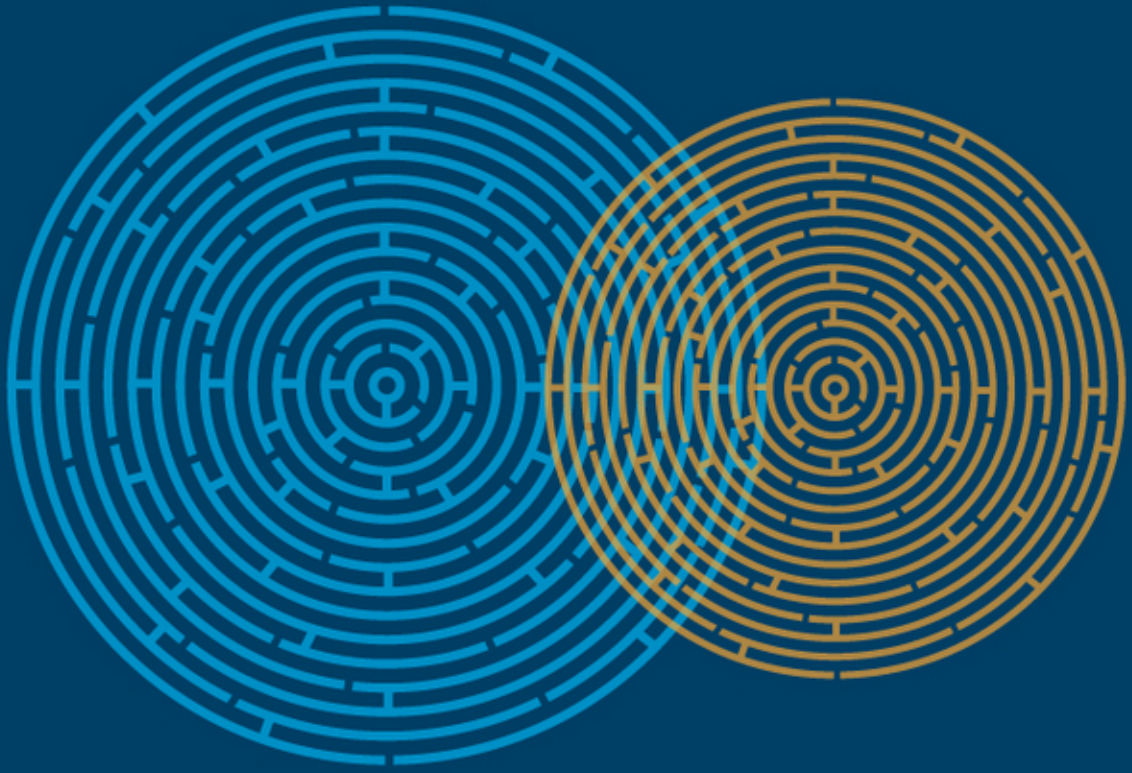
# Ethical Problems in Emergency Medicine

## A discussion-based review

Editor-in-Chief **John Jesus** · Senior Editor **Peter Rosen**

CURRENT TOPICS IN EMERGENCY MEDICINE



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# Current Topics in Emergency Medicine

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# Contents

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# Preface

The emergency department (ED) is a setting in which medicine is practiced with limited time and information, where relationships with patients are stressed and fleeting, and the diversity of population and the human condition is extraordinary. At once humbling and extreme, these situations are replete with ethical conflicts with which emergency clinicians continually grapple. This book is designed to consolidate the relevant literature as well as the thoughts of professionals currently working in the field into a practical and accessible reference for the emergency medical technician, student, nurse, resident, and attending emergency physician. Each chapter is divided into four sections: case presentation, discussion, review of the current literature, and recommendations. Designed to serve simultaneously as a learning and reference tool, each chapter begins with a real case that was encountered in an ED setting. The case presentation is followed by a short discussion of the case, as if at a morbidity and mortality conference, by a panel of experienced attending physicians explaining how they would approach the ethical dilemmas associated with the case, and a review of the existing literature. In the interests of convenience and ease of reading, in the discussion section, the male pronoun alone is often used when referring to a physician or patient. The concluding section contains recommendations, which, in and of themselves, may be used as a quick review and reference guide while caring for patients. Although the book is written from the viewpoint of physicians practicing in the USA, several principles would apply to physicians working in other countries as well.

The concept of this book originated from two sources: the first was a conversation with Richard Wolfe about the relative dearth of literature on ethical problems in emergency medicine. What does exist often appears to be theoretical, derived by professionals who do not practice emergency medicine and are oblivious to the nuances of making decisions in a severely time-constrained environment. The second source of inspiration came from the success of the discussion format used in the difficult airway section in the *Journal of Internal and Emergency Medicine*.

The case-based format of the book is based on the weekly morbidity and mortality conferences at the Beth Israel Deaconess Medical Center in Boston, Massachusetts, USA. This conference has been one of the most successful forms of education of our residency program in emergency medicine. We therefore felt there is educational value in presenting problems based on cases.[1] Each case is presented by the chapter author(s), and then discussed by a panel comprising the book's editors and special guests for the topic when appropriate. The editors were chosen to represent different institutions and schools of thought. We also deliberately chose editors and authors with different amounts of experience and practice, so that we could represent different generations of clinical practice. While we hoped to attain consensus on an approach to ethical dilemmas, you will quickly note that we rarely all agree. Common among all discussants, however, is a shared belief in human dignity and a respectful and collaborative approach to solving ethical problems.

