



Controversy

Emergency physician care of family members, friends, colleagues and self

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ABSTRACT

Emergency Physicians are frequently called upon to treat family members, friends, colleagues, subordinates or others with whom they have a personal relationship; or they may elect to treat themselves. This may occur in the Emergency Department (ED), outside of the ED, as an informal, or “curbside” consultation, long distance by telecommunication or even at home at any hour. In surveys, the vast majority of physicians report that they have provided some level of care to family members, friends, colleagues or themselves, sometime during their professional career. Despite being common, this practice raises ethical concerns and concern for the welfare of both the patient and the physician. This article suggests ethical and practical guidance for the emergency physician as to how to approach these situations.

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1. Introduction

The triage and care of VIP patients in the Emergency Department (ED) has recently been reviewed in the emergency medicine (EM) literature and has been addressed elsewhere in the past [1]. These situations introduce the risk that the physician will vary their actual medical care from the standard treatment and inadvertently produce harm rather than benefit [1]. Similar principles apply to the treatment of family, friends, business associates, colleagues, and subordinates (i.e. co-workers with perceived status inferiority) of the emergency physician (EP) or the EP herself or himself. Emergency Medicine organizations and publications have not addressed these circumstances. Other medical specialties and some hospital medical staff bylaws do address these issues. The American Medical Association (AMA) maintains a policy and first addressed the treatment of family members in its 1901 Code of Ethics [2,3]. This article will examine the ethical and practical issues associated with EPs treating family, friends, colleagues, subordinates and themselves and suggest guidance as to how to proceed.

2. Ethical issues

Three core ethical principles in Western medicine are applicable in this discussion: autonomy, beneficence and nonmaleficence. Patient autonomy refers to the right of a patient to make a free and unencumbered choice regarding their care and to control what happens to their own bodies. This principle affords patients the right to seek medical care for themselves or not. For example, a patient may choose not to seek formal care for a laceration; or alternatively may seek an opinion from or to be cared for by a neighbor who is an emergency physician. In other situations, as discussed below, a patient who is seen in the ED and is offered care by an ED friend or colleague may be placed in a situation in which they are reluctant to express a free choice as to provider or treatment.

Physicians' autonomy is also relevant, which provides moral status to their personal moral values and conscience, their knowledge and obligation to use it wisely and well; and their collective obligations to patients and society [4]. Emergency physicians (EPs) should cautiously apply this principle to provide emergency care when prudent and necessary, but are advised not to in some situations as discussed below.

Beneficence describes physicians' duty to provide benefit to a patient. In cases of family and friends seeking advice, there is an affirmative ethical duty to ensure that the best medical care is afforded to the patient by the most qualified person.

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Nonmaleficence refers to their duty to not do harm. An example of nonmaleficence would be to not attempt to practice outside of the zone of one's skills, training, or knowledge. Juxtaposed to these concerns about the harms of treating family, friends, and self is the potential disservice by choosing not to assist in cases where the physician's expertise and compassion might benefit this group of patients.

Each of the aforementioned principles should be considered in the context of EPs treating a patient who is a family member, a friend or colleague with whom the physician shares a close or even casual personal relationship. Justice, a fourth principle of bioethics, related to resource distribution, is not directly relevant to this discussion.

The consensus of previously published statements and institutional policies is that the major problem in treating seriously ill patients with whom a physician has a close relationship is the loss of objectivity, with possible attendant harms not only to the patient but to the physician caring for them in the event of a poor outcome [5]. In such circumstances, history taking may be hindered because of the tendency to shy away from personal or sensitive subjects, such as drug or alcohol use or sexual matters [6]. The physical examination is often abbreviated, vital signs may not be taken, and the patient may not be completely undressed or examined due to privacy concerns. In addition, the physician may feel obligated to offer an intervention that might not normally be considered, such as a procedure or a medication prescription. Conversely, the physician may shy away from these out of exaggerated fears of complications or bad outcomes.

It is also difficult to be in the position of discussing serious or grim problems, where one might minimize the situation compared to other situations and may recommend suboptimal interventions. In these ways, the ethical duty of honesty by the physician and the protection of the patient's ability to confide in her or his doctor may consciously or unconsciously be compromised.

3. Care of family members

Most existing policy statements, particularly the AMA policy carve out an exception for treating family members during emergencies, and for short term and minor ailments. However, "emergency", "family", "short-term" and, "minor" are not defined, presenting a dilemma for EPs.

The notion of "emergency" for the family practitioner or other specialist aside from the EP may be obvious, but the EP's environment of care is always the ED. The EP could interpret this exception to mean that the EP could or should treat anyone who presents to the ED, but this may be overly simplistic and lead to harm. We believe that EM organizations should offer more nuanced guidance.

