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# Views on Prophylactic Oophorectomy

James J. Quinn, S.J.

*Five opinions on the removal of pre-cancerous ovaries are presented in this article by Father Quinn. His own opinion astutely bridges the traditional/liberal arguments.*

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"Prophylactic oophorectomy has been recommended for a 50-year old woman by her gynecologist because both her mother and sister died of a primary ovarian carcinoma. Results of physical examination and Papanicolaous smear test are normal. What is your consultant's opinion?"

This question appeared in the *Journal of the American Medical Association (JAMA 227:675, 1974)* in a column entitled "Questions and Answers." Five individuals — two consultants, the woman herself, and two editors of *JAMA* — gave their solution to the problem. Before I state my position, it is only fair that the views of these people be properly presented.

First, there are pertinent facts you should be aware of so the question can be considered in the proper perspective. At the present time there are no early signs or

tests indicating the likelihood of developing cancer of the ovaries, and the first evidence of symptoms in the majority of cases indicates an advanced and uncontrollable disease.

It is also a fact that there are a number of families with increased risk of ovarian carcinoma under study at the present time, and among some of these there has been a high occurrence of prophylactic oophorectomies and total hysterectomies. Here, because of the high risk of cancer and death and the lack of early diagnostic techniques, surgery seemed indicated.

Secondly, allow me to explain what I consider to be the traditional morality of prophylactic oophorectomy. The approved moral standard has been that diseased ovaries could be removed if the patient's health or life is seriously threatened. It is, however, morally wrong to remove healthy ovaries. In some of our hospitals one can find Quality of Care and Standards of Practice Committees which oppose prophylactic oophorectomies almost routinely, looking upon them as unnecessary castrations. Also, some Tissue Committees judge the removal of healthy ovaries to be malpractice

or negligence. So, traditionally, good medicine and good morals dictated that only organs which manifested a pathology and which would be detrimental to the patient should be removed.

### Two Opinions

The two *JAMA* consultants depart quite emphatically from this position. The first consultant, Vincent T. DeVita, M.D., from the National Cancer Institute, Bethesda, Maryland, stated that available statistics indicated that if one member of the family developed ovarian carcinoma, the risk to other members of the family is small. However, when a second member does develop the disease, the risk to other women in the family rises significantly. Dr. DeVita gave no statistics for the risk, but Henry T. Lynch, M.D., Chairman of Preventive Medicine and Public Health at Creighton University School of Medicine, believes the risk may be significantly increased and in certain families may even approach fifty percent.

Dr. DeVita claims it is not usually possible to diagnose ovarian carcinoma early enough to effectively control the disease. Because of this inability, he believes that prophylactic oophorectomies should be seriously considered, provided the decision is tempered by the patient's age, marital status, and her desire to have a family. "In this patient, these factors weigh in favor of oophorectomy," is his conclusion.

Hugh R. K. Barber, M.D., from

Lenox Hill Hospital, New York, with the second *JAMA* consultant to answer the question. He offered more statistics. First, he pointed out that ovarian carcinoma is the leading gynecologic cause of death; and normally, 10 women in 1,000 over the age of 40 develop this particular disease. The peak risk years are 40 to 60, and it is after the patient's 50th birthday that eight out of nine malignant neoplasms of the ovary develop. For the past two decades the number of deaths has remained the same — 10,000 women die from this neoplasm each year. The survival rate for invasive cancer is poor — 15% to 20% live for five years.

After stating these facts, Dr. Barber adds a note of concern for the patient: "The sword of Damocles will hang over this patient's head for many years since the ovary may be too old to function, but is never too old to develop a malignant neoplasm." He then concludes: "A strong case has been presented for a prophylactic oophorectomy in this patient."

If Dr. Barber is drawing his conclusion from the statistics he gathered, then he is thinking along the same lines as Dr. DeVita. But he may be saying something different. He puts the "Sword of Damocles" last in his list of arguments. It seems that he attaches some importance to it, but what is the force of the argument? Is it emotional, i.e., sympathy for the woman, or is it

rational, e.g., an argument based on the principle of the lesser of two evils? If it is the latter, he would judge that the removal of the ovaries is a lesser evil than living in oppressive fear of cancer and premature death.

