Physician Patterns in the Provision of Health Care to Their Own Employees

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**Objective:** To determine the level of medical and mental health care that family physicians provide to employees.

**Design:** Mailed survey.

**Setting:** Family practices in Oklahoma.

**Subjects:** Two hundred ninety-one of 735 physicians accessed via the membership roster of the Oklahoma Academy of Family Physicians.

**Results:** The majority of physician respondents (55.6%) reported providing routine health care always or most of the time to employees. Rural practice sites were associated with the provision of broader medical services (Spearman's $r_s = -0.35, P < 0.0001$); 51.7% of respondents reported providing routine health care always or most of the time to employees' families. Breast and genital examinations were more likely to be undertaken in family members (67.2%) compared with employees (50.0%). Only a minority of physician respondents (12.3%) reported providing mental health care always or most of the time to employees; 53% never or rarely provided this service. When mental health care was addressed, respondents provided counseling alone (28.6%), prescription of psychotropic medication alone (8.8%), or both (62.7%). Antidepressants (50.7%) and nonbenzodiazepine anxiolytic agents (36.2%) were most frequently prescribed. When asked about ideal conditions, a significant minority of physician respondents (41.3%) preferred to refer employees to colleagues for medical care, and 59.8% preferred to refer for mental health care.

**Conclusion:** The majority of family physicians in this study reported providing medical care to their employees, whereas only a minority provide mental health care.

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DUAL RELATIONSHIPS in the primary care setting can be a potentially serious challenge for the physician. These relationships are perhaps best characterized as the merger of professional and social roles that occurs when physicians treat family members, friends, or employees.

The literature in this area is sparse, although several investigators have reported on the subject of physicians treating family members. These investigators have generally suggested that physicians exercise caution when providing health care to family members, citing as fundamental concerns the loss of personal objectivity, role conflicts, and the invasion of family members' privacy.

As for the provision of health care to friends and employees, we are unaware of any research in these areas. In comparison with friends, we view the medical treatment of employees with particular interest because of the close proximity of the professional work relationship. The purposes of this investigation were to explore the level of medical care, including mental health care, that physicians provide to their employees and to gain some sense of their comfort in providing these services.

**RESULTS**

Seven hundred thirty-five questionnaires were mailed to family physicians in the state of Oklahoma. Five were returned unopened because the addressees had moved. Three hundred one questionnaires were available at the time of the analysis. Of these, 10 respondents were retired. Two questionnaires arrived after the analysis. The overall response rate was 41.2%. The final working sample consisted of 291 respondents.

The demographics of the sample were as follows: 249 (85.6%) were male; 42 (14.4%) were female. The median age group for the sample was 40 to 49 years; 236 (81.1%) were younger than 60 years old. The median years in post residency practice was the category of 11 to 20 years; 203 (69.8%) had been in practice for 20

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METHODS

Subjects were registered members of the Oklahoma Academy of Family Physicians. With the permis-
sion of the president of the Oklahoma Academy of Family Physicians, a membership roster was ob-
tained from the executive director.

The instrumentation consisted of a one-page, front-to-back questionnaire that was developed by us. The questionnaire included the following: a demo-
graphic section that explored the physician's gender, age, years in practice, and practice type (eg, private, solo; private; group; academic; or health main-
tenance organization) and the population density of the practice area; inquiry into the number and gender of employees; and a series of questions on the provision of medical and mental health care to employees and medical care to employees' family members. These questions were formatted as a Likert scale (ie, a five-item continuum scale in which 1 indicated al-
ways and 5, never) or a simple checklist (ie, a selec-
tion of one of multiple options). These questions in-
cluded the following:

• Do you personally provide routine medical care to employees? If so, what does this entail?
• Do you personally provide routine medical care to employees' families? If so, what does this entail?
• Do you personally provide psychiatric/psychological care to employees? If so, what does this entail? (Options included counseling only, psychotropic medication only, or both.)

The questionnaire concluded with an inquiry into the type of psychotropic medications pre-
scribed to employees over the past 2 years and a sec-
tion that explored, under ideal conditions, what role the physician would prefer to have in the medical and mental health care of employees. At the end of the questionnaire, there was a write-in section that ex-
plored for suggestions regarding the future manage-
ment of employees' health care.

