



Lu Jian Jun. *Antique Dressing Table*, 2002. Oil on canvas, 54" × 54".
Courtesy of Weinstein Gallery, San Francisco, California.

*Integrating the virtues and
principles of bioethical
decision making will assist
in selecting appropriate
management choices for
patients with head and
neck cancer.*

Ethical Considerations in the Treatment of Head and Neck Cancer

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Background: *The second half of the 20th century saw not only important developments in medical science and technology, but also a rapid growth in the application of biomedical ethics in medical decision making. Withdrawal of treatment, allowing to die, informed consent, and patient autonomy are concerns that now comprise a part of the overall medical treatment, particularly in patients with head and neck cancers.*

Methods: *The author discusses ethical issues relating to disfigurement/dysfunction in head and neck cancer patients and examines the aspects of "principlism"—autonomy, nonmaleficence, beneficence, and justice. Two case reports are presented to illustrate the ethical challenges that may confront physicians who treat head and neck cancer patients.*

Results: *Head and neck oncology generates unique problems relating to disfigurement and dysfunction. An algorithm that considers the patient's medical good and greater good, as well as the goods of others, can assist in arriving at appropriate ethical decisions.*

Conclusions: *Bioethical decision making requires the integration of virtues with principles, followed by the application of these standards to each patient.*

"Ethics [. . .] begins with the character of the physician."

-- John Conley, MD

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Introduction

Ethical considerations in the treatment of head and neck cancer comprise a relatively unexplored area within the context of overall cancer care. Intensive study has focused on nonmedical aspects of cancer

care, and many of the ethical issues involved in head and neck cancer are arguably no different than those in cancers of other parts of the body. However, head and neck oncology is associated with unique sequelae, often involving changes to the patient's personal identity.

In cases where disfigurement, dysfunction, and the threat to personal identity are possible consequences of disease management, decisions about treatment planning can become even more complicated than they would otherwise be in treating life-threatening disease. When death is certain or possible, weighing quality of life, treatment morbidities, and length of life against one another is already problematic. In cases where threats to the identity or "intactness" of the person are possible, another issue in cancer care is added. Pneumonectomy, mastectomy, prostatectomy, and bowel resection are life-altering interventions, and decisions to consent to these procedures do not come lightly. The results of these treatments are not necessarily visible to others and do not inevitably change physical appearance or alter social functioning to the degree that laryngectomy, mandibulectomy, and orbital exenteration can. Although an isolated patient may have no more hesitation in submitting to composite resection than to gastric resection, that is not to say that there is no difference in what the patient may be confronted with in giving consent to these interventions. In cases of head and neck cancers, the question of what treatment approach is appropriate, or whether treatment should be considered at all, is accompanied by additional unique questions, such as whether a fundamental change in personal identity can be tolerated, or even whether disfigurement/dysfunction is seen as identity altering at all. Patients with head and neck cancers may be more vulnerable, with their values far more at stake, than patients with other serious diseases.

Thus, it is not surprising that studies to date on the ethical aspects of head and neck cancer have tended to focus on quality-of-life issues as well as more theoretically oriented issues such as moral principles.¹ Quality-of-life studies have included such aspects as psychosocial issues of the head and neck patient — self-image, coping abilities, social relationships, performance and functional abilities, and scales for measuring patient perceptions of disfigurement/dysfunction and quality of life.²⁻¹² Meanwhile, the more theoretically oriented ethical issues have addressed patient autonomy, the character of the physician in the healing relationship, the meaning of life-threatening disease for the patient, informed consent in a highly vulnerable patient, and the line between physician persuasion and coercion.¹³⁻¹⁷ Pellegrino¹⁸ offers the most thorough assessment of this and was the first to offer a systematically related set of clear moral principles combined

with virtues in an approach to ethical decision making. The present article is an attempt to pursue the importance of character and virtue ethics in head and neck cancer a bit further.

Disfigurement and Dysfunction: Loss of the Person

Patients with life-threatening disease are faced with the burden of trying to approach the final chapter of their life narratives in a way that fits their values and prior life experiences. As Conley¹⁴ has noted, we in the West tend to view death as either an outside agent "intruding into human existence as the ultimate mutilation" or an integral, natural part of the human experience. Regardless of our views, we are dealing with the end of being. Nothingness, the void, the end to consciousness are all offensive to the human spirit. The fear and anguish accompanying such thoughts can be overwhelming in contemplating death.