### **The Patient's Decision**

What was the final decision of the woman in the case? Nowhere does *JAMA* quote her directly, but the editor added a note at the end of his column that answers the question: "Followup. — The patient could not be convinced that ovarian cancer is a silent disease and, consequently, preferred to wait until symptoms developed. — ED."

It would be interesting to know what she understood by "silent disease." Maybe she thought it meant that the ovaries would develop cancer without warning signs and when discovered it would be too late for life-saving surgery. Or did she think there was something about her ovaries that made them an easy prey for carcinoma? Whichever, her wish to wait for the appearance of physical signs is consistent with those who think along traditional lines.

It is difficult to evaluate the position taken by the editor of "Questions and Answers." If he was aware of the attitudes of the consultants before he asked them to respond, one might surmise he agreed with them. However, I do detect a slight favoring of the traditional point of view. For what other reason would he report the

patient's reactions? Her attitude, placed at the end of his column, has the ring of a victory bell.

The last point of view to be considered comes from another editor of *JAMA* who directs the "Letters Department." A colleague of mine wrote a letter recently to the magazine agreeing with the consultants' views on prophylactic oophorectomy. The editor wrote back expressing his doubts and difficulties with my colleague's liberal views. It was easy to see that he was not about to reject the traditional position. From the tone of his letter, if I read him correctly, surgery would be tantamount to unnecessary castration. To put it morally or legally, any doctor who removes a healthy ovary for prophylactic reasons is guilty of malpractice.

It seems that all five opinions had different starting points. Though I agree in part with all of them, my starting point is different. I am not going to defend my approach to the problem. All I plan to do is present the way I arrived at my answer.

### **The Total Situation**

Whenever oophorectomy is brought up as a prophylactic treatment in avoiding cancer, the woman's total situation should be considered. I do believe that any "decision will have to be tempered by the patient's age, marital status, and desire to have a family." Here I agree wholeheartedly with Dr. De Vita.

What this should mean is that the woman makes the final de-

cision; but, if she is seeking counsel, all the pros and cons of surgery must be presented to her, even though the physician strongly prefers one course of treatment over another.

Much has been written about the patient's right to be informed before consent or refusal to a medical procedure is given. Most of these articles state that the physician has an obligation to inform the patient of the essentials in the treatment, i.e., after-effects, cost, pain, time, alternatives, etc. If the physician does this, then the patient who agrees is said to give his "informed consent," and one who disagrees gives his "informed refusal." These are two sides to the same coin and they must always be presented as distinct possibilities when the physician informs his patients. The physician may think his suggested treatment is best, yet he should not withhold any piece of essential information which he suspects will cause the patient to refuse treatment. To do so may truly be for the good of his patient, but it destroys the physician-patient relationship, because thereby the physician has complete authority over the patient, since he takes on the patient's personal burden of protecting his life and preserving his health. When this happens, the patient is robbed of his free choice; he is being treated as an object and not a person.

Maybe, in the future, certain discoveries may make decision-making less disparate. For in-

stance, attempts are being made in various parts of the world today to discover scientific ways to diagnose cancer. When these are discovered, the whole problem of prophylactic surgery might end. Suspected subjects could be tested, and, at the first sign of cancer, therapeutic surgery could be performed. But what will most likely happen is that prophylactic surgery will be performed when premonitory cancer indicators disclose the precise risk status of the patient.

Also, those who follow the traditional approach to prophylactic oophorectomy may change their minds and call the operation therapeutic when the cause of "familial" ovarian cancer is discovered. This is quite probable if the cause is clearly defined and demonstrated to be hereditary, because then the ovaries from birth could be classified as "diseased," i.e., aberrant in a very subtle manner rendering them cancer prone.

It will take something as dramatic as the discovery of the etiology of ovarian cancer to change the traditional attitude on prophylactic oophorectomy. And rightly so. The profession must be protected from calumny in order that physicians will continue to be approached by people who need medical care. Being conservative in accepting change is one way to prove to patients that they are the primary consideration of the medical profession.

