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ATTITUDES AND PRACTICES OF DOCTORS IN THE PRIVATE HEALTH CARE SECTOR IN GAUTENG TREATING THEIR OWN FAMILY MEMBERS

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A research report submitted to the faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree of Masters in Family Medicine

Johannesburg, 2010

DECLARATION

I, Sheri Philippa Fanaroff declare that this research report is my own work. It is being submitted for the degree of Masters of Family Medicine in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University.

This study has received ethical approval from the University of the Witwatersrand's Committee for Research on Human Subjects. The approval number is M020808.



Dr Sheri Philippa Fanaroff

Seventeenth Day of May 2010

DEDICATION

Dedicated to my husband, children and parents.

ACKNOWLEDGEMENTS

I wish to acknowledge the following people:

My supervisor, Dr Anne Wright, from the Department of Family Medicine, University of the Witwatersrand, for her ongoing advice, encouragement, eye for detail and wisdom.

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ABSTRACT

Objectives

The purpose of this study was to explore and compare doctors' attitudes and practices when treating their own family members.

Methods

It was a cross-sectional descriptive study conducted among doctors in private practice, who used Lancet laboratories, in Gauteng. Data was collected in 2003 by means of an anonymous self-administered questionnaire, distributed to 279 GPs and 276 specialists, who had been randomly selected from the Lancet laboratory database. Statistical analysis of the data was done using Epi-Info 2000 software.

Results

172 out of 555 questionnaires were returned, giving a response rate of 31%. The research group consisted of 54.1% (91) GPs, 44.7% (77) specialists and 1.2% (2) unmarked GP or specialist. The results showed the sociodemographic profile of the study population to have a wide age distribution, 77% (132) male, mostly married, 62% (91) White, with a mean of 2.4 children, seeing an average of 21 patients per day, residing predominantly in the North and Far North of Gauteng.

The study revealed that a large proportion of the respondents' family members asked for advice (>90%), sought treatment (>92%) and requested second opinions (>73%) from the doctors. Similarly, a large proportion of respondents performed physical examinations (>90%), diagnosed illness (>94%) and prescribed medication (>93%) to their families. Fewer respondents, but still noteworthy numbers, immunised, sutured, operated on and provided sick notes to relatives. 46% (78) of respondents acted as main care providers to their spouses and 53% (90) to their children, and a meaningful proportion were main care providers to more distant family members.

However, what was done in practice did not correlate with the attitudes of the doctors. 77% (134) of respondents agreed that doctors' families should have their own unrelated health care provider, and only 44% (74) of respondents thought that it was an advantage to treat their own families. 38% (65) of respondents indicated that they had refused a family members' request for care and 32% (55) had provided care

outside of their discipline; 38% (65) admitted to receiving a request that made them uncomfortable and 36% (61) perceived family members to be more demanding of their personal time.

Only 46% (56) of formal consultations and 28% (41) of ad hoc consultations with family members took place in the doctors' rooms and only 36% (46) of respondents always kept records when treating family members. Only 21% (26) of respondents billed family members for formal consultations and 11% (17) billed for ad hoc consultations. 30% (51) of respondents referred and 10% (16) investigated family members more often than other patients; 18% (30) referred and 29% (46) investigated family members less often. These results suggest a different standard of care for family members compared with other patients.

Conclusion

Respondents had ambivalent feelings towards treating their families, yet did so even though patient care may be compromised (informal setting, poor record keeping, loss of objectivity). Despite reporting sometimes feeling stressed and uncomfortable and that the care may not be ideal, doctors in private practice in Gauteng reported examining, diagnosing, treating and even operating on their relatives.

Most respondents felt that clarification of ethical guidelines would be helpful. The fact that a large amount of doctors do treat their families needs to be acknowledged and considered if more comprehensive policies and training are developed.

TABLE OF CONTENTS

Page

DECLARATION ii

DEDICATION iii

ACKNOWLEDGEMENTS iv

ABSTRACT v

TABLE OF CONTENTS vii

LIST OF FIGURES xi

LIST OF TABLES xii

ABBREVIATIONS xiv

APPENDICES xv

CHAPTER 1: INTRODUCTION 1

1.1 Background of the study 1

1.2 Aim and objectives 3

1.2.1 Aim 3

1.2.2 Objectives 3

CHAPTER 2: LITERATURE REVIEW 5

2.1 History of treatment of doctors' families 5

2.2 Codes and laws 6

2.2.1 Current policies 8

2.3 Professional courtesy 8

2.4 South African policies 10

2.5 Studies on physicians treating members of their own families 11

2.5.1 La Puma 11

2.5.2 Dusdieker 13

2.5.3 Furman 14

2.5.4 Richards 15

2.5.5 Nik-Sherina 16

2.5.6 Chen 17

2.5.7 Katz-Sidlow 18

2.6 Advantages and disadvantages of treating family members 18

2.6.1 Disadvantages....18
2.6.2 Advantages....25
2.7 Suggested recommendations for doctors treating family members....28
2.8 Conclusion....28

CHAPTER 3: METHODOLOGY....30
3.1 Materials and methods....30
3.1.1 Study design....30
3.1.2 Site....30
3.1.3 Study population....30
3.1.4 Sampling....30
3.2 Measuring tool....31
3.3 Pilot study....33
3.4 Data collection....34
3.5 Ethical issues....35
3.6 Methods of data analysis....35

CHAPTER 4: RESULTS....37
4.1 Response rate....37
4.2 Demographic data....37
4.2.1 Age....37
4.2.2 Sex....39
4.2.3 Marital status....40
4.2.4 Ethnicity....41
4.2.5 Type of speciality....41
4.2.6 Location of practice....43
4.2.7 Number of children....45
4.2.8 Doctors' households....46
4.2.9 Number of patients seen per day....47
4.2.10 Summary of demographics....48
4.3 Medical services requested from and provided to family members....49
4.3.1 Family members asking for medical advice....49
4.3.2 Family members who sought treatment....52
4.3.3 Family members who asked for second opinion....53
4.3.4 Family members on who doctors performed physical examinations 55
4.3.5 Family members in who doctors diagnosed illness....57

4.3.6 Family members for who doctors prescribed medication..... 59
4.3.7 Family members to who doctors administered immunisation.....60
4.3.8 Family members to who doctors administered CPR..... 62
4.3.9 Family members for who doctors sutured wounds.....63
4.3.10 Number of doctors who performed elective surgery and emergency surgery on family members.....65
4.3.11 Number of doctors who gave sick notes or medical certificates to family members 67
4.3.12 Summary table..... 68
4.4 Doctors as main care providers..... 69
4.5 Doctors' opinions on family members having their own health care providers..... 71
4.6 Place of consultation, recording-keeping and billing: comparison between doctors as usual medical carers and doctors giving 'ad hoc' consultations. 72
4.7 Rates of referring and investigating family members and non family member patients..... 76
4.8 Doctors' perceptions of whether their families received better care or worse care than patients who are not relatives.....76
4.9 Refusal of family members' requests.....77
4.10 Requests for medical care that made doctors uncomfortable.....78
4.11 Provision of care to family members out of the usual scope of practice..... 79
4.12 Perceptions of whether family members are more demanding of doctors' personal time.....81
4.13 Caring for own family advantageous or disadvantageous..... 81
4.14 Usefulness of ethical guidelines.....82
4.15 Other comments.....83
4.16 Regular care providers for *none of the* family members respond differently to several questions.....84

CHAPTER 5: DISCUSSION..... 85
5.1 Who is a family member?.....85
5.2 Sociodemographic profile.....86
5.3 Practices..... 86
5.3.1 Requests by family members..... 86
5.3.2 Doctors' treatment practices.....88
5.3.3 Place of consultation..... 90
5.3.4 Record keeping..... 91

5.3.5 Billing practices..... 92
5.3.6 Doctors as main care providers for family members..... 93
5.3.7 Referral of family members..... 95
5.3.8 Investigation of family members..... 97
5.3.9 Refusal of family members' requests..... 98
5.3.10 Provision of care outside of expertise..... 100
5.4 Attitudes..... 101
5.4.1 Attitudes to family members having their own health care providers..... 101
5.4.2 Doctors' perceptions of whether family members receive better care or worse care than patients who are not relatives..... 101
5.4.3 Requests for care that make doctors uncomfortable..... 102
5.4.4 Doctors' perceptions of whether family members are more demanding of their personal time..... 103
5.4.5 Doctors' perceptions of whether it is advantageous or disadvantageous to treat their own families..... 104
5.4.6 Perceptions regarding ethical guidelines..... 105
5.5 Limitations of research..... 106

CHAPTER 6: CONCLUSION..... 108
6.1 Conclusion..... 108
6.2 Recommendations of the study..... 111

REFERENCES..... 113

APPENDIX A – INFORMATION SHEET..... 119

APPENDIX B – QUESTIONNAIRE..... 120

APPENDIX C – ETHICS CLEARANCE CERTIFICATE..... 122

APPENDIX D – PROTOCOL APPROVAL..... 123

APPENDIX E – FURTHER EXAMPLES OF COMMENTS..... 124

LIST OF FIGURES

		Page
Figure 4.1	Family members asking for advice	50
Figure 4.2	Family members who sought treatment	52
Figure 4.3	Family members asking for second opinions	54
Figure 4.4	Family members on who doctors performed physical examinations	56
Figure 4.5	Family members in who doctors diagnosed illness	58
Figure 4.6	Family members for who doctors prescribed medication	59
Figure 4.7	Family members to who doctors administered immunisations	61
Figure 4.8	Family members to who doctors administered CPR	63
Figure 4.9	Family members for who doctors sutured wounds	64
Figure 4.10	Number of doctors who performed elective surgery on family	65
Figure 4.11	Number of doctors who performed emergency surgery on family	66
Figure 4.12	Number of doctors who gave sick notes or medical certificates to family members.	68
Figure 4.13	Doctors acting as main care providers to family members	70
Figure 4.14	Refusal of a family member's request for medical care or advice	78
Figure 4.15	Reception of a request for medical care from a family member that made doctors uncomfortable	79
Figure 4.16	Provision of medical care or advice to a family member that was out of doctor's discipline or not within the usual scope of practice	80
Figure 4.17	Doctors' perceptions of family member patients being more demanding of their personal time	81
Figure 4.18	Advantage or disadvantage for doctors to care for their own families	82
Figure 4.19	Doctors perceptions of usefulness of ethical guidelines regarding treatment of their own families	83

LIST OF TABLES

		Page
Table 4.1	Age distribution of all doctors	38
Table 4.2	Age distribution of GPs and specialists	38
Table 4.3	Sex	39
Table 4.4	Marital status of male and female doctors	40
Table 4.5	Marital status of GPs and specialists	40
Table 4.6	Ethnicity	41
Table 4.7	Specialities of specialist respondents	42
Table 4.8	Practice locations classified into regions	43
Table 4.9	The different work regions of doctors	44
Table 4.10	Number of children	45
Table 4.11	Family members living in doctors' households	46
Table 4.12	Ages of family living in household	47
Table 4.13	Number of patients seen per day	48
Table 4.14	Summary of demographics	49
Table 4.15	Family members asking for advice	50
Table 4.16	Family members who sought treatment	52
Table 4.17	Family members asking for second opinions	54
Table 4.18	Family members on who doctors performed physical examinations	56
Table 4.19	Family members in who doctors diagnosed illness	57
Table 4.20	Family members for who doctors prescribed medication	59
Table 4.21	Family members to who doctors administered immunisation	61
Table 4.22	Family members to who doctors administered CPR	62
Table 4.23	Family members for who doctors sutured wounds	63
Table 4.24	Number of doctors who performed elective surgery on family	65
Table 4.25	Number of doctors who performed emergency surgery on family	66
Table 4.26	Number of doctors who gave sick notes or medical certificates to family members	67
Table 4.27	Summary Table	69
Table 4.28	Doctor's family members should have their own health care provider	72
Table 4.29	Place of consultation	73
Table 4.30	Record keeping	74

Table 4.31 Billing..... 75
Table 4.32 Referral and investigation of family members (compared to patients who are not relatives)..... 76
Table 4.33 Perceptions of whether family member patients receive better care, worse care or the same care as non-relative patients 77

ABBREVIATIONS

AMA	American Medical Association
CBD	Central Business District
CPR	Cardiopulmonary resuscitation
ENT	Ear, Nose and throat surgeon
GP	General Practitioner
HPCSA	Health Professionals Council of South Africa
USA	United States of America
UTI	Urinary tract infection
Vs	versus

LIST OF APPENDICES

Page

Appendix A – Information Sheet..... 118

Appendix B – Questionnaire..... 119

Appendix C – Ethics Approval..... 121

Appendix D – Protocol Approval..... 122

Appendix E – Further examples of comments..... 123

CHAPTER 1
INTRODUCTION

The practice of physicians treating their own families has not been extensively researched. Specifically, there is little research and limited ethical guidelines in South Africa on how doctors should approach treatment of their own family members. The lack of guidelines results in individual practitioners deciding for themselves what is appropriate.

Before guidelines can be established it would first be necessary to understand current attitudes and practices of doctors towards treating their family members. Do doctors treat their own families or not? What types of services are requested and provided? Is the treatment of family members the same as that of non–relative patients? It is important to understand the emotional impact on doctors who treat their own families, and whether this practice is a source of stress.

1.1 Background of the study

While much has been written about the doctor as a patient[1], health practices of doctors themselves,[2] and the issue of 'Physician, Heal Thyself'[3,4,5], there is comparatively little published research on the practices of doctors treating their own families. In his book, 'Married to their careers: career and family dilemmas in doctors' lives', Gerber (1983) barely touches on the subject of doctors treating their own families, although he explores in depth the conflicts that doctors experience with their careers and their families.[6] He reports that some physicians see their role as caring for others while denying care for themselves and their families. He states that medical training continues to emphasize scientific knowledge, and that there is a lack of attention to the physician's personal and family needs. Work overload, high responsibility and time pressures affect the amount of energy and caring a physician has for his patients, his family and himself.

La Puma et al (1992) conducted research at the Lutheran General Hospital in Chicago, and published the first empirical data on doctors treating their own families.[7] This study determined which family members ask physicians

for advice, diagnosis or treatment, and how physicians respond to these requests. The researchers found that the services family members request and the services that physicians offer to their relatives are different. The study showed that doctors diagnosed serious illnesses, prescribed medications and performed major operations on family members. The physicians in the study reported some discomfort when treating their own family members, and reasons for this were explored. Doctors' responses from this study have been used as a basis for comparison in the discussion of this research report.

Furman (1992) did a survey of all practitioners on the Academy of Family Practice mailing list, South Africa, where he found that 90 to 94% of doctors sometimes or always treat their own family.[8] His survey found equally split opinions regarding whether doctors and their families get the same, better or worse care than other patients. Furman's article quotes Sparks, who stated in the 1989 Boz Fehler lecture, that the most fragmented health care occurs with doctors' families, and recommended that relatives of doctors consult their own separate GP. A study of Israeli family physicians (Rennert et al, 1990) revealed that 12% of doctors thought that their own families got better treatment than other patients, 31% thought that they received worse treatment and 57% felt that there was no difference.[9]

Professional courtesy is the provision of care without charge to physicians and their immediate families. The American Medical Association's first code of ethics, issued in 1847, noted that a physician is usually an incompetent judge of his own disease and of illness in family members.[10] The origins of professional courtesy will be fully explored in the literature review. This is relevant because most modern views of doctors treating their own families derive from the initial writings on professional courtesy.[11] The practice of professional courtesy removes the financial incentive for physicians to treat their own family members.

There are both advantages[12] and disadvantages[13,14,15] to the practice of doctors treating their relatives. This contributes to the dilemmas that doctors face when deciding whether to act on requests by family members for care. Advantages and disadvantages of doctors treating their own families will be fully explored in the literature review. This research investigated attitudes

and practices of doctors working in the private health care system in Gauteng, who use Lancet laboratories, to treating their own family members. Gauteng is one of the nine provinces in South Africa. Major cities within the province include Johannesburg and Pretoria, the latter being the country's capital. Lancet is the biggest service provider to the private health sector in Gauteng, with most doctors in private practice and some from the public sector, who also consult in private, being included on their database. Perhaps then some local recommendations can be developed, (based on international recommendations[16]) that will aid doctors in making decisions.

1.2 Aim and objectives

1.2.1 Aim

To determine the attitudes and practices of doctors in the private health care system in Gauteng to treating their own family members.

1.2.2. Objectives

1. To determine the demographics of doctors in the private sector in Gauteng with regard to age, sex, ethnicity, speciality and family structure.
2. To ascertain the extent to which doctors are requested to advise, to treat, or to give second opinions to family members.
3. To describe the specific types of care that doctors do provide to family members.
4. To analyse the differences between places of consultation, record keeping and billing when doctors are the usual carers for their families and when they perform 'ad hoc' consultations.
5. To determine whether doctors are comfortable with providing care to their own families and whether this care is within their expertise.
6. To determine whether doctors think that ethical guidelines regarding doctors treating their own families would be useful.
7. To explore significant differences in doctors' approaches to their families between doctors' different age groups, genders,

marital status, work areas, and family size, and between GPs and specialists.

CHAPTER 2
LITERATURE REVIEW

The literature was searched using keywords on Medline and Pubmed, and related articles were found. Journal articles were retrieved either online or from the library. Articles referenced in relevant articles were also searched for and retrieved. This chapter starts with a history of treatment of doctors' families, and then sets out codes and laws and current policies. Professional courtesy is explored in depth. The seven original research articles on doctor's treating their own families are discussed study by study, so that there is a clear outline of the few studies that have been conducted and their research settings. Finally, advantages and disadvantages are thematically explored, summarizing both the original and the anecdotal literature.

2.1 History of treatment of doctors' families

The earliest writings on the treatment of physicians' own families date back to the Hippocratic Oath 550BC, which reads in part *'I swear to reckon him who taught me the art equally dear to me as my parents, to share my substance with him and relieve his necessities as required; to look upon his offspring as on the same footing with my own brothers, and to teach them this art if they should wish to learn it without fear or stipulation'.* [11,17]

This has been interpreted to mean that in 'looking upon these offspring' a physician would not charge for medical care either.[11] From this would follow that there would be no need for a physician to treat his own family, as free care was available from other physicians. Thus, professional courtesy can be defined as providing free or discounted care to physicians and their immediate families.[18]

It was not until 1803, that Thomas Percival wrote a code of medical ethics for the Manchester Infirmary that spelled out the concept of professional courtesy.[17] Percival's code stated *"All members of the profession, including apothecaries as well as physicians and surgeons, together with their wives and children, should be attended gratuitously by any one or more of the*

faculty residing near them, whose assistance may be required. For as solicitude obscures the judgement, and is accompanied with timidity and irresolution, medical men, under the pressure of sickness, either as affecting themselves or their families, are peculiarly dependent upon each other. But visits should not be obtruded officiously; as such unasked civility may give rise to embarrassment, or interfere with that choice, on which confidence depends. Distant members of the faculty, when they request attendance, should be expected to defray the charges of travelling. And if their circumstances were affluent, a pecuniary acknowledgement should not be declined. For no obligation ought to be imposed, which the party would rather compensate than contract."

Unlike Hippocrates, who emphasized physician collegiality as the basis for professional courtesy, Percival worried that the physician treating family or self would render inferior care.[11] Percival believed that professional courtesy would remove a barrier that might dissuade physicians from seeking treatment and felt that professional courtesy would deter self care. Professional courtesy can be seen as an incentive for physicians not to treat their own families.

2.2. Codes and laws

Following the publications of Percival's code in 1803 with the first reference to professional courtesy, various states and cities in the United States published their own codes, which were almost verbatim replications of Percival's code.[11]

In 1847, the American Medical Association, at its first meeting, adopted a code of ethics based on Percival's treatise of professional courtesy.[11,17] It read: *"All practitioners of medicine, their wives, and their children while under the paternal care, are entitled to the gratuitous services of any one or more of the faculty residing near them whose assistance may be desired. A physician afflicted with disease is usually an incompetent judge of his own case, and the natural anxiety and solicitude which he experiences at the sickness of a wife, a child, or anyone who, by the ties of consanguinity, is rendered peculiarly dear to him, tend to obscure his judgement, 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. Visits ought not, however, to be obtruded officiously; as such-unmasked civility may rise to embarrassment, or interfere with that choice on which confidence depends. But, if a distant member of the faculty, whose circumstances are more affluent, requests attendance, and an honorarium be offered, it should not be declined; for no pecuniary obligation ought to be imposed, which the party receiving it would wish not to incur".

The AMA's code of ethics was revised in 1905, 1940 and 1949. By 1949, the provision addressing professional courtesy read: *"As a general rule, a physician should not attempt to treat members of his family or himself. Consequently, a physician should cheerfully and without recompense give his professional services to physicians or their dependents if they are in his vicinity".*[11]

The changes in attitude to professional courtesy are relevant because professional courtesy determines the context in which physicians' families receive their health care.[18] In 1977, the revised AMA code, read as follows (summarised):[17]

'1. *Where professional courtesy is offered by a physician, but the recipient of services insists upon payment, the physician need not be embarrassed to accept a fee for his services.*
2. *Where a physician or his dependents have medical insurance, a physician rendering service may accept the insurance benefits without violating the traditional ethical practice of professional courtesy.*
3. *Where services to a physician or his family are frequent or time-consuming, fees may be charged on an adjusted basis so as not to impose an unreasonable burden on the physician rendering services.*
4. *Professional courtesy should always be extended to the physician in financial hardship and members of his immediate family who are dependent upon him.'*

The Canadian Medical Association code of ethics from 1968 reads *'An ethical physician will provide medical services to a confrere and his dependant family without fee, unless specifically requested to render an account'.*[19]

The 1989 AMA code of ethics does not mention professional courtesy – the AMA removed the provision of professional courtesy from its by-laws as a *'visitorial anachronism'.*[11] The AMA has become less supportive of the practice.[18] Also, more academics have questioned the ethics of professional courtesy. By 1997, the AMA policy stated only that *'physicians should use their own judgement in deciding whether to waive or reduce their fees when treating fellow physicians or their families'.*[26]

2.2.1 Current Policies

The American College of Physicians Ethics Manual strongly discourages, but does not prohibit, physicians from treating family members, limiting this to necessary situations, and cautioning that the patient be transferred to another physician as soon as practical.[35]

The American Medical Association has a similar position regarding immediate family members; it adds that there are situations in which family members can provide routine care for short-term 'minor' problems, but does not cite any examples. The AMA specifies that doctors should only write prescriptions for controlled substances for immediate family members in emergencies.[35] The Canadian Medical Association says that treatment of family members should be limited to minor or emergency care, or instances when another physician is not available.[35]

2.3 Professional Courtesy

There are several surveys in the literature that explore physician's current practices and attitudes to professional courtesy and these reflect changes in medical practice over the years.

The 1964 survey by the Judicial Council of the American Medical Association found that more than 90% of physicians did not charge for services rendered to other physicians or dependents.[20] The exception was psychiatrists, 70% of who charged for long term care. A national survey was done in 1991 of AMA physicians in the USA.[18] This survey showed that over 90% of respondents in all of the specialties except psychiatry offered free or discounted care as a professional courtesy (49% usually at no charge, 75% usually billing only insurance company and 23% usually giving a partial discount).

The 1991 survey showed that the rate of providing professional courtesy had decreased between only 5 and 10 percent, which was surprising considering other dramatic changes in the practice and financing of medicine.

There is a lot written both in support of continuing professional courtesy and against it. This will be summarised briefly, only in so far as it affects doctors treating their own families. Disadvantages of not being able to pay for care include physicians being reluctant to ask for medical help 'because they are in the position of a beggar rather than a purchaser'[17] and they may feel that they are imposing on a busy colleague.[11] Also, the practice of professional courtesy may affect the doctor-patient relationship, as both may feel uncomfortable; there may be embarrassment, fear of imposing and reluctance to consult for minor complaints.[17,22] Freud was one of the first psychiatrists to discontinue professional courtesy, as psychoanalysis required a long time commitment and was extremely restrictive of the psychiatrists' earning capacity. Freud also insisted on paying normal fees to his surgeon and his internist when he had jaw cancer in 1930.[17,11] Psychiatrists opted to charge fees to physicians not only because of the economic effect of professional courtesy on their practice, but also because of the need for the tangible evidence of investment on the patient's part.[22] The doctor-patient must believe that he can get the care he needs and not be obligated for it; the attending physician also needs to believe that he can give the proper care without feeling over burdened or exploited.[22]

Some authors note that it is too expensive to offer professional courtesy, and comment that most physicians can afford to pay the bill.[17,21] Some

opponents to professional courtesy have noted that it may be unethical to bill only the insurance provider.[18,19] There is no financial reason for professional courtesy since almost all practicing physicians should be able easily to afford health insurance.[22] There are also ethical concerns regarding 'equal care should be provided to all patients and it is unethical for physicians to get special treatment'.[19]

Spock (1962) wrote that the inability of physicians to pay for consultations caused them to hesitate when asking for help and created a feeling of imposition 'at least as painful as the financial debt would have been'.[23] Physician patients who pay for care consult earlier for their families' problems and feel that they are getting their money's worth, without feeling that they are imposing.[22]

Lachs (1994) believes that the 'collegial facets of professional courtesy' should be observed (accommodating physicians' families into schedules, keeping in close contact with physician patients since they are in danger of self-treatment, and ensuring appropriate follow-up).[11] He believes that this will preserve an important medical tradition, so that physicians do not have to look after themselves and their own families. In support of professional courtesy, several physicians have commented that 'to be asked by one's colleague to treat his or her family is the greatest honour and privilege bestowed on a physician'.[24,25] Wassner (1994) writes that 'it clearly bespeaks the deepest trust and respect for the physician's skills and practice of medicine.'[25]

2.4 South African Policies

At the time that the questionnaires in this study were completed in May 2003, the latest ruling by the South African Medical and Dental Professional Board on doctors treating their own families read as follows: *'It is permissible for a practitioner to treat his or her immediate dependents, but it is not permissible for a practitioner to render accounts for services rendered to such dependents, except in the case of laboratory fees and material, for which it would be permissible to render an account'.* This policy had been resolved in September 1999, and in 2001, the Board resolved that *'material' also* included *'dispensary pharmaceuticals'*.[27]

In August 2003, the board reconfirmed the 1999 policy and also resolved that

i) It was not advisable for practitioners to treat their families in cases of serious illnesses;

ii) The matter of charging for services rendered to immediate family, should be viewed in the same light as treating any ordinary patient;

iii) In order for a practitioner treating immediate family to avoid being suspected of unfair financial gain or of abusing his or her rights, it was preferable for practitioners to rather request a colleague to oversee the treatment of his or her immediate family;

iv) This ruling be made known to the professions through the Medical News and Councils bulletin.

In October 2007, it was resolved that both of these previous policies be confirmed.

2.5 Studies on physicians treating members of their own families

There are very few studies published in the literature, highlighting the need for further research on this subject. Because there were only seven major studies found in the literature, it was felt to be necessary to explore them using a study by study approach. Five of the studies were descriptive cross-sectional analyses[7,28,8,2,3] and two were qualitative.[29,30] In this way, the research settings, different methodologies, results and quality of the studies could be set out, for ease of understanding of the discussion where results of these studies were compared. Common themes from these studies as well as other literature have been detailed in Section 2.6, under advantages and disadvantages.

2.5.1 La Puma et al[7]

A study was done by John La Puma et al in 1990, at the Lutheran General Hospital Centre for Clinical ethics, on practices of physicians treating members of their own families. Although the practice of physicians caring medically for their families is not new, and appears to be common, this was the 'first published empirical data on this subject'.[13] The study was published in 1991 and states

that 'stories have been told about physicians treating their own family members, but to the best of our knowledge, this practice has not been studied'.

This study used a self-administered questionnaire distributed to physicians on staff at a university-affiliated suburban community hospital. The questionnaire included only the following four demographic details: age, sex, primary professional role, and number of years in practice. Physicians were asked to indicate which of their family members had asked for advice, consultation, or a second opinion, the frequency of such requests, and their responses to them. Physicians were asked if they had ever diagnosed illness in family members, examined them, prescribed medication, performed surgery, administered CPR, or given immunisations. Physicians were asked if they had ever refused a specific request, and if they had acceded to a request that made them uncomfortable; the reasons behind this were explored.