In the patient who also suffers disfigurement or loss of function, that fear and anguish may be compounded due to several factors. One is that disfigurement may be perceived as a manifestation of the grotesque. The disfigured person is seen, at least subconsciously or symbolically, as something less than fully human, even to those close to him. The individual is surely no less human than before, but a radical change in appearance to the "unnatural" is suggestive of the monstrous, which may then become threatening or frightening and thus repulsive. This can then result in the change of identity of the person, if only minimally and symbolically. Those visible aspects by which we are known in our uniqueness — our facial appearance and the sound of our voice — cannot radically change without that identity being altered and thus "lost." What is lost, then, is not only the unique identity of the individual, but also the "humanness" of the person.

Another factor that compounds fear and anguish is the very loss of personal self. The individual who existed prior to the disfigurement or dysfunction is gone, even while the body continues to live. An enormous gap is then opened between the altered individual and others. The patient is now a stranger in what can be a frightening space without the usual network of connections. The mere suggestion of the grotesque has a distancing effect. The patient is now a person apart, with relationships with others having been broken at some level. Like the protagonist in ancient Greek tragedy who must suffer removal from society because something in his character renders him incompatible with the establishment, the disfigured patient is also seen as someone estranged, at least symbolically. The

separation of the protagonist in Greek tragedy may be effected by his actual death; the disfigured individual may suffer a symbolic death.

Therefore, in head and neck cancer cases, attention must be paid to a loss of or potential change in identity, a loss of the self, or the death of the person within an otherwise living body. Experience shows that some patients do cope well. Studies have also demonstrated that while psychological problems may increase in severity over time,⁶ appropriate interventions to develop coping skills can mitigate these problems.^{4,19} This may seem to be intuitive, but it would be insufficient to teach coping skills without also addressing the loss of self such that patients may be enabled to make their “death of self,” as well as their impending physical death, part of a meaningful whole life narrative that they author. That is, they must be returned to control of their situation. This depends on many factors, such as length and history of the illness, as well as psychological and spiritual issues. Most important is that patient values and a narrative construct compatible with them be seriously addressed if the healthcare team is to help patients make appropriate choices in terms of their care.

To help their patients make those appropriate choices, physicians must develop some understanding of each patient’s value system and life view, whether it be profoundly religious, philosophically highly sophisticated, or relatively simple and unsophisticated. Some argue that it is unrealistic to expect the physician to develop such an understanding.²⁰ Others argue that acquiring some understanding of a patient’s values and life history is not unreasonable.²¹ This article makes the argument that some understanding, albeit limited, of the patient’s value system is possible, and that the physician has a moral imperative to make the attempt to understand it if a true fiduciary commitment is to be kept.

A final point should be made here. Even without the threat of disfigurement or dysfunction in a given case, there remains a problem of intimacy. With head and neck disease being the site of much of the visible manifestation of the person, and to the extent that this is related to the unique character and personality of the individual, head and neck disease affects intimate aspects of the person. The treatment of patients with cancer of the head and neck requires sensitivity to this issue, even if disfigurement or dysfunction does not occur.

Rethinking Rules and Principles

The best known approach to biomedical ethical problem solving that has developed over the past 30

years is principle ethics, or *principlism*. This approach involves examining pertinent aspects of a troubling ethical situation from the point of view of each of the now canonical “four principles”: autonomy, nonmaleficence, beneficence, and justice.²² Principlism requires examining not only the pertinent medical facts of the case, but also the effects of any decision on others (eg, physician, family, society) and any other factors that may have moral claims in the given situation. Because conflicts between principles frequently develop, and especially, it seems, between autonomy and beneficence, the challenge is to specify precisely what each means in a particular case and then balance the principles against one another in an effort to determine which one(s) should take precedence. In cases where the physician recommends continued treatment, believing that real medical good can be accomplished, and where the patient has decided that being allowed to die is appropriate according to his values and life story, autonomy and beneficence must be very carefully specified and balanced. Despite its prominence in the canon of bioethics, however, principlism has its critics. Some argue that principlism by itself is insufficient for ethical problem solving,²³ and others maintain that it is not a systematic method at all but rather a loose collection of principles with no structured process of decision making.²⁴ A discussion on the internal validity of principlism is not included in this article, but some specific aspects of it warrant rethinking, especially in view of disfigurement/dysfunction, loss of the person, and intimacy problems as found in patients with head and neck disease. Particularly important are autonomy and beneficence, as well as sub-elements of each — informed consent and paternalism, respectively.

