BACKGROUND AND OBJECTIVES: The current study was aimed at exploring the challenges that arise in the doctor-patient relationship when the patient is also a physician and identifying strategies physicians use to meet these challenges. No previous research has systematically investigated primary care physicians’ perspectives on caring for physician-patients.

METHODS: Family medicine (n=15) and general internal medicine (n=14) physicians at a large Midwestern university participated in semi-structured interviews where they were asked questions about their experiences with physician-patients and the strategies they used to meet the unique needs of this patient population. Thematic analysis was used to identify common responses.

RESULTS: Three of the challenges most commonly discussed by physician participants were: (1) maintaining boundaries between relationships with colleagues or between roles as physician/colleague/friend, (2) avoiding assumptions about patient knowledge and health behaviors, and (3) managing physician-patients’ access to informal consultations, personal test results, and opinions from other colleagues. We were able to identify three main strategies clinicians use in addressing these perceived challenges: (1) Ignore the physician-patient’s background, (2) Acknowledge the physician-patient’s background and negotiate care, and (3) Allow care to be driven primarily by the physician-patient.

CONCLUSIONS: It is important that primary care physicians understand the challenges inherent in treating physicians and develop a strategy with which they are comfortable addressing them. Explicitly communicating with the physician-patient to ensure boundaries are maintained, assumptions about the physician-patient are avoided, and physician-patient access is properly managed are key to providing quality care to physician-patients.

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Physicians are taught strategies for communicating with patients throughout the clinical encounter. Special circumstances arise, however, when the patient is also a physician. Literature exists reporting the perspective of physicians who have become patients; however, little information is available in the extant literature exploring the experiences of physicians who care for physician-patients. As with other patients, primary care providers will likely provide the first and ongoing contact for physician-patients. Strategies for addressing this relationship and maximizing communication within it need to be explored so that primary care clinicians can provide effective care for physician-patients.

The health care physicians receive for themselves and their families does not always address their unique needs. Several studies show that physicians don’t pursue adequate health care. A survey of general practitioners’ self-reported care-seeking strategies found that physicians tend to “treat themselves or seek an inadequate ‘curbside’ consultation with a colleague.” Problems arise when physicians incompletely describe diagnoses or treatment and assume their physician-patient is knowledgeable on his or her condition, become “chummy” with the physician-patient, and treat them as a colleague rather than a patient.

There are few existing systematic, empirical investigations of the challenges physicians face or strategies they use when caring for physician-patients. Rather, relevant articles addressing caring for physician-patients tend to be general reviews of physician-patient care-seeking behaviors or based on the authors’ personal experiences of caring for physician patients. For example, Krall and Stoudemire and Rhoads make recommendations of how physicians might approach caring for
their physician colleagues based on looking at the literature on physician care-seeking behaviors. They identify the desire for curbside consultations and special access and the difficulty of role reversal as particular challenges in caring for physician patients. As another example, Schneck6 provides recommendations based on personal experiences caring for physicians in his neurology practice. These recommendations include such things as physicians being just as thorough with information gathering through history taking and physical examination with their physician-patients as they are with others and addressing some of the anxiety and awkwardness of the encounter directly.6

The objective of this study is to explore the experiences of a sample of primary care physicians who care for physician-patients to delineate the inherent challenges in this relationship and the strategies used to address them.

Methods

It is standard practice in medical social science research to use qualitative methods when investigating domains of knowledge and/or experience about which little is known.8,9 To achieve a more comprehensive understanding of the actions of physicians who treat physician-patients, a qualitative approach using open-ended interviews and thematic analysis was used. The Institutional Review Board approved this project.

Participant Recruitment

Study participants were physicians at a large Midwestern university who provide care to physicians in the University Health Care (UHC) system. All primary care physician faculty members from the Departments of Family Medicine (n=25) and General Internal Medicine (n=20) were invited to participate. All physician faculty at UHC are given the option to choose a primary care provider as part of the employee health plan and faculty in the two participating departments make up the majority of providers within these plans. Potential participants were introduced to the purpose of the study via emails and announcements at department faculty meetings.

