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life expectancy. Most of our body systems function automatically in synchronized harmony, but our digestive system, to the contrary, is subject to the whims of our self-image. Forgiveness is one of the greatest blessings of our modern world, but often the person most difficult to forgive is one's own self.

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LINCOLN'S MELANCHOLY: HOW DEPRESSION CHALLENGED A PRESIDENT AND FUELED HIS GREATNESS

By Joshua Wolf Shenk, 350 pp, \$25.
 New York, NY, Houghton Mifflin Company, 2006.
 ISBN-13 978-0-618-55116-3.

LINCOLN'S MELANCHOLY, A RECENTLY PUBLISHED BOOK BY Joshua Wolf Shenk, has received widespread acclaim as a scholarly and exhaustively documented work. Although the emotional aspects of Lincoln's life have been minimized by prominent Lincoln historians of the 20th century, contemporary reviews of primary source materials now provide ample evidence that Lincoln experienced an enduring and at times near-fatal depression.

Lincoln experienced at least 2 major depressive episodes, as defined by the *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition).¹ The first occurred in 1835, a time of intense preoccupation with his law studies and with the illness and subsequent death of Ann Rutledge, a woman for whom he had developed a strong affection. In the weeks following her death, Lincoln spoke openly of suicide and confided to a friend that he was so overcome with depression that he did not dare carry a knife. Clearly unable to care for himself, neighbors took Lincoln in until he was able to live safely on his own.

The second episode occurred in 1841. It is likely that several events, occurring in close order, precipitated this breakdown. Lincoln had broken off his engagement to Mary Todd, possibly because of his affection for another woman. He was also undergoing devastating reversals as a representative in the Illinois State Legislature, stemming from his ill-timed support of public works projects. His law practice, while successful, was becoming increasingly hectic, and his closest friend and confidante, Joshua Speed, was about to marry and move away. Speed later gave an account of the breakdown: "Lincoln went Crazy—had to remove razors from his room—take away all Knives and other such dangerous things—&c—it was terrible—."

Once again, it was the supportive intervention and kindness of friends that nurtured him through the episode. Fortunately, this crisis proved a turning point in Lincoln's life. He arrived with clarity at a reason to live. He developed an

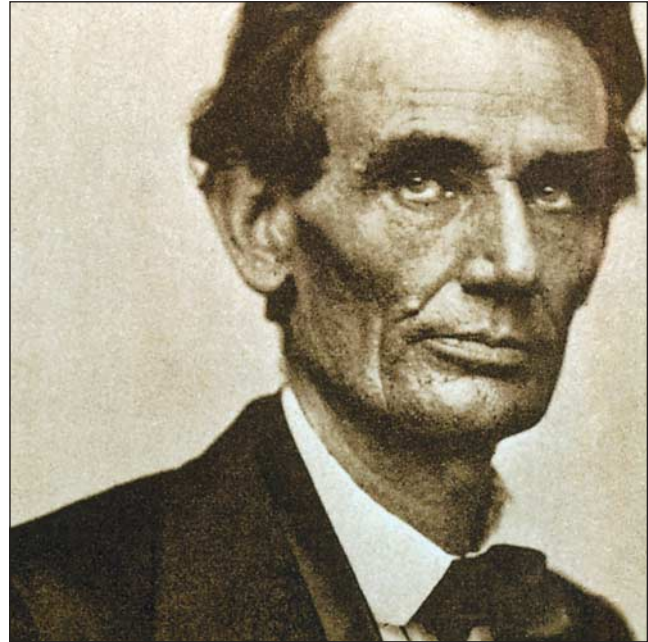


Figure. Abraham Lincoln, 16th President of the United States (1861-1865). Reproduced with permission from Houghton Mifflin.

"irrepressible desire" to accomplish something while he lived, some impact on the events of the day "that would redound to the interest of his fellow man." In this manner, Shenk suggests, Lincoln's illness helped fuel his greatness.

Shenk devotes an entire section of the book to the conscious coping mechanisms by which Lincoln managed his potentially lethal affliction. Of primary importance was the sense of purpose that informed his actions and moderated his manner. He was determined to make some substantive contribution to society for which he would be remembered. He recognized the importance of social engagement and had a wide circle of friends. From an early age, he cultivated the use of humor and storytelling as a means of bonding with others. He read voraciously and found solace especially in the works of Poe and Shakespeare. Finally, he openly acknowledged the fact of his suffering and was a keen observer of his illness. He developed a theory of depression consistent in many ways with modern views. He regarded his moodiness as "a misfortune, not a fault" and recognized that he was constitutionally predisposed to the condition. He also recognized within himself 3 precipitants that gave rise to depression: social isolation, high stress, and periods of bleak weather.