The results of this study will be used as a basis for comparison in the discussion (Chapter Five). The study found that only 1% of respondents had never been asked for medical advice by a family member, 57% of doctors almost always gave advice to family members and 38% sometimes gave it. 83% had diagnosed illness and 72% had performed physical examinations on family members. The proportion of respondents who provided services to family members rose with respondent's age and number of years in practice. In general, physicians reported providing services to family members in proportion to how often they were asked. Respondents in primary care had performed significantly more services for family members than specialists.

The La Puma study reported that the services family members request and the services their physicians, who are family members, offer are different. They stated that family members may request care that requires a complete history and physical examination, facilities that are unavailable or unknown skills; this sometimes embarrasses and frustrates the physician relatives.

In La Puma's study, more than half of the respondents reported having refused a family member's request for diagnosis and treatment, and 22% reported having acceded to a request about which they felt uncomfortable. The most common reasons for refusing were that the clinical problem was not within the physician's area of expertise, and that examination and follow-up might be inadequate. Respondents who had acceded to requests that made them feel uncomfortable also cited the inadequacy of examination and follow-up, the absence of a medical indication for the request, and their own lack objectivity.

La Puma concludes that 'sound judgement is required on the part of a physician who treats a relative'. Adequacy of medical training, willingness to examine a relative's intimate history and perform a complete physical examination, the ability to assess signs and symptoms objectively, and one's ability to negotiate family conflicts should be considered. He states that whether family members will receive high-quality medical care from a relative doctor or whether they would be better off seeing somebody else depends on the judgment of the physician, the medical urgency of the case, and the availability of medical colleagues.

2.5.2 Dusdieker et al[28]

A study by Dusdieker et al was done in 1990 among staff at the University of Iowa Hospitals and Clinics who had children younger than 18 years. The objectives of this study were to determine the types of health care interventions physicians provided to their own children, to identify those conditions most often treated by physician-parents, to compare the differences in treatment practices among physician groups, and to explore the reasons physicians gave for treating their own children.

A self-administered questionnaire was completed by respondents. This included family demographics, types of illness treated, physical examination and laboratory assessment of the ill child before treatment, prescribing medications for own children, consultation with the child's physician, routine health maintenance assessments

by parent physicians, and reasons motivating physician parents to treat their own children.

The study found that 74% of physicians reported usually treating their own children for acute illness without fever (including colds, diarrhoea, vomiting, sore throats, sore muscles, headaches, earaches and abdominal pain). 88% of physicians reported that they usually consult their child's physician for advice during a febrile illness.

65% of physicians reported that they prescribed antibiotics or other prescription medications for their children and in 42% of episodes did not notify the child's physician of record. The most important reason cited by the majority of physicians for treating their own child was convenience (70%). Other reasons given were confidence in own skills (21%), concerns about quality of care (8%), concerns about confidentiality (4%) and cost (2%).

Dusdieker et al comment that their study suggests that physicians may be more likely to contact their child's physician only after the physician-parent's initial treatment plan had failed. They state that in a child with a minor illness, parental intervention is appropriate and a routine part of parenting, as even nonmedical parents often treat minor headaches, vomiting, diarrhoea and upper respiratory tract infections without consulting their child's physician.

They question whether physician-parents are able to perform the dual role of objective physician and emotionally involved parent while providing care to their own children. Their study suggests that physician-parents often prescribed medications, although physical examination or laboratory confirmation was lacking.

2.5.3 Furman[8]

Furman did a study of South African doctors' health seeking behaviour using a questionnaire mailed to doctors on the mailing list of the Academy of Family practice. This survey found that 22.6% of the 548 respondents always treated their own families, 71.5%

sometimes treated their own families and only 4.4% of respondents never treated their families. The survey revealed that 50% of doctors felt they were more likely to refer when treating another doctor and 52.6% were more likely to investigate another doctor. When doctors were asked if they thought that doctors and their families get the same care or worse care than other patients, 34.2% felt it was the same, 34.3% felt it was better and 31.5% thought it was worse.

Furman comments that in doctors and doctors' families who are patients, sensitive or personal investigations may be avoided, diagnostic procedures may be delayed (especially if painful or embarrassing), and decisions regarding follow-up and treatment may be left entirely up to the physician patient. Detailed instructions may not be given because of the assumption that the doctor-patient knows all the information. He also states that professional courtesy may interfere with the doctor-patient and his family receiving optimal care. The reasons for this include feelings of guilt about bothering the treating physician because the care is being provided as a favour, so that there are often delays in seeking appropriate medical attention both for the physician and the physicians' family.

2.5.4 Richards[2]

Richards conducted a study in New Zealand in 1998 amongst 500 practising New Zealand doctors randomly selected by computer from the New Zealand Medical Council. The study was done in order to gain knowledge of the quality of medical care which doctors and their families receive. The author states that it has been thought that doctors and their families receive poorer medical attention than the public, and that 'it is considered unwise for doctors to treat themselves or their families because of lack of objectivity'. The author felt that more instruction regarding self-care and the care of one's family should be introduced into the undergraduate medical curriculum.

66.9% of the 310 respondents said that their family had a family doctor, but only 22.5% said that their partner saw the family doctor for regular asymptomatic checks. Screening tests amongst doctors' spouses were low with only 29.5% of female wives or partners

having had a mammogram, 73.8% a pap smear and 71.6% a breast examination in the previous five years. 72.5% of male spouses or partners had never had a rectal examination and only 22.7% had had either a laboratory or digital test for prostate in the previous five years. While 65.6% of doctors had had a cholesterol examination, only 48.8% of their spouses had had one.

2.5.5 Nik - Sherina[29]

Nik–Sherina et al conducted a qualitative study among primary care practitioners in a teaching hospital in Malaysia in 2006 to explore doctors' experiences and feelings about treating their own family members. Focus group discussions were conducted among 22 primary care practitioners.

All the participants had treated their family members. The type, duration and severity of illness influenced their decision to treat. Most did 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. Most provided explanations and suggestions other than actual medical treatment, especially when consultations were done informally.

Difficulties faced by doctors when treating their families were explored. These included: fear of missing serious conditions and proposing incorrect management, family wanting to 'cut the queue' (expecting better and faster services), confidentiality; emotional involvement (personal emotions clouding emotional objectivity); and effect on personal life and family ties (family consulting outside working hours).

The reasons why doctors do treat their families were explored. These included: responsibility and trust (family obligation); easy access to medication and facilities; the ability to treat; and a sense

of pride. This study concluded that it is difficult for doctors to perform both professional and family roles, and that doctors may not know when to pull back and let another physician to take over. However, the participants felt that they had the skills and confidence to treat their families, in addition to fulfilling their social obligations.

2.5.6 Chen[30]

Chen et al conducted telephone interviews amongst eight senior family physicians that were chairs of academic family medicine departments in the USA in 2001. Their objective was to elucidate the difficulties family physicians have when a family member is a patient, and to elicit the underlying causes of the difficulties.

The eight participants selected all had a parent with a serious or terminal illness episode within the past five years. The author summarises four sets of competing expectations of the physician when a family member becomes ill in the following synopsis:

"Addressing physician family members' role expectations

Ideal family member

- What are my roles in my family?
- What aspects of these roles do I value most?
- How does my medical knowledge change my family role?

Expectations of family members

- What does my family ask of me as a physician?
- How do these requests make me feel?
- How do *I* behave in response to these requests?
- What would be the consequences of behaving differently?

Ideal physician

- What aspects of my professional identity do I value?
- How does my relationship with my family interact with my professional role?

Expectations of other physicians

- How do other physicians solicit my involvements?
- How do these solicitations make me feel?
- What would be the consequences of behaving differently?"

The authors found that all eight of the family members became involved in their parent's care. They state that while family member involvement may cloud critical thinking and sound judgement, the total commitment that a family member physician can provide to a patient may be worthwhile. They conclude that a 'tenable ethical code' is needed that acknowledges the value of the physician's emotional involvement in family member care.

2.5.7 Katz – Sidlow[31]

In a report entitled 'A look at the paediatrician as parent; experiences with the introduction of varicella vaccine' the authors state that 'little has been written about paediatrician–parents' behaviours in caring for their own children, and how these practices may differ from the behaviour that these same paediatricians apply in practice'. A mail survey was done in 2003 amongst members of the American Academy of Paediatrics to determine whether paediatricians' behaviours in parenting their own children differed from their recommendations for their patients. The study found that paediatricians who were parents had no 'double standard'. Most of those who recommended varicella vaccine for their patients had had their own children vaccinated.

2.6 Advantages and Disadvantages of treating family members

There is quite a lot in the literature about pros and cons of physicians treating family members, and several anecdotes of physicians' experiences.

2.6.1 Disadvantages

2.6.1.1 The Physician Patient Relationship

The College of physicians and surgeons of Ontario explain their policy of why physicians should not treat their family members.[31] The principle is that the physician-patient relationship can be compromised when there is a personal, emotional relationship beyond that of the doctor-patient relationship. *'A personal, non-professional relationship can affect many aspects of medical care. Whenever a physician treats someone with whom the physician has*

a personal relationship, there is a risk that the personal relationship will affect the physician's ability to provide good quality care. Treatment of a family member may also prevent the family member from developing a relationship with his own doctor'. The policy goes on to state that it is generally acceptable for physicians to provide episodic care for minor conditions because this is unlikely to give rise to a physician-patient relationship. It is also acceptable for physicians to treat family members in emergency situations because the benefits outweigh the challenges posed by the personal relationship.

When a physician has an emotional relationship with a patient, the physician's own needs and interests may undermine the physician's capacity to focus on the patient's best interests.[29] As a result, the physician may be more inclined to over-treat, or may not present all available treatment options to the patient. The physician may also be more inclined to accede to inappropriate patient requests, such as demands for medically unnecessary tests or habituating drugs.[34]

Because a clinical encounter with a family member is not a typical doctor-patient relationship, physicians may tend to ignore standard guidelines, such as respecting a patient's right to decide about treatment, informing the patient about the benefits and risks of treatment, telling patients the truth and respecting confidentiality.[35] A doctor might withhold the truth regarding a diagnosis from a parent, when he would be honest if the patient was not related to him.[35]

La Puma's data suggests that 'along with limiting their active participation, physicians tend to limit their emotional involvement in family members' care'.[7] He states that physicians recognize the emotional complexity of having dual roles and anticipate problems when there is a family relationship instead of a potentially therapeutic doctor-patient relationship.

Caution is also advised regarding creating a physician-patient relationship when the patient receiving treatment is someone with whom the physician is romantically or sexually involved.[32]

2.6.1.2 Intimacy

Yeo and Longhurst (1996) define professional intimacy as 'the physician's proper manner when intervening in patients' lives'.[33] They divide intimacy into intimacy of physical disclosure and contact (touching and seeing patients in ways that would be inappropriate for others), and intimacy of personal and emotional disclosure (including communications about the body and life situations).

A personal relationship can give rise to unconscious, preconceived notions about the patient's health and behaviour.[32] These preconceptions can affect quality of care, because family member physicians may not ask questions or seek information that could alter the diagnosis or care. Similarly, patients may leave out sensitive but important information when discussing their medical history, activities or symptoms. Physicians may find it difficult to ask family members sensitive questions about drug use, sexual practices or other highly personal issues; also patients may be uncomfortable disclosing this information to a relative.[35] For example, a doctor's teenage daughter may not honestly answer the question 'Are you sexually active'; a dishonest reply may lead to improper medical treatment.

Uneasiness may be caused by physical intimacy when a doctor needs to probe a family member's abdomen or axilla, or perform a rectal or vaginal examination. Performing a mental status examination for a close relative may be even more difficult.[35]

Intimacy creates vulnerability in the patient. Usually, intimacy and vulnerability are asymmetrical in the physician-patient relationship, with the physician in a position of superior knowledge and power, as patients usually do not know their physicians intimately.[33] When a physician is a family member, the dynamics are changed so that physician and patient are more on an equal footing.

2.6.1.3 Objectivity

Concerns about doctors' ability to remain objective date back to Hippocrates, as already discussed. Spock (1962) *'When a member*

of a physician's family develops a symptom, the physician is promptly involved in a conflict of feelings. He cannot, unless he is a most unusual person, detach himself emotionally, while he takes a history and does a physical examination. His natural anxiety tends to make him vacillate between exaggerating and minimizing the significance of the symptom....His unresolved doubts interfere with his laying out a clear plan of treatment'.[23] Dusdieker (1993) asks the question 'Are parent-physicians able to perform the dual role of objective physician and emotionally involved parent while providing care to their own children?' [28]

A close relationship between doctor and patient can cloud the doctor's professional objectivity and impact on their professional judgement. Rosenbaum (1992) describes how he attributed his son's abdominal discomfort to anxiety about a school examination – the abdominal pain turned out to be acute appendicitis.[15] Personal feelings and fears may compromise a physician's professional judgement, causing him either to over or under estimate the seriousness of the patient's condition.[34] The physician may then subject a patient to a series of unnecessary tests in order to exclude all possibility of disease.

With family members, the careful physician feels a great need for surety making him inclined to test too much and causing the 'Ulysses syndrome': expensive delays as investigations track false positive results.[16] The physician in the family may give too many medications, for too long and at maximum doses, thus provoking side effects and complications. Conversely the physician may be reluctant to face the possibility of serious illness in a family member and under investigate, for example he may be unwilling to consider a diagnosis of cancer in a spouse.[35] Doctors may also alter treatment plans to spare a hospital visit, or be less likely to recommend a painful invasive procedure.[35] The physician may also fail to recognize conditions that are outside his or her area of expertise.[32]

2.6.1.4 Confidentiality

According to both the declaration of Geneva that states 'I *will respect the secrets confided in me*', and to the new University of the Witwatersrand Hippocratic declaration that states '*I will not improperly divulge anything I have learned in my professional capacity*' [36], the physician should not reveal confidential issues even to an authoritative family member.

Confidentiality may be harder to maintain and may be at greater risk of being breached because of the physician's personal interest in the patient's well being, or because other family members insist on knowing what is going on.[32] The doctor may be perceived as hiding information from the family.[29] The pressure to reveal secrets that a patient has shared is increased when both the patient and the patients' family are close to the physician. The doctor may find himself the keeper of many family secrets.

Conversely, a physician may be more reluctant to make a mandatory report (e.g. of an impairment affecting the patient's ability to drive) when he has a personal relationship with the patient. Family members may not wish to share sensitive matters with other family members, and may wish to avoid having intimacies become common family knowledge.[16]

2.6.1.5 Informality

A consultation with a family member is often not a formal, structured consultation, but an 'ad hoc' one. When the patient is a relative, the informal nature of the situation may result in compromised care at any of the stages of the clinical encounter: history taking, physical examination, diagnosis, treatment and follow-up.[35] Medical histories are often incomplete or assumed. Physicians may omit or abbreviate physical exams performed on family members, not examine relatives far away or perform examinations without the proper instruments.[35] Physicians may fail to record their encounters, so there may be no documentation.[29] McSherry (1988) wrote a report on his experiences treating children of physician parents at a university.[13] His anecdotes suggest that parents often interfere in

their children's care, even from a distance. McSherry experienced that 'most children of doctors never have complete physical examinations and there is no single, complete source of medical records'.[13] McSherry describes what he calls the 'MD Parent Syndrome' where parents of university children maintain control of the health of their children, out of the realm of their expertise. He states that these children suffer from 'benign medical neglect or medical paranoia' and lack of autonomy even as adults. They don't discuss developmental issues with an uninvolved third party, and learn that medical care involves episodic consultation with a specialist.[13]

The consultation frequently takes place in the family member's or the doctor's own home, rather than a surgery, where often lighting is poor, equipment is unavailable, examination is not on a standardised bed and concerned relatives are hovering.[37] In the La Puma study, many parent-physicians omitted performing physical examinations and laboratory tests, even though they were treating their own children.[7] Dusdieker's results also show that parent-physicians often prescribed medications, although physical examination and laboratory confirmation were lacking.[28]

2.6.1.6 Out of expertise

The Medical Practitioners Board of Victoria believes that there are risks associated with physicians treating members of their own family.[38] They state that family members can sometimes exert pressure for treatment that is difficult to resist. This is particularly dangerous when the doctor is being asked for diagnosis and treatment outside the area of their expertise, or the requested treatment appears to be inappropriate.[38] If a request is significantly outside a physician's professional specialty area, the likelihood of a misdiagnosis or incorrect treatment increases.[35]

2.6.1.7 Responsibility

The physician's normal familial relationships may be affected when the physician has treated a family member, especially where there is a poor outcome. Rosenbaum (1992) wrote '*Physicians who treat*

members of their own families ignore the fact that we cannot be perfect; inevitably we will make errors. At times these mistakes may be serious, even fatal. It is difficult enough to live with these errors when patients are involved, how much more difficult it becomes when the patient is a member of one's own family'.[15]

Freeman (1991) wrote how he acted the role of the concerned but detached physician during his wife's illness, not permitting himself to feel sorrow or frustration while he coordinated her therapy. He writes of intense loneliness, anxiety and sadness and of how his personal needs were forgotten, until he ended up with a severe depression.[40]

Some doctors may experience insecurity and anxiety about the clinical outcome.[29] 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 conflict.[29]

2.6.1.8 Effect on personal life and family ties

The family may consult anytime, regardless of the doctor's schedule.[29] This can affect the doctor's work and family life. Not entertaining the request would make him appear as uncaring. Some relatives only get in touch with their family members if they want to seek medical advice, taking advantage of family ties.[29] Family member patients may cross boundaries, making excessive demands by frequent consultations, after- hour pressure and expecting immediate attention. The family member has unlimited access to the doctor at all hours, having private telephone numbers, including when the doctor is at a social event or on holiday.

2.6.1.9 Abuse

When the physician has an emotional relationship with a patient, he may be more inclined to accede to inappropriate patient requests, such as demands for habitual drugs.[32] Physicians who write prescriptions for addicted relatives may find it difficult to stop.[16]

2.6.1.10 Patient autonomy

When there is an underlying personal relationship between the physician and the patient, the physician's opinion may unduly influence the patient's decision; the decisions may then not be fully free and informed.[32] Physician-parents may maintain even their university aged children in 'a perpetual state of childhood dependency', enforcing parental control over their children's healthcare.[13] The patient may be reluctant to seek a second opinion or decline a recommendation for fear of offending the family member physician.[32]

2.6.1.11 Compliance

'Familiarity breeds non-compliance'.[16] Family members, especially those older than the physician relative, may doubt the abilities and methods of a physician they have known previously as a son, daughter, niece or nephew and may judge his orders not as independent, but swayed by previous experiences.[16] Also, care and advice that is given for free is usually perceived as less valuable than care that is paid for to non–related physicians.[17,19]

2.6.2 Advantages

2.6.2.1 McWhinney's Principles[12]

If one applies McWhinney's principles of family medicine (1997), it would seem that a family member physician is the ideal person to care for a close relative. The family member physician is fully committed to the patient, fully understands the context of the illness, shares the same habitat as the patient, sees the patient in his home, and has good insight into his relationships. What physician could be more able or willing than one's own family member to apply these principles?

a) Commitment

A physician is likely to be fully committed to his family member patient, rather than to the disease. He may also be an exceptionally caring available expert who is able to interpret medical language and help the patient manoeuvre through the medical system.[7] Personal investment in the patient's well-being can motivate a degree of attention to

detail and thoughtfulness that might otherwise be (sadly) lacking.[30] Chen (2001) states that this total commitment to the patient has been undervalued in the formulation of ethical guidelines.[30] A related physician's caring, promptness, loyalty and availability may sometimes outweigh an unrelated physician's expected objectivity and medical accuracy.[16]

b) Context of illness

A family member physician will usually understand the context within which the patient's illness has occurred, including the family dynamics, patient's occupation and community environment. Some doctors have reported feeling that they are in a better position to treat their families themselves because they are familiar with their medical problems and behaviour.[29]

c) Same habitat

McWhinney (1997) suggests that it is an advantage for the family physician to share the same habitat as his patients. The family member physician usually lives in the same household or community as his patient and is familiar with the patient's values and belief system, as well as patterns of health and disease.

d) Sees patients in their homes

The family member physician would usually see a relative where they present, including in their homes or in the hospital.

e) Insight into relationships

The family member physician is often close enough to have excellent insight into the patient's relationships.

f) Convenience

The patient may avoid the inconveniences of both time and travel by consulting the family member physician.[7] In one study, parent-physicians identified convenience as the most important reason for treating their own children.[28] Some doctors have pointed out that they are familiar with medical facilities and have easy access, allowing them to arrange appointments for their relatives to see specialists.[29]

2.6.2.2 Costs

By seeing a family member physician, patients save the fee that would be paid to another doctor. Bordin (1992) comments that the economic benefit can be substantial when a physician treats a family member.[44] The practice of professional courtesy which would remove this incentive is decreasing.[10,11] Dusdieker's study (1993) cited cost as the least important reason given by physicians to treat their own children.[28]

2.6.2.3 Responsibility and trust

Many doctors oblige when faced with family requests because they feel that it is only natural for families to want to consult their physician family members for advice.[29] Family members usually take responsibility to help each other, and the doctor in the family may simply be taking on his responsibility by caring for his family.[39] Some doctors in the Malaysian study (Nik Sherina et al, 2006) considered it as a social and family obligation rather than a burden, especially if they were the only medical resource individuals in the family.[29] Family members may trust their relative-doctor to intervene in their care if he disagrees with that person's care provider.[35]

2.6.2.4 Ability to treat

Many primary care doctors feel that they have the skills to help their families.[29] Minor problems in families may seem too trivial to trouble an unrelated doctor about.[7] Physicians want to be available to their families and they may feel obliged to offer their clinical expertise.[35] They may feel embarrassed when their family bothers a colleague for a simple problem.[27] In the Dusdieker study (1993), respondents ranked confidence in their own diagnostic and treatment skills as the second most important reason for treating their own children.[28] Doctors may feel compelled to become involved in the care of their family members, especially when errors are made.[30]

2.6.2.5 Sense of pride

Some doctors report feeling good and proud in being able to provide medical treatment to their families.[29] Doctors are accustomed to caring for patients and may consider attending to ill family members

to be 'a natural and rewarding opportunity'.[7] The related physician may feel honoured and proud to care for his family.[16]

2.6.2.6 Access to care

The family member doctor is ideally suited to ensure access to care, and can aid patients in manoeuvring through the health care system.[7,16] The family doctor is able to seek competent attention promptly.[17] Some studies suggest that the doctor-relative's best role in caring for his family is to remain as family advocate.[16,30]

2.7 Suggested recommendations for doctors treating family members

In an article entitled 'Is there a doctor in the house?' La Puma and Priest (1992) recommend that doctors ask themselves the following seven questions when asked to diagnose and treat their family members.[16]

1. Am I trained to meet my relatives' medical needs?
2. Am I too close to probe my relatives' intimate history and physical being, and to cope with the bearing of bad news if need be?
3. Can I be objective enough to not give too much, too little, or inappropriate care?
4. Is medical involvement likely to provoke or intensify intra familial conflicts?
5. Will my relatives comply more readily with medical care delivered by an unrelated physician?
6. Will I allow the physician to whom I refer my relative, to attend him or her?
7. Am I willing to be accountable to my peers and the public for this care?

2.8 Conclusion

Although there is a paucity of literature on this subject, all studies reveal that doctors do examine and treat their families, despite most existing policies cautioning against this. Advantages and disadvantages of this practice, as reported in the literature, were explored. Advantages include a

committed doctor familiar with the patient and the context, convenience, saving costs, ease of access to care, and the doctor's sense of pride in treating his family members. Disadvantages include a compromised physician-patient relationship, lack of objectivity, confidentiality issues, informality, treating out of area of expertise, poor patient compliance, and the effect on the doctor's personal life and family ties. It was expected that doctors in this study would have similar practices and attitudes to treating their families as doctors from other parts of the world. This study aims to explore practices and attitudes of doctors in the private sector in Gauteng to treating their own families, as there is almost no South African data on this topic.

CHAPTER 3
METHODOLOGY

3.1 Materials and Methods

3.1.1 Study design

A cross-sectional descriptive study was conducted.

3.1.2 Site

The study was carried out among doctors registered with Lancet laboratories and practicing in Gauteng. Gauteng, as defined by the Lancet list, includes all of Johannesburg, Pretoria, Alexandra, Soweto and Lenasia. This region was chosen because logistically, Lancet couriers have regular access to doctors in these practices.

3.1.3 Study population

All doctors (general practitioners and specialists) registered with Lancet laboratories in Gauteng formed the study population. This includes mostly doctors from the private sector. Even some doctors who predominantly use the other private laboratories, such as Ampath, still appear on the Lancet list. Doctors working in the public sector are usually not registered with this laboratory, unless they also have a private practice. From the original comprehensive Lancet list of doctors, the following were excluded:

a) Doctors practicing outside of Gauteng.

b) Allied medical professionals (including dentists, maxillofacial surgeons, homeopaths, podiatrists and physiotherapists).

c) Where a doctor was recorded as working from more than one location, only one listing was included on the final list.

Both generalists and specialists were included in the study, so that attitudes and practices could be compared between the groups.

3.1.4 Sampling

A sample of doctors was selected from the final Gauteng Lancet list. The 'final list' refers to the complete Lancet database, with the exclusion of those listed in 3.1.3.

The final Lancet list consisted of 5241 doctors, 60% of who were general practitioners (3141 doctors) and 40% of who were specialists (2100 doctors including anaesthetists, cardiologists, dermatologists, ENTs, gastro-enterologists, general surgeons, gynaecologists, cardiothoracic surgeons, neurologists, oncologists, neurosurgeons, ophthalmologists, orthopaedic surgeons, paediatricians, specialist physicians, plastic surgeons, psychiatrists, pulmonologists, radiologists, rheumatologists and urologists).

The expected frequency of doctors treating their own families was set at 80%. This was based on Furman's study where 90 to 94% of doctors treated their own family members[8] and La Puma's study where more than 80% of respondents prescribed medication and diagnosed illness in their family members.[7]

Based on a worst acceptable frequency of 72%, to obtain a 95% confidence level and a 0.05 level of significance, a sample size of 93 doctors was needed from the GP group and 92 doctors from the specialist group, as determined using the "statcalc" on EpiInfo. Thus, expecting a 33 percent return rate, 279 questionnaires were distributed to general practitioners and 276 questionnaires to specialists.

The sample was generated as follows: -
The Lancet list was stratified into two groups: general practitioners and specialists. Within each group, a random number was generated for each doctor on the list, using the Excel random number generator function. The random number and corresponding doctor were ordered from smallest to largest number. From a random starting point in each stratum (GP's or Specialists), every eleventh GP and every seventh specialist were included in the sample. Thus the sample consisted of:-

a) 279 general practitioners
b) 276 specialists

3.2 Measuring tool

The measuring instrument was a self–administered questionnaire completed by the doctors. This was constructed based on questions from Furman's study, some questions from the Chicago study (La Puma) and

some new questions. The questionnaire was constructed after discussion with colleagues and the wording was modified slightly after the pilot study in order to make it more comprehensible. The questionnaire appears in Appendix B.

The questionnaire consisted of questions which took approximately fifteen minutes for doctors to complete in the pilot study. Questions 1 to 10 aimed to collect demographic data about the doctors, including age, gender, whether GP or specialist, type of specialist, and work suburb. To get information on family structure, doctors were asked to list the number of children and other family members living in their household. The number of patients seen per day was asked in order to establish how busy doctors were. A question on ethnicity of doctors was included as it was expected that doctors from different cultures might have different experiences in treating their families.

Question 11 explored which family members had requested medical services from doctors and which services they had provided. Doctors were asked to indicate how frequently the services were requested or provided: never, occasionally or frequently. This question aimed to gather information on current practices of Gauteng doctors as no such data is currently available. It was also asked so that comparisons could be made between doctors in Gauteng and those in other studies, especially the Chicago study.[7]

Question 12 asked doctors to specify for which family members they are the main care provider. Question 13 explored the extent to which doctors agreed or disagreed that doctors' family members should have their own independent GP or specialist. None of the studies in the literature asked these questions directly. However, Richards found that only 66% of respondents claimed a separate doctor for their families.[2] Dusdieker reported that 95% of paediatrician parents in his study stated that a non-parent was the physician of record.[28] La Puma found that 15% respondents had attended a family member as primary physician in the hospital.[7]

Questions 14 to 16 aimed to explore whether doctors had a different approach to treating their own family members as opposed to other

patients, with regards to place of consultation, record keeping, billing, referrals and investigations. Distinction was made between consultations where the doctor was the main health care provider and where there were 'ad hoc' consultations. It was expected that doctors might have different practices when treating relatives and non-relatives, and also different practices for casual and formal consultations. McSherry and Dusdieker both recorded poor record keeping when doctors treat family members.[13,28] Several authors debate billing practices of doctors' families.[7,14,42] La Puma and others reported differing practices of referral and investigation amongst family member patients.[7,8,28]

Question 17 examined doctors' perceptions of the medical care that their own family members received compared with other patients. In Furman's survey, respondents opinions were equally divided whether they thought doctors received the same, worse or better care than other patients.[8]

Questions 18 to 22 aimed to explore doctor's feelings and attitudes towards treating family members. Doctors in several studies in the literature expressed discomfort when family members requested care.[7,29,30]

Question 23 enquires whether doctors would find it useful to have ethical guidelines on this topic. La Puma and Priest have suggested a set of ethical questions to assist doctors in making decisions when treating their families.[16]

Question 24 allowed doctors to make any other relevant comments.

