The case I would like to discuss for the analysis is of a twenty two year old female with malignant germ cell tumor of the ovary with distant metastases. I encountered this case while doing an away rotation at an outside hospital. It sparked my interest most because of the emotional involvement of all of the participating parties. Although I am limited to some of the details associated with the case, I believe it is an excellent manner to discuss end of life care and quality of life.

The patient, Ms. L. is a young African American female with malignant germ cell tumor of the ovary with distant metastases. Her disease process was complicated by pleural effusions, supraventricular tachycardia, deep venous thrombosis and depression. The patient’s family was profoundly involved in her care and the patient conceded all of the decisions regarding her health to her parents. As the patient’s disease progressed, her family found it difficult to cope with the reality of the situation. Although they had numerous discussions about end of life care with the physicians, they did not fully comprehend the severity of their daughter’s condition. When the intensive care service was consulted, they refused to take on the case articulating the futility of trying to sustain the patient’s state. As her health grew worse, the conflict between the patient’s family, the intensivists and gyn-oncologists intensified. The hospital mediators and lawyers became involved in the debate.

Germ cell tumors are the most common ovarian malignancies diagnosed during childhood and adolescence, although only one percent of all ovarian cancers develop in these age groups. The staging of the disease is usually established by laparotomy with total abdominal hysterectomy and bilateral salpingo-oophorectomy. Peritoneal washings and cytologic examination of any ascitic fluid is pathologically examined. The primary tumors is evaluated for rupture and any adherence.

The patient, G.L was originally diagnosed with poorly differentiated malignant germ cell tumor of the ovary in August 2008. She was initially admitted at that time and underwent an exploratory laparotomy with left salpingo-oophorectomy for tumor debulking. The patient had sparing of her right ovary and uterus due to desire to preserve possible future fertility. She also had placement of double-J urethral stents for hydronephrosis.

Prognosis in ovarian cancer is dependent not only on stage but on the extent of residual disease and histologic grade. Patients presenting with advanced disease but left without significant residual disease after surgery have a median survival of 39 months, compared to 17 months for those with suboptimal tumor resection. Patients with advanced disease (stages III and IV) and bulky residual tumor are generally treated with intravenous paclitaxel-platinum combination, and while the overall prognosis is poorer, 5-year survival may reach 15–20%. Due to the significant metastasis, the patient G.L, for further treatment had placement of a left chest tube with four doses of intrathoracic chemotherapy. In the two months to follow, as the patient continued to receive treatments of chemotherapy, her course was complicated by pleural effusion, supraventricular tachycardia, as well as depression.

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2 John O. Schorge et all.
The 22 year old G.L. was hospitalized again on November the tenth, 2008 for an exploratory laparotomy for tumor biopsy and chemotherapy-resistance testing. Post-operative day one she developed lower extremity swelling and pain. After lower extremity Doppler studies were performed she was diagnosed with left common femoral deep venous thrombosis. At this time the patient was started on a therapeutic dose of anticoagulants. During her inpatient stay, the patient’s disease progressed to the development of sepsis and multi-organ failure. At this time, the infectious disease team, and the intensivist physicians were consulted.

After careful evaluation of the case for patient G.L., the intensivist team came to the conclusion that admission to the intensive care unit would be futile because the patient’s condition was terminal. The patient’s family continued to support the need for further intervention. The Principle of Biomedical Ethics, examines the definition for the word terminal as well as the indication of interventions when a patient is in a terminal condition. Under Medicare and Medicaid eligibility rules for reimbursement of hospice care, "terminal" is defined as having 6 months or less to live. This is an administrative rather than a clinical definition. "Terminal" should be applied only to patients whom experienced clinicians expect will die of a specified disease in a relatively short period, measured in days, weeks, or several months at most, despite appropriate treatment. Diagnosis of a terminal condition should be based on medical evidence and clinical judgment that the condition is progressive, irreversible, and lethal.

The importance of establishing this definition is to effectively be able to inform both patients and families of the situation at hand and to give them the opportunity to plan for and arrange appropriate care. However, for even the most experienced physician, giving an accurate prognosis for a time period can be difficult and is often incorrect. Therefore, many physicians shy away from informing their patients of their imminent death. I believe that in part, although the family had been counseled on the state of G.L.’s condition and the prognosis, the imminence of her situation was misrepresented. While it was clear to the intensivist team that further intervention would be futile, the family felt there was still possibility to prolong and improve their daughter’s life.

At this time, I feel the need to further discuss the idea of a medical intervention being described as “futile”. There are many definitions of the word, the Oxford English Dictionary defines it as "incapable of producing any result, failing utterly of the desired end through intrinsic defect." In medicine, what is preferred is the idea of “physiologic futility.” The idea that in intervention, such as admission to the intensive care unit, would not provide the desired response, in this case the resolution of the multi-organ failure and extension of life.

