NOTES ON THE ART OF INTEGRATIVE PEDIATRICS…IN THE KEY OF G

Laurence I. Sugarman, M.D.

Keynote Address
Second Annual Pediatric Integrative Medicine Conference
June 29, 2001
Minneapolis, MN

Thank you…

Now, the invitation requested that I deliver a "Keynote" address. I thought I ought to make sure that I understood what that meant, to get at the full meaning of the word "keynote." These meanings, after all, are the heart of therapeutic communication so we really ought to pay close attention to them. My big Oxford American Dictionary defines *keynote* this way: "(1) prevailing tone or idea; and, (2) musical note on which a key is based"…When I read that, here is what I said out loud: "Gee!... It's a word that's about both ideas *and* music!"

On that note, I found myself contemplating how often I have been a musician, sometimes earning my living that way, and how I have successfully avoided learning much music theory. Pete Seeger said, "Hell, there are no *notes* on the banjo. You just play it." When asked if he ever studied music, he replied, "Not enough to hurt."

Then I remembered reading somewhere that the Italian film director Federico Felini was asked during a tight shooting schedule if he wished to review the previous day's takes. He whispered, "Don't tell me what I am doing! I don't want to know!" He wanted each scene to remain mysterious to the conscious mind, a covert provocateur in the process that was unfolding.

I began to prepare this keynote address with these thoughts in mind and I wondered: How does one find the art in the daily treatment of children and adolescents? What are the essential elements of that art; the keys and notes to play? For that matter, what is my music? What are the themes in my practice that make it creative and purposeful? Why are those themes important to me? I decided to figure it out and tell you what I learned.

In order to do that, I have spent some time on the front lines of primary pediatric care, reviewing each day's scenes and hearing the music. From this study I offer you what I have come to believe is the essence of integrative pediatrics. This will not be a research-based talk because there is not enough evidence to support the art - as distinct from the science - of integrative pediatrics…yet. However, there *is* good evidence to support the efficacy of applied psychophysiology, primarily hypnosis and biofeedback. These, I believe, are the essential instruments in the art of Integrative Medicine. The papers cited in your syllabus provide some of this evidence. In this talk I dig beneath the surface to find the principles supporting our creative work in helping children heal themselves.

I will focus on three areas. First, I will talk about how my interest in mind-body pediatrics began. Next I will present an overview of how we integrate hypnosis and biofeedback into our general pediatric practice. Finally I will discuss what I have come to believe are the essential "key notes" of integrative pediatrics.

I start with my evolution as an integrative practitioner not because it is unique but because it is not. My own formative experiences are probably much like yours. I have chosen the words and ideas that follow to stir your memories and beliefs, both conscious and not-yet-conscious. You can use these words and understandings to affirm and challenge and change your reasons for being here and doing the good work you do.

Now, I earn my living as a general pediatrician running a solo practice in an office in Rochester, New York. I did not go to medical school or train in pediatrics with this intention at all. I imagined that I would teach other doctors, do research, and develop a deep and satisfying mastery over some reductionistic aspect of allopathic medicine, like many of my scholarly mentors. Before medical school I worked as a hospital ward clerk, nurse's aid, phlebotomist, lab technician and physician assistant. In short, I had taken an apprenticeship in the underpinnings of Western allopathic medicine. I had graduated with honors from the school of "scut." I felt ripe to be *in charge of something*.

Then, in that crucible we call pediatric residency - facing the fears of sick children and their families, through those long days, nights and early morning hours - my understanding of therapy and healing began to change. There was a 12-year-old boy brought to the Emergency Department in *status asthmaticus* and respiratory failure. I gave him oxygen, IV isoproterenol, and steroids without much effect and, just as he was about to be intubated, with the laryngoscope at his mouth, he somehow mustered the ability to whisper, “Wait!” then suddenly improved his oxygenation, sat up and smiled. There was the 8-year-old adopted daughter - the youngest in the family - with metastatic adrenal carcinoma. She found a way to hang on to her life for several weeks until all of her family had come home from around the world. On Christmas Day, with her parents and six brothers and sisters at her bedside, she died. There was story upon story: mounting irrefutable evidence of the raw will of so many kids who got better or sicker despite our efforts.

