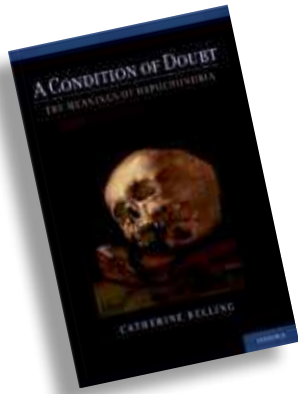


Reviews and reflections

David A. Bennahum, MD, and Jack Coulehan, MD, Book Review Editors



A Condition of Doubt: The Meanings of Hypochondria

Catherine Belling
New York, Oxford University Press,
2012

Reviewed by Sally K. Severino, MD
(AQA, University of New Mexico,
1997)

A *Condition of Doubt: The Meanings of Hypochondria* is written by Catherine F. Belling, PhD, who is Associate Professor in Medical Humanities and Bioethics at Northwestern University Feinberg School of Medicine. As such, she is in medicine but is not a medical doctor. She views medicine and asks the important question, “How can you tell what is health and what is illness?”

She approaches this question by focusing on the medical condition of hypochondria, which she defines as “mental distress caused by uncertainty about the meaning of actual somatic experience.”¹⁶ Hypochondria is not malingering (pretending to be sick), not a delusion, and not a medical syndrome of unexplained symptoms such as chronic pain syndrome. Rather, the five necessary conditions for

hypochondria are: the patient’s fear that disease is present, embodied resistance to surveillance (that is, doctors can find no evidence of disease), doubt about reassurance, informed responsibility on the part of both patient and doctor, and a narrative-based cultural context.

Having defined hypochondria, Dr. Belling approaches her question, “How can you tell?” by dividing her book into four sections:

- “Part One: A Biological Condition” focuses on hypochondria as a function of our human experience as embodied beings who understand our bodies in ways that biological science understands them.
- “Part Two: A Medical Condition” highlights hypochondria’s challenge to the validity of medical knowledge and doctor’s practices.
- “Part Three: A Cultural Condition” portrays the cultural context that frames medical information and gives rise to modern hypochondria.
- “Part Four: A Narrative Condition” describes the challenge that hypochondria poses to medical narrative.

In each section, Dr. Belling views hypochondria not with a physician’s eyes that objectively evaluate a patient’s body, but with the eyes of someone who understands the hypochondriac’s subjective experience of body as represented in literature, drama, and other cultural expressions. This lends itself to a rich experience for the reader as Dr. Belling introduces us to a wealth of serious humanities scholarship that has informed her view of medicine.

In “Part One: A Biological Condition,” Dr. Belling arrives at her view of hypochondria, which I summarize as follows: (1) Hypochondria is not a mental or physical illness but a position, (2) The

position is of one who fears and doubts that disease lurks hidden in the body, (3) The position is of one who expects that there must be a doctor somewhere with technology to expose all the body’s inner threats, and (4) The position is of one who tries to discern the body’s future by listening to its symptoms and examining the body.

In “Part Two: A Medical Condition,” Dr. Belling traces the history of hypochondria and exposes the difficulty that medicine faces when it attempts to include the word or condition in its diagnostic classification. She focuses in some detail on psychiatry’s efforts at classification. In psychiatry’s *Diagnostic and Statistical Manual (DSM)-4*, hypochondriasis appeared as a somatoform disorder. In the new *DSM-5*, published in 2013, hypochondriasis and somatoform disorder are reconceptualized as a new category called somatic symptom and related disorder. This reconceptualization addresses two concerns of Dr. Belling: (1) that hypochondria is a condition of primary care medicine because the patient’s symptoms are real, and (2) that a diagnosis be based on positive signs and symptoms rather than an absence of medical explanation for somatic symptoms. It does not, however answer another issue: the way medical students are formed into physicians. Here Dr. Belling emphasizes the cultural change that occurred in medicine during the eighteenth century. Before Enlightenment science, the patient’s experience and the doctor’s interpretation co-constructed a diagnosis. After Enlightenment science, the doctor’s search for pathological anatomy of a material lesion became more real than what the patient felt. The ramifications of this change have been further



complicated by the social context of health care since the 1970s, in which patients have learned to challenge the evidence or lack of evidence of disease and doctors have been trained to be not entirely sure about whether a hidden biological reason might exist for the patient's symptoms. Hypochondria, thus, is a medical condition at the center of a modern contest between patient and doctor.

