Debates

Should family physicians treat themselves or not?

YES

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A 67-year-old family physician had recently retired from her rural practice and moved to an urban centre. She was recognized by her peers as a competent, professional, and ethical physician. She had a particular expertise in palliative care. Tragically, she was diagnosed with a malignant carcinoma soon after her retirement. Like many others, she was unable to access a family physician after her discharge from hospital and was referred to a local community clinic for home-care follow-up.

Unfortunately, the latest round of health care restructuring had resulted in the closing of the hospital's palliative home-care division. Nurses in the community clinic were expected to coordinate patients' care by consulting with the clinic's only physician and the hospital's oncologist, neither of whom had adequate time or expertise for such consultations.

Several months later, the patient's pain and nausea were difficult to manage. Determined to live at home as long as possible, she began to write prescriptions for herself and to titrate the doses to manage her symptoms most effectively. Understanding the risks of self-medicating, she was willing to be transferred to the hospital the moment the home-care nurse judged that this approach constituted a real risk. The nurse and the pharmacist refused to be implicated in the physician's activities. The clinic's physician and the hospital's oncologist both felt uncomfortable countersigning her prescriptions. The patient was informed that her only choice was to be re-admitted to hospital.

Doctors should not be their own physicians. It's a good rule, as far as rules go. The issue is not so much the rule itself, but rather the disregard for ethically justifiable exceptions to the rule. Are the currently accepted exceptions broad enough, nuanced enough, and clear enough to protect the interests of individual physician-patients adequately? Would, for example, this physician-patient's best interests be protected by the rule?

The primary goal of many rules is to protect the best interests of a group of people. A sick physician, however, is an individual and not a statistical representation of a collective. Is this physician not entitled to advocate for her own individual best interests, as she would for any of her other patients? Are there special situations where the best care physician-patients could receive is, in fact, from themselves? Does the rule currently allow for all of these special situations? Is there a flexible enough mechanism to allow for judicious review of legitimate claims for exemptions from the rule?

What is the physician morbidity and mortality associated with adhering to the rule as it stands? Interestingly, that question is rarely asked, and consequently, there are few data to help us answer it. Without these data, the ethical calculus is one-sided.

Theory versus reality

All patients are entitled to reasonable access to timely, competent care. Are physician-patients not entitled to the same consideration? When physicians cannot reasonably access such care, is it ethical to prohibit them from trying to compensate for the system's inadequacies? Can the system apply a rule categorically, while at the same time eviscerating the social constructs that might make the rule tenable?

In their seminal work The Abuse of Casuistry, Jonsen and Toulmin argue that we should be cautious of the tyranny of absolutes.[1] Rules are developed to serve humanity. Paradoxically, when rules are applied in a decontextualized fashion and without sufficient consideration of justifiable exceptions, individuals are sometimes sacrificed in the very name of the rule that is meant to protect them. Is that ethical?

Recent data suggest that a substantial number of physicians treat themselves. Why is this so? Is it because they are all lazy, arrogant, and lacking insight and judgment? Are they unaware of the risks of self-treatment? Do the percentages of cases in which physicians treat themselves represent inappropriate and dangerous self-treatment, or are some of these cases ethically justifiable exceptions?

A rule that does not meaningfully reflect clinical realities with its justifiable exceptions risks becoming

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irrelevant. If disregard for the rule is as prevalent as some data suggest, is the problem with the large number of physicians who disregard it or with the way the rule itself is currently formulated?

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Competing interests
None declared

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Reference
1. Jonsen A, Toulmin S. *The abuse of casuistry: a history of moral reasoning.* Berkeley, CA: University of California Press; 1988.

CLOSING ARGUMENTS

- Are the currently accepted exceptions to the rule that physicians should not treat themselves broad enough, nuanced enough, and clear enough to protect the interests of individual physician-patients adequately?
- Recent data suggest that a substantial number of physicians treat themselves. Are lower rates of physician morbidity and mortality associated with adhering to the rule against self-treatment as it stands? The question is rarely asked, and consequently, there are few data to help us answer it.
- If disregard for the rule is as prevalent as some data suggest, is the problem with the large number of physicians who disregard it or with the way the rule itself is currently formulated?

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desire for strong sensations, professional burnout, and self-treatment of pain.[3]

Bottom line

Based on my experience at the Collège des médecins du Québec, I can attest to the appropriateness of the rule against self-treatment. I have seen that, when it is not followed, physicians can get into terrible situations. While it does not occur too widely, thank goodness, the abuse of prescribing privileges can lead to fraud. One example is prescribing a medication for another person, such as a relative or patient, with the goal of obtaining the medication for oneself, either at a lower cost or to hide the self-prescription. The abuse of medications, whether benzodiazepines, analgesics, or other psychotropic substances, poses a very real and serious risk. Physicians who develop addictions are drawn into a downward spiral that affects every aspect of their lives: work, family, finances, and personal health, despite all their own efforts and those of their families and the other professionals involved.

To sum up, the medical community must take a clear stand on self-treatment. We need to say "No, we cannot!" rather than Barack Obama's slogan, "Yes, we can!" to what some consider an inherent right.

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Competing interests
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2. Genest v Médecins (T.P.); 700-07-000002-071; 2008 Oct 29 (decision upheld upon judicial review).
3. Hem E, Stokke G, Tyssen R, Grønvold NT, Vaglum P, Ekeberg Ø. Self-prescribing among young Norwegian doctors: a nine-year follow-up study of a nationwide sample [abstract]. *BMC Med* 2005;3:16.

CLOSING ARGUMENTS

- Medical ethics prohibit self-treatment, with certain exceptions.
- Self-treatment deprives physician-patients of the objectivity crucial to a high-quality clinical process and of the empathy of a consulting physician.
- A physician who treats himself puts himself at risk, including at risk of drug addiction.