Physicians Treating Their Own Spouses: Relationship of Physicians to Their Own Family's Health Care

Patricia E. Boiko, MD, Stanley H. Schuman, MD, DrPH, and Philip F. Rust, PhD
Schoharie, New York, and Charleston, South Carolina

Fifty-one family physicians and a comparable group of 65 lawyers were surveyed to determine how each group treated the medical problems of their spouses. There was no significant difference between physician and lawyer controls in the treatment of headaches, sore throats, vomiting, depression, pregnancy, and warts. In fact, the controls treated back pain and stomachaches more often. The physicians treated earaches and deep lacerations more often. The physicians more frequently took a symptom history and examined their spouse. Both groups treated their spouses' headaches, sore throats, and stomachaches at a high rate.

This study supports the impression from a literature review and case studies that unique multiple interacting factors determine whether a physician will treat his or her spouse. These factors are feeling of responsibility to answer a request for treatment, cost, convenience, confidentiality, lack of confidence, emotional involvement or detachment, ego needs, and legal considerations. It is concluded that (1) physicians do not generally treat their spouses more often, but they do evaluate their spouses' symptoms more often than do nonphysicians, and (2) the decision to treat by the physician may compromise good care for his or her spouse. It is recommended that physicians and their spouses have an alternative, nonrelated physician to care for their health.

Diagnosing and treating persons in one's own household is not a new problem for either medical students or physicians. Consider the following incidents.

Case 1: Intern's Laceration. A 27-year-old man lacerated his forehead four days prior to beginning internship. He and his wife (also an intern) were new in town, their medical school insurance coverage had run out, internship insurance coverage had not yet started, and they did not have a physician. They elected to treat the jagged 2-cm laceration themselves.

His wife treated him with direct pressure and butterfly Band-Aids with good wound approxima-

Delivered at the Statewide Family Practice Residency System, Scientific Session, Hickory Knob Statepark, South Carolina, on April 14, 1982, and the South Carolina Academy of Family Physicians Annual Scientific Assembly, Charleston, South Carolina, on November 6, 1982. From the Department of Family Medicine, and the Department of Biometry, Medical University of South Carolina, Charleston, South Carolina. At the time this paper was written, Dr. Boiko was a third-year resident in family practice, Medical University of South Carolina. Requests for reprints should be addressed to Dr. Stanley Schuman, Medical University of South Carolina, 171 Ashley Avenue, Charleston, SC 29425.

pain, and stomachaches. Eighty-two percent of physicians and 52 percent of lawyers treated their spouses' headaches. Sixty-two percent of physicians and 23 percent of lawyers treated their spouses' sore throats. Forty-five percent of physicians and 14 percent of lawyers treated their spouses' stomachaches. Physicians reported treating earaches with prescription medication ($P < .05$) and treating lacerations ($P < .05$) more often than did the controls.

Physicians stated they would personally give their spouses a tetanus vaccine ($P < .05$) or a tuberculosis skin test (PPD) ($P < .0005$) significantly more often than the controls. The physicians would ask a colleague to give their spouses the tetanus vaccine ($P < .005$) and PPD ($P < .05$) more often than would the lawyers. The controls would advise their spouses to see their physician ($P < .0005$) for those procedures. The lawyers, however, reported giving their spouses legal advice significantly more often ($P < .0005$) than did the physicians.

Discussion

Contrary to most expectations, lawyers were as likely to treat most common conditions as were physician peers. The only definable illnesses treated more often by physicians were earaches (with prescription medications) and lacerations (with sutures). Also of note is the finding that both lawyers and physicians treated their spouses' headaches, sore throats, back pain, vomiting, and stomachaches with prescription medications. Presumably, the lawyers obtained these medications from past prescriptions from a physician. Both physicians and lawyers treated their spouses' headaches, sore throats, and stomachaches at a high rate with over-the-counter medication. The study demonstrates that the lawyers did not evaluate the medical conditions as often as the physicians, but treated as often as the physicians. The lawyers represent a sample of the well-informed general population who treat their spouses often, without evaluation of their condition.

Although most physicians and lawyers did not treat beyond the "routine illness," some did elect to treat more extensively. In fact, one of the lawyers and one of the physicians reported delivering their own babies. The topics listed in Table 1 deserve discussion.

Responsibility, Convenience, Accessibility, and Cost

One of the pressures to treat is feeling responsible to answer a request by the spouse for advice or treatment. The power of this emotion is described by Miriam Perr, a physician's daughter and later a physician's wife: "His family, whose sacrifice and devotion helped him through medical school, leaned on him for guidance and support. It was the dividend on their investment, and it enlarged the size of the group for whom he felt responsible."[2] Many spouses have supported, psychologically and financially, a wife or husband through medical training. One may "pay back" such a debt by deciding to care medically for the spouse.

Convenience and accessibility may outrank other considerations when the spouse-patient needs help. Physicians generally have easy access to medications, treatments, and medical records. In contrast to lawyers' spouses, physicians' spouses could receive a tetanus vaccine or tuberculosis skin test without consulting another physician. Similarly lawyers' spouses have access to legal advice without consulting another lawyer.

If inflation continues, cost may become a more prominent feature in the decision to treat. As illustrated by the first case, a new graduate, between jobs, with no insurance coverage, and little available cash after moving, may elect to treat at home rather than go to the local emergency room, where cash or insurance coverage may be required before examination. Some physicians surveyed commented that since their spouses' complaints were too minor to waste a nonrelated physician's time and their money, they gave an initial opinion.

