

Article

Not peer-reviewed version

Examining Physicians' Approaches to Treating Relatives in Primary Health Care Centers: Insights from a Qualitative Study

[Manal R Alhamdan](#)*, [Nouf M Aloudah](#)*, Saleh Alrajhi

Posted Date: 5 September 2024

doi: 10.20944/preprints202409.0461.v1

Keywords: Ethics; Morality; Conduct; Qualitative; In-depth interviews; Treating family members; Theory underpinning; Decision making



Preprints.org is a free multidiscipline platform providing preprint service that is dedicated to making early versions of research outputs permanently available and citable. Preprints posted at Preprints.org appear in Web of Science, Crossref, Google Scholar, Scilit, Europe PMC.

Copyright: This is an open access article distributed under the Creative Commons Attribution License which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

Article

Examining Physicians' Approaches to Treating Relatives in Primary Health Care Centers: Insights from a Qualitative Study

Manal R. Alhamdan ^{1,†,*}, Nouf M Aloudah ^{2,†,*} and Saleh Alrajhi ¹

¹ Family Medicine Department, King Fahad Medical City, Riyadh, Saudi Arabia

² Clinical Pharmacy Department, King Saud University, Riyadh, Saudi Arabia; ORCID number /0000-0002-7603-1642

* Correspondence: manalalhamdan95@gmail.com and naloudah@ksu.edu.sa

† These authors contributed equally to this work.

Abstract: Introduction: Family medicine physicians take care of a diverse population of patients with a variety of acute and chronic diseases. These patients include family, friends, and acquaintances who may ask for direct medical care or help in accessing healthcare products and services, within or outside of officially approved procedures. This is ethically challenging due to an ambiguous medical code of ethics, but it is commonly accepted as normal behavior by society. Clinical ethics and the moral code of conduct together define how physicians should deal with such requests. However, Saudi physicians, like most individuals in Saudi society, are governed by the societal code of conduct when dealing with requests and favors from others. The aim of this study is to explore family medicine physicians' perspectives regarding the benefits, difficulties, and ethics of responding to medical care requests and/or favors from family, relatives, friends, and acquaintances and to make recommendations. **Methods:** The study sample consisted of junior and senior family medicine physicians working in primary healthcare centers affiliated with the Ministry of Health in Saudi Arabia. In-depth semi-structured interviews were conducted to collect data. Using Social Exchange Theory, this qualitative study explores how family medicine physicians perceive and handle requests for medical favors from family members and others. **Results:** Semi-structured interviews were conducted with 19 family medicine physicians with clinical experience ranging from 3 to 20 years. Data analysis identified three themes: perceived benefits and costs of cultural and social connectedness, shortcomings in patient management and healthcare systems, and recommendations to address challenges between physicians and patients who are relatives. **Discussion and conclusion:** The study shows that treating others outside of normal access to healthcare services presents several ethical, moral, and professional challenges. Therefore, policy adaptation requires understanding this intricate dilemma and improving laws, system regulations, and guidelines for physicians and community members to improve access to care, reduce system abuse, empower providers, and enhance community awareness and compliance. Strengths and limitations of this study: 1. This study delves into the ethical challenges that family medicine physicians face when responding to medical requests from family and friends, despite the presence of an ambiguous medical code of ethics regarding this matter. 2. This qualitative study uses Social Exchange Theory to explore how family medicine physicians perceive and handle requests for medical favors from family members and others. 3. The study highlights the ethical, moral, and professional challenges that arise when treating individuals outside of normal access to healthcare services. 4. This study makes some suggestions, given the necessity of policy adaptation to address this complex dilemma. These include improving guidelines to empower providers, enhance community awareness and compliance, and ensure better access to care while reducing system abuse.

Keywords: Ethics; Morality; Conduct; Qualitative; In-depth interviews; Treating family members; Theory underpinning; Decision making

1. Introduction

In Saudi Arabia, family medicine physicians provide continuous and comprehensive healthcare for all individuals and their families, making them the most accessible physicians to the community [1]. They are in a unique position in their daily clinical practice, taking care of a diverse population of patients and managing a variety of acute and chronic diseases; they receive numerous requests for favors regarding medico-surgical care, pharmaceuticals, home medical equipment, and access to care.

