



● *By Cathy Bryant, Risk Management Representative*

PROCEED WITH CAUTION: TREATING FAMILY, FRIENDS, AND STAFF

3rd Edition

OBJECTIVES

At the conclusion of this article the reader will be able to:

1. recognize when the physician-patient relationship begins;
2. identify what the Texas Medical Board (TMB) requires and restricts when treating a family member, friend, or staff member;
3. describe the American Medical Association's and Texas Medical Association's position on physicians treating family, friends, and staff; and
4. discuss potential alternatives when asked to treat family, friends, and staff.

COURSE AUTHOR

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DISCLOSURE

Cathy Bryant has no commercial affiliations/interests to disclose related to this activity.

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This course has been designated by TMLT for 1 credit in medical ethics and/or professional responsibility.

ESTIMATED TIME TO COMPLETE ACTIVITY

It should take approximately 1 hour to read this article and complete the questions.

RELEASE/REVIEW DATE

This activity was originally released on July 15, 2011. The new release date is July 19, 2017 and it expires July 19, 2020. Please note that this CME activity does not meet TMLT's discount criteria. Physicians completing this CME activity will not receive a premium discount.

INTRODUCTION

The request seems so simple. A neighbor or friend — who is not a patient — needs something for a common medical problem. You are a physician and you treat medical problems every day. What should you consider before calling in a prescription for that “common medical problem”?

In this article, a “non-patient” is defined as a family member, friend, boyfriend/girlfriend, or staff member for whom no physician-patient relationship has previously been established. It is important to realize that this “non-patient” relationship ends as soon as you begin to assess and treat that “common medical problem” and the relationship instantly changes to a physician-patient relationship.

“If the conversation/interaction at issue had taken place with this person sitting in your exam room, would you have considered it to be a physician-patient encounter? If the conversation were about his sore elbow, then obviously both you and the patient would feel that a physician-patient encounter was taking place. On the other hand, if the conversation were about health care reform, then neither of you would feel that it was a physician-patient encounter,” explains Austin attorney Dan Ballard.

Additionally, once a physician-patient relationship is established, the physician must meet the requirements of the Texas Medical Board (TMB) for a proper professional relationship.

WHAT WOULD YOU DO?

Professional and personal conflicts can arise when you least expect them. Understanding your responsibilities as a physician and responding appropriately in a variety of situations can help you defend your actions if you are facing a TMB complaint or a medical liability suit.

Family vacation

You are on a family vacation. Your brother is visiting from out of state. One of his children complains of an earache. Your brother assures you that his son has earaches frequently and the pediatrician prescribes drops and an antibiotic. The closest emergency department (ED) is 45 miles away, but there is a small pharmacy in the town where you are staying. What do you do?

- a. Call in a prescription.
- b. Call the child's pediatrician and consult with him before you prescribe anything.
- c. Offer to go with the family to the ED to offer support.
- d. Tell your brother that there are legal and ethical reasons why you can't treat his son.

Small town grocery store

You live in a small town and you go to the local grocery store. A friend asks you “Hey Doc, what do you think this is?” The friend is pointing to a spot on his arm. What do you do?

- a. Examine the spot, tell him that it looks like poison ivy, and suggest he try calamine lotion.
- b. Give him your business card and suggest that he make

- an appointment with you.
- c. Tell him to make an appointment with his own physician about the spot.
- d. Advise him to go the ED and have the spot checked immediately. You don't want to take any chances with skin lesions.

Botox

You are a plastic surgeon and you want your staff to avail themselves of all the procedures you offer. One Friday afternoon, your receptionist — who has never had any procedures done — tells you she would like to try Botox. What do you do?

- a. Instill the Botox injection as she requested. The good results will be free advertising.
- b. Tell her that she needs to review the policy and procedure manual and follow the procedures outlined there before you can give her any Botox injections.
- c. Suggest that she read the Botox brochure and discuss it with you next week.
- d. Have the receptionist complete all your new patient paperwork, including consents. Complete a full assessment and have your full, informed consent discussion. Proceed with her request.