In "Part Three: A Cultural Condition," Dr. Belling focuses on three cultural contexts that frame medical information and give rise to modern hypochondria. The first context is the availability of medical information on the Internet that blurs the boundaries between doctors' and patients' use of this information and generates what she calls "cyberchondria." The second context is public health communication, which moves masses emotionally to behave in certain ways to prevent disease rather than providing medical information about disease. The cautionary tales of public health communication contribute to hypochondriacal anxiety about risk of disease. Early detection of disease has created the term "previvor," someone who has survived a disease before it has begun. Such is the example of Deborah Linder who, when she learned that she carried the gene that predisposes some women to cancer, had both breasts removed. The third context is reading or seeing horror stories. Horror stories offer an infectious anxiety. Both hypochondria and horror prevent closure that would render events meaningful and prevent catharsis that would maintain reassuring order.

In "Part Four: A Narrative Condition," Dr. Belling illustrates how the structure of stories that tell of hypochondria denies closure and how the discourse in which the stories are told denies credibility. Hypochondria is the story that won't begin and won't end. It is like a time bomb. No one knows when it will explode. And, when organic disease is not found, "the patient is trapped in a story that is endlessly just about to begin."^{p222}

In the end, Dr. Belling concludes that the answer to the question, "How can you tell?" is: "Sometimes you can't." Hypochondria challenges medicine to admit that sometimes there is no objective understanding of reality. Hypochondria cannot be reduced to a pathology or a diagnosis.

Hypochondria suspects a diseased body. Medicine, finding no lesion, can best acknowledge that there may be illness within, but since it can't be confirmed, it is best to live as if it did not matter.

Whether you agree with Dr. Belling's portrayal of hypochondria or not, her perspective is erudite and interesting. As an insider—though not for the diagnosis of hypochondriasis—for the revisions of DSM-III-R, DSM-IV, and DSM-IV-R, I welcome Dr. Belling's perspective on hypochondria, on medicine, and on the human condition. As an undergraduate major in the humanities, I commend Dr. Belling for her valuable collection of hypochondria narratives. As a bridge-builder for cross-disciplinary dialogue, I recommend this book to readers who search for much food for thought.

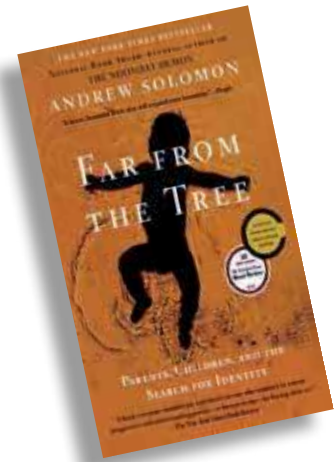
Dr. Severino is Professor Emeritus of Psychiatry at the University of New Mexico Health Sciences Center School of Medicine in Albuquerque, New Mexico. Her address is:
1050 Joshua Drive SE
Rio Rancho, New Mexico 87124-1258
E-mail: skseverino@gmail.com

Far from the Tree: Parents, Children, and the Search for Identity

Andrew Solomon
New York, Scribner, 2012

Reviewed by David A. Bennahum, MD (AΩA, University of New Mexico, 1984)

Andrew Solomon has written a sensitive, informed, and quite extraordinary book that deserves a place in every physician's library. At 960 pages this is not a book to be absorbed in a few days



or weeks, but a work to be consulted over time. For those of us whose understanding of illness is rooted in medical science, Solomon presents not just fact and supposition but the narrative detail of what it is like to care for and to live with those whose many human experiences differ from the norm or the ideal. The author has copious research to buttress his stories, yet this is the least opinionated of works. Rather it is rich with narrative that carries the reader as close as possible to the actual experience of living with and coping with difference. The book is divided into twelve chapters that include "Son," "Deaf," "Dwarfs," "Down Syndrome," "Schizophrenia," "Disability," "Prodigies," "Rape," "Crime," "Transgender," and "Father."

As I watch my son and his wife love and care for their seven-year-old son diagnosed as on the autistic spectrum I was particularly interested in Solomon's chapter on autism. Let me quote from that chapter.