Morality refers to the codes and expectations put forward by society for the conduct of individuals, groups, and organizations; they are derived from faith, religion, and established wisdom. It is a group of social rules accepted by the majority for interpersonal and inter-group social conduct and interaction, which govern general behaviors and actions towards ethical issues faced by societies in medical and other areas of human living. In clinical settings, some ethical and moral issues are ambiguous, challenging, or cannot be resolved through commonly accepted ethical standards and moral codes of conduct [2,3]. For example, La Puma et al. found that 99% of physicians in a community hospital in the United States received requests from family members to prescribe medication (83%), to diagnose medical illness (80%), and to help perform an emergency surgery (4%) [4]. Furthermore, Haneifi et al. found that all interviewed physicians in Malaysia received at least one request from family members during their careers [5].

The Saudi medical code of ethics states: "The healthcare practitioner can, in a non-emergency situation, refrain from treating a patient for personal or professional reasons that would jeopardize the quality of care provided by the healthcare practitioner to the patient, on the condition that this refrain does not harm the patient's health, and that there is another practitioner who is capable of treating the patient instead of him/her" [6]. However, commonly accepted societal moral and ethical norms in Saudi Arabia encourage physicians to respond to personal and intra-familial medical requests. Moreover, family medicine physicians in Saudi Arabia value the need to support strong relationships with their community members [3,7]. Thus, refusing care requests might negatively affect this relationship.

The American Medical Association code of ethics states: "It would not always be inappropriate to undertake self-treatment or treatment of immediate family members, in emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available." [8] Therefore, treating oneself, family, and close friends is sometimes a gray zone in global ethics and practice [8]. The aim of this study is thus to explore family medicine physicians' perspectives regarding the benefits, difficulties, and ethics of responding to medical care requests and/or favors from family, relatives, friends, and acquaintances and to make recommendations.

2. Methods

2.1. Study Design

This qualitative study employs in-depth interviewing design to explore the perceptions of family medicine physicians regarding medical requests made by family members, friends, and acquaintances. The study is grounded in Social Exchange Theory, which provides a theoretical framework for understanding the ethical determinants influencing physicians' management of these requests.

2.2. Theory

Psychological and sociological theories provide a structured framework for understanding behavior, designing interventions, evaluating outcomes, and informing policy decisions. As a

broader sociological theory, Social Exchange Theory (SET) focuses on social interactions and relationships rather than on individual behavior change. Specifically, it seeks to explain social interactions and relationships in terms of the costs and benefits that individuals perceive in their interactions with others [10]. According to SET, individuals engage in social relationships and interactions because they believe that they will receive benefits greater than the costs involved [9]. SET has been applied to a wide range of social phenomena, including interpersonal relationships, organizational behavior, and social networks; it has been used to explain why individuals choose to engage in certain behaviors, such as helping others or risky behaviors, and to predict the outcomes of social interactions and relationships [9].

2.3. Participants and Settings

The Ministry of Health in Saudi Arabia is considered the main provider for healthcare services. Accordingly, the study sample consisted of junior and senior family medicine physicians from primary healthcare centers, working for the Ministry of Health in Riyadh, Saudi Arabia. Purposive sampling was undertaken by emailing invitations for participation in the study to the primary healthcare centers. Interested participants who fulfilled the inclusion criteria were contacted to provide a telephone number to arrange an interview. For junior physicians, the inclusion criteria were physicians enrolled in the family medicine residency program under the Family Medicine Academy of the Ministry of Health with two to four years of work experience. For senior physicians, the inclusion criteria were physicians who were board-certified and held a consultant degree in family medicine working full-time in the Ministry of Health, with more than seven years of work experience.

Semi-structured interviews and focus groups were conducted face-to-face or virtually according to the preference of each participant. Face-to-face interviews were conducted at the participant's workplace. The interviews lasted between 40 and 60 minutes. The interviews were conducted by the primary researcher; they were audio recorded and then transcribed verbatim. The interviews were conducted until data saturation was achieved—that is, when no new information emerged, according to Glaser and Strauss [10].

2.4. Topic Guide

The topic guide was created by the author (NA) based on previous literature. (4,5,11,12) Two physicians reviewed the topic guide for understanding and relevance to Saudi culture. The topic guide was used as general guidance, and further probes were used to motivate physicians to express their point of view. The topic guide is presented in Appendix 1.

