

Doctors Who Doctor Self, Family, and Colleagues

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ABSTRACT

Treating one's self, treating one's family, being a physician-patient, and taking care of colleagues and their families are aspects of the practice of medicine that are not often taught or discussed in any type of venue. They are not new issues. They have been considered since the earliest days of medicine. They are sometimes controversial issues, since physicians have been reluctant to set standards for themselves. This article reviews the prevalence of physicians' treatment of self and their families and the problems that may arise, as well as the regulations that have been developed. It also examines the reluctance of physicians to seek care and the consequences and the special needs of physician-patients. Finally, guidelines for providing care to self and colleagues are suggested. Further education for students and house staff is needed to enable physicians to appreciate the risks of self treatment and to know how to best care for themselves and their colleagues.

INTRODUCTION

Physicians have been given the ability, experience, and power to wield the sword of medicine for others and can use their medical knowledge for their families and themselves. However, with power comes responsibility. How do they use this power? Do physicians usually prescribe medications for themselves or their family? Should they? What is ethically acceptable, and when does it become questionable?

This article will review the issues involved in physicians' care of themselves, their families, and their colleagues. It will further examine the complex problem of self-treatment, including its prevalence, the regulations that have been developed, and problems that tend to arise. Finally, some guidelines that have been developed in an attempt to address this issue will be reviewed.

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DISCUSSION

Prevalence

Self-prescribing and self-treatment among doctors is common and a pattern that is established early in their careers.¹ In the United States and Europe, from 52% to 90% of physicians report prescribing medications for themselves.¹⁻⁴

Taking medications from the sample closet was the most common source of self-prescribing, including 26% of all medications and 42% of all self-prescribed medications. Ten percent of all prescription medications were provided directly by pharmaceutical company representatives. A study with a family practice group reported 51 of 53 physicians, residents, nurses, and staff taking pharmaceutical samples for personal and family use.⁵

A longitudinal study of physicians followed during internship and the subsequent 9 years reported 54% of physicians in their fourth and ninth postgraduate years had self-prescribed at least once during the previous year.¹ Ninety percent of prescription medication during the previous year was self-prescribed, with the most common medications being antibiotics, allergy medicines, contraceptives, and hypnotics. Predictors for self-prescribing included being a male physician with somatic complaints and no primary care physician. Self-prescribing starts early in a physician's career. Efforts to develop a more formidable student assistance program should start in medical school.

When Physicians Treat their Own Families

Most physicians provide some level of care for their immediate family members.⁶ This may be no different than what most nonmedical parents or spouses would do—first try to take care of the problem themselves. Physicians, however, sometimes find it difficult to decide when their intervention is not in the best interests of the “patient.” Prescribing allergy medications or antibiotics is one thing, but what about surgery? Physicians admitted having attempted anything from cosmetic procedures like basal cell removal to abdominoplasty to C-section to pacemaker placement and angiography.

Convenience is most often cited as the reason for physicians to address a problem themselves, with confidence in their own diagnostic and treatment skills, concerns about quality of care, confidentiality, and cost also factoring into the decision.⁷

Data on families of physicians show that they were seen less often for acute illness, had incomplete exams, incomplete or absent medical records, and incomplete documentation of immunizations.⁸ Care of family members by colleagues was formerly seen as part of medical etiquette intended to permit physicians to avoid the difficulties involved in caring for one's relatives, but that practice is now passé and even considered fraud by some insurers.⁹ In fact, Medicare barred payment to physicians who provide care for immediate relatives effective November 13, 1989.

How Self-Treatment Is Regulated

In 1794, English physician Thomas Percival wrote the first code of conduct regarding physicians caring for themselves and their families in his book, *Medical Ethics*, which was to be used in resolving conflicts among physicians. It was published in 1804 with the subtitle, *A Code of Institutes and Precepts, Adapted to the Professional Conduct of Physicians and Surgeons*. It is of note that it was this work that served as the code of ethics for the newly formed American Medical Association (AMA) in 1845.

A passage of interest that is remarkable for its intuitive wisdom:

A physician afflicted with disease is usually an incompetent judge of his own case; and the natural anxiety, the solicitude which he experiences at the sickness of a wife, a child, or anyone who by ties of consanguinity is rendered peculiarly dear to him, tend to obscure his judgment, and produce timidity and irresolution in his practice. Under such circumstances medical men are peculiarly dependent upon each other, and kind offices and professional aid should always be cheerfully and gratuitously afforded.¹⁰

The AMA continued to adhere to this code through revisions up until 1957 when the AMA House of Delegates adopted an abbreviated code and omitted the references to treatment of family or professional courtesy, as does the current, even shorter, 1980 version.