“Quantitative futility” also known as “probabilistic futility” refers to lack of clinical evidence to support performing a certain intervention. However, this term is also difficult to define accurately due to lack of actual clinical trials and wide ranges of success. Finally, futility also has a qualitative meaning: the judgment that the goal that might be attained is not worthwhile. In our case, this would mean that the admission to the intensive care unit would result in a quality of life that would most likely not be desired by the patient’s family.

The results of the intervention of admission to the intensive care unit also caused a dilemma for the patient’s family. They had been explained the procedure of mechanical ventilation and the restricted access of family into the unit. Although they were not certain that

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4 Beauchamp TL, Childress JF.
5 Beauchamp TL, Childress JF.
they wanted their daughter to be in the ICU for an indefinite period of time, they did insist on doing “everything possible” for their daughter. The intensivists counseled the family that upon and after admission to the intensive care unit G. L would suffer from a minimal quality of life. Minimal Quality of life describes patients whose condition fits the criteria for minimal quality of life may have need for life-sustaining interventions. The ethical question is whether such a quality of life justifies support of continued life. If the patient’s life continues, it is likely to deteriorate even further⁶.

At this time, the gyn-oncology team consulted the Hospital attorney and mediators. Unfortunately, the patient’s health continued to deteriorate as her vital signs began to destabilize. The ethical conflict continued to be allowing the patient to pass away with palliative measures versus admission to the intensive care unit with full resuscitation measures. At this time, Ms. L. was beginning to suffer from an altered mental state and her mother and father were in charge of making the immediate decisions. The gyn-oncology team was attempting to provide the family with concrete information regarding the patient’s health while participating in meetings with the intensivist team as well as the hospital attorneys and mediators. In Clinical Ethics: A practical Approach to Ethical decisions in Clinical medicine, the idea of forgoing an intervention that will otherwise end in demise is widely discussed. In this regard, the principle of proportionality is endorsed. The principle states that a medical treatment is ethically mandatory to the extent that it is likely to confer greater benefits than burdens upon the patient. It designates the relation or proportion between the expected benefit or treatment in relation to its burdens, risks, and disadvantages⁷. It is stated that this may be applied even when the burden of omitting treatment is death of the patient. The principle of proportionality would most traditionally be applied to the preferences of the patient in combination with medical indication. In this case, Ms. L. first conceded and later was unable to make judgment regarding benefits and burdens to her health. Therefore, the deliberation over this principle was left to the patient’s parents as well as the physicians.

On the morning of November 24th, the gyn-oncology had their daily meeting with the parents of L.G. There appeared to be no difference between the meeting of that day and those prior. However, something had changed with the way the family perceived the situation. They were informed that the process was still ongoing for the possible admission to the intensive care unit and of the progression of their daughter’s disease. At that time, the mother and father of the patient both agreed that they wanted their daughter to come home with them and be able to pass away with only palliative care. At approximately two thirty in the afternoon, L.G. passed away in her hospital bed surrounded by her mother, father and extended family. The gyn-oncology team was just as devastated as the family members, since they had grown so close to the patient and her family.

When a patient dies while a decision to implement a medical intervention is in the process of being reached there is a possibility of legal implications. Clinical Ethics explains that a physician is acting within the laws, as currently understood, when they recommend that life-supporting interventions be withheld or withdrawn, unless specific law to the contrary exists in any particular jurisdiction. The conditions required for this decision are as follows, first, it is virtually certain that further medical intervention will not attain any of the goals of medicine other than sustaining organic life. This condition is applicable to the case of Ms. L. Even though

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⁷ Albert R. Jonsen Ph.D et all.
she could have been admitted to the Intensive Care Unit, her underlying disease process would not have been reversed due to its severe extent. The second condition is the preferences of the patient are not known and cannot be expressed. This condition also applies to the Case, since the patient was no longer in a state to make her preference be known and had not been strict when giving directive to her parents. The third condition states that the quality of life clearly falls below minimal. This aspect of the case was discussed earlier. Finally, the fourth condition is that the family is in accord. This condition was met at the crucial final moment. The chapter of Clinical Ethics continues to explain that “because despite the legal perplexities, most leading cases thus far adjudicated have affirmed the legal correctness of allowing the patient to die when these conditions are present.”

The other possible outcome of this case could have been successful admission to the intensive care unit with appropriate intervention. However, it is difficult to tell if this intervention would have prolonged the life of Ms. L. and whether she would have been able to spend her last moments with those that love her most.

References


8 Albert R. Jonsen, Ph.D et all.