In principlism, each of the four principles is theoretically equal to the others, at least until the process of specifying and balancing their individual importance in a specific case begins. While there is no hierarchy among them in the abstract, autonomy has effectively become the trump principle today. If a conflict arises between a patient’s autonomy and one of the other principles, autonomy always seems to be the default (except when a patient demands something not medically indicated or that would violate the rights of someone else). The reasons for the ascendancy of autonomy in the 20th century are not reviewed here; suffice it to say that events such as the Holocaust, the Tuskegee Syphilis Study, and other violations of persons in the name of medicine or the good of humanity have been framed largely in terms of the lack of respect for persons and as cavalier paternalism. To respect other persons and their autonomy is to recognize their rights to self-rule or self-governance and their need to act freely, with understanding and without coercion if they are genuinely to act with true autonomy.²² Given the

emphasis Americans have historically placed on the rights of the individual, it is little wonder that autonomy would come to occupy a special place in ethical decision making. Where decisions in health care were once largely in the hands of the beneficent healer, they are now thought to be more appropriately in the hands of the autonomous patient.

This shift in healthcare decision making to the patient can be problematic. The pendulum has swung too far. It was appropriate for the kind of medical paternalism that prevailed up until approximately the midpoint of the last century to be countered by an assertion of the rights of individuals, but its replacement with an equally rigid principle of autonomy will not bear scrutiny as the obvious antidote. There is nothing that argues for autonomy as the antithesis of beneficence except that paternalism, a sub-element of beneficence, will violate another's autonomy if practiced in the extreme. The idea that paternalism, and beneficence by extension, are the opposite of autonomy has emerged as the result of a particular and unfortunate history. Events such as the Tuskegee Syphilis Study, although they are undeniable gross violations of the rights of vulnerable individuals and unquestioned abuses of other persons, are hardly analogous to the actions of the well-intentioned clinician who nevertheless violates a patient's autonomy with strong paternalism. Furthermore, as mentioned above, there is no theoretical hierarchy of principles. Principlists refer to them as *prima facie*, meaning that until it can be shown that one should take precedence over another in a given context, they should all be respected equally. In fact, save for some compelling factor to the contrary, there is no reason that autonomy and beneficence cannot be complementary.

Informed consent is also problematic and demands rethinking. It is generally understood that for consent to be truly informed, certain requirements must be met: the patient must be competent to understand what is conveyed, be able to make a rational decision, and be able to make the decision voluntarily and without coercion. The patient must also receive full disclosure of relevant information and must be given a recommendation by the physician.^{22,25} Determining whether all of the elements are satisfied can be difficult, and even if they are satisfied in a legalistic sense, informed consent may still be merely illusory. How competent can patients be and how clearly can they understand the information given to them when they are faced with life-threatening disease? We know that patients do not "hear" all that is communicated to them when they are in a highly vulnerable state. In addition, can we genuinely affirm that patients make free, uncoerced choices when offered recommendations under the Aesculapian power of their physicians? If informed consent

is truly meaningful beyond legal hoops to jump through to protect physicians and hospitals — and it must be if we are serious about our ethics — these are not just academic questions. In oncology of the head and neck, with its attendant issues of disfigurement, dysfunction, and/or loss of identity, it may be even less likely that any consent to treatment will be genuinely informed than in less threatening medical contexts. Unless these patients are extraordinarily endowed with coping skills and foresight, they are likely to either refuse the indicated treatment out of fear or decide they really have no choice other than to accept the recommendations. In the latter case, there is no truly informed consent. In the former, the coercion afforded by fear and/or the inability to have an accurate understanding of life posttreatment inhibits a truly autonomous decision.

