

ETHICS CASE

How Should Clinicians Respond to Medical Requests from Clinician Family Members of Patients?

Commentary by Andrew Thurston, MD

Abstract

In the medical profession, receiving a request for medical management from a colleague is a routine experience. However, when the colleague is a family member of a patient and the desired or requested medical intervention is not medically indicated in the attending physician's view, the situation becomes more complicated. Ethical issues include respect for patient autonomy and social justice as well as nonmaleficence.

Furthermore, interpersonal and professional relationships may be tested in this situation. Addressing the colleague's concerns with empathy and respect, without compromising one's own medical judgment, is critical in resolving these kinds of conflicts.

Case

Dr. Rose, a family medicine practitioner, is seeing patients at her outpatient clinic. The nurse, Jack, hands her the chart saying, "Room two is ready. It's Dr. Little; she brought in her son, Andrew." Not having had time to look at the chart, Dr. Rose asks, "What was the chief complaint?" Jack responds, "Andrew has back pain." After taking a few minutes to glance through the rest of the chart, Dr. Rose exits her office, walks down the hall to room two, knocks, pauses, and enters.

Dr. Little—a vascular surgeon at a nearby hospital whose family is part of Dr. Rose's practice—greeted Dr. Rose, "How's clinic today?" Dr. Rose replies, "Not too bad." Dr. Rose then turns to Andrew and asks, "What brought you in today?" Andrew says, "I've been having back problems for the last several weeks, particularly after wrestling practice." Dr. Rose locates Andrew's pain in the lower back and then performs a thorough neurological exam. Finding no evidence of any neurological deficiencies, Dr. Rose states, "This is likely musculoskeletal in nature, I would recommend rest and perhaps some pain killers. If it doesn't go away in 4-6 weeks, then come back."

Dr. Little responds, "Would you mind imaging it? An MRI or even a CT would do."

Dr. Rose replies, "None of the guidelines suggest imaging for this clinical presentation—study after study has shown that it's not beneficial."

Dr. Little responds, “I know imaging might not be helpful for the average patient, but it would be helpful just for our peace of mind to know that there’s nothing rare going on.”

Commentary

Dr. Rose finds herself in a tough situation, perhaps one that many clinicians find equally uncomfortable: a medically unwarranted request from a colleague. Certainly differences in opinion exist among professionals in any field, but, in health care, these differences seem to carry a heavier weight—particularly if the difference in opinion involves a potentially life-threatening diagnosis [1]. In the above case, the difference in opinion is further complicated by the fact that one clinician might be considered experienced in the [diagnosis of lower back pain](#) and the other clinician inexperienced.

Treating clinician colleagues or their relatives raises special concerns. Evidence suggests that caring for a colleague or a fellow clinician can generate anxiety in the treating clinician [2], and because of the duality of the patient-clinician role in these cases, care of a colleague should focus on “acknowledging the vulnerable patient in the colleague and acknowledging the identity of the colleague in the patient” [3]. Clinicians who become patients can also experience barriers to access, such as embarrassment, lack of time due to professional constraints, and minimization of symptoms due to clinical knowledge, which can affect the quality and timeliness of care [4]. In addition, children of clinicians might be at risk for lower-quality health care in part due to inappropriate delays in seeking care, treating clinicians’ embarrassment about discussing personal issues with a colleague, and parents’ self-referral to specialists [5]. Thus, factors other than a professional difference of opinion might be complicating this case.

Navigating Conflicts in the Treatment of Colleagues

In the above case study, there are a number of conflicts or issues that Dr. Rose must navigate in addition to balancing her role as the primary care physician of a colleague’s child.

First and foremost is the clinical question of whether or not a particular test is warranted. This is a personal and professional conflict—something that all clinicians deal with on a daily basis, and something that Dr. Rose must consider based on all of her training, knowledge, experience, and every bit of presented clinical information. Should I get more imaging? Should I order that complete blood count? Should I directly admit this person to the hospital? What if I’m wrong? Certainly every clinician has, at one point, struggled with similar questions. In this situation, Dr. Rose has performed a thorough clinical evaluation and determined that imaging is not appropriate for Andrew’s nonspecific low back pain, which is in keeping with the clinical guidelines for the diagnosis and treatment of low back pain [6]. Ordering [a test that is not medically indicated](#) carries with it a separate set of ethical considerations, such as whether or not

we are acting in the patient's best interest. Even a seemingly routine CT scan can lead to unnecessary radiation exposure and potential for complications like contrast-induced acute kidney injury [7, 8]. Assuming the ordered scan would be covered by insurance, Dr. Rose would have to add a diagnostic code to justify the scan—and without such justification (or by adding documentation supporting a diagnosis that Dr. Rose does not believe is appropriate), ordering a scan could be considered unethical.

Second, challenges in this patient encounter may stem from the fact that the request for more imaging is coming from a clinician who, in theory, would know whether and when such a procedure were warranted. If Dr. Little is not aware of the medical standard of practice for the evaluation and diagnosis of musculoskeletal injuries, then Dr. Rose runs the risk of adding insult to her son's injury by insinuating that she is not up to date. Or perhaps Dr. Little is well aware of the standard of practice but makes her assessment based on her experience and her individual patients' unique needs—which is certainly possible and speaks more to the "art of medicine"—while Dr. Rose strictly follows guidelines. However, Dr. Little's reason for requesting imaging ("to know that there's nothing rare going on") suggests that there may be an unidentified emotional component to her request—fear, perhaps, or anxiety that something unusual is being missed even if the clinical exam does not point in this direction. Dr. Little's emotions, which might overshadow her clinical knowledge and experience, as well as differences in the two physicians' knowledge and clinical approach, might contribute to making this patient-physician encounter "difficult."

