The Psychoanalysis and Death of George Gershwin: An American Tragedy

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Abstract: The story of the noted composer George Gershwin's psychoanalysis and death resulting from an undiagnosed brain tumor 70 years ago are known today only in a garbled, incomplete form through biography and legend rather than history among psychoanalysts, neurologists, and neurosurgeons. This article examines his psychoanalysis with Gregory Zilboorg and the events and course of his final illness to the extent possible with the historical material now available. It provides an account of the behavior of his psychoanalyst in a variety of contexts as well as the actions of the other physicians attending him. We cannot know, but can only infer, what went on in his psychoanalytic sessions or his medical examinations; about this the reader will have to draw his or her own conclusions.

George Gershwin was born on September 26, 1898 in Brooklyn, New York. The second of four children, he began his career in popular music at age 17 and went on to compose Broadway musicals, classical orchestral works, motion picture scores, and opera, often in collaboration with his lyricist elder brother Ira. He died on the morning of July 11, 1937 five hours after an unsuccessful neurosurgical attempt to excise a brain tumor from his right temporal lobe. He never regained consciousness after the surgery. He was 38 years old. The psychoanalytic and medical events leading up to his death offer a disturbing narrative of questionable psychoanalytic and medical practices. The bare facts of the matter are that George Gershwin was in analysis with Gregory

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Zilboorg from the spring of 1934 through the end of 1935 at a frequency of, at times, five sessions per week and that he sought medical attention for a variety of neurological symptoms beginning in February of 1937. The shortcomings of his medical care and of his analysis resulted in his death that July. I will contend that Gershwin’s life could have been saved, as late as June of 1937, if the diagnosis that should have been obvious had been made either by his doctors then or, for that matter, by an appropriate neurological referral on Zilboorg’s part in 1934. Much is knowable about Zilboorg’s conduct and behavior as a clinician with a number of other patients. Some things are knowable about the medical and neurological evaluations that were done on Gershwin and the physicians who performed them. As it turns out, the state of the art of neurology circa 1937 is also knowable. However, very little is known about what actually took place in these evaluations or in Gershwin’s psychoanalysis; here we are, of necessity, left to speculation supported by data.

SOURCES AND METHODOLOGY

As short and focused as it is, what is being offered here is a work of biography. From a distance of over 70 years, we are dealing with an interwoven skein of at times conflicting narratives similar to what we would encounter in the writing of any history. I have written elsewhere (Leffert, 2007a, 2007b, 2010) on the subjects of history, narrative, and knowability.

This account draws on materials from different levels of organization ranging from archival material (some newly discovered), to interviews, and formal biography. There appear to be over 700 biographical works that deal with Gershwin’s life, or some aspect of it; I selected eight of them (Ewen, 1970, 1986; Hyland, 2003; Jablonski, 1987; Feyser, 1993; Pollack, 2006; Rimler, 2009), which cite still other biographies. Beginning in 1958 a series of short papers began to appear in the medical literature by a pathologist (Sloop, 2001), a neurosurgeon (Ljunggren, 1982), a neurologist (Silverstein, 1995), an ENT specialist (Fabricant, 1958), and an internist (Carp, 1979). Each brought a different take to Gershwin’s illness, deploying variable amounts of sometimes contradictory historical and medical data. Only two of them (Ljunggren and Sloop) questioned the quality of the medical care Gershwin received or the inevitably of a fatal outcome. All of these authors did little with the psychoanalytic data.

The centenary of Gershwin’s birth led to a number of spirited and at times acrimonious exchanges between correspondents with differing
views on his death that appeared in the "Letters to the Editor" of the New York Times (Jablonski, 1998, Miller, 1998; Peyser, 1998). The debate focused on the nature and duration of Gershwin's illness, and whether or not he might have been saved.

The biographers relied heavily on previous biographies. When a biographer discovered new material, subsequent biographies all include that information. This is not, as it might seem, independent corroboration; rather, it is only repetition. For example, Carp's five-page 1979 paper, "George Gershwin—Illustrious Composer: His Fatal Glioblastoma" offers a summary of the medical records from Gershwin's two Cedars of Lebanon hospital admissions and a letter from the noted neurosurgeon Walter Dandy that he obtained with the family's permission. All references to and quotations from the medical records and Dandy's letter in subsequent biographies stem from Carp's 1979 article. What is now Cedars Sinai Medical Center destroyed the actual records long ago; Carp died before his paper was even published and his reference material went missing, also long ago. The problem is not what Carp reports or quotes from the record; the problem is that there is so much more that we would like to know that is now lost.

Gershwin's life and Gershwin the man are beyond the scope of this paper. It is confined to two subjects: Gershwin's analysis and his psychoanalyst, Gregory Zilboorg, and his last illness culminating in his death in 1937, and the physicians who attended him. Historical and archival source material will demonstrate that Zilboorg's behavior harmed many of his patients, including Gershwin and via omission, very likely contributed to his unnecessary death.

GERSHWIN'S ANALYST AND HIS ANALYSIS

This account broadly falls into four areas: Gershwin's psychoanalysis; biographical and credentialing material about his analyst, Gregory Zilboorg; information about Zilboorg's work with other patients, an account of an investigation and proceedings concerning Zilboorg conducted by the New York Psychoanalytic Society in 1942; and some final thoughts and questions about Zilboorg. Because these accounts are interwoven, it seemed best to proceed chronologically, beginning with the Zilboorg biographical material and then following the order in which they are listed above.
Zilboorg's Biographical Materials and Credentials

Considerable information concerning Gregory Zilboorg's life, academic and professional training, and credentials exists, drawn from three kinds of source materials. First there are published accounts (Alexander, 1960; Fountain, 1960; Mora, 1994) written by those who knew him personally and to whom he communicated. The first two are obituaries, the third is part of a chapter of a book, *Discovering the History of Psychiatry* (Micare & Porter, 1994). These three publications, along with the biographical entries he placed in the membership directories of the American Psychiatric Association (1941, 1950), comprise the only published biographical material I could find about Zilboorg. They are all quite favorable but make no reference to his clinical work. There are documents prepared by the New York Psychoanalytic Society ("Memorandum," 1941; NYPS BoD Report, 1942) in connection with an investigation into a complaint made by a former patient against Zilboorg, related meetings, and a failed motion to censure (N. Thompson, written communication, September 8, 2009) which is discussed in detail below. This material includes Zilboorg's own statements about his credentials and an analysis of those credentials. Then there are his records as a medical student attending Columbia University's College of Physicians and Surgeons (P&S).

Gregory Zilboorg said he was born in Kiev on December 25, 1890. Almost nothing is known of his early life, although there are great disparities in how he variously claimed to have spent his years in Russia prior to immigrating to the United States in 1919. Alexander (1960), Fountain (1960), Zilboorg's own statement quoted in the "Memorandum" (NYPS, 1941), and a biographical timeline that he was asked to prepare in connection with his application for admission to P&S (G. Zilboorg student record, 1922-1926) all assert that he obtained a medical degree from the Psychoneurological Institute in St. Petersburg in 1917. Fountain observes that Zilboorg "writes of fighting in Dvinsk in 1917." The three authors all tell the same story of his becoming involved in the Kerensky government in 1917 serving as secretary to the Minister of Labor "with whom he traveled about, often addressing the crowds, in an increasingly desperate resistance to the insurgent Communists" (Fountain, 1960, p. 381). Zilboorg describes similar events in a biographical statement he prepared in connection with his application to P&S (G. Zilboorg student record, 1922-1926).

