

A Doctor in the House: Ethical and Practical Issues when Doctors Treat Themselves and Those they are Close to

Kanny Ooi¹ 

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Abstract Having a doctor in the family is often seen as beneficial as there is easy access to medical advice and care. It is common for doctors to treat themselves and those they are close to, and some doctors consider this their prerogative. However, there are pitfalls. Primarily, there is a risk of compromising clinical judgement and objectivity when doctors self-treat and treat those they have a close relationship with. This could lead to treating problems beyond the doctor's competence—in some instances, because someone close pressures the doctor. Other pitfalls include trivialising or overtreating a condition, failing to document the care provided, making assumptions about a person's circumstances, and breaching confidentiality. Consequently, despite good intentions, a doctor may not provide the best quality care to those they are close to. This paper examines the ethical and practical issues that arise when doctors treat themselves and those they have a close relationship with. It argues that in the vast majority of clinical situations, doctors should not engage in such care arrangements, and explains why doctors should have their own regular doctor. Several cases where doctors in New Zealand have been censured for self-treatment will be discussed. The paper compares New Zealand's position with Singapore's and explores several factors that contributed to the different positions that were adopted. The paper concludes that this is a fraught area of care so it is important that medical regulators set standards that promote best practice and that provide clear guidance to the profession and public.

✉ Kanny Ooi
kannyooi@hotmail.com

¹ Medical Council of New Zealand, PO Box 10509, The Terrace, Wellington Central 6143, New Zealand

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Introduction

Doctors are often asked for input by their family and friends. These range from requests for medical advice or a prescription to more substantial involvement such as performing a procedure (Eastwood 2009, 1333). Commonly cited reasons include convenience and cost savings along with having someone who is familiar with the health system to help navigate and advocate for the patient (Krall 2008, 280). Some doctors consider it their prerogative to engage in self-care and to care for those they are close to, and that because of their personal relationship with the patient, they are better placed to treat compared to another doctor.

However, doctors have long been discouraged from treating themselves and those they are close to. Percival's *Medical Ethics*, published in 1803, was the first to address this issue (Mailhot 2002, 546). The potential for compromised objectivity, medical errors, incomplete assessments, reluctance to discuss sensitive topics, and interpersonal problems following an adverse outcome were some of the arguments Percival cited against doctors treating themselves and their families (Scarff 2013, 647). Over the years, a number of medical regulators have adopted this position including the Medical Council of New Zealand (MCNZ).

This paper highlights key points from an MCNZ statement for doctors called *Providing care to yourself and those close to you* (the MCNZ statement/MCNZ's statement) (Medical Council of New Zealand 2016). Updated in November 2016, it highlights the pitfalls from such care arrangements and explains why it is important for doctors and their families to have an independent doctor for their ongoing care. Three cases of New Zealand (NZ) doctors who engaged in self-care or care of someone close are examined and a number of lessons drawn. The paper also considers how different medical regulators have dealt with this topic. As well, it compares and contrasts NZ's position with Singapore's. There are several reasons for focusing on these countries. Both have similar-sized populations that are multicultural and comparable health systems that comprise a mix of public and private health care. In addition, MCNZ's statement was revised around the same time as when Singapore Medical Council (SMC) updated its *Ethical Code and Ethical Guidelines* in which SMC examined equivalent codes and guidelines from reference countries such as NZ, Australia, UK, Canada, and Ireland (Singapore Medical Council 2016a). The paper concludes that there are good grounds for prohibiting doctors from treating themselves and those they are close to in the vast majority of clinical situations and that it is important for medical regulators to set standards that promote best practice and that provide clear guidance to the profession and public.

About the Medical Council of New Zealand

MCNZ is one of 16 health registration authorities in NZ governed by the Health Practitioners Competence Assurance Act 2003 (HPCAA). The HPCAA has been acknowledged internationally as a significant and ground-breaking legislation for

regulating health professionals (New Zealand Parliament Hansard Debates 2018). Its principal purpose (as outlined in section 3 of the HPCAA) is to protect the health and safety of the NZ public by establishing mechanisms to ensure that all registered health practitioners are competent and fit to practise their professions. Having one legislative framework ensures a consistent accountability regime across the different health professions regulated by the HPCAA. Along with doctors, other health professions governed by the HPCAA include nurses, dentists, and pharmacists.

