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Different Standards Are Not Double Standards: All Elective Surgical Patients Are Not Alike

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ABSTRACT

Testa and colleagues argue that evaluation for suitability for living donor surgery is rooted in paternalism in contrast with the evaluation for most operative interventions, which is rooted in the autonomy of patients.[1] We examine two key ethical concepts that Testa and colleagues use: paternalism and autonomy, and two related ethical concepts: moral agency and shared decision making. We show that by moving the conversation from paternalism, negative autonomy, and informed consent to moral agency, relational autonomy, and shared decision making, one better understands why the arguments given by Testa and colleagues fail.

We argue (1) why the hurdles that one must overcome to become a living donor are appropriate; and (2) that the similarities between living donor transplant surgery and cosmetic plastic surgery that the authors describe are inaccurate. Finally, we consider the recommendation to treat plastic surgery patients and living donors more similarly. We argue that any change should not be in the direction of becoming less protective of living donors, but more protective of cosmetic plastic surgery candidates.

INTRODUCTION

Testa and colleagues argue that evaluation for suitability for living donor surgery is rooted in paternalism in contrast with the evaluation for most operative interventions, which is rooted in the autonomy of patients.[1] To elaborate upon this point, they compare and contrast cosmetic plastic surgery and living donor surgery. They describe three similarities: (1) the surgery has no curative intent, (2) the risks for both procedures are similar, and (3) both types

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of patients experience coercion. They also describe three differences in the attitudes of healthcare providers: (1) living donors are perceived as vulnerable, whereas cosmetic surgery patients are perceived as autonomous; (2) there is greater focus on the psychological state of the living donor than on the plastic surgery patient, leading to higher rates of candidacy rejection in living donation; and (3) there is greater intrusion into the social support network and financial security of the donor than of the plastic surgery patient. The authors then conclude that reliance upon the principle of respect for patients' autonomy for living donors would be more appropriate and would result in "a wider acceptance of and increase in living donation."

In this commentary we begin by examining two key ethical concepts that Testa and colleagues use: paternalism and autonomy, and two related ethical concepts: moral agency and shared decision making. We then argue (1) why the hurdles that one must overcome to become a living donor are appropriate; and (2) that the similarities that the authors describe are inaccurate. Finally, we consider the recommendation to treat plastic surgery patients and living donors more similarly. We argue that any change should not be in the direction of becoming less protective of living donors, but more protective of cosmetic plastic surgery candidates.

KEY PHILOSOPHICAL CONCEPTS

Paternalism

Testa and colleagues argue that transplant surgeons are overly paternalistic. Although they do not define paternalism, we offer a definition to help clarify and examine the claims that they are making. We employ Dworkin's definition of paternalism that is widely accepted in the philosophy community: "the interference with a person's liberty of action justified by reasons referring exclusively to the welfare, good, happiness, needs, interests, or values of the person being coerced."[2] This definition suggests that the transplant physician's rejection of a candidate is because the physician believes it is in the patient's own interest not to serve as a donor. While this is the case for some donors, particularly those for whom the procedure has a significant probability of severe morbidity or mortality, the term is misleading. In most cases, the transplant surgeon is not interfering with a person's liberty of action, but is refusing to be the agent to perform the requested action. While the result potentially is the same—the person not serving as a donor—the justification is different. The transplant surgeon is not justifying his or her action exclusively in terms of the patient's well-being, but rather with respect to his or her own moral agency. As Carl Elliott explains: "If a patient undergoes a harmful procedure, the moral responsibility for that action does not belong to the patient alone; it is shared by the doctor who performs it. Thus a doctor is in the position of deciding not simply whether a subject's choice is reasonable or morally justifiable, but whether he is morally justified in helping the subject accomplish it."[3]

