



“Sweetheart, you should have that looked at:” Ethical implications of treating family members

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CASE SCENARIO

Dr Experienced (Dr E), a board-certified dermatologist, has managed patients with diverse dermatologic diseases for >15 years and is a volunteer teacher at the local dermatology residency. One morning, Dr E noticed an asymmetric variegated dark macule on her husband's arm. Dr E brought him to her office that morning to evaluate the lesion with dermoscopy, which prompted her to perform an immediate biopsy. Dr E documented her visit and the biopsy and was notified 2 days later that the dermatopathology findings were consistent with an invasive malignant melanoma with atypical cells extending to the margins of the specimen. Given the severity of the diagnosis, Dr E delivered the news to her husband in the comfort of their home.

Dr E should:

- A. Perform the definitive excision of the melanoma that day.
- B. Refer him to a colleague in her practice for excision.
- C. Refer her husband to another practice.

DISCUSSION

Physicians have an inherent duty to uphold the safety and well-being of their patients, regardless of the circumstances. When the patient is also a close family member or personal friend, the physician-patient dynamic becomes complex and emotionally blurred. Although not a novel issue, providing medical care for a family member is an aspect of medical practice that is rarely discussed in medical school or residency.¹

The ethical principles of beneficence (to promote well-being) and nonmaleficence (to do no harm) are applicable in our scenario. Medicare defines immediate family as spouses, parents, children, siblings,

step-parents, step-children, step-siblings, children-in-law, siblings-in-law, grandparents, grandchildren, and spouses of grandparents or grandchildren.² In addition, similar ethical issues arise when treating close friends and should be considered when initiating a physician-patient relationship. Dr E has the best intentions for her husband, offering him attentive, efficient, personalized, and compassionate care. However, there is a concern that a physician's clinical reasoning will be skewed when treating a close relative.³ The physician's baseline emotional intelligence and the complexity of the clinical situation largely determine whether this is true. What if our family member's condition deteriorates after

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numerous failed therapies? The subsequent guilt might negatively impact one's clinical judgment and affect one's confidence and ability to treat future patients. Furthermore, a physician might be reluctant to perform a painful or potentially mutilating procedure on someone they love, resulting in a less objective approach.^{3,4} Physicians might also be inclined to manage problems extending beyond the scope of their training or expertise to expedite treatment for a family member. Dr E promptly examined, biopsied, and recommended excision of the lesion, but now that the diagnosis has been established, it would be in her and her husband's best interests to transfer the care to another expert.

In addition to beneficence and nonmaleficence, autonomy and informed consent are relevant in our case. Physicians should explain the risks and benefits of available treatment options, which might be insufficiently addressed when performing a procedure on someone they know intimately.⁵ When treating close relatives, we run the risk of diminishing, and even eliminating, transparent informed consent and patient autonomy.^{4,5} Family members might not be entirely candid in their answers to questions, nor fully disclose their concerns or feel comfortable seeking outside opinions.⁴ Dr E's husband might prefer for another physician to perform the procedure but is reluctant to express his hesitation due to fear of upsetting his physician wife. How will the physician-patient dynamic change if the relative disagrees with our opinion and seeks outside medical guidance? The discord in opinions might create undue tension, possibly resulting in poor medical management in which the relative might not follow up or further discuss their concerns.

Legally, physicians must document on a medical chart whenever they write a prescription, perform an exam, or perform a procedure for a relative; these actions are important aspects of a physician-patient relationship and require appropriate follow-up. If the medical care was initiated in the setting of the patient's home, documentation might be missing or incomplete, making further management and follow-up difficult. In addition, physicians might have to deliver difficult diagnoses to their patient-family members, as in our patient scenario. The physician must ensure that the patient receives the necessary treatment and emotional support following a life-altering diagnosis. This should be performed in a professional setting, not in the home of the patient as performed by Dr E.

