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RISK MANAGEMENT PERSPECTIVES
OCTOBER 2022

Treating Family, Friends, and Colleagues:

Liability, Ethics, and Professionalism

CASE ONE
Treating a Family Member

CASE TWO
Treating Friends and Colleagues

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Treating Family, Friends, and Colleagues:

Liability, Ethics, and Professionalism

INTRODUCTION

A physician-patient relationship, as opposed to a family or social relationship, exists solely for the patient's benefit.[1,2] Prior or current social or emotional attachment to patients (as when treating a family member, friend, or colleague) can disrupt professional objectivity, which weakens the primacy of the physician-patient relationship and can diminish quality of care. Research indicates that treating family, friends, and colleagues is common among physicians.[3] When physicians have been surveyed about their perceptions of the benefits of providing care to these individuals, they most commonly cite convenience, cost saving, and their perceived greater knowledge or concern for the patient than colleagues.[4] These beliefs align with the ethical principal of beneficence. But good intentions can violate other ethical principles (e.g., nonmaleficence and autonomy); increase liability risk; and increase familial, social, and workplace conflict.[5]

Prior or current social or emotional attachment to patients (as when treating a family member, friend, or colleague) can disrupt professional objectivity, which weakens the primacy of the physician-patient relationship and can diminish quality of care.

In addition to ethical issues, physician and patient emotions and the informality of settings in which care or consultation may take place can increase the risk of patient injury and liability. Consider the potential outcomes of the following issues that are more likely to arise during the treatment of friends and family:[6,7,8,9,10,11]

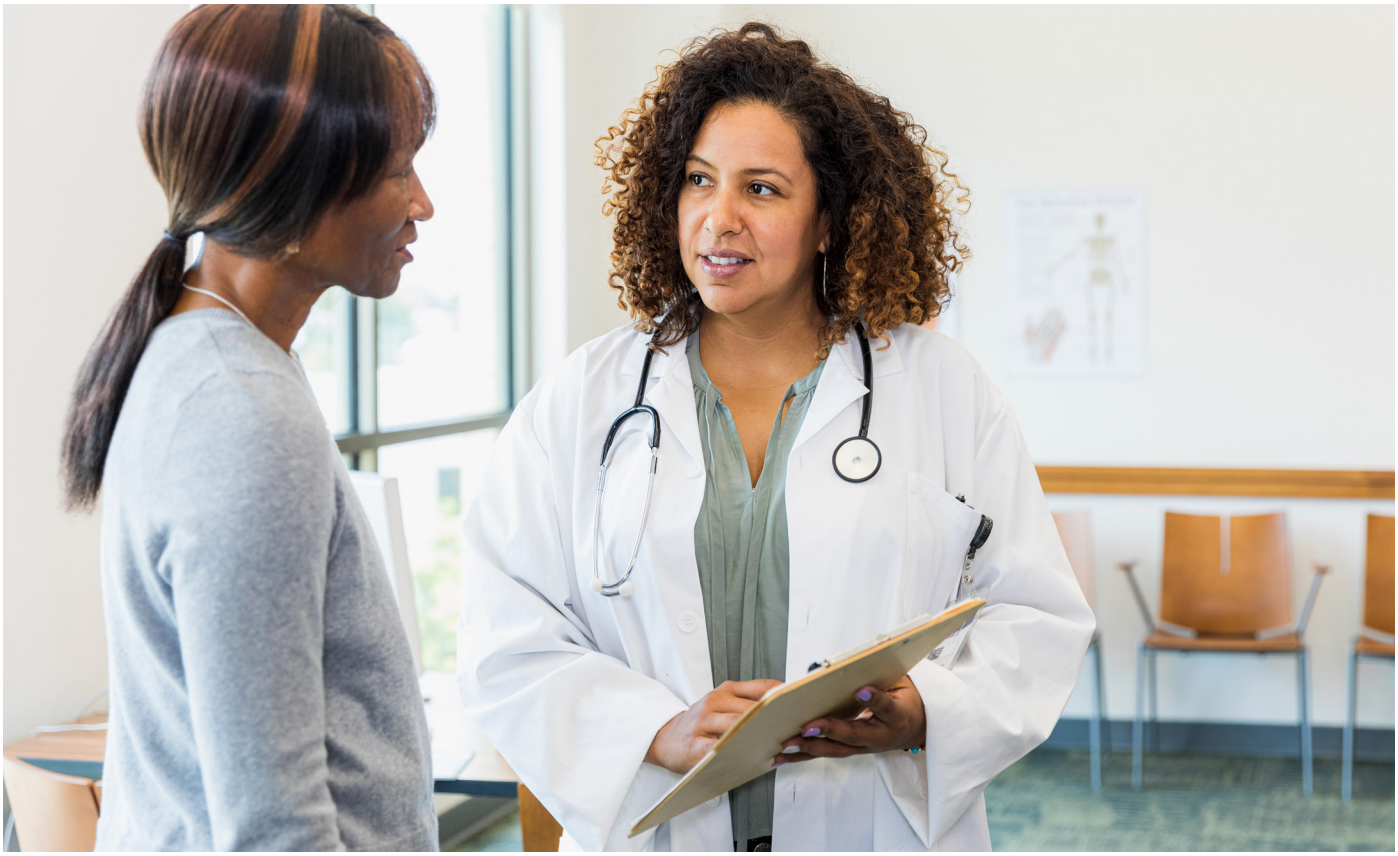
- Questions about sensitive issues may not be asked (e.g., sexual history, drug use, pregnancies, etc.).
- Intimate aspects of a physical examination may be avoided.
- Counselling on sensitive issues may be limited or absent.
- Overtreatment may occur to avoid error, omissions, or delays in healing.
- Physical examination may be absent or inadequate, and performed without proper equipment.
- Necessary tests or studies may be avoided because they will cause patient discomfort.
- Treatment provided may be outside of the physician's area of expertise and training.
- Documentation may be absent or inadequate.
- Medical information may be shared with others in the family or social group.
- The informed consent process may be absent or abbreviated.
- Poor prognoses may not be adequately disclosed.
- Patients may withhold sensitive information due to embarrassment.
- For fear of offending the physician, patients may feel obligated to obtain treatment from the physician, may decline referral to a different physician, or may accept recommended treatment they would otherwise decline in a standard informed consent process.

