REVIEW

The ethics of treating family members

Colin Hutchison[a] and Paul C. McConnell[b]

Purpose of review

Many medical professionals receive requests from family and friends asking for medical advice and treatment. But should medics treat their family? Ethically can we treat, or refuse to treat, family members? This is a common ethical challenge that most doctors face during their career and there is limited evidence available. By examining ethical principles, we aim to answer these questions and provide a framework that will guide decision making in this area.

Recent findings

There is a paucity of evidence available. Many ethical systems exist and have been discussed since ancient Greece but in recent years, bioethics has become more prominent in medical thinking and debate.

Summary

We examine ethical systems such as virtue ethics, utilitarianism, deontology and principlism and how they relate to treating family members. We then look at cases in different contexts and describe a system for approaching such cases, allowing doctors to conform to moral standards, and consider ethical arguments, prior to embarking upon any treatment course with a relative.

Keywords

ethics, systems, treating family members

INTRODUCTION

More than 99% of physicians receive requests from family members asking for medical advice, diagnosis, or treatment [1]. But should medics treat their family? Is it in the best interest of the doctor or the patient if they are related? Ethically can we treat, or refuse to treat, family members? By examining ethical principles we aim to answer these questions and provide an ethical framework to guide decision making.

HISTORICAL AND MODERN GUIDANCE

As far back as 1803, Percival argued for 'separation of professional and personal identities in the care of family members.'[2] Modern guidance echoes Percival. The UK's General Medical Council (GMC) advises 'wherever possible avoid providing medical care to yourself or anyone with whom you have a close personal relationship [3]. The American Medical Association (AMA) says that 'in general, physicians should not treat themselves or members of their own families.'[4]

It is easy to imagine why treating someone with whom you have a close relationship could be difficult. The AMA cite a possible lack of professional objectivity, potential failure to probe sensitive topics or perform intimate examinations and feelings of obligation to perform care for which he or she is unqualified [4]. There are also potential issues with record keeping, confidentiality and continuity of care. However, doctors commonly do involve themselves in care of relatives, 74% have treated their children for afebrile acute illnesses [5]. When asked why, the most common responses were convenience, cost saving and perceived greater knowledge or concern than colleagues [6].

Unfortunately, modern guidance is not clearly defined and open to interpretation and therefore abuse. The GMC suggest doctors should avoid treating family members 'wherever possible' [3] and AMA lists 'minor, short-term' illnesses as exceptions to the rules [4]. No reference is made to indirect involvement in care, such as telephone calls to the family member's physician, only direct involvement and the responsibility that this brings. The

[a]Specialist Trainee in Anaesthesia, Department of Anaesthesia and Intensive Care Medicine and [b]Consultant in Intensive Care Medicine and Anaesthesia, Department of Anaesthesia and Intensive Care Medicine, Royal Alexandra Hospital, Paisley, UK

Correspondence to Paul C. McConnell, MB, ChB (Hons), FRCA, EDIC, FFICM, Consultant Intensive Care Medicine, Royal Alexandra Hospital, Paisley PA2 9PJ, Scotland. Tel: +0141 314 6609; e-mail: paulmcconnell@nhs.net

Curr Opin Anesthesiol 2019, 32:169–173

DOI:10.1097/ACO.0000000000000687

0952-7907 Copyright © 2018 Wolters Kluwer Health, Inc. All rights reserved.

Copyright © 2019 Wolters Kluwer Health, Inc. All rights reserved.

KEY POINTS

- The GMC and AMA advise against treating family members but many medics do treat family and close friends.
- Ethical systems such as virtue ethics, utilitarianism, deontology and principlism do not outright prohibit the treatment of family members.
- Context has a close bearing on whether treating a family member is appropriate.
- We should examine each case carefully, conform to moral standards, and consider ethical arguments prior to embarking upon any treatment course with a relative.

GMC and AMA guidance also contradicts current medical practice in which patients (and therefore doctors themselves) are encouraged to take responsibility for their own care.