1. Alexander was Zilboorg's analyst in Berlin, sometime during the year he spent there in 1929–1930 and was also involved in investigating the complaint.
With the coming of the Bolshevik Revolution of November, 1917, and the liquidation of the Kerensky government, these stories begin to diverge. Fountain (1960) has Zilboorg fleeing with his sister from an unspecified location to Kiev (their flight made more difficult by the destruction of the railroads) two days before the Communists came to “carry him off” (p. 2). Kiev was then occupied by the Germans and Zilboorg “collaborated with Marc Slonim in producing a newspaper so distasteful to the occupying Germans that its editors seldom dared sleep two nights at the same address” (p. 2). Fountain has him making his way “through Hungary, Austria, and Germany, to Holland where he lived for a year in Scheveningen” (p. 2) before receiving a visa to travel to the United States. However Mora (1994) reports that he fled “Russia surreptitiously, which he accomplished by walking out of the country to Finland” (p. 59), then embarking for America, also in 1919. The Port of New York data base (“Port of New York,” 2009, October 18) confirms that Zilboorg embarked from The Hague for New York in 1919 but that Eugenia Zilboorg did not arrive until 1923, port of entry unknown. This is consistent with either account. What is not consistent is their narratives of the period prior to 1919, narratives that could only have originated with Zilboorg. There are other problems with Fountain’s narrative. There seems to have been no fighting in or around Dvinsk in 1917 (Root, 2007). The story of starting a newspaper in Kiev in November, 1917, so egregious to the occupying Germans that he could not risk sleeping more than two nights in the same place is bogus. It could not have taken place because the Germans did not enter Kiev until March of 1918 (Root, 2007) by which time Zilboorg was allegedly already on his way to Scheveningen (?).

Of greater concern is the authenticity of the credentials and degrees Zilboorg claimed to have acquired prior to leaving Russia. The Memorandum prepared for the Board of Directors of the New York Psychoanalytic Society (“Memorandum,” 1941) summarized the lengthy hearings, testimony, and investigations of the complaint made against him, meticulously comparing Zilboorg’s often conflicting claims made in lengthy testimony before the Board against the historical record. Zilboorg testified that he “definitely” received the degree of M.D. from the Psycho-Neurological Institute in St. Petersburg “by the special rule of the government” (p. 45) due to wartime conditions. The Memorandum compares the courses required to be completed in order to be awarded a medical degree in Russian universities with the courses offered at the Institute. There is no overlap between the two curricula; the Institute did not offer any of the courses required for a medical degree nor did
it have degree-granting authority. Zilboorg simply could not have had the medical degree he repeatedly claimed to have been awarded.

Once in the United States, Zilboorg translated Russian literature for a living and attended Columbia College of Physicians and Surgeons (P&S) from 1922-1926, receiving a medical degree. From 1926-1931, he worked at Bloomingdale’s Psychiatric Hospital before opening a private practice in psychoanalysis. Records from his student file at P&S (G. Zilboorg student record, 1922-1926) make it clear that this experience did not include either an internship or a residency in psychiatry. He represents himself as having taken the 1929-1930 year off for analytic training at the Berlin Psychoanalytic Institute. There are two inconsistencies in this story. The Berlin Institute was the first to establish a formal program of study in psychoanalysis leading to graduation. Reeder (2004) states that a compulsory curriculum was introduced in Berlin in 1927. This followed the tripartite model introduced by Eitingon. A series of lectures moved from the theoretical to the more clinical, control cases were treated with supervision and presented in clinical seminars and, most importantly, a personal or didactic analysis was required. The program took “on the average, three to four years to complete” (italics added,” p. 59). Therefore, Zilboorg could not have been a matriculated candidate in Berlin in 1929, nor could he have graduated (a recurrent issue) from a three to four year program in one year. However, the Institute had another program open to people who were just interested in psychoanalysis. They could become “listeners” (Hörer) and, although unable to treat control cases, they could attend any lectures they liked. The purpose of this program was to spread knowledge about psychoanalysis to the community at large, not to train psychoanalysts. The only thing that Zilboorg could have done based on the time constraints was

2. Zilboorg’s student file (G. Zilboorg student record, 1922-1926) contains information and correspondence relating to his admission to P&S. There is a letter by Zilboorg dated February 22, 1922 and addressed to Fanz Zinser, Professor of Bacteriology. The letter implies prior correspondence in which Zilboorg requested advanced standing at P&S as a result of his putative medical studies at the Psycho-Neurological Institute. He was apparently offered some kind of advanced credit by examination. In the letter he declines, saying he has had no contact with medicine for five years, doesn’t want to make a fool of himself, etc. and withdraws the request. Apparently he would have been happy to accept the advanced standing if no such examination were involved. In a memo, dated the following day, Prof. Zinser forwards the letter to the Associate Dean for the latter’s information. In it he commends Zilboorg’s “really considerable intelligence” but observes that, “whether or not, in spite of this, he would be a satisfactory student for this school, is of course [sic] questionable.”
to spend a year in Berlin as a listener auditing some classes while he undertook a personal analysis (with Franz Alexander).³

The second problem is by far the more serious. Zilboorg was in private practice as a psychiatrist and psychoanalyst from 1931 until some time in the 1950s. However, the Division of Professional Licensing Services of the University of the State of New York has no record of his ever holding a medical license in New York (Letter, from the Public Information Unit, 2009). When I inquired if it was possible that the record could have been lost, I was told, “No, there would at least have been something” (personal communication, 2009, October 8).⁴ This body of material raises serious questions concerning Zilboorg’s licensure and claims regarding his training.

Gershwin’s Analysis and the Nature of Zilboorg’s Work with His Patients

Zilboorg opened a practice in psychoanalysis and psychiatry in 1931 in New York City. By the time Gershwin first consulted him in the spring of 1934, he had become the fashionable analyst to see in New York, treating prominent patients drawn from the worlds of theater, literature, music, and finance. His ability to reach this level of success in three years speaks to what Fountain (1960) described as his “brilliance” (p. 5), Alexander (1960) as his being a “great actor” leaning toward the dramatic whose stage was “life itself” (p. 381), and who Mora (1994) described as being “able to exert a magnetic influence on his audience” (p. 61). Gershwin sought out analysis for a number of variously described reasons (Jablonski, 1987; Peyser, 1993; Pollack, 2006). He wanted to find himself, to seek personal and emotional growth. There were somatic problems. One was what he referred to as his “Composers Stomach,”⁵ a term he invented to describe vague but intense episodes of dyspepsia

³. In fairness, Zilboorg’s educational experience in Berlin probably surpassed that of the great majority of psychoanalytic practitioners in the U.S. at that time (Leffert, 2010); it could, however, in no way be considered a completion or graduation from the Berlin Institute.

⁴. A colleague appropriately questioned the reliability of these data, asking, in effect if “these are old records, how do you know the file wasn’t simply lost or misplaced?” Although this could certainly be the case for Zilboorg’s file, the Board also maintains rosters of all physicians licensed by the State of New York; for Zilboorg to have been licensed, the rosters from the years 1926-1959 would also have to have been lost.

⁵. Ewen (1986) states that Zilboorg told him that he had suggested to Gershwin that musicians often suffered from such stomach ailments. Ewen opined that this had led Gershwin to invent the term.
that he had suffered from since 1922 and repeatedly but unsuccessfully sought medical attention for what may well have been iatrogenic constipation. Be that as it may, Gershwin was always constructing strange diets for himself in an attempt to treat the problem. Gershwin also suffered from severe headaches.

Gershwin had been in a relationship with Kay Swift since the late 1920s. The relationship with Gershwin began around music, became a professional collaboration, and then an ongoing affair that was to last a decade. A classically trained musician, she began to compose popular music and at the same time became his devoted "factotum" (Pollack, 2006). Although she and Jimmy Warburg divorced in 1934, Gershwin was as unable to make a commitment to her as he was to any woman. To try to resolve this, Kay referred him to her analyst, Gregory Zilboorg. Zilboorg diagnosed a "neurosis" (Ewen, 1986; Hyland, 2003), recommended psychoanalysis, and saw him up to five times a week at a fee of $35 per session. Warburg also began an analysis with Zilboorg in 1934. So at that time Zilboorg was treating Kay Swift, her husband, and her lover. It should be noted that this was not an unusual practice for Zilboorg who often saw whole groups of people who were closely or intimately involved with one another and who referred their friends to him as well. Lillian Hellman saw Zilboorg from 1940-1948, and "nearly all of [her] friends ultimately saw him professionally [and] ... they all saw him and his wife, Peg, socially too" (Martinson, 2005, p. 155).

