all the French girls were falling in love with him.⁹

Perhaps the first noticeable signs of a decline in Chopin's health occurred in 1835. According to Atwood, these early illnesses were most often cast aside by his Parisian doctors as mere bouts of "bronchitis" or "influenza." Nevertheless, these short periods of sickness appear to often have been quite serious: upon falling sick in November, 1835, Chopin's health had deteriorated so much that rumors of his death began to spread through Poland. (These rumors, of course, were corrected as Chopin recovered.)¹⁰

The composer continued to periodically fall sick over the next few years. In the winter of 1837, shortly after Chopin had first been introduced to his future lover, George

⁷ Niecks, *Frederick Chopin, Vol. I*, 230.

⁸ Franken, *Diseases of Famous Composers*, 175.

⁹ Franken, *Diseases of Famous Composers*, 175.

¹⁰ Atwood, *Fryderyk Chopin: Pianist from Warsaw*, 95, 104.

Sand, the composer/pianist wrote to Anton Wodzinsky that he was suffering—once again—from the flu (grippe). Chopin wrote:

My dearest life! Wounded! Far from us—and I can send you nothing... Titus [Woyciechowski] wrote to ask me if I could not meet him somewhere in Germany. During the winter I was again ill with influenza. They wanted to send me to Ems. Up to the present, however, I have no thought of going, as I am unable to move. I write and prepare manuscript. I think far more of you than you imagine, and love you as much as ever. F.C.¹¹

Franken notes that he was treated for this ailment with vesicle producing plasters and cupping by his childhood friend, Dr. Jan Matuszynski. It seems that Matuszynski was also one of the individuals who suggested to Chopin that he take the short sojourn away from Paris—Ems Spa was a popular location for patients with respiratory problems like tuberculosis.

Ultimately, Chopin did not end up visiting Ems Spa; he did, however, take a short trip to London, where he, once again, became ill. These illnesses have been recorded through Chopin's friends and acquaintances: Ignaz Moscheles, for example, noted in his diary in July of 1837 that Chopin did not want to see visitors while on a trip to London, for social interaction enervated his chest. Likewise, Mendelssohn wrote to Hiller in September of the same year:

They say Chopin came here suddenly a fortnight ago, but he made no visits. One day he played magnificently at Broadwood's, then fled again. It seems that he is very ill.¹²

Chopin had arrived back in Paris by August of 1837. His physicians in Paris once again advised him to leave Paris to go south. It was perhaps this advice that prompted Chopin to accompany George Sand and her two children to

¹¹ Niecks, *Frederick Chopin, Vol. I*, 313.

¹² Bidou, *Chopin*, 139.

Majorca. In her autobiography, Sand included the following explanation for the decision to travel south:

In 1838, as soon as Maurice had been definitively entrusted to me, I decided to find him a milder winter than ours. In that way, I hoped to spare him the return of the painful rheumatism of the preceding year...As I was making plans and preparations for leaving, Chopin, whom I saw every day and whose genius and character I loved dearly, told me on several occasions that, if he were in Maurice's place, he would soon be cured himself. I believed him, and that was a mistake. I did not include him in the trip in Maurice's place, but along with Maurice. His friends had long urged him to spend some time in the south of Europe. They thought he was consumptive. Gaubert examined him and swore that he was not: "You will, in fact, save him if you give him fresh air, exercise, and rest." The others, well aware that Chopin would never make up his mind to leave society and the Parisian scene unless someone beloved and devoted dragged him away, pressured me not to reject this desire of his, so apropos and completely unhopd for...¹³

Franken, in his summation of Chopin's medical history, comments on how puzzling it is that this Dr. Gaubert (whose identity has not been confirmed in medical history) would have on one hand, convinced Sand that Chopin was not suffering from tuberculosis, while, on the other hand, still pushed for his departure from the climate and atmosphere of Paris.¹⁴ The suggestion of a move to the south for the betterment of respiratory ailments such as pulmonary tuberculosis was quite common, and it seems almost contradictory that he suggest a cure for a disease or ailment that Chopin supposedly did not have. One might venture to guess that perhaps Dr. Gaubert was trying to hide the fatal truth from Chopin and Sand while still guiding them according to the proper 19th-century treatment plan.

In terms of Chopin's health, the trip to Majorca turned out to be a disaster at best. Soon after arriving in Palma de Majorca and securing a villa (the only available housing

¹³ Sand, *Story of my Life*, 1090.

¹⁴ Franken, *Diseases of Famous Composers*, 176.

accommodation), Chopin and Sand experienced a drastic weather change: sunny and cheerful morphed into wet and dismal. Letters written by Sand vividly describe the state of the villa and its effects on Chopin, whose ailments were being compounded by the bad weather and living conditions:

The walls of it [the villa] were so thin that the lime with which our rooms were plastered swelled like a sponge... Chopin, delicate as he was and subject to violent irritation of the larynx, soon felt the effects of the damp. We could not accustom ourselves to the stifling odour of the brasiers, and our invalid began to ail and cough.

From this moment we became an object of dread and horror to the population. We were accused and convicted of pulmonary phthisis, which is equivalent to the plague in the prejudices regarding contagion entertained by Spanish physicians. A rich doctor, who for the moderate remuneration of forty-five francs deigned to come and pay us a visit, declared, nevertheless, that there was nothing the matter and prescribed nothing.

Another physician came obligingly to our assistance; but the pharmacy at Palma was in such a miserable state that we could only procure detestable drugs. Moreover, the illness was to be aggravated by causes which no science and no devotion could efficiently battle against.¹⁵

Sand also went on to note the repercussions of the Spanish belief in contagion theory:

One morning, when we were given up to serious fears on account of the duration of these rains and these sufferings which were bound up together, we received a letter from the fierce Gomez [the landlord], who declared, in the Spanish style, that we *held* a person who *held* a disease which carried contagion into his house, and threatened prematurely the life of his family; in consequence of which he requested us to leave his palace with the shortest delay possible.¹⁶

Gomez also requested that Sand buy all the furniture, for he would otherwise have to burn it to prevent spread of Chopin's disease.

¹⁵ Niecks, *Frederick Chopin, Vol. II*, 25-6.

¹⁶ Niecks, *Frederick Chopin, Vol. II*, 26.

In a letter written to Julian Fontana in December of 1838, Chopin described his experiences with three local physicians:

During the last two weeks I have been as ill as a dog, in spite of eighteen degrees of heat, and of roses, and orange, palm, and fig trees in blossom. I caught a severe cold. Three doctors, the most renowned in the island, were called in for consultation. One smelt what I spat, the second knocked whence I spat, the third sounded and listened when I spat. The first said that I would die, the second that I was dying, the third that I had died already; and in the meantime I live as I was living. I cannot forgive Johnnie that in the case of *bronchite aiguë*, which he could always notice in me, he gave me no advice. I had a narrow escape from their bleedings, cataplasms, and such like operations... Thanks to Providence, I am now myself again...¹⁷

Another letter written to Fontana in December also indicated that Chopin could not sleep and was constantly coughing, and was, for treatment, often covered in (harmless) “mustard bandages.”¹⁸ Upon the return of Chopin’s health, Sand, Chopin, and Sand’s children moved from the villa to the *Gorge de Valdemosà*, an old, dilapidated Carthusian monastery. Chopin’s health continued to deteriorate at this other abode.

By February, 1839, the party was more than ready to leave *Gorge de Valdemosà*. Sand and company returned to Palma, where they boarded an unsanitary freighter that took them to Barcelona. Chopin began to cough up blood during this passage; the hemoptysis stopped upon arrival only after the party sought help from a French Navy physician. Due to his feeble health, Chopin and consequently Sand and her family, were forced to remain in Barcelona for a week before departing for Marseilles. As the result of a law propagated by Spain’s belief in contagion theory, Sand was requested by the

¹⁷ Niecks, *Frederick Chopin, Vol. II*, 27.

¹⁸ Franken, *Diseases of Famous Composers*, 177.

Barcelona hotelkeeper to pay for the bed where Chopin had slept and recovered from his illness.¹⁹

But indeed, the return trip from Barcelona to Marseilles was a pleasant and complete change from the experience of traveling *to* Barcelona from Palma. Instead of traveling with pigs, the sickly Chopin was offered a resting place in the captain's personal quarters. Spread of his consumption, it seems, did not matter for the crew of this ship.

Upon arrival in Marseilles, Chopin was placed under the care of Dr. Cauvière, the chief surgeon and professor of the medical faculty there. Chopin's treatment by Dr. Cauvière is best explained through a letter the composer wrote to his friend, Fontana, on March 2, 1839:

I thank you for the friendly help you give me, who am not strong. My love to Johnnie, tell him that I did not allow them, or rather that they were not permitted, to bleed me; that I wear vesicatories, that I am coughing a very little in the morning, and that I am not yet at all looked upon as a consumptive person. I drink neither coffee nor wine, but milk. Lastly, I keep myself warm, and look like a girl.²⁰

It should be noted that milk was actually not an uncommon treatment for patients with tuberculosis; the drinking of milk as a treatment plan can, in fact, be traced as far back as the ancient Greeks.²¹ Despite the questioning of the consumption diagnosis, Chopin was ultimately still receiving the general treatments given to patients with tuberculosis.

The composer recovered remarkably fast under the care of Dr. Cauvière in Marseilles. Although the good doctor kept him in Marseille until May, his health seemed

¹⁹ Niecks, *Frederick Chopin, Vol. II*, 48.

²⁰ Niecks, *Frederick Chopin, Vol. II*, 50-51.

²¹ See Chapter 2 for a fuller explanation.

to have returned to its usual state by the end of March, 1839. But when May did arrive, Sand and Chopin decided to travel to her estate in Nohant, rather than returning immediately to Paris. Chopin would alternate between Nohant and Paris a number of times over the course of the next few years, composing a number of his works while in the more peaceful setting of Nohant. Sand saw to it that her private physician, Dr. Papet, took care of Chopin while he remained in Nohant. According to Sand, Dr. Papet, it seems, was convinced that Chopin was suffering from a “minor chronic inflammation of the larynx” and that all signs and symptoms of a pulmonary disease were missing. This, of course, is a rather curious diagnosis, given that Chopin had suffered from hemoptysis on many previous occasions.

Chopin returned to Paris from his first visit to Nohant in October of 1839. We can see that Chopin had, by this point, already experienced minor, but recurrent episodes of illness. His health was particularly bad while vacationing in Majorca in 1838; Sand’s comments indicate that Chopin’s Parisian friends may already have thought him to be consumptive *before* the trip, and of course, the physicians in Majorca had decidedly diagnosed him with pulmonary consumption.

Chopin’s health slowly continued to deteriorate from 1839 until his death. Sand’s reminisces about the housing arrangements in Paris and Chopin’s feeble health are given below:

I rented an apartment in Rue Pigalle, which consisted of two pavilions at the far end of a garden. Chopin moved to Rue Tronchet, but his lodgings were humid and cold. He once again developed a serious cough, and I saw myself obliged either to give up my role as sick nurse, or spend my time running back and forth. To spare me this, he came daily, his features distorted and his voice faint, to tell me that he was getting along marvelously. He would ask to dine with us, and he would leave each evening, shivering in his carriage. Seeing how much it distressed him to

disturb our family life, I offered to rent him part of one of our buildings. He accepted joyfully.²²

In a letter to his friend Gryzmala (undated), Chopin wrote that he was “sick as a dog; that is why I didn’t come to you.”²³ Chopin complained again in another letter to Gryzmala about his physical setbacks:

To Wojciech Gryzmala.
[Undated. Before April 1842.]

I must stay in bed all day, I have so much pain in my beastly face and glands. You don’t know how cross I am that I couldn’t go to the Roule yesterday. If Raciborski will let me go out tomorrow (Jasi is in bed himself and had bloodletting today), I will come to you at once...²⁴

“Raciborski,” it seems, was one of Chopin’s many Paris doctors. Dr. Papet cared for him in Nohant; while in Paris, however, Chopin sought the advice of a number of physicians, including Adam Raciborski (who was considered to be a specialist in the field of pulmonary and bronchial diseases). Jan Matuszynski (who acted as both friend and physician), and Dr. Molin (a homeopathic doctor) were two other important Paris physicians.

Chopin’s students also remember noticing the effects of Chopin’s illness on his habits and manner of playing on the piano. Franken, for example, mentions that Chopin’s student, Frederike Miller, in 1839, noted that Chopin “was ill, was weak and pale, coughed a lot, took opium drops with sugar or syrup, and massaged his forehead with Eau de Cologne. Teaching became tiring for him, and he was able to do it only by

²² Sand, *Story of my Life*, 1101.

²³ Opieński, *Chopin’s Letters*, 317.