Although the problematic nature of autonomy, informed consent, beneficence, and paternalism in medicine is a complex subject that cannot be covered adequately here, it is evident that these principles require careful consideration, especially in head and neck care. A man who presents with a massive tumor of the base of tongue, who will almost inevitably die of his disease, who receives a strong recommendation for total glossectomy so as not to succumb to an even more difficult disease process, and who nevertheless categorically refuses even to consider such an intervention can probably expect the surgeon to accede to his wishes, albeit reluctantly. The surgeon knows what the patient can understand only marginally at best, which is that the recommended therapy can make the dying process significantly easier, but he will nevertheless respect the patient's autonomy in refusal. This is not to fault the surgeon whose practice environment today will undoubtedly not allow the time to work through the issues with the patient in the hopes of bringing him to a properly autonomous, informed decision. However, if the issue of time constraints is set aside momentarily, there is a potential solution to the apparent conflict between the "beneficence" of the physician and the "autonomy" of the patient.

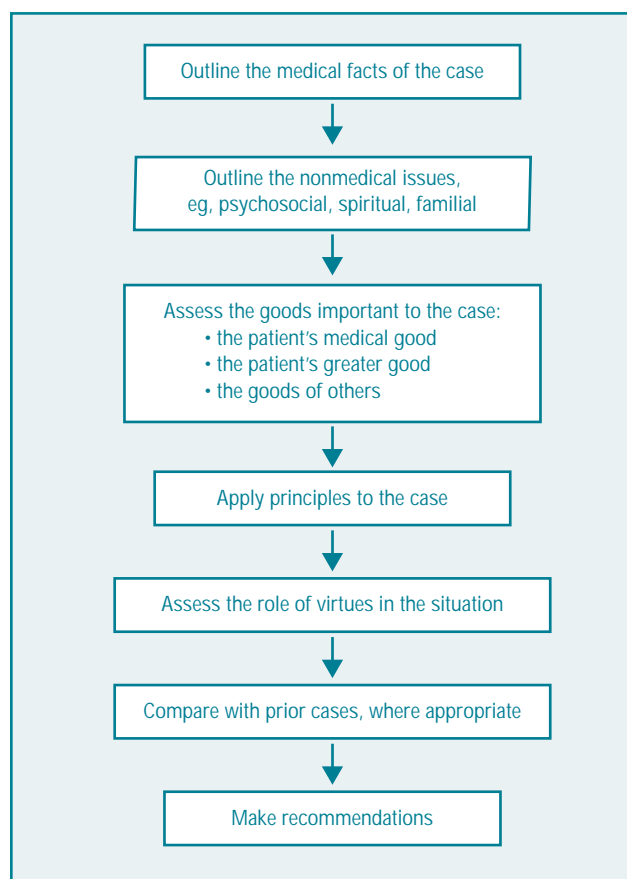
Pellegrino and Thomasma²⁶ offer possibly the best hope for resolution in their concept of "beneficence-in-trust," by which they mean "that physicians and patients hold 'in trust' . . . the goal of acting in the best interests of one another in the relationship." They describe this relationship as a fiduciary one based on the possibility of negotiation and one that rests on treating the whole person. It is guided by beneficence, but not a beneficence that can become paternalistic as usually conceived. This beneficence secures the patient's autonomy through negotiation and an understanding of the patient's values. Under beneficence-in-trust, the physi-

cian is the steward of patient values and preferences in a relationship that neither abandons the patient to some radical notion of autonomy nor becomes outright paternalistic. It is a relationship in which the physician seeks to ensure that the patient acts with real autonomy and informed consent. In this relationship, autonomy and beneficence would appear to flow together and avoid becoming antagonists. This cannot occur, however, without making virtue as much a part of the equation as principles, an issue that will be discussed below.

Ethical Decision-Making Model

A simple yet effective algorithm for approaching biomedical ethical decisions is presented in the Figure.

The first task in the ethical decision-making process is to ascertain the medical facts of the case. The second step is to assess relevant nonmedical issues, which is more challenging. It is here that we must attempt to come to some understanding of the state of mind of patients, their view of their illness history, their relationships with others and their social situations, the spiritual aspects of their lives, and any



Algorithm for biomedical ethical decision making. This scheme is an adaptation of a method for analyzing and working up clinical ethical problems used in the Schools of Medicine and Nursing at Georgetown University.

other factors that will help in understanding the context in which they will have to make a decision.