Sick employee

You are a solo practitioner with one medical assistant (MA). Your MA comes to work on a busy Monday, looking ill. She believes she has strep throat and asks you to give her a shot of penicillin. What would you do?

- a. Ask her if she's allergic to any medications and then give her the appropriate antibiotic.
- b. Suggest she call her own doctor for a prescription for an antibiotic.
- c. Have her complete your usual new patient paperwork, assess her, do a rapid strep test, and make a decision on how to treat her.
- d. Send her home. No matter how busy it is, you do not want an employee spreading germs to patients.

INFORMAL CARE

Concerns about “informal care” include a range of patient safety issues. “Informal care tends to bypass standard routines, safety checks, and supervision. The exam and diagnosis may have provided the patient with a false sense of security. In the case presented by doing the favor, the physician bypassed usual routines and documentation and the patient did not get the usual education and follow up that should be expected. There is a risk for misdiagnosis and lack of scheduled follow up as well. When informal care occurs, another potential safety issue is the failure to document care or follow protocols.”¹

Additional risks include:

- “reluctance to obtain or provide a complete medical history
- reluctance to obtain or submit to a complete medical

examination

- diagnosis and treatment beyond provider specialty, knowledge, expertise, or competency
- loss of patient privacy and confidentiality²
- lack of objectivity on the part of patient or provider
- under- or over-treatment related to “wishful thinking,” hurried/informal nature of encounter, hypervigilance, or other factors
- circumvention of beneficial education and/or procedural
- protocols
- impaired or inadequate patient education
- lack of documentation
- inadequate or absent follow up.”¹

Research published in *JAMA* found that 85% of residents say they have written prescriptions for someone who was not a patient, and up to 95% of those residents said they would do the same given special circumstances. Surprisingly, only 4% acknowledged that they were aware of federal and state laws addressing prescriptions in informal care.³

TMB RULES

Physicians who acquiesce to requests from friends or family members must do so cautiously. What follows is an explanation of the TMB rules that physicians risk violating when treating family, friends, and staff.⁴

Section 190.8 — Practice inconsistent with public health and welfare

As related to treating family, friends and staff, a physician may be found in violation of “failure to practice in an acceptable professional manner consistent with public health and welfare” for:

- “failure to treat a patient according to the generally accepted standard of care;”
- “negligence in performing medical services;”
- “failure to use proper diligence in one’s professional practice;”
- “failure to safeguard against potential complications;”
- “failure to disclose reasonably foreseeable side effects of a procedure or treatment;”
- “failure to disclose reasonable alternative treatments to a proposed procedure or treatment;”
- “failure to obtain informed consent from the patient or other person authorized by law to consent to treatment on the patient’s behalf before performing tests, treatments, or procedures;” and
- “prescription or administration of a drug in a manner that is not in compliance with Chapter 200 of this title (relating to Standards for Physicians Practicing Complementary and Alternative Medicine) or, that is either not approved by the Food and Drug Administration (FDA) for use in human beings or does not meet standards for off-label use, unless an exemption has otherwise been obtained from the FDA.”
- “prescription of any dangerous drug or controlled substance without first establishing a proper professional relationship with the patient.”⁵

Section 190.8 – inappropriate prescription of drugs

The TMB prohibits the prescription of any drug to oneself, family members, or others in which there is a close personal relationship without taking an adequate history, performing a proper physical examination, and creating and maintaining adequate records. Additionally, prescribing controlled substances is prohibited in the absence of immediate need. “Immediate need” shall be considered no more than 72 hours.⁵

Section 190.8 – requirements for establishing a proper relationship before prescribing

The TMB prohibits a physician from prescribing any drug without first establishing a proper professional relationship with the patient. Under TMB rules, to establish a proper professional relationship with a patient, physicians must meet a minimum of four criteria.

1. Establish that the “person requesting the medication is in fact who the person claims to be.” This may not be difficult if you are treating your family, friends or staff.
2. Diagnose “through the use of acceptable medical practices such as patient history, mental status examination, physical examination, and appropriate diagnostic and laboratory testing.” TMB rules specifically state that an online or telephone evaluation by questionnaire is not adequate. However, in 2017, the Texas Legislature passed and Gov. Abbott signed into law SB 1107 – Telemedicine and Telehealth Services. This law allows more flexibility in establishing the practitioner-patient relationship for telemedicine medical services. At the time of publication, the TMB rules have yet to be revised to align with the new law.

