At the coalface

The ultimate curse: the doctor as patient

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Abstract

Doctors may be thrust into the difficult situation of treating friends and colleagues. A doctor's response to this situation is strongly influenced by his or her emotions and by medical tradition. Such patients may be treated as 'special cases' but the 'special' treatment can backfire and lead to an adverse outcome. Why does this happen and can doctors avoid it happening? These issues are discussed in this commentary on Dr Crisci's paper, 'The ultimate curse' (1).

Dr Crisci describes a situation that doctors dread: professional involvement in a case of serious illness in a friend. He describes movingly his experience of dealing with a colleague who, having attempted suicide, ends up in a persistent vegetative state (PVS) - 'the ultimate curse' as he calls it. His paper raises a number of ethical issues: firstly, should a person's desire to end his life be respected; secondly, how should we deal with a case of persistent vegetative state; and thirdly, how should doctors deal with relationships which are both professional (between doctor and patient) and personal (between colleagues and friends). I intend to concentrate wholly on this third area as it is illustrated vividly by Dr Crisci and has not been much discussed.

In order to clarify the problem it might be helpful to compare Dr Crisci's case of his orthopaedic surgeon friend with that of a patient in a similar situation who is entirely unknown to the medical staff. This patient, having injected himself with curare in a serious suicide bid, is admitted to hospital and resuscitation is attempted. Meanwhile, the doctor in charge takes a quick history from the ambulance crew who report that the patient's heart has ceased beating for over ten minutes. The admitting doctor therefore concludes that irreversible brain damage has occurred and stops the resuscitation attempt. The patient dies, as was his intention, leaving grieving and questioning relatives.

Compare this with the case of the orthopaedic surgeon. He also attempts to end his life in a decisive manner. He is admitted to his local hospital (where he works) and resuscitation is attempted. This attempt continues for a prolonged period, longer than that at which irreversible brain damage will occur, and is successful in re-starting the heart. The patient is left in an irreversible vegetative state with his relatives grieving, questioning and watching endlessly by his bedside. The admitting doctor was unable to make the decision in this 'very special' case to cease resuscitation. Other colleagues, faced with their friend in a persistent vegetative state, lack the 'courage' to make the decision to withdraw food and fluids. Their professional knowledge is so blunted by emotion that they start considering the possibility of a cure. Even the hospital administrator is in on this conspiracy to avoid decision-making and does not raise the problem of the cost of keeping the patient in this state.

The only difference between these two cases is that the orthopaedic surgeon was known to the doctors treating him and the other patient was not. The 'curse' for the surgeon is to have been dealt with by his friends, who were unable to exercise their usual professional judgment in his case. We might reasonably ask, therefore, should doctors be treated by their colleagues? This is impossible to avoid. All doctors are colleagues by virtue of being members of the same profession. Even if a doctor is not personally known to the doctor he consults the fact that he is a member of the profession will be revealed in the course of taking a case history. We might, then, more helpfully address two points. Firstly, why do doctors treat each other as 'special cases' and what problems arise out of this? Secondly, should doctors treat each other as special cases and if not is it possible to avoid doing so?

A conflict central to medical ethics is that between the tradition (drawn from the Hippocratic Oath) of non-maleficence and beneficence and the more recent rise of 'patient power' in the principle of respect for autonomy and patients' rights. But less noted is a third tradition, also present in the Hippocratic Oath and of older origin, that of special consideration for those within your professional...
circle. Participants in the oath swear to ‘recon-

t him who taught me this Art equally dear to me as my

to share my substance with him, and relieve

gys if required’ (2). Codes of ethics usually

erubber stamp what is generally accepted within a pro-

fession and this code reflects a longstanding tradition

closeness between medical colleagues. This might

described as a kind of ‘old-boy network’ which

protects its members against outside interference and

criticism. It has its roots in the development of guilds

in the late middle ages to protect the interests

and further the aims of a particular group of

merchants or craftsmen; and it owes its continued

strength to the elitist and enclosed nature of tradi-

tional medical education. It is, therefore, at its

strongest in cities (such as Glasgow) where most of

the doctors have studied at the local university and

remain in the city to work. They may even share a

common bond as far back as school.

‘Perk’ of the job

Another reason for this third tradition of special

treatment for colleagues is more modern in origin

and it is that doctors see this as a kind of ‘perk’ of the

job. In the same way as businessmen may have

company cars, doctors may call on specialist col-

leagues for opinions, thus bypassing the GP and

jumping the waiting list queue.

This third tradition is, therefore, firmly entrenched

in the medical profession. What problems arise from

it? Dr Crisci’s case illustrates some of them. The

doctors treating the orthopaedic surgeon are his

friends. Their relationship with him is therefore

confused. They owe him the rights and duties they

would owe to a patient but they react to him as they

would to a friend – with distress and concern. Their

response reflects concern for him but also for their

own loss, a reciprocity which is absent in the doctor-

patient relationship. The question that the doctor as

the patient’s friend asks is: ‘why has he attempted

suicide?; whereas the question that should concern

the doctor as doctor is: ‘how best can I treat my

patient?’ The ‘re-animator’ failed his patient by

leaving him in an irreversible coma but did what he

thought was best for his friend (and himself) in

struggling against all odds to keep him alive.

