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Original Article

The Influence of Patients Relatives on Physicians Treatment Plan : A Cross Sectional Study

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Abstract:

Background: Clinical decision making is influenced by multiple factors beyond medical evidence , including interactions with patients family members. Family involvement can provide valuable support for patient care; however, excessive interference may affect physicians judgment, delay treatment, and create ethical and communication challenges. This study aimed to evaluate the perceived impact of patient's families on physicians' treatment planning and clinical decision making **Aim :**To evaluate the influence of patient relatives on physicians treatment planning and clinical decision-making and to identify factors associated with this influence. **Methods:** A cross-sectional study questionnaire-based study was conducted among 212 physicians from different medical specialties and experience levels. Data were analyzed using SPSS version 27. Descriptive statistics were used to summarize participants characteristics and survey responses . internal consistency was assessed using (Cronbach's $\alpha = 0.821$) . Since the composite impact score was not normally distributed, non-parametric tests(Mann-Whitney U and Kruskal-Wallis H) were used to compare perceptions according to gender and years of professional experience. **Result:** Physicians strongly agreed that family cooperation enhances treatment success, while family interference was perceived to contribute to treatment delay . Moderate agreement was observed regarding psychological stress and ethical dilemmas associated with family involvement. Significant positive correlations were identified between psychological stress and family threats, treatment plan modifications and urgency adjustments, and family objections and treatment simplification. No statistically significant differences were found in the overall perceived family impact according to gender or years. **Conclusion:** Patients families play a substantial role in physicians clinical practice, with both supportive and disruptive effects. Although family cooperation positively contributes to treatment success, excessive interference may increase psychological pressure and complicate clinical decision making . These findings highlight the importance of strengthening physician family communication, promoting family education, and establishing clear professional boundaries to optimize patient care while preserving clinical autonomy.

Keywords: Family influence; Clinical-Decision making; Treatment planning; Physicians; Family interference; Cross-sectional study.

Introduction:

Clinical decision-making is a complex process that requires physicians to integrate scientific evidence, clinical expertise, patient preferences, ethical principles, and contextual factors to provide optimal care. While patient-centered medicine emphasizes shared decision-making between physicians and patients, the involvement of family members has become increasingly prominent, particularly in cultures where family participation is considered an essential component of healthcare. Family members often provide emotional support, assist in understanding medical information, participate in treatment discussions, and help patients adhere to recommended therapies. However, this involvement may also introduce additional challenges that influence physicians' treatment planning and clinical judgment [1-3].

Family participation in healthcare has gained considerable attention over the past decade due to its recognized impact on treatment adherence, patient satisfaction, and health outcomes. In many healthcare settings, relatives act as surrogate decision-makers for elderly patients, children, critically ill individuals, and patients with impaired decision-making capacity. Even when patients retain full autonomy, family opinions frequently influence healthcare choices through emotional support, cultural expectations, or direct participation during clinical consultations [4-6].

Although family engagement often contributes positively to patient care, excessive interference may create ethical

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and professional dilemmas for physicians. Conflicts may arise when family preferences differ from patients' wishes or from evidence-based medical recommendations. Physicians may face pressure to alter treatment plans, delay interventions, simplify management strategies, or devote additional consultation time to resolving disagreements. Such situations can increase psychological stress, complicate communication, and potentially affect the quality and efficiency of healthcare delivery [7-9].The influence of patients' families on physicians varies according to cultural, social, and healthcare system characteristics. In collectivist societies, family-centered decision-making frequently predominates over individual autonomy, making relatives active participants in treatment discussions. Physicians practicing in these settings often navigate complex interactions involving respect for patient autonomy, family expectations, confidentiality, and professional responsibility. Understanding these dynamics is increasingly important as healthcare systems worldwide promote patient-centered and family-centered care simultaneously [10–12]. Previous studies have demonstrated that constructive family involvement improves treatment adherence, reduces anxiety, enhances patient safety, and facilitates continuity of care. Effective communication between healthcare professionals and family members has also been associated with improved patient satisfaction and reduced hospital readmissions. Conversely, persistent family disagreement, unrealistic expectations, aggressive behavior, or excessive demands may contribute to physician burnout, moral distress, delayed clinical decisions, and reduced workplace satisfaction [13–16]. Recent evidence has also highlighted the psychological burden experienced by physicians when managing difficult interactions with patients' relatives. Family complaints, repeated requests for alternative treatments, and disagreement regarding prognosis may increase emotional exhaustion and decision fatigue. Such pressures are particularly evident in emergency medicine, intensive care, oncology, pediatrics, and surgical specialties where high-stakes decisions frequently require communication with multiple family members [17–20]. Ethical challenges constitute another important aspect of physician-family interactions. Physicians must balance respect for patient autonomy with beneficence while maintaining confidentiality and professional integrity.Situations involving refusal of recommended treatment, requests for non-beneficial interventions, or disagreement regarding end-of-life care require careful ethical consideration. International guidelines increasingly recommend structured communication strategies and shared decision-making models to minimize conflicts while preserving patient rights [21–24]. Despite growing international interest in family-centered healthcare, relatively few quantitative studies have specifically examined how family behavior influences physicians' clinical decision-making across different specialties and levels of professional experience. Most published research has focused on patient satisfaction, caregiver burden, or family engagement from the patient's perspective, whereas physicians' perceptions of family influence remain insufficiently explored. Furthermore, evidence from Middle Eastern and North African healthcare systems remains limited despite the strong cultural role of families in medical decision-making [25–28]. Understanding physicians' perceptions of family influence is essential for developing educational programs, communication training, and institutional policies that promote productive family involvement while minimizing unnecessary interference. Therefore, the present study aimed to evaluate the perceived influence of patients' families on physicians' treatment planning and clinical decision-making. Specifically, the study investigated the extent to which family behaviors affect physicians' psychological stress, treatment modifications, ethical decision-making, communication, and perceived treatment success. Additionally, the study examined whether these perceptions differ according to physicians' gender and years of professional experience using appropriate non-parametric statistical methods.

