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Arthur W. Frank

Narrative Inquiry in Bioethics, Volume 8, Number 1, Spring 2018, pp. 35-40
(Article)

Published by Johns Hopkins University Press

DOI: <https://doi.org/10.1353/nib.2018.0020>



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Commentary

When Professional Rightness is Personal

Arthur W. Frank[†]

[†]University of Calgary and VID Specialized University, Norway

[‡]Correspondence concerning this article should be addressed to Arthur W. Frank, 5904—84 Street N.W., Calgary, Alberta, Canada T3B 4X5

Email: arthurwfrank@gmail.com

Conflicts of Interest. The author reports no conflicts of interest.

Abstract. This commentary discusses twelve stories in which physicians tell what happened when they were involved in the care of a family member. The stories display considerable differences in attitude toward the ethics and usefulness of physicians treating members of their own families. But the more significant tension is between the analytical or objective attitude that all the writers presuppose as necessary for doing good medical work, opposed to the emotions aroused by seeing a loved one suffer. The commentary explores the implications of assuming this binary opposition, whether it is correct, and how far it is actually necessary. Concluding comments discuss what kind of ethics is involved in stories that are all about dilemmas and decisions, but rarely invoke concepts from bioethics.

Keywords. Physician ethics, Narrative ethics, Ethical decision-making, Rightness

“**A**t that moment, I was more a loving son than an analytical physician, buoyed by my dad’s resilience, but stricken by impending loss.” So writes Joseph Fins in his contribution to this collection of stories. Like all the other physician authors, Fins structures his narrative on the binary opposition between “analytical”, the professional attitude, and “loving”, the attitude appropriate to a family member. The dramatic tension of these stories—the tension that pulls the protagonist in different directions and creates suspense over what she or he will do—depends on that opposition. Suspense over how the illness will turn out seems secondary, because the ill person is the object of the

narrator and protagonist’s perspective, a problem for the narrator rather than a subjectivity with which we readers identify.

From that opposition between analytical and loving flow most of the serious questions posed by these stories: who pays what prices, in which currencies, for maintaining the opposition between *analytical* and *loving*? What benefits accrue to whom from this opposition? What happens when this opposition does not fit the demands of the circumstances? What sort of personal and professional ethics follow from either sustaining this opposition or considering it irrelevant? These are by no means the only questions posed by these stories, but they are a start.

Or to put it another way, I read these stories from my location of not being a physician myself and coming from a family in which the only physicians are so far removed in the kinship network that I have to calculate exactly how we are related. It's a measure of my own family's lack of medical expertise that I have been the one to whom my parents and elderly aunts turned for advice. That leads to asking, from the ill person's perspective, wouldn't it be handy to have a doctor in the family? Yet these stories suggest that while the benefits seem clearly on the side of being physician-related, especially when a diagnosis is uncertain and treatment gets complicated, few things in life are unequivocally beneficial. Family members of physicians also incur costs, some of which the stories suggest and others we can speculate upon.

Keeping these tensions, questions, and multiple perspectives in mind, I will consider how the stories differ in attitudes on the fundamental issue of whether or not physicians should treat family members; the benefits and costs of having and being a physician in the family; reading these stories as fables of medical moral education; and finally, how the stories encourage us to understand what counts as *ethics* in healthcare.

Treating the Family: Divergent Views

All these physician narrators present themselves as offering medical advice to family members and being a resource to whom the family turns in times of illness. Among these dozen stories, the issue of whether or not a physician should treat a family member—prescribing medications, making diagnostic and prognostic decisions, directing nursing staff—seems not to occur in three (Fins, although he acts as an ethics surrogate decision-maker, Robins-Brown, and Turnbull, who expresses regret that she did not become directly involved in decision-making). Kathleen Fenton describes herself as “almost another consultant” in her mother's medical decision-making, and I read all the physicians falling into this open-ended description. Frances Nadel is pro-active in arranging second-opinion referrals for her sister, but does not actually treat

her. Ambika Rao makes an emergency call for a critically ill family member, but does not act as her aunt's physician.

