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The ethics of operating on a family member

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In the physician or surgeon, no quality takes rank with imperturbability. Sir William Osler (Aequanimitas)

You have developed an effective new surgical procedure to treat a heretofore terminal disease for which all previous therapies were perilous and ineffctive. The statistical data indicate that you have mastered the learning curve and can perform the operation with low morbidity and consistently good outcomes. Colleagues are beginning to visit your institution to observe your conduct of the procedure, and you plan to present your results on a small series of patients at an upcoming national meeting. You have for many years been recognized as one of the most technically skilled surgeons working in your specialty. This week you've learned that your grandfather has just been diagnosed as suffering from an advanced state of the condition for which you developed the new operation. What should you do?

A. Legal and professional prohibitions prevent you from operating on a family member.
B. You must accept the established ethical principle that a surgeon cannot operate on a family member under any circumstances.
C. Have a qualified colleague at another institution do the procedure.
D. Have a colleague do the procedure under your direct supervision.
E. If you and your grandfather agree, you should do the procedure.

Providing medical or surgical treatment to family, friends, and close colleagues has always touched nerves that lie undisturbed in caring for all other patients.[1] Every physician has had relatives and close friends ask for medical advice or care of one sort or another. Most respond easily with a few suggestions or prescription of a routine noncontrolled medication when the ailment is easily identified, minor, and acute. Many fewer are willing to attempt complex treatment of serious or long-term illnesses among people personally close to them. Surprisingly, one large, well-organized survey found that 9% of qualified physicians had actually operated on family members.[1] Twenty-two percent of the study's respondents said they felt uncomfortable treating family. Another study ranked physicians' comfort levels in treating different relatives.[2] Reagan et al[2] found that physicians were most comfortable when providing therapy for their own children, and were least at ease when treating grandparents, which is why Grandpa was chosen for our case.

Emotional overlay markedly affects performance by contributing all the strengths and weaknesses we refer to when we use the term "being human." Without these feelings we would be without the qualities of empathy, compassion, concern, and much respect for the reasons that there is a medical profession at all. Emotions filter the sensory information we receive and rank-order its importance through personalization. They augment our thoughts, exaggerating or moderating responses; otherwise identical inputs, thus re-interpreted, may yield entirely different reactions dependent upon their emotional contextual interpretation.

Emotional organization of perceptual input also has a critical survival function that augments discriminative processes. When faced with the information that a saber toothed tiger was on the prowl, our hominid ancestors would have had an entirely different emotional response depending whether the tiger was in their immediate area, at the periphery of the tribe's campground, or across the river in the vicinity of another hostile tribe. Great impulsive heroic acts and devotional enhancements to family, nationality, ideals, and religion are stimulated by emotional linkages.

For all the richness emotions add to human life, emotions are generally considered in the world's great literature to be at variance with reason. Considered with words denoting behaviors such as impulses, desires, and passions, the ancients, noted philosophers, and the Bible instruct

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that emotions should be controlled.[3] The ancient Greek philosophers considered emotional actions to be of a lower animal nature, allowing man to act opposite to reason.

As Sir William Osler recommended a century ago, surgeons require detachment and imperturbability because the performance of major surgery is counterintuitive: in any other situation, the slicing of another person with a sharp instrument and invasion of the internal organs is the gravest manifestation of aggression and ill will. Surgery harms before it heals, and the consequences of misadventure can be terrible. A clear, disciplined, and decisive mind is critical in evaluating when and how to operate, manage contingencies, and control risks.

These kinds of important considerations help us to understand the cautionary view of the American Medical Association's (AMA) Council on Ethical and Judicial Affairs: "Physicians generally should not treat themselves or members of their immediate families."[4] The Council is concerned about whether the quality of care a doctor is able to provide will be adversely affected by strong emotional attachments to family members who become patients.

Operating on family members can obscure objective judgments and affect the physician's ability to proceed with high-risk options, even when they are most necessary. The emotionally involved physician may misinterpret or deny data suggesting that a family member's diagnosis is more serious than expected, or worsening despite treatment. The physician so-affected may depart from his proven routine to perform an "extraordinary" operation, sometimes euphemized as a "blue plate special," behaving desperately and ill-advisedly to protect his emotional investment and perhaps ultimately doing the patient more harm than good.

