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A Surgeon Operates on His Son: 
Wisdom or Hubris?

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Introduction
Robert M. Sade, MD

Early all physicians have had opportunities to play doctor to family members: inspecting a sore throat, peering at an eardrum, or writing an antibiotic prescription. Some may have done minor operations such as suturing a minor laceration. Fewer have considered doing a major operation on a family member, yet circumstances of this kind do arise from time to time and may cause consternation among colleagues. Such situations have come to our attention recently, and one of them is presented in the following case, in which the names and certain details have been changed. We presented the case to two cardiothoracic surgeons who have differing views on how a surgeon should respond when faced with a family member’s need for major surgical care.

The Case of the Confident Surgeon

Michael is 25 years old and won a silver medal in the pentathlon at the 2004 Olympics. The pentathlon consists of pistol shooting, fencing, swimming (200-m free-style), equestrian show jumping (350- to 450-m course with 15 jumps), and running (3 km cross-country). He is among the rare Olympic athletes who wear a prosthetic heart valve, having undergone an urgently performed aortic valve replacement 8 years ago for acute valve endocarditis while traveling in Australia. In January 2006, Michael notices shortness of breath and decreasing stamina during training. He is found to have a new diastolic murmur, and echocardiography shows mild aortic insufficiency with structural deterioration of the bioprosthetic valve and calcification of its leaflets.

He is told that the prosthesis could fail at any time and needs to be replaced. Michael is anxious to continue his Olympic training to compete in the 2008 games and does not want a mechanical prosthesis because of the requirement for anticoagulation in view of possible trauma during his rigorous training and competition. The consensus among his care team is that the best treatment for him is a Ross procedure (replacement of the aortic root with his own pulmonary artery and valve), which will give him the best chance of continuing to compete at the Olympic level.

The surgeon in the medical center who is most experienced with the Ross procedure is the chief of cardiothoracic surgery, Dr Yubras, the patient’s father. He has a solid reputation as an excellent surgeon and has written several papers on his large series of aortic root replacements, with reported results that are better than average. It is clear to Dr Yubras that he is the best choice of surgeons to do the operation. When he talks with his son, Michael says that he just wants the best operation available, and since Dr Yubras is the best, he has no objection to his father doing the operation.

At first, Dr Yubras’ surgical colleagues are reluctant to express their misgivings about this treatment plan but finally agree that they have a responsibility to tell Dr Yubras of their concerns. The senior member of the group talks with the chief. He expresses their apprehensions about operating on one’s own son. Emotional issues can cloud even the best judgment; if things go wrong, the fallout can have serious long-term effects on family relationships, confidentiality can be difficult to maintain, and patients may be reluctant to communicate candidly with a close relative. Dr Yubras dismisses their concerns, saying that he is clearly the best-qualified surgeon, he sees no problem with giving his son the best chance of doing well, and he thinks they are speaking out of turn in criticizing the patient’s freely chosen course of treatment.

The next day, the referring cardiologist tells Dr Yubras that he and his department object to the operation for reasons similar to those of the surgeons. They add the observations that Dr Smith at Cross-Town Medical Center has as large a series of Ross operations as Dr Yubras, and his results are at least as good.

The surgeon responds the same way he did the day before, and adds that although Dr Smith is an excellent surgeon, he simply would not have as high a level of concern for the patient as he has for his own son, nor the same determination to make everything turn out...
well. He remains adamant: “Michael wants the best operation and I am his choice of surgeon.” He says that he will do the operation unless someone can show him a law, ethical guideline, or hospital policy that forbids it, knowing that there is none. Should he operate on Michael?

**Pro**

Kenneth Oberheu, MD

“To thine own self be true, and it must follow, as the night the day, thou canst not then be false to any man”

William Shakespeare, *Hamlet*, Act 1, Scene iii

Should a surgeon perform a complex major operation on a family member if he is clearly surgically qualified to do the operation and the family member wishes him to do it? Dr Yubras is a cardiothoracic surgeon who plans to perform a Ross procedure on his son Michael, but his colleagues object to this plan. All agree that Michael’s history and laboratory findings warrant the procedure, but question whether the father should operate on the son. Who should decide whether such an operation will be allowed? Can the boundary of detachment separating a surgeon from his patient remain intact under those circumstances?