In 1977, a comprehensive revision of its Opinions and Reports of the Judicial Council (now the Council on Ethical and Judicial Affairs) omitted all reference to the treatment of family, but retained what they called advisory guidelines to aid physicians in resolving ques-

tions related to professional courtesy. We are now left with this ethical guideline: "Physicians should generally not treat themselves or members of their immediate family."¹¹

Exceptions can be made for emergencies or in isolated instances when no other physician is available, but the AMA further opines that self-treatment raises questions regarding professional objectivity and the assurance of quality medical care.¹²

Each state has its own regulations, and there seems to be some misunderstanding among physicians as to what exactly is allowed under the law regarding self-care and prescription. More than 25 states now prohibit physicians from prescribing controlled substances for themselves or for their immediate families.

In Wisconsin, physician behavior is regulated by 2 sets of precepts. These are the state statutes and an administrative code that governs professional conduct. The state statute specifically prohibits physicians from prescribing themselves controlled substances.¹³

State of Wisconsin Statutes: 961.38 (5): No practitioner shall prescribe, orally, electronically or writing, or take without a prescription a controlled substance included in schedule I, II, III, or IV for the practitioner's own personal use.

The statute does not explicitly prohibit the prescription of such drugs for one's family. Therefore, it is legal to do so. However this must be done in the course of legitimate professional practice as stipulated in the Wisconsin Administrative Code.¹⁴ The code indicates that, in Wisconsin, you may prescribe medications and take care of your family but you must not do so outside the course of legitimate medical practice and you must keep a record. There are numerous examples of physicians being sanctioned by the Medical Examining Board, not because they administered care to family, but because they did not keep adequate records.

Where do we Draw the Line?

It can be argued that in emergencies or in the case of minor ailments, physicians could take care of matters for themselves as the AMA Code of Ethics suggests. However, the definition of a "minor ailment" may be controversial. Physicians have reportedly treated everything from hypertension to diabetes to mental disorders under the guise of minor ailments.¹⁵

Clear-cut rules or guidelines have not been established, and there is the question of the quality of care and objectivity. Some guidelines have been suggested, such as making allowances according to type of medication or indication.⁴ For example, perhaps it is reason-

able for a physician to self-prescribe medications for relatively straightforward conditions such as proton pump inhibitors for gastroesophageal reflux disease or antibiotics for minor infections, but not antidepressants for depression. It is inappropriate for a physician to self prescribe a beta-blocker for hypertension that would require monitoring, but acceptable if the same drug is used occasionally for stage fright for public speaking. In another situation, a physician should not initiate inhaled bronchodilators to treat asthma but it would be more acceptable if the same therapy was prescribed in the past by another physician if the condition is stable and monitoring is not required.

The question remains: is self-care good? There are no data on the quality of self-prescribed care. Previous research suggests that 29%-44% of physicians do not have a personal physician or seek regular medical care.^{3,16-17} Anecdotal accounts suggest that, although physicians as a group are healthy¹⁸ and have healthy lifestyles, their own health care is poor, in terms of their willingness to seek medical care. A longitudinal study of a class cohort of young doctors, first interviewed when they were students, showed that they suffer from frequent minor physical ailments, with women reporting more ailments than men. Despite this, they took fewer sick leaves and took little time off work. In addition, reported health behavior both in terms of response to illness over the past year, as well as predicted response to hypothetical illness, demonstrate maladaptive patterns including continuing to go to work when physically unfit, self-prescribing, and consulting friends and colleagues rather than going for a formal consultation.¹⁹

This may be especially inappropriate in cases of mental illness. Physicians have an increased prevalence of mental health problems, with the first postgraduate years being particularly stressful.²⁰ McCauliffe reported that 25% of 342 surveyed practicing physicians from New England had treated themselves with a psychotropic during the previous 12 months.²¹

It can be a slippery slope. Not all who self-medicate abuse medications, but many of those who abuse started by self-medicating. Compared with controls, physicians are 5 times as likely to take sedatives and minor tranquilizers without medical supervision.²²

In Finland, one of the most common reasons for physician self-medication was a mental disorder or insomnia.²³ When one looks at impaired professionals, self-prescription and abuse of addicting drugs were involved in 40%-75% of referrals to physician impairment programs.²⁴ Additionally, 20% of drug dependent doctors provided addicting drugs to spouses.²⁵

As other writers have observed, "Self-treatment is not to be viewed as simply a cause for physician impairment but as a symptom of poor health care for physicians."²⁶ The broader question remains, why don't physicians get their care from other physicians?