These encounters, like those I am sure many of you have experienced, led me to realize that I was *barely in charge of anything* when it came to *other people’s* healing. I had developed my expertise in physical diagnosis, pharmacology, ordering laboratory tests and procedures with efficiency. By the time I was Senior Pediatric Chief Resident, I could thread an IV or flexible tube into almost anything. But, as Sir William Osler observed on daily rounds, a hundred years ago, “We administer medicines, about which we know little, to treat illnesses, about which we know less, to people, about whom we know nothing.”

I began to understand the truth and mystery of Eric Cassel’s assertion that all healing “consists in, and only in, allowing, causing or bringing to bear those things or forces, (whatever they may be) that already exist in the patient.” I wanted to be a part of learning whatever those forces were.

This desire fueled my decision *not* to pursue a career in academic medicine and instead to put up a sign and create a general pediatric practice. No more limiting my learning about medicine and healing to reductionistic kernels. I decided to go non-linear. I looked forward to

being absorbed into the full spectrum of pediatrics, into what Jon Kabat-Zinn and Zorba the Greek call the "full catastrophe."

As my practice evolved, I became even more aware of the resilience of children and their tremendous capacity to change and grow. Of course, their business is discovering how their minds and bodies are connected. The poetry of the child's symptoms intrigued me: The abdominal pain that came when the boy's father ignored him; the exquisite timing of the episode of asthma, disrupting the family vacation; the power of the child's enuresis to bring the parents together.

This fascination with the child's mind drove me to search for the skill set that would best allow me to both honor the child's resilience and facilitate therapeutic change. I thought: there must be some methodology, some studied system that would allow for the integration of each young person's indomitable will in medical therapeutics.

I learned about Karen Olness by reading Bill Moyer's interviews in his book, *Healing and the Mind*. I read the book she wrote with psychologist Gail Gardner, *Hypnosis and Hypnotherapy with Children*, with *children*. I absorbed Dan Kohen's exquisitely written papers describing hypnosis in the emergency room and other settings. I said: Gee! This is what I have been searching for! This is that skill set: the permissive cultivation of concentration and imagination for the purpose of psychophysiological change.

Now, hungry to learn more, I participated in an introductory hypnosis workshop, sponsored by the Society of Developmental and Behavioral Pediatrics and taught by the wonderful faculty team of Drs. Karen Olness, Dan Kohen, Leora Kuttner, Candy Erickson, Jud Reaney, and the Reverend Jim Warnke. It was more than a "Gee" experience. It was the realization that healing is fundamentally about therapeutic language and relationships. Jim Warnke says, "Hypnosis is art and science masquerading as conversation." I was handed the tools of mind medicine with children: the meaning of the language, the physical cues, and the power of expressing faith in our patients.

At this point I must add that in the years since that first workshop, I have attended, taught and directed many more workshops. Each has brought new delights from the experience of watching hundreds of child health colleagues enjoy similar epiphanies, again and again. I encourage each of you to enjoy the same discoveries.

After that first workshop, I read voraciously in the field of pediatric mind body medicine, especially hypnosis. I sought out Dan Kohen as a mentor. I consider Dr. Kohen to be the world's finest teacher of therapeutic communication with children. He served as a clinical consultant, reviewing and critiquing my videotapes of my work with healing children. I will always be grateful for his kind teaching and friendship.

As I developed my skills, I arranged consultations for those youngsters in my practice living with problems known to be amenable to hypnosis: migraines and other pain syndromes, sleep initiation problems, habit disorders, enuresis and adjustment to chronic disease. **[Video montage begins]** These 30-45 minute hypnotic encounters were exciting and rewarding. Before I was aware of it, I was being drawn into relationships with children and adolescents of increasing depth and intensity. I reveled in the creative minds of the kids in my practice. They, in turn, sensed my enthusiasm and interest in their problems.

I learned more than I ever expected from them. One particular young man, 14-year-old Matthew, broadened my perspective of the clinical value of these skills. He came to see me because of his disabling and frequent migraine headaches. At our first visit together I knew I was dealing with a remarkable person. He asked if it was okay if he read the books he had gotten from the library about hypnosis. I said it was okay as long as he could teach me, too. As is my usual practice, I asked him to monitor how his head felt on a calendar using a scale from zero (normal) to ten (the worst his head could feel). Two weeks later he returned with calendars and a scale that ranged from negative ten to positive ten.

