

What Do You Do When Your Loved One Is Ill? The Line between Physician and Family Member

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Conventional wisdom and professional ethics generally dictate that physicians should avoid doctoring family members because of potential conflicts of interest. Nevertheless, cross-sectional surveys find that the practice is commonplace.

Physicians have unique opportunities to influence their family member's care because they possess knowledge and status within the health care system; however, when physicians participate in the care of family members, they must not lose objectivity and confuse their personal and professional roles.

Because health care systems are complicated, medical information is difficult to understand, and medical errors are common, it can be a great relief for families to have someone "on the inside" who is accessible and trustworthy. Yet, the benefits of becoming

involved in a loved one's care are accompanied by risks, especially when a physician takes action that a nonphysician would be incapable of performing. Except for convenience, most if not all of the benefits of getting involved can be realized by physician-family members acting as a family member or an advocate rather than as a physician.

Rules about what is or what is not appropriate for physician-family members are important but insufficient to guide physicians in every circumstance. Physician-family members can ask themselves, "What could I do in this situation if I did not have a medical degree?" and consider avoiding acts that require a medical license.

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Conventional wisdom and professional ethics (1–3) dictate that physicians should avoid doctoring family members, emphasizing the potential for conflict of interest and lost objectivity. For example, the American Medical Association's Ethics Manual (3) states: "Physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member or the physician is the patient." Nevertheless, cross-sectional surveys have found that the practice of doctoring family members is commonplace (4–6). In a community hospital, 99% of surveyed physicians received requests from family members for medical advice, diagnosis, or treatment and 97% provided a service to family members (4). Few data on the quality of this care are available. A survey examining the processes of care for children of physicians found that although physician-parents had easier telephone access to pediatricians, they were less likely to call with concerns or come in for acute illness visits (6). Pediatricians estimated that physician-parents were more likely to wait inappropriately long before taking their children to be seen and that the patients' social or psychological problems were less likely to be addressed.

In a carefully reasoned ethical perspective, La Puma and Priest (1) suggested 7 questions that physicians should ask themselves when considering whether to provide medical care for family members (Table). However, they proposed that the need to ask those questions does not apply to "acute emergency care and care for most minor recurrent predictable illnesses," because in those instances "care may be given by the physician in the family without overwhelming his or her objectivity or breaching ethical principles, and with much convenience to all concerned" (1). This rule of thumb has risks, however, because emergencies are rarely convenient and "predictable" illnesses may still hamper a physician-family member's objectivity.

We review instances from our own experiences. In some cases, we regretted becoming involved in the care of our family members because we thought that involvement was not helpful and was possibly harmful, and in other cases, we thought our involvement was beneficial. We make recommendations to supplement the questions in the Table for how physicians might manage conflict between their professional and personal roles when a family member becomes ill. Although we focus here on physicians' involvement in family members' care, much of what we write and recommend could also apply to physicians' involvement in their own care (for example, diagnosing and treating themselves) (7, 8).

REGRETFUL INVOLVEMENT

Case 1: Dr. V. and His Wife

My worst moment came last year, when my wife was pregnant. In previous years, we'd suffered through 3 miscarriages, and when she started spotting this time, we quickly came to terms with a fourth miscarriage. Actually, that's not entirely true. I remember it as my lowest moment in medicine, because I was ward attending and rounding with my team, which had been up all night with 12 patients. We were on rounds and I was being yelled at by a patient with chronic pain and a personality disorder when my wife called to tell me of her miscarriage. I couldn't believe that I had to be there at

See also:

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Appendix

Appendix Table

Conversion of graphics into slides

Table. Questions Physicians Should Ask when Considering Providing Care for Loved Ones*

Am I trained to meet my relative's medical needs?
Am I too close to probe my relative's intimate history and physical being and to cope with bearing bad news if necessary?
Can I be objective enough not to give too much, too little, or inappropriate care?
Is medical involvement likely to provoke or intensify intrafamilial conflicts?
Will my relatives adhere more readily with medical care delivered by an unrelated physician?
Will I allow the physician to whom I refer my relative to attend him or her?
Am I willing to be accountable to my peers and to the public for this care?