Current medical literature places a heavy emphasis on "evidence" based on prior research. As one who reads any evidence-based literature knows, however, quality of evidence is hard to define, and is often referenced against the gold standard of a prospective, randomized clinical trial. Although clinical trials are possible within the field of medical ethics, generalizable answers to ethical dilemmas can be elusive. Contributing to this frustrating reality is the concept that there are no hardline principles or rules that apply to all ethical dilemmas. The often cited principles that serve as the basis for US federal regulations include respect for persons, justice, beneficence, and nonmaleficence. What is not as commonly understood, is that these principles are all equally important and should be used as a framework, rather than as strict rules, to assess moral problems in the pursuit of the "'greatest possible balance' of right over wrong."[2] We violate the principle of respect for persons when we physically and chemically restrain the agitated suicidal patient in the ED, for example, because we identify the beneficence in our efforts to protect

patient safety from self-harm as more important. In addition, the value of life in and of itself is not among this list of principles obscuring what should be the fundamental tenet of ethics in medicine.

What about citing prior ethical opinions? This is, in fact, one of the foundations of medical ethics, that prior opinions are useful in helping one to decide what to do. Although useful considerations, they often will not solve a modern dilemma since attitudes change drastically on emotionally charged medical ethical issues. Although we will refer to opinions cited, we will not assign weight or term of evidence for such opinions. Instead, we hope to demonstrate realistic attitudes towards problems that are based not only on generation, but to some degree culture, and individual physician experience. This is not to provide an "answer" that will satisfy all, but rather perspective on how emergency physicians make ethical decisions.

We have tried to cover the major ethical dilemmas discussed in the emergency medicine literature over the past decade, in an attempt to make this work as relevant and useful as possible. That said, we are sure to have omitted important topics readers might deem more important than the ones we chose to discuss. Nevertheless, no book can be infinite in scope, and if our methodology works, readers may find insight herein that may better inform their decisions and approach to ethical problems not specifically discussed. The point of the book is to remember that ethical dilemmas in the ED occur on a daily basis. If one does not reflect on them and establish a coherent management strategy before they are encountered clinically, one can be paralyzed from acting appropriately. It is our hope that this book will help medical professionals reflect on ethical problems, and help guide their decisions before they encounter the real-life situations. We believe that while we may not have always reached a consensus about the ethical dilemmas discussed in this volume, the reader will understand that all decisions about ethical problems are not equal, that reasonable people can and will disagree over how ethical problems ought to be managed, and that there are some decisions that are clearly wrong. However, equally important during disagreements is a serious attempt at respectful resolution through reasoned argument. In the following pages, we hope to stimulate thought, discussion, and perspective on what are difficult ethical problems we all encounter in the modern practice of emergency medicine.

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SECTION ONE

# Challenging professionalism

# 1 Physician care of family, friends, or colleagues

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## Section I: Case presentation

*Dr. Ralph Smith is a 50-year-old emergency physician who has been practicing for 20 years. The 10-year-old son of one of the other emergency physicians, with whom Dr. Smith has worked for 15 years, is brought in by his parents for a 3-cm simple laceration on the mentum of the chin. Dr. Smith is asked by the charge nurse to see this patient. What is the proper response?*

*Dr. Ralph Rogers' cousin Bob and wife Joan are visiting from Texas, and their luggage is lost. The airline informs them that they have no idea where their luggage is, and cannot give them an estimate of when they will be able to locate and deliver the bags. All of Joan's medications were in her checked luggage. On the way to Dr. Rogers' house, she stops by the emergency department (ED) where he is working, asks him to come to the waiting room, and then requests him to write her prescriptions. Dr. Rogers knows Joan is a smoker and has some mild chronic obstructive pulmonary disease and hypertension, but does not know any more of her medical history. She is on an albuterol inhaler, furosemide, atenolol, sertraline, and alprazolam. How should Dr. Rogers handle this situation?*

*Dr. Walter St. John is the Chairman of the ED at a large metropolitan hospital, and has been on staff for 30 years. Dr. Bob Schwartz, an internist on staff for the past 25 years is brought in with vomiting, diarrhea, abdominal pain, and fever. Should Dr. St. John treat Dr. Schwartz?*

*Dr. Elliott Alexander is on duty at a busy ED with several physicians on duty. His brother, age 63, presents with paroxysmal atrial fibrillation with a rapid response. His vital signs are: blood pressure 80/50 mmHg; heart rate 140–150 per minute; respiratory rate 20 minute; temperature 37.2 °C. The patient would like his brother to take care of him. What should Dr. Alexander do?*

## Section II: Discussion

**Dr. Peter Rosen:** As I remember the Hippocratic Oath, it does not restrict who your patients should be. In fact, it gives special attention to the care we all owe to our physician teachers and their families. What then are the ethical issues that prevent most physicians from caring for their friends and family?

**Dr. Joel Geiderman:** One issue to consider is patient autonomy, and whether or not they are situated in a position to refuse care when they know their caregiver socially. Then again, there are also those patients who really want us to take care of them, because they know and trust us. Each situation requires a different approach.

*Ethical Problems in Emergency Medicine: A Discussion-Based Review,* First Edition. John Jesus, Shamai A. Grossman, Arthur R. Derse, James G. Adams, Richard Wolfe, and Peter Rosen.

