

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 4-A-08

Subject: Peers as Patients
(Resolution 1, A-07)

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Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Raymond G. Christensen, MD, Chair)

1 Resolution 1 (A-07), which was introduced by the Resident and Fellow Section, and referred by the
2 House of Delegates, asks the American Medical Association to “study the ethical, psychological,
3 and management implications of housestaff treating co-workers, including but not limited to care
4 provided in the critical care setting.” In examining the issue of housestaff treating co-workers it
5 became clear that many of the ethical, psychological, and management issues that arise when
6 residents treat their peers apply to all physicians called on to provide medical care to colleagues.
7 Thus this report examines the considerations practitioners should weigh in deciding whether to take
8 a peer as a patient. These considerations include confidentiality of patient information, clinical
9 objectivity, and the emotional and psychological health of the treating physician. The report further
10 addresses circumstances specific to resident physicians that make peer treatment especially
11 challenging.[†]

12
13 To be asked to care for a fellow physician is a privilege¹ and may be a gratifying experience and
14 serve as a show of respect and competence. However, providing health care for a colleague
15 requires sensitivities that differ in some ways from those required for nonphysician patients. As
16 with any patient, the individual’s health and welfare must always remain the paramount
17 consideration. In some situations—for example, in emergencies or isolated or rural settings when
18 options for care by other providers are limited or where no other qualified physician is available—
19 physicians should not hesitate to treat peers.

20
21 There is a range of relationships physicians may have with peers, including partners in a private
22 practice, fellow members of a clinical department, distant colleagues in the same specialty,

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[†]This report does not address the ethics of identifying and reporting colleagues who may be impaired due to illness or otherwise as these issues are covered in Opinion E-9.031, “Reporting Impaired, Incompetent, or Unethical Colleagues.” Similarly, this report does not delve into payment issues that may arise when a patient is a physician covered in Opinion E-6.13, “Professional Courtesy.”

1 attending physician-resident, or trainees in a residency program. Physician-patients are entitled to
2 the same respect and care as any other patient. But peer relationships may carry different degrees of
3 intimacy that have distinctive implications for the patient-physician relationship with respect to
4 clinical objectivity, confidentiality, physical privacy, informed decision making, fairness, and
5 ongoing professional relationships. Depending on the clinical condition for which the physician-
6 patient needs to be treated and the nature of the relationship between the physician-patient referral
7 to another physician may be advisable.

8
9 *Clinical Objectivity.* Treating a physician-patient who is also a close personal friend raises
10 concerns very similar to those addressed in Opinion E-8.19, “Self-Treatment or Treatment of
11 Immediate Family Members,”² notably the possibility that the treating physician’s professional
12 objectivity and medical judgment may be affected by his or her emotional ties to the patient,
13 thereby interfering with the care delivered. Moreover, as this Opinion also notes, when the patient
14 is a colleague, physicians may fail to probe sensitive areas in taking the medical history or may fail
15 to perform intimate parts of the physical examination.³ Physicians may want to weigh factors such
16 as the need for an exam, the possible severity of the condition, and necessary treatment options
17 before undertaking care of a peer.³

18
19 Fairness is also a consideration in making treatment recommendations or providing care to a
20 professional peer. When preferential treatment that other patients do not standardly receive for the
21 same clinical indications is given to—or expected by the physician-patient—it may result in an
22 uncomfortable and confusing situation.⁴ Although it is human nature to treat differently someone
23 you know personally or feel a professional kinship to, physician-patients should not receive
24 disproportionate attention and resources beyond what is appropriate to meet their medical needs.

25
26 *Informational and Physical Privacy.* Concerns about the privacy of their personal health
27 information have been cited as a reason physicians delay seeking medical attention.⁴ Physician-
28 patients may be uncomfortable disclosing sensitive information, much in the way friends or family
29 members of the treating physician might react.² The more closely knit the professional community,
30 the more challenging these considerations may become. It is important to remember that physicians
31 have the same obligation to protect the confidentiality of a physician-patient as they do for any
32 patient.⁵ Information regarding the medical care of a fellow physician should be confined to the
33 team of individuals directly involved in the treatment. The treating physician has a responsibility to
34 ensure that all team members appreciate the importance of not routinely sharing the physician-
35 patient’s health information with others, such as well-meaning staff who inquire about the
36 individual. The treating physician should consider, and possibly discuss with the physician-patient,
37 how to respond to the inquiries of other physicians or medical staff who may be aware of the
38 physician-patient’s illness without compromising confidentiality and convey the physician-
39 patient’s preferences to the care team.

40
41 Respecting modesty and physical privacy is important for any patient. When the patient is a
42 professional colleague, particularly one who works in the same health care setting, special attention
43 may be required to ensure that his or her physical privacy is respected. Although such concerns
44 may be most acute in the inpatient setting, they should not be neglected in office or clinic settings.