* Excerpted from reference 1.

the hospital being berated for God knows what by a ridiculous overgrown adolescent while my poor wife was at home with her grief.

That night, my wife complained of pain while I was trying to get to sleep. I half-heartedly examined her abdomen. I told her it was probably just cramping from the miscarriage, but she said the pain was different. I remember feeling overwhelmed—and resentful.

The next day, my wife made an appointment with an obstetrician she'd never seen before, borrowed a car, and drove herself to her appointment. Her obstetrician made the diagnosis of tubal pregnancy clinically, treated her with methotrexate, and ordered ultrasonography "just to make sure." The obstetrician called us at home later that afternoon, chagrined to say that the size of the tubal pregnancy required surgery, and requested that we return that evening.

The surgery went fine, thank goodness. To this day, I feel shame whenever I think of how I handled that situation. Any objective health professional would have thought about an ectopic pregnancy, but I wasn't being objective. It's not that I didn't think of it; I didn't think about anything. In my state of mind, I didn't want to think about anything.

One reason why doctoring a family member is risky is because physicians lack the objectivity to evaluate and treat a loved one, as this case illustrates. Was the physician in this case doctoring his wife or avoiding doctoring her? His abdominal evaluation may have given both the momentary impression of doctoring, but the act was performed without the critical thinking and differential diagnosis that characterizes a professional encounter.

The lost objectivity that renders physician–family members ineffective as physicians may also prevent them from recognizing that they are confusing their professional and personal roles. One way to prevent that confusion might be to ask the question: "What would and could I do in this situation if I did not have a medical degree?" In this way, the physician can assess whether he or she is crossing the lines between their roles and acting as a physician for a loved one. Although it may be tempting for a physician–family member to get involved when the problem is within his or her scope of expertise, it is not necessarily safer. Doctoring a family member with a familiar clinical prob-

lem may be more convenient, but we contend that physician–family members can realize most if not all of the benefit of getting involved by acting exclusively within their roles as family member and advocate.

It may also be tempting for physicians to expedite or improve the care of a family member by pulling strings within the health care system. However, there may be unintended consequences to the physician–family member, patient, and treating physician if roles become confused, as illustrated by the following cases.

Case 2: Dr. W. and His Wife

During my residency, my wife had shoulder pains for which I took her to a sports medicine physician. He ordered a chest radiograph at the time, saying that sometimes intrathoracic problems can cause similar symptoms. He and I looked at the radiograph together and saw nothing. (Eight years later, a hot lamp on this overpenetrated radiograph would reveal a pneumothorax.)

Three years later, my wife developed bilateral hernias and went in for surgical repair. I saw her off to the surgery suite and went to my office in the same hospital to await a call from the surgeon. When he called, he said that the surgery went fine, but chylous ascites leaked out of her abdomen when he made the incision. Ovarian cancer, I thought. Time stopped.

What ensued was terrible. I told the surgeon that I would talk to my wife about it. I went to her bedside, sat by her, and held her hand. I told her that something was wrong, that she had ascites, and that I didn't know of any good things that would cause it. When the scan of her abdomen was performed, the radiologist called me to look at it with him. On the basis of what he saw, he thought it was a very rare disease called lymphangioliomyomatosis. As before, I returned to the room, sat at her bedside, and told her the diagnosis. Her work-up confirmed the radiologist's suspicion.

Looking back, I'm not sure why I thought I should be the one to deliver the bad news to her. I wish I had been on the other side of the bed listening with her to her doctors delivering the news. I wish I had been solely in the husband role that day, rather than putting on my doctor hat. It set us up for a lot of problems as we continued down that path for further work-up and treatment.

In this case, Dr. W. became a physician to his wife in a way that added little to her care and that he later regretted. The wife's treating physicians also demonstrated confusion about their role and the husband's role in this case when they delegated their responsibilities to the willing husband. The case illustrates that role confusion may be greater when physician–patients and physician–family members seek assistance at the institution where they also work. The next case provides additional evidence for why important medical information should be delivered by a non–family member physician.