Some experts argue that we are simply diagnosing it more frequently, but improved diagnosis can hardly be the full explanation for the escalation from a rate of 1 in 2,500 births in 1960 to 1 in 88 today. We don't know why autism is on the rise; indeed we don't know what autism is. It is a *syndrome* rather than an *illness* because it is a collection of behaviors rather than a known biological entity. The syndrome encompasses a highly variable group of symptoms and behaviors, and we

have little understanding of where it is located in the brain, why it occurs, or what triggers it. We have no way to measure it but by its external manifestations. The Nobel Laureate Eric Kandel said, "If we can understand autism, we can understand the brain." That is a generous way of saying that we will understand autism only when we understand the brain.^{p221}

A wonderful quality of Solomon's writing is his ability to switch from the science to the stories. For example in discussing their child Cece, her parents Betsy and Jeff described visiting a neurologist when Cece was four. After examining the child he said, "If she's not talking at all after this high-quality early intervention [the child had had intensive preschool experience], she'll never talk, and you should get used to that. She has serious autism."^{p225}

Cece has actually spoken four times in her life, and every time the words were appropriate to the situation. When Cece was three, Betsy gave her a cookie; she pushed it back at her saying, "You eat it, Mommy." Jeff and Betsy exchanged glances and waited for their world to change. Cece said nothing more for a year. Then one day Betsy stood up to turn off the TV, and Cece said, "I want my TV." At school, three years later, she turned on the lights and said, "Who left the lights on?" Then one day a puppeteer visited the Cece's class; when he asked, "Hey, kids! What color is the curtain?" Cece responded, "It's purple." The capacity to formulate and deliver these sentences suggests a tantalizing lucidity below the silence. . . .

"I think that she might be prelitererate," Betsy said. "I believe that she has a wild intelligence somewhere. I worry that her soul is trapped."^{p225}

In chapter one, "Son," Solomon writes that in 1993 the *New York Times* assigned him to investigate deaf culture.

He writes that parents spend inordinate energy and time trying to help their children communicate, and in the process often neglect other aspects of education such as mathematics, history, and philosophy. He writes that the experience of these children and their parents "felt arrestingly familiar to me because I am gay. Gay people usually grow up under the purview of straight parents who feel that their children would be better off straight and sometimes torment them by pressing them to conform. Those gay people often discover gay identity in adolescence or afterward, finding great relief there."^{p3}

The measure of this book is the courage of the author, whether in writing of his own struggles in coming to terms with his natural identity or with his own depression, which he chronicled in a previous book, *The Noonday Demon: An Atlas of Depression*. The intelligence, honesty, and compassion found in reading *Far from the Tree* leaves one with a sense of hope and optimism that perhaps we can really take the world in for repairs, as Richard Selzer once wrote, if only we listen to our patient's stories as well as studying and learning the science.

Dr. Bennahum is a book review editor for *The Pharos* and a member of its editorial board. His address is:

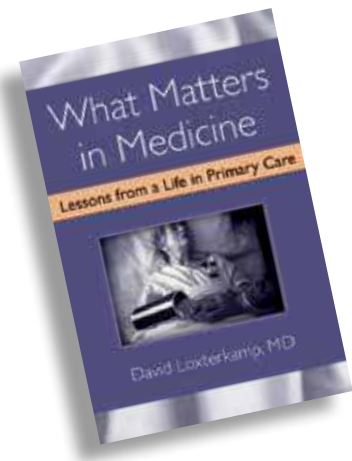
1707 Notre Dame NE
Albuquerque, New Mexico 87106
E-mail: dbennahum@salud.unm.edu

What Matters in Medicine: Lessons from a Life in Primary Care

David Loxterkamp, MD
Ann Arbor, University of Michigan Press,
2013, 184 pages

Reviewed by Jack Coulehan, MD,
MPH (AQA, University of Pittsburgh,
1969)

David Loxterkamp's *What Matters in Medicine* is a fascinating mixture



of memoir, meditation, and health care policy. He weaves these elements together into a design that, for me at least, was not immediately clear, but which, upon further reflection, I found deeply meaningful.

At its most general level, *What Matters in Medicine* asks the question: "What would the practice of medicine look like if it were ruled by common sense, if we set out to do only the right thing?"^{p168} In answering, the author sketches a picture that most of us would find appealing—more time spent with patients, meaningful personal relationships, shared decision making, community support. Will today's rapidly changing medical scene, he then asks, end in the final demise of primary care? In other words, are "common sense" and "only the right thing" dying out, or is there hope for them in tomorrow's medicine?

