

Fear

False Alarm: The Truth About the Epidemic of Fear, by Marc Siegel, 246 pp, \$24.95, 0-471-67869-4, Hoboken, NJ, John Wiley & Sons, 2005.

FEAR IS A BASIC HUMAN EMOTION, shared with nonhumans. But unlike animals, humans can experience damaging, learned fear as well as healthy, circumscribed fear. In *False Alarm*, Marc Siegel, a New York City internist and print-media columnist, shares his experience during the 4 years following September 11, 2001, and thoughts and advice about the pervasive epidemic of fear during that time.

Siegel takes readers through the September 11 attacks; the anthrax scare; and fears about smallpox and gas bioterrorism agents, severe adult respiratory syndrome (SARS), and mad cow disease (bovine spongiform encephalopathy [BSE]). He contends that, although a potential threat to human wellness existed in each instance, perceptions of the threat were exaggerated and excessively personal.

Siegel questions the actions of governmental agencies, politicians, and the media. For instance, he asserts that the Centers for Disease Control and Prevention (CDC) "attached itself to the media megaphone and made us afraid to open our mail." The current administration and major political parties "kept generating fear" over biological and chemical weapons of mass destruction. Leaders created undue fear by predicting impending collapse of our Social Security system or warning direly of either proliferation or usurpation of personal firearms. Out-of-context media bites hyped dangers from rare infections.

Citizens and authorities could have been busy confronting more established enemies, such as AIDS, malaria, and malnutrition, which cause millions of deaths worldwide each year. Instead our attentions were misdirected toward conditions of little or no mortality in the United States. Large quantities of the anthrax and small-

pox vaccines were discarded unused. Meanwhile, little was done to minimize infections from *Escherichia coli*, a potent and far more prevalent food-associated danger than BSE. Internet vendors peddled oral potassium iodide, ostensibly to protect the thyroid against released radiation. Meanwhile there was no debate about how other susceptible organs, including the marrow, would defend themselves in case of a dirty bomb detonation.

Siegel describes how incomplete knowledge of the new threats, manipulation of public perceptions, and profiteering flamed fears into an epidemic of panic. Although responsible for about 150 known cases worldwide, BSE drew disproportionate attention compared with 500 000 annual US cases of salmonella poisoning. Ciprofloxacin was promoted heavily against potential anthrax infection without the necessary scientific basis for its claimed superiority over generics such as doxycycline. Even trusted agencies, such as the CDC and the World Health Organization, and presidential candidates were not sources of tranquility or reason. Media and the CDC breathlessly warned of a severe influenza epidemic because of a few early flu deaths in the fall of 2003. But, then, the capture of Saddam Hussein in mid-December displaced overnight the newsworthiness of flu. Mortality from influenza is much higher, but anthrax, smallpox, and SARS are more feared. We tended to personalize remote fear as if it were a direct threat to life. Travel sequestration during the SARS breakout and beef importation bans were arguable fear-based actions.

Personalization of generalities¹ and extrapolation² have been recognized as human qualities or frailties. They could result in adaptive coping. Instead, Siegel argues, the events of 2001 through 2004 have severely stressed adaptive capacities. He points out that, although fear has served usefully in the flight-or-fight response, unrelenting, dispro-

portionate fear leads to neural alterations, hypervigilance, and maladaptive behavior.

According to behavior scientists, humans modify and reconstruct original judgments in the light of postevent awareness of the outcome.^{3,4} Thus, might one label some of Siegel's year-2005 reassurance of low threat potentials as an instance of such hindsight bias? Not entirely, because, as the events unfolded in real time, he had written columns urging calm, temperate assessments of the true risk potential. For instance, he made the case that less expensive generic doxycycline would have worked as well for anthrax as scarce, overpriced patented products. He tried to quell undue apprehensions stirred by specious duct-tape recommendations during government terror alerts, arguing that agents such as sarin would dissipate within minutes of release, while lethal levels of carbon dioxide would build in a duct-taped room.

Siegel's admission of his own anxieties and internal debates increases his credibility. They are palpable in his ritualistic cleansing to avoid carrying infections home, his transit through the gray ethics of allocating his dwindling vaccine cache, and his account of a family member's fear of inheriting multiple sclerosis. His discussions are supportively annotated, but in-text references and citations for quotes would have been helpful. The reader loses focus in wandering discussions of animal vs human fear, amygdalar circuitry, and a pining for Marcus Welby clichés. For instance, the needless delay brought on by a positron emission tomographic scan while working up his overwrought patient's pulmonary nodule is not directly relevant to the events of 2001-2004. Siegel could have emphasized the double-edged Internet

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even more. Internet debates are particularly relevant in both defusing and detonating worries.⁵ In the end, however, Siegel does offer helpful anodynes, such as a call for restoration of public trust, a return to routines in living, common sense, and faith. It remains to be seen if such generalities can penetrate scabbed sensibilities. A telling conclusion, reminiscent of Orson Welles' 1938 Martian landing broadcast, illustrates how we could be "conned" into fearing.