_Porgy and Bess_, which Gershwin considered his finest work, opened in October 1935 to decidedly mixed reviews. Gershwin conceived of it as an American Folk Opera but it was not much accepted as such in the United States until its revival in 1976. Perhaps because of anger or depression at its reception, Gershwin set out on a voyage to Mexico a month later. He was accompanied by Zilboorg and two other patients, Eddie Warburg (Jimmy's cousin), director of the American Ballet and board member of MoMA, and Marshall Field III, the department store heir (Jablonski, 1987; K. Weber, personal communication, August 27, 2009; Peyser, 1993). They followed a daily routine while on the trip.

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7. Swift married James "Jimmy" Warburg in 1918. The son of a prominent Jewish banking family, Warburg was active in finance on a national level, since 1918. He and Kay Swift had three daughters.
8. At a time when the going rate for psychoanalysis was $5-$10 per session; $35 might seem astronomical, were it not for the fact that he charged Lillian Hellman $75 and Moss Hart $100 (Peyser, 1993; Pollack, 2006).
9. Zilboorg divorced his first wife and, in 1946, married his secretary, Margaret Stone.
Each of the analysands saw Zilboorg for an early morning analytic hour. The four would then meet for breakfast, over which Zilboorg would discuss their ongoing analytic work and they would comment on each other’s analyses (Hyland, 2003; Peyser, 1993). Zilboorg did not pay his own travel expenses. They toured Mexico immersing themselves in its bohemian community. Peyser describes Zilboorg’s behavior on the trip as aimed at humiliating Gershwin. Swift reported that Eddie Warburg told her Zilboorg did everything he could to make Gershwin miserable. Zilboorg manipulated Gershwin into spending time with people who spoke no English, effectively keeping him out of the conversation. On one occasion, he repeatedly harassed Gershwin over his politics in front of their hosts. Zilboorg also carried a loaded pistol, reportedly to protect himself from vengeful Bolsheviks. However, Pollack quotes a letter written by George to his brother, Ira. He writes about his second night in Mexico City, “we had a perfectly swell time, Dr. Zilboorg being particularly amusing” (p. 199). Peyser believes that Gershwin broke off the analysis upon their return to New York because of Zilboorg’s behavior on the trip, yet both Peyser and Pollack comment that Gershwin and Zilboorg continued a relationship, corresponded, and, on occasion Gershwin turned to him for advice. Ewen (1970) concludes that Gershwin broke off the analysis because, like so many other treatments he had tried, it simply was not working.

What conclusions can be drawn from these various reports? No comment from Gershwin survives, if it ever existed. Ewen’s (1970) conclusion is the most plausible. Whatever unhappiness or lack of success Gershwin may have experienced in his life, he retained an absolute conviction in his own importance and his genius. However, according to Swift, he did not take himself seriously and lacked either grandiosity or pomposity. He was almost reverential about his music because he considered it important; as for himself, he lacked both pretense and affectation (Hyland, 2003, p. 218). The effect of any negative approach on Gershwin, if it affected him at all, would have likely been transient. It would come as no surprise then, that shortly after Zilboorg’s harassment, Gershwin was avidly talking leftist politics with Diego Rivera (Pollack, 2006). His conviction in his own worth remained and if it ever weakened, it was as a result of his physical and mental decline in the months preceding his death.

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10 This was in no way an unusual practice for Zilboorg. Marshall Field took him to Europe at his own expense annually (Peyser, 1993) and Eddie Warburg described similar trips with a number of patients (K. Weber, personal communication, August 27, 2009).
Zilboorg's Work with Other Patients

If we lack other direct information about the specifics of Gershwin's analysis, there is a considerable amount of indirect information as well as concerning Zilboorg's treatment of other patients. What emerges is remarkably variable. Kay Swift sought analysis with Zilboorg in 1934. She was head over heals in love with Gershwin, still fond of her husband Jimmy Warburg, and had no idea what to do with her three teenage daughters (K. Weber, personal communication, August 27, 2009). She needed to sort these things out and referred Gershwin to Zilboorg in the hope that he could resolve his conflicts and make a commitment to her. She later told Jablonski (1987) she came to view this as a terrible mistake. While struggling to decide whether to divorce Warburg, Zilboorg railed against the plan, forbade both of them to marry, attempted to separate them by encouraging Gershwin to go to Los Angeles, and threatened to make public the contents of their analyses if they did marry. As preposterous as this might sound, Zilboorg regularly talked to patients about other patients. One of his patients claimed that Gershwin's only "romance was with his enema bag" (p. 224). Other patients talked about similar kinds of confidences Zilboorg had revealed to them.

Swift's analysis got much worse. Peyser (1993) describes Katherine Weber as saying that her grandmother had told her that, during the last eight months of her analysis, Zilboorg had had sexual intercourse with her. Weber stresses that this was not a romantic affair; the sex occurred in his office during her analytic sessions for which she paid by check each time. Weber quoted Swift as saying: "He was the only man with whom I ever had a sexual relationship to whom I was not physically attracted" (p. 263). When I asked Weber, myself, why her grandmother had submitted to this practice, she replied that Zilboorg had told her it was necessary for the analysis to help her and she left each of these "sessions" in tears (personal communication, August 27, 2009). Swift made two subsequent comments, one indirect and one direct, concerning her analysis. Ohl (2004) quotes an interview with Swift (by H. Harrison) published in the New York Journal American of September 11, 1943 in which she seemed to summarize feelings about her analysis and perhaps an aspect of her feelings about the failure of her relationship with Gershwin. "Western men," she comments, "have attained that exhilarating quality for which people in the East pay psychiatrists huge sums of money" (p. 140). Much more to the point were her comments about Zilboorg in a January, 1940 letter to her best friend, Mary Lasker:
Your Grischa [ironic diminutive for Zilboorg] encounter was a riot. Seldom, I believe, has there been a more insecure and jittery little fellow. Of course it would scare him to death to have so powerful an engine as you again [sic] him—and moreover, he would feel eaten with jealousy at the fact that any contributing you or JS [?] did would be made via Alexander or Karl, not himself. [Mary and her husband, Albert Lasker were philanthropists who made significant contributions to medical research. It is unclear who JS was but tempting to think she is referring to Franz Alexander and Karl Menninger.] So I can see him leaping out at you, with a highly unsubtle compliment on his lips (however true it might happen to be) hoping to at least seem to be on good terms with you. . . . Perhaps I do him an injustice; however I wonder now why I took such a lot of unadulterated bull from him, and conclude that he simply made a whip of my own sense of guilt and beat me with it on all occasions . . . When I remember that he informed April [Swift and Warburg’s daughter whom he saw briefly] that she would eventually be insane, I feel I could cheerfully strangle him, and should have taken measures to put him back into a lower grade at that time. . . . I wonder if Jim [Warburg], who seems to be doing important govt [sic] work is well out from under G’s poisonous wing oder nicht [or not]. (italics added)

Several of Zilboorg’s other patients have described their treatment experiences with him, either in comments to family members, biographers or, as Lillian Hellman did, included them in her own memoirs (1969). Hellman’s relationship with Zilboorg was intense, ambivalent, and not well understood by her biographers (e.g., Martinson, 2005). She sought analysis in 1940 and continued for eight years, with at least one interruption in 1945. Zilboorg charged Hellman $75 per analytic hour (his fees seemed to range from $35-$100), that today would equate to upwards of $700. She sought analysis for runaway alcoholism that she feared would consume her and an accompanying depression. She credits Zilboorg with ushering in a long period of sobriety or relative sobriety, telling her at the end of a Friday hour that she was an alcoholic and that, unless she stopped drinking at once, she could not come back on Monday. After her analysis ended, she continued contact with Zilboorg in much the same way as Gershwin. Parts of this sounds like heroic psychoanalysis at its best, but not entirely. Hellman and the mystery writer Dashiell Hammet (with whom she lived from 1931 until his death of lung cancer in 1961) socialized with Zilboorg and his wife, Peg. Peg reportedly told her that her husband planned to cure her chronic lying and her anti-Semitism; Hellman had neither. There were also conversations about other patients’ analyses in her sessions. There were the same intense conflicting demands that Zilboorg made of Kay Swift, that she leave Hammet at once, marry him, or stay by him through
his alcoholism (Martinson). Whereas Swift was quite damaged by Zilboorg's treatment of her and demanded that she and Gershwin separate, Hellman was made of tougher stuff and brushed such demands aside.

