

SURGEON/AUTHOR  
TO SPEAK HERE

Harkening to the time when operating rooms had windows, Dr. Richard Selzer writes: "...at night, in Emergency, there was the pomp, the longevity of the stars to deflate a surgeon's ego. It did no patient a disservice to have Heaven looking over his doctor's shoulder. I very much fear that, having bricked up our windows, we have lost more than the breeze; we have severed a celestial connection."

Physician/author/poet Selzer will speak on the MSU campus May 14-15. He is a surgeon at Yale University and has been described as America's "poet laureate of surgeons."

He is the author of Confessions of a Knife (from which came the above excerpt), Rituals of Surgery, and Mortal Lessons: Notes on the Art of Surgery. His writing has appeared in such varied publications as the "New York Times Book Review" and "Cosmopolitan" magazine.

On Wednesday, May 14, Selzer will describe "Surgery and Writing: The Challenge of Two Careers" at 8 pm in the Tower Room of the MSU Union, as part of MSU's "The Scientist as Writer" lecture series.

On Thursday, May 15, his topic will be "Surgery as Poetry" during a Medical Humanities Program seminar at 8 pm in Room 335 of the Union Building. Both sessions are open to the public.

He is also slated to speak to medical personnel and medical students during surgery grand rounds at Ingham Medical Center at noon on May 15.

Selzer will be on hand for informal discussion at a free wine-and-cheese reception at Jocundry's Books on M.A.C. Avenue in East Lansing at 4 pm on May 14.

His visit to MSU is hosted by the MSU Medical Humanities Program, Department of English, Department of Surgery, College of Arts and Letters, Honors College and Lyman Briggs College.

CASE COMMENTARY:  
MASTECTOMY--  
WHOSE DECISION?

On referral from her local physician, a 38-year-old married, childless woman, Mrs. Dawson, saw Dr. Marshall in his private surgical practice.

She had noticed a lump in her breast several months earlier, but thoughts of women who, after breast surgery, had never regained full use of their arms, failed to adjust, or experienced fits of depression, kept her from making the appointment. She had always been proud of her figure, was terrified by the thought of losing a breast, and--uncertain of her husband's reaction--had not mentioned the lump to him.

Mammography and a breast biopsy revealed a malignancy in the upper, outer quadrant of her breast. Dr. Marshall tentatively classified it as a low-grade malignancy. Signs of extension into the fascia made him uncertain if it was confined to the breast or had spread to the lymph nodes.

Classifying the stage of the malignancy before surgery is an inexact science; a preoperative conclusion of no involvement of the axillary nodes or lymph nodes of the armpit can be wrong 30 percent or more of the time. In as many as 60 percent of women diagnosed to have breast cancer, the cancer cells have spread to the lymph nodes; this nodal involvement greatly increases the risk of distant metastases.

Dr. Marshall faced a controversial choice. Traditionally, a radical mastectomy would have been performed: removal of the breast, the lymph nodes and chest- and upper-arm muscle tissue. Now, however, three simpler procedures are also advocated: removal of the breast only, without the surrounding muscle tissues (simple mastectomy); removal of only part of the breast; removal of only the original mass itself (lumpectomy).

Differing results of studies of the survival rates among breast cancer patients undergoing the various procedures have led to strong advocates of radical mastectomy and equally strong supporters of the simpler procedures. Dr. Marshall ultimately was persuaded by the arguments of a physician who contended that biostatistical data shows that in surgery for breast cancer, "best is most" for longterm survival. Dr. Marshall informed Mrs. Dawson that she must have the radical procedure.

To what extent is the doctrine of informed consent applicable in this case? Is the decision between a radical and simple mastectomy a question of medical judgment; that is, is this the physician's decision? Is this woman competent and qualified to make the decision?

Suzanne Uphaus, PhD  
Assistant Professor  
MSU - American Thought and Language

As happens all too frequently, Mrs. Dawson's doctor will tell her that she *must* have a radical mastectomy, with no indication that there are equally viable alternatives.