Other professions have differing guidance from their professional bodies. Neither the American Dental Association, nor the UK's General Dental Council, advise against treating family members, although the American Dental Association advise that dentists should avoid interpersonal relationships that could impair professional judgement [7] and the Medical and Dental Defence Union of Scotland urge dentists to follow the same procedures when treating family and friends as they do with all other patients [8]. The Law Society of Scotland forbids solicitors from writing a will for a client where they (or anyone close to them such as a spouse or business partner) will benefit from that will [9] and from acting for any client where there is a conflict between the interest of the client and their interest [10]. Intriguingly, the client is not granted autonomy in this regard as 'conflict of interest is not a matter for the judgement of the client – it is a matter for your judgement. Only you have the breadth of experience, training and knowledge to fully advise a client where his interest lies.' [10]

ETHICAL MODELS

A blanket statement by the GMC advising that doctors shouldn't treat family members is perhaps the safest and easiest way for the GMC to react to the potential ethical problems raised but it is ultimately a draconian and unrealistic response. When trying to find solutions to this issue, it is useful to consider both different ethical models and recognize too, different scenarios in which they can be applied. Although many ethical systems exist, it is perhaps easiest to consider the four most well known:

(1) *Virtue ethics* which is doing what we think is right and acting as such in a way which embodies courage.
(2) *Utilitarianism* which is doing what we know will produce the best result for the most people.
(3) *Deontology* which is following the rules and doing what is right out of duty to moral law.
(4) *Principlism* which is built on the works of Beauchamp and Childress and pays equal attention to beneficence, nonmaleficence, autonomy and justice.

Virtue ethics is the principle that good decisions come from the character of the person deciding. Although this has its roots in the Platonic ideal, Pellegrino described the primary virtues of a doctor as: Fidelity to trust and promise, benevolence, intellectual honesty, compassion and caring, prudence, justice and effacement of self-interest [11]. If the doctor acts according to these virtues then what they do is ethically the correct course. Unfortunately this is not always the case and excessive virtue can lead to vice (the tipping point of which can be prosaic and ill defined). Overconfidence in your knowledge and abilities can lead to acting out with your expertise and not referring family members appropriately, compassion can lead to omission to spare the sharing of bad news and prudence can skew the presentation of relative risks to your charge. As such virtue ethics has been criticized as both more psychology than ethical theory and 'too fuzzy' to give concrete direction in moral matters. Yet by holding to the ideals described by Pellegrino and embracing in particular the intellectual honesty to recognize ones limitations and prudence to seek appropriate help, it may permit the treatment of family members in certain scenarios (which we will deal with below).

Utilitarianism describes the principle in which the morality of an act is crystallized by the consequences of the act. The best action is one which maximizes utility. Utilitarianism considers the interests of all beings equally and so is an impersonal theory when applied to healthcare as an act is assessed as to its overall effect on persons in general rather than an individual. There may be at least a weak utilitarian argument for the limited treatment of family members in as much that it may permit others to access appointments and resources that are now not taken up by family members being treated 'at home'. This would, however, only apply to minor conditions and would also require that any treatment/consultation does not deprive the doctors other patients of their service.

Copyright © 2019 Wolters Kluwer Health, Inc. All rights reserved.

Deontology is from the Greek *deontos* meaning duty. The morality of an action is a function of the act itself and not its consequences. Grounded heavily in the works of Kant, an action is worthy if it is performed out of a sense of duty to moral law. The moral law itself can be defined in terms of the Golden Rule; do as you would be done by, and the categorical imperative [12]. The correctness of an action can be found in the universalization test – namely, what would be the consequences if everyone did this? Stealing is wrong, for if everyone were to steal there would be no property and anarchy, lying is wrong because where everyone to lie there would be no truth. Yet applying these rules directly to the question of the treating of one's relatives, there is no obvious prohibition emergent (at least in certain scenarios best defined by the individual). A doctor may well think that they would be happy to be treated by another family member (particularly in the case of an emergency) and therefore would under the Golden Rule be justified in treating a family member themselves. Central to deontology is the concept of autonomy; that individuals are in themselves an end and not a means to an end and it is here that there are strong arguments both for and against the treatment of family members. Any action taken to be right in a Kantian sense must serve to optimize an individual's autonomy, to give them to control of their destiny to ensure that they are an end. Therefore, were a family member to choose to seek your advice and treatment, free from duress, then that in the Kantian sense should be permitted (and even embraced). However, this classical view of autonomy holds it in a vacuum, separate from any other influences. Modern deontologists recognize this is not the case and that 'autonomous' decision are influenced and shaped by societal and environmental factors [13]. That a close relative is now their treating physician, may mean that autonomous becomes blurred with an erosion of self-determination over time as the patient relinquishes their decision making over to their medical relative.