Furthermore, a physician-patient relationship is formed with family and friends when consultation or treatment occurs. Like any other physician-patient relationship, the duty of care continues until the healthcare relationship ends. Unlike traditional patients, with family, friends, and colleagues, after the physician-patient relationship ends, the personal relationship continues, which—particularly if there is a bad outcome—can create challenges for both the patient and physician.

It should be noted, there are emergency and isolation exceptions to ethical prohibitions against treating family, friends, and colleagues.[7] For example, in cases of emergency or disaster, it would be unreasonable to expect a physician to avoid providing care because of a preexisting familiar relationship. It may also be difficult for the family and friends of a physician to find alternatives in a small town with limited healthcare options. In these cases, the well-being of the individual needing medical treatment would outweigh the ethical issues.[12] The American Medical Association (AMA) also makes an exception for short-term, minor problems.[7] That being said, physicians should treat their family and friends in the same manner as they would any other patient under the same or similar circumstances.

Like any other physician-patient relationship, the duty of care continues until the healthcare relationship ends. Unlike traditional patients, with family, friends, and colleagues, after the physician-patient relationship ends, the personal relationship continues, which—particularly if there is a bad outcome—can create challenges for both the patient and physician.

The case studies in this article are based on closed medical malpractice claims. They are presented to illustrate how the treatment of friends, family, and colleagues can and does prompt medical liability claims. Strategies are provided for supporting the separation of personal and professional obligations with the objective of maintaining patient safety and reducing liability risk. Risk reduction strategies following the case studies, although frequently directed in the text to physicians, can also be used by any individual providing medical treatment.



