

SOUNDING BOARD

No Appointment Necessary? Ethical Challenges in Treating Friends and Family

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Physicians may be asked or choose to provide medical care to family members or to give informal or undocumented care to friends, neighbors, or colleagues who are not their patients. Treatment can range from refilling a prescription, discussing a recent injury, or ordering a test to performing major surgeries. The ethical risks of caring for relatives or friends or providing informal and undocumented care are substantial but may be overlooked. Although there may be limited situations in which providing medical treatment for friends and family is acceptable, these situations are often nuanced. We review guidance from professional medical organizations, summarize research on the prevalence and attitudes about physicians' treatment of friends and family, and review the ethical issues and offer guidance for making decisions about when to provide care.

We serve on the pediatric ethics committee at the University of Michigan and were motivated to prepare this article after we were consulted by a pediatric specialist in our institution who was concerned about a referral she had received. The patient ("Elizabeth") was an 18-year-old who had been referred for evaluation of mental health issues. However, on examining the medical records more closely, the pediatric specialist recognized that despite different last names, the primary care physician making the referral also happened to be Elizabeth's parent. Given the concern for patient confidentiality, ethical conflicts in roles, and the potentially sensitive issues that could be raised during the consultation, the specialist conferred with our committee. A review of the chart showed that Elizabeth's parent had served as her de facto primary care physician for many years, and there were multiple case notes in the medical record

regarding her well-child examinations and routine care. Elizabeth was seen in a clinic where her parent worked along with several other primary care physicians.

ETHICAL GUIDANCE FROM PROFESSIONAL ORGANIZATIONS

Not all medical organizations have issued guidelines on this topic. However, all those that have published guidelines recommend against care for self or family other than in exceptional situations, and we are aware of no professional organization that condones this practice. The very first code of medical ethics drafted by the American Medical Association (AMA) in 1847 recommended against physicians treating family members, stating that "the natural anxiety and solicitude which he [the physician] experiences at the sickness of a wife, a child . . . tend to obscure his judgment, and produce timidity and irresolution in his practice."¹

The 1993 guidelines of the AMA Code of Medical Ethics state that physicians "generally should not treat themselves or members of their immediate families."² The code describes many potential pitfalls in the care of family members, including failure to ask about sensitive areas of the medical history or social situation, avoiding important or sensitive aspects of the physical examination, a lack of professional objectivity, conflict among roles with potential complications if the medical care does not go well, practicing outside the scope of training, the possibility that the patient will not be forthcoming, and lack of informed consent and assent by the patient. The American College of Physicians recently updated its ethical principles and asserted that physicians should "usually not enter into the

dual relationship of physician-family member or physician-friend.²³ Similarly, the American Academy of Pediatrics states that “caring for one’s own children presents significant ethical issues.”²⁴ All these organizations recognize that there may be minor care or emergency situations for which no other physician is available in which acute and limited care may be appropriate.

PREVALENCE AND ATTITUDES

In several studies assessing the prevalence of medical treatment of friends or family by physicians, there is a substantial gap between what professional organizations recommend and what physicians actually do. A 1993 survey of physician-parents in Iowa reported that 4% of children had a parent as the physician of record, and two thirds of these physicians prescribed medications for their child.⁵ A 1991 study showed that 99% of surveyed physicians reported having received requests from family members for medical advice, diagnosis, or treatment, and 83% had prescribed medications for relatives.⁶ Physicians cite convenience as a key reason to provide this care, but other explanations have included a wish to save the relative money as well as a belief that “I provide the best care.”⁷

The actual treatments that physicians provide to friends and family range dramatically from acute and minor care to care for serious chronic illnesses and invasive procedures.^{6,8} In one study, 15% of hospital physicians reported serving as the attending for a loved one, and 9% had performed elective surgery on a relative.⁶

Although most surveys suggest medications such as antibiotics, birth-control pills, and analgesics are the most commonly prescribed drugs in these encounters, there are substantial numbers of prescriptions for antidepressants, sedatives, narcotic pain medications, and other addictive substances.⁸⁻¹⁰ Studies have shown that physicians often feel pressured and conflicted about requests to treat friends and family and that most physicians have declined at least one request or indicated that they would consider declining, as observed in clinical vignettes.^{11,12}

On the basis of our clinical experience, we developed three realistic case vignettes as examples of different types of care a physician might be asked or tempted to provide to family members or friends (Table 1). We are not providing “right” or “wrong” answers but use these vignettes as illustrations of potential ethical issues.