"Family member" is vague. Most would agree that first degree family members and grandparents fall into this group. The group is defined by some organizations to include aunts, uncles, cousins, second-cousins, in-laws and in some cases even more distant relatives. In some cultures, those who are considered family members, including those related to a spouse can run into the hundreds. Table 1 delineates family members as defined by Medicare [7].

Short-term is also vague but presumably refers to a brief episodic visit rather than long-term care. For short term episodes, for practical reasons, the physician who is also a family member may suffice as the treating physician if it is for a minor condition. A physician is well advised to leave the long-term care of a family member to another trusted physician. The physician's primary role in that instance is as a supportive family member who can knowledgeably urge them to visit a high qualified, appropriate physician in a timely manner or to help interpret results or explain conditions.

Minor, although not defined elsewhere, is self-explanatory and includes conditions such as sore throat, ear ache, uncomplicated wound, suspected sprain or minor fracture, viral type illness, cough, abdominal cramps, early onset abdominal pain, likely urinary tract infection, etc. (the danger, as all EPs know, is that seemingly minor complaints

Table 1

Medicare definitions: immediate family and household members.

The following degrees of relationship are included within the Medicare definition of immediate relative

- Husband and wife
- Natural or adoptive parent, child, and sibling
- Stepparent, stepchild, stepbrother, and stepsister
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law
- Grandparent and grandchild; and
- Spouse of grandparent and grandchild.

Note: A brother-in-law or sister-in-law relationship does not exist between a physician (or supplier) and the spouse of his wife's (her husband's) brother or sister. A father-in-law or mother-in-law relationship does not exist between a physician and his/her spouse's stepfather or stepmother. A step-relationship and an in-law relationship continue to exist even if the marriage upon which the relationship is based terminates through divorce or through the death of one of the parties. Thus, for example, if a physician treats his step-father after the death of his natural mother or after the step-father and natural mother are divorced or if he treats his father-in-law or mother-in-law after the death of his wife, the services are considered to have been furnished to an immediate relative and are excluded from coverage.

Members of Patient's Household These are persons sharing a common abode with the patient as a part of a single-family unit, including those related by blood, marriage, or adoption, domestic employees, and others who live together as part of a single-family unit. A mere roomer or boarder is not included.

occasionally can presage devastating disease; a lack of objectivity can enhance the chance of a misdiagnosis and precipitate devastating guilt in the clinician). "Minor" should be self-evident but would not include treating an arrhythmia, myocardial infarction, sepsis, stroke, shock or performing an invasive procedure unless there is no other physician available. Despite this, in a comprehensive survey of 691 physicians, 465 of whom responded, in a large suburban Chicago hospital, a small but significant percentage of physicians report treating these types of conditions as well as performing elective surgery on family members [8]. In the same study, 80% of the respondents had reported providing some level of care to a family member. In a Malaysian study of 22 primary care practitioners, every one of them had treated their family members [9].

Some family members may have an expectation and a preference for the physician-relative to care for them if they were to come to the ED. If the first two conditions are met, i.e. the problem is episodic and minor, in the authors' opinion, this is usually acceptable if objectivity can be maintained, there is no coercion, and the consequences of a failed action are small.

It is difficult to draw the line between cares that might begin at home versus the premises of the hospital ED. If a 5-year-old child complains of an earache to mommy-doctor in the middle of the night, who could fault her for examining the ear with an otoscope; or assessing for abnormal breath sounds, fever, clamminess, or meningismus? The same thing could be said for examining a wound or a rash. Therefore, a blanket prohibition against a physician ever treating a family member, including at home, on vacation, or in a medical setting is unrealistic, impractical and improbable to occur. Another recommendation or "requirement" that is frequently mentioned is to keep a record of the visit as one would for any other patient. This too is unrealistic and impractical. Currently, with the electronic medical record being standard, where and how would one keep such a record in the middle of the night? It could be done technically in hospitals that are fully integrated but is unlikely to occur. In the authors' opinion, setting expectations that force the vast majority of people to violate them merely because of normal human behavior or for practical reasons, is not an ideal way to set moral norms.

4. Care of friends

Since family members are covered by the exceptions noted above, the authors assume friends would be as well since they are usually not

as close. Although this may not always be the case, we believe our assumptions generally hold true for both groups.

Friends (or their families) or community members may present to the ED and ask for a particular physician. Sometimes this is to gain access or to get special attention but sometimes just for comfort or because they think the physician-friend possesses special knowledge and skills. As noted above, if the condition is minor and short term, this may be acceptable [10]. No studies exist as to what friends would actually prefer if asked confidentially.

A risk is that friends of a physician may withhold critical information they would reveal to another doctor. One approach is to greet the friend, make them feel comfortable and hand the care off to another physician if one is available and the patient is agreeable. They may in fact prefer it and be more comfortable but be reluctant to express their autonomous wishes if not offered the choice. If no other physician is immediately available, the physician friend should not hesitate to intervene in a true emergency.