Treating a Family Member

The very first code of medical ethics drafted by the AMA in 1847 recommended against physicians treating family members, stating, "the natural anxiety and solicitude which he [the physician] experiences at the sickness of a wife, a child … tend to obscure his judgment, and produce timidity and irresolution in his practice."[13] In addition to the current AMA code of ethics, several major medical professional associations generally discourage the provision of medical care for family members.[14]

In addition to being ethically complicated, some common aspects of family member treatment may be deemed violations of the standard of care and/or unprofessional conduct by a medical board.[15] For example, in the first case study below, the following issues impacted the defense of the physician who was treating her daughter:

- Failure to obtain informed consent
- Lack of appropriate medical history and examination
- Inadequate medical record documentation
- Failure to refer to a specialist
- Failure to provide adequate follow-up care

These omissions would be unusual for a physician during routine care of an unrelated patient. The defendant physician in this case would maintain throughout the civil and criminal actions that she believed she was providing the best care possible to her daughter prior to her death. Other family members disagreed, and filed a wrongful death lawsuit.

CASE ONE

Allegations: The physician's negligent prescribing caused the wrongful death of her daughter.

A family physician (FP) started treating her daughter in 2001, when she aged out of health insurance coverage on her parents' plan and would otherwise not be able to afford the medical care to which she was accustomed. The family physician considered herself her daughter's primary care physician. She managed her daughter's acute illnesses (urinary tract infections, sinus infections), and she also prescribed medications for her chronic conditions (lower back and neck pain, depression, anxiety, and insomnia). The physician did not perform annual physical examinations, but referred her daughter for various issues, including gynecology exams and mammograms. Her daughter did not schedule appointments with her mother, but if she had a medical issue, they would arrange to meet after the end of the workday in her mother's office.

The practice was located in a small community where patients and staff moved in the same social circles, so a patient's medical information could be quickly disseminated throughout the community. An earlier privacy breach had resulted in her daughter's abusive former partner discovering her medical information. Although privacy education had been provided and disciplinary actions had been taken, the FP was not entirely convinced that she could trust her staff. The physician's daughter worried that the practice staff would share her medical information with members of the community again, so the FP accommodated her daughter's request for privacy by not creating any treatment records after 2012.

In 2015, the physician's daughter drove off the road and ran into a building. She died at the scene. Multiple prescription medications were found in her system on autopsy, including therapeutic levels of oxycodone and carisoprodol, and a potentially toxic level of lorazepam. For reasons she could not adequately explain later, the physician had denied that her daughter was taking any prescription medications when initially questioned by the police. The police started an investigation of the decedent's mother, since pharmacy records indicated she was the prescribing physician of the medications found in her daughter's system at death. Medication bottles listing the physician as the prescriber were found in her daughter's bedroom and bathroom and collected by the police for evidence. While the criminal investigation was moving forward, the decedent's husband and sister filed a wrongful death lawsuit, alleging the defendant's negligent prescribing was the cause of death.

The state medical board also opened an investigation into what they alleged was unprofessional conduct. The medical board claimed the defendant's treatment of her daughter was an "extreme" departure from the standard of care, citing pharmacy records that indicated during the year prior to the patient's death, she was prescribed 156 tablets of 250 mg carisoprodol, 156 tablets of 2 mg lorazepam, and 120 tablets of 10 mg oxycodone monthly. They further claimed the medications were prescribed with no diagnostic assessment, no referral to specialists, and no pain medication agreement. They requested the revocation of the FP's license.

DISCUSSION

There were various theories about why the daughter's car left the road, and whether the physician's prescribing practices caused or contributed to her death. The plaintiffs' experts contended the patient lost control of her car and crashed due to her sedation from medications. They noted there was no evidence the patient had been warned not to drive while taking the various medications prescribed by the FP, which was a violation of the standard of care. They further opined, based on the drugs in the patient's system at autopsy, that the defendant prescribed an excessive amount of the medications, which was a violation of the standard of care.

