



# American Head and Neck Society - Journal Club

## Volume 45, Ethics & Professionalism Service Issue

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### AHNS Ethics & Professionalism Service Issue

*This Issue of the AHNS Journal Club has been compiled and reviewed by members of the  
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## [Improving End-Of-Life Care for Head and Neck Cancer Patients](#)

Andrew G Shuman, Joseph J Fins, Mark E Prince

From the *Expert Review of Anticancer Therapy*. March 2012

**Abstract:** Despite improvements in the treatment of head and neck cancer, many patients still succumb to their disease. A litany of medical, psychosocial, and ethical challenges arises in managing the end-of-life experiences within this patient population. In this article, we attempt to review existing data about the end-of-life experiences of this cohort, extrapolate relevant data from other cancer patients, and suggest the most promising avenues for additional research and practice improvement for terminal head and neck cancer patients. Clinical decision-making for patients dying of head and neck cancer requires proactive consideration of quality of life, functionality, symptom control and other patient-centered objectives, and frequently benefits from palliative care team involvement. Additional research aimed toward optimizing the end-of-life experience of head and neck cancer patients and their families is greatly needed.

### Summary statements

- Head and neck cancer strips dying patients of their sense of identity, confounding the challenges already faced by patients and caregivers.
- Involve multidisciplinary experts in end-of-life care early, begin difficult end of life discussions prior to symptom and disease progression/emergencies
- Improvements in end-of-life care are centered upon candid discussions about prognosis, treatment modalities and tailored risks/benefits of those treatments

### Strengths

- Highlights the paucity of evidence pertaining to palliative multidisciplinary care in head and neck cancer treatment and end of life care
- Provides an overview of high-yield points to consider when caring for a terminally ill head and neck cancer patient, allowing the provider to proactively address common, and impending end of life issues

### Weaknesses

- Review article without systematic literature review
- Provides overview with limited high-level evidence supporting certain end-of-life considerations specific the H&N cancer

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## Working Definitions of “Critical Portions” Results from Qualitative Interviews with 51 Academic Surgeons

Alexander Langerman, Kathleen Brelsford, Catherine Hammack-Aviran

From the *Ann Surg.* February 2022

**Objective:** Identify the considerations academic surgeons use when determining which portions of a procedure are “critical” and necessitate their presence.

Background: Teaching physicians are required to be present for the “critical portion” of surgical procedures, but the definition of what constitutes a critical portion remains elusive. Current guidelines defer to surgeons’ expert judgment in identifying critical portion(s) of a procedure; little is known about what concepts surgeons apply when deciding what parts of a procedure are critical.

**Methods:** Qualitative analysis of interviews with 51 practicing surgeons from a range of specialties regarding their working definition of critical portions.

**Results:** Surgeons identified four common themes that they use in practice to define the critical portions of procedures: portions that require their firsthand observation of events, those involving challenging anatomy or structures that cannot be repaired if injured, and portions where an error would result in severe consequences for the patient. Surgeons also recognized contextual factors regarding the patient, trainee, surgeon, and team that might alter determinations for individual cases.

**Conclusions:** Although critical portion definitions are largely treated as subjective, surgeons across multiple specialties identified consistent themes defining “critical portions”, suggesting that setting a minimum standard for criticality is feasible for specific procedures. Surgeons also recognized contextual factors that support the need for case-specific judgement beyond minimum standard. This framework of procedure features and contextual factors may be used as a guide for surgeons making day-to-day decisions and in future work to formally define critical portions for a given procedure

### Summary Statements

- Ventures to define critical portions of surgical procedures through thematic analyses of in-depth interviews with academic attending otolaryngologists, neurosurgeons, and general surgeons.
- Using themes that emerged from these interviews, the authors propose a framework of procedural features and contextual factors that can be used to guide surgeons in decision-making and when considering further efforts to formally define critical portions of surgical cases.
- They conclude that setting a minimum standard for criticality for specific procedures is both feasible and warranted. How such standards would impact healthcare policies and hospital guidelines remains in question.