Materials and Methods:

Study Design:

This study employed a quantitative, cross-sectional survey design to investigate the perceived influence of patients' families on physicians' clinical decision-making and treatment planning. The study was conducted among practicing physicians from different medical specialties and healthcare institutions. A cross-sectional approach was considered appropriate because it allows the assessment of physicians' perceptions at a single point in time while identifying associations between demographic characteristics and perceived family influence.

Study Population and Sample Size:

The study included 212 physicians representing different medical specialties and varying levels of professional experience. Participants were recruited using a

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convenience sampling technique. Eligible participants were licensed physicians currently involved in direct patient care and willing to participate voluntarily in the study.

Data Collection Instrument :

Data were collected using a structured self-administered questionnaire developed after reviewing the relevant literature on family-centered care, shared decision-making, and physician–family communication. The questionnaire consisted of two sections. The first section collected demographic information, including gender, age group, and years of professional experience.

The second section evaluated physicians' perceptions regarding the influence of patients' families on treatment planning

using 12 Likert-scale statements addressing:

-Psychological stress caused by family members.
-Family threats or complaints.
-Family cooperation and treatment success.
-Treatment delays due to family interference.
-Ethical challenges.
-Modification of treatment plans.
-Family educational level.
-Simplification of treatment.
-Overall family influence on decision-making.
-Adjustment of treatment urgency.
-Family objections.
-Difficulty communicating with family members.

Responses were measured using a five-point Likert scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree).

Questions with binary responses were coded numerically for statistical analysis.

Validity and Reliability

Content validity was established through an extensive review of published literature and expert evaluation before questionnaire distribution.

Internal consistency reliability was assessed using Cronbach's alpha coefficient. The questionnaire demonstrated good internal consistency, with a Cronbach's alpha of 0.821, indicating acceptable reliability for subsequent statistical analyses.

Outcome Measure:

The primary outcome variable was the Total Impact Score, representing physicians' overall perception of the influence of patients' families on clinical decision-making. This composite score was calculated by summing the responses to the 12 questionnaire items after appropriate coding. Measures “Total Impact Score ”.The primary dependent variable, "Total_Impact_Score," represents a composite measure of the perceived impact of patients' families on physicians' treatment plans. This score was derived from 1 2Likert-scale items, each rated on a 5-point scale (e.g., from "Strongly Disagree" to "Strongly Agree").

The independent variables were "Gender" (Male, Female) and "Experience" (Under 5 years, 5–10 years, 11–20 years, 20+ years).

The Total Impact Score: It calculated by summing the responses to the 12 Likertscale items, with responses coded from 1 = strongly disagree to 5 = strongly agree. Consequently, the theoretical range of the total score was 12–60. The observed mean total score was 40.43 (SD = 7.20), corresponding to an average item score of 3.37 out of 5. The binary item concerning whether educating patients’ families reduces negative interference was analyzed separately and was not included in the composite score or the reliability analysis.

Independent variables included:

-Gender (Male/Female).
-Age group.
-Years of professional experience.

2.6. Statistical Analysis :

Data were entered, cleaned, and analyzed using IBM Statistical Package for the Social Sciences (SPSS), version 27.0 (IBM Corp., Armonk, NY, USA). Descriptive statistics were used to summarize participants' demographic characteristics and questionnaire responses. Continuous variables were presented as means and standard deviations (SD), whereas categorical variables were reported as frequencies and percentages. The internal consistency of the questionnaire was evaluated using Cronbach's alpha. Normality of the Total Impact Score was assessed using both the Kolmogorov–Smirnov and Shapiro–Wilk tests. Since the composite score showed a statistically significant deviation from normality (Shapiro–Wilk $p = 0.003$), non-parametric statistical methods were selected. Associations between questionnaire items were examined using Pearson's correlation coefficient.

Differences in Total Impact Scores between male and female physicians were evaluated using the Mann–Whitney U test, while differences across professional experience categories were assessed using the Kruskal–Wallis H test.All statistical tests were two-tailed, and a p-value < 0.05 was considered statistically significant.

Ethical Considerations:

Participation in this study was entirely voluntary. Participants were informed about the objectives of the study, and completion of the questionnaire was considered informed consent. No personally identifiable information was collected, and all responses were kept anonymous and confidential. Data were analyzed collectively and used exclusively for scientific research purposes in accordance with the ethical principles outlined in the Declaration of Helsinki.