²⁴ Opieński, *Chopin’s Letters*, 253.

reclining on a chaise lounge and getting up when he wanted to correct something on the piano or play it himself.”²⁵

In terms of Chopin’s playing style on the piano, Gutmann, another pupil of Chopin, mentioned that Chopin had a tendency to play very quietly. Rarely would he ever play *fortissimo*. Likewise, M. Mathias, another student, remarked that Chopin had extraordinary strength, but only in brief bursts.²⁶

Further commentary can be found through concert reviews from the early 1840s, when Chopin gave two major concerts. Critics often made mention of Chopin’s frailty and lack of endurance. In the review that appeared in the *Gazette Musicale* on May 2, 1841, Liszt, who authored this particular article, wrote:

In Monday’s concert, Chopin had chosen in preference those of his works which swerve more from the classical forms. He played neither concert, nor sonata, nor fantasia, nor variations, but preludes, studies, nocturnes, and mazurkas. Addressing himself to a society rather than to a public, he could show himself with impunity as he is, an elegiac poet, profound, chaste, and dreamy. He did not need either to astonish or to overwhelm, he sought for delicate sympathy rather than for noisy enthusiasm. Let us say at once that he had no reason to complain of want of sympathy. From the first chords there was established a close communication between him and his audience. Two studies and a ballade were encored, and had it not been for the fear of adding to the already great fatigue which betrayed itself on his pale face, people would have asked for a repetition of the pieces of the programme one by one...²⁷

This excerpt is important for its mention of Chopin’s “fatigue,” a sure indication that the audience was noticing a certain physical shortcoming that was affecting Chopin, if not in his *ability* to play, then in his endurance at the pianoforte.

²⁵ Franken, *Diseases of Famous Composers*, 179.

²⁶ Niecks, *Frederick Chopin, Vol. II*, 96-97.

²⁷ Niecks, *Frederick Chopin, Vol. II*, 91.

Niecks also included in his biography of Chopin the following excerpt written by Anton Schindler, who marks Chopin as a captivating and expressive pianist, though still limited by his physical condition.

Chopin [*wrote Anton Schindler in 1841*] is the prince of all pianists, poesy itself at the piano. . . His playing does not impress by powerfulness of touch, by fiery brilliancy, for Chopin's physical condition forbids him every bodily exertion, and spirit and body are constantly at variance and in reciprocal excitement. The cardinal virtue of this great master in pianoforte-playing lies in the perfect truth of the expression of every feeling within his reach, which is altogether inimitable and might lead to caricature were imitation attempted.²⁸

Ultimately, it seems that Chopin's supposed shortcomings were actually quite central to the creation of the revolutionary style for which we now remember and embrace the composer and his music. Chopin often played his own compositions, and the partiality towards lyricism, beauty, and tenderness over absolute muscularity and showmanship may have at least partly stemmed from an awareness of his own inherent strengths and weaknesses as a pianist. It is, in other words, possible that his "shortcomings" were subconsciously directing him towards a style of piano-playing and composing that blended virtuosity and athleticism with unmatched expressiveness and sophistication. Of course, technical brilliancy and power are still readily evident in Chopin's music; Chopin was a virtuoso in every right, and even though he chose not to play robustly for long periods of time, there is little doubt that he *could* play forcefully, if the occasion required it. But ultimately, Chopin's compositions are memorable not for their technical ostentation, but for their seamless mixture of force with elegance and unruffled tranquility. Very few, if any, of his works, require constant hammering at the piano in full *fortissimo* for long periods of time. Rather, the moments of mayhem and

²⁸ Niecks, *Frederick Chopin, Vol. II*, 331.

furor give way to quietude, and sooner or later, we find ourselves returning to something calm and lyrical. His physical constraints may have led him to such writing, simply because he was capable of and best at such a style of playing. And indeed, we can sum up such a statement with Moscheles' comment that Chopin's *piano* was breathed forth so softly that he required no vigorous forte to produce the desired contrasts.

One final note should be made in terms of the influence of health and physical well-being on composition and playing: the Chopin of the early and mid 1830s was not the Chopin of the late 1840s. Because these were the years during which his health declined, what stood true in the 30s became a falsehood in the 40s and vice versa. Stephen Heller, who had heard Chopin in both the 1830s and 40s, noted that Chopin, in his final years, became so weak that his playing could barely be heard and that the composer was forced to find new techniques and interpretations for his own music in order to mask his physical emaciation.²⁹ This is of particular importance because it stands as yet one more example of adaptation. When Chopin found that his physical strength would no longer allow him to play his music as originally written, he simply adjusted and found ways to sustain his vision while avoiding overexertion as best he could.

And indeed, if we continue examining his life, we find that his health and personal life continued to deteriorate. In 1845, tension between Sand and Chopin, initiated, it seems, through conflicts between Sand, her children, and Chopin, developed and subsequently worsened. The relationship came to an end in 1847. Franken seems to suggest that the breakup may have partly stemmed from Sand's son, Maurice, who may have felt slightly hostile towards Chopin from fear of being infected by the now much

²⁹ Niecks, *Frederick Chopin, Vol. II*, 97.

weakened composer. Given that France did not, at the time, think tuberculosis to be infectious, such a theory does not seem probable. However, the other conflict regarding the marriage of Sand's daughter, Solange, to the sculptor, Clésinger, did play a role, and the two lovers split in 1847.³⁰

Meanwhile, Chopin's health continued to slip, and he grew weaker. But perhaps due to more pressing financial matters, Chopin ignored his health concerns and left for England in April, 1848, with his pupil Jane Stierling and her sister. Although the trip did not prove to be fatal for Chopin as a similar trip did for German opera composer and consumptive Carl Maria von Weber, Chopin's health certainly did not benefit from the tiring excursion. His sufferings have been preserved through his letters:

To Wojciech Gryzmala.
1 October, Keir [1848]

...If I don't write you jeremiads, it's not because it would not console me, for you are the only person who knows all about me; but because, if I once start, there will be no end to it, and always the same. I am wrong to say the same, because for me the future grows always worse. I am weaker, I can't compose anything, less from lack of desire than from physical hindrances; every week I knock up against a new tree-branch. And what can I do? Still, it saves a few pennies, towards the winter. I have many invitations, and can't accept them if I wanted to: for instance, to the Duchess of Argyl or lady Belhaven, because it is already too late for my health. The whole morning, till 2 o'clock, I am fit for nothing now; and then, when I dress, everything strains me, and I gasp that way till dinner time. Afterwards one has to sit two hours at table with the men, look at them talking and *listen* to them drinking. I am bored to death (I am thinking of one thing and they of another, in spite of all their courtesy and French remarks at table). Then I go to the drawing-room, where it takes all my efforts to be a little animated—because then they usually want to hear me—; then my good Daniel carries my up to my bedroom (as you know that is usually upstairs here), undresses me, gets me to bed, leaves the light; and I am free to breathe and dream till it is time to begin all over again.³¹

Yet another letter from the same month speaks of Chopin's symptoms while in London:

³⁰ Franken, *Diseases of Famous Composers*, 180.

³¹ Opieński, *Chopin's Letters*, 386.

To Wojciech Gryzmala.
London, 17-18 Oct[ober 1848].

My life!

I have been ill the last 18 days; ever since I reached London. I have not left the house at all, I have had such a cold and such headaches, short breath and all my bad symptoms. The doctor visits me every day (Dr. Mallan, a homeopath, well known here, and an acquaintance of my Scottish ladies; Lady Gainsborough is his sister-in-law. He stiffened me up so that I could play yesterday at that Polish concert and ball, which was very splendid); but though I left immediately after playing, I could not sleep all night. My head is very painful, apart from cough and suffocation. Up to now the thick fogs have not begun, but already, in spite of the cold, I am obliged to have the windows opened in the morning in order to breathe a little air...³²

Below is a third excerpt from a letter of particular importance for both Chopin's complaints and his mention of England's famous physician, Sir James Clark:

To Solange Clésinger.
London, Wednesday, 22 [November 1848].

Tomorrow I go to Paris, scarcely dragging myself, and weaker than you have ever seen me. The doctors are driving me away from here. I am swollen up with neuralgia, can neither breathe nor sleep, and have not left my room since November 1st (except the 16th, to play for an hour in the evening at the concert for the Poles.) After that I relapsed; I cannot possibly breathe here; it is an inconceivable climate for persons like me, but only during these few winter months... Sir J. Clark, the queen's doctor, came once to see me and to give me his benediction.³³

Sir James Clark, physician to the Queen from 1837, was actually well known in England for his treatment of patients with pulmonary diseases like tuberculosis. Clark also published a *Treatise on Pulmonary Consumption* in 1835. His treatment of Chopin therefore stands as strong circumstantial evidence that the composer was considered to be a consumptive during his lifetime.

³² Opieński, *Chopin's Letters*, 389-390.

³³ Opieński, *Chopin's Letters*, 399-400.

Even after returning from England to Paris in November, 1848, Chopin did not experience an improvement in his health. Chopin's personal favorite, the homeopath Dr. Molin, had passed away while he was in London, and Chopin was thus forced to look elsewhere for proper healthcare. The pianist consequently found himself visited by an impressive stream of doctors, some of whom are now considered to be the best physicians of Paris in the early 19th century. As he explained to Solange Clésinger in a letter in January, 1849, Chopin was visited by an "M. Louis, Dr. Roth, during two months; and now M Simon, a great reputation among the homeopaths; but they just sound me and give no relief. They all agree about climate, peaceful life, rest."³⁴ Of particular note from the three doctors is M. Louis, otherwise known as Pierre-Charles-Alexander Louis, whose name will be mentioned again in Chapter 2 in connection to an article published in 1831 on the consumption situation in Paris.

Chopin also consulted a Dr. Frenkel, from whom he could not figure "whether to go to some watering-place, or to go south. He has again withdrawn his *tisane* [infusion], and given me another medicament, and again I don't want it. When I ask him about hygiene, he answers that a regular regime is not necessary for me. In short, an empty pate. Joking apart, he may be a very good consultant..."³⁵

And finally, we arrive at Dr. Cruvielle, one of the best physicians of the 19th century who was known primarily for his knowledge of gastric, intestinal, and liver diseases.³⁶ Chopin, upon experiencing diarrhea, had called on Dr. Cruvielle to hear his opinion:

To Wojciech Gryzmala.

³⁴ Opieński, *Chopin's Letters*, 402.

³⁵ Opieński, *Chopin's Letters*, 406.

³⁶ Franken, *Diseases of Famous Composers*, 183.

[Chaillot] Tuesday, 10 July [18]49.

I am very weak, my Life. I have some sort of diarrhea. Yesterday I consulted Cruvielle, who advises me to take almost nothing, and just keep still. He said if homeopathy had done me good in Molin's time, that was because it did not overload me with medicaments and left much to nature. But I see that he also regards me as consumptive, for he ordered a teaspoonful of something with lichen in it...³⁷

After more months of misery, Chopin passed away on October 17th, 1849, between 3 and 4 in the morning. Dr. Cruvielle performed the autopsy on the musician, but his full comments unfortunately have been lost.³⁸

In the end, disease greatly impacted Chopin's life. The following two commentaries, made in reference to two different Chopin portraits, highlight the effects that disease had on the pianist and composer. Upon viewing a portrait of Chopin painted by Ary Scheffer, Henri Blaze de Bury penned the following description in *Études et Souvenirs*:³⁹

It represents him about this epoch [when "neither physical nor moral consumption of any kind prevented him from attending freely to his labours as well as to his pleasures"], slender, and in a nonchalant attitude, gentlemanlike in the highest degree: the forehead superb, the hands of a rare distinction, the eyes small, the nose prominent, but the mouth of an exquisite fineness and gently closed, as if to keep back a melody that wished to escape.⁴⁰

M. Montmartel, on the other hand, penned the following description of the Chopin portrait made by Delacroix (presumably painted much *later* in Chopin's life):

³⁷ Opieński, *Chopin's Letters*, 412.

³⁸ Franken, *Diseases of Famous Composers*, 183.

³⁹ The identity and exact date of the Scheffer painting that Henri Blaze de Bury saw could not be identified. However, given the description of a *robust* Chopin, it seems safe to assume that such a painting must have been done *before* Delacroix made his famous portrait of Chopin.

⁴⁰ Niecks, *Frederick Chopin, Vol. II*, 329.

This is the Chopin of the last years, ailing, broken by suffering; the physiognomy already marked by the last seal, the look dreamy, melancholy, floating between heaven and earth, in the limbos of dream and agony. The attenuated and lengthened features are strongly accentuated; the relief stands out boldly, but the lines of the countenance remain beautiful; the oval of the face; the aquiline nose and its harmonious curve, give to this sickly physiognomy the stamp of poetic distinction peculiar to Chopin.⁴¹

Both descriptions serve to reiterate that Chopin had, indeed, shown visible signs of disease and atrophy as the years progressed. His disease was not, in any way, *disguised*. Rather, it helped shape, in the minds of his contemporaries, Chopin's image as a poet-musician.