The defense argued the combination of lorazepam, carisoprodol, and oxycodone was concerning for the sedating effects, but was not contraindicated. Furthermore, the patient had most likely developed a tolerance for these drugs (judging from her monthly refills of prescriptions for them over the past several years), which might have reduced the sedating effect of the medications. They would argue that there was a good possibility something other than sedation while operating the vehicle had caused the accident. Unfortunately, lack of medical record documentation made it difficult to advance this defense. It also made it difficult to prove the patient was receiving appropriate follow-up care relative to her multiple medications, and that the patient was advised not to drive while taking the medications.

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The defendant physician wholeheartedly believed she was providing the best medical care possible for her daughter. Although she did not document it, or recall specifically asking about it, she believed her daughter was taking her medications as directed. She denied any knowledge of her daughter driving while she was sedated from the medications. She also believed her daughter was well aware of the dangers of driving under the influence. However, she had to admit her daughter was likely driving every day while taking a combination of sedating medications. The FP reported her daughter did not appear intoxicated on the day of the accident shortly before she got into the car. However, she had had an intense argument on the phone with her husband and, as a result, most likely was distracted when she went off the road.

The FP's perceptions and testimony about her daughter's prescription drug use differed significantly from that of her son-in-law and other daughter. The decedent's sister reported to the police that the decedent frequently drove under the influence of drugs prescribed by her mother. She considered her sister a menace on the road. She would not allow the decedent to babysit for her due to her frequent, obvious intoxication, which she assumed was caused by pills, since the decedent was not known to drink alcohol.

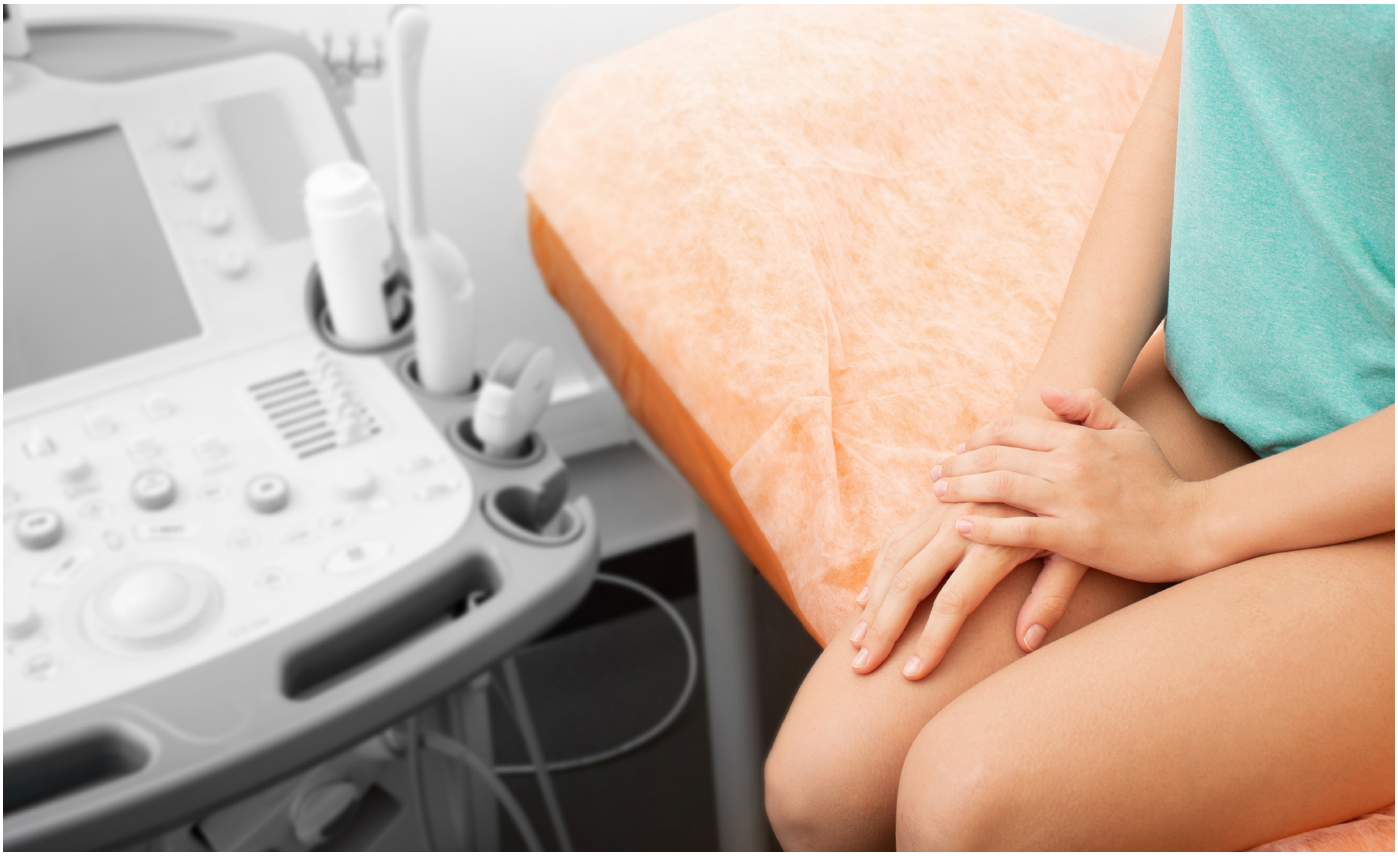
The decedent's husband also told the police his wife was not a drinker, but that she had been recently arrested for driving under the influence, which she later explained had been caused by her medications. In the husband's opinion, the FP had been overmedicating his wife for years. He frequently observed his wife's intoxicated behavior, which included slurring her words and otherwise being obviously intoxicated. When he had confronted his mother-in-law regarding her prescribing practices for his wife, the FP blamed the apparent intoxication on low blood sugar.