According to Elliott, physicians, as moral agents, must decide not only whether an action is moral, but also whether they should be the agent to intervene. "It is not unreasonable, then, for doctors to be reluctant to expose willing subjects to the risk of harm, even while acknowledging the legitimacy of a system which allows subjects to take great risks."[4] Consider the transplant physician who believed that living donation was inadvisable for a particular individual. If the transplant physician were paternalistic, he or she might go to great lengths to prevent the prospective donor from donating under all circumstances. In contrast, the transplant physician, as a moral agent, would advise against donation and would explain the transplant team's consensus reasoning with the potential donor. The transplant physician would also explain that different programs use different criteria and offer the prospective donor the option of seeking a second opinion from another transplant center, as there is wide variability in acceptance of medically complex living donors.[5]

Autonomy

Although Testa and colleagues do not define autonomy, they focus on the "individual patient's right to autonomously determine whether he or she would benefit from cosmetic

surgery." They use the concept of patient autonomy to focus on the competent patient's right to accept or refuse all treatments, including life-saving treatments as expressed by giving or withholding informed consent. This conception of autonomy has been criticized because of its exclusive focus on the negative component of autonomy, the right not to have one's decision interfered with.[6] Information alone does not necessarily promote good decision making by patients.[7] Rather, patient decision making is improved by active engagement with the transplant surgeon and other healthcare professionals in a process of shared decision making, whereby the risks, benefits, and alternatives are not only disclosed, but comprehension is confirmed, and those issues in which the patient is most interested, and those about which transplant team is most concerned, are further elaborated.[8] Such an iterative approach incorporates a positive conception of autonomy that includes the physician's responsibility to empower patients to act in a way that is truly consistent with their autonomy. The inclusion of both a positive and negative component of autonomy has been well explored in the feminist literature and is referred to as "relational autonomy."[9]

The concept of shared decision making rejects the notion that a physician fulfills his or her obligations by reading a list of risks and providing a menu of treatment options. Shared decision making involves a discussion about risks and benefits tailored to the needs of the patient. It is not a mere enumeration of risks and benefits, but a process that ensures understanding, and gives the patient time to reflect on what is heard and to ask about what these risks and benefits might mean for this particular patient in his or her own particular circumstances. As a moral agent, the physician helps to empower the patient to make a decision that best reflects the patient's interests, all things considered. The transplant surgeon is supplemented by other members of the transplant team, who help in both the education and consent process, giving additional meaning to the phrase "shared decision making."

By moving the conversation from paternalism, negative autonomy, and informed consent to moral agency, relational autonomy, and shared decision making, one will better understand why the arguments given by Testa and colleagues fail. It also will help explain why we should not become less protective of living donors, and may be morally obligated to become more protective of cosmetic plastic surgery candidates.

THE SIMILARITIES

First, let us re-examine the three ways in which Testa and colleagues claim that transplant donor surgery and cosmetic plastic surgery are similar: (1) the surgery has no curative intent, (2) the risks for both procedures are similar, and (3) both types of patients experience coercion.

Their first claim is that both surgeries have no curative intent. While it is true that donor surgery has no curative intent for the donor, it has curative intent for the prospective recipient. Testa and colleagues may object that the focus is on the donor, but that is not the case. Imagine that there were an adequate supply of deceased donors or that kidneys could be grown in a lab: no transplant physician would remove the kidney of a healthy individual. The only reason to remove a kidney from a healthy individual is for its curative effect on a potential recipient. The fact that it provides psychological benefit to the donor is important for both the donor and the surgeon, but it is not the intent of the surgery. In contrast, although cosmetic surgery is meant to provide psychological benefit to the patient, it has no physical curative intent or benefit for the individual or any third party.