MCNZ has several legislative functions including setting standards for doctors on clinical and cultural competence and ethical conduct (see section 118(i) of the HPCAA). Other legislative functions include registering only doctors who are fit and safe to practise medicine in NZ (Part 2 of the HPCAA), and initiating a number of processes where there are concerns with the doctor's clinical skills and knowledge, health, and conduct (Parts 3 and 4 of the HPCAA). The standards MCNZ set cover different areas of care including good prescribing practice, advertising, and telehealth. MCNZ's standards are reviewed periodically (approximately once every 5 years) so that they are current and consistent with international best practice. Stakeholders¹ and the public are consulted each time, and the revisions that are made are broadly in line with the views expressed by the overwhelming majority of submitters. All doctors practising in NZ must comply with MCNZ's standards which are used by a number of bodies (including competence review committees, professional conduct committees, the Health and Disability Commissioner, the Health Practitioners Disciplinary Tribunal, and the courts) to measure the doctor's competence, performance, and conduct.

MCNZ is governed by a 12-member Council, 4 of whom are lay members. Section 5 of the HPCAA defines a layperson as someone "who is neither registered nor qualified to be registered as a health practitioner". In other words, MCNZ's lay Council members may not be a practitioner from another health profession. This differs from Singapore so I will revisit this point when I discuss the Singapore Medical Council.

New Zealand's Position on Doctors Treating Themselves and Those they are Close to

Different medical regulators have grappled with the issue of doctors treating themselves and those they are close to. Internationally, there is a trend towards restricting the doctor's prerogative to self-treat and treat those close to the doctor by limiting such care arrangements to emergency situations. For example, the United Kingdom's General Medical Council (GMC) advises doctors to avoid providing medical care for themselves and anyone they have a close relationship with, and this advice extends to prescribing medicines (General Medical Council 2013a, b). Similarly, the Medical Board of Australia (MBA) states that in most cases, providing care to close friends, those the doctor works with, and family members is inappropriate "because of the lack of objectivity, possible discontinuity of care, and risks to the doctor and patient". Where such care arrangements are

¹ In addition to the NZ medical profession itself, other stakeholders include specialist medical colleges (such as the Royal Australasian College of Physicians and the Royal Australasian College of Surgeons), NZ Government bodies (such as the Ministry of Health and the Office of the Health and Disability Commissioner), and the Consumer Advisory Panel.

unavoidable, MBA advises doctors of the need for “careful management of these issues” (Medical Board of Australia 2014). As well, the Irish Medical Council states that doctors should not treat or prescribe for themselves or for members of their family and others they have a close relationship with except in emergencies (Irish Medical Council 2016). While the College of Physicians and Surgeons of Ontario (CPSO) has a similar prohibition, exceptions are made for both minor conditions and emergency situations where another qualified health care professional is not readily available (College of Physicians and Surgeons of Ontario 2016).

The following table lists specific provisions from these medical regulators’ guidelines that caution doctors on treating themselves and those they have a close relationship with. All regulators referenced are based in English-speaking countries that have a comparable health system to NZ and are regulators MCNZ generally aligns with when MCNZ reviews its standards.

Country	Name of medical regulator	Name of guideline	Year	Specific provision cautioning doctors against self-treatment and treating those close to the doctor
UK	General Medical Council	Good medical practice	2013	Para 16g
		Good practice in prescribing and managing medicines and devices	2013	Para 17
Australia	Medical Board of Australia	Good medical practice: A code of conduct for doctors in Australia	March 2014	Para 3.14
Ireland	Irish Medical Council	Guide to professional conduct and ethics for registered medical practitioners (8th edition)	2016	Clauses 58.1 and 60.1
Canada	College of Physicians and Surgeons of Ontario	Physician treatment of self, family members or others close to them	2016	Page 4

NZ’s position (which the author shares) is consistent with the countries mentioned but MCNZ’s statement is more proscriptive. For example, the preamble sets out MCNZ’s expectation that doctors will not treat themselves and those they are close to in the *vast majority* of clinical situations with clause 4 listing specific prohibitions. They include doctors self-prescribing or prescribing psychotropic medication or medication with a risk of addiction or misuse for those close to the doctor, issuing repeat prescriptions where doctors do not have adequate information available to review the suitability of the medication, undertaking psychotherapy, issuing medical certificates, performing invasive procedures, and conducting medical assessments for third parties such as private insurers. In addition, under clause 5 of MCNZ’s statement, it is inappropriate for doctors to accede to personal requests for care where the colleague requesting care is more senior or in a dominant power relationship and/or is seeking to circumvent the normal process by not consulting his/her regular doctor.

MCNZ's statement adopts the phrase *vast majority* because there are limited circumstances where it may be appropriate for doctors to engage in self-care or in caring for those they are close to. Exceptions are made for urgent situations where immediate medical attention is required and where the doctor is working in a particular community where it is difficult for those close to the doctor to access other health practitioners. For example, in remote and rural parts of NZ, medical facilities are often limited and the nearest hospital could be several hours by road. In addition, NZ is increasingly becoming more multicultural, and there are instances where patients from a minority group prefer to consult a particular doctor. It is possible that the doctor already knows the patient personally prior to commencing a therapeutic relationship. In those instances, clause 7 outlines a number of safeguards including carrying out an adequate clinical assessment and referring the patient to another doctor in a timely manner. In addition, it is important that the doctor-family member maintain confidentiality of the patient he/she treats and that the details of the care provided are documented and conveyed to the doctor taking over the patient's care.

