Guidance for the doctor's physician child

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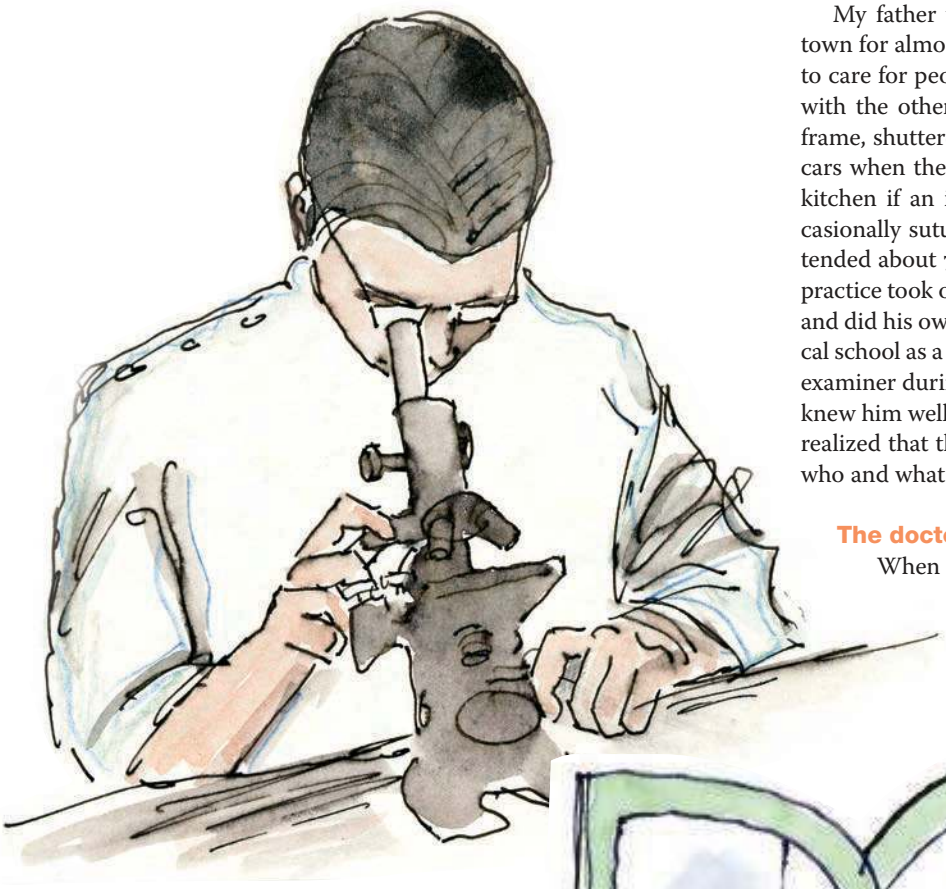


I have been through the family ritual with my sibling of disposing of our deceased parents' personal effects in preparation for selling the family home place. We could not confront this for a long while, but a vacant house does not do well, even with a caretaker, and an acquaintance of my parents who had always liked the house wanted to buy it. I had to deal with the past, which was inextricably linked to my present work.

My father was a solo general practitioner in a small rural town for almost 50 years. He was available virtually all the time to care for people, occasionally trading some evening coverage with the other GP in town. He worked out of a small, white frame, shuttered office, made house calls, saw patients in their cars when they came to the back of our home, or even in our kitchen if an injection or some suturing was needed. He occasionally sutured pets that had been injured in traffic. He attended about 700 home deliveries, and in the early years of his practice took out tonsils in his office, casted extremity fractures, and did his own radiology (he had worked an extra job in medical school as a radiology technician). He was the county medical examiner during most of his practice. Adults around town who knew him well would usually greet him, "Hi, Doc." Much later, I realized that this salutation was the ultimate in acknowledging who and what he was.

The doctor and his wife—A team

When he finally closed his practice, on the advice of a close physician friend, the office and all its equipment were lovingly disassembled and packed by my mother, who for decades had been the business-receptionist staff and prob-

ably dispensed telephone advice to protect him from overwork. It was "their" practice in many ways. I know she did the packing (she said he couldn't bear to do it), because when I found them, all of the surgical instruments and utensils were grouped, wrapped in white towels and labeled (and dated); even the stirrups to the patient examining table were tied together and labeled, left and right. Everything had been placed in sturdy boxes and stored in their backyard garden house—20 years ago. I knew "the office" was all in there, and could not imagine dealing with it. But a local historical society wanted some items to complete a rural doctor's office museum, and this seemed fortuitous because it would preserve some of this tradition of rural medicine as practiced in the past.