Testa and colleagues argue that the risks of elective donor surgery and cosmetic surgery are similar. They cite morbidity of liver donation at 5 to 21 percent and mortality at less than 1 percent from two sources. The first study describes a single institution's experience of 100 donors; the other study is multi-institutional.[10] The data, as presented, are inaccurate. Ghobrial and colleagues are cited, to argue that the highest reported rate of morbidity for living liver donation is 21 percent.[11] In fact, the study states that 82 of 245 donors (21 percent) had one com-

plication, but an additional 66 (17 percent) had two or more complications for a range of complications of up to 38 percent.[12] These data are from nine high-volume centers that participate in the Adult-to-Adult Living Donor Liver Transplantation Cohort Study (A2ALL). Ghobrial notes that "Most reports of complications of adult-to-adult LDLT are based on single transplant program experience. The rates of complications in these single-center publications range from as low as 9 percent to as high as 67 percent."[13] Beavers and colleagues reviewed the literature and found rates of complications cited between 0 and 67 percent.[14] Testa and colleagues reported a complication rate of 50 percent in 30 right-lobe grafts in 2000.[15]

The data on kidney donation that Testa and colleagues describe are also inaccurate. They cite the morbidity of kidney donation at 1.3 percent with mortality as low as 0.03 percent, using one reference from a single institution's experience with laparoscopic surgery from 2004.[16] However, it is only in 2006 that Kocak and colleagues proposed a classification scheme for laparoscopic surgical complications based on 43 complications (7.2 percent) in a series of 600 patients.[17] The Calvien Grading system distinguishes complications into four grades based on severity, the need for intervention, lasting disability, or death.[18]

Since this definition of a complication grading system by Kocak and colleagues, other single-institutional reports have been presented in the literature. One publication describes a single surgeon who performed 750 laparoscopic surgeries: "There were 3 open conversions (0.4 percent) and the overall complication rate was 5.46 percent. Median hospital stay was 1 day and the readmission rate was 1.2 percent. There were 5 re-operations (0.67 percent), none of which was for the control of bleeding. No patients required a blood transfusion and there were no mortalities."[19] Another publication reported that the 30-day donor complication rate was 9.8 percent for two surgeons performing 500 surgeries. At a mean follow-up of 32.8 months for 500 laparoscopic donor surgeries, long-term donor complications consisted of 11 cases of hypertension, nine cases of prolonged pain or paresthesia, two incisional hernias, one small bowel obstruction requiring laparoscopic lysis of adhesions, and one hydrocele requiring repair.[20] A third study found the overall rate of complications in the investigated series of 253 surgeries to be 10.3 percent, including seven intraoperative complications (2.8 percent), three of which required open conversion; and 19 postoperative complications (7.5 percent), three of which required re-exploration for bleeding.[21]

The inaccuracy of data reported by Testa and colleagues is only partly due to an incomplete literature search. The real problem is the lack of living donor registries, a concern expressed by many transplant researchers.[22] One reason that this is so problematic is the long-term health consequences of living kidney donation. Testa and colleagues have focused on the short-term risks of liver and kidney donation, but fail to consider the less well documented long-term risks. Whereas livers regenerate, kidneys do not, and the solitary remaining kidney in a living kidney donor must do all the work. While the remaining kidney will increase its work load, it will not come close to full restoration. And the long-term risks of living kidney donation are not trivial. To date, more than 250 individuals who have donated a kidney have subsequently developed end-stage renal disease (ESRD).[23] This is particularly acute in African-Americans and young donors.[24] The lifetime risk remains unknown because of the lack of registry data.

Testa and colleagues then consider the risks of cosmetic plastic surgery. They note that "Cosmetic plastic surgery is not free of complications or mortality. For certain complicated reconstructive procedures, cosmetic surgery patients must remain under general anesthesia for as long as, or longer than, the most complicated living organ donor operation." They claim that pulmonary embolisms have been reported at an incidence as high as 6 percent in patients undergoing abdominoplasty, a common cosmetic surgery procedure, and that mortality from liposuction has been reported to occur in one in every 5,000 procedures; but they do not provide any references. A review of the literature finds that Testa and colleagues are correct in noting that the risks of some plastic surgery pro-

cedures are significant, particularly in obese patients,[25] and in surgeries in which several procedures are performed during a single operation.[26] Particular procedures also have higher risks; abdominoplasty has one of the highest rates.[27] One study found a 1.2 percent incidence of deep venous thrombosis and a 0.8 percent incidence of pulmonary embolus.[28] But, when combined with other abdominal procedures, the incidence of pulmonary embolus increases (with reports ranging from 1.1 percent to 6.6 percent risk).[29] Most other procedures have a lower rate (usually less than 1.5 percent).[30] One large multicenter series reported by Grazer and de Jong evaluated a database of approximately 496,000 patients from 917 different plastic surgeons, and reported pulmonary embolus as the largest single cause of mortality, affecting 4.6 per 100,000 patients (0.005 percent).[31]