MCNZ also considers it inappropriate for doctors to provide recurring episodic treatment or ongoing management of an illness or condition to those close to the doctor even where that illness or condition is minor. Instead, clause 5 of MCNZ's statement states that another registered health practitioner must be responsible for treatment and ongoing management of such conditions. While some have criticised MCNZ for being overly strict especially as its previous statement was silent on the treatment of minor conditions, MCNZ has always maintained that it is not good practice for doctors to treat themselves and those they are close to even for minor conditions. So that there is no ambiguity on this matter, MCNZ's November 2016 statement defines what a minor condition is² and provides specific guidance on how they should be managed. This is necessary because there are doctors in NZ who assume that they are permitted to treat themselves and those they are close to for minor conditions especially as some overseas guidelines permit such treatment.

Issues with Doctors Treating Themselves and Those they are Close to

Doctors treating themselves and those they are close to is an ongoing issue for MCNZ. So that its position is clear and unequivocal, the MCNZ statement explains in detail the pitfalls from such care arrangements.

Compromised Clinical Objectivity

Treating a family member or someone close is a classic example of a dual relationship whereby the doctor has both a personal and therapeutic relationship with the person the doctor is treating. Arguments for such care arrangements include the doctor's personal

² Clause 1 of the MCNZ statement defines minor conditions as "a non-urgent, non-serious condition that requires only short-term, episodic, routine care, and is not likely to be an indication of, or lead to, a more serious, complex or chronic condition, or to a condition that requires ongoing clinical care and monitoring". The MCNZ statement also clarifies that "complex or chronic conditions are not considered minor conditions even where their management may be episodic in nature." MCNZ's definition is based on how CPSO defines minor conditions in its policy statement although MCNZ's definition omits any examples of minor conditions.

knowledge of the patient and the assumption that he/she can be trusted to provide good care. Proponents consider it beneficial for the patient if they have autonomy to choose their own doctor even if this doctor is someone the patient has a close relationship with (Kling 2015, 118).

However, objectivity is also essential in making appropriate clinical decisions. In general, the closer the relationship between the doctor and the patient, the harder it will be for the doctor to maintain his/her objectivity. Compromised objectivity can lead to a blurring of professional boundaries (Fromme et al. 2008, 826). This could have an adverse effect on the patient's care which is inconsistent with the ethical obligation on doctors to do no harm.

For this reason, MCNZ cautions doctors against treating themselves and those they are close to where the nature of the relationship is such that it "could reasonably be expected to affect [the doctor's] professional and objective judgement". As a point of clarification, MCNZ is not seeking to prohibit doctors from building relationships with their patients and with the community in which the doctor lives and practises in. Rather, MCNZ's statement seeks to guide doctors in situations where they may have to decide whether it is appropriate to treat themselves or someone close to them, to highlight ethical and practical concerns from such care arrangements, and to outline what measures to take in those instances to safeguard themselves and their patients. The statement notes that an incorrect diagnosis or treatment (arising from compromised objectivity on the part of the doctor) could worsen the doctor's health and those the doctor treats. As such, MCNZ also expects all doctors practising in NZ to have their own general practitioner (GP) and for the doctor's family to seek independent medical advice. Doing so is part of best practice (Moberly 2014, 15). Clause 2 of MCNZ's statement explains that as a doctor's health needs change over the course of the doctor's career, it is important that there is an accurate and complete longitudinal record of all the health issues and treatments received over the doctor's lifetime. As with any other patient, this record is best maintained by the doctor's own GP. This is notwithstanding that there are often barriers to doctors seeking help and attending to their own health needs, along with unique challenges for other doctors who care for patients who are themselves doctors (Thurston 2017, 341; Campbell and Delva 2003, 1122).

Compromised Continuity of Care

Continuity of care is concerned with a long-term relationship between a patient and his/her doctor. Evidence suggests that it benefits both doctors and patients (especially those with chronic conditions) as there is continuity of relationships, locality (in terms of the care facility itself, staff who work in that care facility, and the surroundings where that care facility is located), and information that is shared and discussed. As well, continuity of care improves patient outcomes through earlier recognition of and attention to clinical problems and increased patient compliance (Sudhakar-Krishnan and Rudolf 2007, 381). It also reduces the frequency of emergency department presentations and hospitalisations (Kerse and Mainous III 2002).