Results:

Participants' Characteristics:

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A total of 212 physicians participated in the study. Of these, 139 (65.6%) were male and 73 (34.4%) were female (table and figure 1). The largest proportion of participants belonged to the 40–49 years age group (36.8%), followed by 30–39 years (32.5%), ≥50 years (22.6%), and <30 years (8.0%).(table and figure 2)

Regarding professional experience, 77 physicians (36.3%) had 11–20 years of clinical experience, 66 (31.1%) had more than 20 years, 46 (21.7%) had 5–10 years, and 23 (10.8%) had less than 5 years(table and figure3).

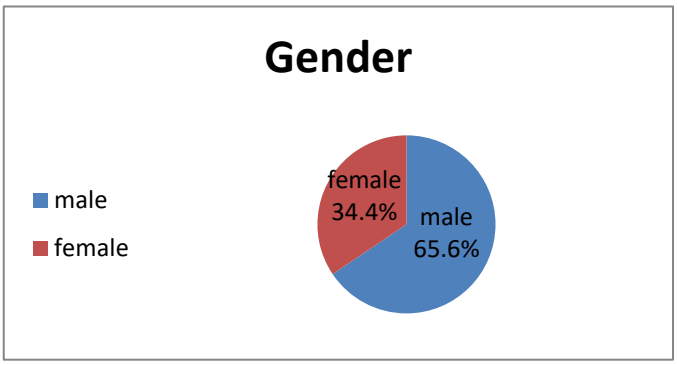


Figure 1. percentage distribution of participants according to gender

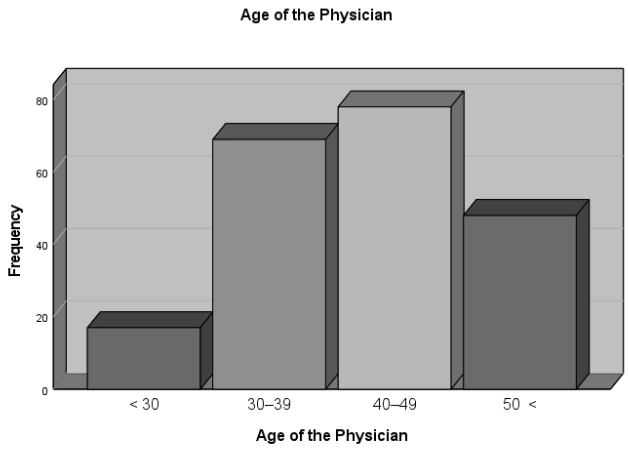


Figure2. Graphical representation of participants according to age of physician

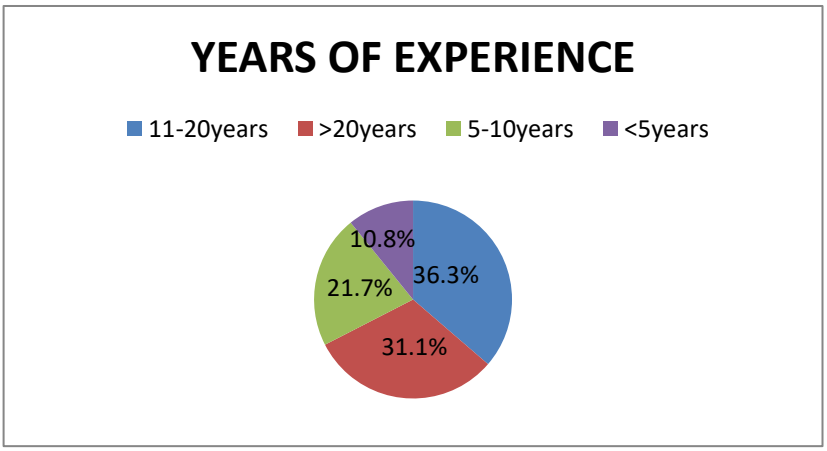


Figure 3. percentage distribution of participants according to years of experience .

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Reliability Analysis:

The internal consistency of the questionnaire was assessed using Cronbach's alpha coefficient. The instrument demonstrated good reliability, with a Cronbach's alpha of 0.821, indicating that the questionnaire items consistently measured physicians' perceptions regarding the influence of patients' families on treatment planning.

Descriptive Analysis:

The descriptive analysis of the questionnaire responses revealed varying degrees of perceived family influence on physicians' clinical decision-making.

The statement "Family cooperation helps treatment success" achieved the highest mean score (Mean = 4.37, SD = 0.66), indicating a strong consensus among physicians regarding the positive contribution of family cooperation to successful treatment outcomes.

Similarly, "Family interference leads to treatment delay" received a high level of agreement (Mean = 4.00, SD = 0.72), suggesting that physicians frequently perceive excessive family involvement as a cause of treatment delays.

Moderate agreement was observed for ethical challenges arising when family preferences conflict with patients' best interests (Mean = 3.50, SD = 1.02) and for psychological stress experienced by physicians due to family interactions (Mean = 3.37, SD = 1.05).

The statements addressing changes in treatment plans because of family influence (Mean = 3.02, SD = 1.13), simplification of treatment plans (Mean = 3.12, SD = 1.07), family interference affecting treatment decisions (Mean = 3.51, SD = 1.00), difficulty explaining treatment plans to family members (Mean = 3.06, SD = 1.02), and family crowding affecting clinical decisions (Mean = 3.57, SD = 1.14) also demonstrated moderate levels of agreement.