To ensure confidentiality, the questionnaires were not marked in any way to identify respondents; only one mailing was intended and undertaken. All question-
naires were mailed with a stamped return enve-
lope. Responses were collected over a 12-week period.

or fewer years. The majority were either in a group pri-
vate practice (43.3% [n=126]) or a solo private practice (29.9% [n=87]). Population densities of the practice areas were fairly evenly distributed from rural to city settings (10% to 18% per category), with the exception of physicians in the highest population density (>250 000) (35.4% [n=103]).

One hundred thirteen (38.8%) of the respondents reported the employment of more than five employees; the remainder employed fewer individuals with fairly even distributions (5.6% to 16.5%) among the categories. Most employee groups were either all female (59.7% [n=157]) or primarily female (37.3% [n=98]).

The level of routine medical care provided to employees and their families in addition to the level and type of mental health care provided to employees is shown in Table 1.

The relationships between the population density of the practice area and the provision of health services to employees and family members were as follows: routine medical services to employees, Spearman's \( p = -0.35, P<.0001 \); routine medical services to families, Spear-
man's \( p = -0.40, P<.00001 \); and psychiatric/psychologi-
sical services to employees, Spearman's \( p = -0.26, P<0.0001 \). The population density of the practice area was signifi-
cantly and inversely related to the extent of services provided to employees and family members (ie, the lower the population density, the greater the likelihood of ser-
ices being provided by the employing physician).

Two hundred eighty-two physicians reported prescribing psychotropic medications to employees at some time over the past 2 years. Only nine respondents (3.1%) reported not prescribing psychotropic medications to employees. The type of psychotropic medication that was prescribed by the remaining 282 physicians is shown in Table 2. The ma-
majority of these 282 physicians (64.5% [n=182]) reported prescri-
bining only one type of psychotropic medication, which was most often antidepressants. The prescription of psychotropic medication was unrelated to the population den-
sity of the physician's practice area.

The response patterns to the final item in the question-
naire, "What role would you prefer to take in the health care of your employees?" are shown in Table 3. Population den-
sity of the practice area was significantly and inversely re-
lated to a preference for providing routine medical services (Spearman's \( p = -0.29, P<.00001 \)) and mental health services (Spearman's \( p = -0.23, P<.0002 \)) to employees. In other words,
as the population density of the practice area increased, physicians were more likely to prefer to refer employees and their families to colleagues for care.

Other findings included the following: as the number of employees increased, the respondent was more likely to provide routine medical services to employees and these services were more likely to be broader in scope (ie, to include breast and genital examinations when indicated). There was a weak relationship between increasing age of the physician and a greater likelihood of and preference for providing routine medical care to employees.

The questionnaire ended with an optional write-in section inquiring about the respondents' recommendations for provision of future health care services to employees. Forty-five percent of respondents (n=131) wrote in responses. Their responses are summarized in Table 4. In addition to these comments, four respondents noted concerns about the loss of objectivity in the medical care of employees, two expressed concern about confidentiality in the treatment of their employees, and two commented that mental health care was difficult to obtain in their area. The following excerpts regarding the care of employees by physician employers are worth noting:

- The "roles become too enmeshed."
- "Ongoing care can be very difficult."
- "More often the problem is expectations involving frequently trivial concerns not really fixable."
- "It is not a matter of passing out pills or advice in the hallway."
- Treating employees "saves lost time from the office."
- This "research is unimportant to the delivery of medicine. . . . [Labor laws will take care of problems as will medical ethics committees."
- Treating employees "is much like treating family, except risking lawsuits instead of being ostracized by family members."
- Intimate examinations of employees "could add unnecessary tension to the workplace and possibly at home."
- Regarding the psychological treatment of employees, "bare souls tend to affect day-to-day interactions."
- Regarding care, in general, it is "basic common sense!"
- "It becomes too time-consuming to see your employees, and they often take advantage of you with frequent daily questions."

The limitations of this study include the small sample size, the geographic narrowness of the sample, and the use of self-report instruments vs direct interview. The strengths of this study include the following: This is the first study that we are aware of that explores the physician-employee relationship from the perspective of the dual roles that evolve when the physician is both employer and treatment provider. The sample was fairly diverse in its demographics. The response rate is respectable given a one-time mailing. Finally, the results appear meaningful and reflect a diversity of attitudes around the complex interface between the physician and the employee.