To facilitate continuity of care, NZ patients are encouraged to have a regular doctor (usually a GP) and to develop an ongoing relationship with that doctor. Because of that doctor's knowledge of the patient, he/she is well-placed to coordinate the patient's care (including any treatments or medications prescribed by other doctors) and to refer the

patient to other specialists if a problem warrants further investigation. While care coordination is often a challenge, it is crucial for safe, good-quality patient care (Manning and Paterson 2009, 162).

Conversely, informal care by doctor-family members potentially compromise continuity of care as any treatment provided is often not documented nor communicated to the patient's regular doctor. This leads to gaps in the patient's medical history and impacts on their ongoing care as the patient's regular doctor is either unaware of the need to follow up or lacks the necessary information for effective follow-up (Gold et al. 2014a, 1256). Such gaps can also create serious quality problems down the line.

Providing Care Beyond the Doctor's Competence

Part of good medical practice involves doctors recognising and working within the limits of their competence. However, when engaging in self-care or in caring for someone close, the doctor may be inclined to treat problems that are beyond the doctor's skill and/or be pressured to do so by someone close. This could be because the doctor or someone close to the doctor overestimates his/her ability or expects a high degree of involvement (Chen et al. 2001, 237). In addition, the doctor could be prompted to treat or issue a prescription that does not align with best practice because of the doctor's own discomfort with the patient's symptoms (for example, chronic pain, insomnia, and weight gain). Irrespective of the motives, treating outside one's expertise can lead to errors in clinical judgement and harm the patient (Evans et al. 2007, 62).

Preconceived Notions, Awkwardness, and Embarrassment

A long-established relationship from a non-therapeutic context may mean knowing someone well on a personal level but that could create preconceived notions about the health and behaviour of someone the doctor is close to. There could also be some degree of reluctance or embarrassment on the part of the doctor and/or the patient to ask certain questions or to discuss sensitive issues especially if it concerns intimate body parts (Mailhot 2002, 547). As well, the doctor's assumptions about a person's circumstances could lead the doctor to decide that it is unnecessary to take a full history or to conduct a clinical investigation (Gold et al. 2014a, 1256). Furthermore, the patient might provide inaccurate information or withhold certain facts to "paint a better picture of themselves".

Ultimately, avoiding or skirting around what is uncomfortable means that the doctor ends up with an incomplete clinical picture of the patient. This could confound the correct diagnosis and any clinical decisions that are made (Jones et al. 2005, 1034). It also raises questions regarding informed consent if full information is not provided to the patient and/or if the patient feels compelled to accept a certain course of treatment because of his/her personal relationship with the doctor (Kerrigan et al. 2011, 434–435). In short, it affects the quality of care (Mailhot 2002, 547).

The Risk of Overtreatment or Overlooking Treatment

Strong bonds with those we are close to is part of "being human", but as discussed earlier, emotions can obscure objective judgement (Jones et al. 2005, 1033). One

example of this is the desire and/or pressure to provide those close to the doctor with “gold standard care” resulting in overtreatment. This could lead the doctor to prescribe medications or request investigations that are not clinically indicated or to duplicate tests that another doctor has already ordered (Mailhot 2002, 547). Although well-intentioned, the unnecessary treatment could be invasive and cause adverse reactions (Moynihan et al. 2012). For example, there could be overexposure to medical radiation from unwarranted radiology procedures while the misuse or overuse of antibiotics could accelerate antimicrobial resistance in a patient. In addition, the patient could also experience anxiety and stigma from certain disease labels (Glasziou et al. 2013).

Patient-centred care does not mean that clinically unindicated tests or procedures should be conducted just because the patient wants it. Rather, best practice requires that the doctor recommend an appropriate course of treatment following a full assessment of the patient that includes comprehensive history taking and evaluation. This is the standard that MCNZ expects in instances where there is no reasonable alternative to doctors providing care for themselves and those close to them. It is also important that the doctor responds with empathy and explore the patient’s basis for requesting a procedure or investigation that is not clinically warranted (Thurston 2017, 343–344). In addition, doctors need to be mindful that overtreatment can waste health resources and impact other patients who may require a particular procedure more urgently (Kerrigan 2011, 435). Overtreatment is also contrary to distributive justice which requires doctors to make the best use of available health resources based on need and evidence of benefit (Gillon 1994, 185–186).

Conversely, strong emotional bonds with someone could skew the doctor’s perception of the clinical situation such that the doctor minimises or makes light of the patient’s concerns or provides inaccurate reassurance if the doctor considers that the patient is exaggerating. This could compromise the outcome if the patient delays consulting an independent doctor. If the subsequent diagnosis is more severe than what the doctor-family member had assessed, not only will it be distressing for the patient but it will also create distrust and affect the patient’s relationship with the doctor-family member and others in their family (Fromme et al. 2008, 827).