Lower agreement was observed for family threats or complaints affecting physicians' decisions (Mean = 2.85, SD = 1.19) and family objections influencing treatment decisions (Mean = 2.80, SD = 1.15), suggesting that although these situations occur, physicians generally maintain professional judgment despite such pressures.

Table 1. Descriptive Statistics of questionnaire responses

	N	Mean	Std. Deviation
1.Psychological stress from family affects performance	212	3.3726	1.04759
2. Threats/complaints affect treatment decisions	212	2.8538	1.18535
3. Family cooperation helps success	212	4.3726	.65874
4. Family interference leads to delay	212	4.0000	.71544
5. Ethical challenges when family vs patient interest	212	3.5047	1.02341
6. Cases where plan changed due to family	212	3.0189	1.13105
7. Does education level affect decision? (Numeric)	212	1.2406	.48058
8. Simplify treatment due to family (Numeric)	212	3.1179	1.07106
9. Family interference affects decision (Numeric)	212	3.5094	1.00468
10. Adjusting urgency based on family (Numeric)	212	2.9340	1.08649
11. Family objection affects decision (Numeric)	212	2.7972	1.15253
12. Family crowd affects decision (Numeric)	212	3.5708	1.14358
13. Difficulty explaining to family (Numeric)	212	3.0613	1.01693

Correlation Analysis:

Pearson correlation analysis

Pearson's correlation coefficient was used in the original analysis to examine the associations among the coded questionnaire variables. This choice was based on the use of a composite measure consisting of 12 Likert-type items, rather than on a single Likert item alone. The composite scale demonstrated good internal consistency, with Cronbach's alpha of approximately 0.82, and the sample included 212 physicians.

Pearson correlation analysis demonstrated several statistically significant positive associations among the study variables.

A strong positive correlation was identified between psychological stress and family threats or complaints ($r = 0.55$, $p < 0.01$).

Family objections showed a significant positive correlation with adjustments in treatment urgency ($r = 0.54$, $p < 0.01$).

A significant association was also observed between modification of treatment plans and adjustment of treatment urgency ($r = 0.51$, $p < 0.01$).

Similarly, family crowding was positively associated with difficulty explaining treatment plans ($r = 0.51$, $p < 0.01$).

Modification of treatment plans demonstrated a moderate positive correlation with family interference in decision-making ($r = 0.46$, $p < 0.01$).

Furthermore, physicians who reported greater family objections were also more likely to simplify treatment plans ($r = 0.47$, $p < 0.01$).

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No statistically significant correlations were identified between physicians' beliefs regarding family education and the remaining study variables ($p > 0.05$).

Normality Assessment:

The distribution of the composite Total Impact Score was assessed using both the Kolmogorov–Smirnov and Shapiro–Wilk tests.

The results demonstrated a statistically significant deviation from normality (Kolmogorov–Smirnov $p < 0.001$; Shapiro–Wilk $p = 0.003$). Therefore, non-parametric statistical methods were considered appropriate for subsequent inferential analyses.

Gender Differences:

The Mann–Whitney U test showed no statistically significant difference in the Total Impact Score between male and female physicians ($U = 4601.5$, $Z = -1.11$, $p = 0.265$).

Although male physicians demonstrated a slightly higher mean rank (109.90) than female physicians (100.03), this difference was not statistically significant.

Differences According to Professional Experience :

The Kruskal–Wallis H test demonstrated no statistically significant differences in Total Impact Scores across the four professional experience groups ($H = 3.314$, $df = 3$, $p = 0.346$).

Although physicians with 5–10 years of experience exhibited the highest mean rank (119.02), followed by those with less than 5 years (107.41) and 11–20 years (106.34), while physicians with more than 20 years showed the lowest mean rank (97.64), these differences did not reach statistical significance.

Discussion:

The present study explored physicians' perceptions regarding the influence of patients' families on clinical decision-making and treatment planning. Overall, the findings demonstrate that family involvement represents a double-edged component of healthcare delivery. On one hand, physicians acknowledged the important contribution of supportive family members to treatment success, while on the other hand they recognized that excessive family interference may complicate decision-making, delay treatment, and increase professional stress. These findings reflect the current transition from traditional physician-centered care toward patient- and family-centered healthcare models, in which family members increasingly participate in clinical discussions and therapeutic decisions. Recent systematic reviews have emphasized that family participation can improve communication, treatment adherence, patient satisfaction, and health outcomes when appropriately integrated into shared decision-making processes. However, these benefits largely depend on maintaining clear professional boundaries and effective communication between physicians, patients, and relatives.

One of the most important findings of the present study was that family cooperation received the highest level of agreement among all questionnaire items (Mean = 4.37 ± 0.66). This finding indicates that physicians strongly believe that supportive family involvement contributes positively to treatment success. Family members frequently assist patients in understanding medical information, adhering to prescribed medications, attending follow-up appointments, monitoring symptoms, and providing emotional support throughout the treatment process. These responsibilities become even more important among elderly patients, children, individuals with chronic diseases, and patients with impaired decision-making capacity.