5. Care of colleagues

In a hospital in which an emergency physician practices regularly, especially for a long time, it may be common to be called upon to treat a physician, their family members, or other medical colleagues or hospital personal they know. In some cases, these potential patients may know all of the ED physicians, making it nearly impossible for an EM colleague to not treat them [11]. Also, as in the examples above, there may also be an expectation or desire on the part of the patient to have the ED physician with whom they are familiar treat them in accordance with their perceived “VIP” status and their autonomous wishes. There also may be a supposed honor conferred by the colleague being treated by the Chair of the department or other senior colleague and conversely, the Chair or other senior colleagues may feel pressured to treat a fellow colleague. However, Chairs or others who have moved on to largely administrative roles may not be best able to provide optimal care in some situations.

Treating physicians must be cognizant to maintain the physician-patient relationship in these encounters and to resist the urge to defer or alter their usual decision making or recommendations out of respect. Physician-patients may also be overwhelmed with well-intended co-workers or acquaintances who wish to offer their services or visit but may ultimately impede care. The emergency physician of record or in some cases, if available, the department leadership should seek to limit such contacts in order to protect the patient's privacy and well-being.

6. Subordinates and other staff members

Because of proximity, other staff members frequently seek care in the ED, formally or informally. If seen formally, guidance similar to treating friends is advised. Short term treatment minor conditions are usually not a problem, and in a true emergency the EP on duty may be the most qualified to treat a patient. In other situations, the EP should ask herself or himself “what would be the consequences if something goes wrong”? Patients in a position of status inferiority may not be well situated to make autonomous choices. True subordinates may also not feel comfortable rejecting advice or treatment with which they may not be comfortable.

Informal consultation is frequently sought too. This is somewhat akin to curbside consultation. A policy of requiring all staff members to sign in and be seen formally is advised in order to keep appropriate records and to ensure appropriate and comprehensive care. Undocumented encounters are fraught with risk to the patient and provider, and may result in inappropriate shortcuts, such as omitting vital signs or laboratory testing. Undocumented visits are generally also not covered by malpractice insurance. Within the limits of institutional policy

and the law, in some circumstances, professional fees may be waived; this is preferable to an undocumented encounter.

7. Curbside and telephone consultations

“Curbside consults” (also called “hallway”, “elevator”, or “sidewalk” consults) are informal consults that are provided to assist a physician colleague with a patient's care without actual in-person physician-patient contact, as a favor or courtesy, and usually without a medical record [12]. This is a time honored practice but has recently been criticized in some respects [13]. Curbside consultations are sometimes useful and generally do not result in malpractice liability, but they do carry risks [14].

More relevant to this article is when they involve the care of friends or family members of a physician. This can lead to an extraordinary level of guilt in the EP. In a case example, an EP's father calls her to say he is having heartburn for the last few days. In the elevator the next day, she asks a gastroenterologist colleague what the preferred proton pump inhibitor is these days and when a workup for *H. pylori* is indicated. After 2 days, her father suffers a myocardial infarction and is pronounced dead in her ED.

Long-distance consultations by specialists who are not emergency physicians may cause harm to patients, by directing tests or treatments that are not appropriate [6]. Worse yet is when a physician parent remotely intervenes and influences the care of their child, for instance, a college student [6].

Related to this category is the entire issue of telephone consultation. The common feature of curbside and telephonic consults is the treatment of a patient without actual in-person contact or the ability to review all relevant information. However, not only is this common but it is evolving in the era of Skype, Facetime, and even robots. Regardless, for the purposes of this discussion, what is important is the ability of the physician to remain objective and try to avoid all but clearly minor to moderate ailments and to stay within their scope of expertise. In another case example, a cousin calls an EP from two states away and asks what he thinks about imaging finding in her liver. He tells her that statistically, there is a 98% chance that it is completely benign, but that she should have it further evaluated; she doesn't. She dies 2 years later from hepatic carcinoma.

8. Existing policies and guidelines on treating family and friends or self

Many organizations have policy statements regarding treating family members, self, or others with whom the physician has a close personal relationship, including The American Medical Association, the American College of Physicians, The American Academy of Pediatrics, the College of Physicians and Surgeons of Ontario and the College of Physicians and Surgeons of British Columbia [15–20]. A separate search of State Board web sites by one of the authors (JMG) reveals that 25 states have policies, restrictions, or have published articles in their newsletters discouraging treatment of some or all of these groups. [21,22] Twenty-five states give no guidance at all. A few local medical societies also discourage this practice. Most Boards that have restrictions refer to the AMA policy, which offers little advice to emergency physicians, especially for “minor” and “short term” treatment, as discussed above. More narrowly, a review performed by the Federation of State Medical Boards at the authors' request found that 28 states have guidance (usually restrictions) specifically as to prescriptions written to family members or self. Most of these are by statute or regulation, although actual outlawing of the practice is rare [23]. Individual hospitals may have policies and proscriptions on care of family members as well. Neither the American College of Emergency Physicians (ACEP), the American Academy of Emergency Medicine (AAEM) nor the Society of Academic Emergency Medicine (SAEM) has addressed this topic, perhaps because the environment and circumstances of practice are quite

Table 2

Beneficial and negative aspects of providing healthcare advice or treatment to family, friends, colleagues and self.