2.5. Data Analysis

In the interview transcripts, the physicians' names were replaced with corresponding pseudonyms. The transcripts were thematically analyzed using MAXQDA Analytics Pro 2020 (VERBI Software). Thematic analysis is a qualitative research method used to identify, analyze, and interpret patterns or themes within a dataset. It involves systematically organizing and categorizing data to uncover meaningful insights and understand the underlying meanings and the experiences of the participants [13]. Each transcript was independently analyzed by two authors (MA & NA), and disagreements were resolved by discussion. As the semi-structured interviews progressed, data were analyzed after each interview to develop the initial codes and identify important and new emerging information. The final codes and themes were discussed with the third author (SA). Two researchers (MA & NA) were heavily involved in the data analysis (debriefing, coding, and interpretation).

In addition, to mitigate bias, each interview ended with a summary to be validated by the participants and to check for any ambiguity; after each interview, the two researchers (MA & NA) met and reflected on the information, came up with the main factors mentioned, and compared them with previous findings. Moreover, they maintained memos and journaling throughout the data collection and analysis using MAXQDA memos and online note software (Google Keep). The data from the interviews were kept on a locked, password-protected computer accessed only by the

primary researcher. The data will be stored for up to five years after publication to enable the verification of data if challenged; then, all documents will be deleted and disposed of appropriately.

2.6. Ethical Approval

The study complies with the Declaration of Helsinki, and all the participants provided informed consent for the recording and use of their anonymized responses. Ethical approval was obtained on July 6, 2022, from King Fahad Medical City (KFMC) research ethical committee. The IRB log number is 22-303. The IRB registration number with KACST KSA is H-01-R-012. The IRB registration number with OHRP/NIH USA is IRB00010471. The approval number of federal wide assurance NIH, USA, is FWA0018774.

3. Results

The semi-structured interviews were conducted with 19 family medicine physicians with experience ranging from 3 to 20 years, practicing as residents (37%), senior registrars (37%), and consultants (26%). Six focus groups were held, each hosting 2–3 physicians. The participants’ characteristics are listed in Table 1.

Table 1. The participants’ characteristics.

Gender	N (19)
Female	14 (74%)
Male	5 (26%)
Experience (years)	
2–5	13 (68%)
5–10	3 (16%)
>10	3 (16%)
Degree	
Consultant	5 (26%)
Senior Registrar	7 (37%)
Resident	7 (37%)
Nationality	
Saudi	17 (89%)
Non-Saudi	2 (11%)

Data analysis identified three themes: perceived benefits and costs of cultural and social connectedness, shortcomings in patient management and healthcare systems, and recommendations to address challenges between physicians and patients who are relatives. The next sections describe each theme and provide relevant quotations. Figure 1 illustrates the themes and subthemes.

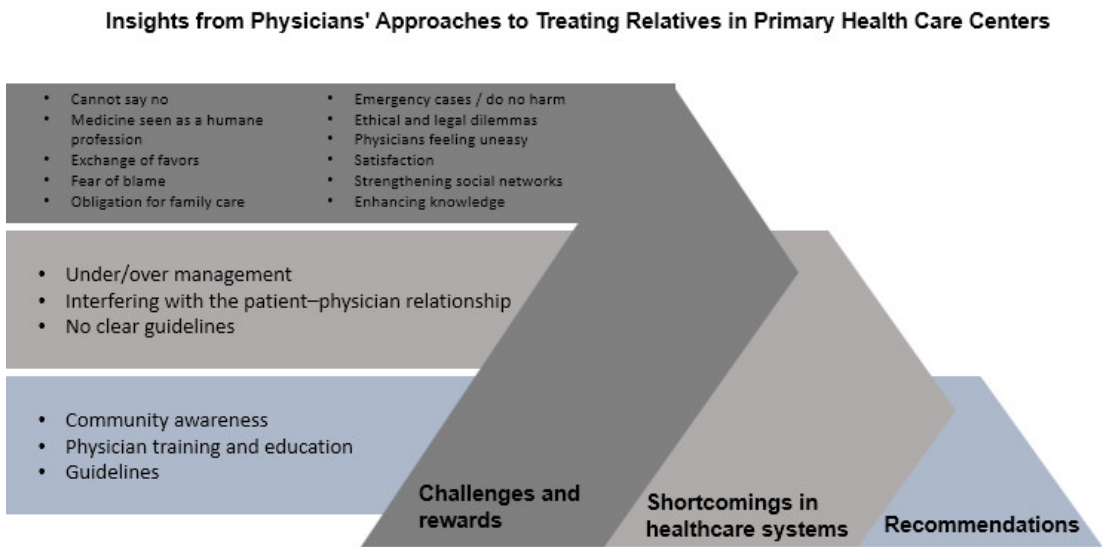


Figure 1. Insights from Physicians’ Approaches to Treating Relatives in Primary Health Care Centers.