Hellman chose to include some of her highly nuanced, though mixed views of Zilboorg, from her journals in her memoir *An Unfinished Woman* (1969). During her trip to Russia in 1945, she had met a "Captain K" just out of the hospital recovering from war wounds and discussed American literature with him. Wondering what became of him, she was able to reconnect with him during a return trip to Moscow in 1966-1967. In a Journal entry from that trip, dated May 12, 1967, Hellman reported that "Captain K" describes her as depressed, and asked about it. Hellman had apparently talked with him about her analysis with Zilboorg during the 1945 trip and he asks if she had continued the analysis upon her return. She nodded and he said, "I would like to hear of such an experience" (p. 206). She then recalled,

'It was a long, painful business. Then it is over and you can’t fit the pieces together or even remember much of what you said or what was said to you, but I no longer have headaches."

'It was good, then?"

'Yes, Zilboorg ended odd.' But the story is too long, too complicated, too American. 'But I respected him and was grateful to him. I went to him in his good years. After he died it took me a long time to believe the ugliness I was hearing. I guess people who mesmerize other people die absolutely on the day they die—the magic is gone’ [italics added].

'...It’s hard to know whether the turn against them comes because the magic has gone or because they really were kind of crazy or—I don’t think it was all venality with Zilboorg, although it looked like it to many people.

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11. As a reference point to the 1945 conversation, the formal analysis ended in 1948 and Zilboorg died in 1959.
He was an old-fashioned Socialist who hated inherited wealth as undeserved, and many of his patients were people like that." (pp. 306-307)

What are these two pages doing in a 300-page memoir to which they bear no particular relationship. The text would in no way have suffered by their omission. Why, then, did Hellman choose to discuss her analysis in a conversation that took place half way around the world and then put that conversation into her published memoirs? Although she refers to and paraphrases diary entries in her two other memoirs, *Pentimento* and *Scoundrel Time*, she does not excerpt them, nor does she do so elsewhere in *An Unfinished Woman*. I believe she is choosing this as a venue for expressing both her ambivalence and her difficulty getting a fix on her analysis and Zilboorg. As have many others, she refers to Zilboorg's magic and magnetism. Pollack (2006), for example, describes "his portrayal in the press as the Svengali of the well-heeled American left" (p. 208). What Hellman does not say is at least as meaningful as what she does. When the memoir was published in 1969, this level of disclosure about one's analyst and one's analysis were unheard of (and is not exactly common today). Hellman was a lifelong diarist and it is likely that she had had a great deal more to say about both Zilboorg and her analysis; she had already gone to the edge of propriety in the memoir. She presents the diary entry as an epiphany. That was true when it was written in 1965 but not in 1969 when she chose to publish it. Her goal could only have been to make public her ambivalent view of Zilboorg to the extent she was able.

There are a few vignettes that illustrate Zilboorg's work with other patients. Pollack (2006) cites Ralph Ingersoll (managing editor of both *Time-Life* and *The New Yorker*) as saying of his analysis with Zilboorg, "from no other experience in my life have I felt so benefited" (p. 744). Peyser (1993) interviewed a prominent New York physician in 1989 who blamed Zilboorg for his wife's suicide and described Zilboorg as "brilliant, dangerous in both simple and complex ways, vicious and exploitative. He did whatever was necessary to create a relationship with his patients which invariably did him some good, financially or otherwise" (p. 218). He also described Zilboorg's travel practices with his patients. The physician once went to Zilboorg's apartment for a consultation. He was invited into his office where Zilboorg was dictating to three secretaries in three different languages. "He brought me in there to show off. He was brilliant but strangely insecure. He had to tell you about his power, to demonstrate it, and he always discussed his rela-

12 Zilboorg is not mentioned anywhere else in Hellman's three books.
tionships with his patients and his patients' lives with whoever would listen" (pp. 218-219).

Edward Warburg was in analysis with Zilboorg for 28 years. He joked with Katherine Weber that the only way for him to break away was for Zilboorg to die. Warburg described Zilboorg as having chronic income tax problems and at one point demanded $22,000 from him to pay back taxes, threatening to immediately cut off Warburg’s analysis if he did not comply (K. Weber, personal communication, August 27, 2009). He also described the travel with other patients, the early morning analytic hours and the sometimes tearful breakfasts that followed (K. Weber, personal communication, November 5, 2009).

Investigations and Proceedings Concerning Zilboorg Conducted by the New York Psychoanalytic Society

There the story might well have ended were it not for a patient, X, who consulted Zilboorg for analysis in December of 1940 (Statement of X, 1941). He abruptly stopped seeing Zilboorg about February 13, 1941 because of what he considered to be Zilboorg’s exploitative behavior. Two events in particular stand out. Zilboorg repeatedly admired his patient’s wristwatch until X offered it to him as a gift. Zilboorg “replied that if [the patient] would take the watch with [him] and have a cordovan strap put on it, he [Zilboorg] would be very pleased to take it” (p. 2) and the patient complied. However, the major issue was that in January Zilboorg asked X about his professional work and suggested that they expand their relationship and that Zilboorg would work with him outside of the analysis for a fee of $5,000, “in return for which he would give me ideas and assistance in [my] professional work” (p. 4). The fee was to be paid in cash. Zilboorg told him he needed the money to pay taxes due on March 15 and that he couldn’t work effectively as an analyst if he was worried about money. Later he told the patient that he wanted the payment in cash “off the books” so he would not have to pay taxes on it.

X broke off the “treatment” in mid February of 1941, shaken by the latter proposition. In early March, he sought a consultation with Franz

13. This could all be dismissed as the reports of an embittered husband grieving for his lost wife, were it not for the fact that it is consistent with the accounts rendered by other patients.
14. Over a hundred pages of documents are summarized here, some of which are themselves summaries of far larger documents.
Alexander, then in Chicago who advised him, among other things to continue in psychoanalysis, this time with Bert Lewin. Meanwhile, David Levy had heard of X’s situation, through another member of the New York Psychoanalytic Society (NYPS), probably also a patient of Levy’s.\footnote{A number of things about this situation should be noted. Alexander had been Zilboorg’s analyst during his sojourn in Berlin. Although inappropriate by modern standards, training analysts in that day were frequently involved in matters of their analysands’ progression. Alexander makes a credible case in his statement concerning the allegations that his primary goal was to be of help to Zilboorg, that Zilboorg admit the matter, “look into himself,” seek further analysis, and that the whole matter be handled privately.} Levy and Alexander met in New York; it emerged that a second patient had made a similar complaint that they decided for whatever reasons not to pursue (NYPS, 1941). Ultimately, Alexander and Levy met with Zilboorg on May 6, 1941 during the annual meeting of the American Psychoanalytic Association (APsaA) at Richmond, Virginia. Both subsequently described Zilboorg as admitting that the allegations were substantially or 75% true (pp. 28-32).

Zilboorg later hotly denied he had said anything of the sort and accused Alexander and Levy of hatching a plot to destroy him (NYPS, 1941). A lengthy investigation, including the examination of all concerned parties conducted by the Board of Directors of NYPS culminated in a Motion of Censure of Zilboorg being brought to the members at a special meeting of the Society held on March 3, 1942 (Lehrman, 1942). The motion was soundly defeated with most members saying they voted against it because they did not find X believable.\footnote{It seems hard to imagine how that the story about the cordovan watch band could have been made up.} Whether believable or not, X was not the only person whose testimony was presented to the members. Both Alexander and Levy had testified that Zilboorg had acknowledged that the allegations against him were 75% true. Society members would then have also had to believe that both of these men were not telling the truth and, as Zilboorg claimed, had indeed launched a plot against him.\footnote{Levy later attempted to get APsaA to take up the case but desisted because of the legal fees involved.} There are two more plausible explanations for the members’ vote. The first is that in the winter of 1941-1942, NYPS was in the midst of a civil war. The battle lines were drawn, as they always have been in our contentious discipline, around theoretical orthodoxy. The orthodox forces were captained by Lawrence Kubie and Fritz Wittels. Their ire was particularly directed at Karen Horney who was accused of heresy and demoted. She resigned. Levy was also one of the protagonists and had his popular course in child psychia-
try taken away from him and given to a European immigrant analyst (see Hale, 1995, for a discussion of the political situation in NYPS at that time). This issue could have “trumped” the proceedings against Zilboorg. The second is that psychoanalytic organizations have always displayed enormous reluctance to censor their members for ethical violations and Zilboorg was a prominent member, having been a past Educational Committee (EC) member and Chair and a co-founder of The Psychoanalytic Quarterly.