**Dr. Taku Taira:** The issues are definitely not black and white, but rather should be viewed as a sliding scale of what interventions are acceptable. The salient question is whether the preexisting relationship will impede good medical care. Then, a secondary consideration concerns the clinician's ability to respect patient autonomy, and to abide by all the other ethical principles by which we are supposed to practice.

**PR:** What is it specifically about patient autonomy that concerns you?

**TT:** Every patient must have the right to refuse care, and ought to expect to have an appropriate patient–physician relationship. The danger lies in the potential to consciously or subconsciously influence patients into having treatments, with which they feel uncomfortable, by nature of the shared non-medical relationship.

**PR:** One example of when patient autonomy may suffer is when the patient is an employee of the physician. Secondary to the mixture of relationships, the employee might not feel comfortable refusing the physician's recommendations. A similarly stressed relationship exists in professional sports, where athletes don't have the opportunity to choose their own physician, and are under an incredible amount of pressure to play, even if they have to play through injuries. One of the most prevalent situations, however, is a physician caring for their own children or spouse.

**Dr. James Adams:** That said, when I was growing up, our family practitioner took care of all of his own children. He would have been offended at the thought of taking his kids to another doctor. The problem, as I see it, concerns a physician's loss of objectivity when caring for friends and family. At some point, we're not able to objectively assess a child because we're too close to the situation. It's hard to be a parent **and** the doctor.

**PR:** It also depends on the circumstances. Attitudes towards treating your own family have changed significantly over the course of my professional lifetime. I used to work in a small town in Wyoming. The day my wife went into labor, she ruptured her membranes, but didn't progress. There were no other doctors in town that week, and after some scrambling I found a gynecologist 90 miles away. Out of necessity, I had to help perform the c-section on my wife; I would not have chosen to do this if I had any other options. I also had a couple of nights during which I sat up all night with a child trying to decide whether the child needed to go to surgery. If I had decided that surgery was necessary, I would have been the surgeon as there were no other surgeons for 80 miles or more. Trying to write rules about what is acceptable should take into consideration what alternatives are available. Yet, I have also found in treating my family that they only respect my advice when they agree with it.

**JG:** One reasonable argument against physicians caring for their friends and family is highlighted by the situation in which a bad outcome occurs. I would imagine that a family death would be devastating to the treating physician. Physicians should protect themselves from this situation. This may only be possible, however, by trying to avoid caring for a truly ill family member.

Here is the other side of the story. When my son was about 5 and a half, he fell off of his bicycle and sustained a simple laceration to his chin. When we arrived home with his wrecked bike, I informed my wife that he needed to be sutured. On the automobile ride to the ED, my son said, "Daddy, I want you to do it." I turned to my wife and asked, "What do you want me to do? I want you to feel comfortable. Would you rather call a plastic surgeon?" She looked at me like I was crazy and said, "Of course, I want you to do it." At that point, I didn't feel that I was in a position to call anyone else, and sutured him myself. He will never forget it and neither will I. To us, the experience was invaluable.

**PR:** I've sewn up my children. Although, I will admit that one of them took out his sutures faster than I could put them in, and didn't have a great result. I really think that ethically there is nothing wrong with taking care of members of your own family. When you feel that you don't have the requisite knowledge or skill, or you feel that someone else can do a better job, then you should involve another physician.

Historically, institutions have set limits on this practice when physicians attempt to treat family members, colleagues, and friends without charging them and without documenting a record of the interaction. This is a mistake, as a physician should document the same way for any patient. I've always felt badly about having to charge other physicians. I was raised with the notion that we took care of each other

without charge—but we aren't permitted to do that anymore.

Physicians must use some judgment about where to draw the line regarding what is and is not acceptable. I didn't particularly like operating on members of my own family (when I was a surgeon), and wouldn't have chosen to do so. That said, I was willing to do it when there was no other option. I agree, I would have felt terrible had any of those family members had a poor outcome, as I feel about any of my patients who don't do well.

**Dr. Arthur Derse:** I don't know of any legal restrictions, but the ethical problem I most identify with in treating colleagues is also the loss of objectivity. In treating colleagues and family members, you may not conduct as thorough an examination or you may avoid certain tests, and your patients may not disclose all the important information that will allow you to make an accurate diagnosis. For example, Groopman, in writing about medical error, wrote about an error he made when caring for a patient he really liked, because he deferred a buttock examination that would have allowed him to discover the abscess causing his colleague's symptoms.[1]

I will remember forever a young teenage woman I saw, the daughter of some friends, who presented with some vague symptoms and appeared a little lethargic. At the time, I thought I would pursue my infectious workup with the exception of a lumbar puncture (LP), because "that's too much." I then thought better of that decision, because I felt that I would have performed an LP on any other patient. She did, of course, have bacterial meningitis, and I have been phenomenally thankful ever since for having performed the procedure. My own objectivity and judgment were clouded, because I struggled with sparing the daughter of friends an uncomfortable procedure.

In addition, although I think most colleagues would level with us if we were to inquire about important parts of their history, there are also some people who might not disclose their sexual or psychiatric histories. There are risks to not getting the complete history.

**PR:** The problem I think is not with the colleague, but with the notion that special patients deserve special care (also known as VIP care). We see this with some frequency—systems seem to shut down or work less efficiently when someone of importance presents to the ED.