Data Collection

Data collection involved open-ended and semi-structured interview questions guided by existing literature8-9 and the study’s content focus. All questions were piloted with three faculty members prior to data collection to ensure the questions were useful for understanding the physician’s perspective on medical encounters with physician-patients. Questions asked physicians about their experiences caring for physician-patients and how providing care to physicians differs from providing care to nonphysician patients. Participants were asked about challenges and strategies they have developed for effectively caring for physician-patients. Participants were also asked to describe both positive and negative examples of caring for physician-patients. All interviews were conducted by the first author (AD-K), a second-year medical student at the time of the interviews.

Analysis

Interviews were tape recorded, transcribed verbatim, and entered into a Nvivo 8 database that allowed for systematic searching, coding, and retrieving of qualitative data (Nvivo 8). Qualitative data analysis software. Doncaster, Victoria, Australia: QSR International Pty Ltd, 2007). Thematic analysis, meaning inductive identification of codes or major topics arising out of the data rather than imposed on the data, was applied to transcripts to identify salient themes in participants’ perceptions and experiences of caring for physician-patients. Using this approach,8,9 each author read through 10 interview transcripts that included the range of physician experiences to identify initial themes that occurred in participants’ discussions of caring for physician-patients. These themes were then compared, and a preliminary coding scheme was developed and applied to coding subsequent transcripts. Content of each code was then reviewed to ensure that all transcript segments reflected the main themes and to identify salient subcategories within each theme. The analytic process used and major themes are depicted in Figure 1. Analysis focused on identifying patterns and challenges in physician relationships with physician-patients as well as strategies physicians identified using in treating physician-patients.

Results

Thirty physicians agreed to participate in the study, including 16 of the 25 family medicine faculty members and 14 of the 20 general internal medicine faculty members. One junior family physician was excluded since he reported caring for no physician-patients during his career. Participants represented a range of experience and reported treating between an estimated 5 to 100 or more physician-patients in their career (See Figure 2). The participants included 16 male and 13 female physicians. Physicians’ responses included descriptions of their personal experience treating physicians as well as their perceptions of the challenges many physicians face in these circumstances. A range of their responses are included in the Results.

Challenges

The three challenges consistently identified by study participants were (1) maintaining boundaries within the physician-patient relationship, (2) avoiding assumptions about patient knowledge or health behavior, and (3) managing care of physician-patients in the context of their high level of access to health care information and resources. The myriad relationships physicians had with their physician-patients created confusion for physicians in determining what their role was in interacting with physician-patients both in and out of the clinic setting and caused
overlap between some of the challenges.

**Boundaries**
Physicians described difficulty in maintaining boundaries between relationships they had with their physician-patients. Some of these relationships included friend, colleague, co-worker, patient, teacher, or learner. One physician stated:

There are some boundaries that have not been acknowledged and then somebody is asking you to cross that boundary in some very personal way... If I'm not in that situation where I have those boundaries up, I simply say to people, I'm about the dumbest person you've ever seen when I don't have my white coat on.’

Another physician noted:

I might be taking care of a doc medically, the next day we'd be in a business meeting...and then the next day we might be sitting down across the table at a wedding. I think your life is not absolutely compartmentalized.

Study participants varied in the extent to which they experienced difficulty in separating relationships with physician-patients. For example:

I don't think you can totally separate them [ie, roles] but I think you have to try really hard to separate them because...when you see somebody in the hall you don't want to hammer at them that they're your patient. You want to just talk to them as a colleague about other things.

Other physicians did not perceive as much trouble separating these relationships. One physician said:

The relationship changes quite a bit when you're in a room talking to somebody. It's more of a patient-doctor relationship. Most physicians assume the role of a patient and defer the role of physician to me.
The issue of boundaries became especially difficult when physicians perceived an emotional component to the relationship with their physician-patient. As one participant noted:

In my case, they [physician-patients] have been colleagues so that’s even harder because not only are you treating a physician, but you’re treating a buddy…You tend to order more tests because you really care about that person.

Many participants found it difficult to discuss sensitive topics because of their professional relationship with physician-patients:

If I’m taking care of a colleague in my own department that I know fairly well, sometimes it’s a little uncomfortable to talk about mental health issues or domestic violence or substance use or sexual risk factors.

The challenge of discussing sensitive topics was further complicated by physician-patients’ concerns about the confidentiality of their medical record. As another physician said:

I think sometimes there’s a reluctance on the part of other physicians to disclose things when they go to see their health care provider because they’re always worried about the medical record and who’s going to have access to it.