3.1. Theme One: Exploring Perceived Benefits and Costs of Cultural and Social Connectedness

Participants shared their perspectives on the perceived benefits and costs associated with cultural and social connectedness when providing favors for relatives and friends. One aspect of the local culture that emerged was the value placed on interdependence, often referred to as “social connectedness.” Participants highlighted the profound impact of social support and deep connections with their families and others. Additionally, local values encouraging strong social support and networking was identified as a significant factor that at times can influence physicians’ decision-making processes.

Furthermore, the participants discussed the use of practical wisdom by physicians during the decision-making process. Physicians engaged in discussions regarding specific issues they encountered and the ways in which they relied on their wisdom to make informed decisions. This exploration sheds light on the unique insights and experiences that physicians draw upon to navigate complex situations and apply practical wisdom in their professional practice. Figure 1 presents the challenges and rewards described by physicians when treating family and friends. This theme is divided to two subthemes: challenges faced by doctors and physician rewards. Each subtheme is comprised of multiple components, which are presented below with supporting quotations.

3.1.1. Challenges Faced by Doctors

Cannot Say No

The participants described their decision as being affected by social influence in that their image will be affected if they refuse to answer the request.

“We are raised in a family-based community, where our life revolves around family, and good deeds are defined by helping and fulfilling different kind of requests, where you can’t actually say no, e.g., I will not help my grandfather’s friend. This is a bad stigma for the family and myself. So it’s difficult dealing with these scenarios in our community.” (Focus group 4, Participant 1)

Medicine Seen as a Humane Profession

The participants conveyed that embodying the role of the physician is synonymous with upholding high moral standards; therefore, declining requests for assistance could lead to the stigmatization of the individual as unhelpful within the community.

“... the medical personnel are seen as [part of] a humane profession, and humane professions don’t have any rules and regulations; any human that needs help needs to be served no matter what, and that’s what causes confusion between what’s ethical and non-ethical.” (Focus group 3 – Participant 1)

Exchange of Favors

The physicians highlighted that there exists a norm within the community, encapsulated by the principle of “if I help you, you help me.” Turning down requests for assistance could potentially hinder them from participating in this customary exchange of favors.

“I respond to requests mainly to avoid hard feelings and benefit from them later on in their respected field.” (Focus group 1 – Participant 1)

Fear of Blame

Furthermore, the physicians have a fear of being blamed for causing harm to the person making the request, a concern that compels them to decline the request.

“If I treated my relative and it resulted as not expected, they will blame me, and even if they didn’t, I will somehow have self-blame. This is very difficult to deal with mentally, but if it is not a relative or a close person to me, I will not have this kind of self-blame because I have done my best and will not doubt myself.” (Focus group 7 – Participant 1)

Obligation for Family Care

The physicians feel a strong sense of personal responsibility to help their family members in medical matters, especially when they are the only medical professional in the family. This responsibility comes from a personal commitment rather than from community expectations, and family takes precedence in their view.

“For me, the relatives whom I would help no matter what are only my mother and father, not even my siblings. Usually, for other relatives besides my parents, I would not talk to another doctor on their behalf.” (Focus group 1 – Participant 3)

Emergency Cases / Do No Harm

Physicians agreed that a physician should provide consistent care, whether for a relative or any other patient. The focus is always on balancing benefits against potential harm. If the potential for harm outweighs the benefit, the physician should step back and refer the patient to another competent physician.

“It’s very unethical for a physician to prescribe medications to a family member or close friend, and in North America they may lose their medical licenses, but in urgent lifesaving, urgent care of an emergency case where if it’s not given it will result in negative outcomes to the patient, I think it’s a must to help, ...” (Focus group 4 – Participant 1)

Ethical and Legal Dilemmas

Physicians discussed that when faced with requests that cross ethical boundaries, a physician recognizes this as more than just a patient–doctor relationship issue—it becomes a matter of legality. The physician prefers to avoid such situations as much as possible.