This political tale is not quite over. It was widely known that George Gershwin had been a patient of Zilboorg’s and that he had died of a brain tumor. In a sense, Gershwin’s ghost hovered over the proceedings of the NYPS. Until at least 1960 (N. Thompson, personal communication, September 18, 2009) training analysts were not appointed at the New York Psychoanalytic Institute (NYPI) for life but had to be re-appointed by the EC every three years. In 1950, three training analysts were not reappointed. Two were, for the times, quite elderly, the third, Gregory Zilboorg, was 60 and in active practice. Zilboorg asked for and was given the names of the EC members but took no other action (Thompson, 2009, September 8). Paul Breuer believed that the failure to reappoint Zilboorg was a result of general ill will directed against him and a view that he was responsible for Gershwin’s death (Peyser, 1993).

Who Was Gregory Zilboorg and What Sort of Analysis Did He Provide George Gershwin?

What can be concluded from these conflicting data and observations about Zilboorg? He was unquestionably brilliant. In terms of scholarship, he was a founding editor of the Psychoanalytic Quarterly and the author of over 25 papers and a number of books. If his writing was not particularly seminal, it was certainly no less so than the great majority of the analytic literature then or, for that matter, now. He was held in high esteem by many colleagues and, certainly, some patients. He spoke and wrote in at least three languages, one of which, English, he taught himself in three months. As a young Russian émigré he traveled, lecturing on Russia and drama, and translated Andreyev into English (Fountain, 1960).

However, a far darker narrative also emerges. There are multiple conflicting accounts, including those furnished by Zilboorg himself, of his education in Russia and subsequent travel to the United States (Alexander, 1960; Fountain, 1960; G. Zilboorg student record,” 1922-1926; Mora, 1994; NYPS, 1941). The New York State Department of Educa-
tion indicates that it has no record of his ever having held a license to practice medicine in New York ("Letter," 2009, October 8). He is variously described as being a magician, a Svengali-like individual able to exert a magnetic influence on others, including his patients (Alexander, 1960; Letter, 2009; Mora, 1994; Peyser, 1993; K. Weber, personal communication, November 5, 2009). There are accounts of venality, exploitative fees (Hellman, 1969; Peyser, 1993), and of boundary violations too numerous to mention. One informant described a need on his part to assert power in the face of an underlying insecurity (Peyser, 1993). In one instance a former patient described his having intercourse with her in his office, during her sessions, under the guise that it was an essential part of her "treatment" (Peyser, 1993). Then, again, there are the conflicting data of the resounding defeat of the motion to censure by the NYPS membership in 1942 and the decision of the Educational Committee of the NYPI not to reappoint Zilboorg as a training analyst in 1950 (Thompson, 2009, September 8). A related issue is the excruciating difficulty psychoanalytic communities have had in attempting to investigate, assess, and take appropriate action in cases of sexual or non-sexual transgression or exploitation on the part of our colleagues. Denial, guilt, and pseudo-identification have all played roles in the failure of communities to act appropriately in these cases (Gabbard, 1995; Gabbard & Peltz, 2001).

There is a literature within psychoanalysis that does address all of these observations; it is the literature of sexual boundary violations (e.g., Celenza & Gabbard, 2003; Gabbard, 1995; Gabbard & Peltz, 2001). Gabbard has consulted in over 150 cases of therapists who engaged in sexual activity with their patients. Celenza and Gabard found that among "sexual-offender therapists" at least somewhere between one-half and three-quarters were one-time transgressors who seemed to occupy a "spectrum with lovesickness at one end, masochistic surrender at the other, and many positions between these extremes showing elements of both" (p. 62). This group includes many therapists with a significant potential for rehabilitation. What is left is a group of narcissistic psychopathic predators (in this case sexual predators although other varieties exist as well) who manifest great charm and charisma. These characteristics led the therapist/analyst predator to believe that he (the large majority are men) was above restrictions of any kind and entitled to do whatever he wished to or with anyone. The issue then is to what extent the work of Gabbard and colleagues applies to Gregory

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18. There also exist accounts of the non-sexual financial exploitation of patients by their analysts (e.g., Kirsner, 2009).
Zilboorg. The answer to this question is beyond the scope of this article and is best left to the reader.

**GERSHWIN’S MEDICAL ILLNESS**

**Issues Pertaining to Narrative Structure**

After several delays, George and Ira Gershwin left New York for Hollywood in August of 1936 and rented an opulent home on Roxbury Drive in Beverly Hills. George was fit, athletic, and an avid tennis player. He had also suffered for years with his self-described “Composer’s Stomach” and headaches. He had repeatedly sought treatment for both of these ailments but had met with no success. However, this is not the point of entry for this story.

**The Illness**

Let us for the moment say that the story of Gershwin’s last illness begins on February 9, 1937, almost five months to the day before Gershwin’s death on the morning of July 11 of that year. There is disagreement among Gershwin’s biographers concerning both the events of that February and their chronology but Rimler’s (2009) account is the most thorough. On February 10th and 11th Gershwin was to conduct and play his *Concerto in F* with the Los Angeles Philharmonic, and a rehearsal for the concert was held on February 9th. As Paul Mueller, Gershwin’s valet and chauffeur, was taking a picture during the rehearsal, Gershwin appeared to lose consciousness and would have fallen from the stage had Mueller not caught him. He recovered immediately, refused help, and continued the rehearsal. The concert on the 10th was flawless but, on the 11th, Gershwin suffered a brief lapse in which he lost track of the score. Afterward he told his friend, the pianist Oscar Levant, that he had also smelled something like burning rubber or garbage and that this had happened a number of times before.

By beginning the story on that February 9th, one could be led to assume that nothing happened before that date, that there was nothing identifiably wrong with Gershwin before February 9, 1937, or, as Zilboorg and his wife asserted, there was nothing wrong with Gershwin before then because if there had been, he, Zilboorg, would have known it. February 9th would, therefore, be a convenient point of entry for Zilboorg in that it relieves him of any responsibility for the events that followed. Zilboorg and his wife also repeatedly told anyone who would
listen that Gershwin consulted with him via telephone after these episodes and was advised to immediately seek medical attention for what was a serious physical problem. Although Ewen (1970) believed this story, Gershwin’s biographers are split on its veracity; there is no corroborating evidence of the call having taken place and it was so patently in Zilboorg’s self-interest. At the urging of family and friends, Gershwin appears to have had some sort of medical examination around the end of February that reportedly failed to turn up anything of a physical nature. Gershwin continues to appear fit and healthy.