The defense team did not believe the chances of prevailing in civil court were strong, based on the evidence already discovered in the criminal action. Settlement prior to the family members being deposed was in the defendant physician's best interest, given the evolving criminal and disciplinary actions against her.

RISK REDUCTION STRATEGIES

Although physicians may consider themselves the best choice for family member medical care, emotional investment can make it easy to lose perspective.[16] Family members with psychiatric diagnoses and pain management needs should be treated in the same manner as any other patient, which might include referral to specialists when their care requires greater training and expertise. When approached to provide consultation or treatment to a family member, consider the following:[9,17]

- Urge family members to seek care elsewhere when other qualified physicians are available. As an alternative:
  - Use your knowledge or contacts to refer the person to another physician.
  - Serve as an advisor or health literacy aide by suggesting questions to ask, explaining medical terminology, accompanying the individual to appointments, and advocating for the individual when healthcare recommendations or care provided are inadequate.
- If there are no alternatives and a family member must be treated, assess and treat the family member like any other patient.
  - To gauge your risk of violating the standard of care, ask yourself the following questions:
    - Do I have the training and expertise to diagnosis and treat the condition?
    - Can I be objective?
    - Will my family member and I be comfortable completing an appropriate physical examination and history?
    - Will I be able to refrain from taking shortcuts during the diagnostic process?
  - Explain the policies that govern patient appointments, insurance payments, and prescriptions, and follow the policies as you would for any other patient.
  - Create a medical record for the family member, and then protect your family member's health information privacy.
  - Carefully consider whether it is appropriate, legal, and within the standard of care to prescribe any medications—particularly narcotics, stimulants, and other highly addictive prescriptions—to family members.



Treating Friends and Colleagues

When a physician-patient relationship evolves into friendship, a physician's friend-like behavior—accepting gifts, greeting with a hug, and discussing personal issues—can cross professional boundaries.[1,2] Similar to treating family members, the dual nature of the relationship when treating friends and colleagues can jeopardize clinical objectivity, which weakens the primacy of the clinician-patient relationship.

