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Re: Delivering Bad News: When My Patient Was My Own Mother

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With enthusiasm, we have read the article titled “Delivering bad news: when my patient was my own mother” by Doctor Tahmasebi published in the latest issue of Archives of Breast Cancer.¹ We congratulate the author for this valued article on such an important theme, and at the same time would like to make some comments regarding the issues presented in that paper.

The author shared her experience as the first degree family member of a breast cancer patient, her mother, as well as the responsibilities she shouldered as her doctor to guarantee the best care. She beautifully described her exigent feelings in performing these two demanding tasks well as withholding the “cancer” diagnosis from her mother: “In avoiding a direct and frank conversation with my mother about her illness, I wonder whose emotions I was protecting, hers or mine?”

When the patient is an immediate family member of a physician, the personal feelings may unduly influence his/her professional judgment and practice. The American Medical Association (AMA) recommends that physicians do not treat their immediate family members due to several challenges such as compromising professional objectivity, patient autonomy, and informed consent. Thus, except for emergencies, minor acute conditions or isolated settings where no other qualified physician is available, AMA discourages doctors from being the physician in charge for their close relatives.² The UK General Medical Council's Good Medical Practice also advises the doctors to generally avoid providing medical care to those with whom they have close personal relationships.^{3,4} Medical boards in Australia, New Zealand and Canada also advise against treating family members.⁵

Another aspect of this paper was withholding the

cancer diagnosis from the patient. Based on the paper, we understand that the patient did not have any problems with that as her daughter, a competent doctor, was in charge. Although this was done with obviously good intentions (i.e. protecting the mother's emotions and maintaining hope) and was accompanied with provision of the optimal care, is not considered a recommended approach.^{6,7} While the author considers this as a common practice in Iran, patients are increasingly more willing to know about their diagnosis and participate in decision-making.⁸ In a study conducted in 11 cancer centers in Iran, 72.7% of cancer patients were aware of their disease at the time of interview and 85.2% were willing to be informed about their disease.⁹ Patients' awareness was significantly associated with some underlying variables including age under 50, female gender, and having breast, skin or head and neck cancer.⁹ According to another survey performed in Tehran, 88% of cancer patients who were not aware of their diagnosis, said that they preferred to be more informed about their diagnosis.⁶ In addition, physicians and nurses are also more willing compared to the past- to share information regarding diagnosis with cancer patients.^{10,11}

As the author of that paper, a skillful practitioner, decided to be responsible for the diagnosis and care of her mother, a breast cancer patient, it would be not be easy to appraise withholding the bad news which simultaneously occurred in that case. As the author said, “I wonder how the end-of-life experience might have been different if I had been upfront with my mother about her diagnosis... Would that have prevented the last chemotherapy she received a week before dying?”

As it seems very exhausting for a physician to tackle with both of these issues, it reflects the underlying reasons that the physicians are advised not to practice medicine for their loved ones.

Conflict of Interest

None

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