The ethical issues that are involved in treating friends and family are numerous and become increasingly problematic as the closeness of the relationship increases. Physicians who are also a family member of the patient face numerous conflicts of interest between their dual roles. Although physicians may see themselves as the best advocate for their family, it is easy to lose perspective when one has emotional investment, and informal care may even pose a risk or be detrimental to the patient.

The issues of beneficence (to provide care in the patient’s benefit or best interest) and non-maleficence (to do no harm) are important in this discussion. In the care of friends and family, there may be inappropriate use of evaluations,



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Table 1. Case Vignettes: Is This Practice Ethical?

Allie, a 15-year-old neighbor with asthma	Allie’s mother knocks on your door and reports that Allie is doing fine but has run out of her albuterol inhaler, which she needs before her soccer game that starts in 2 hours. You know that Allie has had asthma for years and you believe that she is in good health, but you are not her doctor. You agree to write a prescription for albuterol.
Marc, a 55-year-old friend and dermatologist	Marc is a friend from down the hall whom you know through work and have socialized with outside the office. He pops his head in your office before your clinic and asks if you would mind giving him a prescription for fluoxetine because he has been feeling a little depressed since his divorce and wants to see if this will help his mood. You agree, write a prescription for a 3-month supply, and encourage him to see a therapist.
Ralph, a 72-year-old relative	Your father-in-law, Ralph, has just had a car accident and is admitted to the hospital where you work as an emergency department physician. You visit Ralph in the intensive care unit, where he is intubated. You are distressed to see that he is moaning and seems to be in substantial pain. The resident does not respond to your pages, so you write an order to increase his morphine dose.

referrals, medications, and testing (with either overuse or underuse), and physicians may feel pressure to provide services outside their scope of practice.^{5,6,12}

Physicians may not ask important, sensitive questions and may not perform personal or intimate parts of a physical examination with a spouse or family member when they would not think of skipping this step during routine care of an unrelated patient.^{7,13} This issue may be particularly sensitive if the friend is a colleague. Would the physician who wrote a prescription for Marc (in Table 1) be comfortable asking about substance use or suicidality in the informal conversation? One could also question whether intimate personal examination of a family member — albeit important for some medical issues — could potentially be inappropriate. With informal care, there is rarely appropriate medical follow-up and documentation, and care is often not communicated to the patient's primary physician, resulting in inadequate knowledge of the patient's history.^{5,7}

Physicians may skip critical aspects of informed consent, shared decision making, and collaboration if they have a primarily personal or social relationship with the patient. However, the personal relationship may become more complex if there is a complication in treatment or care, and the physician may need to manage his or her guilt and remorse if there is a clinical error leading to an adverse outcome. In addition, there may be hidden and unrecognized conflicts of interest. Calling in a prescription for albuterol for Allie (in Table 1) saves the neighbor time and hassle and prevents any potential conflict with Allie's mother. Prescribing an antidepressant for Marc may lead to a continued good relationship and referrals from his practice.

There is also a substantial risk of diminished or overridden patient autonomy. A family member may not always feel comfortable questioning or declining care, being fully honest, or seeking alternative opinions. Patients may not be allowed to provide adequately informed consent, nor may they have appropriate confidentiality in their care when relatives are the health care provider.⁷ For care of pediatric patients, the issues can be even more complex. Minor patients have the right to participate in health care decisions but may defer input if their parent is the treating physician.

In addition, many states allow some adolescent care without parental involvement or consent; if the parent is providing treatment, the adolescent does not really have the option for such care.

On a practical basis, there are also risks of malpractice or other legal action, since writing a prescription, reviewing patient records, or giving an opinion to a patient can establish a physician-patient relationship, which can open the door to the need for ongoing care and even legal action in the case of adverse outcomes.^{11,14} Although it is possible that family members may be less likely to sue relatives than are unrelated patients, we are aware of cases in which estranged family members have turned in their physician-relative to the state medical board.