Relatives may themselves sense the awkwardness of a profound disruption of long-accustomed family roles and find the adaptation difficult when a spouse, child, or sibling suddenly becomes their authoritative physician. It is not unlikely that relatives may be deeply uncomfortable reporting intimate, perhaps embarrassing, personal information to a treating physician who is also a family member, and they may in fact not do so, providing an inaccurate history that ultimately confounds correct diagnosis.[5]

In most ordinary circumstances, patients understand that they must adopt a dispassionate posture toward their physician during the course of treatment, much like the physician's approach to them, so that therapy can proceed smoothly and rationally. The overlay of normal familial affections (or disaffections) upon the doctor-patient relationship risks the addition of a deadly contaminant to this critical dispassion. Issues of control, authority, and boundaries influence all physician-patient relationships, and are prominent factors in the effectiveness of care; they naturally intensify, and can take unexpected and uncontrollable turns, when physician and patient have a long-established history in an entirely different context.[6] The patient who is also your grandfather may be reluctant to accept crucial instructions for post-operative care from his grandson, and you may be unable to invoke the voice of physicianly authority necessary to ensure that your grandfather/patient will act in his own best interest.

Your obligation to patient confidentiality will become complicated as other family members begin to impose their own expectations and emotional demands upon you. As the treating physician, you will surely learn things about your grandfather and his medical condition that would normally be far out of bounds to his grandson, and might even pique your nonprofessional interest. You will have to be prepared to compartmentalize that information and wall it off from your future affectionate relationship with him.

It will be ethically and clinically vital that you do not permit fantasies of heroism to intrude upon your decisions; your grandfather should receive exactly the same preoperative evaluation that you would give any other patient, and you should proceed to operate only after establishing reasonable certainty that his advanced condition will be susceptible to your surgical intervention. Among the additional, and profound, considerations in treating a relative, particularly surgically, will be the potential damage that a bad outcome might have upon your own emotional well-being and your future interpersonal family relationships.[7]

In our fictitious scenario, the application of a novel procedure that has been neither extensively tested nor peer reviewed is heavily laden with risk despite early successes. The ethical principles involved in implementing a new surgical technology demand a sound scientific basis, careful development and refinement, and close training and supervision of newly minted surgical adherents.[8] The surgical learning curve is real. Even relatively minor procedural changes in a center renowned for its surgeons' technical skills required a period of accommodation and refinement among experienced thoracic surgeons who began to use bilateral rather than single internal thoracic artery grafts for coronary bypass.[9] The pattern is consistently replicated with every technical or technologic innovation in surgery.[10,11]

Despite published opinions urging special caution, including this one, there are in fact no legal or professional prohibitions against operating on family members, eliminating Option A as a reason for rejecting the concept. The AMA's position specifies exceptions: "It would not always be inappropriate to undertake self-treatment or treatment of immediate family members. In emergencies or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available."[7] These considerations reject the absolutist posture of Option B as well. Refusing to provide essential care to a person in need solely on the basis of relativity places an arguable intellectual principle before relief of acute human suffering, and cannot be defended. Option C must be dismissed because there is as yet no surgeon qualified to perform the necessary procedure available at another institution.

Option D at first appears to be ethically acceptable. Having a colleague under your direct supervision at the operating table would allow your expertise to benefit your grandfather and would buffer the emotional constraints.

Most surgical expertise is transferred to inexperienced surgeons in just such a manner during surgical residencies and fellowships. Nevertheless, even a very skilled and adept colleague will still be low on the learning curve, with an added increment of risk to the patient. The possibility that you might have to step in and take over the operation and manage such risk cannot be ruled out.

Option E is ethically acceptable, provided that you frankly acknowledge and prospectively manage the sort of personal and professional conflicts we have just described. The advantage of accepting Option E is, of course, that you are the only surgeon qualified to perform this operation. You can help to minimize the disadvantages by fully adopting your physicianly personae during the course of treatment. Think of and refer to your grandfather in clinical reflection and discussion with colleagues as "the patient" and not as "my grandfather." The words you use will help to frame and discipline your judgment and behavior. You would be well advised to thoroughly review the patient's case with an experienced colleague, accept the dispassionate authority of his recommendations, and ask him to join the case as second surgeon.

You should assure the patient that he can speak freely about his health and other concerns, and describe to him how the usual rules for managing confidential information will be rigorously followed: only information that he specifically authorizes will be disclosed to family. You should not abbreviate the consent process or otherwise permit an atmosphere of familiarity to alter your standard patient procedures. Fully explain both the benefits and risks of the proposed operation, neither shielding the patient from such information nor protecting yourself by hanging crepe. You must anticipate, and discuss with a thoughtful and disciplined colleague, the possibility that the patient could experience major, potentially unmanageable complications. Finally, you should have a frank and detailed conversation with the patient about end-of-life care in the event that the operation leaves him ventilator-dependent in the surgical intensive care unit or otherwise dysfunctional.

You should present Options D and option E to the patient, as well as information about their benefits and risks. You should make it clear to your grandfather that you will implement the alternative that he prefers. Your grandfather has probably lived long enough to have encountered complicated emotions and contending imperatives before, and may even be able to lend you some of his own wisdom to untangle the problem.

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