Case 3: Dr X. and His Wife

After my wife's first surgery and radiation therapy for a brain tumor, we planned a family vacation in Arizona to get

away from things and to be together as a family. My wife had started her adjuvant chemotherapy, and repeated magnetic resonance imaging (MRI) was scheduled just before our trip, with her follow-up neurosurgery appointment after our return. I decided that I wanted to know the results of the MRI before we left so that I could be assured that everything was okay. I called the file room of the hospital in which the MRI was done, stating that I was Dr. X. and needed the results of the MRI. The reading, unfortunately, was that of a recurrence of the tumor despite the treatment my wife was receiving. I was devastated but knew that there was no sense in informing my wife or children because no change in treatment would be made until after our appointment with the neurosurgeon. I kept the information to myself so that my wife and children could enjoy the vacation—as for me, I went and “enjoyed” what I thought would be our last vacation together.

I learned a valuable lesson. Since then, I have refused to call for information about my wife or any of our children. I don't want to be their physician by giving them bad news (or good news, for that matter). I have since relied on appointments to get the information that we need at the same time that my loved one receives the information.

Dr. X.'s experience led him to regret his overlap in roles, resolving to identify more squarely with his role as a family member so that he could receive good and bad news along with his wife in the future. Occasionally, a physician–family member may be pressured by a treating physician, the patient, or other family members to act as primary decision maker or in a physician role. As the follow-up case illustrates, these physicians may mean well but do not recognize the potential problems this could create.

Case 3, Continued

My wife was taking phenytoin to prevent her focal seizures. At one point, the neurosurgeon, who was prescribing the phenytoin, suggested she see a neurologist with expertise in brain tumors who could follow her and prescribe the phenytoin. She and I saw this neurologist. After the neurologist took a history and did a physical examination, she asked my wife why she was seeing her. My wife replied that her neurosurgeon referred her so she could prescribe the phenytoin. The neurologist responded that that was unnecessary and that she did not want to see my wife in the future because I was a physician and could prescribe the phenytoin and follow my wife's problems. We eventually did find a neurologist who was willing to see us as a couple and not as myself being a physician to my wife.

Having learned his lesson after calling for his wife's test results, Dr. X. was careful to avoid becoming inappropriately involved in her subsequent care.

What constitutes “appropriate” involvement? Rather than trying to define propriety, the **Appendix Table** classifies the different ways that physician–family members can be involved in their families' care in terms of comparative risk (low-, medium-, and high-risk categories). Our as-

sumptions in making the table are that the risk to a family member increases when he or she decides not to see a treating physician, when physician–family members perform services that treating physicians ordinarily perform, and when physician–family members make decisions ordinarily made by a treating physician. The risks include false reassurance, which leads to delays in evaluation of important symptoms; increased distress for the patient; decreased effectiveness of the physician–family member as a source of support; and decreased effectiveness of the treating team as a source of independent care.

GRATEFUL INVOLVEMENT

Despite the risks of doctoring a family member, physician–family members can and must protect a loved one from errors or substandard care if these are obvious. By asserting professional opinion or collegial status in these circumstances, the physician–family member benefits not only the patient, but also the treating physicians and medical center.

Case 4: Dr. Y. and His Child

Our 15-month-old son had a respiratory infection and a 3-day history of progressive cough, not sleeping, wheezing, and home nebulizer treatment. After 2 visits to pediatricians in the community, our son was directly admitted to the teaching hospital where both my wife and I are on faculty. Our son was tachypneic and tachycardic and was beginning to have labored breathing, and we just were not able to settle him down. We told the nurse we needed a nebulized bronchodilator treatment now. She said that she could not give the treatment because she did not have a doctor's order. She tried paging the physician, but she had instructions not to disturb the physicians, who were in noon conference. And so it went for what seemed like a long time. One of my wife's pediatric colleagues called, said she'd heard we were in, and asked how our son was. Now I wasn't sure what to say—“Oh, he's okay, we're just waiting for respiratory, and it's taking a little longer than we'd hoped” or the truth? I told the truth: “We are not getting the care and attention that this 15-month-old child needs. We are seeing him in a stage of agitation and tiring that precedes respiratory arrest, so we need help right now before he codes.”

Fairly quickly after that, the pediatric chief resident came up and got things going. The pediatric intensive care unit (ICU) attending also came over, with no stat pages or anything, and agreed with our assessment. Our son received a nebulizer and intravenous steroids and had chest radiography.