In April of that spring Gershwin again suffers a lapse or a “blackout” and a return of the burning odor while sitting in a barbershop chair (Hyland, 2003). In May, he develops an exacerbation of his headaches and recurrent dizzy spells. He still looks and acts fit and begins or continues an affair with the actress Paulette Goddard, then secretly married to Charlie Chaplin (Hyland, 2003; Peyser, 1993). Gershwin’s condition at this point, with now frequent olfactory hallucinations (Pollack, 2006) is enigmatic. He feels terrible but there is still ample opportunity for denial on the part of friends, his brother and sister-in-law, and his mother Rose who has been visiting at the Roxbury house. In early June, it appears that there was a call to Zilboorg who refers him to Ernst Simmel. Simmel, a co-founder of the Berlin Psychoanalytic Institute, then the most advanced psychoanalytic training facility in the world, is unquestionably the dean of Los Angeles psychoanalysis (Shershow, 1986) and remained so until his death a decade later. If Zilboorg thought that Gershwin’s condition was indeed physical in origin, why did he refer him to a psychoanalyst rather than a neurologist? Whatever Zilboorg thought, Simmel was gravely concerned that Gershwin had an organic illness (a brain tumor?) and immediately referred him to an internist, Gabriel Segall, who examined him on June 9, 1937. The biographies say the examination took place at the Roxbury house with Simmel in attendance and, again, there are no physical findings. An episode occurred during this period when Gershwin tried to throw Paul Mueller, his valet and chauffeur, out of their moving car. He could offer no explanation for his actions. Other, similar episodes occur. Still concerned, Segall brings in the neurologist Eugene Ziskind who examines Gershwin on June 20th, and finds only an “impaired sense of smell on the right” (p. 212) and wondered about papilledema.19 He admitted him to Cedars of Lebanon Hospital on June 23rd for further tests, which apparently also proved negative. Gershwin “decided against a lumbar puncture”

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19. Papilledema is a swelling of the ends of the optic nerves that is visible when the retina is examined with an ophthalmoscope. It is a sign of increased intracranial pressure that could indicate the presence of a brain tumor.
(p. 212). Ewen (1986) described the workup as "exhaustive" and added that his doctors had "taken into account the possibility of a brain tumor, but there was simply no symptom to substantiate this suspicion" (p. 279). After refusing a lumbar puncture "as too excruciatingly painful" (p. 280), Gershwin requested discharge to "get back to work," and was released on June 26th with a diagnosis of "most likely hysteria" (p. 212, italics added).

Gershwin's condition deteriorated significantly following his discharge from Cedars of Lebanon. The biographies contain numerous anecdotes of his excruciating headaches, olfactory hallucinations, sitting on the edge of his bed with a glazed expression, coming down to dinner in robe and slippers, becoming unable to play the piano on one occasion, losing the ability to use a fork on another, and treating a box of chocolates as something to smear on his body (Hyland, 2003; Peyser, 1993; Pollack, 2006). A sense of impending doom hung over the house. To be fair, some days were better than others, and friends hoped for the start of a recovery. According to some accounts (e.g., Peyser, 1993) Leonore "Lee" Gershwin, his sister-in-law, ignored and ridiculed his symptoms. Simmel attended him daily and, on July 4th, moved him to the house of "Yip" Harburg, a friend who was leaving for New York, and assigned a psychiatric nurse, Paul Levy, to be with him (in addition to the always present Paul Mueller, his valet). Presumably, Segall and Ziskind attended as well. One reads in horror as the macabre narrative unfolds and friends begin to admit to themselves that Gershwin is critically ill.

At 5 o'clock on the evening of July 5, 1937, Gershwin fell into a coma and the pace of events increased, as if people only now realized how dire the circumstances were. He was never to regain consciousness. Segall, Simmel, and Ziskind had seen him earlier that afternoon (according to their bills; Hyland, 2003) and he was readmitted to Cedars of Lebanon around midnight. A young neurosurgeon, Carl Rand (who would later rise to prominence) was then finally called in and examined him along with Segall and Ziskind. A spinal tap was performed in the afternoon of July 6 and showed "evidence of a brain tumor" (Pollack, 2006, p. 213). Pollack tells the rest of the story best. The search for a top-rated neurosurgeon was now on. Leonore, who had scoffed at her brother-in-law's symptoms as attempts to get attention (Hyland, 2003; Peyser, 1993) telegraphed Emil Mosbacher, a friend of George's and a

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20. It is not clear who actually made this diagnosis. It had to have been either Segall or Ziskind with neither demurring had there been a disagreement.

21. Jablonski (1987) was the only author not to mention this, however, it was known that Ira and Leonore Gershwin were Jablonski's patrons.
financier. Mosbacher contacted Harvey Cushing, then retired, who was the father of American Neurosurgery. Cushing recommended Walter Dandy of Johns Hopkins, his most important student. However, Dandy was vacationing on a yacht on the Chesapeake. Mosbacher then called a White House aid who, depending on which version of the story you prefer, called on either the Navy to send a destroyer or the Coast Guard to send a cutter to retrieve Dandy and take him to a base from where he was flown to Newark, New Jersey and prepared to fly immediately to Los Angeles.

Gershwin's condition continued to deteriorate and, consequently, they sought someone local. They chose the neurosurgeon Howard Naffziger from UCLA Medical School. He was vacationing at Lake Tahoe, but was easily flown back to Los Angeles. The doctors spoke with Dandy, then at Newark airport and told him surgery could not wait so he halted the trip. Although Naffziger was the senior surgeon, Rand actually operated. Ewen (1986) attributes this to the fact that Naffziger did not have either his instruments or his assistants available but one has to wonder if the evident hopelessness of the situation was really the cause of his demurral (Naffziger must have known that his instruments and assistants would not be available when he agreed to come). Family and friends gathered in a waiting room with George Pallay relaying information to them from the operating room.

The surgery began shortly after midnight. The skull was first trepanned and a ventriculogram was performed, which took about an hour and a half. A large cyst was found on the right side of the brain that compressed the left ventricle and shifted the right ventricle across the midline. The family was heartened by the news of a large cyst (as opposed to a tumor) that could be removed but no mention was made of the trauma to the brain tissue that occurred as a result of its herniation and shift past the midline. The cyst was opened but revealed a mural nodule located on its medial side. It was presumed to be malignant. Both the cyst and the nodule were removed and the wound closed. The family, now subdued, all left the hospital around 6 a.m., after completion of the surgery. They expected the worst. Gershwin

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22. In looking back on these efforts, one has to realize just how prominent a figure George Gershwin was in 1930s America.

23. The pneumoencephalogram, of which a ventriculogram was a sub-procedure, involved the injection of air through the spinal cavity into the ventricles to obtain a rough image of the brain and possible structural displacements. It was actually developed by Walter Dandy in 1919. Although producing painful headaches it was relatively safe and remained in use until the advent of CAT scans and, later, MRIs in the 1970s.

24. Living brain tissue has the consistency of stiff pudding. The effect of herniation is somewhat akin to that of extruding dough under pressure through a pastry bag.
was returned to his room where his “temperature rose rapidly to 106.5°
F, his pulse to 180, and his respiration to 45” (Carp, 1979, pp. 475-476,
citing the Cedars of Lebanon hospital records). He died alone, without
ever having regained consciousness, at 10:35 on the morning of July 11,
1937. Carp quotes from the pathologist, Isaac Yale Och’s, report:

A large piece of the tissue shows normal cerebral cortex. Separately, one
sees bits of the tumor mass. Here the cells are much smaller, quite loosely
placed, and there is considerable extravasation of the blood between the
cells. The tissue also contains many young blood vessels. The cells have
small, deeply stained nuclei, and are of small size. Projecting from each
nucleus [sic] in each direction, are very fine filaments of protoplasmic
processes which fuse to connect with those of the adjoining cells. Occas-
ional multinucleated cells are seen, and there is marked variation in the
size of the nuclei. The picture fit with that of a spongioblastoma multi-
forme. (p. 476)

This would be an extremely malignant tumor that today would be
subsumed under the general category of glioblastoma multiforme, the
same tumor that recently killed Senator Edward Kennedy, approxi-
mately one year postdiagnosis.

Immediate Aftermath

Gershwin’s funeral was held on July 15, 1937 at Temple Emanu-El in
Manhattan and a simultaneous memorial service was held in Los Ange-
les at Temple B’nai B’rith (now the Wilshire Boulevard Temple). Nearly
3,500 people attended the New York service. On August 9, 1937 a crowd
of 20,000 attended a memorial all-Gershwin concert at Lewisohn Stadi-
um in New York City, a venue that had been associated with him for
many years (Pollack, 2006).