Meeting these criteria may be more difficult when treating family, friends, and staff. Consider the vacationing brother and the child with an earache. Do you have adequate equipment to complete a physical examination while in a remote location?

3. Physicians are required to discuss with the patient the “diagnosis and the evidence for it and the risks and benefits of various treatment options.” This may be relatively easy to accomplish, but where will this discussion be documented?
4. Ensure availability or arrange coverage for the patient for appropriate follow-up care. What happens when the family member returns home to another state? What can you do to ensure appropriate follow-up care?

In addition to the four criteria, the patient encounter must be documented in accordance with the TMB medical records rule 165.1.

“(a) Contents of Medical Record. Each licensed physician of the board shall maintain an adequate medical record for each patient that is complete, contemporaneous and legible. For purposes of this section, an “adequate medical record” should meet the following standards:

(1) The documentation of each patient encounter should include:

- (A) reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
- (B) an assessment, clinical impression, or diagnosis;
- (C) plan for care (including discharge plan if appropriate); and
- (D) the date and legible identity of the observer.”

PRESCRIBING WITHOUT A PROFESSIONAL RELATIONSHIP

Physicians can prescribe without establishing a professional relationship under the following exceptions:

1. A physician can prescribe medications for the partners of established patients if the physician determines that the patient may have been infected with a sexually transmitted disease. The medications must be prescribed to treat the sexually transmitted disease.
2. A physician can prescribe medications to a patient’s family members if the patient has an illness determined by the Centers for Disease Control and Prevention, the World Health Organization, or the governor’s office to be pandemic.⁵
3. A physician can prescribe to hospice patients if they are supporting a hospice program. Under Section 190.8(1)(L) (ii), “A proper professional relationship is also considered to exist between a patient certified as having a terminal illness and who is enrolled in a hospice program, or another similar formal program which meets the requirements of subclauses (I) through (IV) of this clause, and the physician supporting the program. To have a terminal condition for the purposes of this rule, the patient must be certified as having a terminal illness under the requirements of 40 TAC §97.403 and 42 CFR 418.22.”⁵
4. The TMB allows the prescription of a controlled substance to oneself, family members, or others in which there is a close personal relationship, but only for a period of less than 72 hours. “It’s okay to prescribe for emergency circumstances, and that is what the 72-hour allowance is addressing. But it must be for less than 72 hours,” says Dan Ballard.⁶

DISCIPLINARY ACTION

The TMB can and does discipline physicians for inappropriately treating family, friends, or employees. “The issue frequently seen by TMB disciplinary panels is the prescribing of controlled or dangerous drugs to family members,” says Leigh Hopper, public information officer with the TMB.

These activities are often brought to the attention of the board by a physician’s former employee or spouse. A simple phone call to the TMB reporting that the physician treated staff members without ever establishing a proper relationship or that the physician prescribed a controlled substance to a family member could open the doors to a full investigation.

The board investigator would then request pharmacy records and the medical records from the physician's family member. Since the care was given informally, there would be no medical record to send. The TMB could interpret this as a violation of Section 190.8.⁵

OPINIONS FROM ORGANIZED MEDICINE

According to the American Medical Association's Code of Medical Ethics, "Physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member or the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered."⁷

The Texas Medical Association Board of Councilors' statement on treating family members and friends also offers guidance, but it is not congruent with TMB rules. "One of the physician's primary duties is to alleviate suffering. Thus, it is ethical to treat family and friends. As with all patients, in the course of treating friends and family, a medical record should be maintained; however, in urgent or episodic situations generating a medical record may not be practical or possible."⁸

The statement continues, "Please note that the legal requirements for Treatment of Family Members and Friends and for keeping medical records exceed the above ethics opinion. See Texas Medical Board Rule 190.8(1) (M). Please consult your own retained counsel for legal advice on this issue. (Modified February 2008)"⁸

It is advisable for physicians to follow TMB rules and use sound risk management principles when treating non-patients. Create a medical record of the care given to any person as soon as possible, even in urgent or episodic situations.

