IS IT ETHICAL TO TREAT ONE’S FAMILY AND FRIENDS?

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INTRODUCTION

Most health professionals would, at some time, have been faced with the dilemma of being asked for medical advice by a family member or friend. Usually the level of advice sought is innocuous, but sometimes people request a prescription for a condition such as major depression from a doctor who is not a psychiatrist. Other prescriptions are requested for an already established condition, such as diabetes or gastro-oesophageal reflux, that is being treated by another doctor. Sometimes doctors are consulted by family members or friends about significant medical problems. Many doctors, including paediatricians, treat their own children and I know of sick certificates that were issued for students and staff by siblings or parents who are doctors. Sometimes these familial relationships are not obvious because the surnames differ. Is there something wrong with treating family and friends and, if there is, at what stage may this become problematic?

I read recently in a popular local women’s magazine about a very well-known plastic surgeon who had performed a number of cosmetic surgical operations on his wife. I thought that this was morally wrong, and the thought occurred to me whether she had really wanted these procedures.

Consider the following hypothetical scenarios:

• Dr S is a paediatrician. A good friend of hers develops an upper respiratory infection that does not clear up, and eventually she develops symptoms of sinusitis and bronchitis with wheezing. Her friend asks her to prescribe antibiotics for her, as she does not have medical insurance and cannot afford to see a doctor. Would it be wrong to prescribe an antibiotic? What if the wheezing persists – should she then prescribe corticosteroids? What is the most ethical course of action?

• The same Dr S has a sister, D, who is struggling at work and who Dr S believes is suffering from depression. D refuses to see a doctor, saying “I don’t do depression.” She is, however, prepared to take medication if Dr S prescribes it. Would it be unethical for Dr S to prescribe an antidepressant for D?

WHAT ARE THE ETHICAL CONSIDERATIONS INVOLVED IN TREATING ONE’S FAMILY AND FRIENDS?

Treating a friend or a family member is a classic example of a dual relationship: a relationship that occurs when a doctor (or other health professional) treats someone with whom he or she has another, non-patient-doctor, relationship.1

Arguments advanced for treating one’s family are that the doctor is trustworthy and that s/he will take good care of the person because of the relationship that exists between them and the knowledge that the doctor has of the patient. An additional advantage is the considerable reduction in the cost of the treatment. Citing the ethical principles, this would respect the autonomy of the patient and doctor, and may be beneficial to the patient, while at the same time respecting her right to choose her doctor.2,3

There are a number of arguments against treating one’s family. One is that the standard of care and/or treatment of the patient may be negatively affected by the inability of the doctor to be truly objective.3 Family members may be uncomfortable with disclosure of information to the doctor that may be material to establishing a diagnosis or instituting treatment. The doctor may also feel unable to ascertain sensitive information from the patient. If the doctor, who is a family member or friend, believes that the patient requires an intimate examination, he/she may feel unable to perform this examination, but not disclose to the patient that this is the case. Family or friends who are unhappy with the diagnosis or treatment recommendation may feel uncomfortable or disloyal if that view is expressed.3

The doctor may err by not truly respecting the patient’s autonomy if the patient is family or a friend, and transgress the requirements of informed decision making. At the same time, the patient may not feel empowered to refuse treatment or disagree with a course of treatment or a management plan, because of the relationship with the doctor.3 This is even more important in the case of a child being treated by a parent.3

Is there any risk to the doctor or family member in this therapeutic relationship? What about the ethical principle of non-maleficence (“to do no harm”)? Could harm befall the patient or the doctor? Does the doctor have a right to treat his/her family member, and can the family member see it as his or her right to receive such treatment?

If there is a complication of the treatment or an adverse consequence related to an error in diagnosis or treatment,
this may negatively influence the relationship and result in considerable harm and feelings of guilt. There may even be legal consequences in the case of complications.

**HOW PREVALENT IS THE PRACTICE OF TREATING FAMILY AND FRIENDS?**

Many of my pediatric colleagues are hesitant to treat their own children, except in the case of really minor conditions. Legendary tales abound about professors’ children who were misdiagnosed or wrongly treated by their medical parent(s)!

An article published in 1993 revealed that 4% of doctors were listed as their child’s primary physician, and more than 60% of them had prescribed treatment for their children. A study published in 1991 reported that 99% of 465 doctors, at a large suburban community hospital in the United States, had received requests from family members for medical advice, diagnosis or treatment. Eighty-three percent had pre-

**WHAT DO THE GUIDELINES SAY?**

The Health Professions Council of South Africa does not directly address this issue in its booklet on ethical guidelines for the health professions. The South African Medical Association states the following on its website:

**TREATMENT OF IMMEDIATE FAMILY MEMBERS**

Medical practitioners who wish to treat their own family members should note that the Medical and Dental Professions Board resolved in October 2007 at a Board meeting, that it was permissible for a practitioner to treat his or her immediate dependants. It was not, however, permissible for a practitioner to render accounts for services rendered to such dependants, except in the case of laboratory fees and material for which it would be permissible to render an account. The expression “material” as referred to above could be interpreted to include “dispensing of pharmaceuticals”. Immediate family referred to dependent family members only.