On July 17, Walter Dandy sent a note of condolence to Gabriel Seg-
gall, also asking for a report of the events (Dandy, 1937, July 17; Fab-
ricant, 1958). Segall asked Carl Rand to prepare summaries of each of
the Cedars admissions (Peyser, 1993). Perhaps based on those sum-
maries, he prepared a seven-page letter summarizing Gershwin’s case
for Dandy (Segall, 1937, August 9) and concluding with the pathology
report from the Cedars of Lebanon chart that Carp also quoted (1979, p.

25. This is an error. In these kinds of tumors, processes extend from the individual cells,
not their nuclei.
26. The whereabouts of these summaries, if they still exist, is unknown.
Dandy’s response (Dandy, 1937, August 13) was of considerable importance to the original narrative of Gershwin’s illness and death. To quote from Fabricant (1958):

I do not see what more you could have done for Mr. Gershwin. It was just one of those fulminating tumors. There are not many tumors that have uncinate attacks that are removable, and it would be my impression that although the tumor in a large part might have been extirpated and he would have recovered for a little while, it would have recurred very quickly since the whole thing culminated so suddenly at the onset. I think the outcome is much the best for himself, for a man as brilliant as he with a recurring tumor would have been terrible; it would have been a slow death. (p. 334)

Dandy also inquired if there had been an autopsy and, if so, he requested a photograph of the brain (Dandy, 1937, August 13). No further records exist on this point.

Dandy, in effect, had provided all concerned (undoubtedly with the exception of Kay Swift) with the perfect, feel good, “CYA” ending to the whole sordid affair. It was indeed tragic that a man as gifted as Gershwin was taken so young and so unfairly. Perhaps some family members or friends should have taken his symptoms more seriously. Perhaps even some medical mistakes were made. But, the eventual outcome would have been the same without them; the mistakes were almost a blessing really, in that they shortened his torment. The narrative of the illness that began on February 9, 1937 ended on August 13—not so fast.

The Story Escapes Its Constraints

It is, of course, impossible to know what people were thinking or saying to each other at the time. Possibly Gershwin’s ghost did hover over the proceedings at the New York Psychoanalytic Society on March 3, 1942 that dealt with Zilboorg’s treatment of another patient in his care. The first crack in the public narrative appeared in 1959, in Noah Fabricant’s brief paper “George Gershwin’s Fatal Headache.” Prefiguring a book, Thirteen Famous Patients that he released the following year, he mentions dizzy spells and olfactory auras occurring in the spring of 1937 and cites Carl Rand as having “concluded that Gershwin had a brain tumor.” This was judged purely by the history of “uncinate gyrus attacks” (p. 334; i.e., temporal lobe seizures). I can recall that when I began my analytic career in the early 1970s, the word on the street, analytically speaking, was that George Gershwin had died of a brain tumor that his analyst, Gregory Zilboorg, had failed to diagnose.
The next report in the medical literature is a paper published in 1982 by Bengt Ljunggren, a Swedish neurosurgeon. Ljunggren describes Gershwin’s symptoms occurring in the late winter and spring of 1937 as spells or fits proceeded by a loathsome smell of burning rubber and observed that “Gershwin mentioned these symptoms to his doctors, but they did not realize that their patient presented with regular epileptic seizures from the temporal lobe” (p. 735). He is, in my opinion, far more generous than he should be in suggesting that this is a diagnosis easily missed. Ljunggren goes on to make a very important new observation; that Gershwin’s attacks of constipation, nausea, and gastrointestinal complaints that he could not describe, but instead referred to as “Composer’s Stomach,” in fact represented the auras of temporal lobe epilepsy. These attacks began in 1923. A course of illness of 14 years would immediately rule out a diagnosis of glioblastoma multiforme with its average survival time of something over a year and replace it with that of the very benign tumor, pilocytic astrocytoma. However, Ljunggren does not question the final diagnosis, attributing it to a late malignant degeneration of an otherwise benign tumor that has often been known to exist for decades. Nor does he say, as I would here, that no physician could be faulted for failing to diagnose a temporal lobe lesion based solely on GI symptoms. So despite Ljunggren’s almost brilliant reasoning, the beginning date of the narrative (as opposed to that of the illness) still remains at February 9, 1937.27

However, the date fails with the publication of Peyser’s (1993) Gershwin biography 11 years later. Although Peyser has been much criticized for a gossipy style, lack of formal citations, and, on occasion jumping to conclusions not merited by her facts, her research stands up under scrutiny. In 1934, Gershwin organized a concert tour to commemorate the tenth anniversary of the composition of Rhapsody in Blue. Beginning on January 14, the demanding tour visited 28 cities in 28 days, holding a concert in each city. Mitch Miller, then a young oboist, described the tour in 1988. He recalled that when the train pulled into Detroit, he disembarked just behind Gershwin. Gershwin locked up and said he smelled burning garbage; none of the other musicians smelled anything.28 That recollection provides a hard date for the beginning of Gershwin’s illness of February, 1934, the month before he began his analysis with Zilboorg. Of course, it remains a possibility that Gershwin never

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27. We will consider below whether Gershwin’s doctors should have inquired about such symptoms in the spring of 1937.

28. Unfortunately, Peyser fails to mention the circumstances in which Miller made these remarks in 1988. However, in a letter to the editor of the New York Times (Miller, 1998, November 15), Miller made the same statement, adding that the incident occurred in February, 1934.
told Zilboorg of the incident but this is not really relevant since he insisted that Gershwin could not have had a brain tumor in 1934 or 1935 without his knowing it. There is also evidence that Gershwin had additional olfactory hallucinations prior to February 11, 1937; he told his friend Oscar Levant that evening that he had had a number of previous attacks (Hyland, 2003). Furthermore, Gershwin was always unhappy about his health, talked about his symptoms frequently, and appears to have been an excellent historian whenever he was examined by physicians. Thus, there is a fairly good chance that Zilboorg indeed heard about the olfactory hallucinations and did nothing about them. There is also no record that any of Gershwin’s physicians later connected his GI symptoms with his neurological ones.  

The next important contribution to the literature that further questions the “official history” was Gregory Sloop’s (2001) paper, “What Caused George Gershwin’s Untimely Death?” Sloop takes into account the history of olfactory hallucinations dating from 1934 and the vague but marked GI complaints dating from 1922. He demolishes the discharge diagnosis of “most likely hysteria” from the first Cedars of Lebanon admission, on the grounds that Gershwin’s history and behavior simply do not meet the criteria for somatization disorder, its DSM-IV equivalent. He then offers a differential diagnosis of cystic neoplasms with intramural nodules occurring in the cerebral hemispheres. He points out that the photomicrographs show small, polymorphic spindle cells with distinctive hair-like projections of cytoplasm which, when coupled with the long clinical history are consistent with the diagnosis of pilocytic astrocytoma. Although the cellular polymorphism could lead to a mistaken diagnosis of glioblastoma multiforme, the photomicrographs lack tumor cells undergoing mitosis, new blood vessels with stacking up of endothelial cells and areas of necrosis that are characteristic of such tumors. Sloop goes on to observe that focal malignant degeneration, rare in pilocytic astrocytomas, cannot be absolutely ruled out, absent access to the entire tumor mass for microscopic examination.  

Sloop concludes that, even in 1937, Gershwin’s prognosis might have been good if the tumor had been removed prior to the herniation.

29. By themselves, GI symptoms do not suggest a neurological lesion; it is only in the context of olfactory hallucinations that they should be considered auras.

30. It is worth noting that Carp (1979) quotes from the original pathology report and diagnosis in order to “clarify with factual data misconceptions about the illness and pathology of the brain tumor which caused George Gershwin’s death” (p. 476). However, Dr. David Cowen, who prepared the captions for Carp’s photomicrographs of the tumor, describes them only as “a moderately cellular neoplasm composed principally of astrocyte-like cells with distinct processes. The cells and their nuclei vary moderately in size and shape. Blood vessels are not abundant in these areas” (p. 476). This is not a description of a glioblastoma multiforme.
He refers to a study (Schisano & Tovi, 1963) of 42 patients suffering from pilocytic astrocytoma treated surgically prior to herniation between 1926 and 1957.