In caring for his son, Dr Yubras exhibits the artistry of medicine, which encompasses a range of skills that include mental toughness and psychologic awareness. Dr Yubras is a well-educated and experienced surgeon, whose commitment to his chosen field has helped him to develop his technical skills to an unusually high level. He is highly proficient in performing the Ross procedure, and his outcomes are better than average. His considerable expertise has led to his appointment as chief of cardiothoracic surgery. Dr Yubras believes he is best qualified to do his son’s operation, and Michael has no objection to his father performing the surgery. Dr Yubras counters his colleagues’ concerns with the statement, “Michael wants the best operation outcome and I am his surgeon of choice.”

A surgeon learns anatomy and physiology and is taught how to cut, sew, and tie knots. These are the easiest parts of the educational process. He also learns how to make accurate judgments and when necessary, to redirect the course of treatment rapidly, often with unavoidably incomplete information. He learns to exhibit compassion toward his patients while remaining emotionally detached, and he learns not to take poor outcomes as a personal burden. Perhaps the most important and most difficult of these skills is maintaining compassion and detachment simultaneously when hard decisions must be made and unavoidable risks taken. Dr Yubras’ success as a surgeon and as a surgical educator is testimony to his achievement of these critically important skills.

Education of the surgeon should not only include basic competencies but also a personal and psychologic development and a level of esteem for oneself and one’s abilities. If the surgeon has made reasonable attempts to take appropriate precautions and do the best he can in the care of his patient, a poor outcome should not be perceived as a personal failure.

Dr Yubras appears to have attained the requisite personal psychologic development. After he has studied the anatomy, made the correct diagnosis, and selected the proper procedure, he enters the operating room, the overhead lights go on, and all outside interferences are blocked out. This is his domain. And no one dies here! The surgeon, like a trained athlete, has physical and mental toughness; potential pitfalls sharpen all his senses. In the operating room, and outside, well-trained surgeons use many techniques such as suitable music or absolute quiet to isolate themselves from various distractions.

Even given the above, however, we must be wary of overestimating our capabilities. Robert Sade, MD, recently commented in these pages, “Honest and uncompromising appraisal of our own capabilities are critical requirements for making correct judgments about our own competence” [1]. There is no place for inflated self-confidence and egotism in making critical judgments in surgery.

The ethical doubts expressed by Dr Yubras’ colleagues, one might surmise, concern the possibility of a poor outcome and its consequences, the emotional weight of such consequences on Dr Yubras and his family, and the potential legal ramifications for the hospital and staff. Yet, how would any surgeon feel about a poor surgical outcome? Would it not be the same whether it is a family member or not? Does not each surgeon perform to the best of his ability for every patient? Although an individual operative plan is prescribed for every patient, a certain standard of care applies to every surgical procedure. Each case requires appropriate history, physical examination, education of the patient regarding the disease process, disclosure of the risks and benefits—both immediate and long term—of the procedure, and any alternative treatments. Informed consent. Every surgical patient should receive an excellent operative procedure, performed under the same standards. Should Michael’s case be any different?

If we should be concerned about a surgeon operating on a family member, should we not be similarly concerned about an automobile mechanic putting brakes on the family car or a nurse providing home care for a loved
one? All professionals are faced with the dilemma of providing services to their families and friends. What makes the surgical case so difficult for so many is the obvious possibility of impairment or death at the hands of the surgeon. Yet, a mistake by the auto mechanic or the nurse could also cause harm or even be fatal.