Given the various assessments of Chopin's illnesses, it is difficult to specifically pinpoint if and when Chopin first began to be looked upon as a *consumptive* in Paris. It seems likely, however, that the first suspicions would have appeared soon after Chopin began experiencing repeated bouts of "influenza," "bronchitis," and other respiratory illnesses in the mid 1830s; although direct references to consumption are very rare during these years, it is likely that this connection was still *implied*. Physicians may have refrained from using the word *consumption* in order to prevent scaring their patients. Rather, they may have chosen to tastefully signal to the patient via their suggested treatment plans that he or she was suffering from consumption. Chopin, before leaving for Majorca, had been encouraged to travel, either to Ems Spa or to anywhere with fresh air and a warm climate. Such recommendations, as we learned through Chopin's sister, Emilia, were often reserved for patients with consumption. And of course, Sand explicitly stated, in her comments regarding the trip to Majorca, that Chopin's friends already thought him to be consumptive by 1838. And certainly, for the Majorcan physicians to

⁴¹ Niecks, *Frederick Chopin, Vol. II*, 329.

have so unwaveringly cast him aside as a consumptive suggests that Chopin had already begun to show signs of active tuberculosis by the time of his trip.

By the final decade of Chopin's life, when his health problems had become very frequent and visible, the pianist and composer could not have escaped the fate of being socially associated with the disease. Surely, being visited by two prominent consumption specialists (most notably Sir James Clark and P.C.A. Louis) must have helped to confirm the connection for many people. Again, Chopin noted that Dr. Cruvielle, the other famous, albeit non-pulmonary specialist who visited Chopin at the end of his life, probably thought the composer to be dying of tuberculosis as well, though it was only implied through the treatment suggestions. These incidents, through their overt or covert connections with the disease, indicate that Chopin was, during his stay in Paris, connected with the disease by his contemporaries.

Recently, Majka and coworkers have returned to Chopin's medical history to reassess his diagnosis and have suggested that Chopin may *not* have died of consumption. Instead, they suggest that he was actually a victim of an inherited disease called cystic fibrosis.⁴² In this disease, a defective membrane transport protein results in the secretion of a thick mucus in the airways; the presence of this mucus clogs up the lungs and ultimately increases an individual's risk for respiratory failure and lung infections.⁴³ Because cystic fibrosis did not exist, at least by name, in the 19th-century, this theory, whether true or not, does not actually apply to Chopin in the 19th century. However, it is worth mentioning, since it serves as an interesting, albeit, modern interpretation of

⁴² Majka, "Cystic Fibrosis—A Probable Cause of Frederic Chopin's Suffering and Death", 77-84.

⁴³ Janeway, *Immunobiology*, 6th Ed., 759.

Chopin's ailments. But since our objective is historical rather than clinical, we may still conclude that Chopin was thought to be consumptive during his lifetime.

Because this era did not view innate genius and acquired ailment as wholly individual experiences, Chopin's societal stance as a consumptive may have played a particularly important role in defining his identity as a pianist and composer. And it is for this reason that we must continue forth and investigate the 19th-century medical views on consumption, now justly associated with Chopin, and how these, in turn, colored the 19th-century perceptions of the Polish composer and pianist.

Chapter 2: *From Consumption to Tuberculosis: A Historical Overview.*

A rampant and puzzling disease since early Greek civilization, tuberculosis had reached its peak during the 19th century, when the mysteries and devastation it created had never been greater. Artists, awe-struck by this disease that mercilessly took lives left and right, found inspiration in the images and emotions that it evoked, while physicians of the medical world fought to explain the disease in its various manifestations. Much of this medical debate tapered with Villemin's experiments in the 1860s and ended with Koch's conclusive discovery of *Mycobacterium tuberculosis* in 1882. But until this explosion of enlightenment took hold of the West and initiated the start of today's relatively TB-free era, the world remained in turmoil; mankind was under the control of a stealthy terrorist.

It is perhaps best to begin discussing the troubled and vicious history of tuberculosis by first examining its current state and pathology. While it is true that such comprehensive information about the disease would not have existed during Chopin's life, presentation of the disease's inherent complexity as we understand it today may nevertheless help to clear the cobwebs of the past by allowing us to explain why thinkers of the past clouded the disease with such mystery and why physicians felt so baffled by and unsure of the significance of their findings.

Mycobacterium tuberculosis

Scientists of today know that humans are the only reservoir for *Mycobacterium tuberculosis*, though *Mycobacterium bovis*, considered the etiologic agent of tuberculosis in cows, can also implant itself in humans through the consumption of unpasteurized

milk.⁴⁴ *M. tuberculosis* is unique in a number of ways. Relative to other bacteria, these bacilli multiply slowly, taking between 20-24 hours to double. Organisms of the genus *Mycobacteria* also have an unconventional cell envelope. Like gram-positive bacteria, they do not have an outer membrane. But their cell envelope does contain an unusually high lipid content: It is composed of a core of three covalently linked macromolecules, namely peptidoglycan, arabinogalactan, and mycolic acids, and a lipopolysaccharide, known as lipoarabinomannan (LAM), which is thought to be anchored to the plasma membrane.

Mycolic acid, in particular, is a β -hydroxy fatty acid that makes up more than 50% by weight of the cell envelope. The high abundance of this molecule in the cell wall prevents mycobacteria from staining well with Gram's stain. However, the high mycolic acid content of the envelope also confers upon the bacteria the ability to resist decolorization by acid alcohol when stained with basic dyes. Mycobacteria are therefore categorized as acid-fast bacilli, and the Ziehl-Neelsen technique is used to stain them in laboratories.

Tuberculosis

Tuberculosis, the disease, is chronic, infectious, and granulomatous. There are many forms of tuberculosis, some of which include primary and reactivation tuberculosis

⁴⁴ All information on tuberculosis disease and pathology in this chapter has been drawn from the following sources:

Boyd, *Basic Medical Microbiology*, 3rd ed. 578-585.

Braude, A.I. *Medical Microbiology and Infectious Diseases*, 972-977.

Janeway, *Immunobiology*, 6th ed., 360, 466.

Nesli Basgoz, "Clinical Manifestations of Pulmonary Tuberculosis", (2005), www.uptodate.com.

Nesli Basgoz, "Pathogenesis and epidemiology of Miliary Tuberculosis", (2000), www.uptodate.com.

Nesli Basgoz, "Clinical Manifestations; Diagnosis; and Treatment of Miliary Tuberculosis", (2004), www.uptodate.com.

Lee W. Riley, "Microbiology and Pathogenesis of Tuberculosis", (2005), www.uptodate.com.

in the lungs and miliary tuberculosis, a general term used to encompass all forms of progressive, widely disseminated hematogenous tuberculosis of the extrapulmonary body.

Although the bacillus can infect any organ of the body, as seen by the disease's many forms, it has a strong predilection for the lungs. Primary tuberculosis most often occurs via direct contact with bacilli in droplet nuclei, contaminated milk, or inhalation of contaminated dust particles. The bacilli are first inhaled. One droplet nuclei will usually contain no more than 3 bacilli and is so small (5-10 μm) that it can remain air-borne for long periods of time. Droplet nuclei are generated primarily through talking, coughing, sneezing, or singing. Sneezing generates the most nuclei, which can also travel up to 10 feet away from the infected person.

Upon inhalation, larger droplets will get lodged in the upper passageways where they will not cause infection, while the smaller droplets will reach the alveolar space in the well-ventilated mid to lower lung. Upon arrival, an alveolar macrophage will phagocytose the bacteria. If the innate defense system of the body fails to immediately eliminate the organisms, they will multiply within and eventually kill the macrophages. Indeed, *M. tuberculosis* pathogens have developed the capacity to subvert the effects of the innate immune system by preventing fusion of the phagosome and lysosome (which contains the oxygen radicals and other peptides and enzymes with microbicidal activity) in the activated alveolar macrophages that have engulfed them.

If the bacteria do resist the microbicidal effects of the activated macrophages, a structure called a tubercle (granuloma) may form. Infected macrophages will have produced certain attractant molecules known as cytokines and chemokines to summon

more immune cells, specifically, macrophages, monocytes, and neutrophils, to the site of infection. If the bacterial replication is still not controlled, the tubercle will continue to enlarge, and bacteria may enter the local draining lymph nodes.

The tubercle or granuloma itself is characterized by the accumulation of dense connective tissue around the site of infection and serves to “wall off” the infection. Microscopically, they look like granular nodules, with a well-defined capsule surrounding the central tissue. Large cells made of fused macrophages occupy the center of the granuloma, with activated lymphocytes surrounding this central area.

Approximately two to six weeks after the primary infection, a cell-mediated immune response will have developed. T_H1 and T_H2 cells will participate in the granulomas by helping to regulate granuloma activity and prevent widespread tissue damage. If the cell-mediated immune (CMI) response and tissue repair is not effective, then the disease will continue to progress, with further destruction of the lung. In the granulomas, the large fused cells at the center of the tubercle can die due to a lack of oxygen and the effects of the many microbicidal molecules released by activated macrophages. This process, called *caseation necrosis* due to the cheesy consistency of the central, dying tissue, characterizes a tuberculous lesion. The multiplying bacilli can then continue to spread from the caseating lesions into the lung airways. If the lesions do grow large enough to invade the bronchus and form a cavity, the infected individual may cough up or swallow the liquid caseum. If an artery or vessel is damaged in the process, hemoptysis may result. The patient is now infectious. If left untreated, 80% of these patients will die.

It is also possible for unchecked proliferation of the bacilli to lead to the spread of infection via the lymph and blood vessels to extrapulmonary regions as well. Again, the infection can stop or continue to spread at these new locations.

Luckily, in 85-95% of infected people, the tubercles heal via calcification of the infected area, producing the Ghon complex at the primary and lymph node lesions. Simon's foci may also appear at the apical and subapical areas of the lungs. Both are readily visible on chest x-rays. Such containment will prevent the further spread of the bacilli within the lungs and extrapulmonary body. But unfortunately, *Mycobacterium tuberculosis* has the ability to remain latent—alive, but inactive—at these locations. In particular, the Simon foci of the apical and subapical areas of the lung, where oxygen content is high, often harbor such bacteria. In these cases, the body's defenses have sufficiently *controlled* bacterial spread without having completely *killed* the pathogens.

At a later stage, usually within two years of the primary infection, these latent bacteria can begin multiplying again. Reactivation TB ensues. It is not known what causes an infection to remain in the latent stage or to flare up again. It is known, however, that reactivation TB primarily occurs in immunosuppressed patients. Some immunosuppressed conditions related to reactivation tuberculosis include HIV infection and AIDS, end-stage renal disease, diabetes mellitus, malignant lymphoma, corticosteroid use, and diminution in CMI associated with old age.

As with active bacteria from the primary infection, reactivated bacilli may remain within the lungs or spread via the lymph or blood vessels to other parts of the body. Clinically, patients with pulmonary tuberculosis will present a variety of symptoms, differing in both type and degree of intensity. The manifestations will ultimately depend

on the stage of infection. Patients early in the course of the disease will show little fever or constitutional signs. Their disease will only be evident through a chest roentgenogram, a positive tuberculin reaction, and low bacillary counts in their sputum. Patients with more developed tuberculosis will show more pronounced constitutional signs, including high fever, cough, asthenia, weight loss, cachexia, anemia and hemoptysis, and high bacillary counts in their sputum.

If the bacilli spread to other parts of the body and the resultant foci, most often found in vascular organs such as the liver, spleen, bone marrow, and brain, do not heal by encapsulation in a few weeks or months, the patient will suffer from extrapulmonary tuberculosis. Symptoms for extrapulmonary tuberculosis depend on the affected region; these forms of TB can be difficult to diagnose.

A final form of tuberculosis, in addition to those various stages and forms of pulmonary and extrapulmonary tuberculosis, is worth mentioning. Miliary tuberculosis is a type of tuberculosis disease that can result from the hematogenous spread of a large number of bacilli and is named for its characteristic small, scattered lesions that resemble millet seeds. As with extrapulmonary tuberculosis, clinical symptoms for miliary tuberculosis vary greatly and depend on the particular area of the body that has been affected. This form is particularly life-threatening and can manifest itself in one or many organ systems.

Historical Perspectives

Historically, tuberculosis was first known as *phthisis* (to waste away) to Hippocrates and his contemporaries of the Greek world. Fracastorius called it by the Latin word *tubercula* in the seventeenth century, yet again, to denote the “wasting” aspect of

the disease. The term *consumption* also first appeared in the early seventeenth century as the vernacular derivation of the Latin *consumere* (to eat or devour). This term, however, was used rather broadly, with any wasting disease being referred to as “consumption.” Consumption finally became *tuberculosis* in 1839, after J.L. Schönlein, Professor of Medicine in Zurich, suggested that tuberculosis be used as the generic name for the various manifestations of phthisis, all linked by the formation of tubercles.⁴⁵

Certainly, this simple study of the names shows how science has made progress in its understanding of the disease. The earliest Greek writings about phthisis primarily focused on clinical symptoms and physical alterations, with special emphasis on the manifestations in patients of the later phases of the disease. Aritæus the Cappadocian (50 B.C.), for example, provided a lengthy description on the physical effects of phthisis:

Voice hoarse, neck slightly bent, tender, not flexible, somewhat extended fingers, slender, but joints thick; of the bones alone the figure remains, for the fleshy parts are wasted; the nails of the fingers crooked; the pulps are shriveled and flat, for, owing to the loss of flesh, they neither retain their tension nor rotundity; and, owing to the same cause, the nails are bent, namely, because it is the compact flesh at their points which is intended to support them; and the tension thereof is like that of the solids. Nose sharp, slender; cheeks prominent and red; eyes hollow, brilliant and glittering; swollen, the teeth, as if smiling, otherwise of a cadaverous aspect. So also, in other respects, slender without flesh; the muscles of the arms imperceptible; not a vestige of the mammæ; the nipples only to be seen; one may not only count the ribs themselves, but easily trace them to their terminations, for even the articulations of the vertebrae are quite visible; and their connections with the sternum are also manifest; the intercostal spaces are hollow and rhomboidal, agreeably to the configuration of the bone; hypochondriac region lank and clearly developed, prominent, devoid of flesh; so also with the tibia, now protrudes, the muscles on either side being wasted; the whole should blades apparent like the wings of birds. If in these cases disorder of the bowel supervenes, they are in a hopeless state. But if a favorable change takes place, symptoms the opposite of these fatal ones occur.⁴⁶

⁴⁵ Dubos, *The White Plague*, 72, 84.