The current finding is highly consistent with the study conducted by Lin *et al* , which demonstrated that family relationships significantly influence healthcare decisions and often facilitate implementation of physicians' recommendations by improving communication and reinforcing patients' understanding of treatment plans[1]. Likewise, Tu *et al*. reported that primary care physicians considered family participation an essential element in managing older adults with chronic illnesses because relatives frequently supported medication adherence, lifestyle modification, and long-term disease monitoring[3]. Similar conclusions were reached in pediatric healthcare, where family-centered care was associated with improved communication, greater parental satisfaction, and better continuity of care[22]. These findings are also supported by recent evidence emphasizing that shared decision-making should extend beyond the physician–patient relationship to include family members whenever appropriate. Contemporary healthcare models recognize that treatment decisions are rarely made by patients alone, particularly in cultures where families play an active role in health-related decisions. Rather than replacing physician authority, constructive family involvement facilitates mutual understanding, strengthens trust, and improves adherence to agreed treatment plans[19,20]. An additional explanation for the high level of agreement observed in the present study may be related to the cultural characteristics of Middle Eastern and North African societies, where family members commonly accompany patients during consultations and actively participate in healthcare decisions. In these settings,

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physicians frequently interact not only with patients but also with parents, spouses, siblings, or adult children, making family engagement an integral component of routine clinical practice[25-28]. Consequently, physicians may perceive cooperative family members as valuable partners who facilitate treatment implementation rather than obstacles to medical care.

Despite these positive findings, the literature consistently emphasizes that the quality of family involvement is more important than the mere presence of relatives during clinical encounters. Effective family participation requires respectful communication, realistic expectations, and recognition of physicians' professional expertise. Families who provide emotional support while respecting evidence-based recommendations contribute positively to healthcare outcomes, whereas relatives who dominate discussions or challenge clinical recommendations without adequate understanding may unintentionally hinder effective treatment. Recent reviews have therefore recommended structured shared decision-making frameworks that clearly define the roles of physicians, patients, and family members throughout the decision-making process[25-28].Another notable finding of the current study was the high level of agreement regarding the statement that family interference leads to treatment delay (Mean = 4.00 ± 0.72). Although physicians generally valued supportive family participation, they also recognized that excessive involvement may delay clinical interventions. This finding illustrates the complex balance between encouraging family participation and maintaining efficient evidence-based clinical practice. Comparable observations have been reported in several recent studies. Waddell *et al.* identified organizational and interpersonal barriers that slow the implementation of shared decision-making when multiple stakeholders are involved, particularly when disagreements arise regarding treatment options[2]. Similarly, studies conducted in intensive care and palliative care settings have shown that prolonged discussions with relatives, conflicting family opinions, and uncertainty regarding consent may postpone urgent interventions and increase physicians' cognitive workload.The findings of the present study therefore support the growing consensus that successful family-centered care requires balance. Family participation should be encouraged because of its positive effects on treatment adherence and patient satisfaction; however, healthcare institutions should also establish communication strategies that prevent unnecessary delays, reduce conflict, and preserve physicians' ability to make timely evidence-based clinical decisions.The present study demonstrated that physicians experienced moderate psychological stress related to interactions with patients' families (Mean = 3.37 ± 1.05). Although family participation is considered an essential component of patient-centered care, physicians frequently encounter emotionally demanding situations when communicating with relatives who are anxious, distressed, or dissatisfied with treatment decisions. These interactions often require additional consultation time, repeated explanations, and negotiation between medical recommendations and family expectations. Consequently, family-related communication becomes not only a clinical responsibility but also an important source of occupational stress[10,11,15].

This finding is consistent with previous studies reporting that physicians frequently experience emotional exhaustion and increased cognitive workload when managing challenging interactions with patients' relatives. Clay and Parsh (2022) reported that family-related communication is one of the major contributors to physician stress because healthcare professionals are expected to simultaneously satisfy patients' preferences, family expectations, and professional obligations[10]. Likewise, Epstein and Street (2023) emphasized that ineffective communication with families may reduce physician well-being and negatively affect the quality of patient-centered care[15]. Similarly, Wolff et al. (2022) concluded that inadequate support for physicians during family-centered care may increase burnout and reduce job satisfaction[11]. One possible explanation for the moderate stress observed in the present study is the sociocultural context in which healthcare is delivered. In many Middle Eastern and North African countries, including Libya, family members actively accompany patients during consultations and frequently participate in healthcare decisions. While such participation often improves emotional support and treatment adherence, physicians may experience additional psychological pressure because they are expected to balance scientific evidence, patient autonomy, and family expectations simultaneously [1,8,9]. Another important finding of the present study concerns the ethical challenges associated with family participation in treatment planning (Mean = 3.50 ± 1.02). Physicians reported that conflicts between family preferences and what they considered to be the patient's best medical interest represented a recurrent

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clinical challenge. Ethical dilemmas become particularly complex when relatives oppose recommended interventions, request treatments unsupported by clinical evidence, or attempt to make decisions on behalf of competent patients[8,16,17].