Physician Heal Thyself

Physicians may be no different than anyone else needing health care. It is a common sociological sequence across all cultures: when people need help for their medical condition, they first try to take care of it themselves, then ask the advice of friends, then try home remedies, and finally will seek help and make an appointment for a professional evaluation and care.²⁷

In choosing a provider, there may be concerns about age, gender, special interests, and style. There are issues of convenience, availability, geography, and cost. One may decide based on a friend or family's experience and recommendation.

Physicians often can and will bypass traditional care with informal care and consultations and choose a provider based on reputation, perception of competence, and/or a relationship with that person.^{3,28} Working relationships with other physicians may create barriers to privacy and make it difficult to identify a physician with whom one can comfortably assume the patient role. This type of behavior sometimes results in a somewhat deserving reputation of physicians being the worst patients.²⁹

Doctors Distorted Notions of Treatment

Busy schedules make it difficult for physicians to arrange time for self-care and to schedule appointments for themselves. They often use excuses like "I'm too busy," or "I can't get sick. There is no one else to take care of my patients."³⁰

Physicians, also, since medical school days, engage in self-diagnosis. They practice their own differential diagnostic thinking, and they are prone to "catastrophize," presuming that a twitch might be amyotrophic lateral sclerosis or an adenopathy can be cancerous. On the other hand, they can be in total denial: "There is nothing wrong with me; I don't need to see a doctor."³¹ This kind of presumptive thinking can lead to anxiety and avoidance of seeking care.

Physicians can be concerned about bothering their colleagues for what they presume might be trivial matters. They can be concerned about letting their partners down. If one's self-esteem is tied up in the role of being a doctor, it will be hard to surrender that role. Physicians can be compulsive and overly responsible. "Doctors don't get sick."³²

Other barriers to care include fear regarding

credentialing, licensing, or malpractice coverage. “What will happen if I admit I am depressed or have a drinking problem?”

Some physicians may not trust their colleagues. They may feel that they, themselves, can diagnose a condition, and feel that they are the “best person for the job.”

Then, there are the issues of role reversal. Physicians may not be accustomed to being a patient. There are the annoyances of delays in appointments, the inconvenience and unpleasantness of tests, and the embarrassment of seeing one’s patients in a waiting room.³³ They may have had a bad experience or not like how they were treated or be surprised by cost of care. It is surprising how many physicians are not aware of the limitations of the insurance coverage they have. Additionally, physicians are well aware of side effects and complications of treatment, which can lead to apprehension and avoidance of treatment.

Why Should I Have a Doctor?

Heroism becomes a way of life for physicians who try to work when they are sick¹⁵ and take on more than they can handle or have the myth of eternal youth and invulnerability. Often, they present late for treatment when they do present.³⁴

In spite of this, there are some good reasons for a physician to consider having a primary care provider:

- Knowing one’s limits—There are issues of competence, but in addition, depression, alcohol and drug issues, or fatigue can all affect motivation and judgment.
- An objective perspective—It is useful to have another’s opinion.
- Documentation—All too often care is not documented.
- Some things are hard to do—Exams like a pelvic pap, rectal, or prostate exam require another individual.
- Monitoring and follow-up of results—This needs to be a priority.
- Have an advocate—With insurance issues, administration and licensing, a knowledgeable resource to help navigate the system can be helpful.

Physician care becomes more important from another perspective when one considers Frank’s research, which demonstrates that the health habits of physicians influence the counseling they provide to their patients.³⁵ What is the message to patients if physicians avoid seeking health care for their own problems and prefer instead to manage these issues on their own? “Do as I say, not as I do?”³⁶

Caring for Colleagues Is an Art

If and when physicians do go to a colleague, there can

be associated problems. Professionals owe it to their colleagues to give them the best care possible, but there is no formal training in how to take care of a doctor and his family. It is all on-the-job-training and not always done well. Some providers are comfortable with their physician colleagues and develop a reputation for being a “doctor’s doctor” while others avoid it as an uncomfortable onus.³⁷ Some might feel pressured, strained, or insecure.

There are a number of important issues that must be considered when physicians care for colleagues. The caring physician may perform a perfunctory exam avoiding breast, rectal, or pelvic examination or avoid complete testing to include venereal disease research laboratory (VDRL), toxicology screens, or Human Immunodeficiency Virus evaluations. Caregivers may not completely explain things, assuming that the physician patient will know what the caregiver knows. Some may be tempted to do less rigorous follow-up, feeling that the patient would contact them if needed, or that they can obtain samples from the sample cabinet because it is a cost savings.