These steps are followed by an assessment of the goods important in the case. The most immediate concern is obviously what is good for the patient medically, but that is followed closely by an attempt to understand the patient's overall good — ie, psychological good, good in terms of family and relations, spiritual good, and good in terms of the patient's preceding life history and values. While ensuring the good of the patient is the primary goal, it is insufficient by itself, for the goods of others must also be considered; acting for the good of the patient would be inappropriate if that would mean a lack of respect for the goods of others. Physicians, hospitals, and other health care providers cannot be expected to violate their own values or stated policies.

The principles that apply in the case at hand are then examined, specifying what a given principle means in this case and balancing it against the moral claims of each of the others.²² This exercise may not be sufficient to guide us to a resolution of an ethical problem, however, especially if we refuse to accept autonomy as a *de facto* trump principle. By themselves, principles can become mere abstractions, perhaps even sterile nostrums for dealing with complex issues. Medicine, if anything, is a human and humane practice; it concerns not only the care of others, but also the relationship of the healer with the sufferer.²⁷ Thus, the nature of that relationship is extremely important.

Virtue ethics, another bioethical approach that has received increased attention in recent years, addresses the nature of the relationship between patient and healer, with particular attention to the character of the physician. Pellegrino and Thomasma²³ have presented a detailed analysis of how they interpret the virtues that are essential to medical practice. These virtues include prudence, compassion, fidelity to trust, integrity, self-effacement, justice, fortitude, and temperance.

Prudence is prudence, the kind of prudence that is defined as practical wisdom. It is the ability to choose right action with respect to all of the other virtues. Prudence is the virtue that shapes and guides the other virtues used in disposing one towards right action and good ends. It helps the agent address complex circumstances and discern the right and good in particular acts. In medicine, this means effecting a right and good healing action that is not only correct in terms of medical science, but also morally good in terms of all the interests of patients — their values, aspirations, needs, and beliefs. The character of physicians then depends on their ability to exercise prudence in the proper application of other virtues and principles.

Whether principles or virtues are considered first in approaching an ethical decision is irrelevant. It might seem preferable to work through clarification and balancing of the principles with one another first and then reflect on a tentative decision based on that examination through a thoughtful application of the virtues. The reverse may be just as effective. In any case, a consideration of the virtues in combination with principles achieves several objectives. It enriches the discussion of the case, focusing our attention on the human dimension of the situation and, chiefly through the careful use of prudence, it serves as a guide to a proper understanding and application of principles. While there is always room for error in trying to do the right thing, and while there is often no “right” answer to bioethical dilemmas, the approach described here, followed by a comparison of the case at hand with any prior similar cases, provides more guidance than reliance on principles and rules alone.

The following two cases examine the dynamics of principles and virtues in the context of different individuals and circumstances.

Case 1

A 44-year-old single woman presented to a private otolaryngologist with a sore throat, left otalgia, dysphagia, and a weight loss of 20 pounds over the previous 6 months. She smoked approximately 400 packs of cigarettes annually and used alcohol moderately throughout her adult life. A panendoscopy revealed an extensive tumor in the left hypopharyngeal lateral wall. A biopsy was positive for squamous cell carcinoma, which was staged as T3 N0 M0. She was given a tracheostomy and a PEG tube. She began a course of chemotherapy and radiotherapy that was completed 2 months later. Her tracheostomy and PEG tube were removed 3 months after that. Six months later, she represented with a lesion in the left hypopharynx just above the pyriform sinus, and she was referred to a major cancer center. The biopsy of this new lesion was consistent with squamous cell carcinoma.

Communications with this patient were difficult. She had a significant history of paranoid schizophrenia that required hospitalization at 20 years of age. She also had a history of epilepsy and had suffered two grand mal seizures during her hospitalization 1 year ago when her medications were stopped. The epilepsy was brought under control when medications were resumed. The patient also seemed to have limited mental capacity. She was competent to make her own decisions and had a pleasant demeanor, but she had trouble following a line of thought. She was

usually accompanied by her 65-year-old mother, with whom she lived. The mother would defer to her daughter’s decision about her own health care, but she was of no assistance in helping her daughter think through the issues. It appeared the mother also had limited capacity to process information provided by the physician.