### **Strengths**

- The framework proposed provides a guide for navigating the heterogeneous milieu surrounding critical portions of procedures. Their data reinforce the notion that decisions regarding critical portions of cases are innately surgeon-level choices that must be informed by their morals, ethics, and professionalism.
- Developing a concrete definition of critical portions of any surgical procedure has regulatory implications, affects the supervision of surgical trainees, and impacts the informed consent process and inculcation of professional values within our field.

### **Weaknesses**

- Critical portions were defined in the context of physical presence/absence within the OR rather than allowing trainees to work independently while the attending was still there; this may nuance how individuals define “critical portion.”
- The study involved academic surgeons in three fields and may not be broadly applicable to all surgical disciplines and settings.
- Translating this framework into policy and guidelines for implementation in clinical practice will require further collaboration between surgeons, trainees, patients, and healthcare policy stakeholders.

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## **Untreated Oral Cavity Cancer: Long-Term Survival and Factors Associated with Treatment Refusal**

*Shayan Cheraghlou, Phoebe Kuo, Saral Mehra, Wendell G Yarbrough, Benjamin L Judson*

*From the **Laryngoscope**. March 2018*

**Objective:** Oral cavity cancer is the most common malignant disease of the head and neck. The natural course of the disease is poorly characterized and unavailable for patient consideration during initial treatment planning. Our primary objective was to outline this natural history, with a secondary aim of identifying predictors of treatment refusal.

**Study design:** Retrospective review of adult patients with oral cavity cancer who refused surgery that was recommended by their physician in the National Cancer Database.

**Methods:** Demographic, tumor, and survival variables were included in the analyses. Multivariate Cox regressions as well as univariate Kaplan-Meier analyses were conducted.

**Results:** Patients who were older, uninsured, had government insurance, or had more advanced disease were more likely to go untreated. Survival among untreated patients was poor, but there was a small proportion of patients surviving long term. Five-year survival rates ranged from 31.1% among early-stage patients to 12.6% among stage 4 patients.

**Conclusion:** Although the natural course of oral cavity cancer carries a poor prognosis, there are a number of patients with longer-than-expected survival. The survival estimates may provide supplemental information for patients deciding whether to pursue treatment. In addition to age and extent of disease, system factors such as insurance status and facility case volume are associated with a patient's likelihood of refusing treatment.

### **Summary Statements**

- This is a database study utilizing the National Cancer Database (NCDB) with special attention to patients with oral cavity carcinoma, deemed to be operable candidates, but found to not have undergone treatment.
- A total of 36,261 patients with oral cavity carcinoma were analyzed, and 356 went untreated (nearly 1%). Demographics of this population were the following: majority of untreated patients were white (77%) and male (63.5%) with stage IV disease (64.6%), without comorbidities (78.1%) and owned “government” insurance (62.6%). Most treated patients were white (84.1%) and male (60.0%) with early-stage disease (57.5%) and no comorbidities (78.7%). Black patients comprised of 12.1% of patients who went untreated but only 6.8% of those of who were resected.
- Patient predictive factors of treatment refusal were the following; more advanced cancers (primary and nodal involvement), age above 75 years old, larger tumors (T3-4) being 5.366 ( $p < 0.001$ ) and 7.26 ( $P < 0.001$ ) times more likely to refuse treatment than T1 lesions.



- "Health system" predictive factors included patients treated low volume facilities were higher chance of refusal compared with high volume places. However, those treated at non-academic centers were less likely to refuse than at academic centers (OR 0.772,  $p = 0.043$ ). The most predictive was insurance status - those without insurance or "government insurance" were significantly more likely to go untreated compared with private insurance. In addition, those with government insurance had diminished survival compared to private insurance.
- Survival rates of the untreated were generally poor, with 5-year survival ranging from 12.6% (at stage IV) to 31.1% (early-stage). For comparison, the rates were 49.3% to 72.8% in those who were treated. Of note, "tumor grade" was not significantly associated with survival.