If a physician gives a prescription for a controlled substance to a family member, the state licensing board can become involved and review the prescribing practices. Treating friends and family can also raise potential billing and reimbursement issues when tests or consultations are ordered through nontraditional channels or when billing is altered, as in the case of professional courtesy.^{15,16} Our institution has rules that prohibit providers from prescribing controlled substances to self and family members and from submitting insurance claims for health care services or procedures provided to oneself or immediate family members. The policy requires that all bills be sent directly to the patient. Medicare also prohibits payment for services ordered or performed by a provider for a family member.¹⁷

We recognize that within medical institutions and in small towns or rural areas, physicians often socialize with the same people for whom they provide care, blurring the lines between friend and patient. We would assert, however, that there is a distinction between a friend or colleague who establishes care as a patient in the practice, and for whom the physician keeps formal medical records, and a friend or neighbor who only interacts with the physician socially. Some physicians practice in settings in which there is no other provider to offer care; a surgeon in a rural area may be the only option for a family member who needs urgent or emergent surgery, and in such cases, care would be ethically appropriate. Our ethical concerns center around the provision of informal and un-

documented care to these friends and family members — care outside the usual medical encounter.

CASE AND POLICY DISCUSSION

After reviewing Elizabeth's case, we made the decision to forward the information to our hospital's Office of Clinical Affairs (OCA), which governs faculty practice, owing to concerns that serving as the primary care physician for one's own child might be violating institutional clinical and confidentiality policies. The OCA's investigation revealed that there was another provider who could replace Elizabeth's parent as her primary care physician, and the specialist was comfortable with sending notes to the other physician. We also learned that there was no institutional policy, other than billing, with respect to physicians who are treating friends and family. Therefore, our committee worked with the adult ethics committee to develop recommendations to help guide the OCA.

As we discussed the issue of treating friends and family members among our peers, we heard stories from our colleagues that were similar to those described in the literature. Most of our colleagues were aware of instances in which physicians provided both minor and major care to family members. These examples included cases in which physicians treated colleagues with antibiotics during residency, residents or fellows inserted an intrauterine device or wrote a prescription for contraception for a peer, and providers called in a refill for a child's medication for a chronic condition. However, we also became aware of more substantive medical care, including the performance of major and minor procedures and taking over the hospital care of a family member, as illustrated in the vignette involving Ralph (Table 1).

In our institution, we made several presentations on panels and during grand rounds about the ethical challenges of caring for friends and family. During these events, we were struck by the diversity of opinions among physicians about the appropriateness of this practice. Some physicians asserted it was their right to provide medical care for friends and family and that they were being responsible physicians by taking care of the medical needs of their own child

rather than burdening the system or taking time off from work to seek care. Most people felt that making triage decisions would be appropriate. But others argued that they had earned the privilege through their medical training to write prescriptions for friends or loved ones. We frequently heard that the broader medical system provides care in ways that can be inconvenient, time-consuming, and complicated for patients. Many physicians stated that they often provided care to their family to bypass these frustrating barriers to care, as seen in Allie's case (Table 1). The discussions about care were complex, and we struggled with conflicting values.

CONCLUSIONS

At the request of the OCA, the pediatric ethics committee, in collaboration with the adult ethics committee, was asked to develop concrete recommendations with a focus on the physician's role in hospitals and clinics. We developed a proposed policy that is currently under review by our institution for possible adoption. (A copy of the proposal is provided in the Supplementary Appendix, available with the full text of this article at NEJM.org.) The draft policy advises that health providers avoid medical evaluation or treatment of immediate family members other than in emergency situations or urgent settings when no other provider is immediately available. Physicians who provide treatment are advised to notify the patient's primary care physician as soon as possible to allow for proper documentation. We were asked to focus the policy so that it could be monitored in the institutional setting and avoid a focus on care provided at home.

The draft policy highlights the potential dangers of caring for friends and family through informal relationships and consultation and emphasizes the ethical challenges that must be considered by all providers who are faced with these requests. It defines immediate family members and members of the household and lays out specific types of care that should be avoided except in clear, time-limited emergencies and disasters or situations in which there is a clear and immediate need and no other health care provider is available.

We recognize that these are difficult issues and that the decisions may not always be

straightforward. However, the AMA, along with several medical societies, has emphasized the ethical pitfalls in informal care and strongly advised against such care except in unusual or emergency situations. It is our hope that providers will think through the potential ethical conflicts before offering informal care. We also urge providers who are involved in medical education to help trainees understand the ethical boundaries of care as part of their professional role and encourage them to refrain from treating friends, family members, and themselves.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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