One of the nine Principles of Medical Ethics states, “A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and environment in which to provide medical care” [2]. This principle applies to the case of Dr Yubras and his son. All the elements of informed consent have been satisfied, and Michael has made his choice of surgeon. The surgeon, his father, agrees that he can provide the expertise required and chooses to serve this particular patient.

The surgeon, in accordance with his own judgment and conscience, has the right to provide his expertise in serving the surgical needs of family members. Why should society question this right at the same time as it recognizes the right of power of attorney for nonmedical individuals to make life and death decisions for others? The decision to operate on a family member should be made by the properly educated and trained surgeon in collaboration with the patient, not by legislative acts or hospital committee decisions. Mechanisms to evaluate the physician’s competencies are in place for all medical and surgical specialties. In addition to the six competencies of the Accreditation Council for Graduate Medical Education—patient care, medical knowledge, interpersonal and communication skills, professionalism, practice based learning, and system-based practice [3]—our profession requires mental and physical stamina.

Perhaps certification or recertification should not only test current medical knowledge, but physical and psychologic competency as well. As educators, we should be concerned about the overall fitness of the individuals who enter surgical training and their ability to cope with major stress [4]. As a well-trained and clearly competent surgeon, we can presume that Dr Yubras possesses these qualities. Why, then, should he be limited on whom he can serve? He and his son have made their decision within the context of the sacrosanct relationship of physician and patient.

I developed my strong conviction regarding this issue as a second-year general surgery resident. My son had pyloric stenosis, and I was asked by the pediatric surgeon to assist him at the operative procedure. I inserted the scalp vein access and assisted with the pyloromyotomy. Subsequent to that first experience, I have had the privilege of performing a right upper lobotomy on my mother-in-law. I experienced more gratification from those operations than from any surgical procedures I have ever performed or assisted with in my 40 years of helping, healing, and being of service to my fellow man.

In confronting the situation of operating on immediate family members, Dr Yubras and I came to the same conclusion, knowing our expertise and offering it to our families. I feel honored and immensely privileged to have the right to operate on family members, and to have the opportunity at this time to debate the issue, having experienced it first hand, or I should say, with both hands.

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**Con**

James W. Jones, MD, PhD

“In the physician or surgeon, no quality takes rank with imperturbability”

Sir William Osler, *Aequanimitas*

Providing medical or surgical treatment to family, friends, and close colleagues has always touched nerves that lie undisturbed in caring for all other patients [4]. Every physician has had relatives and close friends ask for medical advice or care of one sort or another. Most respond easily with a few suggestions or prescription of a routine noncontrolled medication when the ailment is easily identified and minor. Many fewer are willing to attempt complex treatment of serious or long-term illnesses among people personally close to them.

And fewer still consider performing major surgical procedures. Surprisingly, one large, well-organized survey found that 9% of qualified physicians had actually operated on family members [5]. The operations were starting intravenous solutions and suturing lacerations, hardly comparable to a Ross procedure. Twenty-two percent of the study’s respondents said they felt uncomfortable treating family, and one-third had observed other physicians inappropriately treating family. Another study ranked physicians’ comfort levels in treating different relatives [6]. Reagan and colleagues [6] found that physicians were most comfortable when providing therapy for their own children, usually in the context of nonoperative treatment of childhood illnesses. Most of the limited available data are not applicable to surgeons, and no publication exists that examines the question of thoracic surgeons treating immediate family members.

Emotional overlay markedly affects performance by contributing all the strengths and weaknesses we refer to when we use the term “being human.” Without these feelings we would be without the qualities of empathy, compassion, concern, and much respect for the reasons that there is a medical profession at all. Emotions filter the sensory information we receive and rank-order its
importance through personalization. They augment our thoughts, exaggerating or moderating responses; otherwise, identical inputs, thus reinterpreted, may yield entirely different reactions dependent on their emotional contextual interpretation [7].

Emotional organization of perceptual input also has a critical evolutionary survival function that augments discriminative processes. When faced with the growling of a saber toothed tiger on the prowl, our hominid ancestors would have had an entirely different emotional response depending whether the tiger was in their immediate area, at the periphery of the tribe’s campground, or across the river in the vicinity of another hostile tribe.