### **Strengths:**

- Prior studies have demonstrated that refusal of treatment has been associated with lower socioeconomic status and thought to be due to poorer understanding of the severity and prognosis of the disease. This study provides stronger insight into the potential health care disparities surrounding this disease process and overall topic.
- Multivariate analysis in this cohort demonstrated that race was no longer significantly associated with patient likelihood of going untreated, but rather systemic factors such as patient insurance status/type was more predictive. As has been shown in literature, oral cavity carcinoma has higher incidence in those with lower socioeconomic status, thus underscoring this finding.
- The study assigns a "survival rate" associated with treatment refusal: 5-year survival ranging from 12.6% (at stage IV) to 31.1% (early-stage) compared to rates of 49.3% to 72.8% in those who receive treatment.

### **Weakness:**

- Primary limitations of this study center on limitations of most database studies.
- This study was able to identify general predictive factors and establish important trends among a large patient population, but in this particular cohort, important factors such as alcohol and tobacco use are not included.
- There are absent data (due to database limitations) regarding reasons for treatment refusal and elaboration on patient factors for either the delay or reasons for deciding against treatment.
- The above limits a comprehensive analysis that may help identify several true "origins" for why a patient may refuse treatment of oral cavity carcinoma.

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## Palliative Care in Metastatic Head And Neck Cancer

Alyssa M Civantos, Aman Prasad, Ryan M Carey, Andrés M Bur, Leila J Mady, Robert M Brody, Karthik Rajasekaran, Steven B Cannady, Lee Hartner, Said A Ibrahim, Jason G Newman, Jason A Brant

From the *Head and Neck*. September 2021

**Background:** Due to inherent impact on quality of life, metastatic head and neck cancer patients are well-suited to benefit from palliative care (PC). Our objective was to examine factors that shape PC utilization and implications for overall survival in stage IVc head and neck cancer patients.

**Methods:** A retrospective study of patients with stage IVc head and neck cancer in the National Cancer Database from 2004 and 2015 was conducted.

**Results:** 7794 cases met inclusion criteria, of which 19.3% received PC. PC use was associated with more recent years of diagnosis, Northeast facility geography, and non-private insurances ( $p < 0.05$ ). Compared to no PC, "interventional" PC, defined as palliative surgery, radiation, and/or chemotherapy, and "pain management only" PC were associated with lower overall survival ( $p < 0.05$ ).

**Conclusions:** Palliative care use increased over time and was associated with demographic and clinical factors. There remains opportunity for improvement in optimal implementation of palliative care.

### Summary Statements

- Despite evidence for several benefits of palliative care services for patients with advanced cancers, they are not widely utilized for head and neck cancer patients.
- This was a NCDB study to investigate the temporal, socioeconomic, facility, and tumor factors that are associated with receiving palliative care in the management of stage IVc head and neck cancer. Also, the objectives focused on evaluating the different forms of palliative care can have on overall survival.
- The patient cohort were patients with stage IVc disease, primary outcome was utilization of palliative care with secondary outcome of overall survival. For analysis purposes, palliative care "designations" were specified as "no palliative care," "interventional palliative care - form of surgery, radiation or chemotherapy was used, "pain management only" and "other."
- A total of 7794 patients were analyzed of which 1501 (19.3%) received palliative care. The median overall survival (OS) was 9.63 (CI 9.33-9.99) months. The median OS of those who received palliative care was 6.93 (CI 6.44-7.43) months compared with 10.51(CI 10.15-10.87).
- Compared with private insurance, those with Medicare or no insurance had increased odds of receiving palliative care. Geographically, those treated in the South, Midwest, and West were less likely to receive palliative care than the Northeast.