The General Medical Council in the United Kingdom has a section on its website called “Good Medical Practice.” This states the following:

**WHAT DO DOCTORS THINK ABOUT TREATING FAMILY MEMBERS AND FRIENDS?**

Studies on prescribing for non-patients reveal that most of the doctors will write prescriptions for family, friends and colleagues. The NEJM ran a poll on three case vignettes and received 1703 responses. Most of the respondents (62%) would write a prescription for albuterol (salbutamol) for a 15-year old neighbour who has asthma, even though the respondent is not the girl’s usual doctor. The vast majority of the respondents felt it was unethical to write a prescription for fluoxetine for a dermatologist colleague, or to write an order for one’s father-in-law who is in the ICU at the hospital where the doctor works as an emergency physician (88% and 79%, respectively).

In a response to the NEJM article, a doctor expressed the view that patients should be able to choose their doctor and the doctor should be permitted to decide whether the situation is problematic or not, and decide whether to treat the patient or not.

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<th>TABLE I: GUIDELINES FOR TREATING FAMILY MEMBERS</th>
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<tr>
<td><strong>THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO</strong></td>
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<td>Physicians should not treat either themselves or family members, except for a minor condition or in an emergency situation; and only when another qualified health care professional is not readily available.</td>
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<td><strong>THE COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA</strong></td>
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<td>Physicians should avoid treating themselves or family members unless the medical condition is minor or emergent and no other physician is readily available. Physicians should exercise sound professional judgement and avoid treating anyone with whom they have another relationship, which may affect the objectivity of the medical care they provide.</td>
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<td><strong>THE MEDICAL COUNCIL OF NEW ZEALAND</strong></td>
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<td>Wherever possible, avoid providing medical care to anyone with whom you have a close personal relationship. The Council recognises that in some cases providing care to those close to you is unavoidable. However, in most cases, providing care to friends, those you work with and family members is inappropriate because of the lack of objectivity and possible discontinuity of care.</td>
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<td><strong>AMERICAN MEDICAL ASSOCIATION “CODE OF MEDICAL ETHICS,” OPINION</strong> 1,10,12</td>
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<td>...physicians generally should not treat themselves or members of their immediate families.</td>
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<td><strong>THE MEDICAL COUNCIL OF IRELAND</strong></td>
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<tr>
<td>Except for minor illnesses and emergencies, it is not advisable for you to treat members of your own family or issue prescriptions, sick certificates or reports for them.</td>
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Other views are situation dependent. A family physician felt that it would not be wrong to prescribe an antibiotic for a tooth abscess for a family member on holiday and away from her home, but would not treat an ear infection in her own young baby. There were differing opinions as to whether an ill neighbour suffering from influenza and dehydration could be managed at home as he did not have medical insurance.2

Obviously, if the doctor practices in a setting in which there is no other healthcare professional, there may be no alternative to treating family and friends. However, this is a formal professional relationship, not the informal care and prescription for which there is no documentation.3

WHAT ARE MY OWN VIEWS?
I believe that prescribing for non-patients is potentially problematic and fraught with conflict and risk. I have self-prescribed antibiotics and anti-inflammatories, and I have prescribed medication, including psychotropic medication on one occasion, for family, friends and colleagues. However, all these encounters have left me feeling uncomfortable and uneasy. I am prepared to prescribe antibiotics under exceptional circumstances and will only prescribe other medication as a repeat prescription after it has been initiated by the patient’s primary doctor. If I were confronted with the hypothetical scenarios depicted in the introduction of this article, I would probably be prepared to prescribe antibiotics for my friend but would draw the line at corticosteroids; I certainly would not initiate a prescription for antidepressants for a sibling, another relative, or friends. It would be interesting to solicit the views of ALLSA members, who have a wide range of practices and experience.

CONCLUSION AND RECOMMENDATIONS
Doctors and other health professionals should reflect on their own situation and decide for themselves what they are prepared to do, in any given situation, regarding treatment of non-patients, while considering the professional guidelines and codes that exist. The major risk that a dual relationship holds for both doctor and patient, is the lack of objectivity which may result in harm to both of them. Hallenbeck1 warns against the “dangerous slippery slope” that may result from the dual relationship, in which “special considerations” insidiously lead from small acts of friendly kindness to requests for favors that lie outside the bounds of propriety.” He continues, “Each step down the slope seems reasonable enough, but, at a certain point, one realizes he is in trouble, and climbing back to safety seems impossible.” He advises the doctor to consider two principles that may safeguard against the slippery slope: (1) “the patient comes first” and (2) “first, do no harm”.1

Latessa and Ray conclude, “Clear-cut answers are rare when someone you’re close to is hurting and you have the power to ease their pain. Thinking about these situations before they pop up can make it somewhat easier to set your personal guidelines. Weigh the ethical questions and opinions with state and federal laws.”2

The HPCSA should include a section on treating family and friends when the guidelines are updated, and institutions should have a policy as to whether doctors are allowed to be the primary physician of their family and friends. My advice is to refrain from treating family and friends, except in emergency situations and where no other doctors are immediately available. All such care should also be carefully documented. In addition, those of us who teach students and junior colleagues, should make them aware of the potential conflicts inherent in such situations, and warn them of overstepping the ethical boundaries of professional care.