

## 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 will have occurred and stops the resuscitation attempt. The patient dies, as was his intention, leaving grieving and questioning relatives.

### Key words

Doctor-patient relationship; medical traditions; doctors as patients.

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 'reckon him who taught me this Art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required' (2). Codes of ethics usually rubber stamp what is generally accepted within a profession and this code reflects a longstanding tradition of closeness between medical colleagues. This might be 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 formed 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 traditional 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 colleagues 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 dramatic 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 consideration 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 relationship. We must now consider whether it is right that 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 implication, 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 resuscitation. 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 their colleagues as special cases. But is it possible to avoid doing so? In terms of the structural differences 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.

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### References

- (1) Crisci C. The ultimate curse. *Journal of medical ethics* 1995; 21: 277.
- (2) The Hippocratic Oath. In: Downie R S, Calman K C. *Healthy respect* [2nd ed]. Oxford: Oxford University Press, 1994: 269-270.
- (3) Aristotle. [translated by Ross D]. *Nicomachean ethics*. Oxford: Oxford University Press, 1980.

### 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.

### 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

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](mailto:appe@indiana.edu).