

## **Gaining Face or Losing Face? Framing the Debate on Face Transplants**

### **Authors**

Julie Woodley  
Faculty of Health & Social Care  
University of the West of England (UWE)  
Glenside Campus  
Blackberry Hill  
Stapleton  
Bristol BS16 1AD  
UK  
Julie.Tonks@uwe.ac.uk

Richard Huxtable  
Centre for Ethics in Medicine, University of Bristol  
73 St Michael's Hill  
Bristol BS2 8BH  
UK  
R.Huxtable@bristol.ac.uk

### **Abstract**

An American surgical team has announced its intention to perform the first human facial transplantation. The team has, however, invited further analysis of the ethical issues before it proceeds and in this paper we take up that challenge in seeking to frame the debate, with a particular focus on the recipients of the transplant. We address seven related areas of concern and identify numerous questions that require answers or, perhaps, better answers. We start by examining the nature of the procedure and its intended benefits, why the procedure is being developed, and whether or not this should be viewed as experimental. Having concluded that this is innovative in nature, we then consider the broad question, who is the patient? Here we perceive difficulties in terms of the autonomy of the recipient, the unpredictable effects of receiving the transplant, and the role and influence of society. We conclude by asking whether the question should be “whether or not?” rather than “when?” particularly while the risks of losing face appear to far outweigh the likelihood of gaining face.

### **Key (Indexing) Terms:**

Face transplant; autonomy; benefit; harm; identity

### **1. Introduction**

The possibility of transplanting one human face onto another human body was brought to international attention by the British surgeon Dr Peter Butler

in 1998.<sup>1</sup> Since then the proposal has attracted much attention in professional, academic and media circles. Professional medical bodies in at least two countries have examined the topic: reports from a British Royal College of Surgeons Working Party and the French National Consultative Ethics Committee for Health and Life Sciences both concluded that the risks currently outweigh any perceived benefits, and have therefore led to a professional moratorium on the procedure.<sup>2,3</sup> However, a team of surgeons from Louisville, in the United States of America, has recently claimed not only that there is a favourable ethical climate in their institution but also that the risks/benefits ratio is far more in equipoise, and they therefore wish to proceed.<sup>4</sup>

The Louisville team have, however, invited further discussion of the issues and in this paper we seek to frame that discussion through identifying seven areas of contention and raising a series of questions, albeit without providing answers in all cases. First, we consider what the procedure would and could be able to achieve for the disfigured. That the initial transplants will result in a hybrid appearance and will not improve facial function are important considerations. Equally important, however, is the prospect of the wholesale adoption of another individual's face, which raises concerns that need to be addressed early. Secondly, we ask why the procedure is being developed, where we note that this is a major surgical procedure primarily aimed at addressing psychological difficulties. Thirdly, as the Louisville team implies, we argue that the procedure is sufficiently novel to warrant thorough analysis and discussion before it is attempted. The British bioethicist Dr Richard Nicholson feels this analysis is premature and unnecessary and he may have a point insofar as the technical expertise required and ethical questions posed are certainly familiar, focusing as they do on the autonomy of those involved and the associated risks and benefits.<sup>5</sup> However, the similarities are only skin deep precisely because we are addressing the face, which has considerable importance in terms of identity, self-perception and one's perception by others. The procedure must therefore be considered experimental and analysed accordingly.

We then proceed to analyse the issues with particular regard for the recipients of the transplant. Fourthly, then, we ask who are the most likely recipients? Here we identify some difficulties in terms of the autonomy of the recipient, which point to a Catch-22 where those most likely to be able to cope with the transplant and its associated risks ironically appear to be the least "in need" of receiving it. Fifthly, we consider how receiving a donated face might affect the individual, particularly given the importance of the face in terms of identity and perception. We note, with reference to some analogous scientific developments, that the effects are far from predictable. Our sixth concern is that the patient might in some sense be influenced by our /unduly coerced by our beauty-fixated society and as such there may be less invasive and certainly less risky means of improving both society's and

disfigured individuals' reactions to facial disfigurement. These observations lead us to consider finally whether the question is best posed as "whether?" or "when?" While we have no major problem with the procedure in principle, it seems likely that there will always be a degree of risk, perhaps even a significant degree, for the recipients. Whether autonomy and thus individual choice should govern in this matter is open to debate, and debate is indeed needed in order to establish how far the possibility of gaining face should outweigh the more likely danger of losing face.