Does this book have any particular relevance for physicians? In 2003, a consensus statement published by *JAMA* pointed out that depression and suicide in physicians is an area historically neglected by the medical profession.²

While the prevalence of depression among physicians appears to be at least as common as in the general population (estimated

at 12% and 18% for men and women, respectively),^{3,4} numerous studies have documented higher rates of suicide in physicians compared with the general population. Reported relative risks among physicians have ranged from 1.1 to 3.4 in men and from 2.5 to 5.7 in women.^{3,4} While data are scarce with regard to risk factors leading to suicide among physicians, available evidence indicates that the primary risk factor is an inadequately diagnosed or treated mood disorder.⁵

It has been pointed out that physicians with depression face a number of barriers to seeking and receiving care. These include lack of time, associated stigma, cost considerations, and practical concerns regarding disclosure. Practicing physicians with known emotional disturbances may encounter difficulties in obtaining health and malpractice insurance, medical licensure, and hospital privileges. They may face unwarranted bias from colleagues, given the low priority accorded to physician mental health within the culture of medicine.^{2,6}

While *Lincoln's Melancholy* is framed as an example of a productive life achieved in spite of chronic depressive illness, the book is also an account of extreme emotional pain and may well serve as a cautionary tale to those who live with their depression in silence. Modern-day treatments have well-established profiles of efficacy and safety.^{7,8} Of the recommendations made in the consensus statement, several are especially compelling. Physicians should establish a regular source of health care, learn to recognize depression and suicidality in themselves, and actively seek treatment when appropriate.² Additionally, the culture of medicine must accommodate the reality of untreated mood disorders among physicians and eliminate the barriers currently hindering the process of seeking and receiving care.^{2,6}

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INESCAPABLE ECOLOGIES: A HISTORY OF ENVIRONMENT, DISEASE, AND KNOWLEDGE

By Linda Nash, 332 pp, \$60.
Berkeley, University of California Press, 2006.
ISBN-13 978-0-520-24887-8.

THIS BOOK SURVEYS THE HISTORY OF ENVIRONMENT AND health in California, more particularly in the Central Valley. It examines regional ideas about the dependence of illness on air, water, and geography. Linda Nash emphasizes the extent to which 19th-century physicians held an ecological perspective. She argues that this wisdom was largely lost around 1900 with the rise of germ theory but that it reemerged after 1960 in critiques about the use of pesticides. Nash's argument entails too much environmentalist romanticism, and its sweeping indictments against "reductionism" and "capitalism" are not convincing. The book, however, does make a significant contribution to the history of environmental quality.

The first half of *Inescapable Ecologies* consists of a broad sketch of disease experience on the California frontier in the 19th century. The large and fertile valley that stretched north and south from Sacramento was particularly challenging for settlers due to seasonal but otherwise unpredictable appearances of malarial, typhoid, and other fevers. Early public-minded physicians—notably Thomas Logan, president of the American Medical Association in 1873—were deeply interested in medical geography. In studying how the valley differed from areas east of the Rockies, they noted its hot summers, great diurnal temperature variations, and semitropical winters, along with the large stretches of stagnant water, many of which were results of mining and irrigation. They reasonably believed that miasmas from these seasonal swamps produced ill health, particularly in the young, weak, and newly arrived, by disrupting the delicate balance between their bodies and their surroundings. Logan, raised in South Carolina, warned that the ongoing environmental disruption of the valley could make it as unhealthy as the rice lands of his former state.

Nash suggests that this nuanced ecological perspective was displaced in the early 20th century by the simplistic "modem" view that the important diseases were the result of parasitic infections. Medical promoters of the "new public health," together with their allies in engineering and entomology, suggested that infectious disease could be controlled in the Central Valley through the elimination of the vectors that enabled microbes to travel and to breach the skin. They blamed the continued existence of disease on immigrant "carriers" and on the careless behaviors of marginal groups. Nash emphasizes that this perspective led to errors (eg, the claim that plague had been imported and the search for animal carriers of valley fever) and to extreme, ineffectual actions (eg, campaigns to exterminate all squirrels as a way to eliminate plague).