The risks of morbidity and mortality in plastic surgery procedures are also greater in office-based surgery facilities or "surgicenters," where there is less oversight and the procedures may be performed by nonboard-certified plastic surgeons. In Florida, a number of highly publicized deaths in surgicenters led to several moratoria on these facilities and greater state regulation.[32]

Thus it is incorrect for Testa and colleagues to report that the risks in cosmetic plastic surgery are comparable to the risks in solid organ donation. There are real risks in cosmetic plastic surgery, but these risks are greatest when combined with other procedures and when formal plastic surgery training and institutional oversight are not optimized. Still, they are much lower than the risks of donor nephrectomy or lobar hepatectomy. In addition, it does not help to compare all plastic surgery procedures and all organ donations, because each procedure can have a very different risk profile. In Testa's own field, the focus on assessing live donors for liver donation is on short-term peri- and post-operative risks, whereas the focus in living kidney donation is both on short-term risks associated with the operation, but, more importantly, on the possibility of long-term health risks, an issue not even raised in the article.

The third similarity described by Testa and colleagues is that both types of patients experience coercion. Strictly speaking, neither living donors nor plastic surgery candidates experience "coercion," which refers to the situation in which force or intimidation is used to obtain compliance.[33] Testa and colleagues are referring to the pressure that both types of surgical candidates may perceive or experience by third-parties. However, they do not provide any references for this concern. Nor do the authors consider whether the type of pressure felt by the two parties is morally equivalent. They are not, in part because of the potential consequences: the failure to undergo donation may result in a dead relative, versus the failure to undergo cosmetic surgery may result, at most, in an unhappy spouse or employer, or perhaps a lost job.

What type of pressure do the two types of surgery candidates experience? The plastic surgery literature suggests that the main pressure may be due to societal conceptions of beauty,[34] but there are no data to show how often this pressure is from a direct contact. Plastic surgery standards do recommend counseling for patients who are motivated to undergo cosmetic surgery, if their goal is to please a third party: "The correct motivation for an esthetic operation is an internal one—to make you feel better about yourself. Other people may not even notice the change."[35]

The concern about a sense of external pressure in living donation has been acknowledged in the transplant literature since the earliest case reports. Fellner and colleagues interviewed early living kidney donors whose recipients all had poor outcomes due to the lack of immunosuppressant. All stated their decision was voluntary.[36] Goldman and colleagues studied the first 22 parents who had an assessment to serve as a living liver donor for their child. One was excluded on medical grounds and one declined to participate after initial consent, even though it may have meant the death of the child, providing evidence that at least some parents could decline, even when their child might die on the deceased donor liver waiting list.[37] To reduce the likelihood of undue pressure, the transplant community has responded by implementing several processes. First, all living donors must

undergo a psychological evaluation in which motivation is explored. If the donor continually describes his motivation as "I feel pressured," the transplant team may reject the patient from donation. Second, all living donors have a donor advocate or donor advocate team who ensure that the donor's motivation is not due solely to external pressure, but rather that the donor is intrinsically motivated to donate.[38]

Thus the three similarities described by Testa and colleagues are not similar when the issues are explored in further detail. The main premise driving their arguments is that the procedures and processes are similar, and so they should be treated similarly. But they are not similar, and so the main premise is false, and the argument for similar treatment fails.

THE DIFFERENCES

Testa and colleagues point out three attitudinal differences between transplant donors and plastic surgery patients which, they argue, are unjustified: (1) living donors are perceived as vulnerable, whereas cosmetic surgery patients are perceived as autonomous; (2) there is greater focus on the psychological state of the living donor than on the plastic surgery patient, leading to higher rates of candidacy rejection; and (3) there is greater intrusion into the social support network and financial security of the donor than on the plastic surgery patient. Let us consider whether these differences are morally legitimate.