⁴⁶ Huber, *Consumption and Civilization*, 42.

Investigations into the *pathology* of the disease did not begin until the Renaissance, when physicians found themselves suddenly dissatisfied with vague observations of fever, aching, and cough. It was during this period that physicians identified the presence of tubercles and the importance of the lungs as the “seat” of phthisis. Called “vomicae” by Jean Fernal in the early sixteenth century, tubercles were first identified by name by Franciscus Sylvius de la Boë of Leyden (1614-72) in his *Opera Medica* in 1679.⁴⁷ Manget, in 1700, observed small tubercles on the body that, to him, looked like millet seeds. (Miliary or disseminated tuberculosis was named after his observations.)⁴⁸

But for these anatomists and their contemporaries, the *significance* of the new pathological discoveries still remained unknown. Physicians constantly debated over the meaning of these tubercles that formed in different anatomical locations with varying appearances and sizes. All sorts of vague and confounding theories were propagated as possible explanations. Many, for example, thought that the tubercles of different sizes and locations were due to multiple diseases, while others suggested that the tubercles were simply minute glands that had been damaged and enlarged by disease.⁴⁹ Indeed, as more and more dissection took place, question after question arose, and physicians tried their best to understand the nature of the disease.

A few answers to these questions finally began to arrive when the very early clinical symptoms and the more recent pathological studies of the past were brought together and significantly improved in the late 18th and early 19th centuries.

Auenbrugger discovered percussion as a method for chest examinations in 1761. In 1804,

⁴⁷ Huber's *Consumption and Civilization* gives the name of the founder of the tubercle as Silenius (44).

⁴⁸ Dubos, *The White Plague*, 72-74.

⁴⁹ Dubos, *The White Plague*, 73-74.

three years after arriving in Paris and beginning his phthisis research, René-Théophile-Hyacinthe Laënnec gave his revolutionary speech, which, as summarized by Dubos, asserted that “infiltration, tubercles and cavities were the expression of a single disease and that the different forms of phthisis were merely the different aspects of tuberculosis of the lung.” Thus, at least one question that had plagued physicians for centuries had now been answered through the methodical examination of over 200 cadavers by one man. (Laënnec, twelve years later, would also invent the stethoscope and the technique of mediate auscultation.)⁵⁰

The question of etiology, however, still remained. Physicians simply did not have the technology or means to understand what *caused* the horrific pathological changes they were examining in their cadavers. By the first half of the 19th century, two main theories existed: the first, which originated in Italy as early as 1546, was contagion theory, and the second, prompted by the Faculty of Paris around 1650, was the essentialist theory of heredity.⁵¹

Florentine physician Hieronymus Fracastorius was one of the first to clearly express concern over the contagiousness of phthisis. Given the power that Italian learning held over much of the continent at that time, his theory quickly spread throughout much of Europe. Physicians and individuals began to discover and relate stories and occurrences that confirmed Fracastorius’ theory. In 1648, for example, there was a story being circulated that three young Brandenburg counts had contracted the disease from their teacher. In 1697, a physician was said to have become consumptive because of his habit of tasting the sputum of his patients. More radical accounts were also

⁵⁰ Dubos, *The White Plague*, 76, 84.

⁵¹ Dubos, *The White Plague*, 28, 33.

being scattered as “evidence” for the contagion theory. Italian physician Panarolli was reported as having seen one man fall dead after stepping on the sputum of a consumptive and another contract phthisis after inhaling the fumes given off by sputum that had been spit onto burning coal.⁵²

Perhaps the fear of infection found in Italy in the 17th century can be summed up in the following excerpt from *The Practice of Physic* by Lazerius Riverius:

Moreover, there are external causes (of phthisis), as contagion, which is the chiefest; for this disease is so infectious, that we may observe women to be infected by their husbands, and men by their wives, and all their children to die of the same; not only from the infection of their parents’ seed, but from the company of him that was first affected. And this contagion is more easily communicated to them that are of kin, wherefore it is not safe for a brother or sister to enter into the chamber, for the miasmata, or vapors infective, which come from the lungs and infect the whole air of the chamber, and being drawn in by others (especially if they are in any way disposed to the same disease) beget the same disease in their lungs.⁵³

18th-century Italian anatomist Morgagni, who avoided performing autopsies on the consumptive dead for fear of being contracting the disease, took early contagion theory one step even further by advocating the establishment of laws for consumption prevention. First proposed in the Republic of Lucca in 1699, regulations were quickly adopted by other Italian cities, as well as Spain.⁵⁴ Reports spread about consumptives and law enforcement soon thereafter. One statement from Nocard related a story about a woman who had died from consumption after having occupied the bed of another consumptive. The bed was publicly burned in the market place of Nancy in 1750. Another record shows that in 1754, the sanitary magistrate of Florence asked for an

⁵² Dubos, *The White Plague*, 28-29.

⁵³ Huber, *Consumption and Civilization*, 44.

⁵⁴ This establishment of laws and regulations within a community represents some of Italy’s first public health initiatives for consumption.

expert opinion from the local medical college on what articles would be most likely to be infected by a consumptive and what could be done to purify them. The year 1760 brought the formation of a new hospital in Olivuzza, set up specifically for the isolation of consumptive patients. (This hospital was, in a many ways, a forerunner to the sanatorium movement that would much later sweep the world.)⁵⁵

In 1782, Naples issued an edict demanding that consumptives be reported, isolated, and their possessions disinfected. Physicians were to report a consumptive patient who showed ulceration of the lungs. Authorities had the right to make an inventory of the infected patient's clothing. All household items that were susceptible to contamination were to be destroyed; those that were not were nevertheless to be cleaned. The poor were required to move to hospitals, and superintendents of hospitals were to keep consumptive clothing and linen separate from those of other patients. Authorities also had the right to replaster and replace all windows and doors of the homes of consumptives and to prevent the inhabitation of such "new" homes for at least a year after the replacement and plastering jobs were completed.⁵⁶

Fines and penalties were even imposed upon individuals who refused to obey.

Huber, in his book *Consumption and Civilization*, writes that:

Those who oppose the officials making their inventories, isolating or removing the clothes to the crematorium, and the cleansing of the places where the patient died, shall be sentenced to three years at the galleys or prison according to the condition of the person, and shall have three years imprisonment and three hundred ducats fine...Regarding physicians who do not reveal the nature of the illness, they shall undergo a fine of three hundred ducats for the first offence, and for the second, ten years' exile...Those who buy an infected robe shall have three years at the galley, and those who sell three times the value of the robe sold, as a fine...Those relations who refuse to send an infected person to a hospital,

⁵⁵ Huber, *Consumption and Civilization*, 44-45.

⁵⁶ Dubos, *The White Plague*, 29.

or remove such an one without the knowledge of the Officer of Health, shall have three month's imprisonment if of low birth, or three hundred ducats if noble.⁵⁷

Certainly, consumption regulations were being enforced during this time, in both Italy and Spain (Spain was known to be even *more* strict than Italy). But opposition emerged beginning in the mid-1700s, and the laws were gradually either revoked or greatly modified in many areas. Florence revoked its edict in 1754. Even strict Naples, for example, eventually handed over consumptive patients “to the diligence and care of the attending physician that he educate his phthisical patients to the wisdom of precautionary measures.”⁵⁸ Naturally, there were still many areas in Southern Europe that remained steadfast in their beliefs in the contagiousness of phthisis; it was probably attitudes such as these that Chopin and Paganini encountered during their trips to Majorca and Naples, respectively.

But while the South of Europe maintained connections to contagion theory, Northern Europe seemed fixated on the notion of heredity as the etiological cause of phthisis. The Faculty of Paris first expressed doubt about contagion theory around 1650, looking to heredity as the answer to the question of etiology and citing multiple cases where siblings all became sick around the same age and died soon thereafter as evidence.

The propagation of this theory and the stronghold it took in Northern Europe continued well into the first half of the 19th century. Of course, by this point, the Romantic era had emerged in the arts, and it seems likely that medicine and the arts influenced each other, with the arts deriving inspiration from the suffering consumptives for their poetry, music, and paintings and medicine developing from the arts a somewhat

⁵⁷ Huber, *Consumption and Civilization*, 45-46.

⁵⁸ Dubos, *The White Plague*, 31.

“dreamy” understanding of tuberculosis, despite the very real pathological advances being made. For many physicians, the etiological answer to tuberculosis lay in psychology, not in physiology.

The best source of information about consumption in France is David S. Barnes. A noted scholar whose research interests include the history of infectious disease, epidemiology, and public health, Barnes has published many articles and two books, namely *The Making of a Social Disease: Tuberculosis in Nineteenth-Century France* (1995) and more recently, *The Great Stink of Paris and the Nineteenth-Century Struggle against Filth and Germs* (2006).

As he notes, by the 1820s, disease was viewed by the French as inherent in one’s essence. Illness was primarily due not to the external, but to the innate internal—the predispositions and tendencies—that defined our characters. Such medical thought was later coined essentialist (essence) medicine. And due to its implications of destiny (the internal) over chance (the external), both heredity and other “natural” inclinations were determined to be the etiological causes of tuberculosis.

The school of essentialist medicine ruled France until the work of Villemin and Koch was finally recognized as acceptable evidence for the existence of a different etiological agent. Laënnec himself was an avid hereditarian. He commented in the 1820s in his *Traité de l’auscultation mediate*:

If the question of contagion may be regarded as highly dubious relative to tubercles, the same cannot be said of hereditary predisposition. Experience proves to all physicians that the children of consumptives are more frequently attacked by this disease than are other subjects.⁵⁹

⁵⁹ Barnes, *The Making of a Social Disease*, 26-27.

Forty years later, Professor Michel Peter of the Paris Faculty of Medicine, who reviewed the latest medical thinking on tuberculosis, corroborated Laënnec's remarks: "If there is a universally accepted proposition, it is that of the heredity of tuberculosis."⁶⁰

Of course, it is known today that tuberculosis is not caused by heredity and that it does not follow the patterns of genetic diseases. Even Laënnec and others who supported heredity took note of this. Heredity simply did not explain situations where only a single child in a family died of tuberculosis or where a family with no history of tuberculosis suddenly found itself devastated by the disease. Clearly, even if heredity had strongly contributed to the manifestation of tuberculosis in certain patients, it could not have been the only factor.

In the end, the French physicians resolved this blip through the creation of a second category of "natural" causes. More specifically, the phrase, *passions tristes*, was added to the list of etiological causes. Translated as "sorrowful passions" by Barnes, *passions tristes* referred to qualities that were related to one's essence. Like heredity, such factors did not exist in the environment and therefore could not be "acquired." Instead, they were innate: they existed within the natural character (thus the term "essence"), through which they most likely directed certain behavior patterns and inclinations peculiar to a given individual

But one might question exactly what kinds of inherent qualities were being embodied by the rather vague "sorrowful passions." The answer is not clear. Admittedly, Laënnec, in an extra section added in 1826 to his book on diseases of the chest, described in some detail what he and his contemporaries meant by the term. While ruminating over why tuberculosis occurred more often in larger cities than in the country,

⁶⁰ Barnes, *The Making of a Social Disease*, 29.

Laënnec wrote that within large cities, “men have more relations with each other, and so have cause for more frequent and profound sorrows; bad morals and poor conduct of all sort are more common there and are often the cause of bitter regrets that cannot be consoled and that even time cannot soften.”⁶¹ We can see from this remark that “sorrowful passions” at least partially alluded to bad morals, poor conduct, and perhaps even the “abnormal” practice of homosexuality. It is quite possible and probable that “bad morals” itself referred to one’s sexual activities—a general recognition that onanism, “coital abuse,” and “excesses [and]...syphilitic conditions” were the culprits (in addition to heredity) responsible for consumption seems to have existed through much of the early and mid 19th century.⁶² Laënnec speculated that such “indulgences” often caused consumption in individuals already naturally predisposed to acquiring the disease. Michel Peter commented that such activities also led to a loss of bodily fluids, which ultimately resulted in an undesired and, given its connection to consumption, *dangerous* physical debility. Additionally, “nerve impulses” were lost due to “convulsions of the *spasme cynique*,” and harmful heart and lung congestion could result from orgasms.⁶³

But even with such clarifications, the definition of “sorrowful passions” still appears insufficient: Explaining one vague term with a second series of equally vague terms (moral failings and bad conduct, for example) does not, in any way, clarify meaning. However, it seems likely that such vagueness was *consciously* put forth. Because “sorrowful passions,” “chagrin,” “regrets,” “poor conduct,” and other such words would have manifested themselves differently in different individuals, it perhaps makes sense for 19th-century physicians to have avoided giving concrete, unalterable

⁶¹ Barnes, *The Making of a Social Disease*, 29.

