



American Head and Neck Society - Journal Club

Volume 12, June 1, 2017

ETHICS COMMITTEE EDITION

This Issue of the AHNS Journal Club has been compiled and reviewed by members of the AHNS Ethics Committee:

*Marita Teng, MD
Sara I. Pai, MD PhD FACS
Andrew Shuman, MD
Kiran Kakarala, MD*

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[Intraoperative Decision Making: The Decision to Perform Additional, Unplanned Procedures on Anesthetized Patients](#)

Langerhans A, Siegler M, Angelos P.

*From **Journal of the American College of Surgeons**, May, 2016*

Summary statements

- Informed consent generally allows surgeons to change the surgical plan based on complications or unexpected circumstances. However, changes in plan must still be based on the basic tenets of beneficence, nonmaleficence, and patient autonomy.
- Intraoperative decisions should ideally be made based on patients' previously stated choices. If the intraoperative scenario was not previously discussed with the patient, the surgeon may consider consulting with the patient's surrogate, either in a decision-making or decision-supporting capacity.
- Ultimately, the responsibility of intraoperative decision-making rests on the surgeon's shoulders. Consider involving a surgical colleague for consultation, and when the decision is so monumental that it requires involvement of the patient, defer additional procedures to allow patient input.

Strengths

- The article succinctly describes recommendations for intraoperative decision-making when unanticipated events occur.



- A useful table lists four key questions, along with companion examples, to address when considering additional interventions on an anesthetized patient.
- The article highlights some important pitfalls in surgical decision-making about performing additional procedures.

Weaknesses

- It is possible that some readers might find the majority of the information in the article to be “common sense,” or the article to be lengthier than necessary to convey its points. But given that it is a narrative article, written with support from literature, it should be useful to most surgeons.

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[The Ethical Implications of the Reclassification of Noninvasive Follicular Variant Papillary Thyroid Carcinoma](#)

Likhterov I, Osorio M, Moubayed SP, Hernandez-Prera JC, Rhodes R, Urken ML

*From **Thyroid**, September 2016*

Background: Several studies have highlighted the lack of consensus in the diagnosis of follicular variant of papillary thyroid carcinoma (FVPTC). An international multidisciplinary panel to address the controversy was assembled at the annual meeting of the Endocrine Pathology Society in March of 2015, leading to the recent publication reclassifying encapsulated (or noninvasive) FVPTC (EFVPTC) as a benign neoplasm. Does this change in histologic taxonomy warrant a change in clinical practice, and how should it affect those who have been given this diagnosis in the past? We consider the financial and psychological impact of this reclassification and discuss the ethical, legal, and practical issues involved with sharing this information with the patients who are affected.

Summary: The total direct and indirect cost of thyroid cancer surveillance in patients is significant. High levels of clinically relevant distress affect up to 43% of patients with papillary thyroid carcinoma, as estimated by the Distress Thermometer developed by the National Comprehensive Cancer Network for detecting distress in cancer patients. Although there are currently no legal opinions that establish a precedent for recontacting patients whose clinical status is altered by a change in nomenclature, the prudent course would be to attend to the requirements of medical ethics.

Conclusion: Informing patients with a previous diagnosis of EFVPTC that the disease has been reclassified as benign is expected to have a dramatic effect on their surveillance needs and to alleviate the psychological impact of living with a diagnosis of cancer. It is important to re-evaluate the pathologic slides of those patients at risk to ensure that the invasive nature of the tumor is comprehensively evaluated before notifying a patient of a change in diagnosis. The availability of the entire tumor for evaluation of the capsule may prove to be a challenge for a portion of the population at risk. We believe that it is the clinician's professional duty to make a sincere and reasonable effort to convey the information to the affected patients. We also believe that the cost savings with respect to the need for additional surgery, radioactive iodine, and rigorous surveillance associated with a misinterpretation of the biology of the diagnosis of EFVPTC in less experienced hands will likely more than offset the cost incurred in histologic review and patient notification.



Summary statements

- There has been a recent reclassification of “encapsulated (or noninvasive) follicular variant of PTC (EFVPTC)” from a malignant to a benign neoplasm, and the lesion is now termed “noninvasive follicular thyroid neoplasms with papillary-like nuclear features (NIFTP).”
- The authors describe the ethical, legal, and practical issues involved in sharing the new terminology and associated clinical implications with affected patients.

Strengths

- A strength of the article is that the authors provide steps on how to identify and inform patients who may be affected by the recent reclassification of EFVPTC.
- A comprehensive breakdown of both direct and indirect healthcare costs associated with the change in diagnosis is provided.
- It is a well-written article and is timely with the availability of advanced technologies such as genetic testing which can provide improved insights into genetic alterations associated with various histologies and which has the potential to impact the reclassifications of other neoplasms as our understanding of diseases evolve.

Weaknesses

None identified.

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Factors Influencing Head and Neck Surgical Oncologists’ Transition from Curative to Palliative Treatment Goals

Kershena Liao, Jennifer Blumenthal-Barby, Andrew G. Sikora

from JAMA Otolaryngology–Head and Neck Surgery, October 2016

Objective. The factors influencing head and neck surgical oncologists’ goals of care and decisions to initiate conversations about transitioning to palliative-intent treatment for patients with limited curative treatment options are incompletely understood. Lack of guidance for physicians on this topic can lead to inconsistent utilization of palliative services, as well as confusing, upsetting experiences for patients and families. We review the literature investigating the clinical factors, inter- and intrapersonal factors, and financial and health care system considerations that head and neck cancer physicians weigh during this decision-making process.