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This most radical form of mastectomy leads to increased disfigurement and discomfort, with no proof of enhanced survival. Since Mrs. Dawson's tumor is in the upper, outer quadrant of her breast, most doctors today would recommend removal of the breast and nodes, leaving the pectoral muscles intact.

But it is not Dr. Marshall's decision as to what form of surgery that I question, so much as his right to make the decision at all. He is making a decision that rightfully belongs to the patient. Mrs. Dawson's "informed consent" is a travesty; she has *not* been informed of all possible treatments and will sign the form believing this is her only choice.

By withholding his own uncertainties and failing to reveal that he considered a variety of treatments, Dr. Marshall has, in essence, lied to his patient--a lie of omission. By fully informing her of all possible courses of treatment, not only would he establish closer communication with her, but he would also relieve himself of that heavy burden of responsibility and guilt, should treatment fail.

This is not to say that he should not make a recommendation, once he has outlined the possible courses. He *should* recommend; in most cases, the patient will follow that recommendation. But the patient should be assured absolutely of continuing support from the doctor, whether she chooses his recommendation or asks him to carry out an alternative.

Many surgeons fail to recognize that a mastectomy has deep emotional repercussions. Complicating this problem is the fact that the surgeon is usually male. Encouraged by society to be submissive and unquestioning before a male authority figure, women have hesitated to question or refuse a doctor's advice for fear of offending or being rejected by this almost paternal figure. Women are becoming more aggressive in demanding their rights; but in the meantime, the male doctor must actively encourage his female patient to question him, while constantly reassuring her of his support.

A further complication is the belief among mastectomy patients that a man cannot understand the operation's devastating psychological impact. The closest parallel is the cutting off of testicles. Many women believe that, were testicles amputated as frequently as mastectomies have been performed, research for alternatives would have begun long ago, their relative safety ascertained, and the patient always allowed the choice of alternative treatments.

While functionally the male sex organs are far more important than the female breast, emotionally the two are very similar. Upon reaching puberty, a young man attaches proof of his manhood to the size and development of his sexual organs; since her sexual organs are internalized, a girl's womanhood is proved by her developing breasts. Over time, the breasts' symbolic import may become subconscious, but a mastectomy reveals their psychological significance. The emotional adjustment to my mastectomy has been far more difficult than I anticipated. Agreed, it is irrational, but we humans will *never* be entirely rational creatures.

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This emotional reaction is deepened by the appearance of the one-breasted body, lopsided and asymmetrical. Not only can many mastectomy patients no longer look at themselves squarely in the mirror, they also fear they will no longer be desirable to men.

While a mastectomy (or any adversity) can draw some couples closer together, others are driven apart--frequently by the woman's conviction of her undesirability, rather than by the man's rejection. For an unmarried woman, loss of a breast may mean total withdrawal from sexual relationships.

Perhaps the most devastating impact of a mastectomy is its constant reminder that there was cancer and it could metastasize. Every time the patient dresses, bathes, puts on a swimsuit, buys a sweater, or makes love, there is that scar, that prosthesis, to remind her of her mortality. Yet this very fear of mortality may prompt many women--given a choice of treatment--to choose the mastectomy in spite of its emotional effect.

In Mrs. Dawson's case, Dr. Marshall decided to perform a mastectomy as if it had no more emotional impact than a tonsillectomy. Proud of her figure, terrified and alone, Mrs. Dawson is so uncertain of her husband's reaction that she hasn't confided in him at all. One of Dr. Marshall's first responses should be to ask her to bring her husband into the decision-making, to share her anxieties and provide reassurance.

Then the doctor should inform her of all options, give her the statistics, advise without pressuring, assure her of the potential of reconstruction if she chooses mastectomy, and encourage her to seek other opinions.

But the patient *must* make the final decision herself. She knows, more than anyone else, what she can stand emotionally, what risks with her life she can live with, what physical deformity she can adjust to. Not only is she qualified to make this decision, Mrs. Dawson is the *only* person so qualified.