Drawing from the literature, as well as from his own broad experience, the author discusses the central features of relationship-centered medical practice and the limits placed upon them in contemporary medicine. He is cautiously optimistic about the Patient-Centered Medical Home (PCMH) movement as a possible future. In fact, his own Seaport Family Practice in Belfast, Maine, was part of a national demonstration project that "sought to determine what was needed to transform existing practices into the PCMH model"^{p163} and is currently engaged in a five-year effectiveness study of twenty-five PCMHs serving 170,000 patients throughout Maine. Among the salient features

the author describes are same-day appointments, utilization of information technology, employment of midlevel practitioners, emphasis on teamwork, measurement of outcomes, and involvement in the community. However, Dr. Loxterkamp also adds a cautionary note, “What is clear . . . is that the medical home will need more than time to succeed.”^{p162}

With this statement in mind, let me return to “Staging: A Moral Capital,” the first third of *What Matters in Medicine*. In this section Dr. Loxterkamp introduces the reader to the lives of three mid-twentieth century general practitioners. The first is Ernest Ceriani of Kremmling, Colorado, who was the subject of “Country Doctor,” a 1948 photoessay by W. Eugene Smith published in *Life* magazine. The young Dr. Ceriani served as the centerpiece of an article glorifying traditional medical practice and opposing President Truman’s drive to establish a national health insurance plan. The second physician he discusses is John Eskell, a British general practitioner who, under the pseudonym “John Sassal,” became the subject of John Berger and Jean Mohr’s *A Fortunate Man*, a book-length photoessay in which Dr. Sassal appears as a consummate country doctor, dedicated to his community and immersed in the lives of his patients. The third general practitioner introduced is the author’s own father, Dr. E. O. Loxterkamp, who lived and practiced in Rolfe, Iowa.

In the stories of these men, Loxterkamp discovers dedication, altruism, and compassion, but he also finds a darker side—alienation and depression. As he grew older, Dr. Ceriani experienced conflicts with colleagues and bitter separation from his wife. Dr. Eskell became severely depressed and eventually committed suicide. The elder Loxterkamp died of a heart attack when David was only in seventh grade. The author writes, “It is tempting to say they died with less than they deserved. They deserved longer and less harried lives, more collegial respect, the understanding and support of their communities, and no less

happiness in marriage than they found in the discharge of their duties.”^{p41} These were men whose lives were defined by their work, which eventually diminished or destroyed them. They had certainly set out “to do the right thing,” but theirs were not the rosy-colored lives that our nostalgia for the general practitioner imagines. Something was missing.

The author then turns to his personal memoir in “Departure,” the book’s second major section: his training in family medicine; his decision to settle in Belfast, Maine; the growth and development of his professional practice; his later aspiration to become a writer; and ultimately his national recognition as a model family doctor (à la Dr. Ceriani) in a 1998 *Life* cover story and an ABC television documentary in 2000. He accompanies this narrative with a series of engaging stories about his relationships with patients.

At this point the reader is left with the contemporary example of the successful—indeed the “model”—Dr. Loxterkamp occupying the foreground, but in the background there remain the three similarly dedicated physicians of the past who sacrificed their health and happiness to the overwhelming demands of primary care. It seems evident that the author views these predecessors as professional role models, but at the same time he has sought to understand and avoid the pitfalls to which they succumbed.

While Dr. Loxterkamp succinctly summarizes his “wish list” for improvements in primary care, he is less direct in explaining how the primary care doctor can maintain his or her own mental and spiritual balance. I think the answers lie in the story of the author’s professional development, along with his brief discussion of Balint groups and reflective practice.^{pp164–67} Though not explicitly stated as such, these insights include creation and nourishment of supportive peer relationships, development of personally-fulfilling interests outside of medicine, a team-approach to practice, and creative engagement with new ideas that actually enhance patient care, i.e., as opposed

to embracing expensive new drugs or procedures for their own sake. Perhaps I am reading too much into the stories of those mid-twentieth century general practitioners, but I can’t help but believe that better care for generalist doctors is a necessary component in providing a viable future for primary care.

