Abstract

Head and neck cancer surgery is associated with unique sequelae, often involving changes in patient’s personal identity. In cases where disfigurement, disfunction and threat to personal identity appear as possible consequences of disease management, decisions about treatment planning can become even more complicated than they would otherwise be in treating life-threatening diseases. In cases of head and neck cancers, the question regarding the treatment of choice, or whether treatment should be considered at all, leads to some other questions, such as whether a fundamental change in personal identity can be accepted, or even whether disfigurement/disfunction is seen as impairing the identity at all.

Bioethical decision-making requires the integration of virtues with principles, followed by the application of these standards to each patient. The diversity of treatment in head and neck cancer patients is often very high. Therefore, it is important for both patients and medical staff to understand the many facets of adjustment to cancer, and the impact of treatment on the patient’s quality of life, as well as its medical impact. Psychological support is often necessary in assisting these patients to comply with all the difficulties they will encounter as a result of their illness. Even long-term survivors report difficulties in coping with this condition, and, therefore, clinicians must remember that patients are confronted with a lifetime adaptation when undergoing treatment for head and neck cancer, and they must make appropriate personal changes in order to assist them in ensuring the highest possible quality of life following this treatment.

Keywords: bioethics, surgical treatment, head and neck cancer

The diagnosis of cancer can have a shattering impact upon individuals and their families. Head and neck cancer is emotionally extremely traumatic because of disfigurement and functional impairment resulting from both the cancer and its treatment (1). Although some studies have dealt with the biomedical ethics and psychosocial issues regarding the patient with head and neck cancer, a comprehensive research in this area has not been conducted yet (2-4). From a psychological perspective, there are numerous concerns for the head and neck cancer patient, including the reaction to cancer itself, the threat of mortality, body image problems, fear of treatment (surgery, radiation and chemotherapy) and potential disfigurement, family, social and vocational problems, and normal psychological reactions, such as anxiety and depression (5,6).

Clinicians who deal with cancer patients must be prepared to encounter the same range of ethical problems as their colleagues in other branches of medicine. What gives the treatment of cancer patients its special moral status is the complexity of the physical, physiologic and emotional potentials of cancer diagnosis. In the case of head and neck cancer, these ethical aspects are enhanced by the real threat of disfigurement, the radical nature of some procedures, and even death, when treatment fails. These factors lead to an increased vulnerability of patients and of clinician’s ethical responsibilities, as well. The main ethical aspects of modern medical practice are clinical competence, respect and concern for patients and their health, treatment decisions, and the awareness of the patient’s need of being integrated in a changing social, economic and political climate. It is necessary to make the patient aware of both the cognitive and behavioral aspects of ethics. At the same time, achieving these aims depends on the character and training of the physician who will be applying these skills. John Conley said: „Ethics begins with the character of the physician” (7).

Weymuller made several remarks regarding the way in which cancer patients should cope with facial disfigurement (8,9). He noticed that the patient’s fear of dying of cancer was intense,
often overshadowing the fear of facial disfigurement. As the fear of possible death diminished, the process of accepting the mutilation could begin. It also seemed important for the patient to accept a different self-image. Therefore, as it seems, the best time to assist patients in returning to their careers or social activities is probably after they have accepted the facial disfigurement. Meeting again with relatives and friends may be of special concern for some patients. Family frequently provide an important support, their usual reaction is that of compassion. Other people may react in a different way, which may induce conflicting reactions from the patient. More than that, patients who experience facial disfigurement can be frustrated when they have to wait to be operated, especially if their treatment is postponed as a result of schedule problems, or they may be faced with lack of empathy from the medical staff. Permanent exchange of information among treatment team members may assist the patient in his recovery. Weymuller (2001) concluded that the process of adjustment to facial disfigurement is extremely difficult from a psychological perspective. The patient must cope first with the possibility of imminent and premature death and then he must accept the fact that his face may be disfigured and people will respond differently to this condition. Facial disfigurement is an extremely difficult challenge to adjustment because the face is in a visually prominent area of human anatomy, it is the mirror of animation, intellect, and emotions, and it serves as a means of communication with others. Unfortunately, society’s emphasis on physical attractiveness may impose additional burdens upon the individual who suffers facial disfigurement or disfunction following surgery. Part of a complete recovery involves a complex process described as body image reintegration, which occurs gradually over time as the patient learns to accept and compensate for anatomic alterations.

Many factors should be considered in looking at reintegration with respect to body image following head and neck cancer: age, sex, marital status, previous body image acceptance, the extent of structural and functional loss, extent of disfigurement, state anxiety (indicative of anxiety at a particular time), trait anxiety (an overall measure of one’s general level of anxiety), previous emotional stability, ability of the individual to be involved in self-care activities, and the patient’s self-acceptance in a social environment (10-12).

Psycho-social rehabilitation of head and neck cancer patient is a special area of work and a lot of associated factors should be considered. Patients have the right and responsibility to ask questions and receive honest answers, so that they can make the best possible decisions regarding their quality of life and treatment (13). It is necessary to consider the common aspects in a particular segment of population of patients (alcoholism), and the patient’s possible problems, such as: family conflict, difficult work histories and lack of satisfying personal relationships, which should be taken into account after surgical treatment. When these problems are associated with the illness, patient’s integration in society may be difficult. It must be recognized that not every patient can be successfully rehabilitated. It is necessary to establish individual goals for each patient. It should not be assumed that the more radical procedure is, the greater psychosocial adjustment should be. Patients who have a good self-image and have good strategies for coping with stress are likely to make a successful adjustment to radical surgery. Unfortunately, the dependent and insecure patient who places his self-esteem primarily on his physical appearance may have an extremely difficult time adjusting to disfigurement associated with surgery, even if it might be relatively minor. The attitude of those individuals involved with the patient is of great importance. Avoidance reactions or expressions of sympathy that could be interpreted as pity can make the patient concerned of being rejected by society. The reactions of family members will have a great role in patient’s adaptation. When patients are encouraged to regain a sense of independence, the support of family is essential. Family members must also make their own psychological and social adjustments. When working with head and neck patients, we should always remember that the patient is dealing with issues associated with disfigurement, speech, eating
and drinking impairment, discomfort, depression and anxiety.

Treatment of head and neck cancer poses interesting and important problems in terms of ethical decision-making and psycho-social rehabilitation. These aspects are related not only to disfigurement and disfunction that are often associated with the treatment, but also to the particularly intimate nature of that part of the body (14,15). Disfigurement and disfunction 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 the 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. 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 on the meaning of these principles in a particular case, and a careful balancing of these principles in deciding which one should gain priority in a given case remains sometimes inadequate, because an ethically appropriate approach should be primarily based on abstract principles. A careful and purposeful inclusion of the virtues is necessary to restore the focus on the physician-patient relationship, to guarantee the human aspects of the relationship, and to 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, but we also reinforce the concepts of caring and responsibility that have always been at the foundation of the philosophy of medicine (16,17).

**Conclusions**

Attention to ethical and psycho-social issues in clinical medicine has increased in recent years as a result of profound changes in both medicine and society.

The outcomes of head and neck cancer surgery can be improved by efforts made to secure a correct and complete informed consent of the patient and, on the other side, to support the patient’s rehabilitation who, consenting to undergo a mutilating operation implicitly understands that he chose for survival at the cost of disfigurement.

**References**

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