Looking at those calendars, I asked, "What's this?"

"Well," he said, "Ten is the worst, and zero is normal right? So, normal isn't the best you can feel. I added negative numbers."

He was aiming for *better than normal*.

He got rid of his migraines.

Here is what else he taught (2'30" videotape).

Now, if Matthew can generalize his skills from migraines to wellness, can we integrate such mindfullness into encounters *before* a psychophysiological problem arises? Can we conceive of health supervision and problem-oriented visits as opportunities for investment in that vast childhood capacity for self-awareness?

The challenge became to make a practice in which the heart of each encounter - each word, pause and gesture - served one, central purpose: to cultivate each young person's self-awareness, self-efficacy, and ultimately, his and her personal mastery.

I began to look forward to the interruptions of those unscheduled kids with injuries. They used to delay me. Now their wounds brought opportunities for learning in hypnosis while I cleaned and sutured and bandaged. One 8-year-old girl with a laceration of her chin breathed carefully and traveled to the amusement park in her mind while I sewed her up. She did a wonderful job. Two days later I received a note from her mother, thanking me for taking the time to help and describing her daughter's pride of accomplishment. Her mother wrote, "Just as we left your office, she stopped and said, 'This is the best thing I have ever done.'" Her mother added, "Remarkable words from a girl who just got stitched up."

These experiences illuminated my practice. It was, for me, as if each examination room suddenly had a transparent floor revealing the infinite depth of thousands of stories – with both meanings of that word - beneath each encounter. I was determined to incorporate teaching self-regulation into all my work.

When children came in with an acute exacerbation of asthma, the pulse oximeter became a biofeedback device and I'd say something like:

> "As you breathe this medicine to help those breathing tubes relax, you can help your breathing get more comfortable and relaxed. Make this number (your heart beat) slow down and make this number that shows how well you get the oxygen into your body, go up… That's right… Isn't it interesting how you already know how to help yourself feel better by paying attention to breathing? And when you pay attention to the tension you help the tension go away."

Every child with asthma, diabetes, irritable bowel syndrome, anxiety, or any chronic problem was a candidate for learning how to be the "boss of their body." Whenever there was an opening for learning self-regulation, I would invite children to play the computerized "Mind-Body" biofeedback game developed by Karen Olness and Glenn Emelko in Cleveland.

It filtered down to daily health supervision visits: an opportunity to use language and the patient's self-awareness to make a physical examination an exploration of healthy reflexes. All those youngsters fearing shots now got to choose ways to alleviate their conditioned fear. We offered them bubbles, pinwheels, view-masters, and stuffed animal friends to hug: not simply redirection of their attentional focus, but skills honoring the power of their imaginations. Zendi Moldenhauer, the wonderful Pediatric Nurse Practitioner with whom I work, began receiving notes from the young women in our care, thanking her for the comfort she provided during their pelvic exams.

The mind-body link was even apparent at those first visits…when seeing a newborn, during that naturally occurring trance that we call the post-partum period. Isn't the baby an exquisitely responsive organic biofeedback system for her mother? The newborn responds to the tone of Mother's arms and voice by providing, with each increasingly full diaper, evidence of the quality of Mother's lactation. Can the focusing and breathing taught to mothers and fathers during prenatal classes extend into parenting?

This quest for mind-body integration means creating an office environment that encourages, accepts, and values the child's imagination, with music and colors and therapeutic

spaces. This room at the end of the hall is for hypnosis, biofeedback…and breast-feeding, too. The biofeedback games can also be brought into examination rooms with a laptop computer. This office is shared with a wonderful group of psychologists I work with collaboratively.