Other Practical Considerations

So far, this paper has established that however well-meaning the doctor may be, ultimately, self-treatment and treating those close to the doctor can result in suboptimal care. There are also a number of practical issues to consider. One is setting undesired precedent in that if a doctor creates an expectation that he/she will treat family members, it will be more difficult subsequently to decline care (Latesa and Ray 2005, 43).

Secondly, confidentiality can be compromised. In general, it is harder to maintain confidentiality regarding a particular family member’s care when other family members take a personal interest and want information on “what’s going on” (Mailhot 2002, 547). The doctor could also assume incorrectly that it is appropriate to share medical information about a relative within their close circle of family and friends (Eastwood 2009, 1334). As well, it can be challenging to maintain confidentiality when other family members impose their own expectations or share information about the patient that the patient might not have wanted the doctor-family member to know. Information

from sources outside the consultation room could in turn pique the doctor's curiosity about a particular family member and influence the doctor's clinical judgement of the patient (Jones et al. 2005, 1034).

A further consideration is that any clinical decisions made in a consultation room follow the doctor and patient to family gatherings and events (Kerrigan et al. 2011, 434). Such occasions are far from ideal for discussing personal medical information and could be uncomfortable or embarrassing for the patient and doctor-family member. This is even more so if there were complications from the treatment. The more adverse the outcome, the greater the risk of damaging the patient and doctor's well-being and their ongoing relationship (Knuth et al. 2017, 242). As discussed, any fallout between them can also sour relationships within the wider family (Oberheu et al. 2007, 723).

Has MCNZ Quantified the Risks of Doctors Treating Themselves and Those they are Close to?

A common criticism of guidelines cautioning doctors against treating themselves and those they are close to is that such guidelines are not based on formal studies or randomised controlled trials (Gold et al. 2013b, 2436–2437). This was something several doctors highlighted during MCNZ's consultation with stakeholders between June and August 2016. Although it is the case that no formal (empirical) study preceded the November 2016 statement, MCNZ's position on doctors engaging in self-care and in caring for those close to the doctor is consistent with a number of medical regulators from comparable health systems (discussed earlier) and with international literature. Indeed, in a literature review conducted, Knuth et al. (2017, 241) commented that there was "hardly any argument in favour of operating on friends and family". While that observation was in relation to surgery, the same can be said for other international literature on this topic in that they tended to caution doctors against treating themselves and those they are close to with exceptions made for emergencies and minor conditions.

Ultimately, it is MCNZ's mandate to protect the health and safety of the public. So, despite some doctors dissenting, MCNZ proceeded with a revised statement that aligns with best practice. This is important because it is for the regulator to set clear standards especially in a fraught area as the next section illustrates.

Cases of NZ Doctors who have Treated Themselves or Someone Close

MCNZ regularly receives notifications of doctors who engage in self-care or in caring for someone close. Some notifications are from pharmacists whose responsibilities include checking that prescriptions are in order before filling them. In NZ, medications are dispensed at a pharmacy rather than at the medical centre where the patient consulted the doctor. This ensures that there are checks and balances in place for prescriptions that are issued and that patients have the opportunity to seek advice from another registered health professional on their symptoms and medications.

This section discusses three of such cases that MCNZ considered over 2014–2017.^{3,4} While the cases vary in severity, each highlight the pitfalls that arise when doctors treat themselves and those they are close to.

Case 1: Dr X—Medical Officer

Dr X came to MCNZ's attention for two prescribing incidents. The first involved prescribing triazolam (a benzodiazepine) for a relative for which Dr X received a warning letter from MCNZ.

A year later, Dr X presented a prescription for Ms A for 30 duromine (appetite suppressant) tablets with two repeats⁵ and 30 triazolam tablets with two repeats. When the pharmacist queried the large quantity of medication prescribed, Dr X explained that Ms A was obese and had insomnia. Although both medications were dispensed, the pharmacist conducted further checks to allay her concerns. In the process, the pharmacist discovered that Dr X's practising certificate had expired 4 months earlier and that Ms A had never been prescribed duromine or triazolam by any other doctor. Dr X subsequently admitted that both medications were for self-use.

Dr X was referred for disciplinary action. Prescribing records revealed that over a 15-month period, Dr X had self-prescribed high doses of zopiclone (a sleeping tablet) and triazolam without appropriate monitoring and had also prescribed these medications for those Dr X had a close relationship with. However, Dr X failed to maintain clinical records of what was prescribed although this is a key obligation for doctors practising in NZ. Furthermore, Dr X concealed the use of zopiclone and triazolam from Dr X's GP and developed a dependency on both medications.