CLOSED CLAIM STUDY – IMPROPER PERFORMANCE

The following closed claim illustrates how treating a staff member can lead to a medical malpractice lawsuit.

Presentation

An ob-gyn obtained additional training to perform gynecological cosmetic and reconstructive procedures, including breast augmentation. The physician's long-time employee — a 49-year-old woman — told the physician that she wanted to be his first breast augmentation patient. The ob-gyn examined her, took her breast measurements, and provided her with information about breast implants.

The ob-gyn and his family had been close to the employee and her family before this incident. In addition to the employment relationship, the families socialized together.

Physician action

Nine days later, the ob-gyn examined the patient again, and completed the informed consent discussion with her for bilateral breast implants to be performed by the infra-mammary approach. The ob-gyn obtained a history and

physical, documenting that the patient was healthy, but had an eating disorder and a history of mood dysfunction. The patient requested "total secrecy" for the procedure from the other employees in the office.

The breast augmentation was completed, as requested, on a Sunday in the ob-gyn's office. Pre-operatively, the patient was given promethazine, clonidine, diazepam and acetaminophen. Only the ob-gyn and nursing staff had knowledge of the procedure. The procedure went well, and the patient was sent home with her husband. She was prescribed diazepam to assist with post-operative discomfort.

Twenty-four hours after the surgery, the patient's husband reported in a phone call that his wife was experiencing shortness of breath. The ob-gyn sent his nurse to the patient's home to assess her. The patient reported chest wall pain and had minimal dyspnea. The nurse examined the incisions and helped the patient take a bath. There was no documentation of this home visit or the nurse's assessment.

Over the next several days there were frequent phone calls between the patient and the ob-gyn's nurse. The patient's shortness of breath was attributed to "panic attacks" by the physician and the patient's family.

On the fifth post-operative day, the patient was seen by the ob-gyn in the office. She continued to complain of shortness of breath and coughing. Her O₂ saturation was recorded as 98%. On the ninth post-operative day, the patient continued to complain of shortness of breath. A chest x-ray revealed a small pleural effusion with no pneumothorax or other lung problem. The patient returned to work 17 days after the procedure.

One day after returning to work, the patient was seen by a plastic surgeon in a neighboring town. The patient complained about the appearance of her breasts and reported dyspnea on exertion. The plastic surgeon examined the patient and found no evidence of wound problems or infection. He ordered a chest x-ray that showed a 10% pneumothorax and fluid at the base of her lung.

The patient was referred to a pulmonologist. His diagnosis was a hemopneumothorax or a resolving pneumothorax with pleural effusion associated with atelectasis. The pulmonologist placed the patient on amoxicillin clavulanate for one week. The patient returned and a chest x-ray showed reinflation of the pneumothorax, resolution of the pleural effusion, and resolution of the infiltrate.

The patient returned to the plastic surgeon and stated that she was unhappy with the appearance of her right breast. She also complained of pain in the inferior crease of the right breast. The plastic surgeon described the right implant as having "tethering of the pectoralis muscle with the superior pole of the implant appearing to be under the pectoral muscle and the inferior pole to be pinched within the pectoral muscle." He told the patient that the implant could stay or he could perform a revision of both implants to the pectoral

plane. The patient elected to have the revision surgery. During the procedure, the plastic surgeon released muscle tissue attached to the capsule holding the implant of the right breast.

Allegations

A lawsuit was filed against the ob-gyn, alleging that he caused the patient's pneumothorax and failed to recognize, diagnose, and properly treat the pneumothorax. The patient also alleged that he improperly placed the right implant and that he did not possess adequate knowledge, skill, training, and experience to perform breast augmentations.

Legal implications

The plaintiff's plastic surgery expert was critical of the surgical and post-surgical care of the patient. He stated that the ob-gyn caused the pneumothorax during the procedure and failed to recognize it, which was below the standard of care. This expert was also critical of the ob-gyn's lack of training to perform breast augmentations.

