An Ethical Dilemma for Surgery

Physicians face ethical decisions daily. We are forced to make difficult choices and use our best judgment. We take chances, but not with our own lives. The only lives that are ever held in limbo are the patients’ lives. When the physician takes a risk it is only the patient that is actually taking the risk. Physicians uphold an ethical responsibility to use the best clinical judgement to help the sick and bring benefit but do not harm. When the principles of beneficence and nonmaleficence are compromised, the physician has a moral and ethical duty to change his decisions and plans. I recently encountered an ethical dilemma that compromised the head clinician’s responsibility to “do no harm” while on an elective surgery rotation in Louisville, KY. The surgeons involved in the case were faced with a decision to operate or provide palliative care, or perhaps do both.

The case involved a sixty-two year old white male with a large retroperitoneal mass observed clinically and by CT scan. The patient was a long time alcoholic and smoker with considerable liver and lung disease. He had been drinking at least twelve beers per day and smoking two packs of cigarettes per day for about thirty-five years. For about one year the patient had stopped drinking alcohol but he was still a heavy smoker. The first ethical decision was made at an outside hospital where the patient first presented. The general surgeon that first evaluated the patient chose to operate, but found a large retroperitoneal mass that he deemed to be unresectable. Tissue samples were
taken at the time and the patient was referred to the surgical oncologists in Louisville for a second opinion.

After presenting to a hospital in KY the chief resident of the general surgery service at the hospital evaluated the patient with the medical student. The patient’s wife gave a vague history of almost a year of abdominal discomfort with a forty pound weight loss. The patient had also experienced nonspecific symptoms of fatigue, a change in bowel habits involving diarrhea and constipation, and a recent complaint of confusion and fever. The patient had recently been able to palpate a large abdominal mass. Most of the history was taken from the wife because the patient was very difficult to arouse, and, according to her, this was a recent development.

Clinically the patient was evaluated to be severely malnourished. He appeared septic and was empirically started on antibiotics. Abdominal exam revealed a very large abdominal mass that occupied the entire left side of the abdomen involving both the upper and lower quadrants. There was a previous laparotomy scar with staples still in place. A CT scan was obtained that demonstrated a nearly 30cm by 55cm retroperitoneal mass that displaced all retroperitoneal and intraperitoneal organs. The contrast study demonstrated extensive vascular supply coming from multiple large abdominal vessels. The tissue diagnosis from the outside hospital suggested a malignant fibrous histiocytoma. The resident and the medical student agreed that surgery was not an option for the patient due to his nutritional status and the difficulty of resection.

At this point in the case, neither the patient nor his wife demonstrated that they completely understood the situation. The previous surgeon had instilled a sense of hope for complete resection with complete recovery to both the patient and his wife. Due to
the extent of liver disease and the size and location of the current tumor, this was an unreasonable goal from a surgical standpoint. According to Jonsen and others, “ethical reflection begins with a realistic evaluation of the goals of intervention” (Jonsen). With this statement in mind the team was expecting, upon evaluation by the attending surgeon, that the decision would be made for palliative care. After the attending was consulted however, he also failed to express the gravity of the disease to the family and the unrealistic expectations were not addressed. Instead, the attending wanted to proceed with surgical intervention to remove the tumor. The patient was admitted to the hospital, started on antibiotics and total parenteral nutrition, and placed on the operating room schedule for the following week.

The events that followed the admission presented ethical discussions and disagreements between the resident staff and the attending surgeon. The motives and objectives of the surgeon and the residents would become obscured and questioned throughout the ensuing week. Was the attempted resection of such an advanced tumor in such an ill patient benefitting the patient? Were the risks of such an intensive operation greater than the benefit to be received by the patient? It is true that without surgery the tumor burden would be too large to support life, but the surgery will probably worsen the patient’s remaining quality of life. The previous thoughts and questions alone present ethical decisions for the individuals involved, but an even more complicated situation develops when disagreements arise between the doctors included.

The chief resident assigned to the case had extreme reservations going into to the case. In one discussion with the medical student the resident even expressed doubt that the patient would survive through the operation. The patient’s preoperative status was so
dire that everyone was nervous entering such a situation. The attending surgeon even mentioned his doubt about the surgery, but he still elected to proceed. At this point in the case the surgeon had two options, to proceed with the surgery for palliative care or pursue clinical palliative care alone. The unreal expectation of surgery for cure presents the heart of the ethical dilemma.

Is this surgery adhering with the ethical principle of beneficence? Even without knowing the outcome of the case, I feel that the answer to the question is obvious. Is this surgery adhering with the ethical principle of nonmaleficence? Once again, the answer to this question is also obvious. Neither of the two main principles of medical ethics was adhered to by the attending surgeon. The attending created even more of a problem by not listening to the reservations of the medical team. The chief resident and the others involved were forced to participate in a difficult case with unclear and unreasonable expectations. The case also presented an ethical conflict with the family and the medical team in that the family was definitely not well informed about the goals, expectations, options, and outcomes of the case.

The patient did undergo a long and difficult surgery for tumor resection. The patient also lost much of his small bowel, most of his colon, his left kidney and ureter, part of his diaphragm, and countless vessels. After surgery the patient was taken to the ICU and eventually he was actually extubated. Shortly before I left Louisville, the patient developed severe delirium and his condition deteriorated requiring pressor support. I currently do not know if the patient survived his hospital stay, but I do know that we did not preserve any quality of life for this patient. The attending gambled with this patient’s quality of life and lost. Surgery was a difficult decision to make, but it also
seemed to be the wrong decision. It was a decision that proved to jeopardize the patient, family, resident, and the entire medical staff involved. Palliative care involving medical management alone still appears to be the most appropriate choice for this patient and his family.

Bibliography

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