One area of conservatism shows

up in the reluctance surgeons generally show when asked to correct some psychological defect by using the scalpel. For the woman whom fear has petrified because of the high risk of contracting cancer, I do believe that gynecologists who are normally opposed to prophylactic oophorectomy should do surgery to alleviate her oppressive fright.

Apart from fear as a major consideration, I must say that I find it hard to reject prophylactic surgery in cases like the one presented. Parts of the body may be sacrificed for the good of the whole person when excision is a good way to benefit the patient. But must these parts always be pathological? Not always. Twenty-five years ago some surgeons routinely removed enlarged tonsils and adenoids which were non-pathological, and even today healthy appendices are excised during surgery when the area is exposed for some purpose other than an appendectomy.

Also, another prophylactic operation which resembles to some extent our present case is routinely done, i.e., a colectomy, prior to the development of adenocarcinoma of the colon in such well-defined genetic disorders as familial polyposis coli and Gardner's syndrome. The resemblance is in one area only. When the colectomy is performed, the colon shows no signs of active cancer. However, signs of its approach are the polyps, and the risk of developing cancer is 100 percent by

the fiftieth year. The over-all risk to female members of families which have a history of ovarian cancer has not approached 100 percent.

There is truly a vast difference between these two cases, but I wonder what the procedure would be today if the risk of developing adenocarcinoma could be reduced, to say 50 percent. The way I see it, colectomy could still be performed routinely.

### Two Judgments

In making this last judgment, I am saying two things. First, the tissue that is removed does not have to be pathological. To lessen any reservations one might have of my views, let me say that I am not creating a new principle, but am looking beyond the barriers erected in the past around the principle of totality. The removal of parts was restricted to parts that were pathological. I believe this principle also extends to the removal of healthy parts if the whole being is benefited thereby. Therefore, prophylactic oophorectomies in cases of high risk of developing cancer seem to me to fall under the natural law from which the principle of totality is derived.

The second thing is that tissue which is removed does not have to be in a condition that will certainly bring death unless removed. I believe it is enough that it be a threat in which the risk of dying is greater than normal. One should not expose himself to

death unless he has a good reason. If the reason is not good, the danger should be removed.

Maybe many women in families which have a history of ovarian cancer will say that they have

good reasons for postponing surgery until menopause. I might even go so far as to say that if the desire for children is not there, the woman has an obligation to remove the danger to her life as soon as she is aware of it.

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## Book Review

### **Pastoral Care of the Sick**

Edited by the National Association of Catholic Chaplains  
Washington, D. C.: U. S. Catholic Conference, 1974

This publication is meant to be a handbook for Catholic chaplains in health facilities. It consists of seventeen articles written about various aspects of pastoral care of the sick and handicapped. The authors of these articles will undoubtedly be known by Catholic hospital chaplains, and all are obviously writing from a very rich experience in the pastoral care of the sick.

After an excellent introductory article regarding the theology of pastoral care of the sick by Walter J. Burghardt, S.J., and a brief history of health care delivery in the United States, an article on the pastoral visitation of the sick offers some very practical guidelines. The next article provides a job description of the Catholic chaplain and sets down the necessary qualifications for the office. This is followed by a chapter presenting guidelines for organizing a pastoral department in a health facility.

The above articles, which deal with the general health facility, are followed by discussions of specialized chaplaincies. There are individual chapters dealing with the chaplain in the mental hospital, pastoral ministry to the mentally retarded, to the aging, to children, and to the drug dependent. Even such a specialized chaplaincy as that to patients who are legally confined is treated in the book. The final chapter deals with ministry to the handicapped, particularly the deaf-mute and the blind, written by a man with many years of experience in the field, Thomas F. Cribbin.

The handbook also includes an article treating the function of the chaplain as teacher, that is, communicator of the Gospel message. Methods are suggested in which the chaplain can best fulfill this function in his relationships with patients, hospital staff and the local community. In addition, the