Real differences occur among the other six stories. Three reject physicians treating family members, and three either accept this role out of apparent necessity or embrace it despite costs that they acknowledge. Among those who reject becoming the treating physician, David Alfandre describes his medical training “as a liability” when his son is critically ill. After being troubled, even offended, when a resident treats him as a detached colleague observing his son's precarious condition, Alfandre eventually settles on an attitude of “deliberate ignorance” when talking to hospital staff. “I spoke as the emotionally exhausted and utterly distraught parent who needed support, education, and patient explanations.” He chooses to be “a father first”; not necessarily for that reason, his story has the happiest ending in this collection. Alfandre accounts for his decision not by invoking ethical principles, but through eloquent descriptions of what he needed and what he was capable of during this crisis.

Alexander Kon tells the most specific story to support his rejection of taking the role of treating physician. After his niece's surgery for a brain tumor, he spends the night in her room and is distressed at her pain and discomfort. He consults another physician whom he describes as a mentor, and this person plays a part that defines the character-type of mentor. The mentor asks Kon if he is trying to treat his niece, and he admits he is. The mentor then calls upon Kon to imagine another child in similar medical circumstances, and asks how he would describe that child's night after surgery. Kon replies that he would say “she did great.” That sets up the punchline: “Right. That's why you don't treat family. . . . You are too close, and you have lost your perspective.” Here, Fins' binary of analytical and loving becomes a distance metaphor of too-close versus capable-of-perspective.

Tania Moerenhout begins in apparent ambivalence between the advice of her medical school professors, who sound just like Kon's mentor, and her observations of colleagues who are apparently

successful at being their family members' doctor: "Their emotional proximity seemed to be an advantage rather than a hinderance in the real-life world." When her grandfather nears end-of-life, she becomes "a sort of liaison figure between the care providers and [her] family members." Her eventual rejection of being her family's physician comes down to this question: "In what role do I want to be there for them at the end of their life?" In her grandfather's dying, she feels she could have played the role of treating physician, but she "did not *want* the responsibility, worries and existential questions that come with that role." Several of the physicians who do treat their family members might reply that they did not want this role either, but in their circumstances, it was the best among limited options. Moerenhaut would understand that; she does not state her position as an ethical imperative, but as a better choice for her, when she had a choice.

Three physicians do treat their family members. Michael Rezak becomes his father's "supervising physician" with explicit ambivalence, claiming his circumstances were an exception to general rules of ethical conduct. Those circumstances include his father's biography as a Holocaust survivor, and his sudden deterioration that results from surgical mismanagement that Rezak is too tactful to label malpractice.

Amos Ritter may be the most unequivocal about treating family members, something he does "all the time." He accounts for this by invoking another version of the binary distinction: "I felt I was able to separate between my emotions and my professional knowledge, and I made sure I treated my relatives the exact way I would treat any other patient." He adds that "if my family member was under the care of another doctor, I would anyhow be involved in the treatment they received." That statement alerts us to one of the categories of unheard voices that hover on the edges of these stories: the voices of those physicians who inherit a patient's family-member physician as their *de facto* consultant. How those physicians feel about this consultation could make for good stories of collegial support and strain.

Ritter's story about being the attending physician at his father's death responds directly to Moerenhaut's question of what role she wants to play when her loved one is dying. That Ritter seems to balance roles successfully—albeit acknowledging that he paid a price—speaks to how variable circumstances can be.

Sergio Salazar takes over the medical care of his father for reasons that range from the difficulty of transporting his father to medical appointments outside of the home where he lives with Salazar and his wife, to the pleasure of the relationship that being his father's physician allowed him. "When my father looked at me, his eyes not only registered love and affection but a new-found respect for my decision-making ability. I perceived that he felt that as his physician I had more control for his total wellbeing. A profound sense of responsibility greater than what I felt for my non-family patients was evident to me." Readers might react to this passage in diverse ways, some finding it a description of an exemplary, ideal doctor-patient relationship, and others asking critically whose needs are being given primacy. One response does not negate others; Salazar knows best how he felt, and he might be the best judge of how his father felt.

We have in this collection what stories usually leave us with: a spectrum of responses to an issue that, in its narrative form, seems less universal—a principle that doctors should or shouldn't treat their families—and more a nuanced, ambivalent response to particular circumstances.