For me, care for our son came first. . . . the line between personal and professional roles was a dynamic, moving entity and the worse my son got, the easier it was to see that I was not crossing a line at all. My family trumped all. This also was holding up a standard of care that we had learned in our residencies, and care was not adequate in this situation.

In addition to demonstrating effective advocacy, this case raises questions about whether the care was initially poor because the parents were physicians. Physician–family

members may be more effective if they are sensitive to the peculiarities of their relationship with treating physicians. This may include a tendency for the treating physician to feel intimidated, to delegate inappropriately, or to practice indecisively or overaggressively. These issues may be magnified when the caregiver is also a professional colleague or when the treating physician happens to be a trainee. Articles on the care of physician-patients and physician-family members offer useful suggestions for treating physicians, such as clarifying roles and confidentiality concerns as soon as possible, speaking directly to the patient rather than the physician-family member, and avoiding patients whose care is likely to arouse an excessive degree of anxiety (9–13).

Case 5: Dr. Z. and Her Mother-in-Law

The week after my 80-year-old mother-in-law, “M.,” arrived from out of town, she lost the ability to walk. The 6 months that followed were the most stressful and logistically challenging time of my life—I was pregnant, I was a working mother of 2 young children, and it was clear that M. could not quickly return home to her small apartment in rural Missouri.

I coordinated what became for her an intensely complicated medical evaluation. It took a series of false starts in consultations and testing, but ultimately an MRI of her neck showed critical spinal stenosis that was on the verge of transecting her cord. We also learned from her MRI that M. had lung cancer. Both problems were operable, and she wanted to rally for both surgeries. But her course after surgery could not have been more problematic. She had postoperative pneumonia and the acute respiratory distress syndrome. She had chest tubes for ventilation-associated pneumothoraces, prolonged altered mental status in the ICU, and hospital-acquired infections. After 4 months on a ventilator, she saw she was not making gains in recovery and chose to have the ICU withdraw support.

I had hundreds of opportunities to help M. as she navigated through the medical system. Despite my hesitation, I think I seized on nearly every chance. I allowed physician courtesy to work to her advantage, facilitating appointments outside of the usual wait times and communication with the family. I accepted every invitation to listen in on ICU rounds, in case my presence could cause the team to be especially thoughtful and thorough. I was vocal when I noticed omissions in her care or decision making that seemed risky. Some of my interventions were important, like the time I reminded the anesthesiologist who was about to reintubate her with standard techniques that she had an unstable cervical spine, or when I pointed out that her antibiotics were missing gram-negative rod coverage. Despite being vigilant, I took great care to avoid being strident or obtrusive toward her treating doctors, fearful that I might make us into a “high-maintenance” family. She received flagship medical care. I couldn’t keep up with the complexity of her case any better than her physicians, but there was no question that my advocacy added value.

One of the most important things I think she gained by having a doctor in the family was that she did not feel so

vulnerable. She could trust the care she was getting and trust that details were not overlooked. My role in her care felt pivotal, and it was harrowing to have that responsibility, but it made me feel proud to be a doctor and glad to help. Being so involved with M. has made me a better advocate for my own patients.

The case illustrates the potential power of a physician-family member to positively affect care. In contrast to the previous cases, Dr. Z. involved herself as a physician in her family member’s care without ambivalence and without taking over or interfering with that care. She maintained a light touch, supporting the treating health professionals in their work rather than taking on their responsibilities. Although she would not have been able to be as involved as she was without her medical degree and hospital privileges, she avoided making decisions, writing orders, or creating ambiguity about her role.

One might wonder how Dr. Z. was able to do all this while also continuing to work as a physician and pregnant mother with young children. Her hardiness aside, physicians who become deeply involved in the care of family members are susceptible to burnout and require the same precautions as other caregivers to ensure they get enough sleep, breaks, and support (14). Also, whatever her relationship was with her mother-in-law, Dr. Z. was able to bear M.’s clinical roller coaster with enough objectivity to remain effective. If their relationship had been more intense or more conflicted, this might not have been possible.

