The ethical case discussed in this paper involves a 69 year old AAM, Mr. B., seen by an ENT doctor locally for difficulty swallowing. The man had been having problems eating and drinking for months which had lead to a substantial weight loss of around 30 pounds. The family also reported that his voice had become weaker and raspier. The man had a long history of alcohol abuse and smoked two packs of cigarettes a day for forty years. During the initial exam, a large mass could be seen in the posterior aspect of his pharynx/larynx that extended out from the walls. After the visit the man was sent to have diagnostic tests performed that eventually lead to the diagnosis of squamous cell carcinoma. The cancer had locally invaded at the time of consultation to involve the right vocal cord, most of the posterior larynx, and various places along the posterior and lateral pharyngeal walls. Via a neck CT scan, the cancer was staged as T3; the cancer had paralyzed a vocal cord and had involvement of the pre-epiglottic/postcricoid areas. There were no distant nodes detected by the scan to be involved but metastatic disease was not ruled out due to the limited nature of the scan.

The treatment options available to Mr. B. included doing nothing, having surgery to remove the tumor, undergoing radiation to the affected areas or combining both surgery and radiation. In talks with the patient and his family (which included two nieces that he currently lived with and one sister that happened to be visiting at the time of the second appointment), surgery was decided on to help debulk as much of the tumor as necessary and possibly serve as a means of survival for the patient if the surgeons removed the cancer in its entirety. The man would then undergo radiation therapy for the remaining tumor. The man fully understood the magnitude of the surgery and
comprehended that if he decided to do nothing, the cancer would get larger and possibly prevent him from breathing in future years.

Mr. B. underwent surgery two weeks later that wound up lasting seven hours and being much more difficult that originally anticipated. The surgeons initially were only going to remove the tumor and the parts of his vocal cord embedded within it, but after dissecting down to see more anatomy, the tumor was found to be much more extensive in size and in depth of invasion. The surgery involved performing bilateral neck dissections, removing part of his right mandible that was almost entirely tumor, removing his entire larynx, creating a tracheostomy hole for artificial respiration and removing almost all muscles bilaterally that were involved with swallowing. The tumor had invaded posteriorly to the spine, up into the nasopharynx and superiorly to the base of the skull. With these characteristics metastatic disease was almost certain and the cancer became a stage IV. At the end of the surgery, the man had lost enough blood to have a hemoglobin of 4.0 and was placed in intensive care with doubts as to his survival or recovery.

This case raised many issues involving the quality of life of patients that undergo surgery with an inoperable tumor; the concept of futility. In this situation the tumor was believed to be operable, but certain tests were not performed that would have demonstrated the more extensive spread of the cancer. Per recommendations by surgical oncology specialists, tumors that are stage III and found in the hypopharynx/ larynx should be treated with a more aggressive approach due to their high rate of spread to the lymphatics and regional sites. However, if the cancer would have been staged correctly, only limited surgery was the recommendation (Goldman 2004). In Mr. B.’s case, his
tumor was so involved, surgery should not have been done and only radiation or palliative care to reduce symptoms should have been addressed.

Many of the actions innate to being human were removed during his surgery including swallowing, breathing through his nose or mouth and being able to verbally communicate with his surroundings. Taking away his right to perform any of these functions fits the definition of “inoperable” meaning performing surgery leaves the patient too functionally disabled (Yorkshire Cancer Head and Neck Group 2009). As part of the Hippocratic Oath, physicians should do no harm to their patients and should seek to keep the “good” of the patient at the highest priority. How could eliminating his ability to do the most human of actions, breathe and eat, improve his quality of life after the surgery? What good did removing only part of the tumor achieve? On the flip side, the surgery was performed as a life saving measure; however, the surgeons did not have all of facts of the case when they made the decision that surgery was the best option. Finally, the surgeons should have stopped the surgery when it was realized the more extensive spread of the tumor; this would have preserved most of the functions they removed as part of the tumor reduction process. By having the surgery, Mr. B. traded in one set of problems for a whole set of more complicated ones.

Medical futility involves interventions that are “unlikely to produce any significant benefit to the patient” (Futility 2008). This case is a classic example of performing a surgery because the guidelines in textbook indicate that it should be done without applying it to the specific case. The family was not adamant to have the surgery done; they wanted the best advice from the doctor and wanted their family member to be happy. The decision was left up to the surgeon who was unprepared and a little rash to
get his hands dirty. The surgery created unnecessary pain for Mr. B. and created high morbidity and possibly early mortality. The surgery was also very costly and with Mr. B. having Medicare, government money was spent in a superfluous way. The money could have gone for hospice care, pain medications or home nursing that would have benefited the patient’s needs more. On the opposite side of the argument, doctors should do everything for a patient that they feel gives them the best chance for survival. Law demands unless the patient expressly wishes it, doctors must perform life sustaining procedures and treatments to keep the patient alive (Fine 2000). The surgery can be seen as such in that if it wasn’t performed, the patient would have most certainly died. However, with stage IV cancer that has probably invaded into the CNS, wouldn’t he have died anyway even with the surgery? After weighing the benefits and harms, the ENT doctor felt that surgery was the only way he could give Mr. B. a chance. Mr. B. and his family were not wrong to trust the doctor; his professional judgment was just wrong in this case.

Mr. B. was in the later half of his life and even though he had to spit in a cup throughout the day due to difficulty swallowing his saliva, there were better options for his care that did not include taking him to the OR and would have preserved his autonomy. In regards to his overall health, the cancer was too far along for any cure, but performing radiation would have decreased the size of the tumor enough for him to swallow again and possibly eat. If eating was not possible, putting in a feeding tube would have given him the necessary nutrients to ambulate and perform activities with his family. Decreasing the size of the tumor with radiation would have also benefited his breathing and delayed the onset of breathing difficulties. A patient representative should
have been used to educate the family more as to the risks and implications of the procedure and the progression of the disease process as it relates to Mr. B.’s overall health. With this information Mr. B. and his family could have made a more informed decision about what was best for his situation and how each option would affect his quality of life.

The case of Mr. B. poses many questions that a physician should ask themselves before recommending a life threatening surgery to a patient that has a very low likelihood of benefiting from it. As physicians we want to do everything we can to save our patients from death, however, when the treatment compromises the patient of the quality of life they are accustomed to, the treatment should not be considered. The overall goal of going to the doctor is to acquire help; help can be in form of surgery or telling the patient nothing can be done and to live out their last days as they want to. Being able to make those calls can be difficult, but as a physician, it is your duty to the patient.
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