Assumptions
Participants described the challenge of avoiding assumptions about their physician-patients. Some physicians assumed that the physician-patient had knowledge above the average patient. One participant said:

They know the ramifications of what might be diagnosed and what medical terminology means and these sort of things. It [the patient encounter] can be more efficient.

Other physicians preferred to avoid assumptions about physician-patients’ knowledge and treat them as any other patient. For example:

In some cases, one’s desire to explain can come off as being condescending…I think in a case of treating physicians, one’s to assume neither too much nor too little. How do you figure that out? You talk. You have a genuine dialogue.

In many instances, physician-patients were assumed to monitor their own symptoms or care, schedule their own follow-up, and know whether or not their issue was serious enough to seek care. One physician said:

I think [physicians] tend to think [physician-patients] are going to notice if something is wrong and tend not to come in unless it is necessary. There are exceptions to that, of course, but I once went 6 years without a pap smear because I just got busy and when I think about it… ‘I’m smart enough to notice symptoms if I see them,’ … I assume that’s how other people think about it too.’

Physicians also described assumptions they made about the lifestyle and behavior of their physician-patients:

I think maybe I assume they’re making the right choices, which might not create a super safe environment.

There was an assumption that a certain comfort level should be afforded physician-patients. As one participant noted:
Physicians sometimes get worse care because others that have been involved in their care tend to make assumptions about what is unnecessary or necessary related to the evaluation or management of a given problem...a certain uncomfortable part of an examination should be skipped or a certain line of questioning should be skipped because it’s uncomfortable and unnecessary.

Physicians discussed how these assumptions could lead to less or, in some cases, more care than they might provide for lay patients. Some physicians described using fewer questions with the assumption that the physician-patient would know what information is important to discuss. For instance:

[The history] is often less work for me to do because I can say, ‘Tell me the story,’ and they’re more likely to know what might be more important aspects of the story. There’s a trust that they’ll feed me the information that I want in a more concise manner.

Other physicians provided a more thorough history and physical exam with the assumption the physician-patient had higher expectations or was evaluating their performance. One physician said:

I think [the physical exam] is a little bit scarier with a physician, especially if we have a partialist that we’re seeing, an ophthalmologist, or an ENT doc, or something like that...when you’re doing the fundoscopic exam you’re going ‘Eh, I hope I’m doing this OK.’ There’s always that concern that they’re going to pick up on something, ‘Oh he didn’t do this or that.’

Similar trends for providing more or less health care than average patients were described with regard to diagnostic testing and treatment of physician-patients.

**Access**

Participants discussed the increased access physician-patients have to medical information and knowledge (their own, research articles, colleagues, etc), self-referrals, and curbside communication. Curbside communication was described as an informal means of contacting their physician, including email, hallway discussions, or social gatherings. Physicians were divided on their feelings about curbside communication. Some found it helpful:

The [health care] process is very much influenced by [physician-patient] access to information, their easy access to curbside consultation, which I don’t think is a bad thing...I think [patient care] actually moves a bit faster.

Others felt it hindered physician-patient care:

There’s no evaluation. There’s no documentation. There’s no follow-up. Those aspects are why I say that I think physicians often get poorer health care than traditional patients, and I will not do [curbside consultations].

Physician-patients also were perceived as having unique health care management because of increased access. They were described as self-referring to specialists, bypassing a primary care physician who otherwise manage and coordinate their care. A participant said:

I think the older I get, the more experienced I get, the more I probably think that the way I treat them should not be different and is not different.

**Ignore the Physician-Patient’s Background**

One strategy was to ignore the physician-patient’s background and treat them the same as other patients. One participant said:

You walk through that door, and you are the doctor. The other person is not a doctor. You have to ‘de-doctor’ them. You have to strip...all those professional assumptions away. They’re just another patient.

In general, physicians using this strategy described setting strict boundaries to avoid altering the care they provided for physician-patients. For instance:

I do give the physician-patients a little disclaimer. I just say, ‘Hey, I’m going to treat you like every other patient, some of the things might be embarrassing or frustrating, but we just have to get through it.’
**Acknowledge Physician-Patient’s Background and Negotiate Care**

Another strategy was to acknowledge the physician-patient’s background and negotiate a care plan agreeable to patient and provider. For example:

There’s probably a little bit more negotiation in some cases… I had to talk with [a physician-patient] about, ‘What would you prefer to take?’ and balance that with what I think was best for her.