In addition to the ethical concerns about these relationships, friends and colleagues may be treated in a more casual manner and environment than an average patient. For example, a neighborhood clinician may be asked by a neighborhood parent to look at a child's injury, or a clinician may be asked by a colleague to give an opinion about the colleague's symptoms or write a prescription. These seemingly harmless exchanges can create liability exposure. Giving an opinion (something akin to a curbside consultation, but to a patient outside of a medical venue) or writing a prescription can establish a physician-patient relationship. The consultation can create a need for ongoing care (e.g., follow-up and referral). Because of the casual nature of the exchange, medical opinions and advice may be given without adequate diagnostic information, which can result in patient harm. If a lawsuit is filed or medical board action is initiated, it is likely there will be no records; lack of informed consent; and an inadequate history, physical, and other aspects of a standard patient work-up.[16] The lack of documentation and other standard aspects of a patient encounter can make these claims challenging to defend.

Furthermore, during healthcare consultations, a clinician and friend or colleague can have different ideas about the lines of demarcation for professional boundaries. When a friendship exists, behavior that was appropriate outside of the office (e.g., an embrace or peck on the cheek following a meeting) can cross professional boundaries, as it apparently did in the following case—at least from the plaintiff's perspective.

CASE TWO

Allegation: Sexual misconduct resulted in emotional distress.

The plaintiff was a long-term member of the housekeeping staff at a small primary care clinic. Over the years, she had become friendly with various staff members and clinicians at the clinic. She was particularly close to a nurse practitioner (NP), who had also emigrated from her home country.

After multiple miscarriages, the woman was newly pregnant. At 11 weeks pregnant, she started spotting. She contacted the NP on his cellphone at the end of the workday, concerned about losing the pregnancy. He agreed to see her in the office that day after hours. She was not a patient, and was uninsured. As a favor, he offered to do the ultrasound off the record, at no cost to her.

Because it was after normal clinic hours, they were alone in the clinic. Before the examination, they hugged and kissed on both cheeks, which was a normal greeting for them. She quickly broke the embrace, explaining that her breasts were tender from the pregnancy. The NP complimented her on the fit of her blouse, noting the increase in her breast size due to pregnancy.

A transvaginal ultrasound was required due to the pregnancy being very early. After confirming the viability of the fetus, the NP asked the woman to hold the ultrasound wand in place as he captured images for a keepsake. He typed on the screen and captured on the printed image of the fetus the words, “Te amo.”

After the ultrasound, the NP told the woman the fetus appeared viable. He left the room so she could get dressed, but reentered while she was dressing, because he had forgotten his cellphone. As the woman left the office, the NP hugged her, gave her kisses on both cheeks, and wished her well. He normally would not hug or kiss patients, but this was a coworker and friend, and hugging and cheek kissing at greeting and departing company was customary in their home country. According to the woman, the NP had an erection when he embraced her, and instead of kissing her on the cheeks, as was customary, he kissed her on the lips, although she attempted to turn her face to avoid it.

A short time after the ultrasound, the woman sued the NP, alleging sexual misconduct. She also sued the clinic, alleging vicarious liability and negligent supervision, hiring, and retention. She also made a sexual misconduct report to the nursing board.

DISCUSSION

In deposition, the NP testified it was a common practice of the ultrasound technicians and clinicians in the office to type a message on the keepsake ultrasound image of the fetus “from” the expectant mother's new baby. It was not meant as a message from the NP to the woman. The encounter was not documented because he knew bringing a patient in without an appointment after hours was against practice policy, and he was trying to avoid the woman having to pay for it.

While the NP sincerely regretted any confusion the woman experienced, and the fact that she expressed dissatisfaction and discomfort with her interaction with him, he categorically denied any wrongdoing or inappropriate conduct. The defense team believed the woman perceived the NP’s behavior as sexual misconduct.

If the woman had been treated as a typical patient, the lawsuit and nursing board action likely would not have been filed.