In modern times, principlism has become a popular movement in bioethics. Based around the works of Beauchamp and Childress [14], this requires ethical reasoning and pays due diligence to balancing beneficence, nonmaleficence, autonomy and justice. Although this may appear an appealing catch-all solution, it does present difficulties within itself, particularly as it is not in itself a unified moral theory, but an amalgam and requires ethical gymnastics to sometimes reconcile its four sometimes disparate principals. That is not to say, however, it is not at least a useful aid memoire to consider the ethical implications of treating family members. Although we have dealt with autonomy in our previous section and the notion what is doing good/doing harm is very much open to interpretation, it is the concept of Justice which we must explore. The principal of Justice often sits ill at ease with autonomy and self-determination and yet the fair (though not necessarily equal) is the cornerstone of ethical behaviour. When treating a family member, there is an inherent danger that they may be rushed through waiting lists, jump queues, have access to resources not available to other patients; that they get 'more than their share of the cake'. John Rawls who attempted to reconcile Kantian ethics with utilitarian principals, spoke of operating behind a 'veil of ignorance' when allocating resource; when cutting the cake, we must do so without knowing who is getting what share and that may prove difficult when dealing with a loved one [15].

Though less celebrated than their four principals, Beauchamp and Childress [14] also highlighted the importance of the four virtues in professional–patient relationships. They listed veracity, privacy, confidentiality and fidelity as moral rules which were key to any doctor–patient relationship and it is attention to these obligations which are perhaps more useful in determining whether a doctor should treat a family member. Although it may be possible to adhere to the requirements of veracity and fidelity, privacy and confidentiality may be difficult to maintain when the relationship is anything other than professional, particularly when interacting with other (non-patient) family members. A desire for privacy may also interfere with the patient's desire to share important, but embarrassing details of their condition and thus compromise care and cause harm. Clearly it is a difficult tightrope to walk, yet none of these ethical systems outright prohibit the treatment of family members. Perhaps then it is the context in which family members are treated that is the determining factor in whether treatment is appropriate?

CONTEXT AND ETHICAL 'TOOLKIT'

We may divide the contexts into emergency and elective involvement and then sub-divide elective involvement by action (advice, prescribing, and physical intervention) and by duration (short-term resolving condition, long-term stable condition, and long-term progressive or debilitating condition). We will also consider briefly the case of the relative who has lost capacity.

In the emergency scenario, things are relatively clear cut regardless of which ethical school we choose to invoke. The AMA makes exceptions to

0952-7907 Copyright © 2018 Wolters Kluwer Health, Inc. All rights reserved.

Copyright © 2019 Wolters Kluwer Health, Inc. All rights reserved.

their guidance in cases of emergency and isolation when clearly it would be unreasonable to expect a medic to stand by and allow harm to a family member – Beauchamp and Childress's principles of beneficence and non-maleficence trumping non-involvement. In the 'elective' scenario, things are less clear cut.

In reality, it is common for medics to treat their families. In one study, 74% admitted to treating their children for afebrile acute illnesses [5] and 85% have written at least one prescription for a non-patient [16]. Nine per cent have even operated on a family member! [1]