⁶² Barnes, *The Making of a Social Disease*, 30.

⁶³ Barnes, *The Making of a Social Disease*, 30.

explanations. Indeed, if such ideas were meant to arise from the *character* which embodied one or all of the generally outlined tendencies, then it makes little sense to strictly define ideas that are, by nature, meant to be abstract and changing. Of course, such an approach would have introduced much bias and speculation into a “scientific” endeavor, since both the public persona of the afflicted and the personal tastes and partialities of the “afflicter” (interpreter of disease) would have played a role in the characterization process. Etiological determination in France, from this angle, was not empirical; rather, it was susceptible to the colored perceptions of the 19th-century mind.

Such essentialist thought remained in vogue for a significant portion of the 19th-century. Laënnec wrote in 1826 that, in addition to heredity, he knew of, “among the intervening causes of pulmonary consumption, . . . none more certain than sorrowful passions [*passions tristes*].” Yet again, Professor Michel Peter followed this remark forty years later with his own unaltered repetition of Laënnec’s findings: Disease arose within the body as determined by an “inherited predisposition and often also by ‘intervening causes’ (*causes occasionnelles*), such as ‘sorrowful passions.’”⁶⁴

In the end, these thought patterns implied a strong connection between moral failings and physical illness. And of course, inherent in such a connection was the understanding that medical treatment could not heal such “essential” failings. Because they were embedded within and, in a sense, central to the existence and definition of the *individual*, “sorrowful passions” and other such “intervening causes” were, it seems, beyond the help of medication.

It is again no wonder that historians consider the early 19th century the Romantic era of medicine. When heredity was not the culprit, sorrowful passions were. Thus, we

⁶⁴ Barnes, *The Making of a Social Disease*, 25.

see that that Laënnec, Peter, and their followers were strong believers in the “medical romantic tradition.” They epitomized essentialist medicine, pointing to heredity and inherent tendencies (especially as understood through improper sexual exercises) as the primary causes for disease.

It is also important to note here that physicians in France at this time were aware of contagion theory and its implications. However, unlike Southern Europe, they found it to go against their observations of the status quo in France. According to Laënnec:

Tuberculosis phthisis has long been thought contagious, and it is still thought to be so by the common people, by magistrates, and by some doctors in certain countries, especially in the southern parts of Europe. In France, at least, it does not seem to be [contagious].⁶⁵

Laënnec questioned why, in French couples that slept together every night, only one individual died of the disease, while the other remained unharmed. For him, the contagion theory did not explain such scenarios, and he, therefore, refuted contagion theory for the essentialist outlook. This debate would continue until the major discoveries by men such as Pasteur, Villemin, and of course, Robert Koch and his *Mycobacterium tuberculosis*, helped bring clarity to the medical world.

Despite the deeply romanticized understanding of the cause-effect relationship of tuberculosis, France, like Italy and the rest of Southern Europe, did see development in these early decades of a societal-based understanding of the disease. Historians have long regarded the years between 1815 and 1848, the time of the Bourbon Restoration and July Monarchy, as a crucial era in the improvement of French medicine and public health. Paris, in particular, became a leading city for medicine, and signs of early modern medicine emerged: “hospital medicine”—based on physical examinations, pathological

⁶⁵ Barnes, *The Making of a Social Disease*, 27.

anatomy, and statistics—took birth, as well as the modern notions of public health and the “scientific discipline of public hygiene.”⁶⁶ Heredity was no longer considered the primary etiological cause of tuberculosis; the *causes occasionnelles*, which now encompassed more than just *passions tristes*, suddenly became more and more important.

Part of the shift in thought may have been due to Paris’ early 19th-century growth spurt. A city that had virtually remained static for centuries suddenly found itself with its population doubled in a span of thirty years. Not surprisingly, the city felt overwhelmed and helpless, struggling to accommodate its new citizens without transforming from splendid to shabby. For historian Louis Chevalier,

Paris looked around and was unable to recognize itself. Another, larger city had overflowed into the unaltered framework of streets, mansions, houses and passageways...filling every nook and corner, making over the older dwellings of the nobility and gentry into workshops and lodging houses, erecting factories and stockpiles in gardens and courts where carriages had been moldering quietly away, packing the suddenly shrunken streets,...overloading the forgotten sewers, spreading litter and stench even into the adjacent countryside and besmirching the lovely sky of the Ile-de-France with [its] vast and universal exhalation.⁶⁷

Jules Janin of Balzac, author of *Un Hiver à Paris*, published in 1845, also vividly described the muck that Paris had become:

Bespattered carts draw up to the door of the sleeping houses to carry off every kind of filth...In the hideous lairs which Paris hides away behind its palaces and museums...there lurks a swarming and oozing population that beggars comparison...A vile bohemian world, a frightful world, a purulent wart on the face of this great city.⁶⁸

Paris, in other words, with its sudden exponential population growth and resultant overcrowding, had become a breeding ground for pathogens and revolution. In terms of

⁶⁶ Barnes, *The Making of a Social Disease*, 25-6.

⁶⁷ Barnes, *The Making of a Social Disease*, 23.

⁶⁸ Barnes, *The Making of a Social Disease*, 24.

political unrest, Paris had just recently experienced a major crisis with the revolution of 1789. With the onset of the 19th century, the city, already volatile and subject to uprisings, found itself collapsing from the inward surge of mostly poor migrants from all the countryside and contiguous cities. Not surprisingly, the political crisis of 1789 was followed in the 1800s by more uprisings in the now densely populated city; most notable were the full scale revolutions of 1830 and 1848. With regards to disease, the rise in population and the resulting problems led to two devastating outbreaks of Asiatic cholera, first in 1832 and then again in 1849. The annual death rate from tuberculosis also steadily rose, finally reaching its peak in 1871, when approximately 12,000 Parisians succumbed to the disease.

Perhaps the greatest discovery in social medicine of the 1830s and 40s was that mortality and tuberculosis were linked to the social structure of the period. The figure whose works should be examined first regarding this new concept is Louis-René Villermé. This individual set into motion the study of social epidemiology through his examination of mortality rates in the arrondissements of Paris. In his works, published between 1826 and 1830, Villermé examined many factors, such as climate, soil drainage, water supply, miasmatic filth, altitude, wind patterns, population density, and poverty, to try and extricate links between these external features and Paris' death rates. Of these various causes, population density and poverty were evidently the most intriguing or promising, for they were most closely examined. Villermé ultimately concluded that no statistical correlation between population density and Paris' death rates existed. He did, however, find the latter factor of poverty to be quite important, and it directly influenced his main conclusion: the poorer became sicker and died earlier than the rich. By using his

own (perhaps questionable) methodology for manipulating numbers, Villermé showed that the rank of arrondissements by mortality matched the inverse rank by wealth nearly exactly. To him, “wealth, affluence, and poverty are...for the residents of the various arrondissements of Paris—by the conditions in which they replace them—the principle causes (I do not say the only causes) to which one must attribute the great differences...in mortality.”⁶⁹ His conclusion was simple enough, but the studies it set into motion were not: Villermé’s investigations marked the beginning of a new age in medicine.

Two other reports of note were published soon thereafter in France’s *Annales d’hygiène publique*. Written in 1834, Henri Lombard’s article, “The Influence of Professions on Pulmonary Consumption,” explored the connections between jobs and tuberculosis incidence. After collecting data listing the professions and causes of death for all patients who had died in specific hospitals across four cities during a certain period, Lombard had compiled two lists: in one list, he had ranked professions according to the number of deaths by consumption; in the other, he had ranked professions according to the number of deaths by all causes combined. Those professions which ranked higher on the consumption list relative to the combined death list were classified as “positive” for consumption.

According to Lombard, the variance in physical health noted amongst the professions could be explained via three categories: degree of wealth or poverty; forced exercise or inaction of certain parts of the body; and the cleanliness of the surrounding atmosphere. Lombard found that the poor were twice as likely as the rich to die of tuberculosis. He also found that inactive jobs correlated more positively than negatively with tuberculosis acquisition. To him, this suggested that muscular activity prevented

⁶⁹ Barnes, *The Making of a Social Disease*, 32-33.

tuberculosis, while inactivity promoted it. Lombard also rejected the long-held belief that constant arm movement, vocal activity, and bent-over body position caused consumption; his analysis proved that professions with such activities did not positively correlate with the onset of tuberculosis.

And most importantly, Lombard found the connection between air quality and consumption. “Of all the circumstances to which workers in the various professions are submitted, none is as important as the surrounding atmosphere, because it acts directly on the lungs, the seat of consumption.”⁷⁰ His first concern primarily rested with the particles, including dust and “aqueous vapors” and other various “emanations.” Aqueous vapors he deemed beneficial for workers, since professions in humid environments correlated negatively to tuberculosis deaths. “Animal” emanations were also considered beneficial (butchers showed a negative correlation to consumption), but “vegetable” and “mineral” emanations were both considered harmful.

Lombard’s second concern dealt with categorizing tuberculosis rates according to indoor versus outdoor jobs. His research showed that 70% of outdoor professions correlated negatively with TB and that consumption was twice as frequent among workers confined to workshops than among those who worked outdoors. In his own words, “one can consider the vitiated air of the workplace as the cause of the large number of consumption cases observed in certain professions, whereas pure and constantly renewed air is an excellent prevention against the disease.”⁷¹ The elaboration of this concept marked a crucial step in the development of attitudes towards tuberculosis.

⁷⁰ Barnes, *The Making of a Social Disease*, 35.

⁷¹ Barnes, *The Making of a Social Disease*, 36.

The second article, entitled “The Influence of Certain Professions on the Development of Pulmonary Consumption” and written in 1831 by Louis-François Benoiston de Châteauneuf, also focused on finding connections between professions and tuberculosis. Through another questionable evaluation method (that predetermined his results), Benoiston, in contrast to Lombard, discovered that professions (like writers, shoemakers, and seamstresses), which made a person hunch over were the most susceptible to tuberculosis. Workers exposed to mercury vapors and “animal” particles were next on his list, while those exposed to non-“animal” particles and vapors were deemed safe. In relation to his findings, he thus suggested that lifestyle changes should be made for those professions that required bending forward.⁷²

Benoiston also examined one more phenomenon occurring in France with tuberculosis—more specifically, he examined the question of why women were affected by tuberculosis far more frequently than men. Indeed, by the 1830s, nearly two-thirds more women than men were dying of tuberculosis.⁷³ Benoiston ultimately came up with two explanations for this trend: The first reason was that women menstruated and became pregnant. For Benoiston, “the precautions that [these phenomena] always demand, the troubles they often go through, the storms of pregnancy, [and] the complications that follow it are enough to show why consumption is more frequent among women from age 15 to 50.”⁷⁴

Benoiston’s second reason was based on the notion that women are inherently weaker than men. For him, this innate weakness made regular life more difficult for women and thereby intensified the experience of poverty for them. Such intensification

⁷² Barnes, *The Making of a Social Disease*, 37.

⁷³ Barnes, *The Making of a Social Disease*, 9.

⁷⁴ Barnes, *The Making of a Social Disease*, 38.

led to improper nourishment, which further emphasized their natural weakness and inability to resist “harmful influences.” And indeed, these same limitations also led women to have desires for life’s pleasures that could not be fulfilled by the state of poverty that they were destined to live in. In the end, the inherent weaknesses of the fairer sex resulted in a “series of imprudences and lapses whose sad effects end up destroying [their] organs, which were already impaired by painful labor and by even more painful privations.” In effect, prostitution (and generally, immoral behavior (*l’inconduite*)), which resulted from economic instability and the inability to live up to one’s dreams, explained why more women died early. In many ways, Benoiston’s conclusion simply paralleled Laënnec’s “sorrowful passions” theory. As he put it, “on the one hand, a weaker constitution, meager wages and the resultant poverty, and on the other hand, active passions and...excesses of all sorts, lead rapidly to the grave for these weak beings, led astray by deceptive dreams.”⁷⁵

A final figure that should be mentioned for his contributions to pre-contagion era tuberculosis studies in the early 19th century is Pierre-Charles-Alexandre Louis. In a contribution entitled “Note on the Relative Frequency of Phthisis in the Two Sexes” that followed Benoiston’s article in the *Annales d’hygiène publique* of 1831, Louis, using the “numerical method” to manipulate numbers, “proved” that women were 37% more likely than men to suffer from consumption. Louis examined two factors that he thought to be contributing women’s higher mortality rate. The first issue he addressed was women’s fashion, namely the tight-fitting corset in vogue in Paris during that time. It was suggested that such corsets precluded chest development and that this ultimately led to downfall via tuberculosis. However, because many of the individuals that Louis, a

⁷⁵ Barnes, *The Making of a Social Disease*, 38-39.

clinician himself, treated were either women from the countryside where corsets were not worn or were simply children who had not yet grown old enough to become fully immersed in the high Parisian fashion, this theory was rejected.

