Family Practice Forum

Take These Hands: An Address to Graduating Family Practice Residents

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What does an internist say to nine young doctors about to begin their own practices as family physicians? Should I tell them, as Alan Alda of *MASH* fame might, that they are great, almost godlike, to have gotten into and out of medical school and then survived three years of residency training in a family practice residency program? Or should I say, as Art Buchwald might, that we physicians of the older generation have given them a perfect world in which to practice—what with the diagnosis-related groups—and we really don't want them to interfere with it. Or should I repeat what an air-conditioning repairman remarked, as I sat sweltering in my office: "Tell them that they should know how to do something with their hands."

Good advice, I thought. The way you use your hands plays an important role in determining the kind of care you give your patients. Your hands can sense the roughness of a thrill, the fullness of a pulse, the rubbery nature of a lymph node, and the rigidity of a belly. It is your hands that gather information to support or rule out a particular diagnosis. But do you actually need to palpate the abdomen and percuss the chest with the availability of computed tomography, ultrasound devices, and scopes—to say nothing of nuclear magnetic resonance, which is becoming more available every day? Can't the machines do everything your hands can, and do it better?

"Definitely not!" said Dr. Dickinson Richards, a Nobel laureate for the part he played in the development of cardiac catheterization. As president of the Association of American Physicians, he told the story of a distinguished professor of radiology who has a stethoscope encased in glass over his desk. It hangs there like an ancient medical tool, rendered useless with the advent of new techniques used to peer into the body.

Dr. Richards questioned this disposition of the stethoscope on the basis of its importance to a close, personal, physician-patient relationship, pointing out that

> in order for the stethoscope to function, two things have to happen—there has to be, by God, a sick man at one end of it and a doctor at the other. The doctor has to be within thirty inches of the patient and it might not be too presumptuous to suppose that in being so close to his patient, the doctor might see or feel or otherwise appre-

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hend something more beyond the momentary lubdub in the earpiece.

How can you calm an apprehensive patient, comfort a grieving mother, and encourage a frightened child unless you are close enough to touch them? As a young father, I can well remember calling our pediatrician, Dr. Emily Bacon, in the middle of night and telling her that Brooke, our youngest, was having a terrible time with the croup. He was on antibiotics and a cough medicine. I had held him in the bathroom with the shower running full blast for more than an hour. All to no avail. He was frightened and so was I. Within half an hour, Dr. Bacon arrived. She examined Brooke, took him in her lap and, as she slowly rocked back and forth, gently stroked his forehead. After an hour, Brooke was obviously better. She got up, put him in bed, gave me a reassuring pat on the back and said, "Don't worry. He's going to be all right." And so he was. It was almost miraculous. No drugs. Just a wonderful woman, someone we both trusted, gently stroking a croupy child. Emily Bacon knew how to use her hands—she was skilled in medicine's art.

My father was an internist, yet his practice was similar to what yours will be. He took care of families, young troubled kids, worried parents, cantankerous octogenerians, cooks, and chauffeurs, too. He, like Emily Bacon, was skilled in medicine's art. He had to be, for through most of his life there was little he could do to cure disease. Patients died or got well in spite of his treatment.

The remainder of his patients had symptoms for which he could find no organic cause. The trick was neither to say, nor do, too much. William Thayer, a distinguished physician in Baltimore and a contemporary of Osler's, also knew the value of "taciturnity"—

> that words change color like chameleons and return like boomerangs and that strong medicines should not be poured into patients since the greatest assistance is given by simple physical and mental means and the careful employment of such drugs as have been adequately studied.

Your specialty was born 15 years ago, not because there was too much science, but because there was precious little art; not because there were skilled specialists for every organ, but because no one seemed to be thinking or caring about the whole being. Today with medicine's vast technical capabilities and huge array of drugs, you as gatekeepers must temper what you promise, use restraint in the medicaments you administer, and be willing to seek help from other specialists when you need it. But above all, you must be as skilled in medicine's art as in its science.