However, treating family members is not always a positive experience, 22% of those questioned in one study reported feeling uncomfortable agreeing to some requests, whereas a third of physicians reported seeing another physician 'inappropriately involved' in a family members' care [1]. The line between professional and personal involvement is a dynamic one that changes with circumstance. Physicians themselves apply context to decision making on involvement in medical care, advising a family member is more common than a surgeon operating on a family member [1]. Relationship with the non-patient, severity of the condition and whether the request is within the scope of their practice are reported as important factors [6,17]. It can be argued to be both for and against the patient's best interests. Yet to even use the phrase 'best interests,' does raise the accusation of paternalism and perhaps it is simply up to the patient themselves to decide who they feel comfortable treating them; however, as previously stated that may ultimately undermine their autonomy and may place the doctor in a scenario where they are working beyond their expertise and comfort and deprived of their professional armour to protect them from poor outcomes or difficult discussions. Each interaction should be critically appraised in an attempt to come to a moral conclusion and minimize harm and anguish to both parties. One must work to reach in each case a reflective equilibrium [15], where a state of balance is achieved through a process of deliberative mutual adjustment among both general principals and particular judgements. This may be accomplished by using a model of *consistency, case comparison and thought experiments* and then applying a reasoning from principles. It is useful to have thought of scenarios in which you would be both happy to treat and certainly you would not become involved. From here, you can ask yourself how the current scenario is different or similar to these previous examples. If you do different things, or make different decisions, in two similar situations then you must be able to point to a morally relevant difference between the two situations that accounts for the different decisions. This involves comparison of different cases to evaluate your reasoning. These cases can be real or hypothetical in the form of thought experiments. An example of this would be asking the question, 'would I do this if I was not related to this patient?' Or even, 'what would I do in this situation if I was not a doctor?' We can then combine this by examining our potential action in terms of beneficence, nonmaleficence, respect and preservation of autonomy, and justice while asking ourselves if we can stay true to the tenants of true doctor–patient relationship adhering to the virtues of veracity, fidelity, privacy and confidentiality.

A practical approach to physician involvement in the care of close friends or family was provided by Fromme *et al.* [18▪] in 2008. They suggested a risk stratification of low, medium and high-risk involvement. Low-risk involvement included suggesting the patient to see a physician and helping to educate, explain medical information and interpret medical jargon. High-risk involvement included ordering tests, coordinating care and making decisions and prescribing medication without involving the treating physician [18▪]. La Puma and Priest [19▪] provided a list of questions that physicians should ask themselves before deciding to intervene (Table 1). If the answer to any of the questions is 'no', physicians should be very careful about getting involved.

TREATING FAMILY MEMBERS WITHOUT CAPACITY

A final scenario to consider is the role of the medical professional in the care of the relative who has lost capacity. This can be especially difficult for medically trained relatives. In this scenario, relatives may be sought to help decide are what an incapacitated patient's 'best interests'. These best interests however, go beyond their 'medical best interests' (which

Table 1. Questions to ask oneself before deciding to intervene in relative's care

Am I trained to meet my relative's medical needs?
Am I too close to probe my relative's intimate history and physical being, and to cope with bearing bad news?
Can I be objective enough not to give too much, or too little, or inappropriate care?
Will medical involvement promote or provoke family conflict?
Will my relatives comply more readily with care given by an unrelated physician?
Will I allow the attending physician to attend to my relative?
Am I willing to be accountable (to my peers and to the public) for this care?

Adapted with permission [19▪].

Copyright © 2019 Wolters Kluwer Health, Inc. All rights reserved.

relatives would not normally comment upon), yet by the very nature of their training and expertise, it may be medical interests that become the focus of the relative. Where advanced decisions are present they must be respected, regardless of the medical relatives' misgivings. When not present, then again asking the question 'what would I do if I were not a doctor?' is a powerful starting point. It is in anticipation of this scenario, that it is appropriate and even important to medically engage with family members. Speaking to them while in health to discuss advanced planning for critical illness and end of life ensures that should they lose capacity then autonomy can be respected, harm minimized and anguish avoided.

CONCLUSION

Despite guidance to the contrary, medical professionals are often both directly and indirectly involved in the care of close family and friends. This has implications for both the patient and the physician. Although many organizations counsel against or even prohibit the treatment of relatives, this is an unrealistic expectation and as a blanket policy not founded in either common sense or ethical ideal. This does not, however, mean that doctors should have carte blanche to involve themselves or treat relatives. It is important that doctors examine each episode carefully, conform to moral standards, and consider ethical arguments prior to embarking upon any treatment course with a relative. Only by constantly questioning whether they are the correct person to deliver care can they hope to do right by both their relative and themselves.