These results indicate that a majority of family physicians provide some level of medical care to their employees. However, under ideal conditions, a significant minority (41.3%) would prefer to refer the care of their employees to colleagues. This suggests that in many instances, care is provided by physicians with some apprehension. Indeed,
this would seem likely given the complex interface in these types of dual roles, particularly in regard to boundary issues. The potential boundary issues are many, including the disruption of physical, professional, interpersonal, and psychotherapeutic boundaries. The disruption of physical boundaries is an obvious concern, particularly given the number of physicians who provide genital examinations for their employees. The disruption of professional boundaries may manifest as incomplete assessments during “hallway” consultations, requests for nonstandard treatments by employees, unexpected time demands by employees for medical care, and tension between staff and physician should an unexpected medical outcome develop in a given employee. The disruption of personal boundaries can entail role conflicts on the behalf of the physician and unrealistic expectations of physicians by employees. Finally, the disruption of psychotherapeutic boundaries can precipitate on the behalf of the physician an ambivalent approach to employee management from a personnel standpoint because of the awareness of the employee’s psychological state. Needless to say, violation of these various boundaries has enormous ethical, personal, and medicolegal implications.

It is important to note that despite these potential boundary hazards, many respondents appeared comfortable providing health care to their employees. Their comments imply that these physicians easily conceptualize the employee in the patient role, view the medical issues at hand as the predominant concern, and emphasize their role as providers of medical care to those in need. A great many respondents reported that the boundary issues were effectively addressed by noting that both parties, physician and employee, needed to participate in the decision regarding treatment. Again, mutual negotiation appeared to be a recurrent theme in these responses.

The differences between providing care to employees vs their families was extremely small and nonsignificant. There was, however, a trend toward more physician comfort with invasive examination of employees’ families compared with employees themselves.

In this study, respondents were clearly more wary of providing mental health services to employees, although a great many had provided counseling as well as prescribed psychotropic medications, most often antidepressants or nonbenzodiazepine anxiolytic agents. We strongly suspect that the management of intense emotional issues with employees adds a unique type of boundary stress to the professional relationship. This impression is underpinned by the multitude of warnings and constraints that are advised in relationships between therapists and patients. These constraints are appropriately designed to reinforce boundaries and preserve a working therapeutic relationship. In the case of physicians and employees, boundary tensions could affect not only the treatment relationship but the work relationship as well.

Of note is that whereas 18% of respondents stated that they never provide any psychiatric and/or psychological care to employees, only 3% had not prescribed psychotropic drugs to employees over the past 2 years. This discrepancy may be explained by the multiple uses of psychotropic drugs for nonpsychiatric reasons (e.g., fibromyalgia, chronic pain, and headaches). The fact that antidepressants were the primary psychotropic medica-

tion prescribed followed by nonbenzodiazepine anxiolytic agents suggests, as we would expect, that the personnel employed in a physician’s office are fairly functional on an emotional level. This may also reflect the overall psychotropic-drug prescribing patterns in a typical primary care setting. These impressions are reinforced by the low prescription of lithium and antipsychotic drugs.

Several respondents were concerned that the information they provided might be used to establish professional guidelines around physicians treating their employees. These respondents were consistently opposed to such guidelines. Again, the fundamental goal of this project was to explore the level and type of care being provided by physicians to employees and to gain some sense of the physicians’ comfort with this.

In conclusion, there was a clear trend in this study for physicians to want to refer the care of employees to colleagues more than they appeared to be doing. This finding may have been influenced by the limited availability of provider options, the convenience of treating employees in the office, and/or the perception by both physicians and employees of noncost medical care as a fringe benefit. However, we are concerned about this trend, which indicates a possible unvoiced discomfort with the practice of treating employees. Indeed, physicians genuinely need to be wary of the potential hazards of dual relationships when treating employees. Although there are clearly times when access to alternative services is not readily available, we encourage physicians to be cautious about providing medical care to employees as a rule and to decide about such care on a case-by-case basis. This will depend on the following factors: (1) the invasiveness of the indicated examination; (2) the availability of options regarding treatment providers; (3) the emotional stability of the patient; (4) whether longitudinal care is indicated; (5) the physician’s ability to recognize and manage boundary issues; and (6) the expertise of the physician regarding the chief complaint. We believe that boundary issues in medical practice are important and hope that this research effort provides some impetus for further research into this area.

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REFERENCES