“When the request asked is not ethical, this relationship is beyond a patient and doctor, it’s a lawful act, I try to avoid such encounters as much as I can.” (Focus group 7 – Participant 1)

Physicians Feeling Uneasy

Participants expressed discomfort with providing free consultations outside of work hours, even to family members. They would prefer if family members visited their clinic during working hours and followed the standard system before they felt comfortable providing medical care.

“I don’t like to give a free consultation outside work hours even if it’s my family, but if they came to my clinic and followed the system, I would not refuse seeing them.” (Focus group 5 – Participant 1)

3.1.2. Physician Rewards

Satisfaction

According to the physicians, answering requests gives them a sense of personal fulfillment and a feeling of being valued and appreciated by those they serve.

"I feel respected in the community because I'm a doctor and helping others gives me a feeling of self-satisfaction." (Focus group 7 – Participant 2)

Strengthening Social Networks

The participants described that fulfilling requests not only meets immediate needs but also serves to deepen their relationships with those they assist.

"First, strengthening the relation between me and my family members, when a relative asks for help it means he trusted me with his issue. Second, I personally feel confident and self-satisfied when helping a family member." (Focus group 2 – Participant 1)

Enhancing Knowledge

Physicians stated that they benefit from responding to the requests because they can enhance their knowledge by exploring various cases.

"It also makes me research and read more when I get asked random questions, receive requests for favors by relatives, which will make me more confident in my daily practice." (Focus group 2 – Participant 3)

3.2. Theme Two: Exploring Shortcomings in Patient Management and Healthcare Systems

The second theme revolves around the shortcomings identified by physicians in patient management and healthcare systems, which impact their behavior. The physicians shed light on the challenges and limitations they face in effectively managing patient care within the current system as factors in providing (or not providing) favors to family and friends. The subthemes that emerged and the supporting quotations are provided below.

3.2.1. Under/Over Management

Physicians shared concerns about how treating family members that might lead to bias in treatment and the possibility of influencing patient honesty—i.e., patients may communicate more openly with a doctor they do not know. Moreover, physicians are concerned about the risk of errors and the overcomplication of diagnoses.

"This is called syndrome of the recommended patient, it's when you have a patient you personally know and he may have something simple, but you complicate it and keep going in circles about it by overtreating or diagnosing." (Focus group 1 – Participant 1)

3.2.2. Interfering with the Patient–Physician Relationship

Physicians discussed always respecting their colleagues' treatment plans and the fact that they might undermine them, but they are sure that primary physicians might know more about their patients' history. Physicians thus encourage their relatives to discuss any potential needs with their primary doctors. Furthermore, the physicians might overlook certain aspects of care, and they encourage their relatives to be proactive in their discussion.

"In cases where there is a need for an extra management or investigation, I will tell them just to ask their doctor if this is needed or not. Sometimes, as a doctor, we may forget, and a reminder will be appreciated. But without interfering with the management plan." (Focus group 4 – Participant 2)

3.2.3. System Shortcomings: No Clear Guidelines

Physicians raised a concern about how some existing rules may lack logical justification, leading physicians or patients to circumvent the system to simplify processes for convenience. Furthermore, the physicians recognize treating family members as a gray zone and suggest a case-by-case approach. They also acknowledge that they might treat family members but are aware that they will be held accountable for their actions. Moreover, participants raised ethical questions about the fairness of withholding help when the system is difficult to navigate.

“Sometimes some rules and regulations are not justifiable by logic, which usually lead to doctors or patients hijacking the system to ease things.” (Focus group 7 – Participant 1)

3.3. Theme Three: Recommendations to Address Challenges between Physicians and Patients Who Are Relatives

The physicians offered recommendations to address the challenges that arise in the context of treating patients who are relatives. They provided insights and suggestions aimed at resolving these issues and improving the dynamics between physicians and their relatives. This theme presents a collection of practical recommendations that can help inform interventions for better communication, establish clear boundaries, and enhance the overall quality of care in these unique patient–physician relationship dilemmas (Figure 1). The subthemes that emerged are presented below.

3.3.1. Community Awareness

Physicians discussed the need to increase community awareness about health matters such as early screening, proper medication use, and healthy lifestyle choices. They recognized that a significant issue is the lack of knowledge about how to access healthcare services.