And on it goes. Each new day in primary care pediatrics is a journey of discovery into the minds of children. Marcel Proust wrote, “The real voyage of discovery consists not in seeking new lands but in seeing with new eyes.” Beneath the ear exams, amoxicillin, constipation, nutrition discussions, allergy therapy, safety and parenting advice and all the rest of the daily details of pediatric practice, I wait expectantly for moments to teach children a new way to “mind.” **[Video montage ends]**

This model of integrative care, presents a variety of challenges. When people first learn hypnosis, biofeedback and related skills, there is a great temptation to view these techniques as a panacea. We should not confuse broad application with an all-purpose solution. It is also easy to be drawn into treating problems beyond one’s therapeutic expertise. If we are not careful, this can lead to inadequate evaluation of difficult to explain symptoms. Headaches can be brain tumors. Recurrent abdominal pain can be inflammatory bowel disease. Even when psychophysiological symptoms are quite responsive to self-regulation therapies, the primary care pediatrician should be careful about acting as the primary therapist. A young patient’s autonomy is important for the success of this work. Patients may view the clinician as a parental ally by virtue of their long-term association. Sometimes, despite our expertise, a fresh therapeutic relationship in a new setting is best.

So far I have given you a bit of personal history and an overview of my practice as it has evolved. Now, I would like to tune into the five “key notes” that underlie this work we call integrative pediatrics. These keynotes are simple and, like all simple things, endlessly hard to master. Here they are:

1. Integrative care means integrating the mind into our work, dismantling Cartesian duality.

2. Integrative pediatrics' *primary* purpose is developing mastery and self-efficacy in children and adolescents.
3. The therapeutic medium in integrative pediatrics is rapport.
4. All effective therapy is essentially hypnotic.
5. There is an irreducible art at the core of integrative care.

I will explain each of these.

1. MINDING

At its core, integrative care is the recognition of the key role of the mind in healing. The mind is not limited to the brain and it is more than the body. The term "Mind-Body" is redundant. I explain this to young patients at every opportunity:

"Is this all in my mind?"

"Well, where do you *imagine* your mind is?" I ask. They usually point to their heads. I invite them then to "mind" their stomach and their legs and their toes, as in a meditative "body scan." I explain that what we call the "mind" is that complex bunch of reflexes, like Slinkies, that attach our thinking and feeling. It's how our brains and bodies talk to each other.

"So," I tell the patient (and all of you too), "now you understand, *everything* is *all* in our minds."

Why is integrating the mind into our work a keynote? Why is this so powerful particularly in pediatrics? I will tell you.

When my daughter, Emily, was 3, we were sitting at the kitchen table together. She was having trouble pulling two "Duplos" - big toddler-size Legos - apart.

I said, "You want some help with that?"

What do you think she said?

"I can do it myself!"

So I, being a grown up, replied, "I know, but would you like some help with that?"

"I CAN DO IT MYSELF!" She insisted.

"I didn't say you couldn't do it yourself."

"Yes you DID!!" said Emily.

In that moment I realized that my efforts to help young patients with methods – even effective methods – that rely on *external* acts, substances, or even placebos, convey a message to children: that they cannot do it themselves. This unintentional statement of our lack of faith in their autonomy and independence is *not* what kids really want to hear. When my daughter taught me that, it was another "Gee" moment.

For so long our culture has relied on external agents, even the illusory powerful hypnotist, to do our healing for us. The default of healing in our culture is the mythical belief that other people fix our problems or they prescribe something that will. My daughter helped me to realize that all our external therapies - penicillin for streptococcal pharyngitis, Echinacea for a cold, or acupuncture for asthma – carry an implied a message that the patient lacks self-efficacy. The healing equation must balance each young patient's autonomy and abilities with our external therapies.

We have a lot of work to do in order to undo Descartes.

The myth of the "rule-out" approach traps us. We don't say: "I need to rule out all psychological causes of this child's headache before I explore the organic causes." So we ought not say: "I must rule-out all the so-called 'physical' causes before investing in this young person's innate capacities to cope." We understand far too little about the complexity of mind-body interactions to ever presume we can rule anything out. In fact we treat both, whether we know it or not. When we realize it, we are more effective in helping patients help themselves. Somebody once said, "Illness is the Western form of meditation."

An 8-year old girl in my care broke her leg while sledding and I saw her a few days later, in her purple fiberglass cast.

"Sorry about your broken leg." I said.

"I don't have a broken leg!" She pronounced. "*I* have a *healing* leg."

Kids get this…and appreciate it when we do too.

Health is in the balance.