Transfusion of guidelines for practice

What I did not expect, after almost 40 years of my own career in medicine, was that I would reconnect so forcefully with this man whom I idolized and wanted to follow. I found myself drawn into the intimacy of his medical practice through handling his instruments and disposing of his office effects. His advice, dispensed during my medical school years and residency, flooded back. I realized that many of his suggestions about caring for patients had been skillfully and subtly transfused into me:

- If the patient's initial symptoms and history are confusing and do not lead to a clear diagnosis, shift questions to the review of systems, which will often provide the diagnostic clue(s) needed.
- Wash your hands and clean the stethoscope's diaphragm before you begin examining the patient and let them see you doing it.
- For patients who are anxious and need to feel more in control of the medical examination, squat down and begin by examining their feet, feeling for pulses and pressing for edema.
- Write out specific instructions for therapy, especially any changes in medical doses, because errors in medications are frequent and cause many health problems.
- You can't communicate too much with the patient (and family). Discuss the illness as time permits, but send the patient a copy of your office notes, laboratory results, and any letters sent to referring physicians.
- Do the test yourself (analysis of a fresh urine sediment, peripheral blood smear or sputum gram stain), if an immediate result is important.

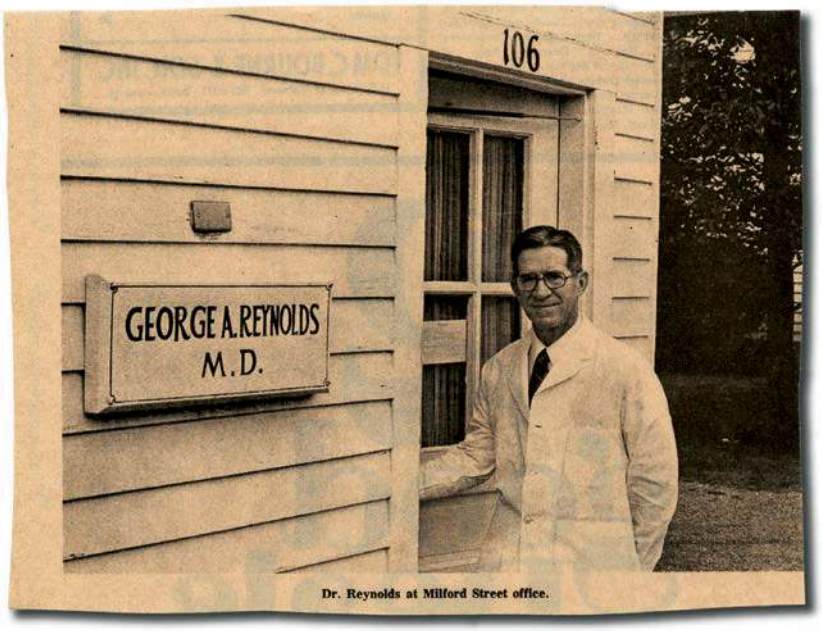
When I touched the instruments and imagined how he had used them, a film of tears welled up. There was the wonderful Zeiss microscope for viewing blood smears and urine sediments (and I wondered how he had gotten along without it for the semester he loaned it to me for my medical histology course). There were long-handled obstetrical forceps, a Boivé cauterizing machine, cervical biopsy forceps, casting frames, a needle to puncture a maxillary sinus for drainage, and a lancet for a myringotomy. These were things I had never used or done, but then he had never managed a patient on a ventilator or been involved with a bronchoalveolar lavage. When I was young, it seemed that he was able to do everything. Though he had all the tools for minor surgical procedures, he always seemed cautious and never a risk taker. He did not prescribe many medications, especially antibiotics. Not giving out an antibiotic for viral upper respiratory infections, he told me, put him on the defensive with some patients who always expected to get one from a doctor. He was criticized for not doing enough treating.

I remembered that he had wanted to train in otolaryngology, but the depths of the depression years in the 1930s precluded that, and he said the prospects of rural practice seemed an attractive option. He always liked to examine and treat naso-oropharyngeal problems, and I realized I did also, and that really the lungs, where I have practiced, were just an extension from the upper respiratory tract.