Great impulsive heroic acts and devotional enhancements to family, nationality, ideals, and religion are stimulated by emotional linkages. For all the richness emotions add to human life, emotions are generally considered in the world’s great literature to be at variance with reason. Considered with words denoting behaviors such as impulses, desires, and passions, the ancients, noted philosophers, and the Bible instruct that emotions require self-control [8]. The ancient Greek philosophers considered emotional actions to be of a lower animal nature, allowing man to act opposite to reason. As Sir William Osler recommended a century ago, surgeons require detachment and imperturbability because the performance of major surgery is counterintuitive: in any other situation, the slicing of another person with a sharp instrument and invasion of the internal organs is the gravest manifestation of aggression and ill will. Surgery harms before it heals, and the consequences of misadventure can be terrible. A clear, disciplined, and decisive mind is critical in evaluating when and how to operate, manage contingencies, and control risks. It is this emotion, the powerful personalization of perceptual input, determiner of behavior that Dr Yubras proposes to confront.

These kinds of important considerations help us to understand the cautionary view of the American Medical Association’s (AMA) Council on Ethical and Judicial Affairs: “Physicians generally should not treat themselves or members of their immediate families” [9]. The council is concerned about whether the quality of care a doctor is able to provide will be adversely affected by strong emotional attachments to family members who become patients.

Klitzman studied how physicians reacted to their own illnesses and found that they had difficulty interpreting their own data correctly; they almost universally exaggerated risks because of emotional overlay [10]. To deny that one could objectify a cardiac procedure on a son, especially if contingencies arose exhibits considerable hubris. Hubris in its Greek root meant pride sufficiently excessive to result in downfall. Such a blinkered personal view was shown in a recent study of operating room errors when senior surgeons were found to consider that they were invulnerable to stress and fatigue [11].

Operating on family members can obscure objective judgments and affect the physician’s ability to proceed with high-risk options, even when they are most necessary. The emotionally involved physician may misinterpret or deny data suggesting that a family member’s diagnosis is more serious than expected or worsening despite treatment. The physician so affected may depart from his proven routine to perform an “extraordinary” operation, sometimes euphemized as a “blue plate special,” behaving desperately and ill advisedly to protect his emotional investment. We all have recognized that some of the worst surgical results come from du jour surgeons who have no routine and every operation they perform becomes an adventure.

Relatives may themselves sense the awkwardness of a profound disruption of long-accustomed family roles and may find the adaptation difficult when a father suddenly becomes their authoritative physician. It is not unlikely that relatives may be deeply uncomfortable reporting intimate, perhaps embarrassing, personal information to a treating physician who is also a family member, and they may in fact not do so, providing an inaccurate history that ultimately confounds correct diagnosis [12].

In most ordinary circumstances, patients understand that they must adopt a dispassionate posture toward their physician during the course of treatment, much like the physician’s approach to them, so that therapy can proceed smoothly and rationally. The overlay of normal familial affections (or disaffections) upon the doctor-patient relationship risks the addition of a deadly contaminant to this critical objectivity. Issues of control, authority, and boundaries influence all physician-patient relationships, and are prominent factors in the effectiveness of care; they naturally intensify, and can take unexpected and uncontrollable turns, when physician and patient have a long-established history in an entirely different context [13]. The obligation to patient confidentiality may become complicated as other family members begin to impose their own expectations and emotional demands. Dr Yubras will have to be prepared to compartmentalize that information and wall it off from a future affectionate relationship with his son. His son should receive exactly the same preoperative evaluation that he would give any other patient. Among the additional, and profound, considerations in treating a relative, particularly surgically, will be the potential damage that a bad outcome might have upon your own emotional wellbeing and your future interpersonal family relationships [12].