Review Methods. Selected literature on head and neck surgical oncologists’ decision making in end-of-life care and palliative therapy was reviewed and analyzed thematically.

Conclusions. Physicians taking into account patients’ clinical trajectories often overestimate the negative impact of head and neck cancer symptoms on their quality of life, suggesting that patients’ expectations of quality of life should be discussed early, before communication barriers arise. How head and neck clinicians perceive and are influenced by patients’ desired degree of autonomy, which varies greatly depending on the severity of illness, is still unclear. Patients’ financial and insurance status affects decision making about hospice care. Finally, physician demographics (eg, age, subspecialization, practice setting), emotions, and philosophical background may exert unconscious biases that have not been fully determined for head and neck surgical oncologists.



Implications for Practice. A more comprehensive understanding of the head and neck surgical oncologist’s approach toward considering a transition to therapy with palliative intent may help guide advancements in this complex counseling process, leading to improvements in patient care, quality of life, and outcomes.

Summary statements

- This state of the art review provides a discussion regarding how head and neck surgical oncologists approach and navigate the transition from curative to palliative goals taking into account multiple stakeholders’ perspectives and the need for a multidisciplinary approach.
- Patient-reported outcomes and individualized assessments of quality of life and ensuing goals of care are critical to navigating treatment decisions with patients facing potentially incurable head and neck cancers.
- Myriad barriers involving communication, symptom management, disfigurement, practice setting, emotional attachment and financial/logistical hurdles all influence how surgical oncologists manage patients with life-limiting head and neck cancer.

Strengths

- Thoughtful and pragmatic thematic analysis of a topic that is relatively understudied and underexplored
- Utilization of contemporary decision science in analyzing variant stakeholder perspectives and patient-centered care
- Clear articulation of “take home points” with clear and actionable recommendations

Weaknesses

- Dearth of empiric, specialty-specific research limits strength of conclusions
- Lack of explicit description of the rationale for article inclusion/exclusion without summarization of extant data
- Reference to and contextualization of existing ASCO, ACS and NCCN guidelines relevant to the topic would be of value

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Patient Reflections on Decision Making for Laryngeal Cancer Treatment

Shuman AG, Larkin K, Thomas D, Palmer FL, Fins JJ, Baxi SS, Lee N, Shah JP, Fagerlin A, Patel SG.

from JAMA Otolaryngology Head Neck Surgery, February, 2017

Objective: To describe the reflections of patients treated for laryngeal cancer with regard to treatment-related decision making.

Study: Design Cross-sectional survey-based pilot study.

Setting: Single-institution tertiary care cancer center.



Subjects/Methods: Adults with laryngeal carcinoma were eligible to participate (N = 57; 46% treated surgically, 54% nonsurgically). Validated surveys measuring decisional conflict and regret explored patients' reflections on their preferences and priorities regarding treatment-related decision making for laryngeal cancer and how patient-reported functional outcomes, professional referral patterns, and desired provider input influenced these reflections.

Results: When considering the level of involvement of surgeons, radiation oncologists, and medical oncologists in their care, patients were more likely to believe that the specialist whom they saw first was the most important factor in deciding how to treat their cancer (Fisher's exact, $\sim\chi(2) = 16.2$, $df = 6$, $P = .02$). Patients who were treated for laryngeal cancer who reported worse voice-related quality of life recalled more decisional conflict ($P = .01$) and experienced more decisional regret ($P < .001$). Of the patients for whom speech was a top priority prior to treatment, better voice-related quality of life overall scores were correlated with less decision regret about treatment decisions ($P < .02$). Of the patients for whom eating and drinking were top priorities prior to treatment, better MD Anderson Dysphagia Inventory global scores were correlated with less decision regret about treatment decisions ($P < .002$).

Conclusion: Patient priorities and attitudes, coupled with functional outcomes and professional referral patterns, influence how patients reflect on their choices regarding management of laryngeal cancer. Better understanding of these variables may assist in ensuring that patients' voices are integrated into individualized laryngeal cancer treatment planning.

Summary: A pilot study was performed in which surveys were given to patients who had previously undergone treatment for laryngeal cancer (surgical and non-surgical) in order to assess “how patients who have undergone treatment reflect on their treatment decisions in the context of their current health and symptom burden”. Surveys assessed patient preferences for treatment, voice and swallowing related quality of life post-treatment, and conflict and regret around their treatment decisions. Unsurprisingly, patients who reported that maintaining voice and swallowing function were top priorities had lower levels of decisional conflict and regret if their post-treatment voice and swallowing function were good. Overall, this data may be useful to support shared decision-making for laryngeal cancer care that incorporates individual patient values and preferences.

Strengths

This study provides valuable information to providers seeking to provide patient-centered laryngeal cancer care that respects the goals and wishes of the individual patient: this data may help guide pre-treatment counseling, inform the creation of a decision aid that providers and patients could use to guide treatment discussions. In particular, the data may help to focus the discussion on key factors that may be important to the individual patient (e.g. survival, voice, swallowing, taste/smell) and how the different treatment options may impact these.

Weaknesses

It would be interesting to have survey data before and after treatment in order to understand the stability of preferences over time (although this has been shown to be relatively stable in other studies)