“Advertising through mainstreaming regarding how to access medical care, how the medical system works, will relieve a lot of the pressure from our family and community.” (Focus group 4 – Participant 1)

3.3.2. Physician Training and Education

Physicians acknowledged the need for specific training to handle situations involving the treatment of relatives, which can be as complex as dealing with an angry patient. Such situations require professionalism to avoid conflicts of interest.

“Residency training and building competencies to self-regulate, I think medical doctors may be the only career that is self-governed. You as a physician are responsible for your own actions and decisions, so raising awareness, competencies, and self-governing. Having a lot of rules and regulations may negatively affect the way healthcare is provided.” (Focus group 4 – Participant 1)

3.3.3. Guidelines

Physicians expressed the need for clear guidance on what is permissible when treating relatives in a clinical setting. They suggested that the rules may need to accommodate different contexts, such as treating a parent in a clinic versus at home, implying that some flexibility is necessary. They also highlighted that when new guidelines and regulations are established by policymakers, it is crucial to effectively communicate them to the intended audience to prevent misunderstandings and ensure compliance.

“Having guidelines doesn’t mean being strict and restricted; it’s important in the long run to regulate the healthcare system. Also, having a flexible guideline is important for patient and physician satisfaction.” (Focus group 7 – Participant 2)

4. Discussion

Our study explored family physicians’ views regarding treating family members and friends. Three themes were identified (Figure 1). We used Social Exchange Theory to understand physicians’ decision-making processes. The analysis showed alignment with the theory regarding how

physicians see many perceived benefits when responding to the requests of family and friends, in addition to costs if they do answer the requests (Figure 1). Furthermore, the physicians highlighted additional factors that cannot solely be explained by social exchange theory, such as the shortcomings of patient management and healthcare systems that impact the decision to treat or not—for instance, requests from patients who do not have access to healthcare. The physicians suggested that community members were unaware of the risks of treating family and friends, and physicians need to be empowered by training and guidelines (Figure 1).

According to social exchange theory, individuals engage in social relationships and interactions because they believe that they will receive greater benefits than the costs involved,[9] which was identified in the first theme of perceived benefits and costs of cultural and social connectedness. Physicians discussed the costs and challenges faced, including that they cannot say no to their relatives and friends in fear of stigma. Medical professions are also seen as humane professions, where it is not acceptable to refuse to help others. Additionally, physicians explained about their fear of answering requests because it might cause blame, either from the requester or from themselves. However, the physicians have also seen benefits in answering personal requests: they strengthen social networks with the requesters and increase their knowledge and awareness. Additionally, the physicians satisfied and were acknowledged by the community.

Patient management and healthcare system shortcomings played a role in deciding whether to respond to the requests or not. The physicians stated that, in some cases, if they did not respond, the family or friend would not receive care. A study conducted in Saudi Arabia showed that the rapid increase in health expenditure in the last years caused a huge challenge; patient care for non-urgent cases may take months to years to be assessed by secondary/ tertiary care providers, which results in patient dissatisfaction and disease progression [14]. This causes a huge impact on family physicians working for the Ministry of Health and dealing with close family members and friends [14]. Also, a recent review about knowledge and attitudes regarding family medicine practice in Saudi Arabia found that 56.6% of the public did not understand the role of the family physician [7]. Even though the public trusts family physicians, they do not believe that they can treat certain chronic diseases such as diabetes and depression, which presents a huge problem in utilizing the new access to healthcare [7,15].

Moreover, the physicians in our study were holding back on answering the requests to avoid over- or under-management. When physicians treat family and close friends, their emotions can jeopardize their decision making, and physicians might over- or under-treat [12]. Our study also showed that the physicians clearly did not want to interfere with the physician–patient relationship; physicians are aware of the consequences of responding to the requests but feel obligated to follow the no-harm rule [16]. The physicians further discussed the impact on patient autonomy [1], as well as interference with patient–physician relationships by providing medical advice and/or management plans to a relative who is not their patient.

Furthermore, the physicians discussed the use of practical wisdom during the decision-making process—for example, they would follow the no-harm rule, and they would intervene if they were consulted by family and friends for an emergency or urgent issue, even if it did not allow them to avoid harm. Given the challenges in accessing healthcare [14], patients end up asking for help from a medical professional relative or going to private institutes. A study conducted in Mexico found that many households tend to pay privately for medical treatment even when governmental insurance is available, and the reasons included the shortage of medications and the non-coverage of certain illnesses—a result of the healthcare system struggling to adequately provide healthcare access [17].