Dr. Coulehan is a book review editor for *The Pharos* and a member of its editorial board. His address is:

Center for Medical Humanities, Compassionate Care, and Bioethics
Stony Brook University
Stony Brook, New York 11794
E-mail: John.Coulehan@stonybrookmedicine.edu



Eugene Braunwald and the Rise of Modern Medicine

Thomas H. Lee (AQA, Cornell University, 1978)
Cambridge, Harvard University Press, 2013

Reviewed by Daniel Friedman, MD

As a young cardiologist I had the good fortune to hear Eugene Braunwald speak on a number of occasions. I first met him when he gave the keynote address at an annual meeting of the Stanley Sarnoff Endowment for Cardiovascular Research. He spoke to a room filled with current and future investigators and

leaders in academic cardiology. Much impressed by his brilliant reputation I had purchased every edition of his famous textbook since entering the field and seen his name on countless papers. Still it was on that day in Washington, DC that I began to recognize the true magnitude of his contribution to modern cardiology.

Dr. Lee gives us an even deeper appreciation of a man who might be crowned the cardiology king of the last half of the twentieth century. Many physicians are familiar with his scientific contributions in ischemic heart disease, textbooks, and teaching. The biography before us tells so much more as Lee gives us insight into his deep involvement in unraveling the consequences of hypertrophic cardiomyopathy and valvular and congenital heart disease.

Although the book is well referenced and largely based on scientific facts, the early portions tell the dramatic and tragic story of his early life in the cauldron of Hitler's Europe. It gives the reader a glimpse of the challenges faced by the young Braunwald when he and his family were forced to flee from Vienna and with great luck landed in New York City in 1939. As a Jew in Austria, "his options had been limited at each stage of his life; but perhaps because of those restriction he wanted to do all he could to keep his future wide open." His decisions along the way are profoundly educational to any young person mapping out an important career. Much of Lee's writing deals with the deliberate manner in which Dr. Braunwald made choices at each respective stage of his life, both personal and professional.

He was careful during aspects of his training in New York to keep his options open. In addition to clinical experiences, he began to learn the art of being an investigator. He then spent a "magical decade" at the NIH as chief of cardiology. During that time he came in contact with many of the great basic and clinical science minds of our time. The list of his colleagues there reads like an atlas of Who's Who in American cardiology.

After the NIH, Braunwald made a crucial and very brave decision to go to the University of California at San Diego, a new medical school, as its first Chairman of Medicine. It was there that he learned to build a great department on the model of Donald Seldin at the University of Texas Southwestern. It was also at the University of California that he learned to lead a research effort beyond his own work and to guide junior colleagues.

In 1972, he and his family headed east once more to New England. The last forty years in Boston has resulted for him in an unrivaled place in this century's history in cardiology. He was the Chair of Medicine at the Brigham Hospital and later also at Beth Israel Hospital, a combination of jobs that he held with some regret, finding it to be highly draining. Still, he helped raise academic cardiology in Boston to the pinnacle of the field. Even before his arrival in Boston, he had become instrumental in the development of the Harvard Community Health Plan, a model for the nation. His support of this early Health Maintenance Organization not only provided good patient care, but also became an important instrument for departmental funding. Several times Dr. Lee mentions Dr. Braunwald's great regard for physician "triple threats," those excelling in clinical, research, and teaching endeavors. Whether we should consider that the best use of creative people today is another question.

The biography also concentrates on the great doctor's personal life. On graduating from medical school, Braunwald married classmate Nina Starr, who became a prominent heart surgeon in her own right. Working alongside Dr. Glenn Morrow, she performed the first mitral valve replacement. The Braunwalds worked together to balance their important careers while raising two daughters. The author pays close attention to this challenge, which can help many young professionals recognize that one partner's success does not have to be at the expense of the other.

The difficulties Braunwald faced are

not ignored. Despite his prominence, he was unable to convince Bristol Myers Briggs to fund several large clinical trials of their products. Far more importantly, virtually every medical professional has heard of the John Darsee affair. This brilliant young investigator working under the supervision of Braunwald committed profound levels of fraud. Lee writes, "The revelation that John Darsee had committed research fraud not just once, but repeatedly over the years at Notre Dame, Emory, and then Harvard came as a shock to the many faculty members who had been so impressed with him at those institutions." Countless papers had to be withdrawn. "Suddenly Braunwald's own prodigious rate of research publications became a focus of criticism instead of respect." The question of whether he had demanded too much of his junior colleagues had to be considered and great lessons were learned. Braunwald himself came to realize that an outside team must pursue the investigation when a team member's research honesty is called into question. He further realized that once fraud is uncovered the "burden must shift from finding other evidence of misconduct to proving the scientists' other data were produced honestly." The book does not play down this momentous event, but it is placed in the context of all of Braunwald's other phenomenal accomplishments.