We should have special mechanisms for reacting to patients like these. Frequently, the professional who evaluates the patient isn't the physician who would normally evaluate the patient, but rather a chair of the division who hasn't seen a patient primarily in 10 years. We administer terrible care when we approach patients in this way. When President Eisenhower had an operation for his inflammatory bowel disease, the army surgeon who performed the procedure admitted using an approach he wasn't used to, because he thought the approach was safer, and he didn't want to perform a risky procedure on the President of the United States. This approach is wrong. We should provide the same best care for the President of the United States as we provide to the janitor of the White House.

**JG:** When I was growing up there was the expression "a doctor's doctor": The connotation being that you could receive no greater compliment than the opportunity to care for your physician colleagues. When a physician patient has been on staff for 15 years, as described in one of our cases, it is nearly impossible to find a physician, to treat him or his family, who doesn't know the patient. At some point, the argument that a physician should never care for a colleague becomes ridiculous, as there will be instances where that is impossible. It's my personal style to give patients a choice when I approach someone I know while I am on shift, "Do you want me to take care of you, or would you prefer someone else?"

**TT:** I would echo that there has to willingness on both sides to be able to recognize that one or the other isn't comfortable with the current patient–physician relationship. This is especially true of the treating physician who must respect the possible lack of objectivity, and do some introspection to determine if he is able to provide a professional service despite knowing the patient.

I had a friend of mine stop by the ED while I was working to talk to me about some upper abdominal pain he was experiencing. We didn't talk for very long before I realized that I would need to perform a rectal examination, and I said, "You know, I'm going

to step out." I asked one of my colleagues to take over, letting him know the patient was a friend of mine, and I couldn't take care of him.

**JG:** We are also approached frequently by a technician, nurse, or a volunteer for prescriptions and medical advice which presents a dilemma. We instituted a policy dictating the need for documentation; it's not that I wanted to charge them for the visit, but we insisted on a record. In fact, I usually offer to write off their bill.

**PR:** There are also unknown patients who drop in, want a really minor degree of medical care, and say, "I've lost my prescriptions, and I'm here from out of town." I used to practice part time in an area where this situation occurred almost every shift. I don't see it as an ethical problem as much as I see it a logistic problem. How can you process patients like this quickly and accurately enough to be safe. If the patient can say, "This is my medicine, formulation and dose; can you fill the script for me," then I am happy to provide them with it. But when they don't know the dose, or are not sure that the indication still exists, and I can't reach a physician or get hold of their records, it's a difficult situation. What sort of legal risk does a physician expose himself to when he attempts to address this situation? Are there ways to stay out of trouble, and still provide these patients with appropriate medical care?

**AD:** There is no question that a physician's impulse when presented with a patient who requests prescriptions because they've forgotten their own, or their luggage has been lost, is to provide them with the necessary prescriptions. If a physician doesn't have the patient's medical record, it is much harder to defend the practice should a problem arise, or if there is a dispute as to what actually happened during the doctor–patient encounter. The situation is even more difficult when the patient requests prescriptions for controlled substances.

On the issue of prescribing a medication for someone you haven't seen or examined, I generally would not recommend the practice as it exposes a physician to tremendous legal risk, and the patient to the possibility of a bad outcome that may have been avoided had the physician performed an appropriate history and physical examination. Internists and clinicians who take call are a little more willing than are emergency physicians to prescribe medication for colleagues for whom they are covering, and for patients who they haven't interviewed or examined. I believe this too is ethically and legally problematic because, without a physical examination to assess the patient you do stand on less firm ground.

**JA:** There are more basic factors to consider. A basic responsibility is to be a competent doctor, and writing prescriptions willy-nilly when you're uncertain what the patient's medical problems are or what the physical examination might reveal is just bad medicine. We had one emergency medicine nurse whose husband complained of headaches for 4 months, to which she kept telling him to stop being a baby; she quickly changed her opinion and response once he was diagnosed with a brain tumor—yet another example of bad judgment and overreach. I'm very willing to write prescriptions, but I am extra cautious about those prescriptions I write for people I know well, because I don't want to make any mistakes, and I don't really want to be abused or called at all times of the night. The driving issue is providing good medical care, and recognizing when you cannot provide that care and excusing yourself when appropriate.

**JG:** In California, writing prescriptions for controlled substances without seeing the patient is not allowed. Physicians are routinely disciplined for violating this proscription. I'm on the credentialing committee at the American Board of Emergency Medicine (ABEM), and currently their policy requires that every license a diplomate holds be unrestricted. If a physician receives a citation and a restriction of any sort to his or her medical license, ABEM will pull the physician's certification until the restriction is corrected.

**PR:** Most of the clinicians who have trouble with these rules are writing controlled substance prescriptions. It's a good rule of thumb to avoid writing prescriptions for controlled substance to any family members or friends. Regarding the situation when a pharmacy calls about a patient that was seen on the previous shift—if you have the information and the record of his visit, why wouldn't you write the script for the pharmacist? On the other hand, if you don't have enough information from the record to make a good judgment, then you may have to determine a way to discover more information. I've had a couple of cases where I've actually had the pharmacist put

the patient on the phone, so that I could conduct an interview on the phone, and find out exactly what was needed.

**TT:** This occurs at our institution on a daily basis. Most of the time, the patient has been discharged with a prescription for a medication that isn't covered by the insurance. I would argue that as a member of a group practice and being a physician with access to most patients' records, that we don't expose ourselves to any increased legal risk in participating in this practice.