Third, Dr. Little is part of a local practice at a nearby hospital and may interact professionally or socially with Dr. Rose on a regular basis, which might create conflicts of interest. Dr. Rose and Dr. Little may have mutual patients, or Dr. Little might refer patients to Dr. Rose or vice versa. A fear of decreased referrals may unduly influence Dr. Rose's clinical decision making in order to preserve the professional relationship and her livelihood. Dr. Little might even be considered a friend, which would further complicate the situation [9]. In fact, several medical organizations such as the American Medical Association, the American College of Physicians, and the American Academy of Pediatrics advise against [caring for friends](#) and family [10-12]. In addition, if Dr. Rose stays the course and doesn't order further imaging despite Dr. Little's insistence, this decision may affect their professional or personal relationship, which could in turn affect the downstream care that future patients do (or do not) receive. For example, Dr. Little may be reluctant to refer patients to Dr. Rose in the future if she feels her knowledge or judgment is being challenged. Perpetuating conflict with a colleague may affect business as well as working relationships with other staff members, making encounters like the above seem even more difficult to navigate.

Fourth, any intervention or procedure may have potential side effects or consequences, even procedures as seemingly benign as an MRI or CT scan. Complications could arise

from contrast dye if used, or an incidental finding may be discovered that leads to further testing that only adds burden rather than clinical benefit. Assuming that a thorough history and physical has been performed, searching for “rare things” is hardly cost effective or in keeping with medical guidelines [6].

Fifth, some might argue that Dr. Little lacks objectivity given the fact that the patient in question is her son and her emotional interests could cloud her clinical judgment. (Would she ask for the same test if the patient in question were not her son?) Although this is perhaps an expected emotional response of a parent with an injured child, it created an interpersonal conflict that Dr. Rose must try to address. For a clinician, balancing the responsibility and burden of medical knowledge with the emotional weight of personal concern can be challenging and risks blurring the lines between personal and professional boundaries [13].

Given all of the above issues, many might consider this a challenging situation, and some might label it a “difficult” patient encounter. How do you address a colleague’s concerns while balancing the working relationship? How do you discuss medical guidelines with someone who should, in theory, know these guidelines without sounding condescending? Sometimes being a clinician patient can positively impact the patient experience by increased access to care and better communication about diagnostic uncertainty [5]. At other times, having a [clinician family member](#) can pose a greater challenge, especially if anxiety affects one’s understanding of the medical facts or a blurring of roles leads to the patient’s intrusion into medical management [2]. What, then, is Dr. Rose to do?

What Are the Next Steps?

I would argue that Dr. Little is in no way being “difficult”: she is being a mother who is concerned and wants the best care possible for her child. As discussed, Dr. Little’s request may be driven by emotional cues—such as anxiety over a sick child, fear of a “rare thing” or undiscovered illness, or fear of the unknown. In this situation, the key is to explore Dr. Little’s and Andrew’s concerns with empathy. Dr. Rose might consider speaking with them both separately, with permission, to see if any new information arises that changes her clinical judgment. Dr. Rose could assess Dr. Little’s concerns by saying something to the effect of “It seems like you’re really worried about something; tell me more about what concerns you.” Perhaps Dr. Rose could explore what Dr. Little means by “the average patient.” The fact that Dr. Rose knows Dr. Little could also add a more personal touch to the conversation. For example, Dr. Rose could say something like “We’ve known each other for many years ... tell me, what are you worried about most?” In addition, Dr. Rose could acknowledge the awkwardness of balancing one’s medical knowledge with the weight of one’s emotions, the latter of which may be pulling Dr. Little further away from standard medical practice. Dr. Rose could say something like “I imagine you’ve seen many terrifying things in your practice, and I bet the mind often

goes there—especially when it’s about a loved one. Is there something in particular you’re worried about with Andrew?”

Exploring some of these emotions with empathy can often help someone see through the emotional fog of illness and grasp the bigger picture (in this case, the fact that there is no indication for further imaging). The reality of this situation is that bad news is being given: Dr. Little is hoping for further imaging; the bad news is that further imaging is not warranted and will not be ordered. As such, using empathetic communication skills in breaking this news is key. One mnemonic for responding to emotion with empathy is NURSE: “name the emotion;” “understand the emotion;” “respect or praise the patient;” “support the patient;” and “explore what underlies the emotion” [14].

Some might argue that clinicians must respect a patient’s autonomy or, in this case, the autonomy of Andrew’s parent, Dr. Little (assuming Andrew is a minor), and therefore order the imaging. However, respect for autonomy does not mean that unindicated tests should be ordered or that a clinician’s clinical judgment should be affected by such demands [15]. Rather, it is the physician’s duty to provide a recommendation based on a full assessment grounded first and foremost in the clinical evaluation. Both the patient’s and family’s emotional and psychosocial status should certainly be evaluated, but to order a test because someone would worry until the test is done might set up a very difficult precedent to overcome.

Conclusion

In this situation, Dr. Rose should not order further imaging because there is no clinical indication to do so. Instead, she should respond to Dr. Little’s emotional cues with empathy and explore the request for imaging both with Dr. Little and Andrew. Dr. Rose should stick with the original plan of conservative management with re-evaluation after several weeks. She might negotiate a “compromise” of sorts—namely, conservative management—but if there is worsening of symptoms or no improvement after several weeks, pursue imaging. This plan would not compromise Dr. Rose’s clinical determination but may alleviate Dr. Little’s concerns and provide appropriate support. If there is still concern after the above approach has been taken, then Dr. Rose should offer the option of a second opinion if Dr. Little wants to pursue imaging, and she should be available to follow up with this imaging and continue to provide medical care for Andrew. Dr. Rose may also want to reach out to Dr. Little in the coming weeks to see how things are going with Andrew and keep open the lines of professional and patient-centered communication.

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