Tom Tomlinson , PhD  
Assistant Instructor  
MSU Medical Humanities Program

The question put here--to what extent is the choice between a radical mastectomy and some other treatment a question of medical judgment for the physician to decide--is an ambiguous one, depending on whose choice is spoken of: There is the choice whether to have a radical mastectomy--clearly a choice properly left to the patient, as Suzanne Uphaus eloquently argues. Then there is the choice whether to offer some simpler procedure as an alternative, even in those circumstances where the radical mastectomy offers better mortality rates. This is a question faced by the physician as a matter of professional ethics. It is not, however, thereby a question of *medical* judgment, but a question of what constitutes a reasonable system of *values*.

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The American Medical Association Principles of Medical Ethics require that "a physician should practice a method of healing founded on a scientific basis." If this requirement were coupled with the view that the patient's continued life is the physician's only proper concern, then the question as to which treatment to offer would be the medical/scientific one of determining which treatment offers the best likelihood of saving the patient's life; so, where the radical mastectomy offered the best chance of survival, it would be the only treatment that an ethical physician could perform.

This view is indefensible. It preserves the claim that the ethical physician's treatment decision is a purely scientific one of medical judgment, through the adoption of a one-dimensional system of values which takes life as the only good to be promoted, or the one to be promoted before all others. But this is an absurd exaggeration of the value of life, which is not taken as an absolute in any reasonable system of values. Life is certainly not taken as absolutely valuable within the confines of sound medical practice in areas outside breast surgery, which countenance potentially fatal surgeries (for example, knee surgeries, cosmetic surgeries) for the sake of goals other than life *per se*. And we don't take it as absolutely valuable in the conduct of our daily lives, not when we go to the movies in our cars, jog in the roadway for recreation, or climb up a ladder to paint the house.

If it is morally reasonable to risk one's life to secure other values, then the physician's question of which treatment to offer is no longer simply the scientific one of determining the surest means to a single end, but also the moral one of where the value of life fits within a reasonable system of values.

The making of a morally sound treatment decision, then, requires not only a knowledge of the medical literature and survival rates, but a full, imaginative appreciation of the other consequences of treatment. Even if (because a man) he can never fully put himself "in her place."

#### READING ROOM DEDICATION

Dedication of the "Sylvia Bass Selesnick Memorial Reading Room" is slated for May 15. The room--C-214 East Fee Hall--will be used for conferences, small class sessions, and individual study in the medical humanities.

Funding to furnish the room has been donated by Leo Selesnick, DDS, Flemington, N.J., in honor of his deceased wife.

A faculty member at New York University's School of Dentistry, Dr. Selesnick has been a benefactor of the Medical Humanities Program since its inception says Andrew D. Hunt, program coordinator.

Dr. Selesnick's son, Mark, earned his MD degree from the MSU College of Human Medicine in 1977.

COMING UP

The hospital medical ethics case conferences are for medical personnel, residents and students. Unless otherwise noted, all other programs are open to everyone. For details, contact Susan K. Theut through the Medical Humanities Program office. Ph. 517 355-7550.

- May 12 "Forced Transfer to Custodial Care"  
Medical Ethics Conference  
E. W. Sparrow Hospital - Lansing  
8-9 am
- May 14 Surgery Grand Rounds/Guest: Dr. Richard Selzer  
Ingham Medical Center - Lansing  
Noon - 1 pm
- "Surgery & Writing: The Challenge of Two Careers"  
Dr. Richard Selzer - Yale University  
Tower Room - MSU Union  
8 pm
- May 15 Dedication: Sylvia Bass Selesnick Memorial  
Reading Room  
By invitation
- "Surgery as Poetry"  
Dr. Richard Selzer - Yale University  
Room 335 MSU Union  
8 pm
- May 16 Portrait unveiling: Andrew D. Hunt  
Life Sciences Building  
By invitation
- May 29 Surgery Grand Rounds  
Ingham Medical Center - Lansing  
Noon - 1 pm
- June 8 Medical Ethics Conference  
E. W. Sparrow Hospital - Lansing  
8 am

PORTRAIT  
UNVEILING

Unveiling of a portrait of Andrew D. Hunt, MD, founding dean of the MSU College of Human Medicine, is slated for May 16.