The Health Practitioners Disciplinary Tribunal found that there had been considerable dishonesty and that Dr X's misuse of controlled drugs was sufficiently serious to cancel the doctor's registration. However, owing to strong mitigating factors, namely ill health and other stresses in the doctor's personal life, Dr X's registration was not cancelled.

Nevertheless, Dr X's case highlights several lessons. First, doctors who engage in self-care or in caring for someone close risk compromising their clinical objectivity and judgement especially if this care arrangement continues for an extended period. Secondly, doctors could find themselves on a slippery slope when they fail to be accountable to their

³ The names of the doctors involved and those they treated have been removed to protect their privacy. Identifying letters that have been assigned bear no relationship to the person's actual name.

⁴ MCNZ is not a disciplinary body, although it manages some complaints to do with professional conduct, competence, and health concerns about the doctor. All patient complaints in NZ are directed initially to the Office of the Health and Disability Commissioner which is an independent government body tasked with promoting and protecting the rights of patients and facilitating the fair, simple, speedy, and efficient resolution of health and disability complaints.

⁵ A repeat prescription is given at the doctor's discretion where the patient's condition is stable and if the patient has seen the doctor within the last 6 to 12 months. A repeat prescription enables the patient to return to the pharmacy for a further supply of the same medication without having to consult the doctor. In the case of Dr X, two repeats for duromine and triazolam meant that an additional 30 duromine tablets and 30 triazolam tablets would have been dispensed on two subsequent occasions if the pharmacist was satisfied that the prescription was appropriate.

peers. Dr X's trajectory parallels Richer's (2009, 782) observation that a downward spiral can affect every aspect of the doctor's life. The process is often insidious, but in due course, "climb[ing] back to safety" can be difficult (Hallenback 2005).

Case 2: Dr Y—Palliative Care Doctor

Dr Y's wife suffered from chronic pain. She was under the care of a hospital chronic pain team.

Following a move to another city, Mrs Y was referred to a new hospital pain clinic but she was dissatisfied with its care. Mrs Y became suicidal about her pain. This distressed Dr Y who resorted to prescribing oxycodone (a narcotic) for his wife.

Over time, Dr Y tried reducing his wife's consumption of oxycodone but Mrs Y pressured him to continue the prescription. Despite recognising that another doctor should be involved, Dr Y feared the repercussions of this.

Dr Y became increasingly distressed about the amount of oxycodone he was prescribing his wife. To reduce suspicion, Dr Y resorted to prescribing oxycodone under different patients' names and filling these prescriptions at several pharmacies.

This case is tragic. Dr Y was at retirement age, but instead of finishing well, he was sanctioned at the end of his career. However, because Dr Y had ceased practice when his case came before MCNZ, he was not referred for further disciplinary action.

Case 3: Dr Z—General Practitioner

Dr Z self-prescribed zopiclone and ibuprofen using the practice's prescription pad. When Dr Z presented the prescription, the pharmacist refused to dispense both medications. Instead, the pharmacist contacted MCNZ to complain about Dr Z.

In response, Dr Z explained that he took zopiclone occasionally for his insomnia and that the ibuprofen was for his postoperative pain. Apart from the zopiclone, Dr Z clarified that he had not taken any other psychotropic medication but admitted that he had also prescribed for his immediate family.

MCNZ adopts a right touch approach by ensuring that the level of regulation applied is proportionate to the level of risk of harm to the public. As this was the first complaint about Dr Z, and the concerns were not as serious, Dr Z was cautioned in writing not to treat himself and those close to him.

What About Singapore?⁶

The last section of this paper discusses Singapore's position on doctors treating themselves and those close to them. Guidance on this is set out in SMC's 2016 Ethical Code and Ethical Guidelines (2016 ECEG) (Singapore Medical Council 2016a) and in the SMC Handbook on Medical Ethics (2016 HME) (Singapore Medical Council 2016b). Both documents were published on 13 September 2016 and came into force

⁶ Comments about the Singapore Medical Council, its 2016 Ethical Code and Ethical Guidelines, and 2016 Handbook on Medical Ethics are the author's personal views and do not reflect or represent the collective views of MCNZ in any way.

on 1 January 2017—around the same time as MCNZ’s November 2016 statement. Specifically, the 2016 ECEG forbids doctors to treat themselves and those close to them for controlled drugs, drugs with significant potential for dependence, and psychiatric care (see guideline B1 point (4) in section B1 “Decisions about providing services”, Singapore Medical Council 2016a). This is consistent with clause 4 of MCNZ’s statement which contains a few other prohibitions as mentioned earlier. Of particular interest is guideline B1 point (5) of the 2016 ECEG which states:

Generally, you may provide care to yourself and those close to you when it is for routine continued care for stable conditions, minor conditions, or in an urgent/emergency situation when no other suitable doctor is available in a timely manner. If you choose to provide significant care such as major surgery to those close to you, you must ensure that your objectivity, judgment and professionalism in medical decision making are not compromised to patients’ detriment due to your emotional proximity.