## **2. What is Envisaged?**

As described by the Louisville team, the procedure will involve de-gloving the facial tissue and vasculature from a recently deceased donor and then reattaching it to a recipient. The surgeons claim that this procedure is technically possible as it utilises many established surgical techniques. Indeed, cases of reattachment of an individual's own face and results from animals where the faces of black rats were transplanted onto white ones further indicate the feasibility of this procedure.<sup>6,7</sup>

In terms of the anticipated results, we do not yet appear to be in the realm of the popular John Woo film *Face/Off*: the recipient will be left with a hybrid appearance, since the donor face will be fitted over the tip of their own nose and they will also retain their own lips, eyelids and, particularly significantly, underlying facial skeleton.<sup>8</sup> As the expertise develops, however, there is the possibility that Woo's science fiction will become science fact, since surgeons might also become able to transplant the donor's underlying bone structure, thereby affording the recipient an appearance much closer to the donor's.

## **3. Why?**

Those expected to benefit from the introduction of face transplants include some people born with facial disfigurement and others who have endured, for example, ballistic trauma, severe burns or facial cancers. Whilst skin grafts from the person's own body are already routinely performed, these have their drawbacks, not least in terms of the series of painful operations that are sometimes required. A face transplant would instead mean one operation, which should result in a more continuous visage.

Christine Piff, founder of the support group *Let's Face It* has suggested that the procedure might at some point benefit those who cannot eat, drink or speak.<sup>9</sup> That development may be some way away, however. Dr Butler has stated that in the early phase the transplanted face will not function as such; only when extensive nerve regeneration is possible will this occur. The transplanted face may however be more flexible than current skin grafts (using the patient's own non-facial skin),<sup>10</sup> and should provide a better aesthetic appearance, but it may well result in a decrease in function. As such, the recipient would effectively be receiving a "mask". If we take the

example of an individual with rigid scar tissue resulting from a burn, they would receive a(n allegedly) better aesthetic appearance albeit at the expense of some facial functioning. It is therefore important to note that we are primarily addressing an improvement in appearance

#### **4. Where is the Novelty?**

In purely technical terms, it might be argued that a face transplant is merely an extension of techniques already familiar to transplant and plastic surgeons. Transplantation of major organs is regarded as relatively uncontroversial in the developed world. Last year, for example, 2,778 organs were transplanted in the United Kingdom alone.<sup>11</sup> Furthermore, surgeons have been performing skin grafts and undertaking reconstructive surgery for years, so facial transplantation could be considered a fairly logical progression of their art. Of course, neither field is free from ethical controversy, as continuing debates over the sale of human organs and the validity of purely cosmetic surgery demonstrate, but the therapeutic value of such procedures is relatively widely accepted.<sup>12, 13</sup> Equally, the ethicist should be in familiar territory, as the issues pertaining to face transplants are readily articulated in terms of harm, benefit, autonomy, dignity and justice. However, lest we become too comfortable, we must acknowledge that we are contemplating the transplantation of a face. Certainly, the face is a living organ, which is possessed of blood and nerve supplies and is one of the most antigenic tissues in the human body. And yet, although we will have more to say on the nature of personal identity, it is undeniable that the face occupies a (loosely drawn) category of organs and tissues that have a special significance to the individual and the wider world within which he or she exists. Hearts, brains and eyes are usually seen as more important and more constitutive of personal identity than organs like, for example, the spleen. In colloquial terms, the heart symbolises our emotional selves (consider terms such as “heartless”, “heart-broken” and “heartfelt”), the brain is connected with our minds and/or souls, and the eyes provide the “windows of the soul”. This category of “special” organs may well be relative to time and place: the Ancient Egyptians, for example, believed that the heart was the “seat of the soul” while the tongue was the “seat of the mind”.<sup>14</sup> Attitudes do therefore change over time, as has apparently occurred in the case of heart transplants, which were widely condemned when first proposed by Christiaan Barnard in 1967.<sup>15</sup> Nevertheless, we predict that the face will continue to occupy a pivotal perceptual position, important as it is in terms of one’s own self-perception and one’s perception by others. The very visibility of the face immediately distinguishes it from other, less obviously visible, forms of transplantation that are located beneath the skin. This might go some way to explaining why the recent transplant of a jawbone performed by Professor Giuseppe Spriano did not attract the same degree of attention.<sup>16</sup>

Thus, although it does indeed build upon pre-existing knowledge and can indeed be viewed through familiar prisms, there is *prima facie* good reason for treating facial transplantation as qualitatively different from existing surgical procedures. Furthermore, familiar issues such as the risk of the tissue being rejected assume an even greater significance in this context. For these reasons, this must be viewed as experimental and analysed accordingly. Research ethicists will be used to addressing the risks and benefits of a proposed innovation and in the remainder of this paper we seek to identify the issues relevant to this calculation through consideration of a central question: who are we treating?

### **5. Who is the Patient? (Part I)**

The first cluster of issues relates specifically to the recipient of the donor face. Who should be considered for the procedure and according to which criteria? Not infrequently appeals are made to notions of autonomy and beneficence (or non-maleficence), such that the ideal subject (patient?) autonomously decides to submit to the procedure, which it is hoped will provide them with some benefit (or at least be no more harmful than existing options).