**PR:** What I don't like to do is curbside medicine for a friend or a colleague. I'll never forget a case where one of the nurses brought a friend in for an injection of penicillin, because he thought he had been exposed to gonorrhea but didn't first ask him what his allergies were. Quite suddenly, I was called in to see a patient who wasn't even registered but was having a major anaphylactic reaction. This practice is simply bad judgment and bad medicine.

I think we all have to be very careful. I remember as a surgical resident operating on a patient who had a perforated diverticulitis. The surgeon said that he had known the patient for 40 years, and that he couldn't make a colostomy for her, because "she couldn't live with a colostomy." I was a second-year resident at the time, and said that everything I had read up until that point indicated that the appropriate intervention in a person with perforated diverticulitis was to operate and create a colostomy. He replied that he thought she would do fine. I went away from that operation thinking that he had just killed this patient, because he was afraid to inconvenience her or embarrass her. She, in fact, had a very rough postoperative course, which taught me a lesson for the rest of my professional life—when you think you might change your usual practice, you had better have some logical reason or good evidence to support your decision, because the worst thing you can do for a patient that you care about is the wrong intervention.

## Section III: Review of the literature

Physician treatment of self, family, friends, and colleagues is common practice. Physicians are often asked for medical advice or treatment for a variety of conditions ranging from the simple to the life-threatening. Studies show that the majority of physicians have provided some level of medical care to family members, colleagues, or themselves.[2–4] This practice is common because there are benefits for both the patient and physician. There may be enormous psychological, professional, relationship, or familial benefits to treating patients who fall into these respective categories. By treating friends, family members, or colleagues, physicians may experience increased stature and respect, and may have improved self-esteem, gratification, confidence, and psychological wellbeing. The patients they treat, in general may thus benefit. The patient benefits from having a physician who's "deep personal investment in the patient's well-being motivates a degree of attention to detail and humanistic thoughtfulness that might otherwise be sadly lacking."[5] Close relatives may feel that they are getting something in return for the long hours the physician spends away from them.

Despite being common, the practice raises ethical concerns. Physicians intuitively acknowledge that there is a boundary between appropriate and inappropriate behavior. A physician described this as "this dangerous feeling that we all have of getting in there and doing something."[5] The American Medical Association (AMA) *Code of Medical Ethics* recommends that, "physicians generally should not treat themselves or members of their immediate families."[6] An exception is made for the treatment of emergencies, and short-term and minor problems, and when practicing in isolated settings.[6–8] The codes of ethics of the American College of Physicians and American Association of Pediatrics expand this recommendation to also advise against the treatment of friends and closely associated employees.[7] In the case of minor problems, the consensus is that "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."[9]

Although it is important that the medical societies recognize the existence of the ethical issues, their recommendations are based on consensus and anecdote, and lack concrete guidelines. There are no definitions or examples of "short-term and minor problems." These exceptions could conceivably be applied to the majority of requests. "Physicians have reportedly treated everything from hypertension to diabetes to mental disorders under the guise of minor ailments."[10]

The lack of definitions shifts the onus onto the judgment of the individual physician. Although it is reasonable to expect physicians to apply their judgment, they may be forced to do so when it is most likely to be clouded by emotions, altruism, and sometimes hubris.

Despite being a common practice with ethical concerns, this issue is rarely discussed in the journals, graduate and undergraduate medical education, nationally, or in the media. Within emergency medicine, none of the national societies have made any statements regarding the treatment of friends and family, let alone made any recommendations. Without discussions and debate among physicians, there is no way that we can build towards a general consensus that can be used to guide us. It is as if "there are rules but no rulebook."[5]

The ethical principles to consider are beneficence—the duty to do what is best for the patient; nonmaleficence—to prevent the patient from being harmed; and autonomy—to do what the patients truly wishes for them. The following sections will explore the complex interplay of all of these forces as physicians are called on to treat family, friends, or colleagues. As we shall see, the path forward is not necessarily obvious.

## Potential risks and benefits to the patient

For the physician who is asked to care for a family member, friend or colleague, the first inclination is to want to say yes. However, that initial reaction is often followed by unease. The physician's unease comes from acknowledgment of the difficulty in providing good medical care for those with special emotional closeness. Physicians have a responsibility to act in the best interest of the patient, even if doing so may cause the patient discomfort, pain, or embarrassment. The role of a friend or a family member is to care for that person, and to shield them from harm. When the patient is emotionally close to the physician, these two goals should be synergistic; however, in practical application these roles can be antagonistic.

The loss of objectivity leading to suboptimal care is the most commonly cited argument against the treatment of friends and family. Physicians have been known to change their usual and regular practice when evaluating a friend or family member. These changes include inadequate histories, avoiding probing into the patient's social history, or deferring intimate examinations in an effort to avoid patient and physician discomfort.[11] Incomplete physical examinations are not limited to deferring genital examinations; "performing a mental status examination on a close relative may be more difficult than examining the relative's body."[12] Although the change from standard practice is understandable, the combination of emotional closeness and the lack of perspective make it difficult to correct these errors. Ironically, the physician fails in his or her role as both physician and friend when they expose the patient to risk by their inadequate evaluation.

The potential problems from the loss of objectivity are most pronounced in the treatment of patients who are very ill. With sick patients, the potential treatments have greater risks and thus require a greater degree of objectivity. The greater need for objectivity occurs at the same time that judgment is obscured by emotional involvement. The loss of objectivity can lead to either failing to pursue risky but necessary interventions, or the pursuit of medically contraindicated or ineffective therapies thereby placing the patient's health and dignity at risk.