Acknowledgements

None.

Financial support and sponsorship

None.

Conflicts of interest

There are no conflicts of interest.

REFERENCES AND RECOMMENDED READING

Papers of particular interest, published within the annual period of review, have been highlighted as:
■ of special interest
■■ of outstanding interest

1. La Puma J, Stocking CB, La Voie D, Darling CA. When physicians treat members of their own families. Practices in a community hospital. N Engl J Med 1991; 3259180:1290–1294.
2. Percival T. Medical ethics, or, a code of institutes and precepts, adapted to the professional conduct of physicians and surgeons; to which is added an appendix containing a discourse on hospital duties, and notes and illustrations. Manchester: Printed by S. Russell, for J. Johnson, and R. Bickerstaff, London. 1803. Chapter 2; p30–52, Available at: https://archive.org/details/b2152113x/page/52 [Accessed 2 December 2018]
3. General Medical Council. Good Medical Practice 2013. Available at: http://gmc-uk.org/guidance [Accessed 30 October 2018].
4. American Medical Association. Treating self or family. Code of medical ethics opinion 1.2.1. Available at: http://ama.asn.org/delivering-care/treating-self-or-family [Accessed 30 October 2018].
5. Dusdieker LB, Murph JR, Murph WE, Dungy CI. Physicians treating their own children. Am J Dis Child 1993; 147:146–149.
6. Scarff JR, Lippmann S. When physicians intervene in their relatives' healthcare. HEC Forum 2012; 24:127–137.
7. American Dental Association. American Dental Association principles of ethics and code of professional conduct, with official advisory opinions revised to September 2018. Available at: https://www.ada.org/en/about-the-ada/principles-of-ethics-code-of-professional-conduct [Accessed 30 October 2018].
8. Medical and Dental Defence Union of Scotland. Treating family and friends presents challenges for dentists. Press release 2/12/2014. Available at: https://www.mddus.com/about-us/media-centre/2014/december/treating-family-and-friends-presents-challenges-for-dentists [Accessed 30 October 2018].
9. Law Society of Scotland. Standards for Solicitors. Available at: https://www.lawscot.org.uk/for-the-public/client-protection/standards-for-solicitors/ [Accessed 30 October 2018].
10. Law Society of Scotland. Rules and guidance. B2.1: Conflicts of interest generally. Available at: https://www.lawscot.org.uk/members/rules-and-guidance/rules-and-guidance/section-b/rule-b2/guidance/b2-1-conflict-of-interest-generally [Accessed 30 October 2018].
11. Pellegrino ED, Thomasma DC. The virtues of medical ethics. ISBN: 9780195082890.
12. Kant I. Groundwork of the metaphysics of morals. 1785
13. Stoljar N. Theories of autonomy. In: Ashcroft RE, Dawson A, Draper H, editors. Principles of healthcare ethics, 2nd ed. McMillan J. Wiley; 2007. pp. 11–18.
14. Beauchamp TL, Childress JF. Principles of Biomedical ethics 5th Edition. ISBN:0-19-514332-9
15. Rawls J. A theory of justice. ISBN: 0-674-00078-1
16. Aboff BM, Collier VU, Farber NJ, Ehrenthal DB. Residents' prescription writing for nonpatients. JAMA 2002; 288:381–385.
17. Giroldi E, Freeth R, Hanssen M, *et al.* Family physicians managing medical requests from family and friends. Ann Fam Med 2018; 16:45–51.
18. ■ Fromme EK, Farber NJ, Babbott SF, *et al.* What do you do when your loved one is ill? The line between physician and family member. Ann Intern Med 2008; 149:825–829.

Interesting article with consideration of cases and risk stratification for treating family members.

19. ■ La Puma J, Priest ER. Is there a doctor in the house? An analysis of the practice of physicians' treating their own families. JAMA 1992; 267: 1810–1812.

Article useful for an 'ethical toolkit' as it includes questions to ask oneself before intervening in relatives' care.

0952-7907 Copyright © 2018 Wolters Kluwer Health, Inc. All rights reserved.

Copyright © 2019 Wolters Kluwer Health, Inc. All rights reserved.