The VIP physician-patient syndrome has also been described.³⁸ Physicians uncomfortable with the patient role may expect special care with longer visits or visits outside of normal patient-seeing hours, or can be demanding by asking for a prescription or consult off the record, or second-guessing recommendations.

These factors can also affect care of physicians’ families. Spouses may be uncomfortable revealing problems with substance abuse or psychological problems for fear of embarrassment or breach of confidentiality. Sometimes physician relatives will intervene or second-guess treatment recommendations. Additionally the medical staff can be as apprehensive in caring for a spouse or family member as caring for a physician.³⁷

Guidelines

There are 2 major issues in taking care of fellow physicians and their families: treating them as colleagues and not treating them as colleagues.³⁹

Physicians should not take on these cases if they are uncomfortable. The relationship needs to be clarified from the outset. It should be collaborative as with all patients, but let the physician-patient be the patient with all the same rights and privileges. There is 1 person in charge, and that is the caregiver. The caring physicians need to treat the patients, stating from the outset that they will be as thorough in their history and physical and explanations as they are with any other patient. If it is too simplistic, it can always be modified, but the patient needs to know that their provider does not want

to compromise their evaluation. It's important to find the appropriate level of empathy and rapport, trying to be "not too chummy and not too distant."

On the other hand, when the patient is a physician or family member of a physician, a colleague should recognize that it might be difficult for him or her to ask for help. An effort needs to be made to dispel their anxiety. The patient should be assured he or she is not wasting time. Spending time listening to their professional concerns is reassuring. The provider should also ask for and listen to their self-diagnosis. Issues of privacy and confidentiality need to be discussed openly. Discuss the plan. If privacy concerns are a barrier, it may require a referral outside the system of care where they work.

For family members, the caregiving physician should deal directly with the patient and not go through the physician-relative. It's important to spend time alone with the patient. Questions of confidentiality should always be addressed, reassuring that nothing goes back to the spouse/parent/relative without their consent. Spouses and children may, sometimes, assume that physicians will talk with their colleagues, and it can compromise their ability to be honest. For follow-up, it should not be assumed that physician relatives will prescribe or order tests for their families.

Guideline for Treating your own Relatives

Providing medical care for your own family and relatives raises a number of ethical, emotional, and competency issues. There are times when it is more convenient, a matter of urgency, or accessibility, but when physicians starts to think they are the best person for the job, perhaps it is time to think again. Physicians from the earliest times purposely devised the custom of professional courtesy to avoid the ambiguities and discomfort of care for relatives.⁴⁰ That practice is now considered obsolete,⁴¹ but it would be prudent to heed this wisdom.

La Puma et al,⁶ who published one of the few empirical studies on these issues, suggested 7 questions that physicians who are asked to diagnose and/or treat family members should ask themselves:⁴²

1. Is the physician trained to meet his/her relative's medical needs? In other words, would the physician be seen as competent to care for this problem by an independent observer?
2. Is the physician too close? Family members may not wish to share issues with a physician relative. They may need that person to be emotionally involved and be the spouse or parent, not the detached clinical caregiver.

3. Can the physician be objective enough to not give too much, too little, or inappropriate care? With all the anguish that goes into seeing a loved one ill or with family conflicts, it is difficult to detach yourself.
4. Is medical involvement likely to provoke or intensify intrafamilial conflicts? Illness in a family may bring members closer together or push them apart. The caregiver needs to be able to separate him- or herself from those dynamics.
5. Familiarity can breed non-compliance. Sometimes family members are more likely to follow advice they are paying for.
6. Will the physician-relative allow the physician-provider to whom the relative is referred to attend the relative? A physician-relative can sabotage treatment with the best of intentions.
7. Is the physician willing to be accountable to his/her peers and to the public for this care? Accountability and liability have become very important in medicine. Care may seem acceptable if nothing goes wrong, but if complications and problems with the treatment ensue, it will be difficult to find supporters.

CONCLUSION

It is difficult to identify clear boundaries that separate inappropriate self-care from more acceptable examples. The culture of medicine is one where self-treatment starts early in physicians' careers, is not formally discussed, and perpetuates itself through training and practice. It is a discussion that needs to be heightened to a more formal venue; practicing physicians should evaluate their own self-treatment practices more closely.

Physicians should avail themselves of the excellent care and benefits they have available, secure a personal provider that they can trust and respect, and not attempt to care for their families or themselves. When colleagues do seek care, it is imperative that physicians be more attentive to the unique circumstances that may arise when taking care of doctors and their families.

More regulations are not needed. Instead, educational programs on self-prescribing and the special needs that arise in the care of colleagues should be developed for students and resident physicians.

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