Taking the autonomy criterion first, a maximally autonomous agent will make his or her choice while mentally competent, free from outside pressure, and furnished with sufficient information. In terms of information, the consent process will obviously need to be extremely rigorous, especially for those in the first wave of trials, and we will return to this issue below. Momentarily assuming that the subject *is* appropriately informed (and we note with approval that the Louisville team has considered this in some detail), we then face somewhat thornier dilemmas in the need for competent and voluntary participation.

Dr Peter Butler has indicated that only those demonstrating a high degree of competence, comprehension and the like will be eligible for his study.<sup>17</sup>

This certainly makes sense when considered in light of the potential psychological and physical effects and the likely level of media interest (and even intrusion), which suggest that the recipient will need to be a pretty robust character. Yet, if that intuition is correct, will such an individual want (or “need”?) the procedure, that is unless or until it is able to restore function? We are reminded here of a barrister, Henry de Lotbiniere, who showed no signs of withdrawal from society or discomfort with his facial disfiguration, as arguably exemplified by his portrait, which was displayed in the *Saving Faces* exhibition at the National Portrait Gallery, London. Ironically, then, such strong characters appear likely to be the very people reconciled to their disfigurement. Contrary to Butler’s view, it is arguable that those most likely to want (or need?) to undergo the procedure will be precisely those who are not so reconciled. These might well be highly vulnerable individuals, whose autonomy could be compromised at least to

the extent that their choice is not entirely free. Would it be overly paternalistic or even self-defeating to deny individuals in the latter group the chance to gain face? Furthermore, who would be the judges of – and accordingly gatekeepers to – autonomy? As, for example, English law stands, the health care professional offering the relevant treatment or the researcher conducting the study assume this role, and there is no strict requirement to call on assistance from psychiatrists, psychologists and the like.<sup>18</sup> Might the present context not be one in which such additional expertise should be called on, rather than leaving the assessment to the surgeons?

There are also difficulties in terms of the “harm” to be tackled and the possible pool of beneficiaries. The Louisville team has already created an online registry in order to identify potential recipients, which it has targeted at those “suffering from a major facial disfigurement.”<sup>19</sup> This wording, along with the published paper, indicate that the team envisages the application of the procedure to those in perceived medical need. However, this is a notoriously difficult concept to unpack: what is “medical” and what is “necessary”? Notably, as the Royal College of Surgeons report recognised, it is not the extent of the disfigurement that determines the individual’s reaction thereto.<sup>20</sup> So who then can be said to be in greatest need in this context? Furthermore, can we preclude (as the American team appears to) a move from perceived necessity to choice i.e. facial transplantation as an elective, cosmetic procedure? One could anticipate the desirability of facial transformation for, for example, criminals and the appeal of adopting a popular celebrity’s appearance, although such speculation might not be entirely helpful. Nevertheless, we need to think seriously about, articulate and defend the principled bases for distinguishing between the necessary and the elective, before the procedure has begun and certainly before it becomes commonplace.

It is not only the harm associated with the disfigurement that warrants careful consideration, but also the potential harms associated with the procedure. As is the case with other transplantation operations involving foreign tissue, the recipient would need to receive anti-rejection therapy, which can have serious side effects. You will recall that Spriano’s jawbone transplant did not attract as much attention as facial transplantation and we suggested that its invisibility could be one reason for this; another reason relevant in the current context relates to the smaller risk of rejection posed by that transplant. The jawbone had been treated with radiotherapy before being inserted into the recipient’s face, which lessened the need for the potentially damaging immuno-suppressant drugs.<sup>21</sup> This would not be possible for the face transplant. Furthermore, recipients do not always cope well with the side effects of such drugs. The first hand transplant had to be removed after the recipient failed to comply with the regime, after suffering quite severe psychological distress and physical symptoms.<sup>22</sup>

Yet even immuno-suppressant drugs cannot guarantee that the body will accept the transplanted tissue or organ. Kidney transplants have the highest success rates, where 3-year survival rates are as high as 83%.<sup>23</sup> If that rate was also obtained for face transplants, (which is highly unlikely in the initial, experimental phases) this would mean approximately one in five faces rejecting within three years. This prospect rightly troubled the authors of the British and French reports, and the Louisville team also acknowledged the risk, albeit with a rather benign reference to the possible “loss of the transplanted tissue”.<sup>24</sup> It is better to be frank here: does a recipient literally risk losing face? While a kidney rejecting is of course a major cause for concern, dialysis may still exist as a fall back. What of the face rejecting? Will a skin graft or the like be viable? To the best of our knowledge a satisfactory fall back position has yet to be published by any of the teams advancing this proposal. Science and society would be all the poorer if scientists lacked the “courage to fail”, but these risks indicate that we presently need a more caution than courage.<sup>25</sup>