3.3 Pilot Study

A pilot study was conducted in January 2003 among 18 doctors attending their first year of the Masters course in the Family Medicine Department, University of the Witwatersrand. Doctors of varying age groups, both sexes and different ethnic groups formed the pilot study group. All these doctors were GPs; there were no specialists.

After discussion with doctors in the pilot study and analysis of the questionnaires filled in, certain questions in the final questionnaire were

modified (only slightly by altering wording) in order to make them more comprehensible and understandable to the respondents. The questionnaires used in the pilot study were not included in the final data analysis.

3.4 Data Collection

Questionnaires were distributed and collected with the help of Lancet laboratories in May 2003. The 555 filled A4 envelopes were sorted in the Lancet collections department into the appropriate route lists. Each courier was responsible for delivering and collecting to and from doctors on their route.

The names and the addresses of the doctors in the study population were printed onto the A4 envelopes. Each envelope contained an information sheet (Appendix A), the two-page questionnaire (Appendix B), and an empty A5 envelope addressed to Mr Sean De La Peyre of the Lancet collections department. The A5 envelopes were not marked with doctors' names. Completed questionnaires were placed in these envelopes to ensure anonymity and confidentiality.

Information sheets and questionnaires were printed on yellow paper in order to maximise visibility on the doctors' desks. The information sheet introduced the researcher and the topic, explained that the questionnaires would be anonymous and confidential, stated how research subjects were selected and invited doctors to participate in the study. The information sheet also explained how the questionnaires would be collected.

Lancet couriers delivered the envelopes to doctors' practices and signed a delivery slip, as they usually do when dropping results and collecting specimens. Once doctors had completed the questionnaires, they placed them in the A5 envelopes. Couriers collected these envelopes and signed collection slips. If doctors chose not to participate in the study, the blank questionnaires were still collected in the A5 envelopes.

In this way, the researcher could tell which doctors had not yet returned the envelopes, although individual questionnaires could not be traced to

particular doctors. Doctors who had not returned questionnaires after two weeks were phoned by the researcher inviting them again to participate in the study. In cases where envelopes were unable to be delivered (for example, where the doctor was unknown or had moved), doctors were replaced with the next doctor on the Lancet list, so that the sample size remained at 555.

Every effort was made to boost the response rate. Thus questionnaires were delivered and collected rather than posted, and couriers signed collection slips. Non-responders were phoned after two weeks, reminding them to return questionnaires; however this did not result in many more returns. All envelopes were collected by Shaun De La Peyre of the Lancet Collections department and returned to the researcher.

3.5 Ethical Issues

Ethical approval for this study was obtained from the committee for Research on Human Subjects, University of the Witwatersrand (See Appendix C). The clearance number is M02-08-08.

An information sheet (Appendix A) was attached to each questionnaire to inform potential participants about the study and enable them to decide whether or not to participate. It was stressed that the return envelopes were unmarked so that respondents were not identifiable to the researcher. In this way, confidentiality and anonymity of participants was maintained.

Lancet laboratories did not have access to the data; their role was only in distributing and collecting the questionnaires. It is the intention of the researcher to make results of the research available to all doctors within the sample.

3.6 Methods of data analysis

The data obtained from this study was processed and analyzed by computer using Epi Info 2000. Statistical analysis was done in consultation with a Medical Research Council statistician.

Data was entered with the aid of Epi Info 2000. Data was analysed on Epi Info using the Analysis program. Descriptive statistics were used to analyse the data. Percentages and frequencies were calculated. Associations between variables were studied using cross-tabulations. Comparisons were made between different Sociodemographic groups, including between male and female doctors, older and younger doctors, general practitioners and specialists, and ethnic groups.

Testing of associations was done using chi-squared and fisher's exact tests. Testing was done at a 5% level of significance ($p<0.05$).

For the purpose of reporting on comments, a thematic analysis was done by the researcher. There was no validation by a second reviewer. Major themes were noted and comments were grouped under headings.

CHAPTER 4
RESULTS

This chapter is very detailed and the results have been presented in their entirety as all results are relevant to the discussion and there are many significant results. Demographic data is presented first, followed by results of respondents' treatment practices and attitudes. Significant results have been analysed under each section.

4.1 Response rate

Of the 555 questionnaires that were distributed, 172 questionnaires were returned, giving a response rate of 31%. 276 questionnaires were distributed to specialists, of which 24.5% (77) were returned. 279 questionnaires were distributed to general practitioners of which 33.7% (93) were returned. Two of the respondents did not indicate whether they were GP's or specialists. Thus the final research group consisted of 44.7% (77) specialists, 54.1% (93) general practitioners and 1.2% (2) unknown.

Every effort was made to boost the response rate, as described in Section 3.6; however this did not result in many more returns (only 24 extra questionnaires received after phone calls). 37 questionnaires were returned completely blank, and these were counted as non-responders.

4.2 Demographic data

4.2.1 Age

The mean age of the 169 respondents was 48 years (SD=12.7), with a range of 27 to 81 years. The age distribution of all doctors is shown in Table 4.1. 88.7% (150) of respondents were between 30 and 69 years old, with 33.1% (56) between 40 and 49 years old.

Table 4.1 Age distribution of all doctors

Age Range	Total Frequency (n=169)	Total %	Total Cumulative %
20-29	7	4.1	4.1
30-39	39	23.1	27.2
40-49	56	33.1	60.4
50-59	34	20.1	80.5
60-69	21	12.4	92.9
70-79	11	6.5	99.4
80-89	1	0.6	100.0
TOTAL	**169.0**	**100.0**	

The age distribution of GPs and specialists is shown in Table 4.2. The mean age of GPs was 46.4 years (SD=13.3) and the specialist group was slightly older with a mean age of 50.3 years (SD=11.4) [p=0.03]. The modal age range for GPs was 30 to 39 years. The specialists were slightly older, with the modal age range being 40 to 49 years.

Table 4.2 Age distribution of GPs and specialists

Age Range	GP Frequency (n=93)	GP %	GP Cumulative %	Specialist Frequency (n=75)	Specialist %	Specialist Cumulative %
20-29	6	6.5	6.5	0	0.0	0.0
30-39	30	32.3	38.7	9	12.0	12.0
40-49	21	22.6	61.3	35	46.7	58.7
50-59	20	21.5	82.8	14	18.7	77.3
60-69	10	10.8	93.5	11	14.7	92.0
70-79	5	5.4	98.9	6	8.0	100.0
80-89	1	1.1	100.0	0	0.0	100.0
TOTAL	**93**	**100.0**		**75**	**100.0**	

For the purpose of analysis, respondents were divided into three groups according to their age:

Young	(< 40 years)	27.2% (46)
Middle-aged	(40 -59 years)	53.3% (90)

Old (> 60 Years) 19.5% (33)

Male doctors were significantly older than female doctors (p=0.006), with 94% (31) doctors in the old age group being male. GPs were significantly younger than specialists (p=0.0005) with 80% (36) young doctors being GP's, 45% (41) middle aged doctors being GP's and 48.5% (16) old doctors being GP's. Middle-aged and old doctors were significantly more likely to have larger families i.e. three or more children (p=0.000). 76% (25) old doctors and 54% (48) middle-aged doctors had large families, versus only 6.5% (3) of young doctors. *No* young doctors had more than three children, representing a modern trend towards smaller families, or families not yet completed.

Young and middle-aged doctors were significantly more likely to have children living in their households than old doctors (p=0.000). There were significant differences between age of doctors and how many patients they saw. 72% (65) middle-aged doctors saw more than 20 patients per day, while only 54% (25) young doctors and 30% (10) old doctors saw this large amount (p=0.0001).

4.2.2 Sex

The sex distribution of respondents is shown in Table 4.3.

Table 4.3 Sex

Gender	Frequency of all doctors	%	Frequency of GPs	%	Frequency of specialists	%
Female	40	23.3	30	32.3	10	13.0
Male	132	76.7	63	67.7	67	87.0
Total	172	100.0	93	100.0	77	100.0

23.3% (40) of the 172 respondents were female and 76.7% (132) were male. 32.3% (30) of GPs were female, while only 12.9% (10) of specialists were female. The sex difference between GPs and specialists was statistically significant (p=0.002).

4.2.3 Marital status

Table 4.4 depicts the frequencies of the respondents' marital status.

Table 4.4 Marital status of male and female doctors

Marital Status	Frequency all doctors (n=172)	% all doctors	Frequency female doctors (n=40)	% female doctors	Frequency male doctors (n=132)	% male doctors
Divorced	10	5.8	5	12.5	5	3.8
Married	151	88.3	34	85.0	117	89.3
Single	7	4.1	1	2.5	6	4.6
Widowed	3	1.8	0	0.0	3	2.3
Total	171	100.0	40	100.0	131	100.0

As can be seen from Table 4.4, most respondents were married (88.3%; 151). 5.8% (10) of doctors were divorced and 4.1% (7) were single. Marital status amongst male and female doctors was similar (p=0.15), except that 12.5% (5) of female doctors were divorced, while only 3.8% (5) of male doctors were divorced.

Table 4.5 depicts the marital status of GPs and specialists. The difference in marital status of GPs and specialists was statistically significant (p=0.03).

Table 4.5 Marital status of GPs and specialists

Marital Status	GP Frequency (n=93)	GP %	Specialist Frequency (n=77)	Specialist %
Divorced	8	8.7	1	1.3
Married	79	85.9	71	92.2
Single	5	5.4	2	2.6
Widowed	0	0.0	3	3.9
Total	92	100.0	77	100.0

92% (71) of specialists and 85.9% (79) of GPs were married. Only 1.3% (1) of specialists was divorced, while 8.7% of GPs (8) were divorced. Married doctors were significantly more likely to have spouses (p=0.000) and children (p=0.000) living in their households.

4.2.4 Ethnicity

Doctors were asked to state their ethnicity. It was expected that there might be differences in attitudes and practices towards family amongst different ethnic groups. 85.4% (147) respondents completed this question. The ethnic distribution of doctors is shown in Table 4.6.

Table 4.6 Ethnicity

Ethnicity	Frequency	%	GP Frequency	%	Specialist Frequency	%
White	91	61.9	42	51.9	47	73.4
Black	30	20.4	21	25.9	9	14.1
Indian	20	13.6	13	16.0	7	10.9
Other	6	4.1	5	6.2	1	1.6
Total	147	100.0	81	100.0	64	100.0

Of the 147 respondents who answered the question, 61.9% (91) were White and 20.4% (30) were Black. 51.9% (42) of GPs were White, whereas 73.4% (47) of specialists were White. 41.9% (34) of GPs were Black or Indian, while only 25% (16) of specialists were Black or Indian. 'Other' doctors could have been Asian or Coloured. Ethnic differences were statistically significant between GPs and specialists to a p-value of 0.049. Indian doctors were significantly more likely to have parents living in their households (p=0.003). Indian and 'other' doctors were significantly more likely to have parents in law living in their households (p=0.002).

4.2.5 Type of speciality

54.7% (93) respondents were GPs and 45.3% (77) were specialists. Twenty different specialities were listed by the 77 specialists who

responded to this question. 3.2% (3) GPs filled in their specialty as Family Physicians, but they were classified as GPs for the purpose of analysis, so have been excluded from this list. Table 4.7 depicts the distribution of specialists in the different specialities.

Table 4.7 Specialities of specialist respondents

Speciality	Frequency (n=77)	%
Allergy	1	1.3
Anaesthetist	2	2.6
Cardiologist	3	3.9
Dermatologist	3	3.9
ENT	8	10.5
Gastroenterologist	2	2.6
Gynaecologist	12	15.8
Haematologist	2	2.6
Nephrologist	1	1.3
Oncologist	2	2.6
Ophthalmologist	6	7.9
Orthopaedic surgeon	7	9.2
Paediatrician	6	7.9
Pathologist	1	1.3
Physician	9	11.8
Psychiatrist	2	2.6
Pulmonologist	1	1.3
Rheumatologist	1	1.3
Surgeon	4	5.3
Urologist	3	3.9
Total	76	100.0

The largest group of specialists was gynaecologists at 15.8% (12). There were also a relatively large number of physicians at 11.8% (9), ENTs at 10.5% (8) and orthopaedic surgeons at 9.2% (7). Other specialties were not as well represented amongst the respondents.

4.2.6 Location of practice

Respondents were asked to state the suburb in which they worked. 91.3% (157) doctors completed this question. For practical purposes, the different work areas have been grouped into six regions. Areas which are close to one another have been grouped under the same region. For the purposes of this classification; 'North' is defined as Northern suburbs of Johannesburg, including Randburg, Sandton and Alexandra township; 'Far North' consists of areas north of Johannesburg, including Midrand, Pretoria and surrounds; 'Central' consists of Johannesburg CBD and immediate surrounds; 'South' consists of areas south of the Southern Bypass; 'East' consists of areas east of the Eastern Bypass, including the East Rand; and 'West consists of areas west of the Western Bypass, including the West Rand. The different practice locations of respondents are shown in Table 4.8.

Table 4.8 Practice locations classified into regions

Region	Areas included
North	Alexandra, Bagleystone, Bedfordview, Blairgowrie, Bramley, Bryanston, Craighall Park, Cyrildene, Fairlands, Fourways, Glenhazel, Greenside, Houghton, Hyde Park, Illovo, Inanda, Linksfield, Melrose, Morngside, Northriding, Parkhurst, Parktown, Parktown North, Randburg, Riviera, Rosebank, Sandton, Savoy, Sydenham
Far North	Arcadia, Brits, Brooklyn, Centurion, Faerie Glen, Groenkloof, Hatfield, Meckleneuk, Moreleta Park, Pierre van Ryneveld,Pretoria, Pretoria West, Shoshanguve, Waterkloof.
Central	Auckland Park, Brixton, City Centre, Fordsburg, Hillbrow, Johannesburg, CBD, Kensington, Mayfair, Newtown,

	Observatory, Turfontein.
South	Diepkloof, Lenasia, Soweto, Winchester Hills.
East	Benoni, Boksburg, Daveyton, Duduza, Dunvegan, Edenvale, Homestead, Isando, Kempton Park, Primrose, Springs.
West	Constantia Kloof, Floracliffe, Florida, Honeydew, Krugersdorp, Noordheuwel, Radiokop, Randfontein, Roodepoort, Strubens Valley, WestRand.

The frequency of doctors working in different regions is shown in Table 4.9.

Table 4.9 The different work regions of doctors

Region	Total Frequency (n=172)	Total %	GP Frequency (n=93)	GP %	Specialist Frequency (n=77)	Specialist %
North	65	41.4	27	31.8	37	52.9
South	9	5.7	6	7.1	3	4.3
East	19	12.1	14	16.5	5	7.1
West	14	8.9	9	10.6	5	7.1
Far North	28	17.8	12	14.1	15	21.4
Central	22	14.0	17	20.0	5	7.1
Total	157	100	85	100.0	70.0	100.0

Of the 157 respondents, the majority of doctors (41.4%; 65) resided in the North, with a larger percentage of specialists (52.9%; 37) than GPs (31.8%; 27) living in this region (p=0.01). Most of the specialists (74.3%; 52) resided in the North or Far North, based around the major academic centres. The GPs were more equally distributed amongst all regions, with 40.7% (64) in Central areas, South, East and West. 75.9% (41) of the 54 doctors working in the North were White and 84.6% (11) of the 13 doctors working in the West were

White (p=0.002). 47.7% (41) of the 86 White doctors worked in the North. Black, Indian and other doctors were more evenly distributed amongst the other work regions. Doctors working in the South were significantly more likely to have parents living in their households than doctors in other areas (p=0.000).

4.2.7 Number of children

It was expected that doctors with larger families might treat their own family members more often than doctors with smaller families. The difference in the number of children that respondents had is shown in Table 4.10.

Table 4.10 Number of children

Number of children	Total Frequency	%	Cum %	GP Frequency	%	Cum %	Specialist Frequency	%	Cum %
0	14	8.1	8.1	9	9.7	9.7	5	6.5	6.5
1	22	12.8	20.9	17	18.3	28.0	5	6.5	13.0
2	58	33.7	54.7	33	35.5	63.4	24	31.2	44.2
3	45	26.2	80.8	19	20.4	83.9	25	32.5	76.6
4	25	14.5	95.3	11	11.8	95.7	14	18.2	94.8
5	5	2.9	98.3	3	3.2	98.9	2	2.6	97.4
6	2	1.2	99.4	1	1.1	100.0	1	1.3	98.7
8	1	0.6	100.0	0	0.0	100.0	1	1.3	100.0
Total	172.0	100.0		93.0	100.0		77	100	

86.7% (150) of the 172 respondents had between 1 and 4 children, with 33.7% (58) having two children. The mean number of children was 2.43 (SD=1.3). For the purpose of analysis, family size was divided into small families (two or less children) and large families (three or more children). 54.7% (94) of the 172 respondents had small families and 45.3% (78) had large families.

Middle-aged and old doctors were significantly more likely to have larger families than younger doctors (p=0.000). Male doctors had significantly larger families than female doctors (p=0.013) i.e. 70%

(28) females and 50% (n=66) males had small families. Female doctors had a mean number of 1.9 children and male doctors had a mean number of 2.6 children. Specialists had significantly larger families than GP's (p=0.006). Specialists had a median of 3 children (mean=2.7) and GPs had a median of 2 children (mean=2.4). Married doctors had significantly larger families than unmarried doctors (p=0.000) i.e. 82% (124) married doctors and only 5.7% (12) unmarried doctors had large families.

4.2.8 Doctors' households

Doctors were asked to state which family members lived in their households and to state the ages of these family members. It was expected that doctors would be more involved in the medical care of family who lived with them than those living apart. Doctors were asked to tick next to the family member if they lived in their households; thus ticks were coded as 'yes' and blanks were coded as 'no'. Table 4.11 depicts the frequencies of various family members who lived in respondent's households.

Table 4.11 Family members living in doctors' households

Household	Spouse Frequency	%	Parents Frequency	%	Parents in law Frequency	%	Children Frequency	%	Other Frequency	%
Yes	152	88.4	8	4.7	6	3.5	127	73.8	23	13.4
No	20	11.6	164	95.3	166	96.5	45	26.2	149	86.6
Total	172	100	172	100	172	100.0	172	100.0	172	100

The majority of doctors (88.4%, 152) had a spouse living in the household, and 73.8% (127) had children living with them. Only 8.2% (14) of doctors had parents or parent's in-law living with them. 13.4% (23) doctors stated that 'other' family members lived in the household. 'Other' included brothers or sisters (14), cousins (1), domestic workers (11), grandchildren (5), life partner (1), and sister in-law (1). The mean ages and age ranges of family members who live in doctors' households is shown in Table 4.12.

Table 4.12 Ages of family living in household

	Spouse	Parents	Parents-in-law	Children
Lowest age	23	51	59	1
Highest age	73	80	83	40
Mean age	44.4	62.5	70.1	12.6

78% (119) married doctors had children living in their households, compared with 38.1% (8) unmarried doctors (p=0.000). When doctors' children lived in their households, doctors were more likely to be their main care provider i.e.61.9% (78) were main care providers when children lived at home, versus 27.3% (12) when they did not. This was significant with a p value of 0.000.

When doctors' parents lived in their households, doctors were significantly more likely to be their main care provider i.e.75% (6) respondents were main care providers when parents lived at home, compared with 18.5% (30) when they did not. (Fisher's exact p=0.001). When doctors' parents in law lived in their households, doctors were significantly more likely to be their main care providers i.e.50% (3) when parents in law lived at home versus 9.8% (16) when they did not. (Fisher's exact p=0.019).

4.2.9 Number of patients seen per day

It was expected that doctors who were busier at work i.e. saw a larger number of patients, would have less time to spend on their family's health problems. The mean number of patients seen by respondents per day was 21.2 (SD=11.4). For the purpose of analysis, respondents were divided into 2 groups:

- 'Quiet' doctors saw less than 20 patients per day- 41.9% (72) respondents.
- 'Busy' doctors saw 20 or more patients per day- 58.1% (100) respondents

(It is acknowledged that doctors who saw fewer patients may have spent longer with their patients or had more complicated cases,

specifically the specialist group.) The number of patients seen by doctors is shown in Table 4.13.

Table 4.13 Number of patients seen per day

Number of Patients	Total Frequency (n=172)	Total %	Total Cum %	GP Frequency (n=93)	GP %	GP Cum %	Specialist Frequency (n=77)	Specialist %	Specialist Cum %
0-9	11	6.6	6.6	2	2.2	2.2	9	12.3	12.3
10-19	61	36.7	43.4	31	34.1	36.3	28	38.4	50.7
20-29	50	30.1	73.5	30	33.0	69.2	20	27.4	78.1
30-39	29	17.5	91.0	16	17.6	86.8	13	17.8	95.9
40-49	10	6.0	97.0	8	8.8	95.6	2	2.7	98.6
50-59	2	1.2	98.2	2	2.2	97.8	0	0.0	98.6
60-69	3	1.8	100.0	2	2.2	100.0	1	1.4	100.0
70+	0	0.0	100.0	0	0.0	100.0	0	0.0	100.0
TOTAL	166.0	100.0		91.0	100.0		73	100	

The majority, 66.8% (112) of all respondents, saw between 10 and 29 patients per day, with 91% (161) seeing less than 49 patients per day. Middle aged doctors were significantly more likely to be busy i.e.72.2% (65), compared with 54.3% (25) of young doctors and only 30.3% (10) of old doctors (p=0.0001). The mean number of patients seen by female respondents was 19.3. This was only slightly lower than the mean seen by male respondents, which was 21.8 (p=0.9).

Only 4.1% (3) of specialists saw more than 40 patients per day, while 9% (15) of GPs saw this large number. GP's were significantly more likely to be busy than specialists (p=0.050) i.e. 65% (60) GPs were busy, compared to only 52% (40) specialists. GPs saw a mean number of 23.2 patients per day (SD=7.3), while specialists saw a mean of 18.9 (SD=10.6) patients per day.

4.2.10 Summary of demographics

Table 4.14 summarises the sociodemographic profile of the respondents.

Table 4.14 Summary of demographics

Age	**Young** (< 40 yrs) 27.2% (46)	**Middle Aged** (40 - 59 yrs) 53.3% (90)	**Mature** (≥ 60 yrs) 19.5% (33)			
Gender	**Male** 76.7% (132)	**Female** 23.3% (40)				
Marital Status	**Married** 87.8% (151)	**Unmarried** 12.2% (21)				
Ethnicity	**White** 61.9% (91)	**Black** 20.4% (30)	**Indian** 13.6% (20)	**Other** 4.1%(6)		
GP or Specialist	**GPs** 54.7% (93)	**Specialists** 45.3% (77)				
Work Suburb	**Far North** 17.8% (28)	**North** 41.4% (65)	**Central** 14% (22)	**East** 12.1% (19)	**South** 5.7% (9)	**West** 8.9% (14
Family Size	**Small family** (0 - 2 children) 54.7% (94)	**Large family** (3 or more children) 45.3% (78)				
Number of patients seen	**Quiet** (< 20 patents per day) 41.9% (72)	**Busy** (≥ 20 patients per day) 58.1% (100)				

4.3 Medical services requested from and provided to family members

In question 11, doctors were asked to indicate how often family members had requested medical services from them, and how often they had provided medical services to family members. They were asked to specify whether they had 'frequently' (f), 'occasionally' (o) or 'never' (n) had services requested, or provided them.

Unfortunately, there were many 'missing' responses in this question. It is unknown whether doctors left out the question because they didn't have a particular family member (e.g. too young to have a grandchild), or because they never provided the service to the family member, or because they found the table too tedious to complete. Where doctors *'ticked'* the table, rather than specifying 'n', 'o' or 'f', the answer was recorded as 'o' for occasionally, rather than leaving it missing.

4.3.1 Family members asking for medical advice

Doctors were asked to indicate how often family members asked them for medical advice. The response rate for this question ranged from 92.4% (159) for spouse to 18% (31) for grandchildren. Table 4.15 and Figure 4.1 show a comparison of the frequencies of family members asking for advice.

Table 4.15 Family members asking for advice

Advice	Spouse Frequency	%	Parents Frequency	%	Children Frequency	%	Grandchildren Frequency	%	Siblings Frequency	%
Frequently	75	47.2	49	34.5	63	42.9	9	29.0	32	25.4
Occasionally	70	44.0	84	59.2	67	45.6	12	38.7	64	50.8
Never	14	8.8	9	6.3	17	11.6	10	32.3	30	23.8
Total	159	100.0	142	100.0	147	100.0	31	100.0	126	100.0

Advice	Parents in law Frequency	%	Brother in law Frequency	%	Niece Frequency	%	Others Frequency	%
Frequently	31	19.5	28	19.7	26	17.7	19	61.3
Occasionally	66	41.5	86	60.6	69	46.9	34	109.7
Never	30	18.9	27	19.0	34	23.1	18	58.1
Total	127	79.9	141	99.3	129	87.8	71	229.0

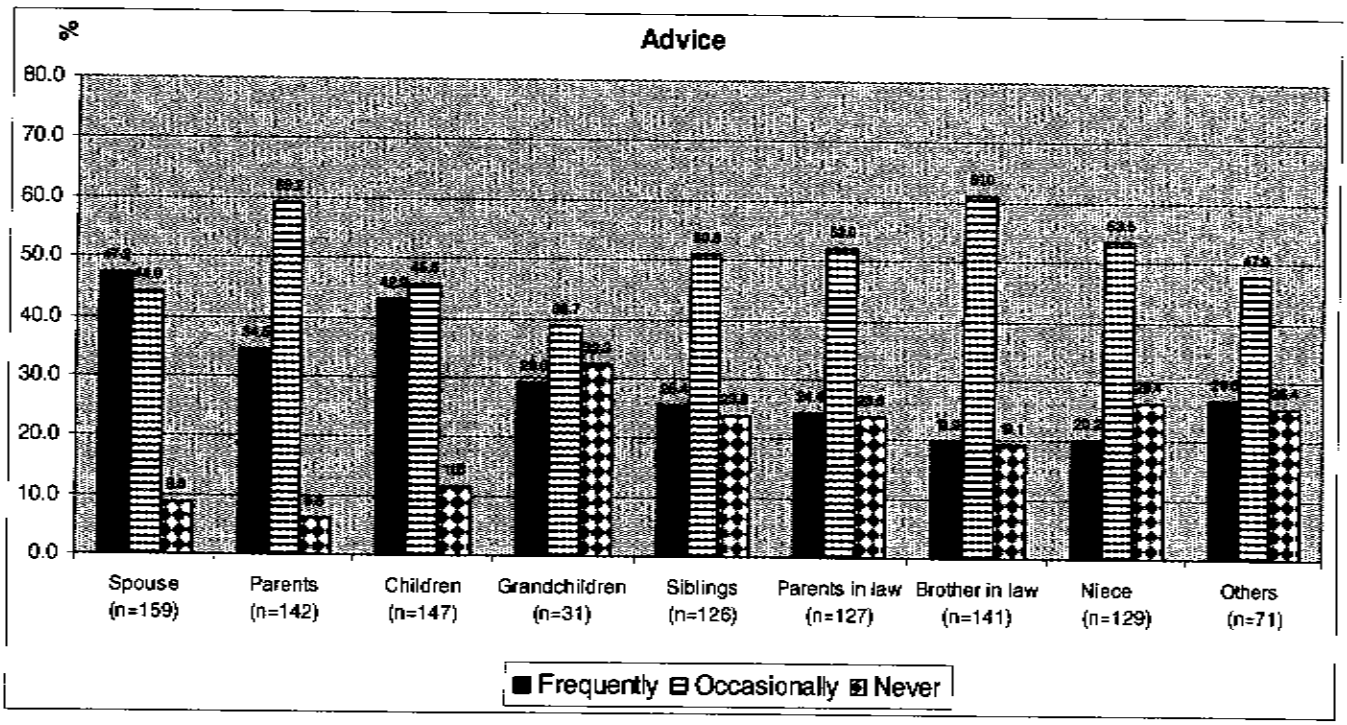


Figure 4.1 Family members asking for advice

All the different family members listed had occasionally or frequently asked the majority of doctors for advice. Family members who most commonly asked for advice (occasionally or frequently) were 93.7% (133) of parents, 91% (145) of spouses and 88.5% (130) of children. The family members with the highest frequency of 'never' asking for advice were 32.3% (10) of grandchildren, 26.4% (34) of nieces and

nephews, 25.4% (18) others and 23.8% (30) of siblings. Where doctors specified who 'other' was, this category consisted of 62.5% (20) cousins, and 28.0% (9) aunts or uncles.