Open communication allowed physician-patients to choose how much they wanted their own medical knowledge to affect the care they received. One physician said:

The range [of physician-patient preferences] was all over the place… I think [communication] was very helpful with opening the dialogue so [physician-patients] knew… I was open to discussing their preferences and that we would include those in future shared decision-making issues as they would arise.

Another physician felt:

Open communication is critical. And I think it actually helps physician-patients feel more reassured there’s no assumptions or corner-cutting going on in their care.

**Care Driven Primarily by the Physician-Patient**

A third strategy was to allow the physician-patient to have the majority of the control in health care decision-making. Participants would go along with requests of physician-patients more than they would with other patients unless it was contradictory to their philosophy of care. One participant said:

If [the physician-patient] said, ‘Why don’t you add a fasting lipid profile?’ and I think to myself, ‘Because it’s not indicated according to the rules,’ but if they ask for it, I might be more willing to do it.

This strategy often resulted in physicians providing special favors for physician-patients or altering their strategy of care to accommodate the physician-patient. For example:

I have a physician who is taking a medication… that I wish I didn’t have to refill all the time. I’m more likely to go along with that. The physician sometimes wants refills without being seen, and I get uncomfortable with that and I think you should be seen at least once a year and usually I’m trying to insist on that but, you know, it’s hard to do with a peer.

This strategy tended to allow physician-patients greater access to care outside of the structured medical encounter than the participants who tended to ignore the physician-patient background.

**Discussion**

Physicians face unique challenges when treating physician-patients, including avoiding assumptions about physician-patients’ knowledge and behaviors, navigating boundaries between the many relationships between physicians and physician-patients, and understanding physician-patients’ increased access to health care knowledge and resources. These challenges are similar to those previously discussed in the literature (curbside consultations, confidentiality concerns, and assumptions regarding health care).1,7 Limited articles exist in the literature that describe strategies physicians should use in caring for physician-patients, and few of these are based on direct empirical investigation of the perspective of physicians providing this care.6,7 These articles do identify some similar strategies to those that were discussed by participants in this study, including discussing roles openly and early, treating a physician-patient as any other patient, and avoiding assumptions by conducting thorough history and physicals and discussing diagnosis and treatment plans.6,7

Thus, this study has empirically investigated and affirmed, from the perspective of practicing clinicians, challenges and strategies for addressing the challenges of caring for physician-patients. It should be noted that some of the strategies for addressing these challenges in part reflect more general models of what is considered effective clinician-patient communication.11 For example, strategies such as not making assumptions about any patient’s knowledge, lifestyle, or experience; engaging in shared decision-making with patients; and directly addressing challenges in the clinician-patient relationships are fundamental, evidence-based approaches identified in the literature that contribute to successful clinician-patient relationships.11

One limitation of our study is the focus on general practitioners’ experiences with physician-patients. Because of the tendency of physician-patients to self-refer, general physicians are sometimes avoided in treatment of illnesses.10 Additional studies are necessary to understand the relationship between specialists and physician-patients.

The purpose of the study was to determine the range of responses and strategies utilized by physicians in treating physician-patients. We were unable, however, to evaluate effectiveness of these strategies. Further studies are warranted to determine which strategies are most successful in approaching the challenges presented by physician-patients. This study focused on the subject’s experience as the practicing physician caring for physicians. The findings from the current study provide a useful foundation for subsequent investigations that could include gathering data from physician-patients about their perception of the prevalence, effectiveness, and challenges in receiving care from
physicians who use these different strategies. A final limitation in the current study is that the population for this study was limited to physicians working at one Midwestern university, and therefore it is uncertain if the same perceptions and experiences exist at other institutions.

Primary care physicians need to understand the challenges inherent in treating physicians and develop a strategy with which they are comfortable for addressing them to ensure that physician-patients are receiving appropriately managed care. Some of the strategies that existed within our study population were: ignoring the physician-patient’s medical background, acknowledging the physician-patient’s medical background and negotiating care, and allowing the care to be driven primarily by the physician-patient. The challenges associated with caring for a physician-patient tended to get easier with experience. Explicitly communicating with the physician-patient to ensure boundaries are maintained, assumptions about the physician-patient are avoided, and ensuring that physician-patient access is properly managed are key to providing quality care to physician-patients. Training could be provided to physicians to enhance their comfort in caring for physician-patients, particularly those that are colleagues.

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