Having a Doctor in the Family, and, Being the Family's Doctor

The advantages of having a doctor in your family are self-evident in these stories, or at least the benefits of having these doctors in your family. They answer your calls, and their colleagues answer their calls. Referrals are arranged with expedience. Kon may be most explicit about the preferential treatment he was able to get for his niece: "some children do not get that kind of workup and care from experts too quickly." When he writes of the importance of "having a good advocate," those of

us without physicians in our families might have a sinking feeling.

A further advantage not spoken of in these stories—a notable silence in a dozen stories about critical illness, mostly occurring in the United States—may be the cost of treatment. Rezak alone refers to the mounting costs of his father’s care, suggesting that expenditure contradicted values his father had lived for. If a cost-comparison by comparable medical condition were possible, it would be interesting whether having physician relations affects what patients pay. None of the physicians who treat their family members discuss billing. It also seems—but we do not know—that these families are above average in either or both affluence and insurance coverage. Like all silences, this one can be variously interpreted, but it is a notable silence.

The main advantage that is discussed is how the physician in the family takes on a role most often described as “translator”, a word used explicitly by several writers and variously paraphrased by all. Perhaps the most evident take-home message of these stories is that medical treatment *requires* translation. Some translation involves simply explaining technical vocabulary. Moerenhaut takes the issue to another level when she writes of the need to “help both sides understand the language and concerns of the other.” She repeatedly observes differences between the medical perspective on how the patient is doing and the family’s view of suffering. She writes that her grandfather’s discomfiting symptoms, which the family took seriously, “were medically sometimes of little interest. . . . From a clinician’s view, it was clear these were unfortunate concomitant symptoms. But from my mother’s point of view, the suffering was unacceptable.” Moerenhaut thus offers a different perspective on the advice that Kon’s mentor gives him. The clinicians caring for her grandfather seem to work from too much distance; they’re missing something that counts in the care of both patient and family. They miss the suffering, as they see only symptoms. Clinicians need to have their patients’ suffering translated into terms they can respond to.

But having a physician in the family, and certainly being the family’s physician, also has costs.

These stories refer explicitly to the price that physicians pay when they treat family members. For example, Salazar describes first arriving in Florida, before his father’s disastrous surgery: “I preferred to watch and hold his hand. After all, I was his son, not his physician.” Then events will turn him into his father’s physician. Ritter poses the question explicitly: “Is the price I paid worth the benefit?” As to whether patients and family members felt they paid some price, we can only speculate, because these voices are among those not heard. Stories always leave some voices unheard, as some characters are rendered marginal to the plot. It seems that as family members become the professional in charge of treatment, they become less available to hold anyone’s hand. Moerenhaut and Alfandre are clearest about not wanting to give up being granddaughter and father, respectively, to their ill loved ones, and we can only assume their loved ones felt the same way. Moerenhaut’s mother and Alfandre’s wife may need their daughter and husband more than they need another consulting physician, even one with an extra level of commitment. When a physician withdraws to the analytical, objective, and distant side of the binary, the rest of the family gain an advocate and possibly a more dedicated clinician, but they lose the person closest to themselves. No universal calculation can advise, much less regulate, that trade-off.

Medical Moral Education and the Question of Binary Oppositions

As I first asserted and have tried to illustrate, all these stories are constructed on a tension between polarities of a binary opposition that is variously posed as analytical versus loving, close versus distant, or objective versus emotional. The stories need this opposition, as a narrative tension, but they also question it. Even physicians who believe they can be on both sides of this binary continue to assert it as an opposition; for example, Rezak writes, “I do believe I was able to compartmentalize adequately.” Yet, a considerable literature suggests the opposition is less real than these writers presuppose.

Possibly the original voice opposing such a binary is the philosopher Martha Nussbaum, writing in one of her most influential early works: “we wish to say that the emotions are cognitive and that a process of rational deliberation that omits them leaves out material of rich informational value” (Nussbaum, 1990). The physicians whom Moerenhaut describes as having little interest in suffering that the family considers “intolerable,” or Kon’s mentor who counsels the clinical irrelevance of the observations that Kon makes as a loving uncle, are, on Nussbaum’s account, leaving out material that ought to count. They have an impoverished understanding of cognition, and that does not serve either themselves or their patients well.