Young doctors were significantly more likely to report never being asked for advice by their children (p=0.005). Old doctors were asked for advice from grandchildren significantly more often than middle-aged doctors (p=0.007). Young doctors were asked for advice from parents (p=0.004) and siblings (p=0.023) significantly more frequently than middle-aged and old doctors. GPs were asked for advice significantly more frequently than specialists by the following family members:

- siblings (p=0.04),
- brothers and sisters in-law (p=0.006)
- nieces and nephews (p=0.0003)
- other family members (p=0.05)

Doctors with large families were asked for advice from their children more frequently than doctors with small families (p=0.001). Parents in-law of Indian doctors were much more likely to ask for advice than parents in-law from other ethnic groups (p=0.000) i.e. 61% (11) Indian doctors were frequently asked for advice, compared to 23.5% (16) White doctors and 4.5% (1) Black doctors. Similarly, parents of Indian doctors more frequently asked for advice compared to parents of doctors from other ethnic groups (p=0.05).

There were also significant differences between frequency of medical advice asked for by siblings of doctors of various ethnic groups (p=0.003) i.e. 50% (9) Indian doctors and 19.7% (13) White doctors had frequently been asked for medical advice; while 43.5% (101) Black doctors had never been asked for medical advice by their siblings. Indian spouses asked for advice significantly more frequently than other ethnic groups i.e. 73.7% (14) Indian spouses and 53.3% (16) Black spouses frequently asked for advice compared to 36.5% (31) White spouses (p=0.03).

4.3.2 Family members who sought treatment

Doctors were asked to indicate how often family members sought treatment from them. The response rate for this question ranged from 88.4% (152) for spouse to 17.4% (30) for grandchildren. Table 4.16 and Figure 4.2 show a comparison of the frequencies of family members seeking treatment.

Table 4.16 Family members who sought treatment

Total	Spouse Frequency	%	Parents Frequency	%	Children Frequency	%	Grandchildren Frequency	%	Siblings Frequency	%
Frequently	48	31.6	38	27.3	55	38.7	7	23.3	22	17.9
Never	25	16.4	32	23.0	12	8.5	13	43.3	49	39.8
Occasionally	79	52.0	69	49.6	75	52.8	10	33.3	52	42.3
Total	152	100	139	100	142	100	30	100	123	100

Total	Parents in law Frequency	%	Brother in law Frequency	%	Niece Frequency	%	Others Frequency	%
Frequently	19	15.6	19	14.2	23	18.1	16	24.2
Never	41	33.6	42	31.3	39	30.7	22	33.3
Occasionally	62	50.8	73	54.5	65	51.2	28	42.4
Total	122	100	134	100	127	100	66	100

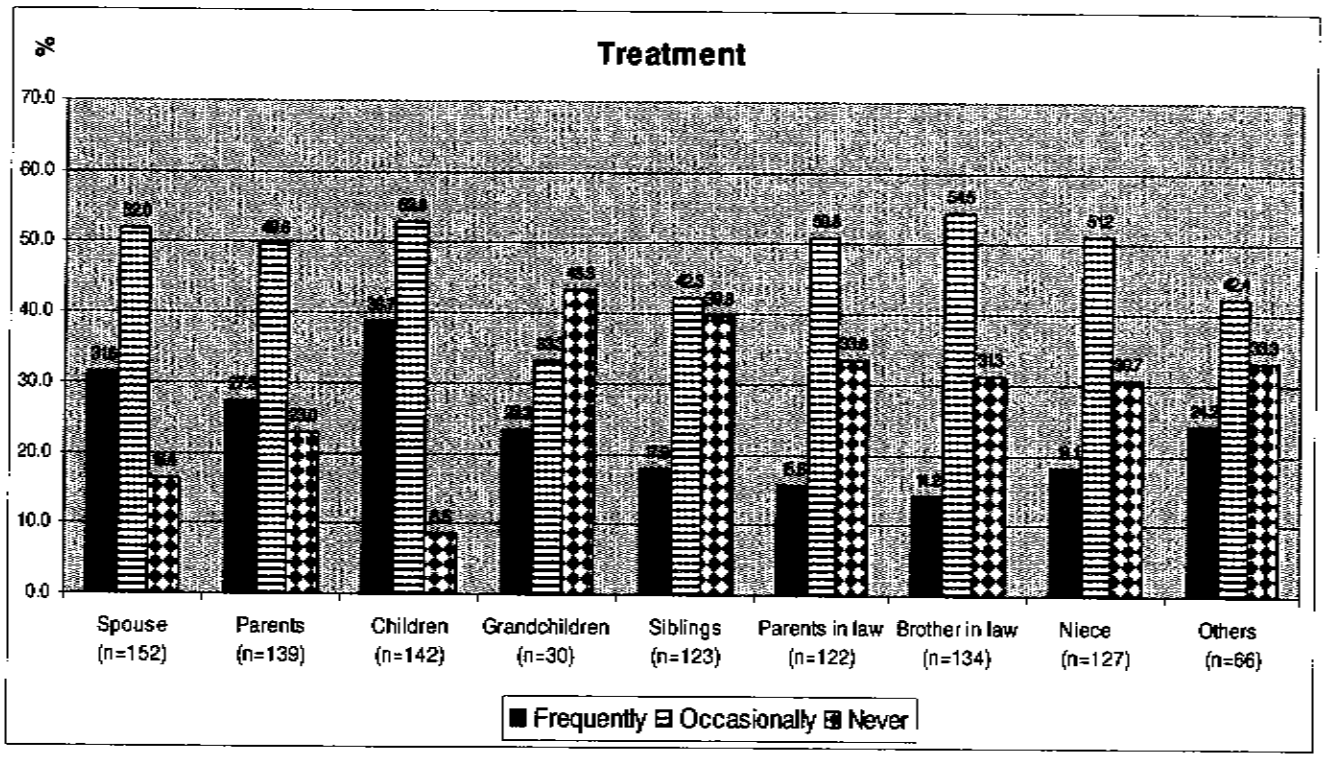


Figure 4.2 Family members who sought treatment

Family members who most commonly sought treatment (frequently or occasionally) were 91.5% (130) of children, 83.6% (127) of spouses and 76.9% (107) of parents. Family members listed most commonly as 'never' seeking treatment, were 43.3% (13) of grandchildren and 39.8% (49) of siblings.

Old doctors were significantly more likely to have treatment sought by their grandchildren than middle aged doctors (p=0.003). The following family members sought treatment significantly more often from young doctors than from middle-aged and mature doctors:

- Nieces and nephews (p=0.04)
- Parents (p=0.019)
- Siblings (p=0.002)

The following family members sought treatment significantly more frequently from GPs than specialists:

- Siblings (p=0.017)
- Brothers and sisters in-law (p=0.02)
- Nieces and nephews (p=0.0002)

The following Indian family members sought treatment significantly more frequently than family members of other ethnic groups:

- Parents in-law (p=0.05)
- Parents (p=0.034)
- Spouses (p=0.05)

The following family members of doctors with large families sought treatment significantly *less* frequently than family members of doctors with small families:

- Parents (p=0.004)
- Siblings (p=0.019)
- Other (p=0.03)

4.3.3 Family members who asked for second opinions

Doctors were asked to indicate how often family members asked for second opinions. The response rate for this question ranged from

84.9% (146) for spouses to 15.7% (27) for grandchildren. Table 4.17 and Figure 4.3 represent the frequency of family members asking for second opinions.

Table 4.17 Family members asking for second opinions

Opinion	Spouse Frequency	%	Parents Frequency	%	Children Frequency	%	Grandchildren Frequency	%	Siblings Frequency	%
Frequently	31	21.2	28	20.9	21	16.2	2	7.4	22	18.0
Never	58	39.7	36	26.9	65	50.0	15	55.6	45	36.9
Occasionally	57	39.0	70	52.2	44	33.8	10	37.0	55	45.1
Total	146	100	134	100	130	100	27	100	122	100

Opinion	Parents in law Frequency	%	Brother in law Frequency	%	Niece Frequency	%	Others Frequency	%
Frequently	15	12.5	15	11.3	16	12.8	12	19.4
Never	47	39.2	42	31.6	51	40.8	20	32.3
Occasionally	58	48.3	76	57.1	58	46.4	30	48.4
Total	120	100	133	100	125	100	62	100

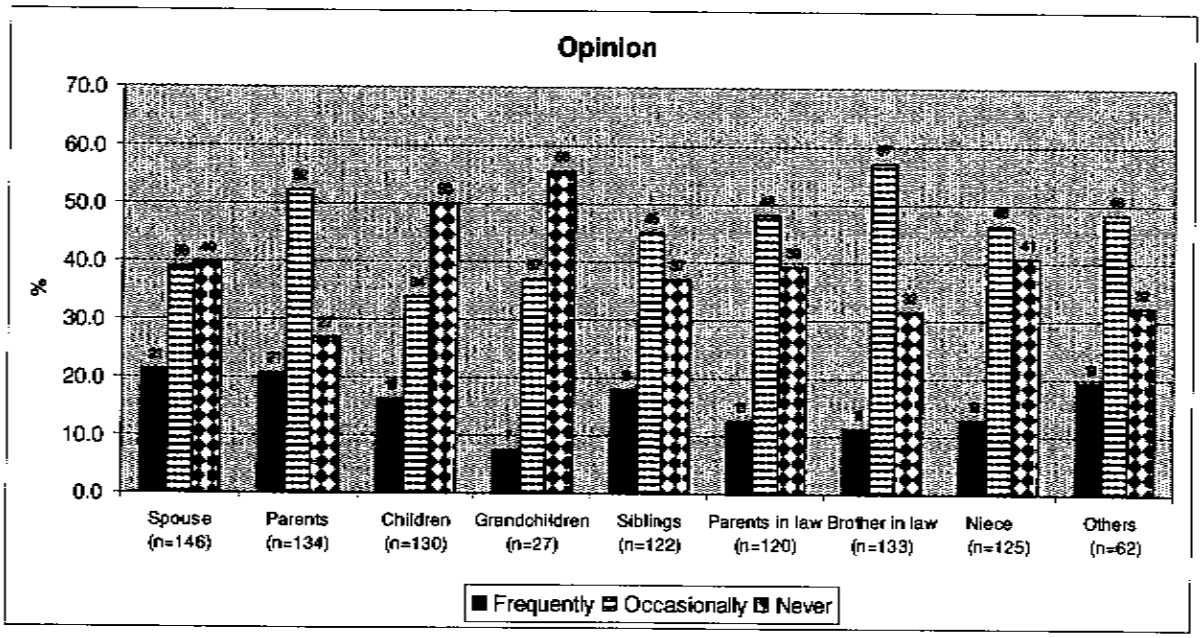


Figure 4.3 Family members asking for second opinions

Family members who most commonly (frequently or occasionally) asked for second opinions were 73.1% (98) of parents, 68.4% (91) of brothers or sisters in-law and 67.8% (42) of others. Family members listed most commonly as 'never' asking for second

opinions, were 55.6% (15) of grandchildren and 50% (65) of children.

The following family members were significantly more likely to ask for a second opinion from young doctors, compared to middle aged and old doctors:

- Nieces and nephews (p=0.001)
- Parents in-law (p=0.022)
- Parents (p=0.001)
- Siblings (p=0.008)

Children more frequently asked for second opinions from middle aged and old doctors (p=0.031). This may be because children of doctors younger than 40 yrs are too young to ask for opinions.

Nieces and nephews asked for second opinions significantly more frequently from GPs than specialists (p=0.01). Unmarried doctors were asked for second opinions from nieces and nephews significantly more often than married doctors (p=0.04). The following family members of doctors with large families asked for second opinions significantly *more* frequently than family members of doctors with small families:

- Spouses (p=0.04)
- Children (p=0.009)

The following ethnic group family members asked for second opinions significantly more frequently than family members of other ethnic groups:

- Brothers and sisters in-law of Black and Indian doctors (p=0.012)
- Nieces and nephews of Indian and Other doctors (p=0.001)
- Parents of Indian doctors (p=0.006)
- Siblings of Indian doctors (p=0.01)

4.3.4 Family members on who doctors performed physical examinations

Doctors were asked to indicate how often they performed physical examinations on family members. The response rate for this

question ranged from 87.2% (150) for spouses to 16.2% (28) for grandchildren. Table 4.18 and Figure 4.4 show the frequency of family members on who doctors performed physical examinations.

Table 4.18 Family members on who doctors performed physical examinations

Examination	Spouse Frequency	%	Parents Frequency	%	Children Frequency	%	Grandchildren Frequency	%	Siblings Frequency	%
Frequently	31	20.7	20	14.7	46	31.5	5	17.9	13	10.7
Never	38	25.3	57	41.9	18	12.3	13	46.4	71	58.2
Occasionally	81	54.0	59	43.4	82	56.2	10	35.7	38	31.1
Total	150	100	136	100	146	100	28	100	122	100

Examination	Parents in law Frequency	%	Brother in law Frequency	%	Niece Frequency	%	Others Frequency	%
Frequently	14	11.4	11	8.2	16	12.6	10	15.4
Never	66	53.7	67	50.0	56	44.1	32	49.2
Occasionally	43	35.0	56	41.8	55	43.3	23	35.4
Total	123	100	134	100.0	127	100	65	100

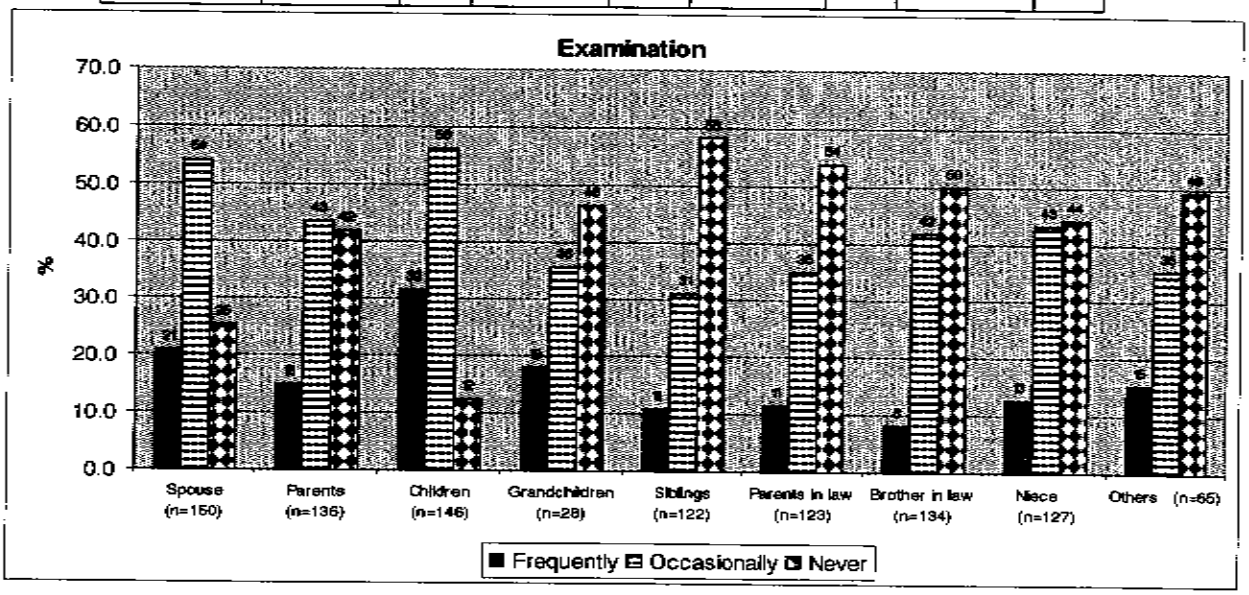


Figure 4.4 Family members on who doctors performed physical examinations

Doctors most commonly (frequently or occasionally) performed physical examinations on 87.7% (112) of children and 74.7% (128) of spouses. Doctors most commonly 'never' performed physical examinations on siblings (58.2%; 71), parents in-law (53.7%; 66) brothers or sister in-law (50%; 67), and 'others' (49.2%; 32).

Old doctors examined grandchildren significantly more frequently than middle-aged and young doctors (p=0.007). Young doctors examined nieces and nephews (p=0.041) and siblings (p=0.002) significantly more frequently than middle-aged and old doctors. Female doctors were significantly more likely to examine their children than male doctors (p=0.067). GPs examined the following family members significantly more frequently than specialists:

- Siblings (p=0.011)
- Brothers and sisters in-law (p=0.020)
- Nieces and nephews (p=0.000)

The following ethnic group doctors performed physical examinations significantly more frequently on the following family members:

- Indian and 'other' doctors examined their children (p=0.038)
- Indian doctors examined parents (p=0.029)
- Indian doctors examined parents in-law (p=0.02)

Unmarried doctors examined siblings significantly more frequently than married doctors.

4.3.5 Family members in who doctors diagnosed illness

Doctors were asked to indicate how often they diagnosed illness in family members. The response rate for this question ranged from 87.8% (151) for spouses to 16.9% (29) for grandchildren. Table 4.19 and Figure 4.5 indicate the frequency of family members in who doctors diagnosed illness.

Table 4.19 Family members in who doctors diagnosed illness

Diagnose	Spouse Frequency	%	Parents Frequency	%	Children Frequency	%	Grandchildren Frequency	%	Siblings Frequency	%
Frequently	43	28.5	32	23.4	52	35.1	5	17.2	16	13.2
Never	15	9.9	29	21.2	9	6.1	9	31	50	41.3
Occasionally	93	61.6	76	55.5	87	58.8	15	51.7	55	45.5
Total	151	100	137	100	148	100	29	100	121	100

Parents in law Frequency	%	Brother in law Frequency	%	Niece Frequency	%	Others Frequency	%
18	14.8	10	7.6	17	13.4	11	16.9
46	37.7	50	37.9	42	33.1	23	35.4
58	47.5	72	54.5	68	53.5	31	47.7
122	100	132	100	127	100	65	100

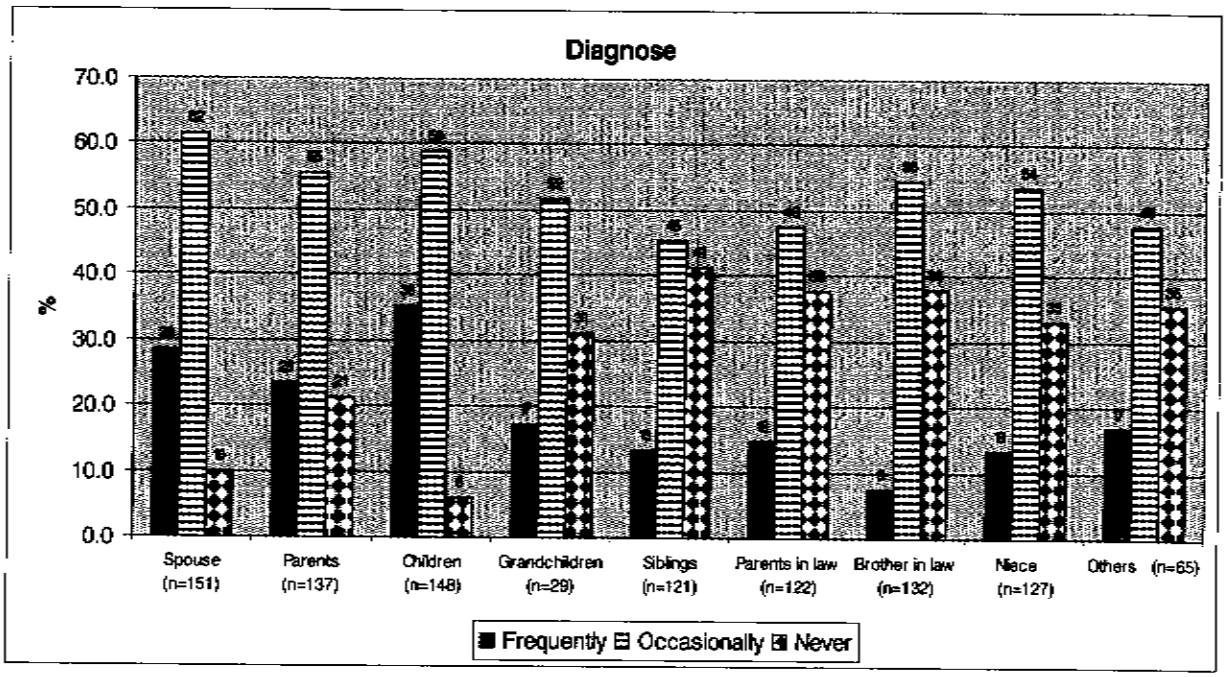


Figure 4.5 Family members in who doctors diagnosed illness

Doctors most commonly diagnosed illness in 93.9% (139) of children and 90.1% (136) of spouses. They least often or 'never' diagnosed illness in 41.3% (50) of siblings, 37.9% (50) of brother's in-law and 37.7% (46) of parent's in-law.

Old doctors diagnosed illness in grandchildren significantly more frequently than middle-aged and young doctors (p=0.007). Young doctors diagnosed illness in the following family members significantly more frequently than middle aged and old doctors:

- Nieces and nephews (p=0.027)
- Siblings (p=0.007)

GPs diagnosed illness significantly more frequently than specialists in the following family members:

- Children (p=0.019)
- Siblings (p=0.001)
- Brothers and sisters in-law (p=0.004)
- Nieces and nephews (p=0.000)

Unmarried doctors diagnosed illness in siblings significantly more frequently than married doctors.

4.3.6 Family members for who doctors prescribed medication

Doctors were asked to indicate how often they prescribed medications for family members. The response rate for this question ranged from 88.9% (153) for spouses to 16.9% (29) for grandchildren. Table 4.20 and Figure 4.6 represent the frequency of family members for who doctors prescribed medications.

Table 4.20 Family members for who doctors prescribed medication

Prescribe	Spouse Frequency	%	Parents Frequency	%	Children Frequency	%	Grandchildren Frequency	%	Siblings Frequency	%
Frequently	54	35.3	43	30.9	57	39	5	17.2	16	12.8
Never	13	8.5	25	18	6	4.1	12	41.4	48	38.4
Occasionally	86	56.2	71	51.1	83	56.8	12	41.4	61	48.8
Total	153	100	139	100	146	100	29	100	125	100

Parents in law Frequency	%	Brother in law Frequency	%	Niece Frequency	%	Others Frequency	%
23	18.7	18	13.4	20	15.7	12	18.5
37	30.1	44	32.8	42	33.1	24	36.9
63	51.2	72	53.7	65	51.2	29	44.6
123	100	134	100	127	100	65	100

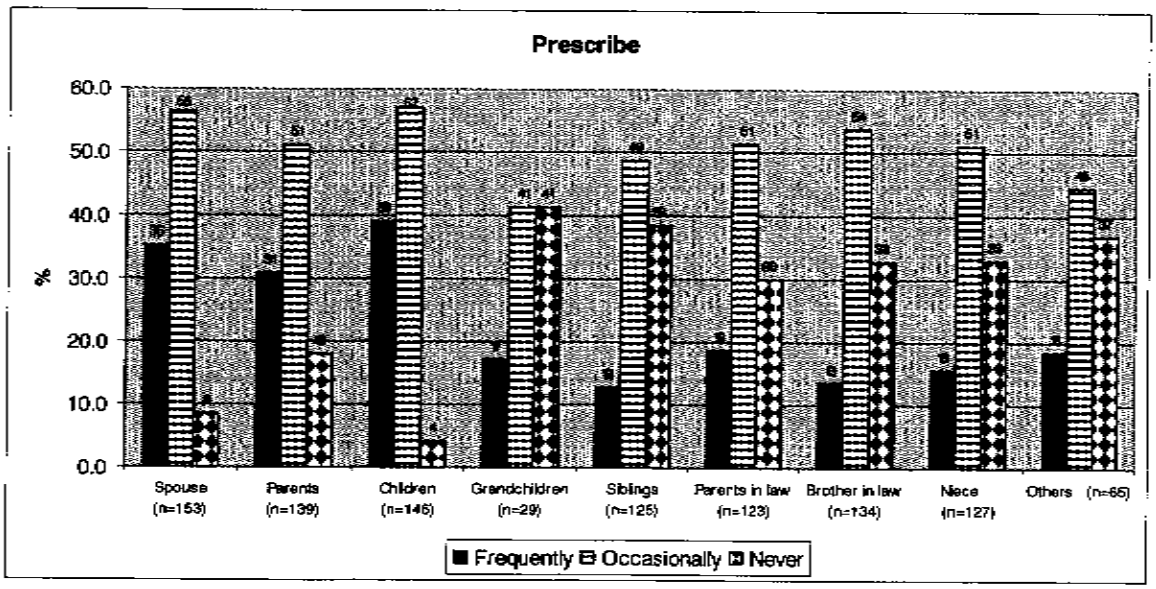


Figure 4.6 Family members for who doctors prescribed medication

In all cases, doctors prescribed medication to their family members 'occasionally' more than 'frequently'. More than half of all doctors prescribed medication to their family members at least occasionally.

More than 90% of respondents prescribed medication 'occasionally' or 'frequently' to spouses and children and more than 80% of respondents prescribed to parents. Doctors most commonly 'never' prescribed medications to grandchildren (41.4%; 12) and siblings (38.4%; 48).

Young doctors prescribed medications for the following relatives significantly more frequently than middle aged and old doctors:

- Parents (p=0.004)
- Siblings (p=0.019)
- Nieces and nephews (p=0.024)
- Others (p=0.019)

Old doctors prescribed medications for grandchildren significantly more frequently than middle aged and young doctors:

GPs prescribed medications significantly more frequently than specialists in the following family members:

- Brothers and sisters in-law (p=0.021)
- Nieces and nephews (p=0.000)

Significantly more White doctors never prescribed medication to 'other' family members. Doctors with small families prescribed medication to the following family members significantly more frequently than doctors with large families:

- Nieces and nephews (p=0.03)
- Others (p=0.05)

4.3.7 Family members to who doctors administered immunisation

Doctors were asked to indicate how often they administered immunisations to family members. Immunisations could have included all childhood vaccines, influenza vaccines, travel vaccines and others. The response rate for this question ranged from 83.7% (144) for children to 16.3% (28) for grandchildren. Table 4.21 and Figure 4.7 indicate the frequency of family members to who doctors administered immunisations.

