

“Call Dad for My Epidural”

By Robert Johnstone, M.D., Morgantown, West Virginia

The following is a very personal and touching piece about a father and his daughter. It directs our attention to the AMA's Code of Medical Ethics about treatment of immediate family members. How many of us have “treated” our loved ones in one way or another? Taking the responsibility of physician for a family member is an historically honored privilege, but one that should never be taken lightly or without deep reflection.

—Editors

“Erica is in 628,” the obstetric nurse said. “She wants an epidural.” The request startled me, as much as a code-blue page, because Erica was my oldest daughter. She was in labor with her first pregnancy. I knew she wanted me to place her epidural, and I'd been thinking about it. Erica's request, and my dilemma, began two generations ago.

My grandfather, a rural general practitioner, provided comprehensive health-care, including home deliveries. He helped with the birth of my father, and provided his childhood healthcare. It was a near necessity then, with only a few doctors scattered among several towns. Dad became a physician himself, and provided my sister and me with our healthcare, even though we lived in a city. It fit Dad's concept of family, as did cutting my hair with electric clippers every other weekend while I sat on a kitchen stool. During one of these rituals he explained that physicians didn't charge other physicians or their families, and our self-sufficiency meant we weren't burdening anyone.

Dad's loving, diverse care worked. I grew up healthy and graduated from medical school. I started a family and, like my father, provided some of its healthcare. It wasn't to avoid burdening other doctors, since professional courtesy was disappearing. It was convenient and fostered my own feelings of fatherliness. I limited the care, though, since medicine was becoming complex and specialized. I wanted the best for my family. Often that meant relying on others with knowledge and skills that I didn't have.

Erica was born during my anesthesiology residency training, on a call night. After a faculty anesthesiologist placed an epidural catheter in my wife for pain relief, I scurried about the labor and delivery unit, comforting her, and caring for others. Stories of the night became family lore. The births of my other daughters added to it. Emily came shortly after I entered private practice. A senior obstetrician, about to perform a saddle block anesthetic for the delivery, suddenly recognized me, the father, as an anesthesiologist. He held out the

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needle, and said, “You do it.” Feeling awkward, but sensing urgency, I did. The obstetrician and I never discussed this afterwards. He retired the next year.

Stephanie was born soon after my wife was rushed to the hospital with bleeding. I was the anesthesiologist on duty. I started an intravenous infusion, as the obstetrician diagnosed placenta previa, and ordered a cesarean section stat. Before any partners could arrive, I had placed an epidural catheter, dosed it to mid-thoracic levels, and watched the birth of a healthy daughter.

My daughters, all healthy, grew up knowing that I had helped with their births. They felt lucky to have a father physician. I recognized my good fortune that everything had gone well. Erica attended the medical school where I teach. Her grandfather hooded her at graduation. She loved him and his medical stories. He was retired, above the daily fray, and talked about the personal and trusted care physicians gave when he practiced.

Erica became pregnant during her year as chief resident of internal medicine. She often reviewed difficult patient courses at grand rounds. As chief resident, healthcare seemed to be overrun with complications. When a friend of Erica received a labor epidural that didn’t work well, and had a baby born with a skull fracture, Erica suspected the anesthetic was to blame. Like other mothers, she wanted a healthy baby, delivered comfortably. Unlike other mothers, she could make unique anesthetic requests.

Erica and I are closer perhaps than many fathers and daughters. We shared caring for her mother, my wife, who had ovarian cancer, and was relapsing after a second round of chemotherapy. Erica reviewed the medical literature for treatment options and outcomes. I drew the blood samples and placed the intravenous catheters that my wife needed, something I did well. We supported the oncologists and other doctors, who seemed to appreciate our involvement. When my wife needed abdominal surgeries, threatening events, my colleagues did the anesthetics.

I’ve never advocated that anesthesiologists anesthetize family members. In 32 years of practice, I’d only seen it once. That occurred when an anesthesiologist was on duty as his wife presented for emergency surgery. I relieved the anesthesiologist halfway through, and found him shaking. Yet I comfortably placed intravenous catheters in my wife, something she learned to request after failed attempts by others. Placing intravenous catheters differed from inducing anesthesia, though, because an anesthetic mishap could quickly cause death.

Colleagues offered diverse opinions about my dilemma. Most provided some care to family members, usually health form completions or prescription

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renewals. Few spoke in absolutes. The AMA ethical guidelines reinforced what I already knew, “Physicians generally should not treat themselves or members of their immediate families,” while adding, “It would not always be inappropriate.” Concerns included objectivity, consent, and comfort.

Erica was certainly knowledgeable. We worked in the same hospital. She’d seen my care, and that of my colleagues. We’d had many conversations about her mother, and understood and trusted each other.

I was the department chair, and I had a policy that we honored the requests of patients whenever possible. Members of the department would thus trade assignments when a patient requested a particular anesthesiologist. I didn’t encourage such picking though. We had a department of competent anesthesiologists, and more than one had anesthetized my wife during the preceding years. Erica had nine months of pregnancy to reflect on this.

I felt a high duty, of course, to my daughter. I recognized she was more comfortable with me than with other members of the department. We shared medical philosophies, family ties, and commitment. I’d done thousands of epidurals for deliveries and had good results. I reasoned that a vaginal delivery in a labor room was less of a procedure than surgery in an operating room. Erica was in good health, a perfect candidate for epidural analgesia. What Erica wanted seemed more like the intravenous catheters I’d been placing in my wife than the general anesthetics I’d not administered to her. I looked forward happily to the impending delivery of my first grandchild.

Erica’s obstetrician was a colleague, with whom I’d worked many times. He had cared for my family, and I had anesthetized him. Still I didn’t know whether Erica or the obstetrician would call me for the epidural, or how I’d respond. When the obstetric nurse did call though, and paused for a response, I said, “Okay, I’ll be right there.” Almost on automatic pilot, I checked with the obstetrician, notified a partner, assembled supplies, and placed the epidural. It worked perfectly, and my first grandson was born a few hours later, healthy and welcomed by loving family members, including my wife and me.

Physicians generally shouldn’t treat family members, especially with anesthetics. Providing an epidural for my daughter, Erica, though, wasn’t just an anesthetic, it was an act of love.

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