2. MASTERY & SELF-EFFICACY

This leads to the second keynote. While it is vital that *we* understand the power of psychophysiological therapies for children; it is also incumbent upon us to teach children *what a gift this really is*. Each encounter is an opportunity to invest in each child or adolescent's self-efficacy, or we diminish it. There is no middle ground. Eldridge Cleaver preached, "You are either part of the problem or part of the solution."

This means every child who comes to our offices with a problem has the opportunity to develop coping skills. This is not what I was taught in medical school. When a child had recurrent abdominal pain, I was taught to wait for the food diary, the pain records, the blood work, the gastroenterology consultation, the barium studies, the endoscopies, the compilation of results, the beginning of medication trials and *then* – whether the diagnosis was irritable bowel syndrome, inflammatory bowel disease, gastritis, depression, or a missed simmering appendicitis – *only then* - when the child's worst conditioned stress responses had been reinforced by all of this evaluation – *only then* – might I *finally* take the time to address the potential power of the child's imagination and capacity for self-awareness in coping, regardless of the diagnosis.

We owe each child with chronic disease the chance to learn how to cope *from the beginning*. Young patients often feel victimized by the authority of external therapies, however effective they may be. We ought to check young people's understanding of their medications and relevant therapies at the start. Kids ought to know what we believe asthma is and how to take care of it. Then *we* ought to know what *they* think asthma is. We ought to figure out where the medicines stop and their own abilities start. And we should realize that we don't have all the answers, especially when the etiology or pathophysiology of a problem is really uncertain. A child's belief affects how a drug, herb, or procedure works. Sometimes I say, "You know, how

you imagine it works, might really be how it works." *How each child understands his or her disease is as important as our clinical understanding of their condition.*

Of course, when you think about it, the best time to introduce coping skills to children with a chronic disease is *before* they have the chronic disease. When we teach children to blow away "shot" pain; when we teach them to tolerate that throat culture; when they learn abdominal breathing for test anxiety; when imagery allows them to cope with the pelvic exam; we are building self-efficacy, mastery and that holistic balance we call "health."

Many of us who have integrated hypnosis, biofeedback and other self-regulation methods into our pediatric practices have anecdotes about children who have built on these skills:

- A 7-year-old big sister teaches her 5-year-old little brother how to blow away shot pain *before* his visit.
- A child brings her imaginary pinwheel to the emergency department when she is injured.
- And Heather, at age sixteen, uses hypnosis and biofeedback to cope with disabling anxieties and headaches so successfully she stops using the medications she has relied upon for years. Focusing on her breathing becomes a powerful post-hypnotic suggestion that helps her find poise and self-control to face future challenges. Before leaving for college, she thanks me by email with a message that ends: "My breathing is so important to me. I want to move through each day without wasting one breath."

I know that these anecdotes are not evidence, but they suggest hypotheses for further research. Might our steady investment in children's coping capacities decrease morbidity, diminish our cultural reliance on expensive external therapies, build self-efficacy and equanimity in adulthood and even be cost-effective?

3. RAPPORT IS THE MEDIUM

The third keynote has to do with the foundation of interpersonal communication: rapport. From the French, *rapporter*, to bring back, rapport refers to our ability to empathize, to respect and reflect another's feelings and circumstances. The Viennese physician, Franz Anton Mesmer - maligned champion of Animal Magnetism - is rumored to have brought this word to the modern medical lexicon in the mid-1700's. Early in his career, Mesmer, wrote that he believed that there was a *science* to the therapeutic phenomena of interpersonal communication that other physicians called the "art of medicine."

Mesmer's study of magnetic influences fueled 260 years of study of the power of rapport. I wonder. How far have we come in learning about the science and value of those characteristics of interpersonal and intra-personal communication that contribute to and, I theorize, lie at the core of, health and disease? Human energy research by pioneers like Drs. Gary Schwartz and Linda Russeck may be bringing Mesmer's work full circle.

Now, in the consultation or hospital room, rapport with our patients does not exist just because we are kind, respectful, or well intentioned. Rapport cannot be assumed. It can only be inferred, like gravity. The evidence for rapport lies in the physical cues: eye contact, nodding assent, and open posture of our young patients as we talk with them. Children and adolescents know when we empathize with them. When we respect their abilities to change and grow. And they know it when we don't. And when there is no clear evidence of rapport in those subtle physical cues, we ought to interpret it as a huge "STOP" sign. We need to address the issues that get in the way and impede therapy. Often the reasons underlying the lack of rapport are at the heart of a young person's problems…and many times they are our problem.