This is considerably more permissive than NZ. For example, it allows doctors in Singapore to provide ongoing care for stable and minor conditions including prescribing for them. The 2016 HME expands on “simple, minor conditions” by listing “common colds, gastroenteritis or simple lumps and bumps” as examples (Singapore Medical Council 2016b). Although doctors in Ontario are also permitted to treat themselves and their family members for minor conditions, that treatment can only take place “when another qualified health-care professional is not readily available” (College of Physicians and Surgeons of Ontario 2016). This same restriction does not apply to doctors in Singapore since the unavailability of another doctor refers only to urgent/emergency situations. Guideline B1 point (5) is concerning because it assumes that doctors can readily ascertain what a minor condition is and that such conditions do not require another health professional’s input. While this may be true on some occasions, there are also instances when symptoms that are seemingly minor are an indication of something more major. For example, a stiff neck, headache, and fever may seem minor on their own, but collectively, they are symptoms of meningococcal disease, which can be life-threatening.

Another concern with guideline B1 point (5) is that it permits doctors to undertake “significant care such as major surgery” for those close to the doctor so long as it does not compromise the doctor’s “objectivity, judgment and professionalism in medical decision making” (Singapore Medical Council 2016a). What is particularly worrying is that this clause does not expressly restrict doctors to providing care within the limits of their competence. Whether or not this was the intended interpretation, this clause on its own⁷ gives Singapore doctors considerable leeway unlike their NZ counterparts who are prohibited from performing invasive procedures for themselves and those close to them. Treating outside one’s expertise is inherently risky. Patient safety is further compromised

⁷ It would have been preferable if guideline B1 point (5) was cross-referenced to guideline A3 point (1) of the 2016 ECEG which requires doctors in Singapore to practise within the limits of their competence. Guideline A3 point (1) also prohibits doctors in Singapore from engaging in unsupervised practices where they do not have the requisite skills, knowledge and experience (Singapore Medical Council 2016a).

if the doctor's knowledge is outdated and if the doctor is not undertaking any continuing professional development in the area where they are providing (significant) care.

There is some sympathy for the SMC Working Committee who considered doctors treating themselves and those close to them “a difficult area to resolve” because that too was MCNZ's experience. But how the Working Committee ultimately settled this topic is questionable. Although SMC's Explanatory Notes acknowledge that patients who are close to doctors “have the right to care that is objective, professional and unaffected by emotional interference”, the notes also state that doctors treating themselves and those close to them “is clearly something our medical profession would like to retain” (see paragraphs 25 and 26 of SMC's Explanatory Notes—Principles of Revised ECEG, Singapore Medical Council 2016c). The latter is extremely concerning. First, it suggests that doctors in Singapore do not see any issues with treating themselves and those they are close to—is this partly because SMC has been slow to highlight the inherent risks to the profession?⁸ Secondly, whose interests is SMC really protecting? SMC is supposedly the medical watchdog for patients in Singapore, and public watchdogs are charged with upholding patients' interests and encouraging best practice (Paterson 2006). That SMC acceded to the profession's demands suggests that patient safety is not its primary consideration. In part, this could be because Singapore does not have any legislation equivalent to the HPCAA that focuses on protecting public health and safety which in turn provides the framework for how MCNZ sets its standards for regulating doctors. Furthermore, SMC's approach is also contrary to the privilege of self-regulation which requires that the regulator act first and foremost in the public's interest (Irvine 2001a, 166).

Although the Working Committee sought to align its 2016 guidelines to the ethical standards applicable in other developed jurisdictions including NZ, Australia, UK, Canada, and Ireland, the extent to which doctors in Singapore are allowed to treat themselves and those they are close to makes SMC somewhat of an outlier. In the author's personal opinion, SMC's position reflects a largely paternalistic medical profession. Unlike MCNZ which seeks submissions from the public and the Consumer Advisory Panel⁹ each time it reviews its standards, there is no indication from SMC's Explanatory Notes that the draft ECEG had been circulated for public feedback at any point during its review process which took nearly 6 years. Although laypersons from SMC's Complaints Panel were involved in the focus group discussions on the draft ECEG, a number of laypersons on SMC's Complaints Panel are nurses, dentists, and pharmacists, so in reality, SMC's lay representative is still skewed towards health professionals. Furthermore, SMC's 25-member Council comprise entirely of doctors unlike the governing Councils of MCNZ, MBA, and GMC who each have several lay members to encourage a wider representation from the community. There are benefits to more public involvement in medical regulation including fostering greater confidence in the regulator and developing policies that reflect more effectively the needs

⁸ Section B1.2 of the 2016 HME expands on guideline B1 point (5) of the 2016 ECEG by highlighting the inherent risks involved when doctors treat themselves and those they are close to (Singapore Medical Council 2016b). The 2002 ECEG contained no guidance on this topic.