1 *Informed Decision Making.* When physicians undertake the care of a colleague they may assume
2 that the physician-patient has a good medical knowledge base and that they need not fully explain
3 the condition or plan of treatment.⁴ It is important that an open dialogue take place in which a
4 physician-patient and the treating physician discuss the condition at hand. The treating physician
5 should keep in mind the physician-patient's general medical background but make no assumptions
6 on the depth of his or her knowledge about a particular disease, especially one outside the
7 physician-patient's specialty area.

8
9 *Effects on Professional Relationships.* Providing medical care for a peer may also lead to tensions
10 in a physician's professional relationship with that individual. For example, a negative medical
11 outcome or disagreement over best course of treatment may have disruptive effects on the parties'
12 working and personal relationships with one another. The possible outcomes and reactions to those
13 outcomes should be considered and weighed before undertaking the care of a colleague.
14 Additionally a physician should always consider the treatment wishes of a physician-patient and
15 respect a wish for a second opinion.

16 17 SPECIAL CONSIDERATIONS FOR PHYSICIANS IN TRAINING

18
19 There are additional considerations for physicians in training and medical students when it comes
20 to the ethics of treating peers. Resident physicians and medical students practice in circumstances
21 that differ in ethically important ways from the work situations of other physicians. They function
22 in a highly structured and often stressful environment and have less autonomy in making decisions
23 about what work they undertake than do more senior colleagues. At the same time, they are part of
24 the close-knit group of a residency training program or medical school class, going through
25 significant professional learning experiences with their peers and often forming close personal ties
26 within the group. The nature of the residency and medical school experience and residents' and
27 medical students' working conditions thus may heighten the concerns noted above. Even in the
28 absence of a personal friendship, the intimacy and intensity of shared professional experience can
29 create relationships not unlike those of family members or close friends. Opinion E-9.055,
30 "Disputes Between Medical Supervisors and Trainees" states that "Medical students, resident
31 physicians, and other staff should refuse to participate in patient care ordered by their supervisors
32 in those rare cases in which they believe the orders reflect serious errors in clinical or ethical
33 judgment, or physician impairment, that could result in a threat of imminent harm to the patient or
34 to others."⁶ Moreover, except in emergency situations, resident physicians, like other physicians,
35 are free to choose whom to serve under Principle VI of the AMA's *Principles of Medical Ethics*.⁷

36
37 When feasible, then, residents' and medical students' choice not to treat or participate in treating a
38 peer should be respected. When residents and medical students who are required by exigent
39 circumstances to provide medical care to a fellow member of the housestaff, appropriate support
40 should be provided.

41
42 The opportunity to care for a fellow physician is a privilege and may be a gratifying experience and
43 serve as a show of respect or competence, but providing health care for a colleague requires
44 sensitivities that differ in some ways from those required for nonphysician patients. When
45 undertaking the care of any physician-patient, special attention must be paid to the privacy of the

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1 physician patient. The physician-patient should receive the same high level of care as
2 nonphysician-patients, including full explanation of the condition and treatment without
3 assumptions of prior knowledge.

4
5 **RECOMMENDATION**

6
7 The Council on Ethical and Judicial Affairs recommends that the following be adopted, in lieu of
8 Resolution 1 (A-07), and that the remainder of this report be filed.

9
10 The opportunity to care for a fellow physician is a privilege and may represent a gratifying
11 experience and serve as a show of respect or competence. In emergencies or isolated or rural
12 settings when options for care by other physicians are limited or where there is no other
13 qualified physician available, physicians should not hesitate to treat peers. There are, however,
14 a number of ethical considerations to weigh before undertaking the care of a colleague.

15
16 (1) Physicians who provide care to a peer should be alerted to the possibility that their
17 professional relationship with the patient may affect their ability to exercise objective
18 professional judgment and make unbiased treatment recommendations. They must also
19 recognize that the physician-patient may be reluctant to disclose sensitive information or
20 permit an intimate examination.

21
22 (2) Physicians providing care to a professional colleague have an obligation to respect
23 informational and physical privacy of physician-patients as they would for any patient.
24 Treating physicians should consider, and possibly discuss with the physician-patient, how
25 to respond appropriately to the inquiries about the physician-patient's medical care from
26 other physicians or medical staff. Treating physicians should also recognize that special
27 measures may be required to ensure that the physician-patient's physical privacy is
28 respected.

29
30 (3) Physicians providing care to a colleague should respect the physician-patient's right to
31 participate in informed decision making. Treating physicians should make no assumptions
32 about the physician-patient's knowledge about her or his medical condition and should
33 provide information to enable the physician-patient to make voluntary, fully informed
34 decisions about care.

35
36 (4) Physicians in training and medical students face unique challenges when asked to provide
37 or participate in care for peers given the circumstances of their roles in medical schools and
38 residency programs. Except in emergency situations or when other care is not available,
39 physicians in training should not be required to care for fellow trainees, faculty members,
40 or attending physicians if they are reluctant to do so.

41
42 (New HOD/CEJA Policy)

Fiscal Note: Staff cost estimated at less than \$500 to implement.

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