Despite published opinions urging special caution, including this one, there are in fact no legal or professional prohibitions against operating on family members, making the issue a matter of individual conscience. The AMA’s position specifies valid exceptions: “It would not always be inappropriate to undertake self-treatment or treatment of immediate family members. In emergencies or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available” [12]. These considerations reject the absolutist posture. Refusing to provide essential care to a person in need solely on the basis of kinship places an arguable intellectual principle before relief of acute
human suffering and cannot be defended. But as presented in the case, there is a surgeon equally qualified to perform the necessary procedure available at another local institution. Dr Yubras makes my point when he disagrees with multiple other professionals who consider Dr Smith to be equally skilled. He considers his advantage to be his interest in his son’s welfare, which as the previous discussion indicates, may well be detrimental. Dr Yubras’ son has requested his father because his father, conflicted as he is, said he was the best. What son would doubt a professional father’s advice in such a matter?

Science denies absolute truth and chooses courses of action on the basis of the preponderance of evidence.

The preponderance of evidence is against Dr Yubras operating on his son; there are many potential drawbacks and few advantages. In the practice of medicine, a crucial factor is the best risk-benefit ratio, here in Dr Yubras’ hands, it is uncertain at best. Dr Yubras assumes that he can control his emotional overlay, and perhaps he is correct. However, unless he has previously performed major procedures on a close relative, his contention is untested. Battle testing of soldiers has always been considered essential in knowing who will perform well. Dr Yubras should consider that proceeding to perform the procedure would constitute a mouse experiment with his son’s life and health being the ante.

Concluding Remarks

Robert M. Sade, MD

Medical ethics contains no absolute laws and only a few firm rules. Most ethical opinions are merely guidelines that must be interpreted and acted on in the context of concrete circumstances; that is, most ethical statements take the modal verb “should” rather than “must.” Avoidance of providing medical care to a family member or close friend is one of the least prescriptive ethical guidelines, partly because the presenting circumstances are extremely variable [12]. What could be wrong with Doctor Dad looking at little Johnny’s throat to decide whether his pediatrician needs to do a more detailed examination for diagnosis and treatment? The emotional overlay in such situations is not great, the procedure or examination is easily done, and any error is not terribly consequential. Nevertheless, it has been my personal policy to decline providing even the most innocuous medical care to my own family.

When my children were younger, my wife did not hesitate to express her frustration when I refused to do even seemingly trivial bits of doctoring, such as examining an eardrum for possible otitis: “That’s why we have a pediatrician,” was my stock explanation. My attitude of providing zero medical care for my family stems from a minor operation I did several decades ago to treat a paronychia of the index finger of a niece’s right hand. At the time, the accepted procedure for an extensive subungual paronychia was excision of the nail, soaking, and a small bandage. I did the minor procedure under digital block without difficulty or complication. The problems came many weeks later when, contrary to my assurances at the time of the procedure, the nail failed to grow back as good as new, rather, it grew back with the appearance of a washboard that had been run over by an automobile. To this day, it still is visibly deformed. My niece has remained in good humor about this 40-year-old incident; yet, despite my request that it never be mentioned again, the story still comes up from time to time, and when it does, the passage of decades notwithstanding, I still feel a twinge of regret.

This experience was the substrate for the growth of my determination not to provide even minor care for family members or friends but to refer them to their own doctors or relevant specialists. Different experiences have led individual surgeons to a diversity of views on what is right or wrong in providing medical or surgical care to family members or close friends and have moved them toward the position either of Kenneth Oberheu or of James Jones. Whether we should operate on members of our own families depends on the concrete circumstances of each such situation, but, in general, the greater the risk of errors and complications and the more serious their potential consequences, the more wary we should be of accepting the surgeon’s role.

If faced with a request for care, however, we must always be mindful of one important fact of human nature: we tend to overlook our own limitations and fail to recognize the undue influence we sometimes have on others. Operating on a family member or friend may reflect wisdom or hubris, but if we are tempted to do it, we must always question whether we are in the best position to make that decision and should conscientiously consider the views of our colleagues.

References


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