Three years ago when you graduated from medical school, you knew more about the whole of medicine than you ever will again. Tonight as you finish your residency training, you know more about the whole of family medicine than you ever will again. Even so, there is much more to be learned, and it is of this continuing educational process that I now wish to speak.

My chief, Dr. Francis Wood, spoke at the commencement of the medical students at the University of Pennsylvania Medical School last year. He spoke of one kind of learning that had been of value to him, and I think it will also be helpful to you.

> 'There is a remarkable fund of information,' he said, 'of a more or less practical nature which would be of real value to physicians and which is largely unpublished because no one knows who made the discovery in the first place. It is passed from one physician to another by word of mouth. These items have to do with the management of all sorts of situations which confront us in our medical lives and our practices.'

He called his anecdotes "tricks of the trade" or "new and nonofficial remedies." I would categorize them as part of medicine's art. Let me tell you of a remedy that Dr. Wood heard from a colleague, and then a trick I learned from my father.

One night Dr. Wood saw a patient with renal colic. As was the custom, he gave him a dose of morphine and relieved him of his pain. Upon hearing of Dr. Wood's treatment the next day, Dr. Thomas Fitzhugh, a colleague, said, "Next time, put him in a hot tub. It usually works quite miraculously, relieving the intense pain in less than a minute. No one knows exactly how it works."

My father was interested in sickle-cell disease long before electrophoretic identification of the hemoglobinopathies became commonplace. To make the diagnosis, he wrapped a rubberband around the end of a finger; he waited for several minutes, until the oxygen saturation had fallen

significantly, before puncturing the finger and taking a blood sample. Sickle-shaped cells were readily found on the slide, even in patients with sickle trait.

While there is much to be learned from your colleagues, there is even more to be learned from your patients. Nowhere is this clearer than in the pages of a small book entitled *Epidemiology in a Country Practice*. It was written by William Norman Pickles and published in England in 1939. If you have never read it, I urge you to do so, for it is a remarkable story of what can be learned about disease in a rural practice—the kind of a practice that some of you may be starting in the very near future.

Pickles lived and practiced in England, in Wensleydale, "a peaceful valley surrounded by noble hills in whose villages there was hardly a soul, man, woman or child, whom he did not know personally." Pickles felt "that there is something in country practice—the deep bond of friendship, which exists between doctor and patient—that breeds content."

The object of his book was "to stimulate other country doctors to keep records of epidemic disease" and "to put before them the advantages medical men practising in the country have for the acquirement of medical truths of the highest order."

During his long life, he determined the incubation periods of the common infectious diseases by studying the manner in which they spread through his beloved valley. On the basis of his observations, he was able to predict not only the occurrence of epidemics, but also their duration. His study of 150 patients with catarrhal jaundice led him to valid conclusions as to the disease's incubation period, its infectious nature, and mode of transmission.

While the car, train, and plane have made epidemiologic studies of the kind that Pickles carried out far more difficult, your close relationship to families for long periods of time gives you advantages not enjoyed by other specialists for the study of disease, especially its multifactoral nature and, in particular, the effect of the environment on gene expression. Almost 50 years ago, Pickles wrote, "You as practitioners are in a position to supply facts from your observation of nature. It's your plain duty to make use of this unique opportunity." I sincerely hope that you will do so.

Answers and Discussion

1. B, C, and D are true. There is evidence that the development of a diurnal sleeping pattern and uninterrupted sleep periods are related to CNS maturation as well as other factors, but sex differences in the development of these patterns have not been shown.[1] Premature infants, infants of heroin- or methadone-addicted mothers and neurologically damaged infants may all show disrupted sleep patterns.[2]

Normal newborns sleep an average of 15 hours in each 24-hour period; the normal range seems to be 12 to 18 hours.[3] Most newborns are unable to remain asleep for longer than 3 to 5 hours at a time.