Louis' second theory dealt with what he termed "lymphatic temperament." The idea of lymphatic temperament stemmed from the ancient Greek disease theory of the Four Humors originally found in Hippocrates' *The Nature of Man*. Louis thought that women were more susceptible to this temperament, which was described as languid and sluggish, and that this inherent tendency predisposed them to tuberculosis. This was, to him, the only way to explain the statistics he came up with. Yet again, Louis' theory about women was quite similar to the essentialist medicine outlook first outlined by Laënnec.⁷⁶

For these essentialists, tuberculosis was primarily the result of an inherent propensity, related to one's essence, rather than to external problems. Such thinking did not entirely disappear from France until the latter half of the century. As stated previously, contagion theory, although already in existence, did not become the accepted theory until much later after Villemin, a military physician, announced that he had succeeded in inoculating tuberculosis into laboratory rabbits. His experiments marked the first time that contagion theory had been experimentally proven. Naturally, Villemin's discovery was not immediately accepted; it was actually contested quite strongly by many essentialists. However, time and more research put a complete stop to all of their arguments, and France joined Europe by finally accepting contagion theory.⁷⁷

⁷⁶ Barnes, *The Making of a Social Disease*, 39-40.

⁷⁷ Barnes, *The Making of a Social Disease*, 29, 41-47.

Since no individual yet knew what to combat, treatment of tuberculosis throughout Europe during the seventeenth to nineteenth centuries was at best, varied and shaky. Few new treatments were introduced over the course of these three centuries, although a variety of options were available from the start. One particular treatment in vogue was alkaline mineral waters. This remedy stemmed from the writings of Sylvius, who, as mentioned before, is recognized today as the “founding father” of the tubercle. Sylvius developed a specific therapy for consumption that relied primarily on distinguishing the differences between the acid and alkaline states of the body as they related to disease. Thomas Willis, a contemporary of Sylvius, carried these ideas further, and their work led to the use of mineral waters for treatment.

In England, physician Thomas Sydenham (1624-89) found that horse-back riding was by far the best cure for consumption. His contemporary, Richard Morton (1637-1698), also of England, thought otherwise and published in *Phthisiologia* in 1689, an extensive section on treatment of tuberculosis at its various stages. For what he labeled the “Original Consumption of the Lungs,” milk (which had been a suggested cure since the times of Hippocrates), chalybeate mineral water, and cough-soothing drugs were recommended. The pernicious was to be removed via vomiting, purging, diuresis, and sweating. Bleeding was also recommended to “prevent the hectic and colliquative heat or catarrhus state of the blood, or at least lessen it.” Morton thought that bleeding six to ten ounces at relatively close intervals would also help with cough and expectoration and other symptoms that led to consumption. However, he did note bleeding to “do mischief sometimes in confirmed consumption,” though still “very beneficial in the beginning.” And like Broussais of France would later suggest, Morton recommended a small diet for

late consumptives, along with timely bleeding, plentiful use of “soothing remedies,” opiates for sedation, and Peruvian bark for fever.

As understood through the writings of William Nisbet (1759-1822), consumptives of the eighteenth century and onwards were to be treated through four main procedures. Alkaline mineral waters and various woods, such as guaiac and sassafras, were used to “correct acrimony” (stemming from the humoral theories of Hippocrates), while mercury, antimony, and cream of tartar were used to treat the “excitation of vessels.” Cold bathing and Peruvian bark increased bodily tone, and irritation was expelled by nightshades and opium.⁷⁸

Italy, of course, still favored contagion theory, and Antonio Cocchi wrote in 1857 that phthisis patients were to live in large airy rooms exposed to rising or midday sun, especially during the winter months. Windows were to be kept open, for having the windows and doors shut would only make the air more putrefied and therefore more dangerous to both the patient and others around him or her. The patient was required to spit only in vessels of glass or dried porcelain, and these containers were to be cleaned thoroughly. Small rooms were to be whitewashed; it was okay if larger rooms were whitewashed only to the height of the infected.⁷⁹

One can, with today’s knowledge, now understand why many prominent physicians of the 19th century were so convinced that tuberculosis could not be cured. Other than the recommendation of fresh air, the available remedies could not produce solid results because they did not address the disease’s natural pathology. Given the relatively primitive state of medicine, physicians of the 19th century could really only

⁷⁸ Long, *A History of the Therapy of Tuberculosis*, 43-48.

⁷⁹ Huber, *Consumption and Civilization*, 44.

attempt to prevent *spread* of the disease. Even Frenchman Laënnec wrote in his *De L'auscultation Médiante*:

To conceive the possibility of a cure in some cases, after the formation of a cavity in the lung by ulceration, may perhaps appear simple enough to many medical practitioners who are not anatomists, and nevertheless absurd to most of those who have prosecuted any consecutive research in the realm of pathological anatomy. Before the characters and course of development of tubercles were known, and as long as phthisis was generally ascribed to chronic inflammation and slow suppuration of the lung tissue, physicians entertained no more doubt than is still entertained by the public at large as to the possibility of curing pulmonary phthisis by suitable treatment, above all when the disease is taken in time, and whilst it is still in the first degree. Nowadays, on the contrary, all followers of the healing art who are acquainted with the recent progress of pathological anatomy are of the opinion that tuberculous disease, like cancerous disease, is without possible cure because nature's efforts are all directed against cure, and the efforts of medicine are unavailing...⁸⁰

It is probably because of this dismal outlook that Laënnec, like the Italians, simply favored the clean air of the outdoors over any “soothing concoction.” Inspired by the low rate of tuberculosis amongst the country peasants and small-town people, he felt that fresh air (and especially marine air) contained a special something that protected an individual from contracting the disease. And because of this belief, Laënnec always recommended a treatment of fresh air for his patients. And when he himself became a consumptive towards the end of his life, he insisted on leaving his windows open at all times.⁸¹

There is no doubt that tuberculosis was a significant problem in the 19th century. Unfortunately, science simply had not progressed far enough for physicians to really understand how to treat consumption and prevent its spread. Instead, physicians did as best they could, theorizing, diagnosing, and treating patients based on their observations

⁸⁰ Long, *A History of the Therapy of Tuberculosis*, 46.

⁸¹ Dubos, *The White Plague*, 90.

of anatomical changes, clinical symptoms, and societal trends. Admittedly, with the constant interchange between the arts and sciences, the approach to public health and medicine was not always scientifically sound. But nevertheless, considerable progress was made during the century, all of which, in the end, has helped give us today's tuberculosis medications and relatively disease-free environment.

Chapter 3: *Abstract Intersections: Gender, Consumption, and Chopin.*

When understood through the 19th-century *medical* mind, Chopin really was, in many ways, the perfect candidate for tuberculosis. Admittedly, he did not satisfy every “criterion” of the potential consumptive. He did, however, have the appropriate familial background and career choice for a consumptive, and in many ways, his musical output embodied the inherent, “effeminate” qualities so often associated with the disease.

As noted in Chapter 2, in the early 19th century, consumption was largely thought to be a hereditary disease. A parent passed the disease on to his or her child, and thus contributed to the constant spread of the disease within society. Chopin, of course, had been intimately introduced to the disease from a young age, when his sister Emilia, died from the disease. His father, who died while Chopin was living in Paris, may also have succumbed to tuberculosis or some other related cardiac or respiratory disease.

This simple connection to a family with a recent history of the disease would probably have been enough to secure for Chopin an “at-risk for consumption” label. However, because the disease was so prevalent in Europe during the late 18th and early 19th century, physicians did not simply stop at genetics. Too many unanswered questions and atypical consumption cases existed for them to settle for such a limited theory. Instead, physicians and some of the earliest public health officials began examining more closely the etiology and social epidemiology of the disease. Chapter 2 covers a number of the articles and treatises regarding the pathology and epidemiology of consumption that were published in France in the early to mid 1830s, when Chopin first arrived in Paris.

We shall begin by discussing the points laid out in the treatise by Henri Lombard. Written in 1834, Lombard’s “The Influence of Professions on Pulmonary Consumption”

primarily contributed to consumption records by attempting to correlate jobs with disease. He came up with three categories: the first pertained to wealth; the second to physical exercise and movement; and the third to the surrounding atmosphere. Of primary importance for discussing Chopin was the second category. Given that Chopin's income was generated primarily through composition and teaching, with the occasional public concert, it is likely that Chopin would have been classified as living by an inactive job. The term "inactive," of course, was not used to imply lethargy; rather, it was used by Lombard to characterize the amount of body movement associated with the work. Teaching and composition, of course, primarily requires movement of the upper body—both tasks can be, and are, most logically performed while sitting in one place. Both tasks also make use of the arms—composition requires the hands, and piano-playing also depends on the upper body. The relative inactivity of such a job, for Lombard, would have rendered its doer more susceptible to acquisition of consumption, though the musician's particular use of the *upper* body versus the lower body made no difference. Benoiston, as we saw in Chapter 2, thought otherwise: For Benoiston, whose article had been published only three years before that of Lombard, bias towards certain muscle groups *did*, in fact, affect an individual's susceptibility to consumption. For him, workers with professions that required hunching over (seamstresses and writers, for example) were more likely to be struck by consumption.

In hindsight, one must acknowledge that such a notion fits seamlessly with the Romantic era fascination with the effects of consumption on poets, writers, and composers. All three professions, of course, require the genius to hunch over his or her

masterpiece, and the 19th-century artist, it seems, could always benefit from the otherworldly, creativity-enhancing effects of consumption. Alexandre Dumas noted:

In 1823 and 1824, it was the fashion to suffer from the lungs; everybody was consumptive, poets especially; it was good form to spit blood after each emotion that was at all sensational, and to die before reaching the age of thirty.⁸²

Lombard's stance on bodily motion, as just noted, differed from Benoiston's. Therefore, it is unlikely that he would have felt that Chopin or any other composer was more susceptible to the disease for having pursued a career that required such bent-over body positions. He would, however, have found Chopin to be more susceptible to the disease for remaining within closed doors for so many hours. Treatments during this century usually took patients to places with warmer climates and fresh air. It therefore was perfectly logical for Lombard to have come to the conclusion that persons with indoor jobs were more likely to be stricken with consumption than those who could take advantage of the clean, replenishing air of the natural world.

From these simple comparisons, we note that Chopin, by nature of his job and position as a composer, instructor, and performer, was an ideal candidate for tuberculosis in the minds of 19th-century physicians. Admittedly, these two articles, which also examined the correlation between financial status and diseases, found the poor to be twice as likely to die from consumption as the rich. Although Chopin was often tight on money, he, by no means, lived the difficult life; his situation, in fact, was quite the opposite: Chopin socialized in the highest circles of society, dressed immaculately, and never experienced a life even remotely resembling that of what a 19th-century Parisian surviving in poverty might have experienced. The important correlation between wealth

⁸² Dubos, *The White Plague*, 58.

and disease state did not directly apply to him. He was, in this sense, an anomaly. But Paris certainly knew that consumption was not a disease *exclusively* for the poor. The rich had their genetic faults, and the rich had their own set of inherent tendencies which made them open to acquisition of consumption.

Chopin, Sorrowful Passions, and the Effeminate

From here, we turn to some of the most important implications of tuberculosis for Chopin. We can begin by quickly reexamining a few of the concepts that emerge from the epidemiological studies of consumption in 19th-century. It should be noted that geography had a significant impact on the nature of consumption theories during that century and that each country had its own outlook on the disease. But given that Chopin spent the majority of his adult life in Paris, we shall, in this chapter, focus on the medical literature from France.

For the French, disease was the result of an individual's essence, and thus, one's inherent moral standing and temperament, especially as they related to gender, were just as important as an individual's family history in determining susceptibility to consumption. (A full discussion of the 19th-century medical literature on consumption can be found in Chapter 2.) *Passions tristes*, a phrase propagated by the famous French physician, Laënnec, originally suggested that certain individuals had inherent traits (or perhaps *flaws*) in their character that automatically increased their likelihood to die of consumption. Although Laënnec and Peter clarified its meaning to an extent (with special emphasis on morality and sexuality), the definition of *passion triste* remained extraordinarily open.

As noted in Chapter 2, the 1831 report by Benoiston extended or rather, further defined *passion triste* by connecting it directly to women. Benoiston believed that women were more susceptible to consumption than men and offered two explanations. The first dealt with bodily mechanisms: Women menstruated and became pregnant. These hardships that their bodies were forced to endure greatly heightened their chances for infection. (As unnatural as the notion is for us today, such a conclusion was perhaps not so bizarre for Benoiston's time, when so many women died during pregnancy, due to infection and/or blood loss.) The second explanation suggested that the female sex was naturally predisposed to acquiring consumption due an inherent moral and sexual weakness. This second speculation, thought to be a truth in the 19th century, is the direct expansion or redirection of Laënnec's theory of *passions tristes* towards women. Clearly, Benoiston found the tendency towards wrongdoing to be stronger in the "weaker" sex, and like his fellow medical thinkers, viewed the relation between consumption and women in a negative light.

