Otolaryngology–Head and Neck Surgery (2006) 134, 351-353

LETTERS TO THE EDITOR

Bioethics of Appearance and the Quality of Life Issue: Who Makes the Decision?

The article by Sulmasy[1] presents interesting and important observations on ethical issues concerning otolaryngology and head and neck surgery. Moreover, it very intriguingly deals with one of the eternal questions of philosophy, namely, the relationship between ethics and esthetics. Sulmasy enters this traditional debate by revisiting Plato's philosophical system consisting of 3 basic values (forms): beauty, truth, and goodness.[1] Sulmasy structures his observations around a particular case of a patient who, at his own insistence, had undergone a total glossectomy and laryngectomy for squamous cell cancer. His social supports were weak. He was homeless, unemployed, and had just recently moved to New York after living much of his adult life in a California hippie commune abusing drugs, alcohol, and tobacco. He stated that his diagnosis led him to religion and a life without addiction. He did remarkably well with surgery, and his recovery was quick. Although rendered unable to eat or speak, with a large scar, and with a high likelihood of dying from his underlying disease, he seemed optimistic and happy. Sulmasy ends this case report with the question, "Where is the beauty, truth, and goodness in such a situation?"[1] He then takes into consideration Plato's argument that goodness and truth are deeper than the mere appearance of beauty.

When we reflect on Plato and his contemporaries, we cannot ignore the figure of Hippocrates who lived in more or less the same period and was probably influenced by Plato's philosophical deliberations. We also know that Plato admired Hippocrates' work.[2] Should we, therefore, consider the possibility of putting this case report in the framework of traditional medical ethics, so-called Hippocratic ethics, which is based on 2 main principles: nonmaleficence and beneficence?[3]

We encountered a distressing case at the Clinic for Maxillofacial and Oral Surgery in Rijeka, which enriches the debate but presents a slightly different perspective. Our 68-year-old patient visited our clinic for the first time in 1971 when a right-side jaw tumor mass was diagnosed. He refused both biopsy and surgery and for 20 years avoided any examination. In 1991, he presented a large tumor the size of a child's head localized to the right half of the jaw but crossing the median line. The tumor mass was present in the entire oral vestibule with protrusion into the oral cavity and tongue as well as to part of the cheek skin, which presented multilocal scars and purulent fistulations. He was not able to speak and swallowed with great difficulty. This time he agreed to a biopsy, which showed a planocellular cancer. He underwent extensive surgery during which subtotal mandibular, maxilla, and tongue resection was performed. Because of metastatic lymph nodes, a radical neck dissection on the right side and a selective one on the left side were performed. At this time (he was hospitalized 4 times in 6 years), he underwent reconstructive surgery using a microsurgical radial free flap and a microsurgical fibula free flap. Because of postoperative infections and fistulations of the cheek skin, additional reconstructive surgery was done using a tubular inguinal flap. The general esthetic result was not satisfactory, but the functional result was very good. The patient regained the ability to breathe, swallow, and speak. The tissue donor sites healed well, and no signs of recurrence of the tumor in the operation field were found. However, a conflict occurred because the surgical team insisted on further reconstructive surgery to produce a more satisfying appearance for the patient, but the patient was persistent in refusing any further operative procedures. As he repeated on several occasions, the reason he underwent surgery in the first place was the loss of function, not the disfigurement.

Now let us return to the section of the previously mentioned article by Sulmasy in which the author considers 2 situations in which surgeons confront ugliness and deformity, first when they restore the natural beauty ravaged by injury or disease, and second when they have to undertake procedures that cause deformity. We analyzed our patient from the perspective of the question, "In the name of beauty, truth, and goodness, by what authority might any person claim to do such things?"[1] Our analysis gave us no satisfying answer.

At this point, our case prompts us to turn toward the modern concept of the body as an object of bioethical deliberation[4] and enters the framework of 1 of the 4 main bioethical principles (ie, the principle of autonomy).[3] More precisely, we take up the procedure of decision making and the process of giving and obtaining informed consent, especially considering consent to procedures involving quality of life. Seen in this context, our case challenges Sulmasy's statement: "The beauty you strive to restore must be for the good of the patient. And any beauty you forgo for the sake

doi:10.1016/j.otohns.2005.10.024

of cure or palliation must be for the good of the patient."[1] The statement, although correct, is incomplete because it does not specify who has the authority to decide what defines the good of the patient. Accepting the fundamental principle of respect for patient's autonomy, we argue that it should be the patient who decides. In our case, the patient resolutely decided not to submit himself to any further procedures because in his opinion he had obtained the goal of surgery that he sought—regaining satisfying function. In his perception, an adequate quality of life had been attained.

In conclusion, in his article, Sulmasy[1] importantly turned the attention of both surgeons and bioethicists toward complex issues on which some concrete guidelines could, with great difficulty, be made. We suggest that an open discussion with an interdisciplinary team (which is one of clinical bioethics' more important characteristics) could greatly help this dialectic process that has become central to modern medicine and work to ensure that the patient is respected as the active subject of decision making.

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doi:10.1016/j.otohns.2005.10.024

Response to Sorta-Bilajac

Among the privileges of working in bioethics are the staying power and the universality of the work. It is gratifying to know that an article written in 2001, based on a talk given in Denver, CO, has attracted the attention of a group of surgeons working in Croatia in 2005. The questions they raise are timeless, deserve our careful attention, and make our efforts to reflect on the writings of such luminary figures as Plato and Hippocrates worthwhile.

Yet it always comes down to cases—*this* patient, at *this* time, in *these* circumstances. The case described by Sorta-Bilajac et al raises the perennial question is beauty merely in the eye of the beholder? In other words, does adherence to the principle of informed consent imply that the beauty of a patient is defined solely by that patient?

I would answer, no. Beauty is always particular, but this does not mean that it is merely subjective. The authors have provided us with enough detail to understand that their patient's refusal of cosmetic reconstruction expresses a very deep beauty—the beauty of a person with a certain toughness, a lack of concern for the superficial notions of beauty that often preoccupy the rest of us, and a nobility of character and a humility that demands from life no more than is necessary. It seems that their patient has taught them these lessons. These are lessons particular to their patient. Informed consent did not define this beauty but gave it the space to express itself. Only through violence could this beauty have been suppressed.

This is why, in the article cited by the authors, I described John Conley as one who "believed firmly in the doctrine of informed consent, sharing the truth with his patients and involving them in all his treatment decisions."[1] Wise surgeons do not obtain informed consent before cosmetic reconstruction because beauty is a subjective notion, but because it is through the process of informed consent that they (and their patients) will have their best chance of discovering the beauty, truth, and goodness that are already there to be discovered.

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doi:10.1016/j.otohns.2005.10.025

Conductive Hearing Loss in Facial Nerve Schwannoma

I read with great interest the article "Facial nerve schwannoma presenting as conductive hearing loss" by Dr. Montague et al.[1] The authors presented a case of a facial nerve tumor confined to the middle ear cleft, where the main presenting symptom was a unilateral hearing loss confirmed to be conductive in type on audiometry with a deficit of 35 dB. I am particularly concerned about the post-operative hearing threshold that showed no improvement even after 18 months duration of follow-up. Despite the constant and common symptoms of facial nerve schwannomas, the presenting symptom(s) depend entirely upon the site of origin and the size of the tumor.[2] In the present case, I assume that conductive hearing loss was caused by subsequent interference or disruption of the ossicles, as shown by other authors.[3,4] The authors, however did not comment on the