Unfortunately, a constellation of circumstances during the encounter likely fueled misunderstanding and complicated the NP's defense. If the woman had been treated as a typical patient, the lawsuit and nursing board action likely would not have been filed. Treating the patient in an empty office, without the typical witnesses who would have been there (e.g., an ultrasound technician or chaperone), made this a claim in which a jury ultimately would decide whose story was more believable. Additionally, the ultrasound being conducted after hours, without charge, without follow-up recommendations, and without documentation, other than the keepsake ultrasound image, made it challenging to defend the encounter as a standard medical procedure, in response to the plaintiff's allegations that she was a victim of predatory sexual behavior.

Furthermore, the case would come to trial at the height of the #MeToo movement. The defense team believed a jury or nursing board panel might give greater weight to the account of the patient and discount the explanations by the NP, making a plaintiff's verdict and board discipline more likely. The NP believed adverse publicity would irreparably damage his reputation. Therefore, he requested settlement of the case. He was later disciplined by the nursing board.

The plaintiff also alleged the clinic was vicariously liable for the NP's sexual misconduct. Generally, vicarious liability allows a plaintiff to hold a third party financially responsible for the negligence of the person who caused the injury. In malpractice litigation, vicarious liability is most frequently associated with an employment relationship. In other words, in this case the clinic would be deemed vicariously liable for patient injuries caused by the negligence of the NP. However, sexual misconduct is an intentional tort, which would fall outside the course and scope of the NP's employment. If the plaintiff could prove sexual misconduct, it would necessarily negate any alleged vicarious liability, and the clinic would have no legal liability. The only avenue for the plaintiff to attach liability to the clinic would be to prove the clinic had or should have had knowledge of the NP's alleged inappropriate activities to the extent that the clinic was on notice of his proclivity for inappropriate behavior. There was no evidence the NP had been accused of inappropriate behavior before, or that the clinic otherwise had notice of inappropriate behavior. Based on this lack of evidence, the plaintiff was convinced to dismiss the claims against the clinic.

If the plaintiff could prove sexual misconduct, it would necessarily negate any alleged vicarious liability, and the clinic would have no legal liability.

RISK REDUCTION STRATEGIES

Even when a clinician's intentions are innocent, adding social touch to procedural touch during examinations can confuse patients and result in their sense that a professional boundary has been crossed.[1,2,11] When a friend or colleague asks for medical advice or treatment, clinicians should stay vigilant regarding the potential for boundary crossings and, as much as possible, separate their personal and professional obligations. In addition to the risk reduction strategies presented earlier for the treatment of family, consider the following strategies for treating friends and colleagues:[1,2,11,18]

Clinicians

- Educate yourself about the ethical aspects of boundary violations to understand your professional and personal vulnerabilities and risk factors when approached to treat friends or colleagues.
- Know the legal and regulatory limits placed on treating friends or colleagues.
- Avoid social touch during an examination, and carefully consider whether social touch is appropriate before or after an examination.
- Do not comment on aspects of the patient's body or clothing that are unrelated to the medical necessity of the exam.
- Use a chaperone when examining an intimate body part, or during any examination when the potential for a boundary violation or a misunderstanding of procedural touch is high.

- Before procedural touch, explain what you will be doing.
- Do not consider patient silence as consent for procedural touch.
- Inform the patient the examination can be stopped at any time and stop the examination if the patient requests it.
- During procedural touch, explain how your touch relates to its clinical purpose, particularly when intimate areas are involved.
- Use only the amount of physical contact necessary for diagnosis and treatment.
- Remain vigilant for patient signs of discomfort (e.g., the patient pulls away when touched) and possible misunderstandings of procedural touch.
- At the conclusion of the examination, leave the room and allow the patient adequate time to dress.
- Ask yourself what a neutral outsider would say while observing your conduct, and adjust it accordingly.
- If you cannot maintain professional boundaries while treating a friend or colleague, make a referral to a different clinician.