Table 4.21 Family members to who doctors administered immunisation

Immunise	Spouse Frequency	%	Parents Frequency	%	Children Frequency	%	Grandchildren Frequency	%	Siblings Frequency	%
Frequently	17	11.6	9	6.7	19	13.2	2	7.1	2	1.6
Never	106	72.1	109	81.3	95	66.0	23	82.1	112	91.8
Occasionally	24	16.3	16	11.9	30	20.8	3	10.7	8	6.6
Total	147	100	134	100	144	100	28	100	122	100

Immunise	Parents in law Frequency	%	Brother in law Frequency	%	Niece Frequency	%	Others Frequency	%
Frequently	4	3.3	6	4.5	5	3.9	2	3.0
Never	107	89.2	120	90.2	111	87.4	58	87.9
Occasionally	9	7.5	7	5.3	11	8.7	6	9.1
Total	120	100	133	100	127	100	66	100

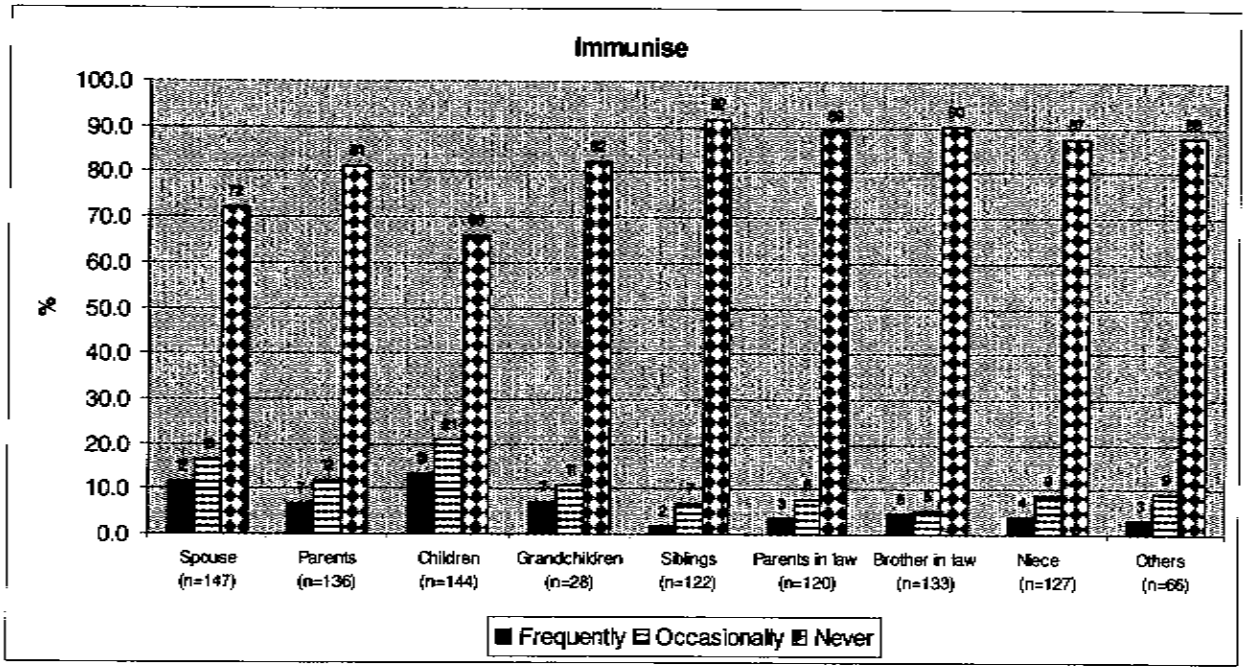


Figure 4.7 Family members to who doctors administered immunisation

Doctors most commonly immunised their children and spouses i.e. 34% (49) of doctors occasionally or frequently immunised their children and 27.9% (41) occasionally or frequently immunised their spouses. Only 8.2% (10) ever immunised their siblings and 9.8% (13) ever immunised their brothers or sisters in-law.

Young doctors were significantly more likely to immunise 'other' family members (p=0.010) than middle aged and mature doctors.

GPs were significantly more likely than specialists to administer immunisations to the following family members:

- Siblings (p=0.009)
- Brothers and sisters in-law (p=0.035)
- Nieces and nephews (p=0.003)

Doctors with small families immunised the following family members significantly more frequently than doctors with large families:

- Nieces and nephews (p=0.043)
- Others (p=0.013)

4.3.8 Family members to who doctors administered CPR

Very few respondents had administered CPR to family members. Table 4.22 and Figure 4.8 show a comparison of frequency of family members to who doctors administered CPR. Doctors reported never having performed CPR on spouses, grandchildren, siblings, brothers or sisters in-law, nieces or nephews and others. Only 2.2% (3) had administered CPR to parents, 1.7% (2) to parent's in-law and 0.7% (1) to their child.

Table 4.22 Family members to who doctors administered CPR

CPR	Spouse Frequency	%	Parents Frequency	%	Children Frequency	%	Grandchildren Frequency	%	Siblings Frequency	%
Frequently	0	0	0	0	0	0	0	0	0	0
Never	149	100	133	97.8	144	99.3	29	100	123	100
Occasionally	0	0	3	2.2	1	0.7	0	0	0	0
Total	149	100	136	100	145	100	29	100	123	100

CPR	Parents in law Frequency	%	Brother in law Frequency	%	Niece Frequency	%	Others Frequency	%
Frequently	0	0	0	0	0	0	0	0
Never	119	98.3	134	100	127	100	67	100
Occasionally	2	1.7	0	0	0	0	0	0
Total	121	100	134	100	127	100	67	100

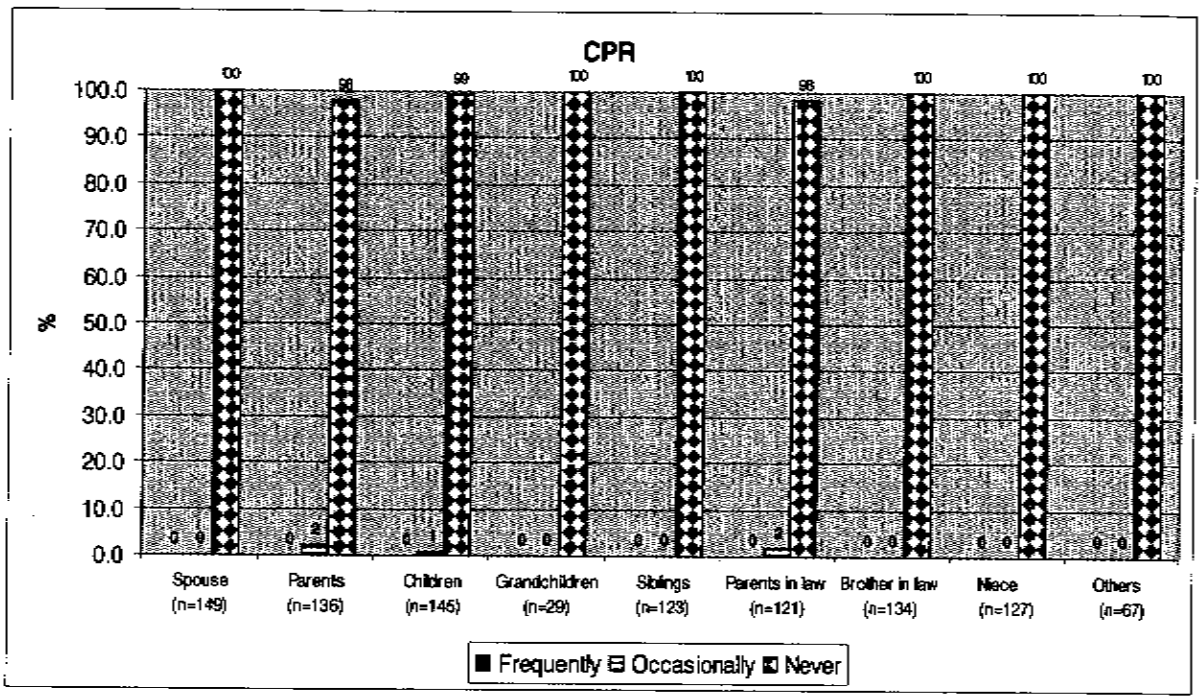


Figure 4.8 Family members to who doctors administered CPR

4.3.9 Family members for who doctors sutured wounds

Doctors were asked to indicate how often they sutured wounds for family members. Table 4.23 and Figure 4.9 indicate the frequencies of family members for who doctors sutured wounds.

Table 4.23 Family members for who doctors sutured wounds

Suture	Spouse Frequency	%	Parents Frequency	%	Children Frequency	%	Grandchildren Frequency	%	Siblings Frequency	%
Frequently	3	2.0	2	1.5	6	4.1	1	3.4	0	0.0
Never	128	86.5	122	89.7	100	69.0	25	86.2	117	94.4
Occasionally	17	11.5	12	8.8	39	26.9	3	10.3	7	5.6
Total	148	100	136	100	145	100	29	100	124	100

Suture	Parents in law Frequency	%	Brother in law Frequency	%	Niece Frequency	%	Others Frequency	%
Frequently	0	0.0	0	0.0	0	0.0	2	3.2
Never	114	95.0	124	93.2	110	87.3	53	84.1
Occasionally	6	5.0	9	6.8	16	12.7	8	12.7
Total	120	100	133	100	126	100	63	100

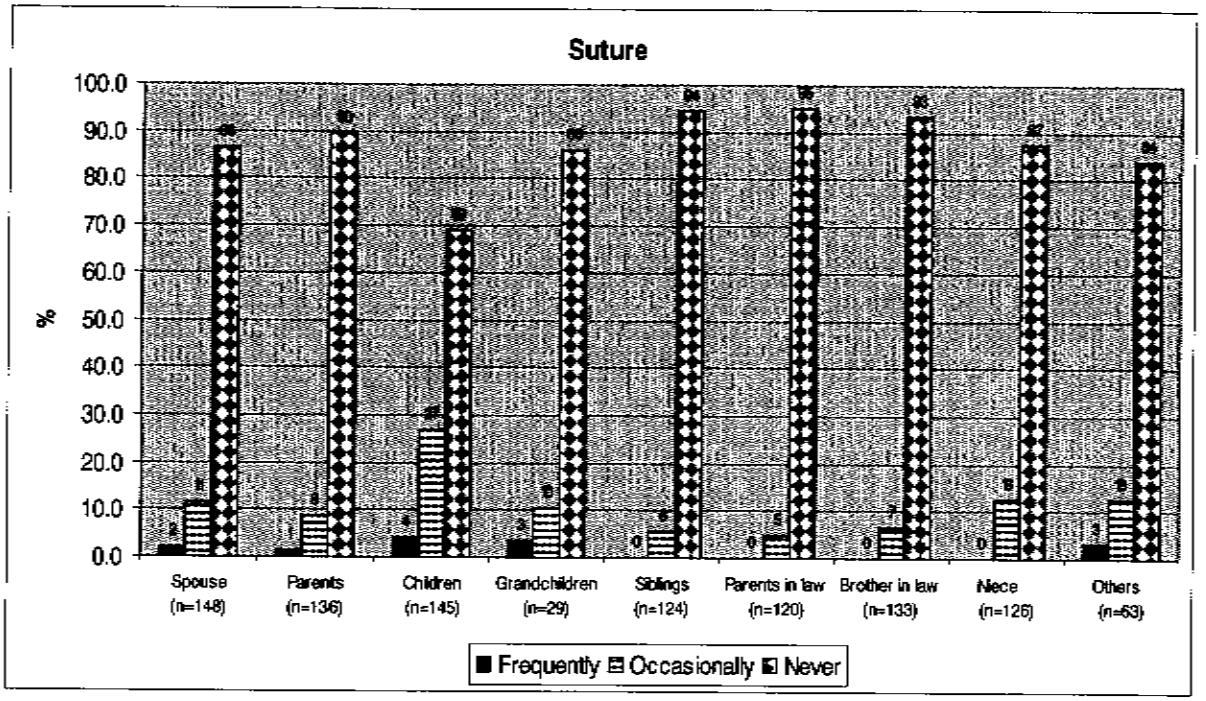


Figure 4.9 Family members for who doctors sutured wounds

In general, doctors seldom sutured wounds for family members. They most commonly sutured wounds in children (26.9% [39] occasionally and 4.1% [6] frequently), and others (12.7% [8] occasionally and 3.2% [2] frequently). Respondents most often never sutured wounds in parent's in-laws (95%; 114) and siblings (94.4%; 117).

Middle aged doctors sutured their children significantly more frequently (p=0.034) than young and old doctors. Male doctors were significantly more likely to suture wounds for their children than female doctors (p=0.024). GPs were significantly more likely to suture wounds than specialists for the following family members:

- Parents in-law (Fishers exact p=0.036)
- Siblings (Fishers exact p=0.010)
- Spouses (p=0.050)

- Significantly more White doctors sutured 'other' family members compared to Black and Indian doctors (p=0.024). Doctors with large families sutured wounds in children significantly more frequently than doctors with small families.

4.3.10 Number of doctors who performed elective surgery and emergency surgery on family members

Doctors were asked to indicate how often they had performed elective surgery and emergency surgery on family members. Table 4.24 and Figure 4.10 show the frequency of family members on who doctors performed elective surgery. Table 4.25 and Figure 4.11 show the frequency of family members on who doctors performed emergency surgery.

Table 4.24 Number of doctors who performed elective surgery on family

Elective Surgery	Spouse Frequency	%	Parents Frequency	%	Children Frequency	%	Grandchildren Frequency	%	Siblings Frequency	%
Frequently	1	0.7	0	0.0	0	0.0	0	0.0	0	0.0
Never	137	91.9	132	97.1	137	93.2	29	96.7	119	96.0
Occasionally	11	7.4	4	2.9	10	6.8	1	3.3	5	4.0
Total	149	100	136	100	147	100	30	100	124	100

Elective Surgery	Parents in law Frequency	%	Brother in law Frequency	%	Niece Frequency	%	Others Frequency	%
Frequently	0	0.0	0	0.0	0	0.0	1	1.5
Never	115	95.0	126	94.0	121	95.3	65	97.0
Occasionally	6	5.0	8	6.0	6	4.7	1	1.5
Total	121	100	134	100	127	100	67	100

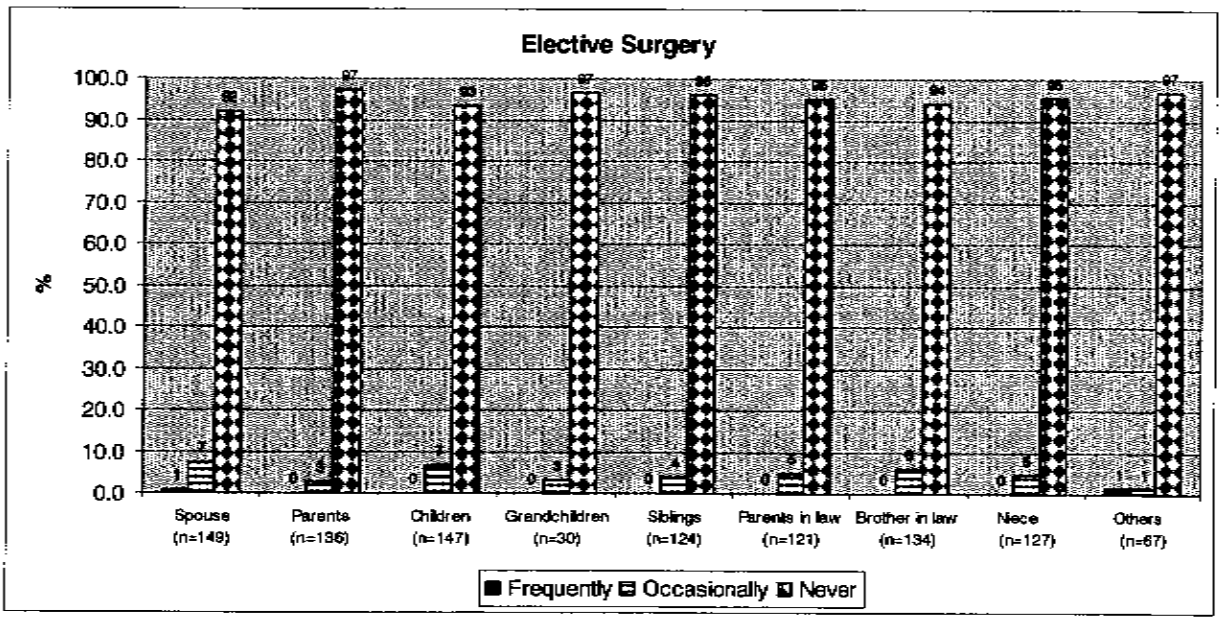


Figure 4.10 Number of doctors who performed elective surgery on family

Table 4.25 Number of doctors who performed emergency surgery on family

Emergency Surgery	Spouse Frequency	%	Parents Frequency	%	Children Frequency	%	Grandchildren Frequency	%	Siblings Frequency	%
Frequently	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Never	142	95.9	135	99.3	137	93.8	29	96.7	122	99.2
Occasionally	6	4.1	1	0.7	9	6.2	1	3.3	1	0.8
Total	148	100	136	100	146	100	30	100	123	100

Emergency Surgery	Parents in law Frequency	%	Brother in law Frequency	%	Niece Frequency	%	Others Frequency	%
Frequently	0	0.0	0	0.0	0	0.0	1	1.5
Never	120	99.2	133	99.3	125	98.4	63	96.9
Occasionally	1	0.8	1	0.7	2	1.6	1	1.5
Total	121	100	134	100	127	100	65	100

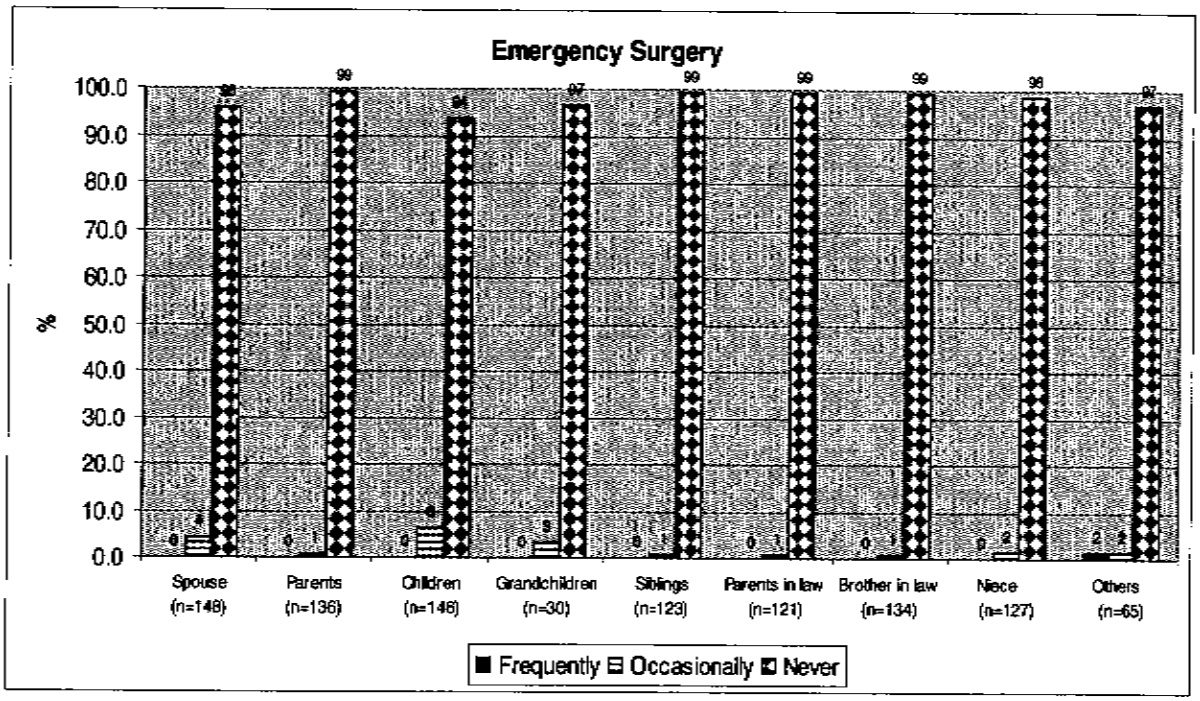


Figure 4.11 Number of doctors who performed emergency surgery on family

Very few respondents had performed these procedures at all; only 1.5% (1) frequently performing both elective and emergency surgery on 'other' family members and only 0.7% (1) frequently performing elective surgery on a spouse. Only 7.4% (11) of respondents had occasionally performed elective surgery on their spouses, 6.8% (10) on their children and 6.0% (8) on their brothers or sisters in-law.

Only 4.1% (6) of respondents had occasionally performed emergency surgery on their spouse, and 6.2% (9) on their children. Specialists were significantly more likely than GPs to perform emergency surgery on their children (Fishers exact p=0.045) [10.8% (7) Specialists, versus 2.5% (2) GPs].

4.3.11 Number of doctors who gave sick notes or medical certificates to family members

Doctors were asked to indicate how often they had given sick notes or medical certificates to family members. The response rate for this question ranged from 86.6% (149) for spouses, to 16.9% (29) for grandchildren. Table 4.26 and Figure 4.12 show the frequency of family members to who doctors gave sick notes.

Table 4.26 Number of doctors who gave sick notes or medical certificates to family members

Sick note	Spouse Frequency	%	Parents Frequency	%	Children Frequency	%	Grandchildren Frequency	%	Siblings Frequency	%
Frequently	0	0.0	0	0.0	7	4.8	0	0.0	2	1.6
Never	131	87.9	131	96.3	99	67.3	27	93.1	104	83.9
Occasionally	18	12.1	5	3.7	41	27.9	2	6.9	18	14.5
Total	149	100	136	100	147	100	29	100	124	100

Sick note	Parents in law Frequency	%	Brother in law Frequency	%	Niece Frequency	%	Others Frequency	%
Frequently	0	0.0	0	0.0	2	1.6	3	4.5
Never	115	95.0	107	78.7	102	81.0	51	77.3
Occasionally	6	5.0	29	21.3	22	17.5	12	18.2
Total	121	100	136	100	126	100	66	100

Respondents most often (occasionally or frequently) gave sick notes to 32.7% (48) of children, 22.7% (15) of other family members and 21.3% (29) of brothers or sisters in-law. They least commonly or never gave sick notes to their parents (96.3%; 131) and parents-in-law (95%; 115).

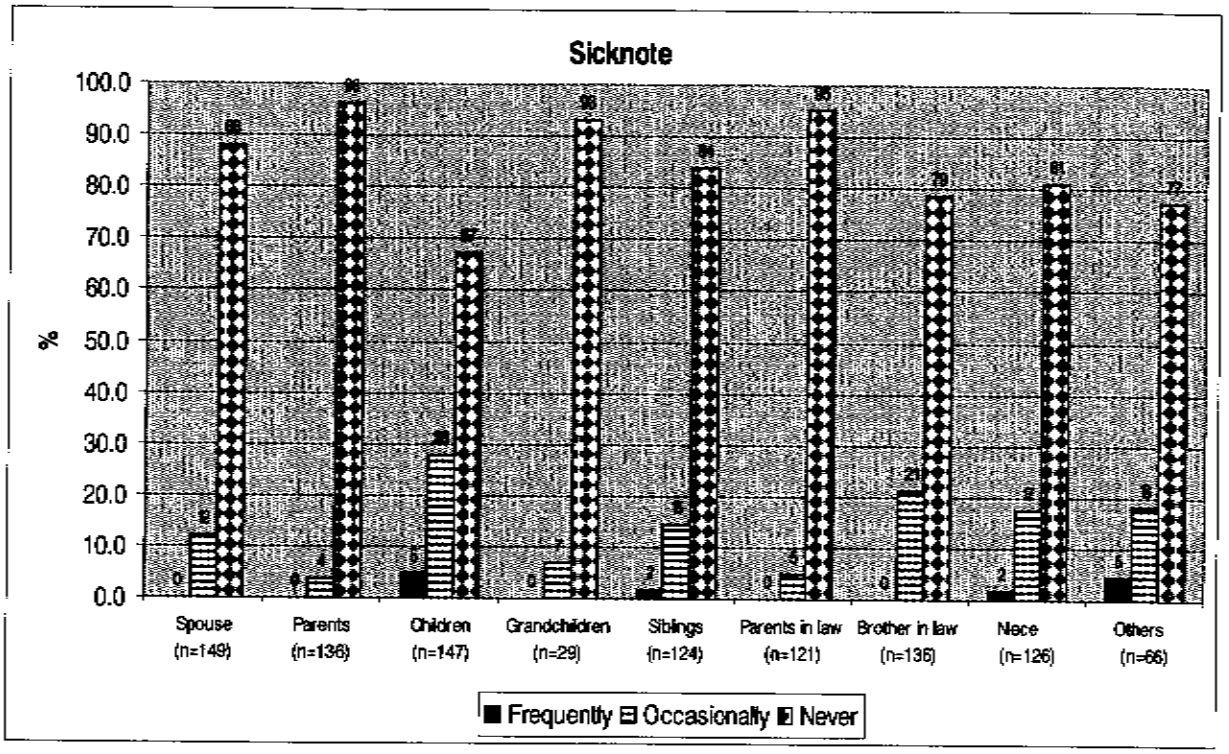


Figure 4.12 Number of doctors who gave sick notes or medical certificates to family members

Middle aged and old doctors gave sick notes or medical certificates to their children significantly more frequently than young doctors (p=0.000). In fact, 100% of young doctors (33) reported having 'never' given a sick note to their children. GPs were significantly more likely than specialists to give sick notes or medical certificates to brothers and sisters in-law (p=0.033) and siblings (p=0.024). Indian and 'other' ethnic group doctors were significantly more likely to give sick notes or medical certificates to their nieces and nephews (p=0.012) and parents in-law (p=0.000). Doctors with large families gave sick notes significantly more frequently than doctors with small families to their children (p=0.013).

4.3.12 Summary table

Taking into account the readings across all family members, the results for question 11 have been broadly summarised into Table 4.27. This table indicates that these numbers of doctors performed the services detailed to *at least one family member*.

Table 4.27 Summary table

	Family who		
	Asked advice	Sought treatment	Requested second opinions
Frequently	47.2%	38.7%	21.2%
Occasionally	60.6%	54.5%	57.1%
Never	6.3%	8.5%	26.9%

	Doctors who								
	Perform physical exams	Diagnose illness	Prescribe medication	Immunise	CPR	Sutured wounds	Perform elective surgery	Perform emerg. surgery	Gave sick notes
Frequently	31.5%	35.1%	39.0%	13.2%	0.0%	4.1%	1.5%	1.5%	4.8%
Occasionally	56.2%	61.6%	56.8%	20.8%	2.2%	26.9%	7.4%	6.2%	27.9%
Never	12.3%	6.1%	4.1%	66.0%	97.8%	69.0%	91.9%	93.8%	67.3%

4.4 Doctors as main care providers

Using a tick chart, doctors were asked to indicate for which family members they acted as the regular GP or specialist (i.e. main care provider). Where doctors ticked the family member, it was recorded as 'yes', and where the family member was left blank, it was recorded as 'no'. Two doctors made no mark on this question; thus the response rate was 98.8% (170). Figure 4.13 shows the frequency and percentage of doctors acting as the main care provider. More than half of respondents (52.9%; 90) acted as main care providers for their children, and almost half (45.9%; 78) for their spouse. Doctors were least often main care providers for 'other' family members (2.9%; 5), grandchildren (3.5%; 6) and aunts or uncles (8.8%; 15). Only 28.2% (48) of respondents stated that they were the main care provider for 'none' of their family members.

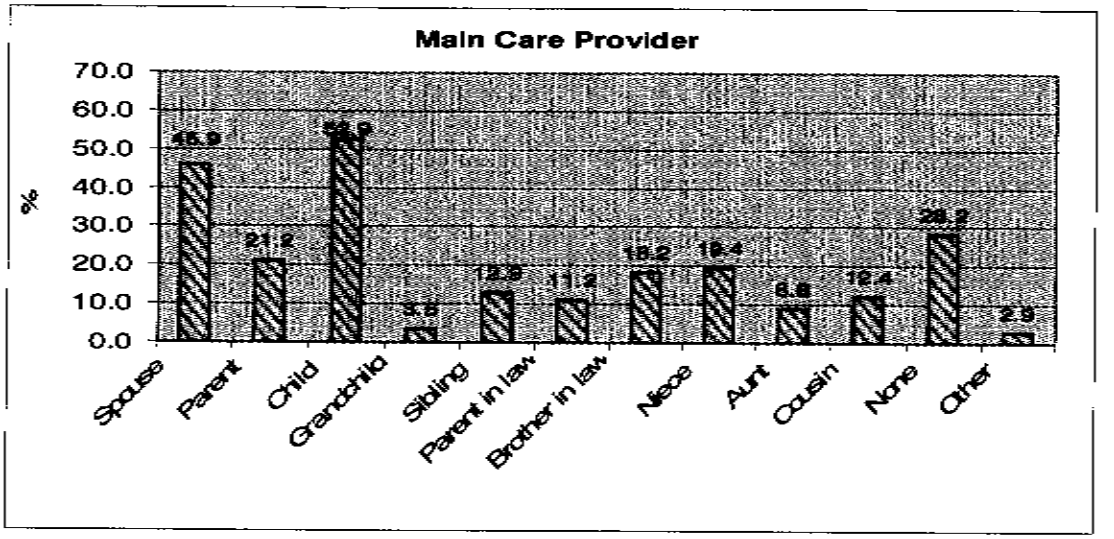


Figure 4.13 Doctors acting as main care providers to family members

Old doctors were significantly more often the regular main care providers for their grandchildren (p=0.008) compared with young and middle aged doctors. Young doctors were significantly more often the regular main care providers for siblings compared to middle aged and old doctors (p=0.001).

Significant differences between male and female doctors acting as the regular GP or specialist:

- 72.5% (29) of female doctors acted as the regular GP or Specialist for their children, compared with only 46.9% of male doctors (p=0.004).
- 32.3% (42) of male doctors, and only 15% (6) of female doctors stated that they were not the regular GP for any family member (p = 0.03).