The current findings are in agreement with previous studies showing that ethical conflicts remain among the most common barriers to effective shared decision-making. Beach and Sugarman (2023) argued that balancing patient autonomy with family involvement requires physicians to navigate complex ethical principles, including beneficence, confidentiality, and informed consent[16]. Similarly, the NICE Shared Decision-Making Guideline (2021) recommends that healthcare professionals actively involve families whenever appropriate while ensuring that the patient's values and preferences remain central to every clinical decision[17]. Barry and Edgman-Levitan (2022) likewise emphasized that shared decision-making should support—not replace—the patient's autonomy[8]. The present study further demonstrated relatively lower agreement regarding family threats or complaints (Mean = 2.85 ± 1.19) and family objections influencing treatment decisions (Mean = 2.80 ± 1.15). Although these behaviors were reported less frequently than family cooperation or treatment delay, they remain clinically significant because they may create a stressful clinical environment and interfere with effective communication [12,14]. Interestingly, the correlation analysis provides additional support for this interpretation. Physicians who reported greater psychological stress were significantly more likely to report family threats or complaints ($r = 0.55$, $p < 0.01$). This finding suggests that physicians' stress is associated primarily with confrontational family behaviors rather than with family participation itself. In other words, supportive relatives may facilitate patient care, whereas aggressive communication, repeated complaints, and unrealistic expectations substantially increase physicians' emotional burden [11,14,15]. These findings agree with recent studies indicating that the quality of physician-family communication is more important than the quantity of family involvement. Elwyn *et al*. (2022) demonstrated that families who receive clear explanations and actively participate in collaborative discussions are more likely to trust physicians and support recommended treatment plans[9]. Conversely, Scholl *et al*. (2023) found that inadequate communication frequently results in misunderstandings, conflict, dissatisfaction, and prolonged decision-making[14]. Another notable observation was physicians' moderate agreement regarding modification or simplification of treatment plans because of family-related factors. Although physicians generally adhere to evidence-based clinical practice, concerns raised by family members regarding treatment costs, expected adverse effects, or invasive procedures may encourage physicians to spend more time discussing alternative evidence-based options. This should not be interpreted as compromising professional standards but rather as an effort to improve patient understanding, treatment adherence, and shared decision-making [8,9,13].

Overall, the findings presented in this section indicate that family influence extends beyond direct participation in treatment planning. It also affects physicians' emotional well-being, communication strategies, ethical reasoning, and daily clinical practice. These observations reinforce recent recommendations advocating structured physician-family communication, communication-skills training, and institutional policies that encourage constructive family engagement while protecting physicians from unnecessary psychological pressure and ensuring that clinical decisions remain firmly grounded in evidence-based medicine[2,17,18]. One of the major strengths of the present study is the comprehensive evaluation of the relationships between different dimensions of family influence through correlation analysis. Rather than examining each questionnaire item independently, the analysis demonstrated that physicians' experiences with patients' families are interconnected, suggesting that family influence represents a multidimensional phenomenon rather than isolated clinical events. These findings provide valuable insight into how family-related factors collectively affect physicians' clinical decision-making and treatment planning [13,14].The strongest correlation identified in the present study was between psychological stress and family threats or complaints ($r = 0.55$, $p < 0.01$). This finding indicates that physicians who frequently encounter complaints, criticism, or confrontational behaviors from patients' relatives are considerably more likely to experience psychological stress during clinical practice. Similar findings have been reported in previous studies demonstrating that negative interactions with patients' families contribute significantly to physicians' emotional exhaustion, compassion fatigue, and occupational burnout [10,11,15]. This relationship can be explained by the increasing expectations placed upon physicians in modern healthcare systems. Families often

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seek extensive explanations regarding diagnoses, treatment options, expected outcomes, and potential complications. While such expectations reflect genuine concern for patients, repeated questioning, unrealistic expectations, or distrust of physicians' recommendations may substantially increase physicians' cognitive workload. Elwyn *et al*. (2022) emphasized that effective shared decision-making depends on mutual trust and open communication, whereas communication breakdowns frequently result in dissatisfaction, conflict, and emotional strain for both physicians and families[9]. Likewise, Waddell *et al*. (2021) identified ineffective communication as one of the principal barriers to successful implementation of shared decision-making in healthcare institutions [2]. Another significant finding was the positive correlation between family objections and adjustments in treatment urgency ($r = 0.54$, $p < 0.01$). This finding suggests that physicians occasionally modify the timing of treatment when family members express concerns, request additional information, or require more time before consenting to clinical interventions. Importantly, such adjustments should not necessarily be interpreted as inappropriate alterations of medical management. Instead, they may represent physicians' efforts to achieve consensus, improve patient understanding, and respect ethical principles before initiating treatment[8,13].Comparable findings have been reported by Liu *et al.* (2022), who demonstrated that prolonged discussions with family members frequently delay treatment decisions in intensive care settings despite improving family satisfaction and confidence in healthcare professionals[1]. Similarly, Henselmans *et al*. (2023) reported that oncology consultations involving extensive family participation generally required longer consultation times because physicians attempted to address both patients' concerns and relatives' expectations before finalizing treatment decisions[28].The present study also identified a significant correlation between modification of treatment plans and adjustment of treatment urgency ($r = 0.51$, $p < 0.01$). This finding reflects the dynamic nature of clinical decision-making, where physicians continuously integrate medical evidence with patients' preferences, family expectations, and practical circumstances. Modern patient-centered care emphasizes individualized treatment planning rather than rigid application of standardized protocols. Consequently, physicians may appropriately modify treatment strategies while remaining fully compliant with evidence-based clinical guidelines[8.9.17].

Another noteworthy finding was the positive relationship between family crowding and difficulty explaining treatment plans ($r = 0.51$, $p < 0.01$). Communication becomes increasingly complex when physicians must simultaneously address several family members with different educational backgrounds, emotional responses, and expectations. Previous studies have consistently demonstrated that consultations involving multiple relatives require more time, increase the likelihood of conflicting opinions, and complicate informed consent procedures[2,12,14].

