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ORIGINAL ARTICLE

Doctors treating family members: A qualitative study among primary care practitioners in a teaching hospital in Malaysia

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Abstract

Aim: To explore primary care practitioners' experiences and feelings about treating their own family members.

Methods: A qualitative study was carried out using focus group discussions. Five sessions were held among 22 primary care practitioners (five academic staff members and 17 medical officers).

Results: Most participants treated their family members, especially their immediate families. They considered factors such as duration and severity of illness before seeking consultation with other doctors. Some participants felt satisfied knowing that they were able to treat their own families. However, most felt burdened and uncomfortable in doing so, mainly due to the fear of error in diagnosis and management. They were concerned that strong emotions may make them lose objectivity. Many were aware that negative outcomes resulting from their treatment may affect future relationships.

Conclusions: While some doctors were comfortable about treating their own families, some faced significant conflict in doing so. Their decisions depended on the interplay of factors including the doctor, the family member and the relationship they share. A doctor needs to consider the potential conflict that may arise when carrying out one's professional role and at the same time being a concerned family member.

Key words: doctors, family, Malaysia, primary care, self-treat.

Introduction

It is common for people to consult their physician relatives about health and illness. They do so for the convenience, to avoid clinic visits and to cut costs.¹⁻³ There is a familiar person guiding them through the medical systems.¹ However, doctors may face conflict of interests and ethical dilemmas when they treat family members. They may under- or over-estimate the significance of certain symptoms. They may prescribe medication without performing physical examinations or laboratory investigations.²⁻⁴ Requests from family members can be a source of embarrassment and frustration.⁵

According to the British Medical Association guidelines “it is not advisable for doctors to assume responsibility for the diagnosis and management of their own health problems or those of their immediate family, except in the most unusual circumstance”. However, many doctors continue to provide health care to their families.¹⁻³ In a survey among physicians, minor prescribing was most commonly done compared to other types of treatment.⁷

Most research on this issue has focused on the extent of the problem rather than understanding reasons behind this phenomenon. Moreover, the majority of research has been conducted in the West, with different health care systems, family structures and dynamics. Therefore, we decided to conduct a qualitative study in a group of primary care practitioners in Malaysia to explore their experiences and reasons for treating their family members.

Materials and methods

This study was carried out at the Department of Primary Care Medicine, University of Malaya Medical Center, a primary care clinic based in a teaching government hospital. Twenty-two doctors gave written consent to participate in the focus group discussions (FGDs). We obtained ethical approval from the hospital's Medical Ethics Committee.

Based on our discussions and a literature review, we designed a semistructured interview guide for the FGDs in which we took turns to moderate and take notes. Participants were grouped according to their clinical experience and seniority to encourage free expression of opinion without feeling intimidated. Each session was audiotaped, transcribed in full and checked. The researchers analyzed the data independently by reading the transcripts repeatedly and looking actively for themes that emerged as discussions progressed. Data were coded and managed using the N6 software (NUD*IST 6.0; QSR International, Melbourne). Themes identified from earlier groups were presented to later groups for discussion.

Results

We conducted five FGDs with 22 participants (5 lecturers, 12 postgraduate trainees in the Masters in Family Medicine program and 5 medical officers). Their mean age was 36.1 years (range 30–52 years). The number of years from graduation ranged from 3–25 years (mean duration 10.6 years, median 8.5). The participants' demographic profile is shown in [Table 1](#).

Doctors treating family members

All the participants had treated their family members. The type, duration and severity of illness influenced their decisions. Most do not hesitate to treat acute self-limiting conditions such as upper respiratory tract infections. However, for care of chronic diseases, the majority referred their family members to other doctors. Most had no qualms about treating their children, especially for minor illnesses, but were cautious in treating spouses and parents. Almost all the participants had been consulted by relatives, formally or otherwise. The frequency varied from once in many months to very frequent for some, occurring almost weekly. Most obliged by providing explanations and suggestions rather than actual medical treatment, especially when consultations were done informally or through the telephone.