Siegel's message may not be new or prescient, but it is timely and needed. It carries additional epicenter authenticity because his narratives unfold from New York City. Since the publication of this work, other contretemps—hurricanes, mass transit bombings, news of ineffective vaccines—have generated new anxieties in gullible psyches only just vacated by earlier calamities. At such times we need soothsayers and explicators to redirect the ready-fire-aim mindset. Siegel's book fulfills this role well.

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Pediatric Memoir

Attending Children: A Doctor's Education, by Margaret E. Mohrmann, 212 pp. \$24.95, ISBN 1-58901-054-X, Washington, DC, Georgetown University Press, 2005.

ATTENDING CHILDREN: A DOCTOR'S EDUCATION, by Margaret E. Mohrmann, MD, deserves a special place in the library of each and every medical professional who cares for children of all ages. Although the focus is on the author's

patients, the book is also a spare and elegant memoir of a remarkable physician. The luminous quality of her writing is rare in medicine and rivals the best writers in the English language. Mohrmann's examination of her own development as an engaged and attentive physician is uncompromising and powerful.

Mohrmann describes *Attending Children* as "a book of stories from my career as a pediatrician in academic medical centers." And what a career it has been: chief resident in pediatrics, pediatric intensive care attending, primary care pediatrician, teacher, and theological ethicist. Her express purpose in crafting this book is to allow the stories to compel us to think about "how doctors learn to be doctors—that is how physicians learn to attend to patients, as opposed to how they learn scientific facts. . . ."

The book is divided according to the three meanings of *attending*: "Listening," "Accompanying," and "Waiting." Each part is composed of stories about individual children and their families encountered in the course of the author's career. Writing elegantly in a clear voice, this gifted writer has sifted her experience like sand and found gold.

The clinical anecdotes in "Listening" are culled from the author's years in pediatric residency. Her own words best characterize the key element of this part of the book:

In these encounters I am learning to pay attention to the truth of my patients' situations and needs as they know them to be. I am becoming someone who listens. I had to; the children and their parents were knocking, loudly and insistently, at the doors of both my brain and heart. They woke me up. When I left Baltimore in 1976, I was not the same person who arrived in 1973. I had become a doctor: one who attends the sick.

In the five stories of part 1, Mohrmann relates her encounters with seven children whom she cared for during her residency. All but one died in the hospital. What unfolds is a remarkable exposition of how the author developed her listening skills from attending to children with terminal illnesses. The honesty and clarity with which Mohr-

mann examines her lack of skill, for example, in giving bad news to families, is exemplary. As an intern, Mohrmann assisted in a code during which the child died. She was sent to inform the family:

They were sitting together on the sofa holding hands. I stood in front of them and said, "We're still working on him, but he isn't responding to what we're doing."

His mother looked up at me for a long five seconds and said, "Are you trying to tell me that my baby is dead?"

"Yes," I said. "I'm sorry." Then I left them and went back to Joel's bedside.

I did not know until she asked me that that was what I was trying to say. After all, my colleagues had used the same circumlocution: nothing's working. I had not yet translated that euphemism for myself; Joel's mother did it for me, and I knew she was right. I was horrified, then as now, that I had forced her to tell me that her child was dead.

The stories of part 2, "Accompanying," are from the author's tenure as a physician in a pediatric intensive care unit (PICU). In current academic parlance, she has now moved from being a reporter to being an interpreter:

Although the business of shepherding children and parents through a critical or chronic illness is clearly something I am in still the process of learning in the following stories, my voice in these tales becomes more thoughtful, saying more about what is going on rather than simply reporting what happened.

She uses the stories in part 2 to describe how she was

. . . formed in the P.I.C.U. by staying beside children as they died, staying with parents as they wept or raged, . . . taught me also how to accompany the children who lived. . . . The obligation of the attending physician to be present, to walk alongside, is no less important when patients are facing the dilemmas of living than when they are confronting the distresses of dying.

She used these particular patients to explore "two basic choices" of all physicians:

One is to run away, mentally if not physically, to shy away from the bare truth of loss, the intimations of inadequacy, the grief or anger, or sometimes hardest to bear, the gratitude of those bereft. The other option is to stay, mentally as well as physically, and to remain open to what is there to be known and felt, opened to being moved and thereby changed into a physician who now understands better what is asked of him or her.