Only six died of their tumor or complications of surgery. Of the 34 patients alive at the time of the report, 27 had full capacity for work, three had partial capacity for work but were self-supporting, and four were completely disabled. Twenty-seven subjects had been observed for more than 10 years, and 19 for more than 20 years. (Sloop, 2001, p. 30)

Although there is no way to completely substantiate it, I would suggest that Gershwin’s tumor herniated sometime on July 9, 1937 resulting in his gradually falling into a coma. Further evidence was seen in the post-operative elevations of body temperature, respiratory rate, and pulse rate that all pointed to brain stem damage resulting from that herniation. It is important to recognize that Gershwin did not die of his brain tumor. The tumor itself was small and most likely benign. He died from the mechanical effects of the rapidly enlarging cyst on his brain; compression followed by herniation. It seems possible that Gershwin’s life and talent might have been preserved had surgery been done as late as the morning of July 9; he certainly could have been saved if it had been done at the time of the first Cedars of Lebanon admission, June 23-26.

Some Further Considerations

I can easily foresee objections, perhaps to Sloop’s (2001) position, but certainly to my own. Such objections would go something like this: What narrative relevance can the psychoanalytic and neurological advances available in 2010 have seven decades after these certainly tragic events played out around the actions of Gershwin’s physicians? I asked myself the same question and concluded that arguments made in 2010 would seem to have limited relevance to Gershwin’s admittedly tragic situation. I wondered how might it be possible to find this information in the narrative of 1934-1937. The answer I came up with seemed obvious in retrospect; see what contemporaneous neurology textbooks were saying about these conditions and symptoms. A subsequent search led to a first edition of Neurology, a 900-page textbook of neurology written by Roy Grinker31 and published in 1934. It seemed to me that any information concerning temporal lobe lesions, malignancies, and seizures present in

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31. Ironically, given Zilboorg’s claims about himself, this is Roy Grinker, Sr. who was also a noted psychoanalyst and was analyzed by Freud.
that 1934 text was fair game to expect a neurologist, a neurosurgeon, or a psychoanalyst claiming competence in neurology to know.

So what does Grinker (1934) have to say? I am going to review his discussions in three areas; epilepsy, malignant brain tumors in general, and temporal lobe tumors.

1. Epilepsy. Classification is always based on the characteristics of the particular seizure. Auras occur in 60% of cases. “Epigastric auras are extremely frequent and comprise sensations which are very poorly described by the patient” (p. 829). Psychic auras may occur. “A feeling of unreality passing into a dreamy state occasionally precedes an attack and may be accompanied by gustatory or olfactory sensations . . . This type of aura accompanies the so-called uncinate fits which, from our experience with tumors, we know to be of temporal lobe origin . . . It becomes important to know the type of aura an individual patient experiences and to understand the localizing significances of these manifestations, especially when neurosurgical therapeutic procedures are considered” (p. 829, italics added).

2. Malignant Brain Tumors. By far the two largest groups of such tumors are glioblastoma multiforme (GM) occurring in 30% of cases and having a mean survival time of 12 months from onset of symptoms and astrocytomas occurring in 37% of cases and having a mean survival time from onset greater than 76 months. Glioblastomas vary histologically, lack margins, and have a rapidly expanding blood supply with frequent hemorrhagic, necrotic, degenerate, and xanthochromatic areas where the tumor has outgrown its blood supply. They are highly cellular and present many mitotic figures. Many thin-walled vessels are present with endothelial overgrowth to the point of occlusion (hence the hemorrhages). “Many pathologists feel that such abnormalities are essential to a diagnosis of glioblastoma multiforme” (p. 477). The tumor tissue of astrocytomas tends to be relatively avascular and acellular in contrast to GM (similar to the photomicrographs of Gershwin’s tumor). They are often cystic, with the cysts becoming quite large. Tumors are of two different types, a fibrillary type (Gershwin’s) with numerous cellular fibrils, and a protoplasmic type in which the fibrils are absent. Malignant degeneration does occasionally occur, much more commonly in the protoplasmic type. When such degeneration does occur, the cellular picture becomes that of glioblastoma multiforme, in other words it changes from that of Gershwin’s tumor. Based on the histology and history, Gershwin’s tumor was a pilocytic astrocytoma; only the absence of a record of an examination of the gross
specimen in its entirety makes it impossible to absolutely rule out some malignant transformation.

3. Temporal Lobe Tumors. The physical examination is often unre-
markable until quite late, when the tumor has reached a large size. Left-sided tumors are often accompanied by an aphasia, which is easy to recognize. The diagnosis is made by careful evaluation of a history of characteristic auras, vague GI complaints, olfactory hallucinations and the nature of the seizures themselves. The patient transiently loses touch with his environment, experiences a sense of unreality or dizziness as happened to Gershwin on several documented occasions. Visual hallucinations may be present. The seizure may end at this point or progress to generalized con-
vulsions which, “except [for] the prodromata” (p. 536, italics added), are no different from convulsions brought about by other causes. In another context, Grinker aptly observes “it should be clearly understood that he who would supplant careful clinical study or reinforce careless observation . . . is most surely headed for numerous disappointments and sad mistakes” (p. 547).

So what really happened to Gershwin? In his letter of August 9, 1937 to Dandy, Segall (Dandy, 1937, July 17; Fabricant, 1958) tells us that as of June 9 Gershwin had had headaches for three weeks (actually for years), dizzy spells for three months, GI symptoms for many years, and olfactory hallucinations of burning garbage of unstated duration. The headaches occurred in the early morning hours, which is characteristic of tumor headaches. Ziskind performed a neurological examination that was essentially negative on June 20th and saw him again at Cedars of Lebanon over June 23-26, 1937. Segall and Ziskind note the presence of the olfactory hallucinations but dismiss their localizing significance because they believed Gershwin’s state of consciousness was undisturbed during the attacks, which was manifestly false. Instead, he left Cedars of Lebanon with the diagnosis of “most likely hysteria.” Ewen (1986) describes Gershwin’s workup as “exhaustive,” that his doctors had “taken into account the possibility of a brain tumor, but there was simply no symptom to substantiate this suspicion” (p. 279). However, it was all there in Grinker (1934); his doctors should have known better but they just got it wrong. Instead of discharging Gershwin, they should have told him that he most likely had a brain tumor that would prove fatal, perhaps quite soon, and that he needed a pneumoencephalogram to localize the tumor followed by surgery to remove it. Instead, the first person to make the diagnosis was Carl Rand, toward midnight of July
9, 1937, when Gershwin was comatose with an already herniated brain, and, at that point, his case was hopeless.

A FINAL NOTE

What can we learn from this lengthy narrative of dusty events occurring three quarters of a century ago? Gershwin’s sad experiences serve as a cautionary tale for two clinical32 subspecialties; psychoanalysis and neurosurgery. Ask any psychoanalyst or neurosurgeon, perhaps aged 60 or older, about Gershwin and you will get some brief, garbled version of their specialty’s version of the story. As described above, I had heard at some point in the 1970s that Zilboorg had failed to diagnose the brain tumor and Gershwin had died as a result. That is what I thought until two or three years ago, when, while engaged in a different line of research, a footnote referring to Simmel as Gershwin’s analyst caught my eye. Where did he come in? A bit of poking around produced some references that told conflicting stories or half-stories. Thinking that archival research might be an interesting change of pace, I decided to pursue the question. Unlike Gregory Sloop, who told me he had been fascinated by Gershwin’s Concerto in F, I had only a modest interest in Gershwin’s music and, in truth, an equal interest in the lyrics and the story they both told of life in the 1930s. I thought also that Gershwin deserved to have his story told, as much of the narrative knowable today in 2010.

The medical part of the story was much easier to write than the psychoanalytic part. There is something about a good, clean story of plain medical incompetence based on clinical fact that is easier to accept than a story that documents the unethical behavior and apparent character pathology of a distant colleague.33 However, taken together, they do tell the story of just what did happen to George Gershwin.

32. Psychoanalysis is no longer a subspecialty confined to medicine, although, at the time of our story, it mostly was.
33. Gabbard and Peltz (2001) have described on the institutional level the resistances we have to dealing with such issues in colleagues.

REFERENCES


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