Our study showed that physicians are pushed to treat family members because they feel responsibility and obligation towards their family, close friends, and relatives. This obligation emerged from their own moral beliefs and from community pressure. Similarly, a qualitative study conducted with 22 primary care physicians in Malaysia found that physicians respond to requests by family because they felt responsible for their family members; they felt they were able to treat family members better than other physicians, providing easy access to hospitals and medications [5].

Additionally, participants raised the concern that the guidance in the literature for physicians to consider before answering medical requests was not sufficient. It is necessary to empower physicians with tools to assist decision making, such as the seven steps by La Puma et al. The tool consists of the seven-question method: physicians are required to ask themselves seven important questions before dealing with medical requests from family and friends. These include: Can I undertake an intimate history and exam if needed? Is answering such requests likely to result in intrafamilial issues? Am I willing to be held accountable for any decision I have taken? [2,18] Moreover, other institutes and communities have a clear policy that regulates treating the self, family members, and other close personal relations, which sets a clear path for physicians to act accordingly, [19] even though physicians still bypass it sometimes. Physicians must be enforced to not treat their family members, coexisting system flows must be fixed, and access to care must be ensured.

Our study offered a comprehensive insight into the reasons why family physicians choose to treat, or refrain from treating, their own family members and friends. However, its applicability was constrained by the inherent limitations of the qualitative research design, which lacks generalizability. Nevertheless, the exploratory nature of qualitative research played a crucial role in illuminating globally prevalent practices, suggesting that similar contexts could benefit from our findings. Subsequent research could leverage the factors we identified to develop targeted interventions and foster the development of guidelines for physicians. Such efforts could also enhance community awareness about the potential risks and implications associated with receiving medical care from a family member.

In conclusion, the study shows that treating family members presents several ethical and professional challenges. Policymakers can address this intricate dilemma by improving laws, system regulations, and guidelines for physicians and communities. This will improve access to care, reduce system abuse, empower providers, and enhance community awareness and compliance.

Author Contributions: Conceptualization, Manal R Alhamdan, Nouf M Aloudah and Saleh Alrajhi; Methodology, Manal R Alhamdan and Nouf M Aloudah; Software, Manal R Alhamdan and Nouf M Aloudah; Validation, Manal R Alhamdan, Nouf M Aloudah and Saleh Alrajhi; Formal analysis, Manal R Alhamdan, Nouf M Aloudah and Saleh Alrajhi; Data curation, Manal R Alhamdan, Nouf M Aloudah and Saleh Alrajhi; Writing – original draft, Manal R Alhamdan; Writing – review & editing, Manal R Alhamdan, Nouf M Aloudah and Saleh Alrajhi; Supervision, Nouf M Aloudah and Saleh Alrajhi.

Funding: This research received no external funding.

Institutional Review Board Statement: The study complies with the Declaration of Helsinki, and all the participants provided informed consent for the recording and use of their anonymized responses. Ethical approval was obtained on July 6, 2022, from King Fahad Medical City (KFMC) research ethical committee. The IRB log number is 22-303. The IRB registration number with KACST KSA is H-01-R-012. The IRB registration number with OHRP/NIH USA is IRB00010471. The approval number of federal wide assurance NIH, USA, is FWA0018774.

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: The data from the interviews were kept on a locked, password-protected computer accessed only by the primary researcher. The data will be stored for up to five years after publication to enable the verification of data if challenged; then, all documents will be deleted and disposed of appropriately.

Acknowledgments: We would like to thank all the physicians who participated in this research.

Conflicts of Interest: The authors declare no conflict of interest.