Periods of sleep gradually coalesce, with 70 percent "settling" at three months and 83 percent at six months.[4] "Settling" in this study was defined as uninterrupted sleep from 12 midnight to 5 AM, a definition not all parents would find ideal.[1]

2. C and D are true. A and B are false. It is generally well accepted that young babies cannot be "spoiled" by prompt attention to their cries. Bell and Ainsworth[5] showed that babies who were responded to quickly and consistently actually cried less by the end of the first year. A baby this age, if not interfered with, will sleep as much as needed and will wake up when rested, hungry, or uncomfortable. Many advisors suggest moving the baby out of the parents' bedroom, however, so that they do not mutually awaken each other with the usual sounds of sleeping and moving at night.

Total sleep requirements during the first year do not change as dramatically as one might think. One-year-old children frequently sleep only an hour or two less than newborns. The differences lie in the consolidation and regularity of sleep periods.[1]

3. A is true; B, C, and D are false. Sleeping and bedtime problems in children can precipitate child abuse.[6] Family physicians are often in a unique position to recognize children at risk for neglect and abuse.[7]

Contrary to popular belief, children who once begin to sleep through the night are not always able to maintain this pattern. Moore and Ucko[4] found that 40 to 50 percent of children who once slept through the night began waking again months later. More than 40 years ago Gesell[8] contrasted the ease with which a one-year-old could be put to bed with the difficulties many parents experience with preschool children. These problems range from elaborate bedtime routines, curtain calls for parents, special toys and lights to tearful night awakenings. Beltramini and Hertzig[9] found that 62 percent of his sample of preschool children had regular problems with nightmares. Although frequent, night terrors are much less common than nightmares, and unlike the case of nightmares, the child is not easily arousable and has no recall of the event. The onset of night terrors in late childhood or frequent attacks over several years may suggest a more serious disorder.[1] In general, both nightmares and night terrors abate with age.

4. A, C, and D are true. B is false. Various treatments for sleeping problems have been suggested, although their effectiveness has not been systemically evaluated. Anders and Keener[1] do not endorse the use of hypnotic drugs. Bedtime rituals, if not allowed to become too complex, can give security[10] and behavioral cues to two- and three-year-old children. Leach[11] proposes returning to the crying child at short intervals and briefly repeating part of the bedtime ritual. Jones and Verduyn[12] report success with behavioral interventions that include sitting with the child until he is asleep. The time of sitting with the child is gradually shortened.

Sleeping problems should not be approached in isolation. As in all cases of behavioral and developmental problems in children, it is important to do a careful physical examination and elicit a complete history including "sleep milestones," both day and night sleeping patterns, family life events, stressful interpersonal relationships, and prior management attempts.

References

1. Anders TF, Keener MA: Sleep-wake state development and disorders of sleep in infants, children, and adolescents. In Levine MD, Carey WB, Crocker AC, Gross RT (eds): Developmental-Behavioral Pediatrics. Philadelphia, WB Saunders, 1983, pp 598-601

2. Fraser VE: Infant temperament and sleep patterns, thesis. School of Nursing, University of Oregon Health Sciences Center, Portland, Oregon, 1982

3. Klackenberg G: Sleep behaviour studied longitudinally. Acta Paediatr Scand 1982; 71:501-506

4. Moore T, Ucko LE: Night waking in early infancy: Part I. Arch Dis Child 1957; 32:333-342

5. Bell SM, Ainsworth MDS: Infant crying and maternal responsiveness. Child Dev 1972; 43:1171-1190

6. Illingworth RS: The Normal Child. Edinburgh, Churchill Livingstone, 1979, p 246

7. Miller KA: Child abuse and neglect. J Fam Pract 1982; 14:571-575

8. Gesell A: The First Five Years of Life (ed 2). New York, Harper & Bros, 1940

9. Beltramini AV, Hertzig ME: Sleep and bedtime behavior in preschool-aged children. Pediatrics 1983; 71:153-158

10. Ames LB: Sleep and dreams in childhood. In Harms E (ed): Problems of Sleep and Dream in Children. New York, Macmillan, 1964, p 21

11. Leach P: Your Baby and Child. New York, Alfred Knopf, 1981, p 300

12. Jones DPH, Verduyn CM: Behavioural management of sleep problems. Arch Dis Child 1983; 58:442-444