It would be beneficial to pause here for a moment and explore a little of the other 19th-century trend regarding consumption and women. As Barnes notes, unlike the medical world, the arts viewed consumption in women in a more sympathetic way, implying through their stories that suffering women had been graciously granted the power of heightened sensitivity and redemption.⁸³ From one angle, these schools of thought appear contradictory; one views the effects of consumption as stemming from inherently negative tendencies, while the other suggests that the acquisition of consumption ultimately *empowers* a woman. On the other hand, however, they complement each other. Although one speaks of consumption as a tragedy resulting from

⁸³ Barnes, *The Making of a Social Disease*, 48-58.

negative tendencies while the other views consumption as a redeeming quality that helps a woman to both purify and realize her purity, both schools ultimately center on the fundamental importance of the innate. Consumption, in other words, was directly related to the female essence for both the physician *and* artist.

This emphasis on the “essence” is important, for it shows that the 19th century mindset was distinguishing, for better or for worse, a difference between the female consumptive and nonconsumptive via an abstract concept centered on *inherent* qualities rooted in the temperament and character. Such qualities were specific to the individual and could not be acquired from the external environment; rather, one could only be guided, consciously or unconsciously, by this essence to redemptive or retributive suffering.

The connection between this thought and Chopin is rather curious. From the surface, at least, relations between the effeminate and consumption appear irrelevant for a study on Chopin, a *male* composer. Since it cannot be said that Chopin was ever criticized for any moral or sexual failings, the notion of “sorrowful passions,” as understood through these two terms, also does not appear to directly apply to him.

In the end, Chopin was known best as a musician, an advocate for his dear Poland, and a visionary in the world of artists. Other than his relationship with George Sand, his character and personal life, while still important, played a role secondary to that of his public life as a musician, composer, and teacher. Thus, if we are to look for evidence of Chopin’s “essence,” it makes most sense to look towards Chopin, the artist, to see how he may have been related to and influenced by the theories on consumption and women.

We begin with the general perceptions of Chopin's musical style and immediately note that "sexual" or "immoral" passages cannot be readily pinpointed in his music. But given Chopin's choices to cultivate, for example, the effeminate nocturne genre and a revolutionary style of playing complete with twisted fingering and the use of *tempo rubato*, we, at the same time, cannot help but note that Chopin, even during his day, deviated from tradition. His style was, in one word, *different*.

For many, this represented a step into the unknown; Chopin's music was therefore both criticized and praised for being unnatural. Criticism prevailed during his earliest days in Paris. In particular, the editor of the *Iris*, Relstab, complained about the difficulty and originality of Chopin's music. Of the Mazurkas, Op. 7, he wrote:

In the dances before us the author satisfies the passion [of writing affectedly and unnaturally] to a loathsome excess. He is indefatigable, and I might say inexhaustible, in his search for ear-splitting discords, forced transitions, harsh modulations, ugly distortions of melody and rhythm. Everything it is possible to think of is raked up to produce the effect of odd originality, but especially strange keys, the most unnatural positions of chords, the most perverse combinations with regard to fingering.⁸⁴

While reviewing the Three Nocturnes of Op.9, Relstab made the following comparison between John Field, the originator of the nocturne genre, and Chopin:

Where Field smiles, Chopin makes a grinning grimace; where Field sighs, Chopin groans; where Field shrugs his shoulder, Chopin twists his whole body; where Field puts some seasoning into the food, Chopin empties a handful of cayenne pepper...In short, if one holds Field's charming romances before a distorting concave mirror, so that every delicate expression becomes coarse, one gets Chopin's work...We implore Mr. Chopin to return to nature.⁸⁵

⁸⁴ Niecks, *Frederick Chopin, Vol. I*, 269.

⁸⁵ Niecks, *Frederick Chopin, Vol. I*, 269-70.

Even Chopin's fingering was considered to be revolutionary. As with his compositions, the new style was not welcomed enthusiastically at the beginning. The great pianist Moscheles found them initially irksome:

I like to employ some free hours in the evening in making myself acquainted with Chopin's studies and his other compositions, and find much charm in the originality and national colouring of the *motivi*; but my fingers always stumble over certain hard, inartistic, and to me incomprehensible modulations, and the whole is often too sweetish for my taste, and appears too little worthy of a man and a trained musician. (1833)⁸⁶

He wrote again:

I am a sincere admirer of Chopin's originality; he has furnished pianists with matter of the greatest novelty and attractiveness. But personally I dislike the artificial, often forced modulations; my fingers stumble and fall over such passages; however much I may practise them, I cannot execute them without tripping.⁸⁷

Soon though, the forced modulations and bizarre fingerings in Chopin's music came to be accepted by a larger portion of the cultivated musical world in Paris. Chopin's creations were captivating and exciting; they were novel, and they represented a new form of expression. And it was this thrill that won over the critics and audiences alike. Favorable reviews that followed the early criticisms often expressed astonishment and *delight* at Chopin's inventive style for the pianoforte. Meyerbeer, for example, expresses his approval of Chopin:

I had not seen Chopin for a long time, I love him very much. *I know no pianist like him*, no composer for the piano like him. The piano lives on *nuances* and on *cantilena*; it is an instrument of intimacy.⁸⁸

A report from the *France musicale* noted:

⁸⁶ Niecks, *Frederick Chopin, Vol. I*, 271.

⁸⁷ Niecks, *Frederick Chopin, Vol. I*, 271.

⁸⁸ Niecks, *Frederick Chopin, Vol. II*, 169.

In listening to all these sounds, all these *nuances*, which follow each other, intermingle, separate, and reunite to arrive at one and the same goal, melody, do you not think you hear little fairy voices sighing under silver bells, or a rain of pearls falling on crystal tables? The fingers of the pianist seem to multiply *ad infinitum*; it does not appear possible that only two hands can produce effects of rapidity so precise and so natural...⁸⁹

And lastly, written after Chopin's death, the following, rather poetic, comment by Énault sums up Chopin's music and its gradual acceptance in society:

For Chopin, music was destined to evoke passions, to render them palpable, to communicate through them the sighings of the wind. He established an invisible magnetism between the souls of the listeners and the sonorous vibrations of the instrument. Chopin, if we may use a term from the old school, was an "artiste pathétique." This passion did not appeal to the crowds, because it manifested itself through the forms and styles still unusual for the time, and, in music, anything that departed from convention needed the help of time.⁹⁰

Chopin, we can see, was regularly noted during his day for an unusual approach to piano playing. The presence of this deviation serves as the first step in establishing a "uniqueness" that may have set Chopin's "essence" apart from the masses.

This peculiarity, however, did not manifest itself solely through the originality of Chopin's playing. As the previous few excerpts suggest, it wasn't *novelty* that was attracting the attention of the critics and musicians; rather, it was a blend of novelty with beauty and *expressivity* that was setting him apart. Never had such a mixture of serenity, passion, and freedom been heard before. Chopin's music had the ability to conjure images of the ethereal in the listener's mind. And when the pianist lost himself in his own private, dream world, the piano took on a life and expression that could not be matched by any. Liszt wrote:

When this kind of inspiration laid hold of Chopin his playing assumed a distinctive character, whatever the kind of music he executed might be—

⁸⁹ Niecks, *Frederick Chopin, Vol. II*, 94.

⁹⁰ Énault, *Frédéric Chopin*, 13. Translated by Carl S. Leafstedt.

dance-music or dreamy music, mazurkas or nocturnes, preludes or scherzos, waltzes or tarantellas, studies or ballades. He imprinted on them all one knows now what nameless colour, what vague appearance, what pulsations akin to vibration, that had almost no longer anything material about them, and like the imponderables, seemed to act on one's being without passing through the senses. Sometimes one thought one heard the joyous tripping of some amorously-teasing Peri; sometimes there were modulations velvety and iridescent as the robe of a salamander; sometimes one heard accents of deep despondency, as if souls in torment did not find the loving prayers necessary for their final deliverance. At other time there breathed forth from his fingers a despair so mournful, so inconsolable, that one thought one saw Byron's Jacopo Foscari come to life again, and contemplated the extreme dejection of him who, dying of love for his country, preferred death to exile, being unable to endure the pain of leaving *Venezia la bella!*⁹¹

It should be emphasized again here that consumptive women were thought to possess a heightened sensibility or emotional acuity. Chopin's extreme, but exquisite expressivity—his ability to elegantly summon forth the deepest shades of emotion—thus serves to distinguish his “essence” as not only different, but as *effeminate* and *feeling*. Indeed, it perhaps serves as one of the key factors that relates and related Chopin to the female.

His concerts certainly captured the fancy of women: the typical Chopin event was filled with the perfumes of the fairer sex. A review in the *France musicale* covering a second concert given by Chopin in 1842 gives us a sense of the audience that came to hear the renowned musician:

Chopin has given in Pleyel's hall a charming soirée, a *fête* peopled with adorable smiles, delicate and rosy faces, small and well-formed white hands; a splendid *fête* where simplicity was combined with grace and elegance, and where good taste served as a pedestal to wealth. Those ugly black hats which give to men the most unsightly appearance possible were very few in number. The gilded ribbons, the delicate blue gauze, the chaplets of trembling pearls, the freshest roses and mignonettes, in short, a thousand medleys of the prettiest and gayest colours were assembled, and

⁹¹ Niecks, *Frederick Chopin, Vol. II*, 100.

intersected each other in all sorts of ways on the perfumed heads and snowy shoulders of the most charming women for whom the princely salons contend.⁹²

The following excerpt is yet another example of how popular Chopin was with women. Madame de Girardin wrote in 1847:

Mdlle. Merara is a pupil of Chopin's. He was there, he was present at the triumph of his pupil, the anxious audience asked itself: "Shall we hear him?"

The fact is that it was for passionate admirers the torment of Tantalus to see Chopin going about a whole evening in a *salon* and not hear him. The mistress of the house took pity on us; she was indiscreet, and Chopin played, sang his most delicious songs; we set to these joyous or sad airs the words which came into our heads; we followed with our thoughts his melodious caprices. There were some twenty of us, sincere amateurs, true believers, and not a note was lost, not an intention was misunderstood; it was not a concert, it was intimate, serious music such as we love; he was not a virtuoso who comes and plays the air agreed upon and then disappears; he was a beautiful talent, monopolized, worried, tormented, without consideration and scruples, whom one dared ask for the most beloved air, and who full of grace and charity repeated to you the favourite phrase, in order that you might carry it away correct and pure in your memory, and for a long time yet feast on it in remembrance. Madame so-and-so said: "Please, play this pretty nocturne dedicated to Mdlle. Stirling." —The nocturne which I called the dangerous one.—He smiled, and played the fatal nocturne. "I," said another lady, "should like to hear once played by you this mazurka, so sad and so charming." He smiled again, and played the delicious mazurka. The most profoundly artful among the ladies sought expedients to attain their end: "I am practicing the grand sonata which commences with this beautiful funeral march," and "I should like to know the movement in which the *finale* ought to be played." He smiled a little at the stratagem, and played the *finale* of the grand sonata, one of the most magnificent pieces which he has composed.⁹³

There is no doubt that Chopin's physical frame and refined manners also served him quite well in settings such as the one just described. It could be argued that the pianist, with his pale, slender figure; aristocratic, refined manners; and extreme attentiveness to attire, blended in rather well with the women of society. Speaking of

⁹² Niecks, *Frederick Chopin, Vol. II*, 93.

⁹³ Niecks, *Frederick Chopin, Vol. II*, 152.

Chopin's youth, Énault draws upon the reminiscences of an "unknown friend" who writes of his early days in Poland:

Gentle, sensitive, exquisite in every way, Chopin had, by age 15, all the graces of adolescence blended with the gravity of a mature man. He remained delicate in spirit as well as body. But this absence of muscular development allowed him to preserve a beauty, an exceptional physiognomy, that in a manner of speaking, owed itself neither to age nor sex. This was never the hardy and baleful spirit of one descended from a race of ancient magnates who knew only how to drink, hunt, and wage war. Nor was it the effeminate graciousness of a rose-colored cherub. It was more like those ideal creations found in poetry from the middle ages, an ideal individual paying homage before a decorative Christian temple. Or an angel, beautiful of face—a woman sad, pure, and slender in form like a young goddess from Olympus. And crowning these features: an expression both tender and severe, chaste and passionate.⁹⁴

Énault, elsewhere in his biographical sketch, captures Chopin in his delicacy and femininity:

Chopin was an enigma with regard to his character and his talent. He was born to be strong, and he was weak. When one took his hand, which seemed small, you were surprised by the bony resistance that you felt right away. His was the skeleton of a soldier covered over by the muscles of a woman. A man with a gift for words mentioned one day in front of me: "Chopin is a bass with the strings of a violin." These qualities seemed destined for suffering. But one could scarcely doubt that his reserve grew with his sufferings.