We agree with the first claim, that transplant donors are perceived as vulnerable. The reason is that demand for deceased donor kidneys is much greater than the supply, and so potential candidates are encouraged to find a living donor. Prospective donors are asked to compromise their short-term (kidney and liver) and long-term (kidney) health for the benefit of a third party. In contrast, a plastic surgery candidate chooses to take risks for her or his own benefit. The transplant scenario involves two individuals as patients, whereas the plastic surgery scenario has only one patient.

The difference between deciding about risks and benefits for a procedure that involves one person who consents for him- or herself is different than a procedure that involves two persons, one who will consent to be exposed to physical risks for the physical benefit of a second party. This is not to deny that both parties may experience psychological benefits as well. But from the perspective of the surgeon who must make not only a medical but also a moral decision of whether or not to operate, the issue of operating on a healthy person for the benefit of another is the crux of the decision in the donor transplant world.[39] Maternal-fetal medicine physicians face a similar issue in proposing fetal surgery, which requires operating on a healthy pregnant woman for the potential benefit of her fetus. However, in these cases, it is the pregnant woman who must consent for both herself and the fetus. In living donor transplant surgery, in contrast, surgeons operate on a healthy individual patient for the physical benefit of another, with the consent of both. That is, the donor knows that there is another person dependent upon his or her action, and that the decision may be life or death for the other. The cosmetic surgery candidate is less vulnerable, because the decision is rarely about life and death, and the benefits and risks accrue to the same individual.

The vulnerability of a transplant donor is further magnified because of how the patient arrives at a pre-operative consultation. In the case of a plastic surgery patient, it is the patient who decides that he or she wants to change his or her physical appearance and takes the initiative to locate a surgeon. In contrast, leaving aside the dozens of individuals who have agreed to donate to a stranger, living donors generally seek surgical consultation only after being informed by a family member or friend that they need a living donor. The timing in organ donation, then, is imposed by the needs of another, and urgency creates additional pressure. As we have noted, this urgency may compromise the autonomy of a potential donor.

Testa and colleagues make the point that "while there may be some inner pressure to donate, for the most part in Western culture, tremendous familial coercive pressure on donors is rare." Their description is correct, and

there are processes in place to prevent donation from individuals who experience such pressure. Transplant programs employ a living donor advocate (or donor advocate team), required by federal mandate, for two purposes: to ensure that a candidate is informed and that the decision is voluntary.[40] The living donor advocacy program thus enhances a patient's autonomy by promoting the capacities for making an informed and voluntary consent.[41]

How frequently cosmetic surgery patients undergo procedures because of pressure from a third party is unknown. However, plastic surgeons do exhort each other to identify those patients who are "unsuitable for plastic surgery" including the "surgiholic," those facing marital or familial disapproval, those who are pushed into surgery by others, and those with body dysmorphic disorder.[42] The reasons to reject the patients are both patient- and physician-oriented: (1) the increased risk of multiple surgeries, (2) the decreased likelihood of being satisfied with the results, and (3) the increased likelihood of being litigious.[43] To the extent that some candidates feel external pressure, they are vulnerable. This would argue for greater protection for them and not for less protection for donors. To the extent that Testa and colleagues are correct that some plastic surgery patients feel a degree of pressure by family members or other third parties to undergo surgery, a patient advocate or psychological counseling would be useful.