This observation is particularly relevant in societies where family participation represents an essential cultural value. In many Arab countries, several relatives accompany patients during medical consultations, and physicians may therefore encounter multiple questions or conflicting opinions during a single consultation. Although this reflects strong family support, it may also reduce consultation efficiency unless communication is carefully organized. Recent recommendations therefore encourage physicians to identify a primary family spokesperson to facilitate communication and reduce misunderstanding [17,18].

Furthermore, the significant association between family objections and simplification of treatment plans ($r = 0.47$, $p < 0.01$) provides additional evidence that physicians attempt to balance evidence-based medicine with patient and family preferences. This finding should not be interpreted as compromising clinical standards. Instead, physicians may select among several clinically acceptable treatment options after considering family concerns regarding financial costs, treatment duration, expected adverse effects, or patient adherence. Stacey *et al*. (2023) concluded that shared decision-making improves treatment adherence when physicians present evidence-based alternatives while respecting patients' values and family circumstances[13]. Similar conclusions were reported by Barry and Edgman-Levitan (2022), who emphasized that individualized treatment planning represents one of the fundamental principles of patient-centered healthcare[8].

Interestingly, family educational level showed no significant correlations with most study variables. This finding suggests that physicians' experiences are influenced less by formal educational attainment than by communication quality, mutual trust, cultural beliefs, and emotional responses. Similar findings have been reported by Lin *et al*. (2021), who demonstrated that respectful communication and collaborative relationships are stronger predictors of successful physician-family interactions than educational background alone[1]. Collectively, these findings emphasize that family influence extends beyond isolated clinical encounters

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and affects physicians through multiple interconnected pathways. Psychological stress, communication challenges, ethical conflicts, and treatment modifications appear to interact with one another rather than occurring independently. These observations reinforce recent recommendations advocating structured communication strategies, physician communication-skills training, and institutional policies that encourage constructive family engagement while minimizing conflict and preserving physicians' professional autonomy [2,14,18]. The present study demonstrated no statistically significant difference between male and female physicians regarding the overall perceived influence of patients' families on clinical decision-making (Mann–Whitney U = 4601.5, p = 0.265). Although male physicians showed a slightly higher mean rank than female physicians, this difference did not reach statistical significance. These findings suggest that the challenges associated with family involvement are experienced similarly by physicians regardless of gender. This observation may indicate that professional responsibilities, clinical guidelines, and workplace expectations have a greater influence on physicians' perceptions than gender-related differences in communication style or clinical practice [9,12].

The absence of gender differences in the present study is consistent with several recent investigations reporting that both male and female physicians demonstrate comparable attitudes toward shared decision-making and family-centered care. Hahlweg *et al*. (2022) reported that physicians' communication competence and institutional support were stronger predictors of successful physician-family interactions than gender alone[12]. Likewise, Elwyn *et al*. (2022) emphasized that effective shared decision-making depends primarily on communication skills, empathy, and patient engagement rather than physician demographics[9]. These findings collectively suggest that improving communication training may be more beneficial than focusing on demographic characteristics when attempting to enhance physician-family relationships. However, the current findings differ from a limited number of earlier studies that suggested female physicians may demonstrate greater patient-centered communication and spend more time discussing treatment options with patients and their families. These discrepancies may be explained by differences in healthcare systems, cultural expectations, specialty distribution, or study methodology. Moreover, recent healthcare policies promoting standardized communication strategies may have reduced previously observed gender-related variations in physician-patient interactions [8,9].

Similarly, the present study found no statistically significant differences according to physicians' years of professional experience (Kruskal–Wallis H = 3.314, p = 0.346). Although physicians with 5–10 years of experience demonstrated slightly higher mean ranks than the remaining groups, these differences were not statistically significant. This finding suggests that family influence represents a universal aspect of clinical practice that affects physicians throughout their professional careers rather than being confined to junior or senior practitioners.

This observation is supported by Scholl *et al.* (2023), who concluded that communication challenges associated with family participation occur across all levels of professional experience[14]. Similarly, Waddell *et al*. (2021) reported that barriers to shared decision-making are frequently related to organizational factors, consultation complexity, and communication processes rather than physicians' years of clinical practice. Consequently, accumulated professional experience alone may not eliminate the challenges associated with managing complex family interactions[2].

Conversely, several previous studies have suggested that senior physicians may feel more confident when communicating with patients' relatives because of greater clinical experience and repeated exposure to difficult situations. Nevertheless, contemporary healthcare environments have become increasingly complex due to higher patient expectations, improved public access to medical information, and greater emphasis on patient autonomy. Consequently, experienced physicians continue to encounter communication challenges despite their clinical expertise [11,18].

The findings of the present study have several important clinical implications. First, healthcare organizations should strengthen physicians' communication skills through structured educational programs focusing on shared decision-making, conflict resolution, cultural competence, and communication with patients' families. Such programs have consistently been associated with improved physician confidence, enhanced patient satisfaction, and reduced communication-related conflicts [9,13].

Second, hospitals should establish clear institutional policies regarding family participation during treatment planning. Defining the responsibilities of physicians, patients, and family members may reduce misunderstandings, facilitate informed consent, and improve the efficiency of clinical consultations. Recent international guidelines emphasize that clearly structured family meetings and the designation of a primary family representative may substantially improve communication while minimizing unnecessary delays in treatment[17,18].