Funding for the painting; which will hang in the MSU Life Sciences Building, is largely from contributions by College of Human Medicine faculty. The artist is William Smith of Bucks County, Pennsylvania.

Among those who will give remarks during the unveiling ceremony will be the dean of Harvard Medical School.

BLOOD TRANSFUSION  
REFUSAL:  
A READER COMMENTS

I have some comments on the Case of the Jehovah's Witness Refusal of Blood Transfusion: (Winter 1980 issue of this newsletter)

I agree with Beals and Miller that the Jehovah's Witness should not be transfused. My reasoning is somewhat different, and I believe there is another crucial issue here. Decisions to follow or not to follow certain courses of therapy should be based on the relative balance of the life purposes of patient and therapist and on the social decisions concerning the allocation of resources made "available;" that is, on social purpose and social means.

If the balance of therapeutic means and/or ends violates the patient's concept of life or life purpose, he or she should refuse treatment, and this refusal should be respected. In the case of the Jehovah's Witness, the therapy which seemed reasonable to the physician might have seemed suicidal to the patient. In contrast, the physician may have regarded the patient as deluded and/or suicidal in her refusal of the therapy. Whether or not such differences are decidable is a complex issue.

If the purposes of the patient severely contradict, violate or threaten to violate those of the physician, the physician should transfer the patient to another physician. This might occur if the patient, during a period of lucidity, avowed that he or she would kill the physician or some member of his or her family (or anyone else); it might also occur if the patient had committed gross (political) crimes or intended to do so, as in the case of the Shah of Iran. The physician's treatment in such a case might be regarded as complicity, or as a form of suicide, a sacrifice of self. The physician's responsibility to heal (and not to heal), moreover, extends not only to his or her patient and her or himself, but also to the broader society.

It is not clear to me what the physician should do if no other physician is available. In part, solution of this dilemma would accord with the prior commitment or contract between the physician and the patient (as well as with other therapeutic agents.)

There is also a question of "available" resources. What is available depends in part on how much one or all are willing to expend achieving it. While the patient would not have "survived" a return to Houston, perhaps a saline-primed oxygenator pump could have been flown in from elsewhere; or perhaps an expert in some other form of therapy might have been brought in; or perhaps the patient might have been "saved" by some extravagant therapy never used otherwise because of prohibitive cost. The question then is, "How much of *our* limited resources (in time, money, personpower, or other forms of therapy, etc.) are we going to spend on any given patient, and how much on the particularities of individual patients?" How broadly should we define the social units which "possess" resources, and for whom resources should be expended? Unwittingly and/or politically, but not rationally, decisions on such vital issues are "made" in practice if not by plan.

The condition of patience (ie, the bearing of affliction) as well as sources of disease and its relief, are more widely distributed through society and its environment than is commonly assumed.

Robert Hahn      Postdoctoral Fellow, MSU - Medical Anthropology

THE MSU MEDICAL  
HUMANITIES PROGRAM

For most of the value-laden questions that arise in the medical context, there are no experts and no unequivocally authoritative answers. The thoughtful collaboration of those trained in medicine, nursing, religious studies, history, law and philosophy can, however, help us to make more thoughtful decisions.

The aim of the MSU Medical Humanities Program is to assist the academic community in its efforts to understand and enhance the interrelationships of medicine, health, and the humanistic disciplines.

The program aims to stimulate inquiry by medical professionals, academicians, students and laymen and to heighten public awareness and understanding of the various issues.

The Medical Humanities Program coordinates teaching, facilitates research, provides consultation, and encourages general collaboration between medical and humanistic disciplines.

The Medical Humanities Report is published Fall, Winter, and Spring terms. Program coordinator is Andrew D. Hunt, MD. Assistant coordinator is Martin Benjamin, PhD. Editor is Linda Christensen.

We invite letters in response to the Case Commentary and other newsletter articles. Write: Medical Humanities Program, A-110 East Fee Hall, Michigan State University, East Lansing, MI 48824. Ph. 517/355-7550.

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