The second claim by Testa and colleagues is that there is greater focus on the psychological state of a living donor than on the plastic surgery patient, leading to higher rates of candidate rejection. One reason for the emphasis on the living donor's psychological health is to ensure voluntariness. If there were enough deceased donor organs, or if replacement organs could be created by stem cells, no one would ask a relative to serve as a living donor. Or, more accurately, no transplant surgeon would agree to remove a solid organ from a healthy person for the benefit of another, since it would not be necessary. Because of the scarcity, individuals in end-stage organ failure are encouraged to seek out healthy individuals to serve as donors. The transplant team colludes with the recipient by evaluating the potential donor for a surgical procedure performed to benefit the recipient. Thus, the transplant team is partly responsible for agreeing to expose a healthy donor to risk when it removes a healthy organ from an individual to benefit a third party.[44] To ensure the voluntariness of the donor and to ensure that the donor is not experiencing undue pressure to donate against his or her own best judgment, the donor will undergo a thorough psychological evaluation. The cosmetic plastic surgery patient is unhappy with his or her physical appearance and seeks help to change his or her appearance to promote his or her own psychological well-being. There is a difference. To the extent that Testa and colleagues are right that many cosmetic plastic surgery patients undergo procedures due to pressure from a third party, a more stringent consent process and/or the routine involvement of other health professionals may help surgeons uncover threats to autonomy and help prospective cosmetic surgery patients decide whether this is something they want to do for themselves.

The third claim by Testa and colleagues is that there is greater intrusion into the social support network and financial security of a donor than that of a plastic surgery patient. This is true, and for a good reason. There are now more than anecdotal data showing that, post donation, living donors experience some difficulties in obtaining insurance,[45] whereas no problems with insurability after plastic surgery have been identified in the literature.

It is ironic that transplant teams are more focused on social support and financial status due to a significant difference that is not noted by Testa and colleagues: the financial differences between donor surgery and plastic surgery. In general, it is the recipient's insurance that pays for a donor's surgery and for short-term post-operative complications. Virtually all U.S. citizens who develop end-stage renal disease are eligible for insurance from the federal government (Medicare).[46] As such, society pays for the living donor's surgery. In contrast, much cosmetic plastic surgery is paid for out of pocket, and often in advance. If there are operative com-

plications, they may or may not be covered by insurance. That the recipient (or society) pays for the living donor procedure makes it financially easier for someone to be a donor than to have plastic surgery, and is why a transplant team feels partly responsible for a donor's well being. The transplant team endeavors to help the recipient, in collusion with the donor and society at large.

Testa and colleagues suggest that there are several differences between how we evaluate cosmetic surgery patients and potential transplant donors. They argue against characterizing a living donor as vulnerable (or at least as more vulnerable than a plastic surgery candidate); that there is too much attention paid to a donor's psychological state; and that there is too much intrusion into the social support of living donors, but not of plastic surgery candidates. These differences are real and justified. Living donors are more vulnerable because donation places them at risk of self-harm to benefit a third party, justifying a more thorough psychological work up. There is a more extensive clinical work up as well, to assess a donor's organ adequacy and residual functional reserve, and because of the generally greater risk of short- and long-term adverse medical sequelae without any benefit of personal health improvement. Finally, the need for help in the performance of activities of daily living in the post-operative convalescence period is complicated when two patients (donor and recipient) need assistance from the same cohort of support individuals, a problem not encountered for a cosmetic surgery patient. The unique characteristics of living organ donation justify the more elaborate and multistepped processes used to educate living donor candidates so that they can give truly informed consent.

Although not mentioned by Testa and colleagues, a key difference between transplant donors and cosmetic plastic surgery patients is the consent process that each undergoes. Consent for cosmetic plastic surgery procedures typically takes the form of a standard consent for an operative procedure. A surgeon or surrogate explains the risks of the operation to the patient, either in a pre-operative office visit or just prior to the surgery in the hospital or outpatient surgicenter. The patient then signs a consent document. There are opportunities for consultation with other healthcare professionals, if deemed necessary. Consent for a transplant donor, however, is a multistep process, beginning with consent to undergo evaluation for donation and including separate discussions of the planned donation with different members of a multidisciplinary transplant team. Typically, a team is comprised of a nurse who coordinates the potential donor's medical evaluation, a social worker who assesses the potential donor's psychosocial status, an independent physician/healthcare professional who acts as the potential donor's advocate, and a surgeon. Psychiatric consultation, consultation with other medical specialists, and with a financial specialist (also members of transplant programs), are available as needed. Suitability for organ donation is a consensus decision by this team. As with plastic surgery procedures, an operative consent is obtained by a surgeon or surrogate. The different processes reflect the different degrees of risk and that, in living donor transplantation, the clinical benefit accrues to a third party.