Difficulties faced by doctors when treating their families

Fear of missing serious conditions and proposing incorrect management

The fear of missing serious conditions or proposing incorrect management is real because consultations are usually carried out informally, often without adequate history-taking or examination. There is also a personal bias in not wanting bad things to happen to one's own family. The emotional tie between family members

makes it hard to be a physician and a concerned family member at the same time. Doctor S, a female lecturer remarked: *'I just cannot take the role as a doctor with my own father.'* Because of this, some doctors experience insecurity and anxiety about the clinical outcome. They fear that their relatives may seek another consultation elsewhere, thus questioning their professional abilities. They may be blamed if relatives don't get better, which may bring on family conflicts. Doctor D, who refuses to treat family members remarked: *'If you treat your relatives and let's say something goes wrong, then they will talk about it for three generations from now.'* (Female, medical officer.)

Family wants to 'cut the queue'

Due to hospital patient loads and waiting times, some people expect their physician relatives to abuse their access to hospital facilities, expecting better and faster services. These situations put the doctors in a dilemma. Doctor F commented: *'Because you are a doctor so they feel that you get things done quickly. I'm not the sort of person to cut queues because I think it is unfair for the other patients who have been waiting.'* (Female, medical officer.)

Confidentiality

Maintaining confidentiality is a challenge when other family members ask for details. The doctor may be perceived as hiding information from the family. One participant commented of her parents: *'They know I am seeing them and then they want to ask, and they expect that I tell them the problems of the extended family.'* (Doctor A, female, postgraduate trainee.)

Emotional involvement

It is difficult to remain objective in dealing with sensitive issues such as breaking bad news. Personal emotions may cloud clinical objectivity. A respondent remarked: *'Not feeling comfortable to explain thoroughly about the disease. Sometimes we try to hide what was supposed to be told. Like you've got a barrier, what the problem was, because we are afraid that she will maybe have cancer. Sometimes it's very difficult; like before I tell them maybe I will be crying first.'* (Doctor N, female, postgraduate trainee.)

Effect on personal life and family ties

The family may consult anytime, regardless of the doctor's schedule. This can affect the doctor's work and family life. Not entertaining the request would make them appear as uncaring. Doctor T said: *'I don't like them. I feel much burdened. I can't cope but at this moment they're better. They are not disturbing me. They know what's really my problem. I don't want to listen anymore but otherwise I feel very, very stressed.'* (Female, lecturer.)

There were some doctors who felt that family ties should not be taken advantage of. Some relatives would get in touch with them only if they wanted to seek medical advice. As one female lecturer revealed: *'My husband's family consults us a lot. And there are a whole lot of them we only hear of them if they're ill. That kind of irritates me.'* (Doctor U, female, lecturer.)

Why do doctors treat their families?

Responsibility and trust

Most of the participants oblige when faced with family requests because they feel that it is only natural for families wanting to consult their physician family members for advice. Some doctors considered it as a social and family obligation rather than a burden, especially if they were the only medical resource individuals in the family.

Access to medication and facilities

Some doctors pointed out that since they were working in a hospital, they had easy access to medication and were familiar with medical facilities. This also allowed them to collect prescriptions or arrange appointments to see specialists.

Ability to treat

Being primary care doctors, the participants felt they had the skills to help their families. Some doctors do so because they had difficulty finding suitable doctors to treat their families. They felt that they were in a better position to treat their families themselves because they were familiar with their medical problems and behavior.

Sense of pride

Some doctors felt good and proud in being able to provide medical treatment for their families. Doctor F said: *“We are quite happy treating others. If they have any problem and we cannot sort it out, we try to arrange for them to see and make sure that we do it.”* (Female, medical officer.)