Potential beneficial aspects	Potential negative aspects
The physician can address and treat emergent situations until other clinicians are available.	History and physical examination may be limited due to privacy concerns.
The physician has informed knowledge based on education and experience to offer patient.	The patient loses confidentiality and potentially withholds important information.
The physician can interpret medical conditions, diagnostic tests, and reports.	There may be associated guilt or blame if there is a negative interaction or outcome.
The physician can help discuss specialists, proposed interventions and protocols.	The patient may hold the physician to blame for a bad outcome, even if it's an accepted side effect or complication or the natural course of the disease.
The physician can help explain procedures along with risks and benefits based on literature and training within one's area of expertise.	There may be an element of coercion, if the patient feels obligated to follow the physician's advice.
The patient may prefer being taken care of by a physician they know and in fact, may get special care by the doctor and her or his associates.	Specific recommendations by the physician may be based on fear of errors or omissions, rather than the usual standard of practice.

These columns are not meant to be symmetric.

variable and current recommendations by other organizations are either vague or non-existent. This leaves member EPs without guidance on an important topic.

Medicare and other insurers bar payments for treatment of immediate family members and members of their household mostly because of the concern that unscrupulous providers may engage in fraud. The rules are complicated and the average physician may not be aware of them. Table 1 defines these relationships according to current Medicare law [7].

9. Self-prescribing and treatment

An oft-quoted adage of Sir William Osler is “A physician who treats himself (sic) has a fool for a patient”. Nevertheless, multiple studies show that self-treatment during some point during training or practice is common. Studies from the United States, Great Britain, Norway and elsewhere report the incidence to be from 52%–90% [24]. This begins as early as residency [25]. While often condemned or discouraged,

Table 3

Recommendations and suggested guidelines for the treatment of family, friends, colleagues, and self.

<ul style="list-style-type: none"> Recognize the ethical boundaries and possible medical and psychological repercussions of treating family members, colleagues, friends and co-workers. In true emergency situations, whether inside or outside the ED, provide care until another competent healthcare provider is available. It is generally acceptable to treat minor, episodic conditions, if the consequences of failure are small. Know the legal and regulatory limits placed on this behavior by various professional bodies (e.g., state laws, state medical boards, professional organization ethical codes, hospital bylaws). If asked, provide advice about what type and which physician to see for a problem. Help those who ask to interpret laboratory and imaging results (if within one's competency), and to interpret what their physician said. Discuss appropriate communications and questions to ask with the treating physician of record. When questions arise as to a questionable situation and the patient is uncomfortable, encourage a second opinion rather than providing a curbside consultation. Emergency physicians should encourage professional societies to develop guidelines to help their physician members traverse the legal, ethical and practical morass these situations present. EM organizations should address these issues.
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some have defended it as practical and realistic under some circumstances, such as refilling one's own prescription for an oral contraceptive between menstrual cycles or an anti-hypertensive between visits to another doctor. In general, a strict prohibition that is violated up to 90% of the time seems to run counter to reason and human instinct. Nevertheless, self-prescribing diagnosis, or treatment introduces potential harm to the physician in some circumstances, such as new, unexplained conditions.

As noted, twenty-eight states have some sort of explicit prohibition of prescribing for self or family members, specifically for certain controlled substances, usually through statutes or regulations [26]. North Carolina and Tennessee have Medical Board policies, the violations of which can be subject to Board disciplinary actions. Physicians would do well to be familiar with the laws and regulations in their states.

10. Discussion and conclusions

Not every source agrees that there should be strict prohibitions on treating family, friends or colleagues or in some situations, for treating minor ailments or prescription refills of non-controlled substances for physicians themselves [27–29]. Half of state medical Boards address some or all of these issues and half do not. Potential positive and negative aspects of caring for family and friends are listed in Table 2.

In the emergency setting it is even more difficult because of the lack of clarity on exceptions for “emergencies” and “short-term” treatment. Clearly, geographic location should be considered because of the lack of other resources in rural areas and states with large geographic spreads of populations. The authors of this paper encourage organizations and societies to address this issue and provide guidance to members.

Table 3 lists suggestions and recommendations for EPs and EM organizations.

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