Braunwald told this story the day I met him at the Sarnoff meeting. He was telling young investigators how a remarkable career develops. He told the story in a simple matter of fact way. He was not boasting, but rather putting together a brief road map of an almost unbelievable path. Dr. Lee takes us further down that road.

Dr. Friedman is Director of the Presbyterian Heart Group in Albuquerque, New Mexico. His address is:

Presbyterian Heart Group
201 Cedar SE, Suite 7600
Albuquerque, New Mexico 87107
E-mail: dfriedma@phs.org

Poetic encounters: A review of poetry by four clinicians

Reviewed by Jack Coulehan, MD
(AQA, University of Pittsburgh, 1969)

Sometimes I fantasize that poetry is a healing wave sweeping over the face of contemporary medicine. When I was young, doctor poets were rare. Perhaps a few existed, but they didn't publish. Who could have imagined that one day poetry would appear as a regular feature in medical journals like *JAMA*, *The Lancet*, and *Annals of Internal Medicine*? While an average literary journal might reach one or two thousand readers, a poem published in *JAMA* might be read by 360,000. Nowadays dozens of poetry collections by physicians appear each year. Poetry conferences and workshops have invaded many medical schools. And some clinician-poets, like Rafael Campo, Roy Jacobstein, Richard Berlin, and David Moolten have "broken out" of the strictly medical realm to win major national poetry competitions. It's a different world out there.

In this review I want to consider several recent collections by new or lesser known clinician poets. The first is *Minimally Invasive*, a remarkable chapbook by Maria Basile, a practicing colorectal surgeon.

Minimally Invasive: poems on a life in surgery

Maria Basile
Gynedd Valley, Pennsylvania, The Lives
You Touch Publications, 2011

Minimally Invasive breaks completely with surgery's macho image—I should say *macha* image, I suppose, for a feminine surgeon. Some characteristics remain. Surgeons cut to the heart of the problem and fix it, if they can. They don't take detours, or beat around the bush. Likewise, Dr. Basile's poems on a life in surgery demonstrate a unique combination of precision, lyricism, and honesty that cuts to the core of experience. Consider her precise images



drawn from professional practice: the panoply of surgical clamps, "the rabbit hole" a surgeon plunges into, the "fatty curtain," "the clap of steel on rubber glove," and "good guts" sliding "to quiet corners" of the abdomen. Consider also the extraordinary lyricism of poems like "So Good," "Euterpe," and "Goodnight Womb," with its evocation of a well-loved children's bedtime story.

The transparent honesty of Maria Basile's work is perhaps its most striking characteristic. In this era of glib emotion, her integrity shines through in every line. In the final stanzas of "To Sylvia," addressed to the unstable Ms. Plath, Basile reflects on her own work:

The surgeon at 2 a.m. is
stroking sunset blood on college-ruled
canvas, breathing blue
abandonment between lines,
drenching gauze decay in bleach
and lye.

She is writing
for her life.^{p16}

Here the sentiment, the scene, the meaning are utterly convincing. In his *Autobiography*, William Carlos Williams wrote that medicine "was my very food and drink" as a writer, "the very thing which made it possible for me to write."¹ Likewise, in "Truant" Dr. Basile writes:

I have found poetry in the hands of
a patient, read history by the lines
on his face, heard symphonies in the
rumbles of his gut.

These lines strike the reader as a

metaphorical truth beyond doubt. *Minimally Invasive* offers us an amazingly tender look at a life in surgery.

