Primary Care of the Premature Infant, Dara Brodsky and Mary Ann Ouellette, Philadelphia, Saunders Elsevier, 2008, 312 pp., $59.95, hardback.

The textbook Primary Care of the Premature Infant is written by a physician, a pediatric nurse practitioner, and 36 additional contributors. Written in a “team approach to care” spirit, it is easy to read and has proven to be a useful addition to my library.

The chapters are arranged by physiologic “issues,” such as the neurosensory system. Each commences with an overview of the issue and is followed by A, B, and C subchapters that explain specific pathology in more detail. Brief explanations of the pathophysiology of each systems disease process and how it would have been addressed in the hospital is both helpful and interesting, especially for those of us who do not do NICU care. In the subsequent subchapters, the authors go into much more detail about sequelae for both the child and family. A particularly useful example is the chapter on colic, which seems to be a relatively simple and straightforward problem. However, research shows that the quality of crying differs in premature babies and may be perceived as more irritating and lead to increased caregiver stress.

The book makes liberal use of tables, algorithms, and pictures. In the subchapter on enteral tubes there are five pages of pictures of different types of tubes with excellent descriptions of how each is used in various settings, such as in an infant that requires constant gastric decompression. Also useful in this chapter is a table on gastrostomy tube trouble shooting.

One of the final chapters is on supporting the parents of the premature infant. When recommending the book, I urge residents to read this chapter first. Information is included on educating parents regarding the normal behavior of a premature infant, normal variations, and coping with the many associated stresses of caring for a premature baby. Anticipatory guidance for any parent is one of the most important things we do at the well-child visit, and the premature infant can challenge our knowledge base. This book provides the information we need to help advise parents. There is also a section on understanding the grief process that parents may experience on the loss of the “wished for, healthy baby.” Mothers in particular may be at increased risk of postpartum depression following the birth of a preemie, and we know that this can affect infant development. I especially appreciated the recommendations provided on approaches to this question.

This text is appropriate for residents and practicing physicians who provide infant, child, and adolescent care. The specialty nature of the material is such that it is less likely to be useful for medical students. Advances in technology and neonatal care have led to increased numbers of surviving and healthy premature infants in many family medicine practices. I recommend this book for any practitioner’s reference library that cares for this population.

Karen Bartley, MD
Carolinas Medical Center
Matthews, NC

Books That Shaped Family Medicine


In just 15 years, from 1966 to 1981, family practice evolved from a highly debatable abstraction to the third largest graduate medical education enterprise in the United States (behind internal medicine and surgery). Many writers, including John Geyman and Robert Taylor, have chronicled the history of family practice, but the clearest description of the theoretical basis of the new specialty belongs to Gayle Stephens. A humble man from Kansas who counted his blessings as a witness to history, Gayle became the towering voice for family practice as a specialty of reform within medicine.

The Intellectual Basis of Family Practice is an anthology of collected essays and lectures Gayle gave during those first years when family practice developed out of the ashes of general practice. Gayle and the other founders of the specialty knew that the essence of the physician-patient relationship must be preserved in a new intellectual and academic context. Gayle drew from many sources, most notably the behavioral sciences, ethics, and religion, to mold and describe not only what family practice was but also what it should become as a specialty.

The book is divided into five parts, containing 24 essays and lectures. The first part (“Why Family Practice?”) makes the case for family practice as a legitimate and necessary medical care discipline. The second part presents family practice as a reform specialty and contains perhaps his most famous essay, “Family Medicine as Counter-Culture.” The third and fourth sections cover family practice as a clinical discipline, arguing for the central role of the behavioral sciences and the healing nature of the
The final section discusses the struggles family medicine endured in an academic world increasingly enamored with reductionistic science.

An appropriate closure of this review is to republish “A Decalogue for Family Practice Residents Entering Practice,” presented to the Department of Family Practice at the Medical University of South Carolina in 1979 and placed as an appendix to the book:

DON’T give up the reform ethos. Keep on the side of responsible change in education, practice, and social justice.

DON’T lose faith in the power of relationships and the therapeutic use of self. (Or, don’t hire anybody to save you from spending time with patients.)

DON’T turn your practice into a mere business. It may not be less, and it should be a great deal more.

LEARN to distinguish between uncertainty and ignorance; only the latter is remediable and potentially culpable.

FIND some way to practice charity; willingly give a part of your services consistently to those who cannot pay.

TRY to see that the groups in which you hold membership are at least as moral as you are.

HUMANIZE and personalize the microsystems in which you work.

ACT at all times as if the patient is fully autonomous; the weaker the patient is, the more vulnerable you are to violating his/her personhood.

REFLECT on your professional experiences. Within the bounds of protecting patients’ privacy, think, talk, and write about your clinical stories.

WORRY less about patients becoming overly dependent on you than your becoming undependable.

Joseph E. Scherger, MD, MPH
University of California, San Diego

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chfm@aafp.org
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