The exception allowing for the treatment of "minor problems" is not a shield against the dangers associated with the loss of objectivity. It is very easy for the physician to approach the care of a friend or family member with either a "wellness bias" or a "sickness bias." As emergency physicians, we are especially attuned to the possibility that a simple chief complaint may in fact be caused by a serious or even life-threatening condition. As a person close to the patient, we want to believe that the person is well. When this wellness bias is combined with incomplete history and physical examination, it can be difficult to pick up on subtle cues pointing towards a serious illness. Conversely the physician may have a desire to make a "great diagnosis" ignoring the fact that most patients with minor complaints are well. This sickness bias can lead to over-testing and over-diagnosis.

The difficult balance between the physician's role as friend or family member and as a physician is especially pronounced when the evaluation reveals that the patient has a serious or life threatening diagnosis. The role of the physician is to inform the patient of the diagnosis and medical implications, and to discuss treatment. As a friend or family member, the role is to provide caring and emotional support.

When the physician has a dual role, both the physician and the patient can suffer. The patient can suffer from either having a physician who is unable to objectively answer questions about the condition, or having a family member who is emotionally unavailable. The physician suffers from an additional psychological burden of having to give bad news to a loved one and struggling to do so.

Another barrier to developing a therapeutic physician–patient relationship when caring for friends or family is that it is difficult, if not impossible, for both the patient and physician to enter a patient–physician relationship and discard the preceding relationship. The typical patient–physician relationship is asymmetric.[13] The physician has knowledge that the patient does not have, as well as the ability to provide therapies that the patient cannot provide for himself or herself. This is in contrast to the symmetric relationship between the physician and a colleague or a spouse.

When the preceding relationship is based on equality, both the physician and the patient may have difficulty in assuming their new roles. It is hard to predict or measure the consequences of the previous relationship. The patient may have difficulty accepting the physician's authority in the medical evaluation, especially with recommendations that the patient disagrees with, leading to poor treatment compliance. On the other hand, it is possible that a patient may be **more** likely to assert his or her autonomy with a physician to whom they are close. It's possible they will be more open in expressing fears, preferences or anxieties leading to better compliance and outcomes.

The physician caring for a work subordinate, such as an employee, introduces additional potential risks and benefits. Both parties enter the relationship with the physician as the superior. The distance between the superior and the subordinate can be magnified further in the physician–patient relationship. This added distance might make it difficult for the patient to disagree with the physician's recommendation introducing the possibility of coercion. It is equally possible that the patient can build on a base of previously earned trust. The patient may be more likely to accept a difficult recommendation that is in the patient's best interest because of an accumulation of trust, which may lead to better outcomes.

Establishing a therapeutic physician–patient relationship can be especially difficult when the patient is a physician colleague. There are several barriers that exist when caring for any physician. To begin with, physicians are less likely in general to seek medical care, leading to an unfamiliarity with the patient role.[14] When the physician is a patient, there is disorientation because "the familiar aspects of the hospital are unrecognizable from a stretcher."[12] The physician as a patient may enter the relationship "unable to dissociate the individual and the new role from the previous expectations, and from vestiges of the former identity in the old role."[15] This applies to the difficulty for the physician accepting the new relationship with the treating physician and the medical staff, as well the medical system.

Both physician and patient anxiety and frustration may be exacerbated if the illness or complaint falls within the expertise of the physician patient.[16] Such a situation can lead to therapeutic and diagnostic negotiations that lead to over- and under-testing and treatment. It can increase the treating physician's anxiety, leading to timidity. The converse is equally dangerous. The treating physician may falsely assume that the physician patient has the same level of knowledge and expertise with regards to the medical complaint. As a result, the physician may fully explain the risks and benefits as would be done for a non-physician patient, leading to poor choices by the patient and physician.

When the physician patient is a colleague, there are additional potential barriers. Physicians often choose a personal physician on the basis of a previous relationship, and not on objective factors.[17] The patient may have chosen the physician because of the previous collegial relationship, and a desire to maintain that collegiality in the patient–physician relationship. Choosing a physician on the basis of social interactions can "further compound the development of a working doctor–patient relationship."[18]

### Risks and benefits to the physician

The potential risks are not limited to the patient. Physicians who take care of friends or family are exposed to personal risk. Medical involvement can "provoke or intensify intrafamilial conflicts . . . [as the physician is] thrust into the lead as hero or scapegoat, depending on the course of the family member's illness."[9] The risks to interpersonal relationships exist regardless of the physician's choice about

involvement. Patient, family, and colleagues may be hurt because the physician was "not willing" to help them, even if the physician refuses for noble reasons. Different expectations from different family members can lead to conflicts, no matter what the physician decides to do.

The greatest risk to the physician is psychological. In treating friends, family, or a colleague, the physician may experience a great deal of anxiety, mostly from a desire to "get it right." The psychological impact of the death, disability or even morbidity (due to complications) of a friend or family member may be devastating if the physician had a direct role in or responsibility for the poor outcome.

Physicians should consider the legal risks they expose themselves to by providing informal care. Regardless of the physician's or the patient's perception of a request for medical care, providing medical advice to a person constitutes the establishment of a patient–physician relationship. As a result, the physician is legally liable for the consequences of the advice. In addition, the majority of casual medical interactions have no documentation, making the practice difficult to defend when there is a negative outcome.