CONCLUSION

As a physician becomes involved in a family member’s care, there is a dynamic tension between personal and professional roles. These cases have described questions that arise within that tension: Where does one draw the line between the 2 roles in general, and what principles govern where the line should be drawn? How far may one choose to move that line toward one role or another in a particular instance? How does one meet the expectations of loved ones, colleagues, the profession, and society at large? How should one avoid undesirable complications from acting too much from one role or the other?

Overall, having a physician as a family member is a good thing. Because health care systems have become so complicated, medical information so difficult to understand, and medical errors so common, it can be a great relief for families to have someone “on the inside” who is accessible and trustworthy. Insider advantage aside, a family member does not have to be a physician in order to advocate effectively for a loved one. Advocacy by nonphysician family members can also be beneficial, particularly if that family member is actively engaged in communication during the visit (15).

However, the benefits of becoming medically involved in a loved one’s care are not without risks. As a rule of

thumb, before acting on behalf of a family member, physicians should ask themselves, “Could I engage in this action without a medical degree?” Asking this question requires a degree of self-awareness that may need to be cultivated in advance (16). When the answer is “no”—that is, when the action can only be performed by a medical professional—physicians should exercise caution about getting involved in their family member’s care to avoid the conflicts in roles that may occur and to avoid both harm to the patient and distress to the physician–family member. The **Appendix Table** classifies specific actions in terms of how risky they are. We have also prepared a patient information page that may be shared with family members to help them understand the risks and benefits involved when physician–family members become involved in their care (**Appendix**, available at www.annals.org).

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APPENDIX: PATIENT INFORMATION: SUGGESTIONS FOR FRIENDS AND FAMILY MEMBERS OF PHYSICIANS

Having a physician in the family is a good thing. Because health care has become so complicated, medical information so difficult to understand, and medical errors so common, it can be a great relief for families to have someone “on the inside” who is accessible and trustworthy. We have found that even first-year medical students routinely get requests for medical advice and assistance from friends and family members. However, the benefit of involving a physician–family member in the care of his or her close friends and family is not without risk. Understanding these risks can help ensure that both parties make best use of their relationship.

First, physician–family members and families must understand that informally consulting a physician–family member is not a substitute for formally consulting a physician. Formally consulting a physician in his or her office gives you access to other health professionals (nurses, dietitians, and counselors) as well as easy access to laboratory studies, radiography, and other tests and referrals to specialist consultants.

Physician–family members may not be comfortable asking personal questions or examining private body parts that could be essential to making a correct diagnosis or decision.

Families often include complicated relationships and obligations that can render physician–family members incapable of being objective at the worst times. Unfortunately, the more serious the situation and the closer the relationship, the harder it may be for the physician–family member to be objective or to recognize that objectivity has been lost.

The **Appendix Table** outlines low-, medium-, and high-risk ways that physician–family members can be involved in their families’ care. The table assumes that there is greater risk when deciding not to see a treating physician, when physician–family members perform services that ordinarily only a treating physician can do, and when physician–family members make decisions that are ordinarily made by the treating physician. Risks include being falsely reassured and thus delaying or avoiding evaluation of important symptoms; increased distress or decreased effectiveness for you, the physician–family member, or the treating team; and poor medical care.

Appendix Table. Low-, Medium-, and High-Risk Involvement by Physicians in the Care of a Close Friend or Family Member

Low risk

- Helping to explain medical information, such as diagnoses
- Suggesting the patient should see a physician
- Answering questions about whether the patient should see the physician
- Answering questions about medications
- Providing education, such as how to take care of a sprained ankle
- Helping to navigate the health care system (for example, finding the right physician)
- Attending medical visits
- At medical visits, helping to ask the right questions and interpret medical jargon

Medium risk

- Suggesting that the patient does not need to worry about a problem or see a physician
- Refilling a medication prescribed by the treating physician 1 time only
- Suggesting over-the-counter medications

High risk

- Prescribing a medication not being prescribed by the treating physician
- Prescribing a controlled substance* or psychoactive medication
- Ordering tests
- Checking results
- Coordinating care
- Making decisions without involving the treating physician or patient
- Performing a procedure beyond first aid

* Inappropriate prescription of controlled substances to family members may result in license suspension and may violate state law.

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