

When Physician Family Members Are Involved in Patients' Care

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Case scenarios are written to express typical situations that family physicians may encounter; authors remain anonymous. Send scenarios to afpjournal@aafp.org. Materials are edited to retain confidentiality.

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Case Scenario

A 75-year-old man with newly diagnosed advanced cancer was admitted to the hospital for a four-week duration. His prognosis was uncertain. The patient had six children, three of whom were always by his bedside, along with his wife. As the patient's condition worsened, his three other children joined them. All three were practicing physicians. One was a family physician, one an oncologist, and another a palliative care specialist.

Initially, the attending physician and clinical team actively managed the patient's condition. During the first two weeks, the attending physician would speak with any of the physician children present, but as the prognosis worsened, she began communicating directly with the son who was the palliative care physician, whom the family had designated as their spokesman. Although the clinical team presented an optimistic outlook to everyone during family meetings, they were more realistic when speaking privately with the palliative care physician.

After two weeks, when it became clear that the patient would not recover, the clinical team began placing the burden of breaking bad news on the palliative care physician family member who was acting as the primary decision maker. Although family meetings continued, the clinical team assumed that the son would provide the palliative care, and they did not schedule a palliative care consultation or discuss palliative care with the family. How can attending physicians and staff best interact with physician family members, and how should their roles have been handled in this case?

Commentary

It is not unusual for physicians to care for patients who have physician family members. This can be advantageous for patients, their families, and the clinical team because physician family members often better understand the clinical situation, its severity, and the treatment options. They can also assist the clinical team in educating the patient and other family members. However, the presence of a physician family member can also become a barrier to the delivery of care.¹ A physician family member may let personal stress and emotional conflicts get in the way of rational care. The need for control may lead the physician family member to overstep boundaries and affect clinical decisions by redirecting care,² which may cause increased anxiety among the clinical team.

At the same time, the family may have unrealistic expectations of the physician family member, calling on him or her to direct the clinical team. Concomitantly, the clinical team may also have unrealistic expectations of the physician family member, for example, expecting the person to break bad news or deliver support to the rest of the family, even though his or her objectivity may be compromised. To ensure everyone's needs are met, ground rules outlining roles, responsibilities, and expectations need to be established by the clinical team and the family up front and an open channel of communication created.³

ESTABLISHING GROUND RULES

The first step in interacting with a family where a physician family member is involved is to discuss the roles of the different parties as soon as possible. In the case described here, ►

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communication was better while the patient was stable; however, when the patient's status deteriorated, the communication faltered. This situation could have been avoided by having a discussion early on about the various roles within the family and the clinical team. Such conversations should cover who from the clinical team will communicate with the family, what sort of communications are appropriate for the whole family and how they will be delivered, and in what circumstances the physician family member will be addressed privately.

All parties need to agree on how much detail from the medical record should be shared and with whom specific aspects of the patient's condition should be discussed. Establishing roles in this manner fosters open communication. The clinical team should ask about communication preferences, including the method (e.g., e-mail, telephone, in person) and frequency. Secure and protected communication via e-mail to share laboratory results and arrange meetings is a reasonable option. The relationship of the physician family member with the clinical team needs to be outlined, including whether the clinicians should address the physician family member as doctor or by his or her first name (Table 1).⁴

THE PHYSICIAN FAMILY MEMBER'S ROLE

The physician family member has a responsibility to both the patient and the clinical team.

He or she must not intimidate the team, place unrealistic expectations on them, or obstruct their work. The physician family member must try to be conscious of losing objectivity when caring for a loved one. He or she may understand the medical aspects of care, but emotionally may be less able to accept the situation than the other family members. If the physician family member is not coping well, emotional support should be provided to help him or her be present for the patient.⁵

THE CLINICAL TEAM'S ROLE

The clinical team in this scenario placed increasing responsibility on the physician family member as the patient's health deteriorated. This suggests that they were avoiding potentially uncomfortable confrontations and conflicts. Perhaps they found the presence of three physician family members intimidating. In addition, the clinical team apparently relied on the palliative care physician family member to share the news and provide support to the family. The clinical team may have placed too much responsibility on the physician's professional persona without leaving room for him to grieve and experience other emotions as a family member. The clinical team should have offered an independent palliative care consultation to the family instead of placing this burden on a family member because of his perceived expertise. A physician family member should

Table 1. Establishing Roles in the Care of a Patient with a Physician Family Member

<i>Area to address</i>	<i>Potential approach</i>	<i>Possible phrasing from clinical team</i>
What access to medical records is provided?	Daily e-mail updates, including test results, with physician family member	"Would you like daily updates on all test results?"
How often and through which method would the physician family member prefer to communicate?	Daily face-to-face update with family and physician family member while rounding; weekly family meeting with clinical team to discuss patient's progress; telephone communication in the event of sudden status change	"Would you like patient-progress meetings individually or as a family, and how often do you want an update?"
What role would the physician family member like to have in directing patient care?	Allow physician family member to interpret medical information for patient and family; physician family member to serve as a patient advocate	"Given that this is an emotional time for you, we are here to offer our expertise, guidance, and emotional support to you as an advocate for the patient. What involvement would you like to have in medical decision making?"

Information from reference 4.

not be expected to take on the role of medical team member or subspecialist physician for the patient.³ He or she should have personal needs and concerns addressed in a manner similar to those of other family members.

Physician family members may also have more complex needs than other family members because of their different and often divergent roles. Defined roles and open, facilitative communication serve as the starting point for engaging physician family members and their loved ones in a collaborative and supportive approach to care.

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