Chopin never permitted himself the energetic expression of his most animated feelings: he only let his friends see what was gentle in him and affectionate. He clothed the rest "with care and with the guile of the oppressed." He was ever a woman in this regard. [Il était femme encore sur ce point.] The ease of his relations with those around him, the fairness of his humor, the constant goodness of his gaze, left little reason to suspect his internal preoccupations.⁹⁵

It is not the least bit surprising to find the spirit of Chopin so embedded within a web of angelic, mythical, and feminine metaphors. The excerpts and explanations above serve as evidence that Chopin was associated with the fairer sex and the ethereal quite

⁹⁴ Énault, *Frédéric Chopin*, 27-28.

⁹⁵ Énault, *Frédéric Chopin*, 7.

often. Kallberg, in his article entitled “Small Fairy Voices: Sex, History, and Meaning in Chopin,” expounds upon this very subject, commenting on how “sex ‘spoke’ music [and] how (and if) sex entered into the reception of music at a given historical moment.” More specifically, he writes on the prevalence, both during and after Chopin’s lifetime, of otherworldly metaphors that implied connections between Chopin and the androgyne, hermaphrodite, and sodomite.⁹⁶

Of course, Chopin was not actually *female*; he just consciously or unconsciously embraced certain qualities that allowed his essence to be defined by conventionally feminine characteristics. His music was extraordinarily and uniquely expressive for his day; from the medical perspective, such qualities served to render his essence atypical enough to warrant consumption as a justifiable and expected outcome. From the artist’s perspective, these traits made him the ideal consumptive “heroine.” Music was his redemption and from his imbalanced essence came salvation and sweet musical reverie. Chopin’s slight frame and polished manners probably served to cement this delicate image already being promoted by his musical ideals.

Op. 27, and the lymphatic temperament.

We have now seen how Chopin was, in many ways, associated with the effeminate. One more area of importance, however, remains to be examined. In a sense, this final topic is yet again an extension of the same theme from before. Pierre-Charles-Alexandre Louis, in his “Note on the Relative Frequency of Phthisis in the Two Sexes” from 1831, examined the effect of temperament on the acquisition of consumption. Louis found that the “lymphatic temperament,” epitomized by the relaxed and languid

⁹⁶ Kallberg, “Small Fairy Voices: Sex, History, and Meaning in Chopin”, 62-86.

individual, lent itself well to consumption. Women, of course, were more prone to the lymphatic temperament than men.⁹⁷

Again, we find the connection between Chopin, the lymphatic temperament, and women in the composer's music. More specifically, we find the connection in Chopin's extensive development of the nocturne genre. Although the genre was originated by an earlier contemporary of Chopin, John Field, Chopin is arguably the first to fully explore the potential of the genre. His Op. 27 Nocturnes in C# minor and Db major were published in 1836 but composed in 1835, only a few years after P.C.A. Louis had published his findings relating consumption, women, and the lymphatic temperament.

Kallberg has already addressed certain connections between the nocturne genre and women.⁹⁸ He has suggested that the noticeably gendered responses to nocturnes may have been prompted by the skewed demography (women were the main consumers of piano music) and association of women with detail and darkness. Kallberg has also noted how the gender associations may have functioned to devalue the genre as a whole. Here, I shall include from his essay a single quotation that, penned by an anonymous critic, refers directly to the Op. 27 Nocturnes:

The names of the creations, Nocturnes, . . . admit nothing else but a fancifully dark hue. . . It is the dream, which celebrates its round dances with longing, longing which chose pain on its own, because it could not find again the joy that it loves. For that reason these new Nocturnes, like the old ones (as different as they are from them), will again always be more attractive to all hearts inclined toward the feminine.⁹⁹

⁹⁷ I have been unable to consult Louis' article directly. My discussion of his lymphatic temperament idea has been taken from Barnes, pp. 39-41.

⁹⁸ Kallberg, "The Harmony of the Tea Table: Gender and Ideology in the Piano Nocturne", 30-61.

⁹⁹ Kallberg, "The Harmony of the Tea Table: Gender and Ideology in the Piano Nocturne", 33.

In such ways the Nocturne was very explicitly linked to women and thus therefore tainted from a strong gender bias. Its connection to the lymphatic temperament also stems from this gender preconception. By examining the Op.27 Nocturne in C# minor, we can see how many of the “feminine” qualities of Chopin’s nocturnes also connected them to the lymphatic temperament.

The C# minor nocturne can be structurally described as falling into a simple ternary form with a coda to conclude the piece. The first section, mm. 1-28, is slow, steady, and solemn. It begins in the key of C# minor with repeating arpeggiations in the left hand. The first two measures outline C# minor triad, with the C# pedal tone as the lowest note. As is the case with many Chopin compositions, no strong downbeat can be heard in these arpeggiations; the effect of the left hand, which continues outlining various chords through most of this first section, is directionless: It makes no great entrance and creates no striking effect on the listener. The sound exists, but quietly and steadily and solemnly.

The first, chromatic melody enters in m. 3. The effect created by the entrance of the right hand is like that of the voice joining its accompaniment in a solemn art song. Although there is direction in its movement, the right hand, like the left hand, appears uninterested in making a grand entrance. It emerges and it is recognized, but it nevertheless remains unaffected and unadorned. The melody is simply lyrical and characteristic of Chopin’s compositions in its ability to float over the left hand.

First heard in mm. 3-6, the melody is repeated again, but left unfinished, in mm. 7-9, and leaves the listener with the impression of a full, yet strikingly unfinished seven-measure melodic phrase. It could be argued that the resolution to the second repetition

does indeed come—but a measure too late. Only after the paradoxical hovering and transitioning of the left hand in m. 10 does the right hand return with its response of resolving C# octaves (m. 11), functioning to both end the previous melody and begin the second idea.

Once again, this second melody remains song-like; the motions are primarily stepwise, and the section is composed quite simply of two repetitions of a four-bar phrase. Mm. 19 brings the return of the first idea, but with greater embellishment. A countermelody is heard in the right hand under the now familiar opening theme; the texture of the piece has become denser, and the listener is better prepared for the emphatic message of the B section.

With the arrival of the middle section, the listener is suddenly introduced to more assertive writing. Gone are the gentle, timid, and melodic sounds of the Section A. A shift in mood occurs, and the gargantuan leaps of the sprawling left hand arpeggiations in the A section are replaced by triplets alternating between notes separated only by a major second interval. While the left hand quietly rumbles, the right hand begins playing accented octaves. Through repetition of both rhythm and the melodic contour, a sense of urgency is created. It begins quietly; the disturbance is noted, but it is suppressed. However, unable to contain itself, the sound grows louder and louder; the left hand frees itself from its two note cage and finds more complex patterns of expressions. The right hand also frees itself from the strict use of the dotted rhythm pattern that had characterized its sound earlier in the B section: the emphatic appeal of triplets and the straightforward, but commanding voice of quarter notes (see mm. 41-47) are now heard. The music continues to build, in volume and density until, amidst the climactic moment,

an unexpected key change emerges. From these multiple measures of anticipation and building emerges an authentic cadence in the key of Ab major. (Interestingly, Ab stands as the enharmonic equivalent of G# or the dominant in C# minor.) The mood shifts almost immediately, and the listener, after the anticipation of the previous moment, finds him or herself suddenly listening to a driven, but contained repetition of the agitation and growing insistence found in the early B section material. The left hand returns to its two note triplets, albeit the intervals have grown much wider than the original major second. An Ab pedal in the left hand helps unify and anchor this episode beneath the otherwise shifting tonalities.

The music eventually leads the listener to a repeated and accented fully diminished chord on C (mm. 63-64) before being diverted into a most unexpected, but animated waltz in Db major (beginning in m. 65). Here, Chopin introduces a few measures of delight and playfulness, using inversions of simple dominant and tonic chords to create the new mood. Relative to the previous sections, the feeling is much lighter and amiable and thereby stands in contrast to the hammered and heavy sounds of only a moment before. But for whatever reason, the cheer is short-lived, and the waltz suddenly shifts its sounds to C major (mm. 72-77) for a brief moment before once again losing itself in a series of chromatic chords that prepare it for the journey back to the beginning.

Between the waltz and the return of the A section lies perhaps the most dramatic moment of the entire nocturne. At the end of the B section, after the piece has found its way back to its home base of C# minor, Chopin sets the pianist free for a brief moment. A V7 chord on G# is heard and held, followed by a descending proclamation played by

the left hand using a series of chromatic octaves (mm. 83). Bold, dramatic, and free from the strictures of triple meter, this final cadenza stands as the final, impassioned plea from the B section and of the nocturne as a whole.

Only moments after the B section has finished its final thoughts, the hovering arpeggiations of mm. 1 return and with them, the song-like melody of Section A. The melody is heard twice, with a countermelody once again accompanying the second hearing (see mm. 89-94). The B# of the second repetition resolves up to a C# in mm. 94 and is followed by the loveliest of surprises. Chopin inserts a E# into the next chord to signal yet another shift in mood for the nocturne. And indeed, the tonality permanently shifts from C# minor to C# major, and the general mood of the nocturne is lifted: solemnity changes to serenity. The weightiness of previous sections is removed, and a newfound gentleness and sweetness takes over. The listener is transported to another world where only the restful can exist; urgency and persistence are unheard of in this world.

Ultimately, it is this world that Chopin loves best, for a plagal cadence in C# major is heard in the concluding remarks of the nocturne. Only the C# major tonic, played very softly and gently and with its mediant on top, is heard after the cadence as the nocturne's final farewell to the listener. Chopin has ultimately chosen serenity over solemnity, and at the nocturne's final farewell, the listener is left to dream in a restful and calm night.

While such repose is more wistful than lethargic, it can be argued that the mood of the nocturne has elements of Louis' lymphatic temperament. As examples of Romantic era character pieces for piano, Chopin's nocturnes are all relatively short compositions.

Apathetic they are not; however, by nature of their genre, they are usually “languid” compositions. This does not mean that Chopin’s nocturnes are dull, simplistic, or easy to play, nor is it to say that the variety between compositions or even within a single composition is limited. Rather, it is to say that, despite often turbulent and technically difficult middle sections, most nocturnes begin and end peacefully, as if to recreate the entrance and exit of the night sky. In this sense, they, like the lymphatic temperament, give an overall sense of being inactive and somewhat dreamy. Certainly, listening to the C# minor nocturne does not leave one with a feeling of having experienced a profound revelation or elevated thought; rather, the nocturne leaves the listener with a sense of calm and exquisite rapture. It is, in this sense, a genre for the “weaker” souls—those who are incapable of experiencing something more tumultuous, assertive, or philosophical. And because of this, the nocturne can be argued to embody the lymphatic temperament of the consumptive female.

Certainly, Chopin’s compositions were original and expressive, both of which lent themselves to the establishment of his atypical or imbalanced “essence.” His musical embodiment of the gentle and refined, coupled with his dedication to the development of the nocturne genre functioned to associate him with the fairer sex and Louis’ lymphatic temperament. And lastly, Chopin’s small build, physical frailty, perfect manners, and immaculate taste in attire, helped match the external with the internal. Given the close parallels between these Chopinesque qualities and those mentioned in the medical literature on consumption, it is clear that Chopin was, at least for the 19th-century citizen of Paris, France, the perfect candidate for consumption.

Of course, one might question why, given the negative implications of embodying such an imbalance, Chopin was still so well received in society. There is certainly no evidence that the composer, if actually believed to have the inherent “flaws” of the female, consumptive soul, was ever ostracized or shunned by society. In fact, the commentary and reviews that have been preserved from the 19th century suggest quite the *opposite*: according to most of these, Chopin was considered to be an *angel*, not a cursed soul with undesirable feminine tendencies!

Perhaps the best explanation for the acceptance of Chopin’s simultaneous embodiment of both the angelic soul and the lymphatic temperament and “sorrowful passions” of a female consumptive can best be explained in the following excerpt, written by Victor Hugo in his preface to *Lucrece Borgia*:

Take the most hideous, repulsive, and complete *moral* deformity; place it where it stands out most prominently, in the heart of a woman, with all the conditions of physical beauty and royal grandeur which give prominence to crime; and now mix with all this moral deformity a pure feeling, the purest which woman can feel, the maternal feeling; place a mother in your monster and the monster will interest you, and the monster will make you weep, and this creature which caused fear will cause pity, and this deformed soul will become almost beautiful in your eyes...¹⁰⁰

For a woman, the veil that hid her monster was motherhood. For Chopin, it was music. Music gave him the sweetness, the originality, and the beauty that entranced his listeners. Thus, the sorrowful passions intrinsic in his effeminate character and the weaknesses that led him to his final fate were rendered acceptable, even *desired*, by the compositions it drove him to create. Consumption granted Chopin a greater sensitivity and heightened appreciation of the subtle, and in the end, his music pacified, and his music united.

¹⁰⁰ Niecks, *Frederick Chopin, Vol. I*, 265-6.

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