Psychological Characteristics of the Physician-Spouse Relationship

Some of the psychological characteristics of persons who choose medicine as a career are described by Mackie[3] and Sharaf and Levinson.[4]

Two of these personality traits could lead to subconscious pressures to treat a spouse. First is the "quest for omnipotence,"[3] which could be manifested by what Sharaf and Levinson described as an "unrealistic exaggeration of the (psychiatrist's) therapeutic power,"[4] or by "the refusal to accept therapeutic defeat," described by Main.[5] A physician questing for this power over life and death may treat his own family as proof of this power.

What about the spouse as patient? The scenario is familiar: the physician's spouse is intelligent and resourceful but seems helpless when he or she must apply common sense, first aid, or triage medicine. Such helplessness occurs when the spouse, a patient, feels threatened by and therefore denies his or her own wish for omnipotence, especially if it is seen as competitive with the physician's expertise.[3]

Emotional Substitutes

Another psychological pressure to treat may involve compensation for inability to provide sufficient emotional support for a spouse. Evan's studies[6] of the records of 50 physicians' wives admitted to psychiatric hospitals illustrate this particular physician-spouse relationship: The physician is secure in his omnipotent role with patients but rejects his wife's strivings for dependency, except when they demand "medical" attention. He then, without acknowledging their emotional basis, gratifies these needs by resorting to his professional role.[6] There are as yet no similar studies of female physicians and psychiatrically impaired husbands.

Responsibility, Inconvenience, Confidentiality, Prepaid Health Plans, and Professional Courtesy

It was noted in the study that most physicians do not treat their own spouses more often than do lawyers. The pressures not to treat may outweigh the pressures to treat.

The physician-spouse may not feel responsible for treating the partner, or that partner may refuse the advice or treatment given, either through ingratitude or through early independence of spouse support.

In addition, there are certainly inconvenient times to request medical help from a spouse. In a letter to the *British Medical Journal* in 1948, a physician's wife wrote, "the newspaper, a pipe and after a few minutes loud catarrhal snores. Woe betide the wife who inquires for medical remedies at this juncture; they are doomed to be cast off as mere psychological flights of fancy."[7]

Prepaid health plans and professional courtesy make the cost of medical care less of an obstacle influencing the decision not to treat.

Psychological Factors of the Physician-Spouse Relationship

Another factor may be fear of error in diagnosis and treatment. McClinton writes, "It is almost illegal for her husband to treat her. If he loves her, he's afraid to. If he doesn't [love her], she's afraid to let him."[8] A prospective study of people who went into medicine found that physicians were "statistically more likely to exhibit the traits of dependency, pessimism, passivity and self-doubt."[9] Such passivity, pessimism, and self-doubt could certainly lead a physician to refer a loved one for medical treatment.

The Law

A compelling reason for a physician not to treat his or her spouse is the current existence of regulations forbidding such treatment. The physician in Case 2 was advised of a South Carolina Bureau of Drug Control regulation that "a physician . . . cannot prescribe narcotics (or other controlled substances) for himself, or members of his immediate family."[10] This agency has concluded that the physician does not have a valid physician-patient relationship with his or her own family. Certainly, the physician-spouse–physician-patient relationship is an aberration of the classic physician-patient relationship. The former is a special relationship with certain barriers to adequate care, which include the physician's denial and lack of objectivity when treating his spouse.

Barriers to Adequate Care

The denial concept is relevant to this study, as many of the physicians and spouses surveyed acted as triage or dealt with "minor" problems. A serious condition, such as the newly discovered "lump" or laceration (Case 1), could be diagnosed as a minor ailment if there is denial.

The lack of objectivity and the presence of the physician's own needs are also barriers to adequate care. A physician is expected to "work toward a balance, on the one hand, give emotionally—both warmth and firmness—to his patients; on the other hand, maintain a certain distance, meeting the patients' needs rather than his own."[4] It is difficult to maintain a professional distance while being emotionally warm to a patient. In the context of marriage it can appear most unnatural for a physician to maintain this distance while treating the spouse.

The converse of denial is overuse of procedures that may not represent good medical care. Do physician couples demand more specialized procedures more often than the general population? Franklin et al[11] compared appendectomies and tonsillectomies in physicians' families with those in a general population. He found that members of physicians' families had a considerably younger mean age for tonsillectomy than their counterparts, suggesting "pressure from a medical family to get something done about a child's recurrent bouts of tonsillitis."

Alternatives for the Care of Physician's Spouse

Some physicians may acknowledge the barriers to adequate care and decide not to treat. Then the physician's spouse may be cared for by another physician. This physician may be a friend of the physician, resulting in an adulterated physician-patient relationship. As Barrand writes,[12] "Because he doesn't have a GP of his own, he picks out the specialist he believes to be the top man in the trade. The specialist takes a little extra care not to miss anything in the doctor's wife or child, so the unfortunate patient finds a specialist peering into every available orifice, making long lists of tests to be done and prescriptions for remedies neither needed nor wanted." Such specialized overkill may impress the physician colleague but may result in diagnostic and therapeutic misadventures.

Conclusions

The study demonstrated that physicians and lawyers medically treated their spouses similarly, and for some problems at a high rate; however, there are unique and complex pressures surrounding the physician's decision to treat a spouse. If such pressures are recognized and managed, physicians can do a better job of triage and limited treatment. In any case, it is probably better for physician families to agree upon a nonrelated physician before an emergency. In this way, the physician can relinquish the physician role, and the spouse can seek necessary medical care.

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