### Refusal of care

Both the physician and the patient may experience a difficult time saying "no," when it comes to a patient being cared for by a person with whom they enjoy a special relationship. Both parties must be free to acquiesce or not, and the choices should be independent, not reciprocal. The sense of duty and a desire to be a good colleague or family member plays a role in the physician's willingness to provide care, but may lead to the provision of care against one's better judgment.[3]

Even though the majority of physicians have provided some degree of medical care to friends and family, a majority of physicians have also refused requests.[4] It is rare that a physician would agree to all requests for treatment. Common causes for physician refusal include: requests for care outside of one's area of expertise, inadequate ability to follow up, inadequate opportunity for examination, absence of medical indication for the request, and lack of objectivity.[4]

It is clear that there is a sliding scale of appropriate and inappropriate treatments. In examining the characteristics of physician treatment of family members, La Puma et al. find that the majority of physicians have provided some degree of medical care for family members. Moreover, 22% of physicians honor a request for treatment by a family member with which they felt uncomfortable, and 33% of physicians observe another physician who was "inappropriately involved" in a family member's care. Physicians report performing elective invasive surgeries and procedures such as angiography, colectomy, and pacemaker placement.[4] Although these procedures may be routine for the physician they can hardly be called minor.

The practical question remains, for any given situation, when should a physician refuse to perform medical treatment for family or friends? "Is this ethics, etiquette, or just sound judgment?" Whether family members will receive high quality care from a related doctor, or whether they would be better off seeing someone else, probably depends on the judgment of the physician, the medical urgency of the case, and the availability of medical colleagues."[4] Several authors have proposed self-reflective questions to guide physicians considering treating a friend or family member (Box 1.1). In addition to self-reflections, the physician should consider several characteristics of the request itself. These include: the chief complaint, the setting, the person making the request, and patient expectation.

The physician should first consider the chief complaint. There are complaints that have a predictable workup and a low risk of a poor outcome. These include problems such as mild ankle pain, or rhinorrhea during allergy season with no constitutional symptoms. However "family members may also request care that requires a complete history and physical examination, new knowledge, or facilities that are unavailable, thus sometimes embarrassing and frustrating the physician relatives."[4] The physician should be wary when the chief complaint has a less predictable diagnostic workup or clinical course, or if there is a possibility of a serious underlying condition.

The request for medical care in the informal setting, or the "curbside" evaluation, can be problematic. Although it may be convenient for the patient, the curbside evaluation may magnify some negative aspects of the treatment of friends and family. By its informal nature, there is a tendency for the physician

**Box 1.1 Self-reflective questions to guide physicians in the treatment of friends and family**

- Am I trained to meet my patient's medical needs?
- Am I too close to probe my relative's intimate history and physical being and to cope with bearing bad news?
- Can I be objective enough to not give too much, too little, or inappropriate care? To do or order necessary procedures that may cause pain?
- Will my relatives comply more readily with medical care delivered by an unrelated physician?
- Am I willing to be accountable to my peers and to the public for this care?[9]
- Can I maintain an appropriate doctor–patient relationship or is an inappropriate collegial rapport likely to ensue?
- Do I have excessive anxiety that may jeopardize my ability to care for family, a colleague or friend?
- Can I maintain the patient's confidentiality?
- Can I always act for the good of the patient even if it means making decisions that may jeopardize the friendship?[18]
- Can I anticipate and negotiate family conflicts?[4]

to be overly casual in the evaluation. Even if the physician wanted to perform a complete evaluation it is impossible in an informal setting. This is especially true if the request is for a third party person who is not the actually consulting the physician. In such a situation, there is an increased risk for incorrect diagnosis, improper treatment, and medication-related risks. Further the informal nature of the request may increase the social pressure to "help" the person.

The physician should consider requests made by the patient, and requests made by staff or the patient's family member differently. When the patient has not made the request, they may not truly want to be treated by that physician, and should be allowed to exert autonomy. Upfront discussions with the patient can ensure alignment of the patient and physician expectations, desires, as well as affording both parties the ability to terminate the relationship without guilt or anxiety.

When a physician makes a decision about providing care, he or she should remember that responsibility of the physician is first and foremost to protect the health of the patient. The physician should "act for the good of the patient even if it means making decisions that may jeopardize the friendship."[18] Even though physicians are more highly motivated to help those who are closest to them, greater emotional distance may afford greater objectivity and a better medical outcome.[3]

Although physicians may feel pressure to be involved, refusing to be directly involved does not equate to an unwillingness to help. The physician is still available for love, caring, and emotional support. The physician can aid the medical care through access to the medical system through direct referral to a trusted colleague, or advocacy within the hospital.

## Special circumstances

Under most circumstances there is no ethical obligation to treat a patient. However when "no other physician is available, as is the case in some isolated communities or when emergency treatment is required . . . the physician is morally bound to provide care."[7] This situation would be common in rural areas, and in times of disaster and war. If the patient has a life-threatening emergency, it would be prudent to reevaluate the appropriateness of the relationship as circumstances allow.

## The emergency medicine perspective

The practice of emergency medicine has many unique aspects to it, yet, as previously noted, there is little available to specifically guide emergency physicians through this dilemma. None of the literature that was reviewed was published in an emergency medicine journal; we could find no emergency medicine book chapters that addressed this; and the organized emergency medicine groups are silent on the issue. Some hospital bylaws address the issue, but often in vague terms that lack specificity for the emergency physician.