When given the recommendation for a total laryngectomy with pectoralis major flap reconstruction, the patient at first appeared to accept that, saying, “Well, I guess we better do the operation then, right?” The surgeon responded that indeed he thought that the wisest course of action, but in wanting to ensure that she understood what that meant, he said, “Do you realize that we will remove your voice box in order to try to stop this cancer? We have ways of helping you communicate after the surgery, but you will not have your own voice box.” She then quickly responded that she did not want to lose her voice box. The surgeon explained that she could make that choice if she wished but that she would then certainly die of this cancer, would no doubt suffer more in the long term, and would be back on the feeding tube before long. “Oh, then I guess we’ll have to do the operation,” she replied. This circular conversation was repeated several times with the surgeon asking her to think about what they had discussed and return for another visit in a week. At this follow-up visit, the same pattern repeated itself. The surgeon determined that she was unable to make a rational decision.

In this case, the woman was competent in the eyes of the law and society to make her own life choices, ill-advised as they might be. However, inasmuch as she could not follow a rational argument, she was incapable of giving truly informed consent, or even refusing treatment, with an understanding of the consequences. Should the physician try to arrange for a more capable surrogate? First in line would be her mother, but she appeared no more capable than her daughter, and in any case, the patient would never be declared legally incompetent to make healthcare decisions for herself.

The medical facts and the psychosocial issues seem to be clear. Because we must assume that she is competent, albeit irrational and incapable of processing information effectively, it would appear that the only ethical approach is to defer to her right to make her own decision, to respect her autonomy. She cannot have beneficence forced on her. However, the bow to autonomy is too easy an answer in this case. Moreover, it neglects the physician-patient relationship while granting trump status to autonomy in a difficult situation.

If the virtues are made part of the calculus, we do not have to end up just declaring autonomy the winner out of some sort of default, and we can ensure a genuine caring for this patient. Guided by prudent choices, and practicing the virtues of compassion and fidelity to the patient, we are led in a slightly different direction. Compassion guarantees that the physician share the patient's suffering no matter what treatment she chooses, and fidelity ensures that he remains caring of her, does not "abandon" her, and keeps her greater good in mind, not solely her medical good. In focusing on the virtues as guides to the proper balancing of principles and focusing on character in relationship to this patient, we are led more in the direction of nonmaleficence than anything else. We cannot force her into a laryngectomy. It also appears that no amount of beneficent persuasion is likely to secure her consent and that whatever decision she makes will not be informed. However, if we fall back onto autonomy out of frustration, little more than abandonment results. In this case, nonmaleficence, the principle of doing the least harm, is the principle most in tune with virtuous professionals who maintain their commitment to their patients in a healing relationship. If we cannot do much good, we should at least do as little harm as possible. That means following this patient's wishes regardless of the harm that may come to her as a result, for to do otherwise would be to bring even greater harm on her despite the good that was intended. One of the fears the surgeon had, as his conversation with this patient developed, was that she might eventually consent to surgery, allow it to take place, and in another reversal regret the loss of her larynx after the operation. He was justified in fearing that this could well destabilize her and precipitate a serious crisis. This might then do her even more serious harm than if she were left with her disease unresected, and it would certainly destroy the physician-patient relationship, a *sine qua non* for healing of any kind to occur.

In the end, we must ask if there is any real difference in outcome if we yield to autonomy due to our inability to communicate effectively with this patient, or if we lean in the direction of nonmaleficence. We must answer that there is, for in the first instance, we have merely come down on the side of the abstract principle that seems to bear the greater weight, while in the second, we have focused on the character of the healer, that which is largely responsible for the relationship between physician and patient. This patient left the clinic and was lost to follow up, but the context in which she did so was significant. Instead of disconnecting or backing off and letting her have her autonomy out of frustration or because of impasse, the physician maintained the physician-patient relationship

through his exercise of the virtues. There was no indication that further attempts to bring her to some functional level of understanding would be successful, but in going through the decision-making process that he does, prudence ensures that he maintain his obligation to her in terms of fidelity. At the same time, the character of the physician is reinforced.