Reference

1. Williams WC. The Autobiography of William Carlos Williams. New York: New Directions; 1951: 357.



Scissored Moon

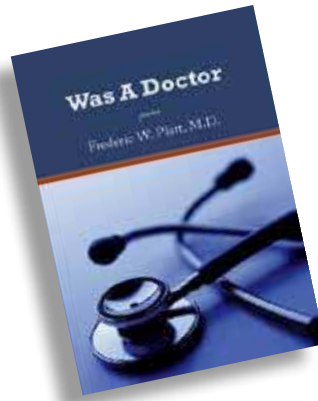
Stacy R. Nigliazzo
Winston-Salem, North Carolina, Press
53, 2013

Lyricism is also prominent in *Scissored Moon*, a first book by emergency room nurse Stacy Nigliazzo. In "Confidant"^{p10} she begins

I am your nurse.

No one knows
the things
I know.

And later affirms, "Face to face—/I will listen." Indeed, Nigliazzo's poems reflect active listening, as well as compassionate seeing and sensitive touch. *Scissored Moon* embraces all the senses in exquisite detail. Her book depicts a nurse's world fraught with illness, trauma, loss, endurance, hope, and sometimes healing. This is a world of vibrant images, like "his pupils quivering . . . slowly spilling over like bursting inkwells," "Her



voice, a razored sliver . . .,” “clover in the green fleck of my eye,” and “a baby bird collected from the sidewalk—/a freshly incised gallbladder.”

Yet, the true genius of these poems lies in their empathy, in the poet’s ability to express deep connections with her patients, “I see myself always . . . reflected in the eyes of my patients.” In the Catholic Church the word “viaticum” refers to the holy oil used to bless a dying person. In the poem of that name, Nigliazzo delivers her own very physical blessing,

I tied her wrists to the bed
when she started to hit herself. Gave
more
sedatives to keep her
comfortable.^{p34}

Many of her poems touch on the themes of end-of-life care and saying goodbye. For example, in “Valediction” she visualizes assisting her patient as she embarks on her last journey,

I am the needle—
the weeping blood on bone—
the ripple of pulse and breath
on spiraling wax paper.
I carry you
like butterfly wings . . .^{p68}

With *Scissored Moon* Stacy Nigliazzo joins a select group of nurse-poets, like Courtney Davis and Judy Schaefer, whose work demonstrates the highest standards of craft, as well as the deep insight of compassion.

Was a Doctor

Frederic W. Platt
Denver, Colorado, Big Owl Press, 2014

The title of Frederic Platt’s *Was a Doctor* highlights the identity crisis many physicians experience when they retire from medical practice. Dr. Platt was a pioneer in the field of physician-patient communication and has published several books on medical

interviewing and the clinical encounter. It’s not surprising, then, that most of his poems reveal little “sparks” of insight that arise from interactions with patients. These insights are engaging, sometimes humorous, and always humane. They reveal Platt’s underlying humility in the face of life’s slings and arrows. For example, in “Fired”^{p10} a patient’s wife dismisses him as her husband’s doctor, a tactic she has employed with many other doctors. Even so, “when I’m told I need to study bedside manner/it pains.” The poem concludes, “There’s no pleasing everyone,/from which I take/no solace.”

The first half of *Was a Doctor* consists of practice-poems, collectively called “The Stories.” In “L-thyroxin” there is the 102-year-old woman who “drags a bit.” She is hypothyroid, “so I fixed her,/spruced her up with/L-thyroxin,/livened her up to eighty or so.” But she doesn’t take the medicine. What happens? Now she is 104 and “still she drags.”^{p33} And what about the man, “enormously fat, with a huge head”? He talks funny and “I’m convinced he’s crazy/until I look in his throat . . .” and see the pus “boiling” behind his tonsils. Platt reflects, “I feel a lot of remorse/that I had so little compassion,” yet he is thankful he can prescribe penicillin: “At least there I can help.” (“Streptococcus,” p. 30)

The past tense of *Was a Doctor* jumps to the fore in the book’s second half, after retirement, when “All that is left are/the memories and the stories/and the fading ring upon the water.” (“Was a Doctor,” p. 59) These poems are full of thoughtful nostalgia, as in “Lost or Misplaced,”^{p61} which ends,

Disconnection. I miss
the relationships where I was
important to someone and
could pretend to be in charge.