Administrators

- Create policies and procedures for the treatment of friends, family, and colleagues.
- Make policies and procedures consistent with legal and regulatory limitations.
- Require all patients to be seen formally and during business hours.
- Require documentation of treatment of friends, family, and colleagues.
- Create chaperone policies and protocols. (See additional recommendations below.)
- Educate clinicians and staff about what behaviors constitute sexual misconduct.
- To protect against allegations of negligent hiring, independently validate all details of any clinician or staff applicant's qualifications, licensure, and credentials; check references; question and reconcile all gaps in employment history; and perform a comprehensive criminal background check. Document the results.
- Create a workplace culture that conveys a zero-tolerance policy for sexual misconduct.

ADDITIONAL RESOURCE

ProAssurance: Sexual Misconduct Allegations: Liability, Ethics, and Professionalism[19]
Claims Rx article covering legal, professional, and ethical issues associated with sexual misconduct allegations, available to ProAssurance and NORCAL Group insureds for CME credit

CHAPERONE USE

Policies and Procedures

When performing an intimate examination on a patient—including friends, family, and colleagues—chaperones should be used. Chaperone use can serve dual purposes: It can protect clinicians from false allegations of sexual misconduct by providing a witness who can testify to a clinician's appropriate behavior, and it can protect patients by discouraging clinicians who are tempted to act on sexual feelings.

Chaperone policies and procedures can help clinicians and staff determine when chaperones should be offered to patients and the role chaperones serve in the examination process. However, policies and procedures are only effective if they are consistently applied: Some claims involve sexual misconduct allegations arising from an encounter during which an existing chaperone policy was not followed. Consider including the following elements in chaperone policies and procedures:[20]

- Describe how the availability of chaperones will be communicated to patients.
  - ► Place posters and printed materials in conspicuous locations in waiting rooms and exam rooms, and in patient education packets.
- Identify patients who should be offered a chaperone.
  - ► Include special directions for pediatric patients.
- List procedures for which chaperones are required.
  - ► Require chaperones for sensitive examinations and any other examination when requested by the patient.
- Explain the process for managing a patient's refusal of a chaperone, including documentation.
- Describe chaperone roles, responsibilities, protocols, and training requirements.
- Explain clinician responsibilities, including documentation of the presence, name, and title of the chaperone in the medical record.
- Set forth methods for monitoring the effectiveness of the chaperone policy.

ADDITIONAL RESOURCES

University of Michigan: Medicine Chaperone Policy[21] and **Johns Hopkins Medicine:** Chaperone Policy[22]
Examples of chaperone policies

ProAssurance: Professionalism in Medical Examinations[23]
"Two-minutes: What's the Risk?" video outlining a chaperone policy

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CONCLUSION

Prior or current social or emotional attachment to patients—particularly patients who are family members, friends, or colleagues—can disrupt professional objectivity and weaken the primacy of the physician-patient relationship during a medical encounter. The disequilibrium can cause or contribute to patient injury. For example, emotional proximity can result in inadequate history and examination, and under- and overtreatment. Patient autonomy may also deteriorate, as family, friends, and colleagues may not feel comfortable questioning or declining care; and risks and alternatives may not be fully described. Other risks may arise when a physician-patient relationship evolves into friendship, or when a physician treats a friend. Friend-like behavior, such as social touching and discussing personal issues, can confuse patients and result in their sense that a professional boundary has been crossed. Furthermore, tensions may develop when patient and physician do not have a mutually implicit or explicit understanding of the expectations and limits of the treatment relationship. When a treatment outcome is unexpected, these issues can contribute to an individual's choice to file a legal or medical board claim. As family, friends, and colleagues are often treated with a more casual approach, lack of documentation and lack of informed consent can complicate the defense. Consequently, when family, friends, and colleagues seek medical advice or treatment, and alternatives are not available, they should be treated with the same professional expertise and judgment as any other patient.

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ENDNOTES

The NORCAL Group documents referenced in this article, along with many other risk management resource documents and past editions of *Claims Rx*, are available in the Risk Solutions area of MyACCOUNT, or by policyholder request at 855-882-3412.

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