⁹ The Consumer Advisory Panel is a 12-member panel representing a cross-section of consumers who use NZ's health and disability support services such as Māori, Pacific Island, the elderly population, mental health patients, those with disabilities and chronic conditions, and the migrant community. Established in 2003, the panel provides advice to MCNZ from a consumer's perspective on strategic and operational health and disability issues.

and experiences of patients and the public (Council for Healthcare Regulatory Excellence 2011).

Allowing doctors considerable leeway to treat themselves and those they are close to exposes them and their patients to the pitfalls discussed earlier. It also leads to fragmented care because patients will be less inclined to consult an independent doctor and to build a rapport with that doctor if it is acceptable for them to seek care from a doctor-family member. This is hardly optimal especially for chronic conditions which are a significant cause of illness and death in Singapore (Ministry of Health Singapore 2010). It is also contrary to the Singapore Ministry of Health's "One Singaporean, One Family Doctor" vision for every person to establish a long-term partnership with a regular family doctor who is familiar with the patient's needs (Ministry of Health Singapore 2017).

Paragraph 27 of SMC's Explanatory Notes acknowledges that in Singapore's "local cultural context, treatment of self and those close to doctors has become a norm" (Singapore Medical Council 2016c). While this may be the case, it is up to SMC as the ultimate guardian of the profession's standards to set clear guidelines that encourage best practice (Irvine 2001b, 1810). Regrettably, SMC failed to do so. Simply stating that there are inherent risks in such care arrangements yet permitting doctors to engage in them conveys mixed messages to the profession and public. It also leaves SMC in a precarious position if it has to enforce its standards in this area.

Conclusion

Numerous ethical and practical issues arise when doctors treat themselves and those they are close to, and these appear to outweigh any benefit the doctor or patient might derive. These issues are highlighted in MCNZ's statement which says that it is not advisable for doctors to self-treat or treat those they are close to in the vast majority of clinical situations. Although this may be perceived as restrictive, it is important that a medical regulator encourage best practice within the profession even if that position may be unpopular with some doctors. In any event, MCNZ's position is consistent with a number of overseas medical regulators who also limit such care to emergency situations. However, compared to regulators such as the MBA and GMC, MCNZ is more proscriptive in that its statement details the pitfalls of self-treatment and treating those close to the doctor, as well as the importance of doctors having their own regular doctor. Because this is a fraught area of care, clear standards are essential to guide the profession and public.

In contrast, doctors in Singapore have considerably more leeway to treat themselves and those they are close to. This is notwithstanding that SMC sought to align its revised guidelines with the ethical standards applicable in other developed jurisdictions including NZ, Australia, UK, Canada, and Ireland. It is regrettable that greater precedence was given to the profession than to promoting best practice when SMC devised its guidelines on this topic. Until and unless SMC takes a stronger stance on why it is generally not advisable for doctors to treat themselves and those they are close to, this care arrangement will remain a norm in Singapore. Along with the pitfalls discussed, care is likely to remain fragmented which is not optimal for managing chronic diseases. Ultimately, patients stand to lose if they do not have any doctor with a comprehensive understanding of their care.

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Compliance with ethical standards

Conflict of interest I am a Senior Policy Adviser and Researcher at the Medical Council of New Zealand. Over 2016, I was primarily responsible for reviewing MCNZ's statement for doctors on *Providing care to yourself and those close to you*. This included conducting stakeholder consultations, reviewing written submissions from doctors and the public, facilitating focus group discussions with the Consumer Advisory Panel, and writing policy papers for MCNZ's governing Council.

I previously worked for the Singapore Medical Council and was involved in the initial review of its revised *Ethical Code and Ethical Guidelines*. My views about SMC and its guidelines are purely personal and do not reflect or represent the collective views of MCNZ in any way.

Abbreviations CPSO, College of Physicians and Surgeons of Ontario (Canada); GMC, General Medical Council (United Kingdom); GP, General Practitioner; HPCAA, Health Practitioners Competence Assurance Act 2003 (New Zealand); MBA, Medical Board of Australia; MCNZ, Medical Council of New Zealand; SMC, Singapore Medical Council; 2016 EGED, Singapore Medical Council's 2016 Ethical Code and Ethical Guidelines; 2016 HME, Singapore Medical Council's 2016 Handbook on Medical Ethics.

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