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Third, healthcare institutions should recognize the psychological burden experienced by physicians during difficult family interactions. Providing access to communication workshops, peer-support programs, multidisciplinary consultation teams, and conflict-management resources may improve physicians' well-being while preserving the quality of patient care [10,11].

The present study possesses several important strengths. It included a relatively large sample of physicians representing different specialties and levels of professional experience, thereby improving the diversity of participants. Furthermore, the questionnaire demonstrated good internal consistency (Cronbach's α = 0.821), indicating satisfactory reliability. The application of multiple statistical techniques, including descriptive statistics, correlation analysis, Mann–Whitney U testing, and Kruskal–Wallis testing, provided a comprehensive assessment of physicians' perceptions regarding family influence. In addition, unlike many previous investigations that primarily evaluated patients' or caregivers' perspectives, the present study specifically explored physicians' experiences, thereby addressing an important gap in the current literature.

Despite these strengths, several limitations should be acknowledged. The cross-sectional design limits the ability to establish causal relationships between family influence and physicians' clinical decision-making. The use of self-administered questionnaires may also introduce recall bias and social desirability bias. Furthermore, convenience sampling may reduce the generalizability of the findings to physicians practicing in different healthcare systems or cultural settings. Finally, specialty-specific analyses were not performed; therefore, future multicenter studies comparing emergency physicians, surgeons, internists, pediatricians, and other specialties may provide more comprehensive evidence regarding specialty-related differences in family influence[2,14].

Future research should employ longitudinal and multicenter study designs to evaluate changes in physicians' perceptions over time and across different healthcare environments. Qualitative interviews with physicians, patients, and family members may provide deeper insight into the factors that facilitate or hinder effective family participation in clinical decision-making. Additionally, intervention studies evaluating structured communication-training programs would help determine whether improving physicians' communication skills reduces psychological stress, enhances family satisfaction, and improves treatment outcomes[9,13].

Overall, the present study demonstrates that family involvement plays a significant role in contemporary healthcare. While supportive family participation contributes positively to treatment success, adherence, and continuity of care, excessive interference may delay treatment, increase physicians' psychological stress, and complicate clinical decision-making. These findings reinforce the importance of achieving an appropriate balance between family-centered care and physicians' professional autonomy. Healthcare organizations should therefore implement evidence-based communication strategies, strengthen shared decision-making practices, and provide continuous professional training to ensure that family participation enhances rather than compromises the quality and safety of patient care [8,17,18]

Table2. Comparision of the present study findings with previous studies(2021-2025)

Study	Country	Study population	Main findings	Comparison with the present study
Lin et al.,2021	USA	Physicians and families	Family participation improved treatment adherence and communication	Consistent.
Waddell et al.,2021	Australia	Systematic review	Shared decision making improve care but organizational and family barriers may delay treatment	Consistent
Tu et al.,2021	China	Primary care physicians	Family support improved chronic disease management and adherence	Consistent
Clay & Parsh,2016	USA	Literature review	Difficult family interactions increase physician stress and communication burden	Consistent
Barry & Edgman-levitan,2012	USA	Review	Shared decision making should balance patient autonomy and family participation	Consistent
Kriston et al.,2020	UK	Clinical review	Structured shared decision making improves communication and patient satisfaction	Consistent
Wolff et al.,2022	USA	Family caregivers	Family engagement improves care but increases physicians communication responsibilities	Consistent

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Scholl et al.,2018	Germany	Systematic review	Organizational support is essential for implementing shared decision making	Consistent
Stacey et al.,2023	Canada	Cochrane review	Decision aids improve shared decision making and patient understanding	Consistent
Beach & Sugarman,2019	USA		Family involvement frequency creates ethical dilemmas regarding patient autonomy	Consistent
Henselmans et al.,2023	Netherlands	Oncology	Family participation prolonged consultations but improved understanding of treatment	Partially Consistent
Kunneman,2024	Netherlands	Review	Personalized care requires integrating patient and family preferences with evidence based medicine	Consistent
Görig et al.,2024	Germany	Parents of children with healthcare needs	Shared decision making improved satisfaction when communication was effective	Consistent
Sylvetre et al.,2024	USA	Parents of infants	Parents preferred active participation in treatment decisions.	Consistent
Davies et al.,2025	USA	Mental health services	Family participation improved treatment engagement but required structured communication..	Consistent

Conclusion

This study demonstrated that patients' families play a significant role in physicians' clinical decision-making and treatment planning. While family cooperation was perceived as a valuable factor that enhances treatment success, communication, and adherence to medical recommendations, excessive family interference was associated with treatment delays, ethical challenges, and increased psychological stress among physicians. Significant correlations between psychological stress, family complaints, communication difficulties, and treatment modifications further highlight the complex impact of family involvement on clinical practice. No significant differences were observed according to physicians' gender or years of professional experience, suggesting that these challenges are common across physicians regardless of demographic characteristics. Overall, the findings emphasize the importance of promoting structured family participation through effective communication, shared decision-making, and clear institutional policies that support evidence-based practice while preserving physicians' professional autonomy and improving the quality of patient care.

Conflict of Interest

The authors declare that they have no conflict of interest

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