RECOMMENDATIONS

Let us assume that Testa and colleagues are right that transplant teams are paternalistic towards potential living donors and plastic surgeons show respect for their patients' autonomy. To the extent that cosmetic plastic surgery candidates are as vulnerable, psychologically at risk, and/or in need of the same social supports as transplant donor candidates, Testa and colleagues have not provided arguments why we should reduce the evaluation and requirements for living donors. Instead, they may have provided reasons why we should increase scrutiny for cosmetic plastic surgery candidates.

There is some support in the plastic surgery literature for greater protection of cosmetic surgery patients, or at least for a greater emphasis on the moral principles of professional responsibility and beneficence.[47] Marcia Spear, a plastic surgery nurse practitioner, explains: "as enhancement procedures are elective and based

on patient choice, the ethical principle of autonomy becomes a dilemma for the provider. It becomes more of an ethical responsibility not to succumb to patient desires alone. It becomes apparent that it is necessary to develop frameworks that resolve such dilemmas in this specialty area."[48] Likewise Ross Zbar, a plastic surgeon, and colleagues write that plastic surgeons do not perceive autonomy as the only guiding principle, and argue that society holds them to a higher standard: "society anticipates that plastic surgeons will make ethical decisions that are solely in the best interests of their patients."[49]

In developing the arguments for their article, Testa and colleagues assume that plastic surgery candidates are otherwise healthy adults who seek a minor procedure. However, many cosmetic surgeries are not so minor, and candidates are not always healthy. Some higher risk cosmetic surgeries involve obese candidates who are at increased risk for certain complications: "Honouring autonomy might become problematic as operative risk increases. Risk inherent in the type of procedure (e.g., extensive liposuction) may be compounded with preexistent disease, bringing respect for autonomy, professional duty, and nonmaleficence into conflict."[50] That is, the principle of patient autonomy does not imply an absolute right to choose to undergo any procedure, regardless of risk. Surgeons do not have an obligation to accede to any request from an autonomous patient. Indeed, surgeons have an obligation of nonmaleficence to refuse such requests when procedures involve significant physical or psychological risk.

In some respects, then, it is the autonomy of living organ donors that is truly valued. Transplant teams expend a great deal of time and resources to promote and respect patients' rights to decide affirmatively or negatively. Plastic surgeons and plastic surgery candidates, on the other hand, are generally aligned in focusing on candidates' right to say yes.

CONCLUSION

Testa and colleagues argue that transplant physicians are paternalistic and that there are lessons they can learn from their plastic surgery colleagues. This argument assumes an incomplete conception of autonomy that focuses solely on its negative component, ignoring the role of healthcare professionals to empower patients to make better decisions. The authors also argue that differences in the treatment of candidates for living donor surgery and cosmetic plastic surgery are unjustified; we contend that these differences are justified, given the different risks and benefits.

Even if the two surgeries are qualitatively different, the question of a surgeon's role in patients' decision making remains relevant. A transplant surgeon, as a member of a multidisciplinary team, collaborates with prospective donors in a model of shared decision making to promote prospective donors' capacity to make decisions that truly reflect their own interests. If ultimately the consensus of the multidisciplinary team is that a candidate is not appropriate for donation, and a candidate disagrees, the transplant team and physician can respect the candidate's moral agency and autonomy by referring him or her to another transplant program for re-evaluation. Given the issues raised about the physical and psychological risks inherent in cosmetic plastic surgery, it may be that plastic surgeons need to examine whether they adequately educate and empower patients to be able to make informed and voluntary decisions. That is, it may be that plastic surgeons, and not transplant surgeons, need to re-assess their practice and place greater emphasis on shared decision making.

NOTES

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