GP's were significantly more likely than specialists to act as the regular main care provider to the following family members:

- Spouse (p=0.003)
- Children (p=0.006)
- Siblings (p=0.006)
- Brothers and sisters in-law (p=0.035)
- Nieces and nephews (p=0.000)
- Aunts and uncles (p=0.001)
- Cousin (p=0.002)

Specialists were significantly more likely than GPs to state that they were the regular main care providers to *none* of their family members (p=0.000) [46.1% (35) specialists versus 14% (13) GPs]. There was no significant difference between GPs and specialists being main care providers for:

- Parent (p=0.06)
- Parent in-law (p=0.204)
- Grandchildren (p=0.15)
- Other family member (p=0.5)

Married doctors were significantly more likely to be the regular GP or specialist for their parents in-law (p=0.03) and for their spouses (p=0.000). Unmarried doctors were significantly more likely to be the regular GP or specialist for their siblings (p=0.000). Doctors with large families were significantly more likely to state that they were not the regular GP or Specialist for any family member (p=0.03). Busy doctors were significantly more likely than quiet doctors to be the main care providers to the following family members:

- Aunt / Uncle (p=0.042)
- Cousin (p=0.043)
- Nieces / Nephew (p=0.036)
- Parents in-law (p=0.03)

Doctors working in Central areas were more often the regular care providers for their cousins, compared with other areas (p=0.018).

4.5 Doctors' opinions on family members having their own health care providers

Using a four-point scale, doctors were asked to indicate to what extent they agreed or disagreed with the following statement: 'Every doctor's family member should have their own (non–relative) GP or specialist'. The response rate for this question was 98.8% (170).

Table 4.28 Doctor's family members should have their own health care provider

	Frequency	%
Strongly Agree	78	45.9
Agree	56	32.9
Disagree	31	18.2
Strongly Disagree	5	2.9
Total	170	100

45.9% (78) of the 170 respondents strongly agreed with the statement and 32.9% (56) agreed. Thus only 21.1% (36) did not agree with the statement. Only 2.9% (5) of doctors strongly disagreed with the statement. There was a significant difference between GP's and specialists, with 61% (47) specialists strongly agreeing and 27.3% (21) specialists agreeing with the statement, while only 34.4% (31) of GP's strongly agreed and 38.5% (35) agreed [p=0.004]. There was no significant difference between male and female doctors' response to this statement (p=0.7).

4.6 Place of consultation, record-keeping and billing: comparison between doctors as usual medical carers and doctors giving 'ad hoc' consultations

Doctors were asked to indicate (using a tick chart) the place where consultations most often took place (doctor's rooms, doctor's own home or patient's home), whether formal records were kept (always, sometimes or never), and how they usually charged family members for their services (normal rates, cheaper rates or no charge). Question 14 required a response when doctors were the usual medical carers for their family members, and Question 15 required a response when doctors consulted with family members on an 'ad hoc' basis. Table 4.29 shows a comparison of frequency of place of consultation where doctors are the families' 'usual' medical carers and where doctors give 'ad hoc' consultations.

Table 4.29 Place of consultation

USUAL		AD HOC	
Doctor's Rooms		**Doctor's Rooms**	
Frequency (n=123)	%	Frequency (n=146)	%
56	45.5	41	28.1
Doctor's Home		**Doctor's Home**	
Frequency (n=123)	%	Frequency (n=146)	%
58	47.2	59	40.4
Patient's Home		**Patient's Home**	
Frequency (n=123)	%	Frequency (n=146)	%
9	7.3	46	31.5

Where doctors were the usual medical carers, of the 123 respondents, 47.2% (58) of consultations usually took place in the doctor's own home, 45.5% (56) took place in the doctor's rooms, and 7.3% (9) took place in the patient's home. For 'ad hoc' consultations, of the 146 respondents, 40.4% (59) usually took place in the doctor's home, 31.5% (46) in the patient's home, and only 28.1% (41) in the doctor's rooms. "Ad hoc" consultations took place more frequently in the doctors' rooms when doctors had large families, while they were more likely to take place in the patients' home when doctors had small families (p=0.025).

Table 4.30 shows a comparison of frequency of record keeping, where doctors are the families' 'usual' medical carers and where doctors give 'ad hoc' consultations.

Table 4.30 Record keeping

USUAL		ADHOC	
Always		**Always**	
Frequency (n=127)	%	Frequency (n=152)	%
46	36.2	34	22.4
Sometimes		**Sometimes**	
Frequency (n=127)	%	Frequency (n=152)	%
42	33.1	39	25.7
Never		**Never**	
Frequency (n=127)	%	Frequency (n=152)	%
39	30.7	79	52.0

Almost equal numbers of the 127 respondents who are the usual medical carers indicated that they kept formal records 'always', 'sometimes' or 'never'; i.e. 36.2% (46) always kept formal records, 33.1% (42) sometimes did, and 30.7% (39) never did. However, for 'ad hoc' consultations more than half of the 152 respondents (52%; 79) never kept formal records, 25.7% (39) sometimes did, and only 22.4% (34) always did.

Doctors in the East and North who were the usual medical carers for family members reported 'always' keeping records significantly more often than doctors in other areas; while doctors in the South who were the usual medical cares reported 'never' keeping records significantly more often (p=0.003) i.e. 64.7% (11) doctors in the East and 40.4% (19) doctors in the North always kept records and 83.3% (5) doctors in the South 'never' kept records.

Table 4.31 shows a comparison of frequency of billing, where doctors are the families' 'usual' medical carers and where doctors give 'ad hoc' consultations.

Table 4.31 Billing

USUAL		AD HOC	
Normal Rates		**Normal Rates**	
Frequency (n=125)	%	Frequency (n=152)	%
7	5.6	6	3.9
Cheaper Rates		**Cheaper Rates**	
Frequency (n=125)	%	Frequency (n=152)	%
19	15.2	11	7.2
No Charge		**No Charge**	
Frequency (n=125)	%	Frequency (n=152)	%
99	79.2	135	88.8

Most doctors did not charge family members for consultations. 79.2% (99) of the 125 respondents did not charge when they were the usual medical carer and 88.8% (135) of the 152 respondents did not charge for 'ad hoc' consultations. When they were usual medical carers, 15.2% (19) of the 125 respondents charged cheaper rates, and only 5.6% (7) charged normal rates to family members. For 'ad hoc' consultations, 7.2% (11) of the 152 respondents charged cheaper rates, and only 3.9% (6) charged normal rates to family members.

Old doctors did not charge family members for consultations significantly more often than young and middle aged doctors (p=0.042), who were more likely to charge normal or cheaper rates. When doctors saw family members on an 'ad hoc' basis, there was a significant difference between the various ethnic groups' billing practices (p=0.001). Of the 129 respondents, 92.4% White doctors (73), 96.3% Black doctors (26) and 88.9% (16) Indian doctors did not charge for ad hoc consultations. However, 40% (2) 'other' doctors charged cheaper rates and 20% (1) charged normal rates. Unmarried doctors were significantly more likely to bill their family members for 'ad hoc' consultations (p=0.05).

4.7 Rates of referring and investigating family members and non family member patients

Using a tick chart, doctors were asked to indicate whether they referred and investigated family members more often, less often or the same as other patients. Table 4.32 shows a comparison of the frequency of doctors' referrals and investigations.

Table 4.32 Referral and investigation of family members (compared to patients who are not relatives)

	More		Less		Same	
	Frequency	%	Frequency	%	Frequency	%
Refer	51	30.20	30	17.80	88	52.10
Investigate	16	9.80	46	28.20	101	62.00

More than half of the 169 respondents (52.1%, 88) thought that they referred family members the same as other patients. Nearly one third (30.2%, 51) felt that they referred family members more often, and 17.8% (30) felt that they referred family members less often. GPs referred family member patients more often than non- relative patients significantly more than specialists (p=0.034). Busy doctors referred family members significantly more often than quiet doctors (p=0.025).

62% (101) of the 163 respondents felt that they investigated family members the same as other patients. 28.2% (46) thought they investigated family members less often, and fewer than 10% (16) of doctors felt that they investigated family more often. Doctors in the North and Central areas investigated family members more often (p=0.005) and doctors in the South investigated family members less often..

4.8 Doctors' perceptions of whether their families receive better care or worse care than patients who are not relatives

Doctors were asked to indicate, using a tick chart, whether they thought that their own family members received better care, worse care or the same

care compared with other patients. They were asked to indicate the quality of care received from other doctors (who knew that the patient was related to the doctor). Table 4.33 shows the frequency of doctors' perceptions of the quality of care (better, worse or same) that their family members received from other doctors.

Table 4.33 Perceptions of whether family member patients receive better care, worse care or the same care as non-relative patients

	Better		Worse		Same	
	Frequency	%	Frequency	%	Frequency	%
Your care	23	13.70	27	16.10	118	70.20
Other doctors' care	62	38.00	5	3.10	96	58.90

Most doctors (70.2%, 118) felt that family members received the same care from them as other patients. However, only 58.9% (96) felt that family members received the same care from other doctors as regular patients. 16.1% (27) of the 168 respondents felt that they gave their own families worse care, and 13.7% (23) felt that they gave their own families better care than other patients. Only 3.1% (5) of the 168 respondents thought that their families received worse care from other doctors, while 38% (62) thought that their families received better care from other doctors, compared with regular patients.

4.9 Refusal of family members' requests

Doctors were asked to indicate whether or not they had ever refused a family member's request for medical care or advice. 61.8% (105) of the 170 respondents answered no and 38.2% (65) answered yes.

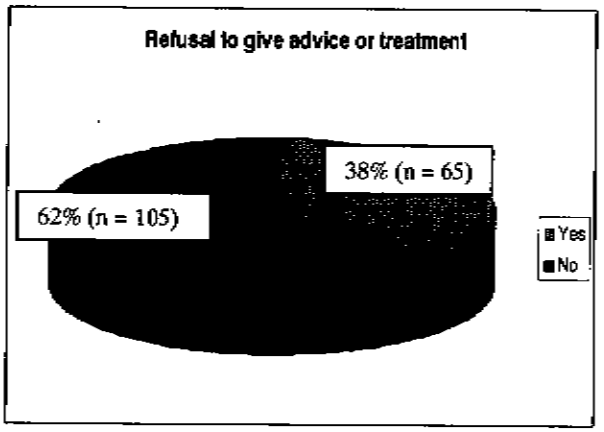


Figure 4.14 Refusal of a family member's request for medical care or advice

Respondents were requested to explain their answers. See Appendix E for further examples of comments. Comments from those doctors who *did refuse requests* included the following themes:

a) Problem outside doctor's area of expertise (6.3%; n=11)

b) Fear of loss of objectivity or emotional involvement (5.23%; n=9)

c) Avoidance of intimate examinations (4.6%; n=8)

d) Advice not given without a proper medical assessment (8.1%; n=14)

e) Intrusions (2.32%; n=4)

Comments from doctors who had *not ever refused* a request for care included:

a) It is not possible (5.23%; n=9)

b) It is not necessary (3.48%; n=6)

c) Feel responsible (2.32%; n=4)

Busy doctors were significantly more likely to report having not received a request for care that was out of their discipline (p=0.049).

4.10 Requests for medical care that made doctors uncomfortable

Doctors were asked to indicate ('yes' or 'no') whether they had ever had a request for medical care from family members that made them uncomfortable.

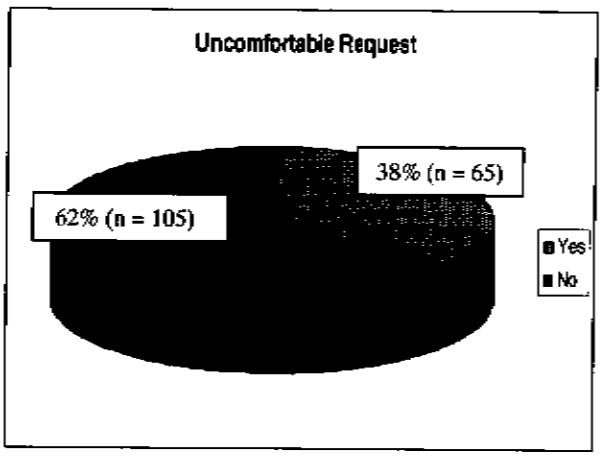


Figure 4.15 Reception of a request for medical care from a family member that made doctors uncomfortable

38.2% (65) of the 170 respondents answered 'yes' and 61.8% (105) answered 'no'. Doctors were requested to explain their answers. See Appendix E for further examples of comments. Comments from doctors who responded *yes* included the following themes.

a) Emotional intimacy (6.9%; n=12)

b) Physical intimacy (7.5%; n=13)

c) Requests outside of scope of practice (4.6%; n=7)

d) Inappropriate requests (6.9%; n=12)

e) *Loyalty to other doctors (2.3%; n=4)*

Two doctors (1.1%) stated that <u>all</u> requests from family were uncomfortable. Comments from respondents who responded *no* (63%; 11) mainly centred on doctors' confidence in their ability to treat impartially and remain objective: 'Nothing to feel uncomfortable about'

'Confident I will refer when indicated'

4.11 <u>Provision of care to family members out of the usual scope of practice</u>

Doctors were asked to indicate ('yes' or 'no') whether they had ever provided medical care or advice to a family member that was out of their discipline, or not within their usual scope of practice.

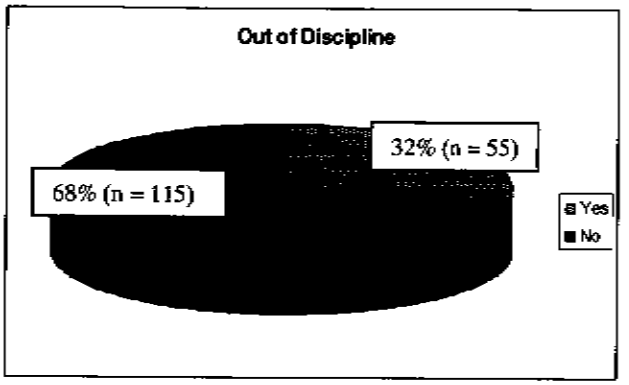


Figure 4.16 Provision of medical care or advice to a family member out of discipline or not within usual scope of practice

32.4% (55) of the 170 respondents answered 'yes' and 67.6% (115) responded 'no'. Doctors were requested to explain their answers. Comments included the following themes: (See Appendix E for further examples of comments)

a) GP level problems treated, although I am a specialist (6.3%; n=11)

b) Emergencies only/No other doctor available (5.8%; n=10)

c) Give advice (5.2%; n=9)

d) Refer (4%; n=7)

One doctor commented 'all the problems encountered so far are within my level of competence'.

20% (8) female doctors and 36.2% (47) male doctors said that they had provided care or advice to a family member that was out of their discipline or not within their usual scope of practice (Fisher's exact p=0.04). Specialists had provided medical care or advice to family members that was out of their discipline significantly more than GPs (p=0.000). 59.7% (46) of specialists and only 8.8% (8) GPs admitted to this practice. This may be because GPs consider themselves to be generalists with few limitations on their scope of practice. Doctors in the North and Far North were more likely to report providing medical care or advice to a family member that was out of their discipline (p=0.026). This is probably because more specialists worked in these areas and specialists more often provided care out of their discipline.

4.12 Perceptions of whether family members are more demanding of doctors' personal time

Doctors were asked to indicate ('yes' or 'no') whether they found that family member patients are more demanding of their personal time.

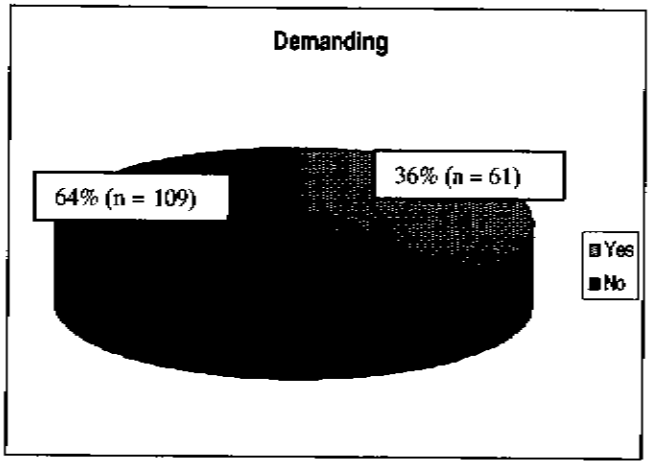


Figure 4.17 Doctors' perceptions of whether family member patients are more demanding of their personal time

36.3% (61) of the 168 respondents indicated 'yes' and 63.7% (107) indicated 'no'. Doctors were requested to explain their answers. See Appendix E for further examples of comments. Comments from respondents who reported *more demanding* families included the following themes:

a) After-hours requests/ easier access (6.9%; n=12)

b) Family expects special treatment (5.8%; n=10)

c) High expectations/ more critical (6.3%; n=11)

d) Intrusive (8.1%; n=14)

Respondents who said that their families were *not more demanding* (4%; 7) mainly commented that their family members were considerate:

'Usually undemanding'

4.13 Caring for own family advantageous or disadvantageous

Using a tick chart, doctors were asked to indicate whether they felt that caring for their own family was an advantage or a disadvantage, or whether they were not sure.

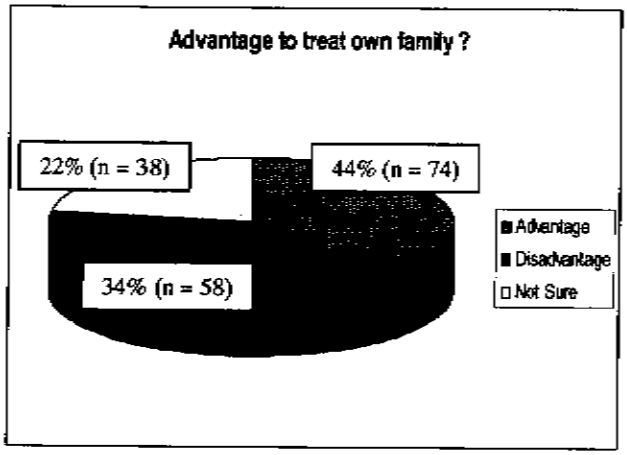


Figure 4.18 Advantage or disadvantage for doctors to care for their own families

43.5% (74) of the 170 respondents felt that it was advantageous to care for their own families, 34.1% (58) felt that it was a disadvantage, and 22.4% (38) were not sure. Doctors were asked to explain their responses. See Appendix E for further examples of comments. Comments from respondents who thought it was an *advantage* include the following themes:

a) Convenience (8.1%; n=14)

b) Personal knowledge of the patient (6.3%; n=11)

c) Caring doctor (5.8%; n=10)

d) Financial incentives (5.2%; n=9)

e) Self-confidence (3.4%; n=6)

Respondents who thought treating their own families was a *disadvantage* commented that:

a) Objectivity is clouded (7.5%; n=13)

b) *Inadequate history, examination and record-keeping (6.3%; n=11)*

c) Too much responsibility (3.4%; n=7)

d) Disadvantage if outside of speciality (1.1%; n=2)

4.14 Usefulness of ethical guidelines

Doctors were asked to indicate, using a tick chart, whether or not they thought it would be useful to have ethical guidelines regarding doctors' treatment of their own families.

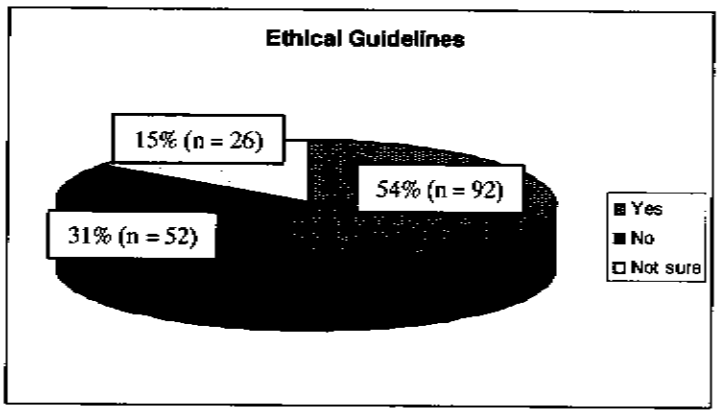


Figure 4.19 Perceptions of usefulness of ethical guidelines regarding doctors' treatment of their own families

Of the 170 respondents, just over half (54.1%, 92) responded 'yes', 30.6% (52) responded 'no' and 15.3% (26) indicated that they were 'not sure'. Respondents who thought ethical guidelines *would* be useful gave some of the following comments (grouped into themes). See Appendix E for further examples of comments.

a) *Useful to have something written to refer relatives to (4.6%; n=8)*

b) *Clarification would be helpful (4%, n=7)*

c) Doctors should never treat their family (2.3%; n=4)

Respondents who thought ethical guidelines *would not* be useful gave the following comments:

a) Not necessary (6.9%; n=12)

b) Not practical (3.4%; n=6)

c) Too prescriptive (1.7%; n=3)

4.15 Other comments

Respondents were given the opportunity to make any other comments. Comments have been grouped into themes and a few examples have been transcribed. See Appendix E for further examples of comments.

a) *Doctors should never treat family members (8.1%; n=14)*

b) *Doctors should only treat mild illness (7.5%; n=13)*

c) *Doctors should treat family members (10.4%; n=18)*

d) *'Pressures on doctor' (8.1%; n=14)*

e) *Objectivity is clouded (6.3%; n=11)*

f) *Relatives should be treated the same way as all patients(4.6%;n=8)*

g) *Problems out of expertise should be referred (3.4%; n=6)*

h) *Different standards for relatives (2.3%; n=4)*

i) *Where do we draw the line? (1.1%; n=2)*

j) *Comments on the topic (4%; n=7)*

4.16 Regular care providers for *none of the* family members respond differently to several questions

Doctors who reported being main care providers for no family members were significantly more likely to:-

- Refuse a family member's request for medical care or advice (p=0.003).
- Have had a request for care that made them uncomfortable (p=0.020).
- State that family members were not more demanding of their time (p=0.042).
- See being the regular care provider for a family member as a disadvantage (p=0.0002).
- Strongly agree that every doctors' family member should have their own non-relative GP or specialist (p=0.000).

Doctors who reported being the main care provider for *at least one* family member were significantly more likely to:-

- Think that family members received better care from them than from other doctors (p=0.038).
- Always keep records for ad hoc consultations (p=0.014).

CHAPTER FIVE
DISCUSSION

In this chapter the main findings of the study will be discussed, making comparisons with other studies in the literature. Although, the study populations and research settings were different in the various studies, doctors' attitudes and practices could be compared, taking these limitations into account. Comparisons between this study and the studies in the literature are thus done with reservation.

5.1 Who is a family member?

For the purpose of this study, 'family member' is defined as a doctor's spouse or partner, parent, child, sibling, grandparent, grandchild, parent-in law, brother or sister in-law, niece or nephew. The South African policy statement does not define 'family'.[27] In the USA, Medicare's list of family members includes spouses, parents, children, siblings, step-parents/ children/brothers/sisters, children-in law, siblings-in law, grandparents, grandchildren and spouses of grandparents and grandchildren.[7] Some policies interpret 'family member' to also include any individual with whom the doctor has personal or emotional involvement.[32] La Puma points out that 'not all relatives are emotionally close, and some people who are emotionally close are not relatives.'[7] In this study, friends were *not* included as family members.

It may be difficult for doctors to evaluate the emotional nature of a relationship and the impact that this may have on the doctor-patient relationship and the quality of care that can be provided. The American College of Physicians Ethics Manual states that the type of relationship is less important than one's emotional closeness when deciding whether a patient is too much of an intimate to treat.[35] A close friend may be more intimate than one's sibling or child. The manual suggests that if it is unclear whether one's closeness to the individual obscures the physician's ability to be objective, one should consult with another physician.

5.2 Sociodemographic profile

Although the response rate was only 31%, this is comparable to other South African doctor surveys.[41,42,43] The research group included 172 doctors practising in Gauteng, of which 54.7% (93) were GPs and 45.3% (77) were specialists, residing mainly in the North and Far North. Doctors were predominantly married (88%; 151), between the ages of 30 and 59 (mean age was 46.4 years). 77% (132) were male and 23% (40) were female; 62% (91) were White, 20% (30) were Black and 13% (20) were Indian. The average doctor had 2.4 children, and most had a spouse and children living with them.

In the La Puma study, there were 465 completed questionnaires (a 67% response rate).[7] All participants were on staff at a teaching hospital in Chicago. The mean age was 45.7 years and 81% were male, which is a very similar distribution to this study. The Furman study had 548 responses (44% response rate) of which 86% were male and 13% were female.[8] All the doctors in his study were general practitioners (members of the Academy of family Practice). The Richards study, done in New Zealand, had a 62% response rate, most respondents aged between 30 and 49 years, 80% married, predominantly with 2 or 3 children; 45% were general practitioners and 43% were specialists.[2]

The Dusdieker study, done in a University Hospital in Iowa, had a 70% response rate; 72% of respondents had children living in their households.[28] The Nik-Sherina study was a qualitative study done in a University medical centre in Malaya. [29] The 22 participants were younger than those in this study, with a mean age of 36.1 years (range 30-52 years).

5.3 Practices

5.3.1 Requests by family members

The study shows that a large percentage of doctors were asked for advice or treatment by family members (more than 94% were asked for advice, more than 92% were asked for treatment and more than 73% were asked for second opinions by at least one family member). This is comparable to the La Puma study where only 1%

of respondents reported that they had never been asked for medical advice by a family member.[7] The family members who did the asking were most frequently parents, spouses and children. This is also comparable to the La Puma study where those reported as making requests were most frequently spouses, children and mothers.[7]

In general, younger doctors were asked for advice, treatment and second opinions more frequently than older doctors, especially from parents (p=0.01), parents-in-law (p=0.02), siblings (p=0.02), nieces and nephews (p=0.04). Older doctors were asked for care more frequently than younger doctors by children (p=0.03) and grand-children (p=0.007). This is partly because younger doctors were unlikely to yet have grandchildren, and may have had children who were too young to ask. These findings are different to the La Puma study where relatives' requests were evenly distributed between older and younger physicians.[7] Family members generally asked for advice, treatment and second opinions significantly more frequently from GPs compared to specialists, especially siblings (p=0.01), in-laws (p=0.02), nieces and nephews (p=0.01). Perhaps GPs are seen as more approachable or available for a broader spectrum of problems by extended family members.

Parents, parents-in-law, siblings and spouses of Indian doctors, and spouses of Black doctors, requested care significantly more frequently than family in other ethnic groups (p=0.03). This may be because Indian and Black doctors tend to have closer physical relationships with extended family members and live with them more often in the same household, compared to White doctors. Doctors with large families were asked for advice by their children significantly more frequently than doctors with small families (p=0.001), and asked for second opinions more frequently by their spouses (p=0.04) and children (p=0.009). However, doctors with large families were asked for treatment less frequently by parents (p=0.004), siblings (p=0.01) and other family members (p=0.03) compared to doctors with small families. Perhaps doctors who had 3

or more children were more involved with their nuclear families' medical care, and the extended family did not want to bother them.

5.3.2 Doctors' treatment practices

Most doctors in the study did provide medical services to family members. More than 90% had examined a family member, more than 94% had diagnosed illness and 93% had prescribed medication to at least one family member. These findings compare favourably with those in the Furman study which reported that between 90% and 94% of doctors sometimes or always treat their own family (22.6% always treated, 71.5% sometimes treated and only 4.4% respondents in the Furman study never treated their own family).[8]

In the Nik-Sherina study all of the participants had treated their family members.[29] Evans did a survey amongst neurologists and found that 80% treated their family members for acute minor illnesses and 33% for chronic condtions.[45] More than 88% of respondents in the current study had performed physical examinations on at least one family member – this was higher than the 72% in the La Puma study who had performed physical examinations on a relative. More than 94% of doctors had diagnosed illness in a family member (compared to 80% in the La Puma study), and more than 90% had prescribed medication to a family member (compared to 83% in the La Puma study).[7]

Spouses and children were most often the recipients of all these practices, which was a similar finding by La Puma.[7] Fewer doctors reported administering immunisations to family members (3.4% in this study, compared to 31% in the La Puma study). This could be accounted for by the fact that in South Africa, the majority of children, even in the primary health care sector, are immunised by clinics or paediatric nurses, rather than by private doctors. Only a small number reported having administered CPR to family members (2.9% in this study, compared to 1% in the La Puma study).[7]

30% of respondents had sutured wounds in at least one family member, and the majority of these were in their children. 7.4%

respondents had performed elective surgery on a family member (compared to 9% in the La Puma study), and 6.2% had performed emergency surgery (compared to 4% in the La Puma study).[7] More than 33% of respondents reported giving sick notes to at least one family member, most often their children.