Jean Cocteau wrote, "Mirrors really ought to reflect a bit before throwing back images." Rapport is about how we reflect the patient in the mirror of ourselves.

Our internal language – the language we think in, the language we are indoctrinated with in medical school, reflects our beliefs and what we come to expect. Our internal language shapes the mirror of ourselves. The language of the western allopathic tradition presents an

adversarial, "*us versus them*" context that objectifies and minimizes the patient's capabilities and power to heal themselves.

- When we tell clinical stories we often say "I have this patient…" No we don't. We might hope that the patient has us.
- We say, "I put the patient on [such and such] a drug…" Well, we may think so, but in fact we *offered* it to them…and how we hand the prescription to the patient has a lot to do with how it works.
- We refer to patient "compliance" when only *co-operation* is effective.
- Worst, and most symptomatic of allopathic tunnel vision, we use diagnoses, which are at best flawed models of our limited understanding of illness, as adjectives, referring to people who cope gracefully with adversity as "asthmatics," "diabetics," "cystics," and "leukemics."
- For some reason that I struggle to understand we give up on grammar entirely when it comes to learning disorders and refer to people with ADHD (whatever *that* really is) by saying that "he or she *is* ADHD." No they aren't. But then "I suppose it depends on what the meaning of "is" is."

To change one's internal language is difficult and wonderfully refreshing. It is the most profound lesson learned by participants in our hypnosis workshops. Every time I witness this reeducation process I remember the statement made by the Wizard Gandalf in Tolkein's *The Lord of the Rings*. Reborn, Gandalf says, "I have forgotten much that I thought I knew, and learned again much that I thought I had forgotten."

Refining our language means that we change our long-held assumptions about our roles in helping our patient patients heal themselves: becoming facilitators, coaches and teachers rather than operators, and manipulators. That reminds me of another wizard, the Wizard of Oz whom Dorothy calls "a very bad man." He replies, "Oh no. I am a very good man, just a very bad wizard."

4. ALL THERAPY IS HYPNOSIS

The fourth keynote is based on a statement made by Dr. James Maddox, here at the University of Minnesota. He said, “All hypnosis is not therapy, but all therapy is hypnosis.”

Do you remember your childhood visits to the doctor? I have vivid memories of climbing those steps to Dr. Epstein’s second floor office, propelled from behind by my mother’s firm hand on my shoulder, drawn forward by the ever-intensifying perfume of isopropyl alcohol. I recall that waiting room with the small wooden chairs, the *Highlights for Children* magazines offered like the last cigarette before the firing squad, and that lurking fear: “Will I get a shot?”

Every visit to the doctor is trance. Children, adolescents and their parents come to us in a focused, intensified state of awareness, conditioned by previous similar experiences, full of heightened expectancy and sensitivity to the words we say and the pauses… between them. Then, add that most infectious of all germs, parental anxiety; not to mention the introspective focus caused by discomfort and fever. This is the trance of the encounter.

Why is this significant? It is significant because hypnotic processes are catalysts for conditioned responses. If coming to see us is hypnotic induction, then all we say and do is hypnotic suggestion, carrying with it more intensity and power to change. The language we use, the language and behavior of the receptionist, nurses and other supportive staff, the office’s sights, sounds, and smells are all elements in the hypnosis of the encounter, conveying a message to the families for whom we care. The experience of blowing away shot pain, of learning how to care for asthma or changing a habit is intensified by these elements. Recognizing this, we need to pay careful attention to the hypnotic messages we give. Our patients certainly do.

The experience of the visit is not only the patient’s trance. It is ours too. The Pulitzer Prize winning physician William Carlos Williams may have never studied hypnosis but he understood the trance of the visit. He wrote about it in his essay entitled, *The Practice*. Here are his words:

> It's the humdrum, day-in, day-out, everyday work that is the real satisfaction of the practice of medicine; the million and a half patients a man has seen on his daily visits over a 40-year period of weekdays and Sundays that make up his life. I have never had a money practice; it would have been impossible for me. But the actual calling on people, at all times and under all conditions, the coming to grips with the intimate conditions of their lives, when they were being born, when they were dying, watching them die, watching them get well when they were ill, has always absorbed me.
>
> I lost myself in the very properties of their minds: for the moment at least I actually became *them*, whoever they should be, so that when I detached myself from them at the end of a half-hour of intense concentration over some illness which was affecting them, it was as though I was re-awakening from a sleep. For the moment I myself did not exist, nothing of myself affected me. As a consequence I came back to myself, as from any other sleep, rested.