This special treatment can lead to other, less

drastic problems. Doctors and their families may

get earlier appointments to see a specialist and may

see the specialist in person rather than a junior

doctor. However, this may lead to vital steps in the

process being missed. The ‘special’ patient may miss

out on routine investigations which are usually

carried out by juniors before they see the consultant.

Follow-up arrangements may not be formalised, as

the patient may be told: ‘Just give me a ring and I’ll

fit you in’ and he is reluctant to do this for fear of

calling on too many favours. Communication with

GPs is often missing, meaning that GPs have a

patchy knowledge of their medical patient’s case

history. Thus, being treated as a ‘special case’ may

mean not being part of a structured, ordered

approach to patients which is in place for a reason –

so that nothing gets missed.

We have seen that this tradition of special con-

sideration for colleagues is a longstanding one in

medicine and that it can lead to problems for two

main reasons: firstly, in that the emotions of doctors

might be too intimately involved when they are

treating friends and, secondly, in that important

steps in a structured approach to patient care might

be missed by the more informal nature of the rela-

tionship. We must now consider whether it is right

to doctors should receive special consideration and

whether (in view of the possible risks) they can avoid

this.

The case under examination here shows how this

special consideration for colleagues can lead to

infringement of most of the major principles which

guide ethical decision-making in medicine. If some

patients are treated as ‘special’, others are, by im-

plication, treated as less special and the principle of

justice is disregarded. The ‘re-animator’ in this case

did not respect the principle of non-maleficence in

that his patient was left in a vegetative state because

of his inability to make a decision to stop resusci-

tation. The orthopaedic surgeon’s autonomous

decision to end his life was disregarded. This may

have been the case with any patient in a similar

situation but the attitude of the attending medical

staff was clearly paternalistic – the implication was

‘we knew him, he couldn’t possibly have wanted

to take his own life’. It might even be argued that the

principle of utility was ignored in the response of the

hospital administrator who was unwilling to consider

the ‘cost-benefit’ implications of the case.

Accountable to management

It seems, then, that it is not right for doctors to treat

t heir colleagues as special cases. But is it possible to

avoid doing so? In terms of the structural differ-

ences in treatment this should be possible. For

example, doctors treating friends should slot them

into their routine appointment and follow-up

systems. This might have been difficult to envisage

in view of the strength of foregoing tradition but

nowadays (at least in the UK) the traditional power

of hospital consultants is being eroded by the rise of

managerialism in the National Health Service

(NHS). Consultants are becoming accountable to

management for the way in which they run their

clinics and it may no longer be possible to exercise

favouritism to friends. However, it is not possible to

ignore the emotions in a relationship between

friends, even if it has become a doctor-patient

relationship. As Dr Crisci’s case shows, emotional

involvement with the patient can cloud the

judgment and blunt the knowledge of the attending
doctor. This problem is unavoidable as friendship would be worthless if it did not engage the emotions in a reciprocal way: ‘To be friends, then, they must be mutually recognised as bearing goodwill, and wishing well to each other’ (3).

The doctors looking after the unfortunate orthopaedic surgeon should not be criticised for acting as they did; they could not have acted differently, given their friendship with their patient. Perhaps doctors must accept a certain risk to their own health in entering the profession. They are notorious for making ‘bad’ patients and it seems that they are in danger of making their colleagues into bad doctors.

References

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**News and notes**

**JME Editor appointed Professor of Medical Ethics**

Dr Raanan Gillon, Editor of the *Journal of Medical Ethics*, a part-time General Practitioner, and Visiting Professor of Medical Ethics at St Mary’s Hospital Medical School, Imperial College, London University since 1989, has been appointed Professor of Medical Ethics in the University of London, at the same institution/s, from October 1, 1995.

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**News and notes**

**Fifth Annual Meeting of the Association for Practical and Professional Ethics**

The Fifth Annual Meeting of the Association for Practical and Professional Ethics will convene February 29–March 2, 1996, in Saint Louis, Missouri. Keynote speaker will be Amy Gutmann, Dean of the Faculty and Laurance S Rockefeller University Professor of Politics, Princeton University, and co-author with Dennis F Thompson of the forthcoming *Democracy and Disagreement* (Belknap Press of Harvard University Press).

The annual meeting is open to members and non-members of the association and provides an opportunity for persons from various disciplines and professions to discuss common concerns in practical and professional ethics. The meeting is an opportunity to meet practitioners, professionals, and scholars who share concerns in ethics.

Programme highlights include a special ethics centre colloquium for ethics center directors or their representatives; Theory and Practice, a symposium on casuistry; a mini-conference on Public Service Ethics and the

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Public Trust, March 2–3; Breakfast With an Author, and a video fair.

The association welcomes submissions of papers, pedagogical demonstrations, and case studies for presentation at the annual meeting, as well as the nomination of members’ recently published books for Breakfast With an Author. Submissions are invited on ethical concerns in various fields such as public administration, law, the environment, accounting, engineering, computer science, research ethics, business, medicine, journalism, the academy, and on issues that cut across professions. Demonstrations in ethics teaching, discussion of moral development, and curriculum development are also welcome. **Deadline for submissions is October 31, 1995.**

For submission forms or further information please contact: Association for Practical and Professional Ethics, 410 North Park Avenue, Bloomington, IN 47405, USA; phone 812/855–6450; fax 812/855–3315; e-mail: appe@indiana.edu.
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