In general, younger doctors in this study examined, diagnosed illness in, prescribed medications and immunised family members significantly more frequently than middle-aged and old doctors, especially nieces and nephews (p=0.04), siblings (p=0.01), parents (p=0.04) and other family members (p=0.02). This is in contrast to the La Puma study where the proportion of respondents who provided services to family members rose with the respondents' age.[7] This difference in findings is difficult to explain, especially since the mean age of doctors in this study and in the La Puma study was similar (46.4 years and 45.7 years respectively). The difference may be due to different geographical practices, or due to differences in the research setting (e.g. La Pumas study was done in an academic hospital, while the current study was done amongst private sector doctors).

The exceptions in this study were that middle-aged and old doctors examined, diagnosed illness in and prescribed medication significantly more frequently in grandchildren (p=0.007); middle-aged doctors sutured their children more frequently (p=0.03), and middle-aged and old doctors gave sick notes to their children more frequently than younger doctors (p=0.000). Older doctors obviously had more children and grandchildren than younger doctors, which accounts for some of the difference.

Mainly, female doctors examined and diagnosed illness in their children (p=0.006) and parents (p=0.07) significantly more than male doctors. This may be because in South Africa, mothers are more often than fathers the primary care givers for their children. Male doctors sutured wounds in their children more frequently than female doctors (p=0.02). In most cases, GPs were significantly more likely to examine, diagnose, prescribe medicines for, immunise,

suture and give sick notes to family members than specialists (p=0.01). This is similar to the La Puma study, where respondents in primary care had performed significantly more services for family members than specialists.[7] Specialists were more likely to perform emergency surgery on their children than GPs (p=0.04).

Generally, Indian doctors examined (p=0.03) and gave sick notes (p=0.02) to their families more frequently than other ethnic groups. This may be due to convenience, because Indian family members lived in the doctors' households more commonly than family members from other ethnic groups. Unmarried doctors examined (p=0.04) and diagnosed illness (p=0.001) in siblings significantly more frequently than married doctors. Doctors with small families prescribed medications to and immunised nieces, nephews and other family members significantly more frequently than doctors with large families (p=0.02). Doctors with large families sutured wounds and gave sick notes to their children significantly more frequently than doctors with small families (p=0.01). Obviously, the more children in a family, the more commonly a child will be sick or injured.

5.3.3 Place of consultation

When doctors were the usual medical carers for their family members, consultations took place in almost equal numbers in the doctor's home (47%) and in the doctors' rooms (46%). Very few (only 7%) took place in the patient's home. For 'ad hoc' consultations, many more were in the patient's home (32%) which is a less formal setting, compared to 40% in the doctor's home and only 28% in the doctor's rooms.

Where examinations take place in an informal setting, medical histories are more likely to be incomplete or assumed, physical examinations are more likely to be omitted or abbreviated, and the physician may perform the examination without the proper instruments.[35] The American College of Physicians ethics manual suggests that physicians contemplating treating family members should carefully assess the limitations of the medical setting.

Whenever possible, care should be delivered in the standard practice environment; if the setting is unusual, physicians must be sure that this alternative environment does not compromise quality.[35] In some cases reported in the literature, there was no place of consultation, and prescriptions were given over the telephone by a physician to a family member far away.[13] Where the consultation takes place in the family member's or the doctor's own home, often 'the lighting is poor, equipment is unavailable, examination is not on a standardised bed, and concerned relatives are hovering'.[37] Conversely, home visits may offer invaluable information about the context of the illness, and may be a comfortable, relaxed place for the patient to be examined.

In this study, 'ad hoc' consultations took place more frequently in the doctors' rooms when respondents had large families, and more frequently in the patient's home when doctors had small families (p=0.025).

5.3.4 Record keeping

In many circumstances, formal records were not kept for family member consultations. When doctors were the usual medical carers for their family members, one third always kept formal records, one third sometimes kept formal records and one third never did. When consultations were 'ad hoc', much fewer doctors reported keeping formal records: 52% never did and only 22% always did.

McSherry states that in many children of physician parents, there is no single complete source of medical records.[13] This results in the children experiencing poor medical care when their health problems fall outside the realm of their parents' expertise.

The American College of Physicians Ethics manual suggests that when care is given to family members, physicians should keep records and communicate with the patient's primary physician. Notes on the care of a family member should be accessible and shared with other caregivers. When there is a bad outcome, cases

involving family members are appropriate for discussion at morbidity and mortality rounds.[35]

The Medical Practitioners Board of Victoria states that if a medical practitioner decides it is appropriate to treat a family member, good medical records must be maintained, the consultation should be formalised, and follow up should be arranged.[38]

Dusdieker notes that physicians often fail to record their encounters with family members so that there is often no documentation and no chart to consult.[28] This may make doctors prone to admissions, abbreviations and informalities, which may compromise care and harm patients.[35]

In this study, doctors working in the East and North reported always keeping records when they were the usual medical carer significantly more frequently than doctors in other areas. Doctors working in the South reported 'never' keeping records significantly more frequently ($p=0.03$). However, doctors in the South were under-represented in this study, so this result may be an over-generalization.

5.3.5 Billing Practices

Most doctors did not charge their family members for consultations – only 21% reported billing when they were the usual medical carer, and only 11% billed for 'ad hoc' consultations. Of those doctors who did charge family members, most billed cheaper rates for both formal and 'ad hoc' consultations.

The South African Medical and Dental Professional Board resolved in 2007 that the matter of charging for services rendered to immediate family should be viewed in the same light as treating any ordinary patient.[27] However the Board also reconfirmed a previous policy regarding the treatment of dependents that 'it was not permissible for a practitioner to render accounts for services rendered to immediate dependents, except in the case of laboratory fees and material (including dispensing of pharmaceuticals) for

which it would be permissible to render an account.[27] In the USA, major medical aids like Medicare and BlueCross do not pay for patient care charges by immediately related physicians.[7,46] There may be a financial motive for doctors to treat their own families, especially with the dwindling practice of professional courtesy, which has been discussed in Chapter Two.

Old doctors (>60 years) were significantly less likely than young and middle-aged doctors to bill their family members for consultations (p=0.042). Perhaps they were more traditional to the outdated practice of professional courtesy than younger doctors. Also, younger doctors tend to be unmarried and less financially stable; they possibly feel less obligated to provide free services to family members. Unmarried doctors (p=0.05) and doctors of 'other' ethnicity (p=0.001) were significantly more likely to bill their family members for 'ad hoc' consultations.

5.3.6 Doctors as main health care providers for family members

Only 28.2% of respondents stated that they were the main care provider for '*none*' of their family members. Significantly more of these were male rather than female (p=0.03) and specialists rather than GPs (p=0.000). More than half of the respondents (52.9%) acted as the main care provider to their children, almost half (45.9%) for their spouse and 21% for their parents. Significantly more female doctors were main health care providers for their children (p=0.003).

None of the other studies in the literature ask this same question directly, so it is unknown whether the 78% of Gauteng respondents who act as the main care provider to at least one family member is similar to other areas. In the La Puma study, 15% of respondents had attended a family member as primary physician in the hospital.[7] In the Richards study, 66% of respondents claimed that their families had a separate family doctor i.e. 33% did not.[2] However, only 22% of these respondents said that their family members saw the family doctor for regular asymptomatic checks. This suggests that the respondents often provide the doctoring themselves.

In the Dusdieker study, nearly all respondents reported that their children had a nonparent as the physician of record.[28] Only 3.6% listed the father or mother as the physician of record, and 1% listed no primary physician for their children. However, 74% reported that they usually treat their own children for acute afebrile illness and 45% for acute febrile illness. Only 12% of parent physicians regularly performed routine physical examinations on their children.[28] In a study amongst neurologists, 87% respondents treated family members for acute minor conditions and 36% treated family members for chronic conditions.[45]

McSherry (1988) describes some physician parents who are the main care providers for their children as over-controlling.[13] He feels that these children experience poor medical care when their health problems fall outside the realm of their parents' expertise and believes that developmental issues like sexuality are often ignored.

In the present study, as expected, old doctors were significantly more often the regular main care providers for their grandchildren, compared with younger doctors (p=0.008). Young doctors were significantly more often the regular main care providers for siblings (p=0.001).

GPs were significantly more likely than specialists to act as the regular main care provider to most family members, including spouses (p=0.003), children (p=0.006), siblings (p=0.006), siblings-in-law (p=0.035), nieces/nephews (p=0.000), aunts/uncles (p=0.000) and cousins (p=0.002). This makes sense as GPs are more likely to see themselves as primary care givers, and act as such for family members. Specialists were more likely to state that they were the main care provider for *none* of their family members (p=0.000). It would be less usual for a specialist to be a main care provider as this is a primary care function. It would also be easier for specialists to refuse this role, citing that the practices are outside of their area of expertise. Interestingly, there was no significant difference between GPs and specialists being main care providers for parents, parents in law, grandchildren and 'other' family members. This

suggests that some respondents, particularly specialists, are providing care out of their usual scope of practice to these relatives.

Married doctors were significantly more likely to be the regular GP or specialist for their spouses (p=0.000) and parents in law (p=0.03) [obviously, they had these family members], while unmarried doctors were more likely to play that role for their siblings (p=0.000). Unexpectedly, doctors with large families stated more frequently that they were not the regular GP or specialist for *any* family member (p=0.03).

Busy doctors were significantly more often than quiet doctors the main care providers for several family members, including parents in law (p=0.03), aunts and uncles (p=0.04), nieces and nephews (p=0.03) and cousins (p=0.04). This may be because those doctors seeing more than 20 patients per day were more often the GPs than the specialists. When family members lived in doctors' households, doctors were significantly more often the main care providers, including for children (p=0.000), spouses (p=0.000), parents (p=0.001) and parents in law (p=0.01). Convenience probably plays a big role in doctors choosing to care for those family members living in their household.

5.3.7 Referral of family members

52% of respondents claimed that they referred family members the same as other patients. 30.2% stated that they referred family members more often and 17.8% stated that they referred less often. In the La Puma study (1992), 48% of respondents reported referring the family member for whom they had made their most important diagnosis, 21% diagnosed the illness and treated and then referred the patient, and 31% diagnosed the illness and treated the patient themselves.[7] However, there is no comparison between referral of family members and referral of other patients, so no conclusions can be drawn as to whether the referral rates are similar to the present study.[7]

Furman's South African study (1992) found that 50% of respondents stated that they were more likely to refer when treating another doctor, but does not address this question for doctors' families.[8] The Dusdieker study (1993) of physician parents found that 29% of physicians referred their child directly to a subspecialist without prior consultation or notification of their child's physician of record.[28] A difference in doctors' referral of acute and chronic illnesses in family members has been described.[28] In the Nik-Sherina study (2006), most doctors treated acute self-limiting conditions, but the majority referred their family members to other doctors for care of chronic diseases.[29]

In the present study, GPs referred family members significantly more often than specialists (p=0.03). They may have wanted their family members to have more specialized or expert opinions for various problems, thus possibly over-servicing their relatives in an attempt at better care. This is in contrast to the Dusdieker study where primary care physicians were *less* likely than specialists to refer their child for acute febrile illness.[28] However, in Iowa, where Dusdieker's research was done, all children are all registered with a primary care physician; while in South Africa there is no 'record doctor'. The Dusdieker study was only about doctors referring their children, while the current study included referral of all family members, and had only 6 paediatricians.

The present study also found that busy doctors were more likely to refer their family members than quiet doctors (p=0.02); perhaps the doctors who saw fewer patients had more time to spend on their families, although quiet doctors were less often the main care providers for several family members. This could also be explained by the fact that the more relatives or patients seen, the greater the chance of needing to refer. Dusdieker states that by referring the child to a subspecialist, the physician parent has usurped the physician of record's opportunity to treat the child. The child's physician of record may have concurred on the need for a consultation, if asked, and recommended the most suitable consultant.[28] In South Africa, where there is no official physician of

record, the referral of patients to a specialist is less formal; patients may even refer themselves without first seeing a general practitioner. This makes referral to a specialist more accessible than in other parts of the world.

5.3.8 Investigation of family members

La Puma and Priest caution doctors to be aware of the possibility of over and under treating family members.[16] They describe how a family member physician may feel a great need for surety, ordering unnecessary tests to track false positive results. In the present study, 62% of respondents stated that they investigated family members the same as other patients; 28.2% said that they investigated family members less often, and 9.8% responded more often. The only significant sociodemographic difference between investigation rates was that respondents working in the North and Central areas investigated family members more often, while doctors in the South investigated family members less often. (p=0.005). This may be because doctors in the North and Central areas have easier access to investigative facilities, as these areas are where more of the specialised facilities are based.

Some authors have stated that a loss of objectivity can affect diagnostic work-ups: to exclude all possibility of disease, some doctors obtain more tests on relatives than might be done in similar cases for other patients.[35] Conversely, sometimes doctors may be less likely to recommend invasive or painful procedures to relatives.[35]

Respondents in the La Puma study described physicians being inappropriately involved in the care of a family member.[7] 44% described physicians who had lost their objectivity, not performing procedures needed to investigate serious illness or pursuing investigations that the respondents considered futile.[7] La Puma and Priest highlight that expensive or uncomfortable procedures are often omitted to spare the relative who is the patient.[16]

Furman's survey stated that 52.6% of respondents were more likely to investigate when treating another doctor, but did not address this issue for doctors' families.[8] Furman describes how doctors may omit examinations or abbreviations for doctor-patients to avoid discomfort or offence, or how unnecessary investigations may be requested to demonstrate that nothing is overlooked.[8] These same reasons probably apply to doctors over or under investigating their family members.

Other authors describe how physicians subject their family members to a series of unnecessary tests in order to make a diagnosis.[34] They may be more likely to accede to inappropriate requests from relatives, such as inappropriate tests.[32] Conversely, they may be reluctant to face the possibility of a serious illness in a family member and under-investigation may lead to a missed diagnosis.[34,32]

Richards found that doctors' families may be under investigated, especially with regard to screening procedures.[2] In his study, only 71% of female spouses or partners had recent breast examinations, 29% had mammograms, 73% had blood pressure checks and 49% had cholesterol tests.

Parent physicians in the Dusdieker study often omitted performing physical examinations and laboratory tests when treating their children.[28] As a result, they may not have had adequate data to assist in making an objective treatment plan for their child. Schneck (1998) comments that modifying routines to save the patient time, trouble and money, may result in poor medical care.[47]

5.3.9 Refusal of family members' requests

Only 38.2% of respondents had refused a family member's request for advice. This figure is lower than that in the La Puma study, where 57% of respondents reported refusing a family member's request for diagnosis or treatment.[7] In the present study there was no significant difference between older and younger doctors refusing a request for care. However, in the La Puma study, fewer older physicians than

younger physicians reported refusing a request (53% of older physicians and 64% of younger physicians).[7]

One reason why so many doctors don't refuse requests might be that doctors want to be available to their families and feel obliged to offer their clinical expertise.[35] Another reason is that doctors may be embarrassed when their family members bother a colleague for what seems to be a simple problem.[35]

In the La Puma study, the most common reasons given for refusing a request for care were that the clinical problem was not within the doctor's area of expertise (34%) and that examination and follow-up might be inadequate (18%).[7] In the present study, reasons given for refusing a request for care included inadequate medical assessments (8.1%; 14), the request being outside the doctor's area of expertise (6.3%; 11), fear of loss of objectivity or emotional involvement (5.2%; 9), and avoiding intimate examinations (4.6%;8).

In the Malaysian study (Nik-Sherina et al, 2006), many respondents said that they obliged family members by providing explanations and suggestions rather than actual medical treatment, especially when consultations were informal or telephonic.[29] Most of the respondents considered responding to requests for care to be a family obligation, especially if they were the only medical individuals in the family. The study cites the socio-cultural milieu in Malaysia as a reason that doctors don't refuse requests for care; family members are expected to help each other; younger members are expected to respect their elders and comply with their requests.[29] The present study found no significant differences between different ethnic groups' rates of refusal of requests for care. La Puma and Priest (1992) suggest that doctors ask themselves the question 'Am I trained to meet my relative's medical needs before deciding to treat a family member?' They advise against inappropriate care, cautioning doctors that they need to be accountable to their peers.[16]

5.3.10 Provision of care outside of expertise

32.4% of respondents admitted to providing medical care or advice to a family member that was out of their discipline or not within their usual scope of practice.

The American College of Physicians ethics manual urges doctors to consider whether the service required by the family member falls within their area of expertise, stating that the likelihood of a misdiagnosis or incorrect treatment increases if a request is outside the physician's speciality area.[35] The Medical Practitioners Board of Victoria states that it is particularly dangerous when family members exert pressure for diagnosis or treatment outside the area of the doctor's expertise.[38]

In the present study, providing care outside of expertise was more common amongst male respondents than female (p=0.04). Not surprisingly, specialists provided care out of their discipline significantly more than GPs (59.7% of specialists and only 8.8% of GPs; p=0.000). This may be because GPs consider themselves to be generalists with few limitations on their scope of practice. Some specialists in this study justified this practice by commenting that they were GPs before they specialised and thus capable of treating GP problems. Dusdieker (1993) expresses concern about overall quality of care received by children of physicians, having found that physicians treated their children regardless of their training level or speciality.[28]

Quiet doctors in this study were more likely to provide care that was out of their discipline compared to busy doctors (p=0.049). This was probably because 'quiet' doctors were more often specialists. Respondents working in the North and Far North more frequently provided care to relatives that was out of their discipline (p=0.026). This is probably because more specialists worked in these areas.

5.4 Attitudes

5.4.1 Attitudes to family members having their own health care providers

78.8% of respondents agreed or strongly agreed with the statement "Doctors' family members should have their own non-relative health care provider". There was no significant age, gender, ethnic or geographical difference between doctors' responses to this statement. Specialists were significantly more likely than GPs to agree or strongly agree with the statement (p=0.004). This relates to the fact that fewer specialists were main care providers for their family members.

Furman (1992) quotes Sparks, who in delivering the Boz Fehler lecture, stated that all doctors must have a GP for themselves and their families, stating that we should not take care of our own families as we become 'bothered, offhand and neglectful'.[8]

Section 5.3.6 discusses results from some other studies where between 22% and 66% of respondents reported that their families had separate doctors.[2,7,28]

5.4.2 Doctors' perceptions of whether their families receive better or worse care than patients who are not relatives

The majority of doctors in the present study felt that family members received the same care from them (70.2%) and the same care from other doctors (58.9%) as other patients received. 16.1% of respondents felt that they gave their families worse care and 13.7% felt that they gave their families better care than other patients. 38% of respondents thought that their families received better care and only 3.1% worse care from non-related doctors compared with other patients.

This finding is in contrast to the Furman study, which found that doctors believed that they and their family received the same care (34.2%), better care (34.3%) or worse care (31.5%) in almost equal numbers.[8] Furman did not differentiate between care from the family member doctor and care from an unrelated doctor. The attitudes

found in the present study are similar to those in the study of Israeli family physicians (Rennert, 1990), where 57% of respondents said there was no difference between treatment received by their own families and other patients, 31% said that their own families received worse treatment, and 12% said better treatment.[9]

One author comments that in the care of family members, medical care may be optimal, while emotional care may be ignored.[46] This has been documented where physician-husbands compromise good care of their wives.[46] McSherry (1998) feels strongly that interference of parent-physicians in their children's care results in the children receiving suboptimal care.[13] Spock (1962) comments that the physician's family receives intermittent care; he feels that this is because doctors are inhibited and delay asking for care for their families.[22] Other authors have described how doctors' families receive poor care because doctors are reluctant to impose on busy colleagues, or believe that they will look foolish for seeking help; self-referral and self-treatment result in periodic and episodic care.[22]

5.4.3 Requests for care that made doctors uncomfortable

In several studies in the literature, doctors have expressed discomfort when receiving requests for medical care from family members.[7,29,30] Discomfort may stem from role conflicts, maintaining objectivity and crossing ethical boundaries.[7]

In the present study, 38.2% of respondents had received a request for medical care that made them uncomfortable. There were no significant socio-demographic differences in the responses to this question. Where respondents commented on the sources of the discomfort, these were most often to do with emotional intimacy (6.9%; 12), physical intimacy (7.5%; 13), inappropriate requests (6.9%; 12), or requests outside the doctor's scope of practice (4.6%; 7).

These findings are similar to the La Puma study, where 22% of respondents had acceded to requests that made them uncomfortable. Reasons for acceding to requests despite discomfort

cited by these respondents were mainly the inadequacy of the examination and follow-up (23%), the absence of a medical indication for the request (20%) and their own lack of objectivity (20%).[7]

The Malaysian study reported that most participants felt burdened and uncomfortable when treating their own families, mainly due to the fear of errors in diagnosis and management.[29] Participants were concerned that strong emotions may make them lose objectivity. Many were aware that negative outcomes resulting from their treatment might affect future relationships. Some doctors expressed discomfort with regards to maintaining confidentiality when other family members asked for details.[29]

5.4.4 Doctors' perceptions of whether family members are more demanding of their personal time

Family members often expect a high degree of involvement in their illness from physician relatives.[30] Demanding family members may impact on the doctor's personal life and family ties.[29]

In this study 36.3% of respondents indicated that they found family members to be more demanding of their personal time, compared to regular patients. Some respondents commented that their family requested information or help after hours, especially for minor ailments, much more often than regular patients (8.1%; 14). Some stated that discussions with family around illness were ongoing, and some expressed that family members pushed boundaries, such as bypassing the receptionist and wanting to be seen without queuing (5.8%; 10). Some doctors said that family members had easier access to them and always knew how to contact them (6.9%; 12). There were no sociodemographic differences in responses to this question.

Similar comments were made by respondents in the Malaysian study.[29] Some of these doctors reported that the family may consult at any time, 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. Other doctors experienced their family expecting them to abuse their access to hospital facilities, expecting better and faster services and wanting to 'cut the queue'.[29] Freeman describes how, when looking after his ill wife, his 'personal needs were forgotten and sleep was impossible'.[40]

5.4.5 Doctors' perceptions of whether it is advantageous or disadvantageous to treat their own families

43.5% of respondents felt that it was an advantage to care for their families, 34.1% felt that it was a disadvantage and 22.4% were unsure. There were no sociodemographic differences in responses to this question.

Advantages and disadvantages of doctors treating their family members have been discussed in the Literature Review. Similar attitudes were expressed by respondents in this study and by those in the literature. Respondents perceived the main advantages to be convenience (8.1%; 14), personal knowledge of the patient (6.3%; 11), a more caring doctor (5.8%; 10), financial incentives (5.2%; 9) and self-confidence (3.4%; 6). These views are similar to those in the Dusdieker study (1993), where convenience was given as the most important reason for doctors treating their children, followed by confidence in their own diagnostic and treatment skills, quality of care concerns, concerns about confidentiality and cost.[28] In the Nik-Sherina study (2006), advantages cited were easy access to medication and facilities, doctors' ability to treat and a sense of pride.[29] Respondents in the Chen study (2001) listed the main advantages as total commitment to the patient and personalized care.[30]

Perceived disadvantages by respondents in this study were mainly clouded objectivity (7.5%; 13); inadequate history, examination and record-keeping (6.3%; 11) and stress for the doctor (3.4%; 7). Disadvantages found by Nik-Sherina (2006) included fear of missing serious conditions or proposing incorrect management due to informal assessments; maintaining confidentiality; emotional involvement and lack of objectivity; and the effect on the doctor's

personal life and family ties. In the Chen study (2001), disadvantages listed were mainly emotional involvement that could cloud critical thinking and sound judgement, and the role conflict of the family member doctor.[30]

5.4.6 Perceptions regarding ethical guidelines

The South African Medical and Dental Professions Board resolution is set out in full in Chapter Two. It states only that 'it is not advisable for practitioners to treat their families in cases of serious illnesses' and specifies that immediate family may be charged for services, but not dependents. Various American, Canadian and British guidelines were also discussed in the literature review.

54.1% of respondents in this study felt that it would be useful to have ethical guidelines regarding doctors' treatment of their own families. 30.6% did not think it would be useful and 15.3% were not sure. There were no significant sociodemographic differences in responses. From those respondents who felt ethical guidelines would be useful, the main reasons were that it would be useful to have something written to refer to, especially when refusing family members' requests (4.6%; 8), and that many doctors were unsure of professional boundaries (4%; 7). The respondents who felt that guidelines would not be useful gave reasons such as the fact that it would not be practical as they would still have to treat (3.4%; 6), that it should be the same as for other patients, and that each doctor should make his own choices (6.9%; 12).

La Puma stated that physicians need a forum for the discussion of the medical care of family members, since some requests for care are troublesome to practitioners.[7] La Puma and Priest suggested some ethical questions for physicians to ask themselves before treating family members (see Literature Review) – these are useful, but not widely published.[16] Allowing each doctor to create his/her own guidelines may create varying standards and different approaches to practice, leading to difficulty in defining what good practice is. At least guidelines provide a framework within which each doctor may be flexible.

Chen concludes that physicians need a tenable ethical code that honestly acknowledges that physicians do treat their families.[30] He suggests that the code does not speak in absolutes, but should provide guidance for carers. He urges physicians to be aware of the conflicting expectations (of family members and of other physicians), suboptimal care conditions and consequent dilemmas that they will face in these situations.[30]

Latessa and Ray suggest that each doctor creates his own set of guidelines to make him comfortable with decisions around treating friends and family.[46] La Puma and Priest do not believe that the solution to the dilemma of doctors treating their families lies in more numerous or stringent guidelines.[16] Instead, they suggest that doctors arrive at personal answers to the questions that they pose, so that they can use discretionary reasoning to make appropriate decisions.

5.5 Limitations of Research

The following limitations were taken into consideration:

a) *Selection bias* may have occurred due to the exclusion of some doctors from the Lancet lists. Some doctors practising in Gauteng, especially those in the public sector are not registered on the Lancet lists. However, it is felt that the Lancet lists are representative of all cultural and racial groups in Gauteng, including urban and township areas. Doctors in the private sector using other laboratories exclusively and not registered with Lancet and most doctors in the public sector were not included in the study.

b) *Participation bias* was a problem, as some doctors chose not to, or had no time to, complete the questionnaire. There is a possibility of bias from the group who did not respond. In order to minimise non-responders, questionnaires were couriered to doctors with the aid of Lancet couriers (rather than doing a postal survey). Doctors were assured of confidentiality and anonymity in order to encourage participation. Reminder phone calls were made to doctors who had

not returned the questionnaires after two weeks. Although there was only a 31% response rate, this rate is comparable to other South African doctor surveys.[41,42,43] It was a randomly selected survey and respondents are typical of Gauteng doctors with regard to age and gender.

c) Bad experiences could have been under-reported compared to good ones, because doctors may be uncomfortable with talking about the bad ones, leading to *reporting bias*. It is possible that doctors who did not fill in the questionnaire had a specific reason not to do so, for example, a bad experience when treating a family member; this may have caused a biased sample.

d) *Recall bias* may have occurred in this study. For example, doctors who have a family member with significant illness may recall situations better than a doctor with a relatively healthy family.

e) Another concern with survey research is that it measures the behaviour reported by respondents, not their actual practice.[18] However, the fact that almost all doctors report that they sometimes treat their own families, supports the conclusion that the practice is widespread.

CHAPTER SIX
CONCLUSION

6.1 Conclusion

Attitudes and practices of doctors in the private health care sector in Gauteng, who use Lancet laboratories, to treating their own family members have been explored. Important sociodemographic characteristics of respondents were described, such as age, gender, marital status, ethnic group, family size, work area, gender and speciality. The study further discussed these aspects and their probable influence on doctors' attitudes and practices.

This study showed that the overwhelming majority of doctors were asked for medical treatment by family members and most of them did provide some form of treatment. More than 90% of respondents were asked for advice by immediate and extended family, more than 90% of respondents' family members sought treatment, and more than 73% of family members asked for second opinions. Spouses, parents and children were the family members who most frequently requested these services. Young children may have had these services requested by their parents.

More than 88% of respondents had performed physical examinations; more than 94% had diagnosed illness, and more than 91% had prescribed medication to at least one family member, most frequently children and spouses. More than one third of respondents had immunised a family member and nearly one third had sutured a wound for a relative. Less than 12% reported having performed elective or emergency surgery on a family member and less than 4% had administered CPR to a family member. Many doctors had given sick notes to family members, with 33% of respondents having given one to a child, 22% to brothers and sisters and 23% to other family members.