Most policies that do exist have exceptions allowing for care of family during emergencies and for short-term and minor ailments. The terms "emergency," "family," "minor," and "short term" are all open to interpretation. No literature or policies specifically address treatment of friends or colleagues. In point of fact, these groups are different and require different approaches.

*Family*

Some policies that proscribe treatment of family members specifically confine this to immediate family members, but other polices, including those adopted at one of the authors' hospitals (JMG) is much more expansive and includes aunts, uncles, in-laws, and even ex-in-laws. However, there are still exceptions for emergencies and minor conditions. It is clear that there is a sliding scale rather than hard and fast rules. For reasons outlined above, emergency physicians should avoid treatment of serious illnesses or performing complicated procedures on family members to whom they are emotionally close, unless absolutely necessary. Rendering minor care may be acceptable.

In fact, drawing a line on treating family members that begins at the ED entrance is somewhat arbitrary. If the spouse of an emergency physician awakens him or her because their child has fever, who would expect that the doctor would not look at the child, and render an opinion as to whether or not they needed to go to the hospital? The examination might even include looking in the ears with an otoscope or checking the neck for meningismus. There is always the chance that the initial decision may be wrong, but how does one separate oneself from the fact that he or she is a family member and a doctor at the same time? Further, rendering an opinion that precludes taking the child to a doctor or the hospital could help avoid unnecessary tests or treatment. Taking the child to the hospital, where caregivers are likely to know that the parent is a doctor, might bias them into thinking the child is sicker than actually is the case. There are biases and risks associated with any course.

*Friends*

It is similarly hard to draw hard and fast rules regarding friends. Similar to the interaction with family, for many friends of the emergency physician, the physician's advice (which constitutes the practice of medicine) is often rendered well before they ever get to the ED. In some cases, friends will prefer that they or their family are taken care of by the emergency physician they know, and they may even expect it or be upset if the physician demurs. It is not always clear if such care will be better, worse, or the same, as could be rendered by another physician. Some doctors might feel compelled to over-test while others, because they understand the human nature of their friend and may be able to provide close personal follow-up, may save the patient from needless tests.

For emergency physicians who have lived and worked in the same neighborhood and hospital for many years, it is likely they will see friends, acquaintances, fellow religious organization members, etc., often, perhaps even on a daily basis. It is hard to avoid treating these patients, and in many cases they will expect it, and desire it. It may make them feel special. There is little downside in providing such care in routine circumstances.

It is probably best to avoid rendering care to very sick friends to whom one is emotionally close (or their very sick immediate family members) for reasons that have been previously discussed, unless there is no other choice. The physician can then be free to serve as a friend and confidant, and is free to offer advice and counsel.

The emergency physician may be called on by friends to write or refill prescriptions. This is fraught with dangers, both legally and from a regulatory standpoint.[10,18] In addition, prescribing controlled substances to persons a physician has not examined may result in licensure problems. It is best for the emergency physician to adopt a firm policy against writing prescriptions for friends (and for that matter family or colleagues) unless they are formally seeing them in the ED setting.

*Colleagues*

Physicians who work in the same hospital regularly for many years are likely to know many of the medical staff, nurses, and others fairly well. Similarly, particularly for active medical staff members, they are likely to know all the emergency physicians. Therefore, if a physician colleague presents to the ED for care, some colleague will have to be the one to render care. This arrangement should not present any major ethical problems as long as the emergency physician main-

tains objectivity and professionalism, and does not alter what would be done for another patient in a similar situation Moreover, an emergency physician choosing to be cared for at their own institution by another specialist is likely to choose a colleague for care. There are always risks of hard feelings or a spoiled relationship if things do not go well, but these are risks a physician always is subject to when practicing the profession.

The colleague presenting to the ED, may have a preference for one emergency physician over another. Some attempt should be made to assure that the colleague can make as autonomous a choice as possible, but since it an emergency visit, it may not be possible to accommodate the wish. Traditionally, physicians have treated colleagues and their families free of charge, in some ways influenced by the Hippocratic Oath, the writings of Thomas Percival, and the rich traditions of the profession. Nowadays, compliance (anti-kickback) laws place limits on our ability to do this. Physicians should neither waive a payment as an inducement, nor decide to treat a colleague purely for financial gain.

*Confidentiality*

Confidentiality is almost always a primary duty of physicians. In treating family, friends, or colleagues, human nature may tempt physicians even more than usual to violate this duty. Nevertheless, unless confidentiality can be completely assured, and the integrity of the EP is known to be above reproach, patients may be reluctant to disclose necessary information to physicians. This is another danger in entering into a therapeutic relationship with these individuals. Physicians who do not adhere to expected confidentiality in these situations are committing an even greater ethical breach than when they violate the same duty with strangers; in addition to violating a professional duty, they have disregarded a personal trust.

## Section IV: Recommendations

- Objective research should be done on the actual positive and negative effects of caring for family, friends, and colleagues in the emergency setting.
- Professional emergency medicine societies and other influential bodies should promulgate policies to guide emergency physicians.
- Emergency physicians should avoid treating first-degree relatives in the hospital setting, except for minor, routine situations, unless there is no alternative. The decision to treat other relatives should be based on the complexity of the situation, emotional distance, and the estimated ability to remain objective.
- Treating friends and colleagues in the emergency setting is mostly an acceptable practice.
- In deciding to treat family, friends, or colleagues, an earnest attempt should be made to ascertain their true autonomous choice as to physician.
- Confidentiality must be adhered to except in extraordinary circumstances, e.g., in order to save a life or to prevent bodily harm.

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