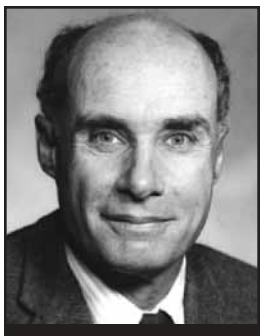

BY WILLIAM G. WILKOFF, M.D.

LETTERS FROM MAINE

Too Close for Comfort

The old highway sign—"Maine, the Way Life Should Be"—was hard to miss as one left the toll plaza in Kittery heading north toward Portland on I-95. Those of us fortunate enough to live here know that those words weren't simply a catch phrase cooked up by some big city PR firm.

With its rich supply of recreational opportunities and low population density, Maine is a beautiful and safe place to raise children. Like Montana and a few other heavenly places, though, we have trouble finding work for our adult children, and many of them are forced to leave this idyllic place to find employment that matches their education.

So you can imagine how excited Marilyn and I were when our son called to say he had landed a good job at L.L. Bean and would be moving back to Maine. In fact, he had already begun to look for a house here in Brunswick, and his wife was pregnant with our first grandchild.

As we proudly shared the good news with everyone who would listen, one of the most frequently asked questions was, "Well, who's going to be the baby's pediatrician?" In a few cases, the question was rhetorical, because our closest friends knew how uncomfortable I would be shouldering the responsibility of caring for my own grandchild.

But many of the questioners clearly didn't understand that being a pediatrician often requires a difficult and schizophrenic separation of one's natural instincts, even when the patient is neither a friend nor a relative. The ability to fluctuate between compassion and objectivity and still keep the whole process in balance isn't easy.

I recall an incident when I was an intern struggling to perform a lumbar puncture on a febrile 10-month-old girl. The gray-haired nurse who was holding the child for me said, "Will, you usually don't have this much trouble with LPs. Your daughter must be about the same age."

She was correct. Fortunately, I was able to wall off my paternal emotions long enough to collect a clean sample of spinal fluid, but I knew that, had this little patient actually been my own daughter, I would have most likely bungled the tap or given up prematurely because I thought I was hurting her.

By the time I was a senior resident, I had promised myself that I wouldn't lift a therapeutic or diagnostic finger when one of my own children was ill. My steadfast adherence to this philosophy has meant that on several occasions, my poor wife had to drive for hours in rush-hour traffic to see the official pediatrician for what was obviously an otitis media. I may keep my good-luck stethoscope in my knapsack, but my otoscope always stays at the office. This eliminates any temptation to examine the ears of either kin or neighbor.

I've made a couple of exceptions over the years, with nearly disastrous results. The first incident involved my son's knee laceration, which I attempted to repair with inadequate anesthesia. Neither the scenario nor the result was pretty. In another episode, I nearly sent my daughter back to school with a fractured humerus after a cursory kitchen-table examination. Her mother saved the day and my ego by urging a second and wiser opinion.

Family and medicine don't mix well. Despite our best efforts to prevent it, some of our diagnostic and therapeutic procedures are painful. Under the best of circumstances, it is sometimes difficult to do the right thing, but when the patient is one's own child or grandchild, it may be impossible.

A good clinician must be able to submerge his own emotional attachment to the patient long enough to allow his rational decision-making skills to rise to the surface, while still demonstrating that he cares.

I know that when my grandchild arrives, I won't be able to suppress my own emotions. I just want to be his or her grandfather, and I hope I can let someone else be the pediatrician. ■

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