Case 2

A 70-year-old man presented with a history of squamous cell carcinoma of the larynx first diagnosed by a privately practicing otolaryngologist 1½ years earlier. He underwent primary radiation therapy at an outside facility, but that failed and he underwent salvage laryngectomy 3 months later. Six months postoperatively, he presented to a major cancer research and treatment center for evaluation for a tracheal esophageal puncture. At that time, the head and neck surgeon noticed a lesion in the posterior tracheal wall. A biopsy showed the lesion to be consistent with recurrent squamous cell carcinoma. The patient underwent a resection of the stomal recurrence with mediastinal tracheostomy, pectoralis flap reconstruction, total thyroidectomy, and partial parathyroidectomy. A 3.5-cm mass was removed at surgery, which showed high-risk features of perineural invasion and extracapsular spread.

Considerable debate over appropriate treatment developed between the attending head and neck surgeon and the radiation oncologist. The patient did not qualify for any of the protocols active at this center at the time. The radiation oncologist argued that there were no data available to suggest a likely positive outcome from re-irradiation in diseases of this type, and that he also would be concerned about comorbidities. Additionally, he expressed concern for a slippery slope, fearing that treatment off-protocol, as was being suggested, included a risk of damaging the research integrity of the institution. He also noted that the chance of cure in this patient was small.

The surgeon countered that while these observations were true, patients often came to the cancer center as a last hope when treatment elsewhere had not been successful. He agreed that the cure rate was approximately 5%, but he also believed that patients who want to continue to fight their disease should be offered whatever treatment the center reasonably could provide. As for the dangers of re-irradiation, he believed that if the risks were not absolutely contraindicated, then taking the risks should not summarily be ruled out since many standard medical therapies have resulted from calculated attempts to go beyond established norms. How can this be resolved?

The medical facts of the case are clear to the oncology team responsible for this patient's care. Inasmuch as this man has been in their care for the past several months, they have also become familiar with his family, especially his wife and niece who have always accompanied him. The family understands that the disease is serious and that his life is in jeopardy, but they and the patient look hopefully to the physicians to give him every chance at extended life. The patient's outlook remains positive, supported by a strong religious faith. He has said that he is eager to try anything.

The patient's medical good at this point is realistically limited to forestalling rapid progression of the disease and to palliation. His greater good now would be to come to terms with his approaching death. This means envisioning the remainder of his life in a way that is most fulfilling in terms of his values and past life, one that provides a satisfying and logical conclusion to his life narrative in some holistic sense. Any consideration of the goods of others is most appropriately centered on his family, and here their good is ideally to be an effective and meaningful part of the composition of this final chapter of his life.

This is a case in which the autonomy of the patient is not at issue, but certainly the other three principles need to be examined. Beneficence is the goal of the surgeon who would offer the patient additional radiation and possibly chemotherapy, for three reasons: to slow the progress of the disease, to palliate, and to offer the patient a tool that may be useful to him in crafting the end of his narrative. Despite the expectation that additional treatment may have no long-term effect, it is a symbolic tool in the patient's struggle, of his response to the events of his life, and it may figure prominently in the patient's effort to author that final chapter. The surgeon is also concerned with nonmaleficence, though to a lesser extent than beneficence. He hopes to prevent unnecessary harm to his patient — in this case, unnecessary suffering that can be alleviated by radiation.

The radiation oncologist in this case also has concerns for beneficence and nonmaleficence, though he views them differently. He believes the amount of good that can realistically be achieved is minimal, and he is genuinely concerned that re-irradiation may well bring more harm than is warranted for any good that may be accomplished. He is also legitimately concerned with the harm that may come to the institute if they begin to stray from its research mission, departing essentially from standard therapy outside of active protocols.

The major issue in this case could be viewed as a debate over justice. The surgeon has argued that the cancer center offers treatment to patients with little

hope of cure in an effort to "stay with them" and provide every last measure of effort available. Against this microview by the physician of this specific patient, the radiation oncologist has taken the macroview in favor of many potential patients. If the center's research program is followed carefully, avoiding off-protocol use of therapies not clearly indicated or of doubtful efficacy, the promise of doing more good for more patients in the long term is protected. His view is not one of unconcern for this patient but rather the espousal of the classical utilitarian approach of "doing the greatest good for the greatest number," which he considers as part of a research center's mission.