Why did he close his practice? As he says in “Nobody Dies on My Shift,” for many reasons,

but most of all I was getting tired of
patients dying, especially
people I had known so long
and loved so much
and never wanted to bid goodbye.^{p65}

The retired physician—but very active poet—acknowledges these feelings, while also experiencing a sense of unexpected joy and freedom. As he tells us in “Some Days,” there are times he can wake up and

hum a little tune . . .
and the world is fine, so fine
you might imagine no one anywhere
has it in for his neighbor or for us
and those days I know I’m going
to do all right.^{p74}

Common Illness

Aaron McGuffin (AQA, Marshall University, 2002)
Wentworth & Collins, Publishers, 2013

Turning now to a younger generation, Aaron McGuffin is a pediatrician and medical educator at Marshall University in West Virginia. *Common Illness*, his first collection, is structured around the human life cycle, with six sections ranging from infancy to old age. He begins with a certain clinical detachment, as evidenced in the first poem, “Common Illness,” which concludes, “Death is a common illness,/diagnosed at birth.”^{p8} Detachment is transformed into gentle humor in “Press Conference,”^{p19} which describes an imaginary encounter with reporters over a breast milk stain on the front of this pediatrician’s shirt. They ask him about his “lactation sources” and “pump” for more information. Finally,



the weary poet confesses:

I can tell they see holes in my story,
that my heralded claims
of being the world's first male wet nurse
are all titular.
I'm about to be all dried up.

However, beneath McGuffin's coolness under pressure lies a vein of deep feeling. Many of his poems evoke the tension in medicine between steadiness

of purpose and tenderness of action. He mourns a young boy run over by a truck. At a clinic in Honduras, in a room is packed with suffering patients, McGuffin reflects, "There is everything in their nothingness." The oldest in a family of six children runs over to him,

I touch and we talk in a universal
tongue,
the smile of my eyes
staring back at our normalcy.^{p87}

The empathic connection is universal and normal. Or at least it should be.

These poems are remarkable for their clarity, intelligence, and engaging images. And, again, McGuffin has the uncommon ability to convey the medical experience with self-deprecating humor, as in "A Doctor in a Dentist's Chair," which begins, "I hate it/on the

other side/when I must be the patient." As he reflects on his own sometimes cavalier or trivializing reassurance to patients, he awaits the dentist's version of the same,

This won't take long,
you shouldn't feel a thing,
we're almost done.^{p79}

Common Illness betrays its title. It is, in fact, an uncommonly fine collection of poems.

Dr. Coulehan is a book review editor for *The Pharos* and a member of its editorial board. His address is:

Center for Medical Humanities,
Compassionate Care, and Bioethics
Stony Brook University
Stony Brook, New York 11794-8335
E-mail: john.coulehan@
stonybrookmedicine.edu

2014 Helen H. Glaser Student Essay Awards

The thirty-second annual Alpha Omega Alpha Helen H. Glaser Student Essay Awards were made in May. This year's winners are:

First prize: Amy Huang of the Class of 2017 at the State University of New York Downstate Medical Center College of Medicine for her essay, "In the Hollow of Her World: Healing and the Defiance of Illness in *Christina's World*."

Second prize: Steven Krager, Class of 2014 at Creighton University School of Medicine for his essay, "The Lullaby."

Third prize: Melissa Pritchard of the Class of 2017 at Boston University School of Medicine for her essay, "23andWe: How Can Doctors Decode Direct-to-Consumer Genetic Testing?"

Honorable mention: Marc Polacco of the Class of 2014 at the University of Iowa Roy J. and Lucille A. Carver College of Medicine for his essay, "The Six-Million-Dollar Physician: A History of Robotics Making Surgeons Better, Stronger, Faster."

Winning essays will be published in future issues of *The Pharos*.

2014 *Pharos* Poetry Competition winners

The *Pharos* Poetry Competition awards were made in April. This year's winners are:

First prize: Bryan Cheyne of the Class of 2014 at the University of Utah School of Medicine for his poem, "Wounded."

Second prize: Alyse Marie Carlson of the Class of 2016 at the University of Iowa Roy J. and Lucille A. Carver College of Medicine for her poem, "The Weight of Marbles."

Third prize: Aisha Harris of the Class of 2017 at Georgetown University of Medicine for her poem, "Sandglass."

Honorable mention: Trang Diem Vu of the Class of 2016 at Mayo Medical School for her poem, "Breast Exam."

Honorable mention: Glenna Martin of the Class of 2014 at the University of Washington School of Medicine for her poem, "Third Year Medical School Encounter."

Winning poems will be published in future issues of *The Pharos*.