I was aware that he had graduated second from the top in his medical class at a first-class school; he was smart in a very logical but thorough manner that made you feel he was always examining all the possibilities. He read incessantly, making neat notes on a pad. He ripped and filed journal articles. He attended CME courses faithfully—his recreation, I thought. He was a good diagnostician, as I learned when a specialist colleague of his told me, "Your dad only refers for confirmation and has the problem all figured out in the referral letter he writes." Attached to a pack of obstetrical instruments was a newspaper picture and caption about a young honors graduate from a local university who was going to graduate school in engineering, with a note written on it (by my mother) that this man was the last infant he delivered. And why wouldn't he be interested in following the career of an alumnus of his prenatal care program, as I have followed the students, housestaff, and fellows in our training and research programs?

Grateful and loving payback

But the gratitude felt by patients may never be known completely by the physician, or it may come unexpectedly. This occurred for my father, as his life was closing. He was nearly 90 years of age, had chronic dementia, and lived in a local nursing facility. He seemed particularly well cared for. One night I commented on this to his charge nurse. She looked directly at me and remarked, "Your father borned me and a couple of the other staff working here also, and he took care of us as



Dr. George A. Reynolds. Photo taken from the *Caroline Progress*, weekly newspaper of Caroline County, Virginia, Bowling Green, Virginia, June 23, 1976.

children, too. We take care of Doc." I hoped, though never knew for sure, he could feel their devotion and admiration, but we, his family, certainly did.

Although doctors have to give a great deal of themselves to patients and the community, perhaps at the cost of some neglect to their families and personal interests, the practice of good medicine helps people immensely, and it is appreciated.

Acknowledgment

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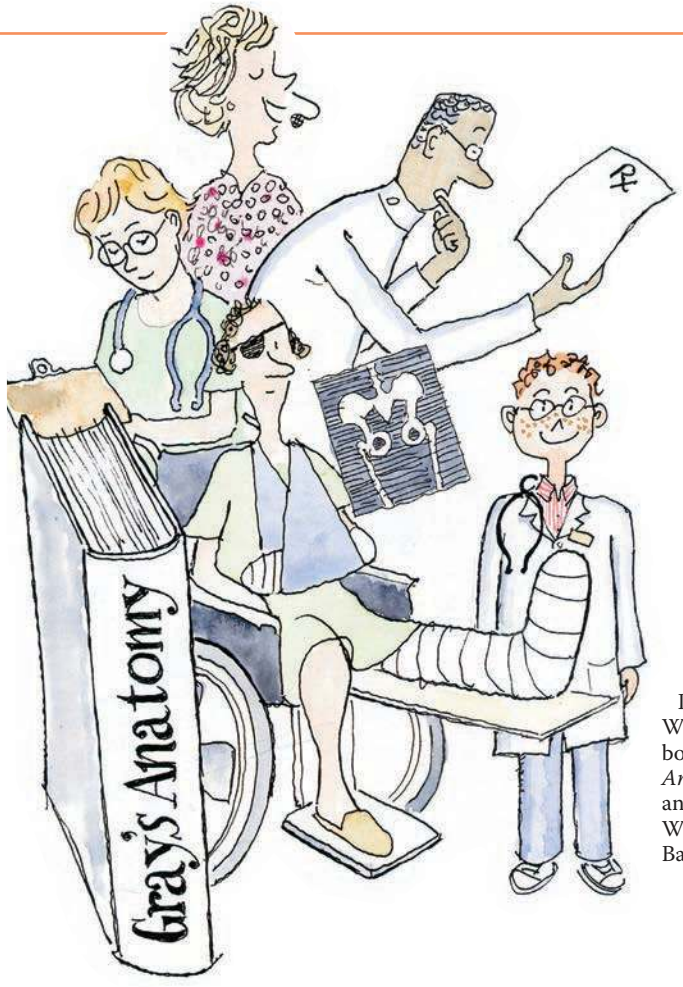

What Doctors Depend On

Intuition, insight, and interns
Patients' stories
Nurses' stamina
Pharmacists who can decode cryptic script
Resilient receptionists
Computers, CAT scans, and coffee
Gray's Anatomy
Second opinions
Gumption
And grace
Occasional comic relief
Stethoscopes, X-rays, and common sense
Seeing, touching, and talking
People who don't expect miracles
And people who do

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