Previous research reports that family members of physicians are less often seen for acute illnesses, have shortened exams, and incomplete or absent medical records.¹ The quality of care might be diminished for the patient-relative due to lack of

formal follow-up, documentation, or physical exam to expedite treatment and maximize convenience. However, there are no research studies available investigating the quality of care differences that exist in patient-relatives versus nonfamily member patients.³ Moreover, treating family does not eliminate the risk for legal action if an adverse event transpires, especially if the relationship between the physician and relative deteriorates.³ Concerned by the repercussions of treating family, Medicare barred the payment of physicians who cared for immediate family members on November 13, 1989.¹

When the American Medical Association (AMA) drafted the first code of medical ethics in 1847, they recommended against physicians treating their family members because "anxiety associated with the sickness of a wife or child tends to obscure judgment, and produce timidity and irresolution in his practice."^{5,6} The guidelines were reiterated in 1993 in the AMA code of medical ethics, which stated "physicians generally should not treat themselves or members of their immediate families."^{5,6} However, the AMA code of ethics states that physicians are allowed to treat their relatives if the care is short-term, if the family member has minor problems, and in emergency or isolated settings.⁵ What types of situations fall under the category of short-term care or minor problems? Is it reasonable to drain a painful cyst, prescribe topical steroids for an acute flare of eczema, or even administer botox for a close relative? Although the American Academy of Dermatology (AAD) code of ethics states, "the dermatologist is expected to provide competent and compassionate patient care, exercise appropriate respect for other health care professionals, and maintain the patient's best interests as paramount," there are no recommendations regarding the ethics of treating family.

Many of today's physicians perform both major and minor procedures on close family.³ A survey of 465 physicians inquiring about their habits concerning the medical care of family revealed that ~99% of the physicians reported requests from family members for medical advice, diagnosis, or treatment. About 80% of the responders had diagnosed a medical illness in the past, and 72% performed a physical exam on a loved one. Further, 9% reported performing dermatologic procedures, including nonmelanoma skin cancer surgery, cryosurgery, laceration repair, and nail removal on close relatives. A total of 262 respondents reported refusing a relative's request for medical diagnosis or treatment, and 214 of these individuals provided a reason. Of the 214 respondents, only 8 participants (4%) cited ethical or legal concerns. Physicians should openly discuss the

medical care of family members early in their careers, setting boundaries for their relatives and friends. Given that almost 100% of physicians receive questions regarding medical care from family members, doctors should inform their patient-relatives that medical concerns should be discussed in appropriate settings (ie, office, clinic) to maintain the integrity and privacy of the patient-relative's medical information and to ensure proper documentation and history taking. La Puma et al³ suggest that before treating a loved one, physicians should answer 7 questions:

- 1) Am I trained to meet my relative's medical needs?
- 2) Am I too close to be able to openly discuss intimate details of the history and physical?
- 3) As the physician, can I be objective enough to not give too much, too little, or inappropriate care?
- 4) Is my medical involvement likely to worsen familial conflicts?
- 5) Are my relatives more likely to adhere to the advice of an outside physician?

- 6) Will I allow the physician to whom I refer my relative to attend to the relative?
- 7) Am I willing to be accountable to my peers and the public for this medical care?

We postulate 4 additional questions that are important to consider before agreeing to provide medical care for immediate family:

- 1) Would my relative be better served seeing a specialist?
- 2) Would the relative feel pressured to adhere to my treatment suggestions when not wanting to go that therapeutic route?
- 3) How will the relative respond if the treatment has complications?
- 4) Are their potential future malpractice implications?

Though a consensus on the topic has not been reached, most physicians agree that treating a family member in an emergency situation is appropriate if the patient's ailment is within the physician's medical expertise.^{1,4-6}

ANALYSIS OF CASE SCENARIO

Choice A, performing the procedure would not be the optimal choice for Dr E, given that her husband's procedure is not an emergency and will require continued follow-up. In light of the ethical principles of beneficence and non-maleficence, it would be best for Dr E to refer her husband to a dermatologist at a different practice.

Choice B, referring her husband to a colleague for treatment is a feasible alternative,

but not the best choice. Dr E's husband might feel more comfortable being treated by a dermatologist to whom he has no personal ties.

Choice C, in our opinion, would be the best option for Dr E and her husband. There are a number of ethical, emotional, and competency issues that arise when treating a family member. To provide care in accordance with the AMA and AAD code of ethics, Dr E and her husband should find a physician at an outside practice that will provide the best care for her husband.

BOTTOM LINE

In accordance with the AMA code of ethics, a physician should avoid providing care for family members or close friends. Dr E risks the potential of violating the ethical principles of beneficence, non-maleficence, autonomy, and informed consent if she decides to perform the excision on her husband. As physicians, it is best to address this topic early to prevent future misunderstandings regarding the emotional and legal implications of treating our immediate family.

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