Nussbaum’s argument proceeds to tell us why it’s important that these physicians tell *stories* about their experiences, and how these stories are crucial to both their own moral education and the education of other clinical professionals. “*Narratives* are essential to the process of practical reflection: not just because they happen to represent and also evoke emotional activity, but also because their very forms are themselves the sources of emotional structure, the paradigms of what, for us, emotion is” (1990). To gloss this dense argument, we humans have to feel in order to think well, and stories teach us how to feel. Stories not only teach what feeling is, stories themselves constitute feeling. Perhaps that underlies why Salazar ventures that he was a *better doctor* to his father than to his other patients; not treating family members the same as other patients, as Ritter claims, but adding value to family members’ care.

Nussbaum’s argument has been refined and expanded both in her later work and in many others’ writing. One side of the argument focuses on what is lost when emotions are ignored. The other side is that emotions always figure into what are experienced as rational cognitions. How far any of us can “compartmentalize,” as Rezak idealizes, is questionable. The question is not whether emotions are affecting us; rather it’s how aware we are of which emotions are affecting us in what specific ways, and whether we take those effects into consideration.

Recent work in cognitive science suggests—some would say proves—that ethical decisions are made quickly and pre-consciously. Reasons are invoked *post hoc* to make those decisions accountable to others and to oneself (see, as the most recent example, Mercier and Sperber, 2017). My reading of these stories is that they support that line of understanding. These physicians seem to know, in advance of any rational decision-making, what it is *right*, and thus necessary, to do or not to do. Then they describe circumstances in ways that justify that decision.

As fables of medical moral education, these stories are about moments when a physician learns a lesson that sounds cliché when stated in the abstract: caring for human persons is more than caring for bodies as collections of parts prone to breakdown and sometimes amenable to fixing. Care is a human relationship. That has been said so many times, but these stories remind us that each and every clinical professional has to learn it anew in her or his own experience. And the lesson must include *telling the story* that makes the experience something of durable use.

An Ethics of Rightness and Dialogue

In conclusion, what kind of *ethics* do these stories not recommend? It does not seem to be bioethics, because only Fins describes what happens as involving any bioethical issue. Rather, the ethics involved seems closer to what I have described as *rightness* (Frank, 2017). What interests me most about the ethics of these stories is that a physician’s sense of the rightness of what is done—whether she or he treats a family member or refrains from actively participating in the medical treatment—depends on on-going dialogue with others, who may be family members or professional colleagues. “Fortunately, I had supportive colleagues available whenever I needed them for consultation in my decisions,” Rezak emphasizes. “The latter point is crucial. No physician could or should do what I did in isolation; the input from colleagues is crucial.”

What Rezak states most explicitly can be found in all the other stories, in which it is clear that the narrator was in constant dialogue with other family

members as well as colleagues. I read these stories as affirming the principle asserted by the anthropologist Webb Keane in his research on everyday moral life: “the coherence of ‘ethics’ in any given instance is constructed through social processes,” and later: “people’s self understanding as ethical beings is most often instigated by the very dynamics of interaction” (2016). As in my brief reference to Nussbaum’s work, here I gloss a complex argument, but the point is sufficiently clear. In these stories, people’s sense of the rightness of what they do is constituted in talk with others: spouses and siblings, mentors and colleagues. These conversations undoubtedly continued after the event with which the story we hear only seems to end. The dialogue continues in the writing of these stories themselves, whom the writers show the stories to, how those readers respond, and so on. In those dialogues moral life is actually *done*.

Each of these stories is as much a question as it is a claim. The claim is to have done the best that one could do, in very difficult circumstances. The

question is whether others, now the readers of these stories, will affirm that what was done was right, at least as right as circumstances allow. These stories expose their writers, rendering them vulnerable to criticism, both professional and personal. We humans risk that exposure because we need the affirmation that can be gained only by taking a risk. Our sense of rightness in our actions is endlessly fragile. We need others’ acceptance of our stories in order to believe we are the people we aspire to be.

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