References

1. Abdulrahman KB, Alnosian MY, Alshamrani AA, ALassaf HI, Aldayel AS, Alaskar YA, Alshehri MA. Job satisfaction among family medicine physicians in Saudi Arabia. *J Family Med Prim Care*. 2021 Aug;10(8):2952–2957. doi: 10.4103/jfmpc.jfmpc_2476_20
2. Hill H, Hill M. When your mother wants a script: The ethics of treating family members. *JAAPA*. 2011 Feb;24(2):59–60. doi: 10.1097/01720610-201102000-00012

3. Althobaiti MH, Alkhalidi LH, Alotaibi WD, Alshreef MN, Alkhalidi AH, Alshreef NF, Alzahrani NN, Atalla AA. Knowledge, attitude, and practice of medical ethics among health practitioners in Taif government, KSA. *J Family Med Prim Care*. 2021 Apr;10(4):1759–1765. doi: 10.4103/jfmpc.jfmpc_2212_20
4. La Puma J, Stocking CB, La Voie D, Darling CA. When physicians treat members of their own families. Practices in a community hospital. *N Engl J Med*. 1991 Oct 31;325(18):1290–4. doi: 10.1056/NEJM199110313251806
5. Hanaf NS, Chirk-Jenn N. Doctors treating family members: A qualitative study among primary care practitioners in a teaching hospital in Malaysia. *Asia Pac J Fam Med*. 2006;5(2):1–6.
6. Ministry of Health in SA. Health professional practice system [Internet]. Available from: <https://laws.boe.gov.sa/BoeLaws/Laws/LawDetails/f1de206c-eef4-4a76-904a-a9a700f2899a/1>
7. Murad MA, Kheim IRM, Toras MM, et al. Community perspective on family medicine and family physician in Saudi Arabia 2020. *BMC Primary Care*. 2022;23(1):16. <https://www.ncbi.nlm.nih.gov/pubmed/35172729>.
8. The AMA Code of Medical Ethics' opinion on physicians treating family members. *Virtual Mentor*. 2012 May 1;14(5):396–7. doi: 10.1001/virtualmentor.2012.14.5.coet1-1205.
9. Ahmad R, Nawaz MR, Ishaq MI, Khan MM, Ashraf HA. Social exchange theory: Systematic review and future directions. *Front Psychol*. 2023 Jan 12;13:1015921. doi: 10.3389/fpsyg.2022.1015921
10. Cohen DJ, Crabtree BF. Evaluative criteria for qualitative research in health care: Controversies and recommendations. *Ann Fam Med*. 2008 Jul–Aug;6(4):331–9. doi: 10.1370/afm.818
11. Giroldi E, Freeth R, Hanssen M, Muris JWM, Kay M, Cals JWL. Family physicians managing medical requests from family and friends. *Ann Fam Med*. 2018 Jan;16(1):45–51. doi: 10.1370/afm.2152
12. Opsahl JH. Doctors' treatment of family and friends. *Tidsskr Nor Laegeforen*. 2020 Sep 15;140(13). doi: 10.4045/tidsskr.20.0608.
13. Braun V, Clarke V. Using thematic analysis in psychology. *Qualitative research in psychology*. 2006;3(2):77–101. doi: 10.1191/1478088706qp063oa
14. Walston S, Al-Harbi Y, Al-Omar B. The changing face of healthcare in Saudi Arabia. *Ann Saudi Med*. 2008 Jul–Aug;28(4):243–50. doi: 10.5144/0256-4947.2008.243
15. Alasiri AA, Mohammed V. Healthcare transformation in Saudi Arabia: An overview since the launch of Vision 2030. *Health Serv Insights*. 2022 Sep 3;15:11786329221121214. doi: 10.1177/11786329221121214
16. Chipidza FE, Wallwork RS, Stern TA. Impact of the doctor-patient relationship. *Prim Care Companion CNS Disord*. 2015 Oct 22;17(5):10.4088/PCC.15f01840. doi: 10.4088/PCC.15f01840
17. Garcia-Diaz R. Effective access to health care in Mexico. *BMC Health Serv Res*. 2022 Aug 12;22(1):1027. doi: 10.1186/s12913-022-08417-0
18. La Puma J, Priest ER. Is there a doctor in the house? An analysis of the practice of physicians' treating their own families. *JAMA*. 1992 Apr 1;267(13):1810–2. doi: 10.1001/jama.267.13.1810
19. CPSO – physician treatment of self, family members, or others close to them. <https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Physician-Treatment-of-Self-Family-Members-or>

Disclaimer/Publisher's Note: The statements, opinions and data contained in all publications are solely those of the individual author(s) and contributor(s) and not of MDPI and/or the editor(s). MDPI and/or the editor(s) disclaim responsibility for any injury to people or property resulting from any ideas, methods, instructions or products referred to in the content.