The defense argued that a pneumothorax was a recognized complication that can and does occur without negligence. Shortness of breath is not an unusual complaint following breast augmentation surgery. When the patient's complaints continued, the ob-gyn appropriately ordered a chest x-ray that did not identify a pneumothorax. The defense expert — an ob-gyn who performs breast augmentation procedures in his office using the same anesthesia and procedures as the defendant — testified that the defendant was properly trained and qualified to perform breast augmentations. This was the ob-gyn's first breast augmentation procedure and it was performed on a Sunday in his office procedure room.

Disposition

Three years after the breast augmentation was performed, the lawsuit against the ob-gyn was dismissed when the court ruled that the plaintiff's expert testimony was insufficient.

Risk management considerations

When initiating new procedures, those procedures should occur when and where adequate support is available even when attempting to honor a patient's special request.

Timely assessment of post-operative complaints of dyspnea should be completed by the physician and not delegated to nursing staff. Referral to an emergency department should be considered if the physician is not available to assess significant post-operative complaints. All contacts, phone calls, home visits, and office visits should be documented in the medical record.

This case demonstrates that anyone — even long-time employees and friends — will often seek legal counsel when they believe they have been injured during treatment or surgery. Though this employee was eager to have the procedure and was well informed when she consented, she was dissatisfied with the result and filed suit against the physician.

SCENARIOS REVISITED

After a thorough discussion of the issues related to informal care, reflect back on your initial responses to these scenarios. Have your answers changed?

Family vacation

None of the options presented offered a clear best choice. If you chose to call in the prescription, you should make a chart note of your assessment, your diagnosis, and your treatment just as you would for an ordinary patient that you saw in an exam room at your office.

Small town grocery store

This scenario presents several viable options. It would be reasonable to assess, prescribe, and chart in this scenario given that for some disease entities, special equipment and tests are not required to make the diagnosis. Conversely, if a more thorough history or examination is required, referral is the better option.

Botox

"C" is a good choice. Treat employees as you would any patient seeking treatment from you. "B" is also an option if you have a process for treating employees spelled out in your policy and procedure manual. "D" is also a viable option.

Sick employee

No matter how busy your office is, it is advisable to send employees home who are ill. If medical treatment is needed, either send them to their own physician or follow appropriate treatment protocols.

RISK MANAGEMENT CONSIDERATIONS

Physicians are frequently asked to treat family members, friends and staff members. Thinking through the issues and establishing your own personal guidelines can make these situations easier to manage. There may be select cases where treating is the best option; however, a physician should consider the following carefully before making the decision to treat.

1. Consider whether treating family, friends, and staff would create exceptions that are in conflict with your professional standards of care. Examples would be treating without completing a physical examination or without diagnostic testing.
2. Consider whether you can be objective when treating this person as a patient.
3. Does your family, friend, or employee need specialized medical care that you cannot provide?
4. Consider HIPAA privacy issues and protect your medical records.

If you decide not to treat a family member, friend or employee, be prepared to give supportive responses.

1. "That is something you might want to consider talking to your physician about" can express your concern without giving a medical opinion.
2. "There are legal and ethical reasons that make it ill-

advised for me to treat you” will allow you to support the patient in other ways, such as referral or going with him to the ED for care.

3. For staff members, physicians may want to consider communicating their guidelines on treatment during staff meetings or in the practice’s policy and procedure manual.

If you decide to treat a family member, friend, or employee, comply with TMB rules.

1. Establish a proper professional relationship as defined by the TMB.
2. Establish and maintain medical and billing records as you would any other patient.
3. Use the same standard of care for these special patients as you would for any patient in your practice. Order diagnostic testing, prescribe medications and treatment, and make referrals as necessary.

To treat or not to treat — that is a question only you can answer. Whether to document whom you treat and what you did should never be a question. At some time during their careers, most physicians will face decisions about whether to treat a family member or friend. Following proper treatment protocols and documenting the encounter should serve as protection for both physicians and patients.

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