Only 38.2% (65) of respondents indicated that they had refused a family member's request for care. Considering that more than 90% had been

asked for advice or treatment, it seems as though a lot of requests are acceded to. The main reasons given for refusing care were that the problem was outside the doctor's area of expertise and a fear of loss of objectivity. More than one third of respondents admitted to providing medical care outside their scope of practice; mainly specialists treating general practice problems and when no other doctor was available.

This study highlighted that more than half of consultations with family members took place outside of the doctors' rooms. This indicates that both usual and 'ad hoc' consultations with family members often take place in an informal setting without proper medical equipment. Less than half of respondents kept formal records for ad hoc consultations, and less than 70% for formal consultations with family members. This correlates with other studies which found that doctors' families had incomplete medical records.

Regarding billing practices, most doctors did not charge family members for consultations. Only 20% of respondents charged and most of these offered cheaper rates to their relatives. This practice might lead to either under use or abuse of the family member doctor, and resentment by the doctor.

The majority of respondents thought that they referred and investigated family members the same as other patients, but significant numbers referred more often (30.2%; 51) and investigated less often (28.2%; 46). This suggests that there may be a different standard of care for family members compared with regular patients.

The extent to which doctors do treat their families on a regular basis can especially be determined by whether or not they are the main care providers. Only 28.2% (48) respondents stated that they were not the main care provider for *any* family member. More than half (52.9%; 90) were the main care providers for their children and 45.9% (78) for their spouse.

Doctors' attitudes towards treating relatives were explored. In many cases, the attitudes (agreeing that family should have their own GP, feelings of discomfort) do not correlate with the actual practices. For example, 78.8% (134) of respondents agreed or strongly agreed that doctors' family

members should have their own health care providers, yet more than 52% acted as main care providers for at least one relative. Most respondents (70.2%; 118) felt that family members received the same care from them as other patients. However, many felt that their families received better care from other doctors and some felt that they gave their own families worse care than regular patients. Yet, despite admitting to these feelings of inadequacy when treating family members, doctors still reported doing so.

Family member patients were proven to be a significant source of stress for doctors. 38% (65) of respondents reported receiving requests from family members that made them uncomfortable, mainly due to emotional and physical intimacy. 36% (61) of respondents perceived family member patients to be more demanding of their personal time.

The study highlighted that doctors continue to treat their families even though it may not be in anybodies' best interests. Only 43.5% (74) respondents felt that it was advantageous for doctors to care for their own families, although a much larger number indicated actually doing so. The main reasons given for feeling it was advantageous included convenience, personal knowledge of the patient and context, caring for the patient and the financial incentive. The 34.1% (58) who felt it was disadvantageous cited clouded objectivity, inadequate examinations and burden of responsibility as the main reasons.

In conclusion, doctors have ambivalent feelings towards treating their families, yet do so even though patient care may be compromised (informal setting, poor record keeping, loss of objectivity). There is a great deal of stress involved and pressure on the doctors. Nevertheless, family members do request care from doctors, and in many circumstances, doctors comply with these requests. Despite reporting sometimes feeling uncomfortable and that the care may not be ideal, doctors in Gauteng reported examining, diagnosing, treating and even operating on their relatives. A large proportion of doctors report being the main care providers for both immediate and extended family. These findings need to be considered if more comprehensive policies and ethical guidelines are to be developed. The policies need to acknowledge that doctors do treat their families and

that the majority of respondents felt that clarification of guidelines would be helpful.

6.2 Recommendations of the study

- The fact that the majority of doctors do treat their families needs to be acknowledged by the Health Professionals Council.

- Further training at an undergraduate and a postgraduate level should be introduced into the medical curriculum (taking into account the differences between GPs and specialists and other sociodemographic differences).

- Ethical guidelines should be published, aimed at providing a framework on how doctors should handle providing care to their family members. This will aid doctors in evaluating the impact that emotional involvement with the patient may have on the quality of care.[16,32]

- Before a doctor treats family members, he/she should ask himself/herself the following questions:[16,32]
    1. Am I trained to meet my relatives' medical needs and do I have the appropriate experience and expertise in this particular field?
    2. Could the personal relationship affect my ability to recognize and act in his/her best interests?
    3. Can I be objective enough to not give too much, too little or inappropriate care?
    4. Would I be too uncomfortable to ask the questions and do the examination necessary to make a proper diagnosis, particularly on sensitive topics?
    5. Am I able to maintain patient confidentiality?
    6. Can I respect the patient's autonomy?
    7. Is medical involvement likely to provoke or intensify intra-familial conflicts?
    8. Am I willing to be accountable to my peers and the public for this care?

- Recommendations for further research
    1. Attitudes and perspectives of the doctors' families towards their own healthcare (especially spouses, parents and children).
    2. Retrospective study of cases where doctors have been responsible for family members' care, assessing quality of care and exploring outcomes such as morbidity and patient satisfaction .
    3. The doctor-patient relationship when the doctor is a family member.
    4. Doctors' self-treatment practices (this has not been extensively studied in the South African setting).
    5. Friendships with patients and the impact on patient care when the doctor is a friend of the patient.

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APPENDICES

Appendix A – Information Sheet

Appendix B – Questionnaire

Appendix C – Ethics Approval

Appendix D – Protocol Approval

Appendix E – Further Examples Of Comments

APPENDIX A

University
of the Witwatersrand,
Johannesburg

Department of Family Medicine

7 York Road, Parktown, 2193, South Africa • Telephone: +27 11 717-2041 • Fax: +27 11 717-2558

Dear colleague,

Have you ever had that sinking feeling when your mother-in-law phones to ask you about her chest pain? Have you been at a family dinner when your cousin asks what he should take for his heartburn? Do you treat your own children? Do you wonder how other doctors handle these situations?

My name is Sheri Fanaroff. I am a general practitioner in Parkhurst, Johannesburg. I am a postgraduate student in the Department of Family Medicine, University of the Witwatersrand, and I am conducting research as part of the requirements for my Masters in Family Medicine. The aim of the research is to determine the attitudes and practices of Gauteng doctors to treating their own family members.

Potential research subjects have been randomly selected from Lancet lists of doctors (general practitioners and specialists) practicing in central Gauteng. Lancet is kindly assisting in the distribution and collection of questionnaires.

I would like you to assist me in my research by filling in the attached questionnaire, which should take five to ten minutes of your time. The questionnaire will remain anonymous (there is no way the identity of the respondent can be revealed as questionnaires are unmarked) and confidential (the data will only be accessible to the researcher and supervisor). Please complete it as carefully and honestly as possible. If you don't wish to answer any question for whatever reason, please feel free to leave it out.

If you are willing to fill in the questionnaire, please do so, replace it in and seal the envelope, and leave for collection by Lancet with your usual specimens. Participation is of course entirely voluntary. If you decide not to fill in the questionnaire, I request that you nevertheless seal the envelope and leave for Lancet to collect.

If you would like more information about this study, you are most welcome to contact me at the numbers below. The results of this study will be made available to all participants.

Thank you for your time and assistance.

Dr Sheri Fanaroff MBBCh (Wits) MCFP (SA)
Tel: (011) 788-3404 (Work)
0834597723 (Cell)
Email: sherifanaroff@peregrine.co.za

APPENDIX B

Questionnaire (Tick applicable boxes)

1. Age ☐ 2. Sex (m) Male | (f) Female 3. (g) GP | (s) Specialist 4. **If specialist**, state which ☐

5. Marital Status (m) Married | (s) Single | (w) Widowed | (d) Divorced

6. Number of children ☐

7. Who of the following live in your household?
(tick and state ages of family living in household)

	Tick	Age(s)	
Spouse	☐	☐	s
Parents	☐	☐	p
Parents in law	☐	☐	l
Children	☐	☐	c
Other (specify)	☐	☐	o

8. Work Suburb ☐

9. Number of patients seen per day ☐

10. Ethnic group most strongly identified with ☐

11. Indicate how often family members have **requested** the following medical services from you, and how often you have **provided** the following medical services to family members. Please use **N** for **Never** requested or provided, **O** for **Occasionally** requested or provided and **F** for **Frequently** requested or provided.

	Spouse	Parents	Children	Grandchildren	Siblings	Parents in Law	Brother/sister in law	Nieces/nephews	Other (specify eg cousin)
Asked for medical advice									
Sought treatment									
Asked for your 2nd opinion									
Performed physical examination									
Diagnosed illness									
Prescribed medications									
Administered immunisation									
Administered CPR									
Sutured wounds									
Performed elective surgery									
Performed emergency surgery									
Given sick note or medical certificate									
	s	p	c	g	sb	l	b	n	o

12. For which of the following family members do you act as the **regular** GP or specialist (ie main care provider)? (tick)

	s	p	c	g	sb	l	b	n	a	cous	no	o
	Spouse	Parent	Child	Grandchild	Sibling	Parent-in-law	Brother/Sister-in-law	Niece/Nephew	Aunt/Uncle	Cousin	None	Other

13. Indicate to what extent you agree/disagree with the following statement: 'Every doctor's family member should have their own (non-relative) GP or specialist.' (tick)

(sa) Strongly Agree	(a) Agree	(d) Disagree	(sd) Strongly Disagree

14. When you **ARE** the **usual medical carer** for your family members, indicate a) where the consultations usually take place, b) how often records are kept and c) how you usually charge family members for your services ? (tick)
(Please skip this question and go to question 15 if you are never the usual medical carer for any family member)

a)	Place where consultation most often takes place	Doctor's rooms or hospital (dr)	Doctor's own home (dm)	Patient's home (Family member's home) (pa)
b)	Formal records kept	Always (a)	Sometimes (s)	Never (n)
c)	Billing	Normal rates (n)	Cheaper rates (c)	No charge (nc)

15. When you **ARE NOT** the **usual medical carer** for your family member, but have seen family members on an 'ad hoc' basis, indicate the following: (tick)
(Please complete this question even if you have answered question 14)

a)	Place where consultation most often takes place	Doctor's rooms or hospital (dr)	Doctor's own home (dh)	Patient's home (Family member's home) (ph)
b)	Formal records kept	Always (a)	Sometimes (s)	Never (n)
c)	Billing	Normal rates (n)	Cheaper rates (c)	No charge (nc)

16. Do you usually **refer** or **investigate** family members more or less often than patients who are not your relatives? (tick)

	m	l	s
	More Often	Less Often	Same
Refer			
Investigate (eg x-rays, blood tests)			

17. Do you think that your own family members usually receive **better or worse care** compared with other patients? (tick)

	b	w	s
	Better Care	Worse Care	Same Care
Care received from you			
Care received from other doctors (who know the patient is related to you)			

18. Have you ever **refused** a family member's request for medical care or advice ?

Yes	No

Please explain _____

19. Have you ever had a request for medical care from a family member that made you **uncomfortable**?

Yes	No

Please explain _____

20. Have you ever provided medical care or advice to a family member that was **out of your discipline** or not within your usual scope of practice ?

Yes	No

Please explain _____

21. Do you find that family member patients are more **demanding** of your personal time ?

Yes	No

Please explain _____

22. Do you think that caring for your own family is an advantage or a disadvantage for their care?

a	d	n
Advantage	Disadvantage	Not sure

Please explain _____

23. Do you think it would be useful to have **ethical guidelines** regarding doctor's treatment of their own families ?

y	n	ns
Yes	No	Not sure

Please explain _____

24. Any other comments? _____

APPENDIX C

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

COMMITTEE FOR RESEARCH ON HUMAN SUBJECTS (MEDICAL)
Ref: R14/49 Fenaroff

CLEARANCE CERTIFICATE **PROTOCOL NUMBER** M02-08-08

PROJECT

Attitudes and Practices of Gauteng Doctors to Treating Their Own Family Members

INVESTIGATORS Dr S Fenaroff

DEPARTMENT School of Clinical Medicine, Private Practice

DATE CONSIDERED 02-08-30

DECISION OF THE COMMITTEE Approved unconditionally

Unles otherwise specified the ethical clearance is valid for 5 years but may be renewed upon application *This ethical clearance will expire on 30 July 2007.*

DATE 02-10-24 CHAIRMAN .....(Professor P E Cleaton-Jones)

* Guidelines for written "informed consent" attached where applicable.

c.c Supervisor: Dr A Wright
Dept of School of Clinical Medicine, Wits Medical School
Works2\lain0015\HumEth97.wpb\M 02-08-08

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and ONE COPY returned to the Secretary at Room 10001, 10th Floor, Senate House, University.

I/we fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. I agree to a completion of a yearly progress form. I/we agree to inform the Committee once the study is completed.

DATE .....SIGNATURE .....

PLEASE QUOTE THE PROTOCOL NO IN ALL QUERIES : M 02-08-08

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

APPENDIX D

Faculty of Health Sciences
UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG
7 York Road PARKTOWN Johannesburg 2193 Telegrams WITSMED Telex 4-24655.SA
FAX 643-4318 TELEPHONE 717-2075/2076
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DR SP FANAROFF
17 SANDTON GLEN
FROOME RD
ATHOL GARDENS
2196

APPLICATION NUMBER 9101278M
STATUS (DEG 23) (MMY00) PZZ

2003-02-01

Dear Dr Fanaroff

Approval of protocol entitled Attitudes and practices of gauteng doctors to treating their own family members

I should like to advise you that the protocol and title that you have submitted for the degree of Master Of Family Medicine (Part-Time) (Coursework) have been approved by the Postgraduate Committee at its recent meeting. Please remember that any amendment to this title has to be endorsed by your Head of Department and formally approved by the Postgraduate Committee.

Dr AE Wright has/have been appointed as your supervisor/s. Please maintain regular contact with your supervisor who must be kept advised of your progress.

Please note that approval by the Postgraduate Committee is always given subject to permission from the relevant Ethics Committee, and a copy of your clearance certificate should be lodged with the Faculty Office as soon as possible, if this has not already been done.

Yours sincerely

ME Fick (Mrs)
Faculty Registrar
Faculty of Health Sciences

Telephone 717-2075/2076

Copies - Head of Department_____Supervisor/s

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The University seeks to serve South Africa by furthering access to equal opportunity while striving for excellence in teaching, learning and research

APPENDIX E

Further Examples of Comments

4.9 Refusal of family members' requests

Comments from those doctors who *did refuse requests* included the following themes:

a) *Problem outside doctor's area of expertise (6.3%; 11)*

'I am a paediatrician so I don't see adults'.

'I refer gynaecological or urological problems'

'Refer procedures outside usual scope of practice'

'Refer gynae problems'

'Referred a matter about which I did not know enough'

b) *Fear of loss of objectivity or emotional involvement (5.23%; 9)*

'Refuse all serious complaints'

'Not prepared to be involved'

'Can't maintain good family ties'

'Asked sister with infertility to seek advice elsewhere'

'My wife does not listen to my instructions, so I refuse to listen to her complaints'

'Can't be objective'

c) *Avoidance of intimate examinations (4.6%; 8)*

'Too close to patient so could not do proper physical examination'

'Gynae problems referred'

'Refer gynae and psych problems'

'Refused to do surgery on my wife'

'Refused TOP'

d) *Advice not given without a proper medical assessment (8.1%; 14)*

'Refer them on if it necessitates examination'

'Only treat minor illnesses'

'Can't give an appropriate second opinion over the telephone'

'Refuse repeat prescriptions'

'Refused when they would not make time to come to my rooms for official consult'

'I refuse all serious complaints'

'They often want advice but are not willing to be examined'

'They know to make an appointment at my rooms'

e) *Intrusions (2.32%; 4)*

'I refuse when they arrive on weekends or after hours'

'I refuse to give advice at parties'

Comments from doctors who had *not ever refused* a request for care included:

a) *It is not possible (5.23%; 9)*

'I am obligated to assist'

'In my community, refusing to treat a relative is suicidal'

'It is just not possible to refuse to treat'

b) *It is not necessary (3.48%; 6)*

'I have full confidence in my abilities'

'I am in a position to help, so why not?'

'I usually agree if requested'

c) *Feel responsible (2.32%; 4)*

'I feel some kind of responsibility'

'I am in a position to help'

4.8 Requests for medical care that made doctors uncomfortable

Comments from doctors who responded *yes* included the following themes.

a) *Emotional intimacy (6.9%; 12)*

'Issues about sex and private matters'

'Too many emotional implications'

'Too much responsibility'

'Personal problems are too personal'

'Patient had signs of immunocompromised state and needed to advise HIV tests'

'Relative is a hypochondriac and it is difficult for me to take her complaints seriously'

b) *Physical intimacy (7.5%; 13)*

'Asked opinion about testicular nodule'

'Uncomfortable to do physical exams, therefore can't make diagnosis'

'Delivered sister-in law's baby'

'Case of proctalgia fugax'

'Surgery on a grandfather'

'Female vaginal examination'

'Sister in-law's gynae and personal problems'

'Mother-in-laws armpit boils'

c) *Requests outside of scope of practice (4.6%; 7)*

'Can't refuse treatment even if out my field'

'If it is outside of my scope of practice'

d) *Inappropriate requests (6.9%; 12)*

'Sleeping pills for husband'

'Medication requested without examination done'

'To perform TOP when unethical'

'Medical certificate requested which was not given'

'Sick notes often requested'

'Arriving late at night for a minor complaint'

e) *Loyalty to other doctors (2.3%; 4)*

'Previous' doctor was a known colleague'

'Uncomfortable about second opinion when I disagree with prescribed treatment or diagnoses'

Two doctors (1.1%) stated that <u>all</u> requests from family were uncomfortable.

Comments from respondents who responded *no* (63%; 11) mainly centred on doctors' confidence in their ability to treat impartially and remain objective:

'Nothing to feel uncomfortable about'

'Confident I will refer when indicated'

'I am a very comfortable caregiver'

'I happily treat members of my family'

4.11 Provision of care to family members out of the usual scope of practice

Comments included the following themes:

a) *GP level problems treated, even though I am a specialist (6.3%; 11)*

'I was a GP before I specialised'

'Plus and mild illness treated'

'Treat minor conditions like hypertension and UTI's'

'I worked as a GP before specialising'

'Quite capable of treating GP problems'

b) *Emergencies only/No other doctor available (5.8%; 10)*

'Rugby injury on my son'

'Only if no other doctor available'

'I treat my father who is housebound'

'Only as an interim measure for minor ailments'

c) *Give advice (5.2%; 9)*

'People expect doctors to know everything, so I try to give some advice'

'Advise as much as my knowledge permits'

'Give advice instead'

d) *Refer (4%; 7)*

'I refer if unsure of diagnosis'

'Referred cosmetic surgery' if

'Refer to appropriate specialist'

'Refer if out of my scope'

One doctor commented 'all the problems encountered so far are within my level of competence'.

4.12 Perceptions of whether family members are more demanding of doctors' personal time

Comments from respondents who reported *more demanding* families included the following themes:

a) *After-hours requests/ easier access (6.9%; 12)*

'Require care out of working hours'

'Phone after hours for advice'

'Request information or help at odd times, especially at night'

'They know your address and telephone numbers'

'As for attention at inconvenient times'

'They phone anytime'

b) *Family expects special treatment (5.8%; 10)*

'they bypass the receptionist'

'they want to be seen without queuing'

'always get priority and preferential service'

'they feel that they have more right to attention from me than other patients'

c) *High expectations/ more critical (6.3%; 11)*

'They expect you to have all the answers'

'More demanding of me, especially since they are not paying fees'

'Very critical and demanding'

'Quick to tell you that treatment didn't help'

'Require more convincing and complain more often'

d) *Intrusive (8.1%; 14)*

'More likely to phone for minor ailments'

'Other patients only phone after hours for serious concerns- family phone anytime for minor things'

'Consultation becomes ongoing and topic of discussion'

'They expect me to leave everything and attend to them'

Respondents who said that their families were *not more demanding* (4%; 7) mainly commented that their family members were considerate:

'I have very reasonable family members'

'Usually undemanding'

'They are hesitant to accept service from me'

'They are very considerate'

4.13 Caring for own family advantageous or disadvantageous

Comments from respondents who thought it was an *advantage* include the following themes:

a) *Convenience (8.1%; 14)*

'convenient to treat minor problems of own family'
'they don't have to wait or pay'
'can assess on a daily basis'
'can better monitor the process'
'easier follow-up'
'especially when another doctor is unavailable'
'ease of access'
'advantage for immediate care when I can't get hold of my paediatrician because I can start treatment immediately'

b) *Personal knowledge of the patient (6.3%; 11)*

'I know them and their context better'
'More personal'
'Compliance is easier to control'
'Personal knowledge of the symptoms is useful'
'Assess before symptoms are advanced'

c) *Caring doctor (5.8%; 10)*

'go out of your way for your own family'
'I give them my full attention'
'Extra-cautious'
'All possibilities are thought of'
'able to listen and explain more'

d) *Financial incentives (5.2%; 9)*

'cheaper rates'
'they don't have to pay another doctor for something I can do'
'cost-saving'

e) *Self-confidence (3.4%; 6)*

'I never trust other doctors due to my own experience'
'My family have full faith in me'

'I am quite capable of treating my own children'

Respondents who thought treating their own families was a *disadvantage* commented that:

a) *Objectivity is clouded (7.5%; 13)*

'difficult to remain detached or objective'
'you become too emotionally involved with the patient'
'create inadvertent biases in health management'
'mistakes could be made because of emotional involvement'
'tend to overtreat or undertreat with own family'
'always imagine worst-case scenario'
'we are not always impartial and one gets overcautious'

a) *Inadequate history, examination and record-keeping (6.3%; 11)*

'give advice without all the relevant information'
'not in fully-equipped room'; 'often not in the rooms'
'full examination not done or quick diagnosis made'
'they do not always reveal everything and want opinions without being willing to be fully assessed'
'leave out unpleasant investigations'

c) *Too much responsibility (3.4%; 7)*

'doctor worries too much about mistakes'
'unfair on me'
'very stressful for doctor'

d) *Disadvantage if outside of speciality (1.1%; 2)*

4.14 Usefulness of ethical guidelines

Respondents who thought ethical guidelines *would* be useful gave some of the following comments (grouped into themes):

a) *Useful to have something written to refer relatives to (4.6%; 8)*

'useful to give written reason when refusing to respond to requests'
'especially with unnecessary referrals or issue of sicknotes'
'guidelines should also be known to relatives'
'relatives get annoyed if care not given'

'guidelines could be used to explain to family members why it is better that they see someone else'

b) *Clarification would be helpful (4%, 7)*

'Useful for ethical issues that may arise'

'would make decisions easier'

'many doctors are unsure of professional boundaries'

'many grey areas exist - where does home care end and professional care start?'

c) *Doctors should never treat their family (2.3%; 4)*

'Guideline should be that doctors never treat their family'

'Anything outside minor ailments should be treated by other doctors at all times'

Respondents who thought ethical guidelines *would not* be useful gave the following comments:

a) *Not necessary (6.9%; 12)*

'should be same as for other patients'

'I am confident, practical and highly ethical in my practice'

'We understand the ethics- don't require guidelines'

'I know when to refer'

'existing guidelines are adequate'

'I have my own ethics'

'I treat them the same as everyone else'

b) *Not practical (3.4%; 6)*

'would still have to treat'

'each doctor must make his/ her own choices'

'cases differ and trust is of the essence'

'difficult to put down on paper'

c) *Too prescriptive (1.7%; 3)*

'each doctor should decide for himself – already we are over-regulated'

'we are old enough to decide for ourselves what to treat and when to refer'

4.13 Other comments

Respondents were given the opportunity to make any other comments. Comments have been grouped into themes and examples have been transcribed:

a) *Doctors should never treat family members (8.1%; 14)*

'I won't do elective surgery – even within my discipline'

'Doctors should never treat their own family members'

'Don't treat your own family members- success is very rewarding, but failures are devastating'

'Rather remain as patient's advocate'

'Doctors should not treat family members'

'I strongly agree that all doctors' families should have a primary care physician. My children always go to their GP for any problem and only to the paed if the GP deems necessary'

'I think a memorandum should be forwarded to the HPCSA suggesting strict guidelines regarding the inadvisability of doctors treating their family members'

'I tell family and friends that I would prefer them to have another GP and I am available for a second opinion verbally'

b) *Doctors should only treat mild illness (7.5%; 13)*

'Doctors should only treat mild illnesses

'Only treat dermatology problems'

'My family all have a GP and I only treat simple coughs and colds'

'I treat common colds without fever, or give analgesics for headache, or odd blunt injury, nothing more'

'I would never operate on a family member'

'I treat my husband and child for minor illnesses'

'Mild ailments can be treated, but severe illness should be referred'

'If the problems are more than minor ailments, they need to see another doctor; this is usually my partner in the practice'

'I sometimes give antibiotics and scripts for malaria prevention'

'I give regular immunisations, like fluvax and tet-tox, otherwise they wouldn't get done'

c) *Doctors should treat family members (10.4%; 18)*

'Do as much as comfortable with'

'Relatives feel comfortable when assured of diagnosis or when doubts are settled'

'It is natural to go to a family member. There is more trust and the patient is more comfortable'

'Treat if knowledgeable enough about the particular problem'

'My family consult me because they trust my opinions and advice.

'They have respect for my clinical acumen. In 20 years of practice, I have not let any of my relatives down clinically'.

'My mother-in-law sees me regularly. I am extremely lucky that my family do not have chronic illnesses and are not ill often.'

'I always attend to my immediate family (spouse and children) for minor ailments, and then refer if not resolved in a few days. For extended family, I give advice or opinion but prefer to encourage them to see their own GPs'

'I am usually disgusted with other doctors' clinical examination of my family and do not find that they treat them better than I would have done. I treat them but refer them for second opinions quite often. I do not like the responsibility of diagnosing and treating on an informal basis.'

'We can do fewer investigations with our own families, when explaining the rationale is easier'

'I will give a prescription for chronic meds for limited time if relative is unable to see their regular GP'

'Patients feel reassured by having their doctor relatives treating them'

'It is unavoidable to treat and advise family. I always insist that it is done formally and not casually over dinner'

d) *'Pressures on doctor' (8.1%; 14)*

'It places huge responsibility on oneself'

'Tend to self-blame for adverse outcome'

'I do not like treating family members- it is too stressful'

'I am often asked to do favours which I find difficult to refuse, especially sicknotes for relatives and friends' children, and prescriptions'

'I don't like treating family, but I expect my wife, who is a GP, to treat me'

'My prescriptions do not work on family members, yet I keep on being asked for help'

'It is uncomfortable to perform physical examinations on family members and without a thorough physical examination, an appropriate diagnosis cannot be reached'

'Relatives get annoyed if care is not given'
'Doctors make mistakes, but making an incorrect diagnosis on a family member makes me feel self-conscious and uncomfortable in their presence'
'Relatives feel as if you do not care for them if you decline to treat them'

e) *Objectivity is clouded (6.3%; 11)*
'It is difficult to be objective'
'Subjectivity seems to subvert to objectivity when I have to service my family members'
'We need guidelines on how to behave when emotion may affect critical judgement'
'I am reluctant when asked to treat family members as I feel my objectivity is clouded and I cannot manage family members in the same way as other patients'
'We tend to over-react and are not objective'
'Should one not feel comfort able and clear-headed about his management, one should rather refer'
'My family are fully aware that to guard against loss of objectivity, they need to assist me'

f) *Relatives should be treated in the same manner as other patients (4.6%;8)*
'Records are very important- each patient must have his own file'
'If you elect to treat your own family, they must be treated as you would your patients'
'Family members should be regarded as any other member of the community, unless the family member feels uncomfortable'
'Records are critical especially treatment date and time; files should be kept for bloodtests and investigations'

g) *Problems out of expertise should be referred (3.4%; 6)*
'I only treat dermatology problems' – *a dermatologist*
'Gynae problems referred'
'Procedures outside general scope referred'

h) *Different standards for relatives (2.3%; 4)*
'I am probably slightly more careful and thorough with family members'

'If not paying fees, detailed investigations might be ignored to their own detriment'

i) *Where do we draw the line? (1.1%; 2)*

'Where does usual home remedy end and professional care start? This tends to overlap, especially with children'

'Many grey areas'

j) *Comments on the topic (4%; 7)*

'An excellent choice of topic – I don't know if there are any guidelines'

'I compliment you on choosing this topic to study, as it is a logistical nightmare'

'Interesting topic'

'I'm not sure this research will change much. The question is, why do family members choose to talk to you instead of another doctor?'