Now, before leaving this particular keynote, I ought to mention a caveat. I do not mean to imply that we label all visits to the pediatric office or all health care encounters as hypnosis. In our present legal climate, with debates about hypnotically induced false memories and therapists being sued for using hypnosis because of lack of data to support it, attorneys would fall into a feeding frenzy. I mean to say that the study of hypnosis: the careful use of language, attention to states of awareness, and the respect for the power of each individual's potential for subconscious change is fundamental to each encounter, whether we recognize or not. Remember Reverend Warnke's definition of hypnosis as the art and science of conversation. Finding the hypnosis in each encounter increases the value of our healing work.

5. THE ART

The fifth and last keynote is about the art. The principles and skills I have discussed so far are the techniques, the media, the paintbrushes, and the other instruments *of* the art. They are not the art. The healer's art is not paint by number. Art is the creative expression of self.

So what is the "art" in integrative pediatrics? The art is *how we integrate our selves into our work*.

The art is expressed in how we enter the room, who we first address there, the music and lyrics of our language, the metaphors and framing we use in our exploration of the patient's problems. The art is in our touch. It is in our silence. It is in our humor. It is in our intuition. In the midst of it, when it is going well, we can feel like Fellini, complaining to the cognitive, analytical part of our minds, "Don't tell me what I am doing! I don't want to know!"

But, of course, we need to know. We grow in that process. Each new encounter, the ecology of each visit, can challenge our own assumptions about who we are and what we thought we knew. We are not only Jean Cocteau's mirrors for our patients. Our patients are mirrors for us. What do we need to change for ourselves in order to lose ourselves, as Dr. Williams did in "the properties of their minds?" What parts of us resist that change? Why? What do we need to learn? *How can we possibly know our patients better than we know ourselves?*

Once upon a time, during a typically crowded day in the office, I entered exam room number 3 to see Danny and Matthew, 6 and 8 years old, respectively, for their yearly "well-child" visits. Like many of the young people I care for, I have been their pediatrician since birth…theirs… not mine. Anyway, Danny, the younger, was bouncing as he sat on the examination table, eager to ask an urgent question. When I sat down, mother said, "Okay, Danny, you can ask now."

Danny asked, "Dr. Sugarman, do you *live here*?"

I knew I was going to disappoint him. I almost considered lying to him, then I said, "Uh…no. I live about a mile and a half down Westfall Road…but it's really close."

Matthew, the elder brother, feeling quite superior, chimed in, "*See!* I *told* you he didn't *live here*!" Then Matthew paused for moment as his own question came to his mind. "But Dr. Sugarman…what's your *work*?"

I was dumbfounded.

Where did that question come from? How, in the process of creating the pediatric practice I believe in, did my “work” become imperceptible? What does that mean about this work …I suppose my life work (as distinguished from my “job”)…and your work, too?

As we find our selves in our work, the boundaries become invisible.

In his wonderful book, *The Dancing Healers*, Dr. Carl Hammerschlag writes of the Pueblo priest and clan chief, Santiago, who gets up from his deathbed to teach the author to dance, saying, “You must be able to dance if you are to heal people.” Santiago counsels him, “I can teach you my steps, but you will have to hear your own music…” If nothing else, my message is about hearing our own music…in all its notes and keys… It is about discovering how that inner melody, and how we hear it and dance to it, and how it resonates with our patients, relates to our healing practices. It is about those moments that make us stop in the middle of the measure, rest for a beat, and utter that exclamation of self-discovery, “Gee…”

Allow me to end with my own music. Many, many years before all this professionalism and seriousness about work began, when I was 8, my big brother and I got me a banjo… and now a banjo hangs in my office, a friend since childhood. We sit together and play each day when I am done with my work. We always will. It is how I hear my music. It just seems right to end by playing for you all …in the key of …G…