- Patients who underwent “interventional palliative care” had decreased overall survival compared to those who did not receive any palliative care. Those who has “pain management only” or “other” modalities had lowest OS rates.
- Study able to demonstrate an overall increased trend in utilization from 13.9% in 2004 to 22.5% in 2015. This is commensurate with increased palliative care programs in US hospitals from the year 2000 to 2016 (which has tripled in percentage).
- There is an inherent underutilization of palliative care services in end staged head and neck cancer

### **Strengths**

- Those who received “pain management only” had greater decrease in survival than “interventional” palliative care.
- Although overall survival may be lower in those utilizing palliative care, we must keep in mind the goals of palliative care to enhance quality of life, prioritize patient comfort measures, and symptom control.
- There is literature in other cancer domains (for example advanced lung cancer) that suggest that early palliative care intervention provided throughout “standard care” improves not only quality of life but also prolongs survival by months.
- This was large scale study to demonstrate that there is an underutilization, yet increasing trend towards the use of palliative care services in end staged head and neck cancer

### **Weaknesses**

- Database limitations unable to elaborate or comment on the impact of a given palliative care modality on quality of life.
- The timing of palliative care modalities being offered is also not able to be fully analyzed, thus patients may have been offered, but in delayed fashion or late in their disease course.
- There is limitation on the true nature or “intent” of interventions being offered to this patient cohort that cannot be ascertained via the retrospective and database limitations. This limited the knowledge of duration of treatments and the distinction between “curative” vs. “palliative” intent of interventions.

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## **Telehealth Practice in Surgery: Ethical and Medico-Legal Considerations**

Danny W H Lee, Kar-Wai Tong, Paul B S Lai

*From the Surgical Path.* February 2021

**Abstract:** There was rapid growth of telehealth practice during the COVID-19 outbreak in 2020. In surgery, there were beneficial effects in terms of saving time and avoiding physical contact between healthcare professionals and patients when using telehealth in the delivery of perioperative care. As telehealth is gaining momentum, the evolving ethical and medico-legal challenges arising from this alternative mode of doctor–patient interaction cannot be underestimated. With reference to the “Ethical Guidelines on Practice of Telemedicine” issued by the Medical Council of Hong Kong and some published court and disciplinary cases from other common law jurisdictions, this article discusses relevant ethical and medico-legal issues in telehealth practice with emphasis on the following areas: duty of care; communication and contingency; patient-centred care and informed consent; limitations and standard of care; keeping medical records, privacy, and confidentiality; and cross-territory practice. Whilst existing ethical and legal obligations of practicing medicine are not changed when telehealth is used as opposed to in-person care, telehealth practitioners are advised to familiarize themselves with the ethical guidelines, to keep abreast of the medico-legal developments in this area, and to observe the licensure requirements and regulatory regimes of both the jurisdiction where they practice and where their patients are located.

### **Summary Statements:**

- Telecommunication in surgical practices exploded during the COVID-19 pandemic due to demand for no-contact practice as well as improved technology in broader areas. It has become very popular for patients due to convenience, less time off work and ability to access a wider network of surgeons.
- Telehealth poses a unique challenge in determining “duty-of-care” for patients who surgeons may have never examined or even met such as cases where another physician consults with a specialist.
- The standard of care will always be comparable to conventional in-person evaluations and treatments.
- Due to lack of or reduced non-verbal cues, communication is even more important to set clear boundaries and limitations and determine what providers (both physician and advanced practice providers) are evaluating the patient.
- Telehealth requires informed consent prior to starting interaction to discuss potential need for face-to-face interaction, potential technological issues, and the limitations of telehealth. Telemedicine lends itself to breaches in privacy given the variable nature of patients’ locations/homes. It is always wise to have the patient introduce who is with them and re-visiting informed consent prior to divulging any sensitive information.
- Medications should only be prescribed to patients who have been seen in person at some point in the doctor-patient relationship.



- Rules, regulations, and licensure requirements need to be followed in both locations (for instance different states) of both the surgeon and patient.

### **Strengths**

- Broad overview of the medical, legal, and ethical considerations when thinking about bringing telehealth into a surgical practice
- Cites multiple international examples of various principles
- Discusses “Ethical Guidelines on Practice of Telemedicine” by the MCHK (Medical Council of Hong Kong) as a widely used reference.

### **Weaknesses**

- Doesn't go into detail regarding the challenges or benefits of telehealth in different clinical settings (i.e., outpatient preoperative clinic, post operative visits or intraoperative consultations).
- With significant access to care issues in the US, telehealth as the initial and sometimes only encounter preoperatively has become increasingly common. There is little discussion in the article about how this model may impact quality of care and patient experience.

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