Ethical Problems
in Emergency Medicine
Current Topics in Emergency Medicine

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Ethical Problems in Emergency Medicine

A discussion-based review

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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. 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 non-maleficence. 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.” 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
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.
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. 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.” 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.” The American Medical Association (AMA) Code of Medical Ethics recommends that, “physicians generally should not treat themselves or members of their immediate families.” An exception is made for the treatment of emergencies, and short-term and minor problems, and when practicing in isolated settings. 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. 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.”

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.”
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.”

The ethical principles to consider are beneficence—the duty to do what is best for the patient; non-maleficence—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. 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.” 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. 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 physician 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. When the physician is a patient, there is disorientation because “the familiar aspects of the hospital are recognizable from a stretcher.” 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.” 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. 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. 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.”

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.” The risks to interpersonal relationships exist regardless of the physician’s choice about