The problem could be solved by referring the patient to a privately practicing radiation oncologist who would not be faced with such a dilemma. While this is pragmatic, and the patient would receive the attending physician's recommended treatment, it circumvents an ethical issue that should leave us still feeling uncomfortable.

In this particular case, the virtue of fidelity to trust is significant. The patient has sought the help of the head and neck surgeon who has, in first accepting him as a patient, promised to use his knowledge and expertise to the best of his ability for the good of the patient. He has also promised tacitly to accompany him through his care. Although there is an appropriate way to refer this patient out, this physician would be abandoning his obligation to his patient in terms of fidelity to trust. The surgeon feels that if this virtue is not maintained, the physician-patient relation would be needlessly and thus wrongly broken. He views his current concern as his duty to *this* patient. This is not to discount the research mission of the center or the value to large numbers of persons if protocols are strictly followed, respecting the spirit and purpose for which they were funded. He nevertheless views his first priority, by careful practice of the virtue of prudence, to be that upon which the philosophy of medicine is founded, or the duty to effect a right and good healing action.²⁸ The healing in this case will clearly not be cure of the disease, but rather a faithful, compassionate response to the patient's having chosen the resources of this center in anticipation of care that will be responsive to his view of his situation at this time. The surgeon sees that as the greater good for this patient, given the patient's stance before the disease and the support of loved ones in terms of some meaningful struggle for all of them. In his mind, not to follow through with his own response to these needs, where he reasonably can, would be to fail in fulfilling his obligation to his patient.

Here again, including the virtues with a careful balancing of appropriate principles serves to maintain

the intimate nature of the physician-patient relation in terms of the classic philosophy of medicine. However, this is not to declare the surgeon "right" and the radiation oncologist "wrong." Both physicians are equally committed to patient good. Nevertheless, following the algorithm above ensures a more detailed, systematic view of the problems encountered in medical care and helps us become aware of the ethical foundations on which our ethical decisions can be based. If the purpose of medicine and its obligation to patients is to heal, there is no less an obligation to know how and why the decisions intended to do that are formed, regardless of what is meant by healing in a particular context.

Conclusions

Treatment of head and neck cancer raises interesting and compelling issues in terms of ethical decision making. These issues surface due to not only the disfigurement and dysfunction that often occur with treatment, but also the particularly intimate nature of that part of the body. Disfigurement and dysfunction are problematic because of concerns for cosmesis (personal appearance), and they also represent threats to the person or to personal identity. This is exacerbated because both the disease and therapeutic attempts at healing it are invasive of intimate body parts that are at least symbolically the site of much of the person's identity. These factors must be considered in addressing ethical issues in head and neck cancer.

In the treatment of head and neck cancer patients, an approach that includes the application of the established principles of biomedical ethics, a nuanced view of what the principles mean in a particular case, and a careful balancing of these principles against one another in determining which should take precedence in a given case remains inadequate. This approach is inadequate because, while we may arrive at an ethically appropriate position, it will be largely in terms of abstract principles. A careful and purposeful inclusion of the virtues is necessary to restore the focus on the physician-patient relationship, to guarantee the humane aspects of that relationship to the extent possible, and to develop and strengthen the character of the physician in this specialty dealing so intimately with critical elements in the nature of the person. In that way, we not only help to ensure that the physician-patient relationship is not merely an impersonal, albeit professional, one where the two parties are seen largely as autonomous equals, but we also reinforce the concepts of caring and responsibility that have always been at the foundation of a philosophy of medicine.^{23,28} Nonetheless, considerations such as these will

also bring us to a re-examination of some of the "sacred cows" of biomedical ethics as they are often applied today. Questioning a concept such as autonomy may raise the specter of a slippery slope, but that is a worthy risk in trying to assure ourselves that it is not being invoked reflexively because it is the "ethical" thing to do. Bioethical decision making through a process that includes thoughtful integration of virtues with principles is one way to do that. It is also one way to respond to Conley's call to ethics and character of more than 20 years ago.

References

1. Some might view quality of life issues as having but a tangential relationship to ethics, but to do so would be to define ethics too narrowly. Ethics is more than just principles, rules, and virtues. Normative ethics is inevitably grounded upon value systems, and it is those value systems that will be operative in making quality of life decisions.
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