Discussion

Our findings support previous reports that doctors do treat family members despite the various disadvantages. The respondents feel they have the skills and confidence to treat their families, in addition to fulfilling their social obligations. Their family members are comfortable with them, and some genuinely do not mind helping. This study highlighted the important issue that although some doctors were uncomfortable treating their families, they were pressured to do so. One possible explanation may be the socio-cultural milieu in Malaysia, where generally it is expected that family members help each other. It is also common for extended family members to maintain close ties. This is in contrast to family structures in some Western countries that stress the separateness of individuals rather than their interconnectedness.⁸ Furthermore, family hierarchy exerts an important role where younger members are expected to respect their elders and comply with their requests. Some doctors would jeopardize family relationships if they refused to treat senior family members.

From this study, we identified three interconnecting elements when doctors are confronted with treating families. First, doctors are expected to maintain both professional and family roles. While some manage quite well, there are others who feel it is challenging. Second, individual family members have their own health concerns and expectations. Naturally, they seek advice from people with whom they are familiar. Finally, there is the strength of relationship between the two parties. The delicate balance of these three elements determines whether doctors are able to perform their dual roles effectively without compromising their professionalism. If they are able to draw an appropriate boundary in the context of their professional roles and relationships, they are less likely to be trapped in awkward situations. They should highlight to their families the potential problems if they were to treat them. It would be appropriate to advise them to seek help from their regular doctor, or to recommend a suitable medical professional to look after them.

In reality, the potential danger in treating family members is that doctors may not know when to pull back and let another physician take over. It is important to come to terms with one's own feelings as well as to increase one's self-awareness about such an important issue.¹⁴

Are there any solutions for doctors who want to treat family members? La Puma and Priest suggested some questions for physicians to ask themselves before treating family members.⁵ These include: ‘Am I too close to probe my relative's intimate history and physical being and to cope with bearing bad news if need be?’ and ‘Am I willing to be accountable to my peers and to the public for this care?’⁵ Doctors should have adequate medical training to meet relatives' needs. They must be willing to examine their relatives' intimate history, perform complete physical examinations, assess signs and symptoms objectively, convey bad news and negotiate any family conflicts that may arise.^{3,5,15,16} Finally, it is important to set and to know one's own limits in providing care to family members.^{4,9}

Limitations

Participants were limited to those working in a public hospital-based primary care setting and their views may differ from those in the private sector. We were also aware of the possibility of interviewer bias. The researchers, who are also the lecturers in the department, may have influenced the group dynamics. Both the junior doctors and the lecturers may have been pressured to say the ‘right’ things.

Realizing this, we made a conscious effort to group the participants according to their seniority and, as far as possible, the researchers had used open-ended questions and adopted a non-judgmental approach during the FGDs.

Conclusion

This study highlighted the difficulties doctors face in treating their relatives. Despite feeling uncomfortable and pressured, they continued to carry out the doctor's role in their families. This could be attributed to many reasons, including unique family dynamics in the local Malaysian setting and a sense of family obligation. It is our hope that this study will help to sensitize and alert doctors as well other health professionals to the potential conflicts and consequences that may arise when treating their own relatives.

Summary of implications for GPs

Many doctors would have faced situations where they need to treat their own families. As primary care practitioners, we are equipped with the knowledge and skills to deal with most of the common medical conditions. However, it is important to realize that it is difficult for doctors to maintain dual roles. We should be prepared to say 'no' to our relatives and explain to them the conflicts between professionalism and family duties. If we were to decide to treat our families, we have to draw a boundary and know when to refer on.

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Table 1 Participants' sociodemographic characteristics

Variables	Frequency: n (%)
Mean age, years (range)	36.1 (30.0–52.0)
Gender	
Male	6 (27.3)
Female	16 (72.3)
Race	
Malay	7 (31.8)
Chinese	6 (27.3)
Indian	5 (22.7)
Others	4 (18.2)
Marital status	
Single	5 (22.7)
Married	17 (77.3)
Number of years of practice (years)	10.6 (3–25)
Position	
Medical officer	5 (22.7)
Postgraduate trainee	12 (54.5)
Lecturer	5 (22.7)

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