In our discussion thus far we have referred to the recipient as both a “subject” (of research) and a “patient”. Given the considerations just outlined, however, it could be argued that the recipient only *becomes* a patient after the procedure has been performed. Guy Foucher, President of the International Federation of Hand Surgeons, opposed hand transplants on this very basis, commenting that the procedure “transformed a healthy, one-handed man into a sick man with two hands”.<sup>26</sup> Aside from any psychological difficulties that the person might be experiencing, we would assume that the proposed recipient would be otherwise healthy at the time of the face transplant. The healthy person with a facial disfigurement is then transformed into a morbidly ill individual who must endure a fairly toxic regime of drugs for the remainder of their life. At a bare minimum this information would have to be imparted during the consent process.

In terms of the potential recipients there are therefore a host of important questions that demand answers or, perhaps, better answers. The Catch-22 of facial transplantation is especially difficult: if you are robust enough to submit yourself to the procedure and all it might entail, you may be least likely to want it; if, on the other hand, you do desire the new face, you may be less able to cope with the risks posed by this procedure. It is therefore not only the physical effects that matter but also, as we have seen throughout this analysis, the psychological effects of receiving (or, indeed, not receiving) the face transplant. These effects relate also to questions of principle, primarily concerning personal identity, to which we now turn.

## **6. Who’s Who?**

Some of the risks highlighted in the previous section might be minimised in time, especially if the procedure is allowed to proceed and the science develops accordingly. However, there are other risks that that might not be

so easily tackled. As Caplan and Katz briefly noted in an early commentary, face transplants “involve tissues that are associated with each individual’s personal identity”.<sup>27</sup> Even in the early stages of the phenomenon we believe there will be threats to individual identity, which would obviously be magnified if the science developed along the *Face/Off* lines. While we do not hold that the recipient would in some way “become” the donor, we perceive a dynamic relationship between the body and the mind, such that changes in the one will affect the other.

Caplan and Katz rightly talk only of an “association”, since a popular philosophical account of personal identity actually seems most likely to hold that face transplants present no difficulties in terms of identity. The philosophical literature is replete with attempts to pinpoint the necessary and sufficient conditions for holding that a person is *that* person; in other words, attempts to answer the related questions, “who am I?” and “what makes me *me*?” These questions are often considered along spatio-temporal lines, in terms of re-identification, where the quest is to discover the conditions that make a person at time T1 the same person as at time T2. Broadly speaking there are two rival criteria, based in physical and psychological attributes, respectively.

The first view essentially holds that sameness of body means sameness of self or person. Supporters of this view of the spatio-temporally-continuous human should readily grasp the significance of face transplants for personal identity. Indeed, if the face is seen as a particularly important identifier, those in the “body camp” might well ask, who is the donor and who is the recipient? Is my body receiving your face or is your face receiving my body?

There are alternatively those who emphasise the importance of certain psychological properties, such as a functioning brain (or brain stem), personality and memory. Parfit, a leading proponent of this view, suggests that personal identity be characterised by psychological continuity.<sup>28</sup> The essential point of such accounts is that the continuing presence of a particular human body is not sufficiently or even necessarily required for identifying that human body as a particular person. Indeed, on some religious accounts, the “person” (or soul) is utterly distinct from the body and can therefore exist without a body or after the body’s demise. This psychological conception has been employed in analyses of, for example, the meaning of death, whether the demented patient is continuous with the pre-demented patient, and the validity of advance directives, which are expressed by the competent patient but applicable to the body of that patient when incompetent.<sup>29</sup>

Whether theistic or otherwise, strict adherents to psychological criteria would probably deny that my face is essentially constitutive of who I am. As such, a face transplant appears to pose no problem in principle, even if the science did develop to enable the wholesale adoption of another person’s

face. Yet while the present authors are *most* inclined towards the “mind camp”, we also feel that a face transplant can and will impinge on identity, and accordingly present challenges for both recipients and donors (and their loved ones).

First, we must recall that the face transplant as currently proposed will offer only improvements in aesthetic appearance. In stark contrast to other transplantation procedures, the physical, functional benefits will be absent. Why then would an individual wish to undergo this procedure? Surely the primary motivation must be the attendant psychological benefits offered by the anticipated improvement in appearance. If one’s psychological make-up provides the key to identity, it is therefore plausible to hold that a face transplant would indeed have an impact on identity. If this logic succeeds, the question then becomes: is this impact likely to be benign or malign? Unfortunately, this is difficult to predict with certainty before the transplant is attempted, as the following evidence should demonstrate.

Research already suggests that transplanted tissue can feel “foreign” to the recipient, regardless of the tissue’s apparent association (or lack thereof) with personal identity. A Swedish study conducted by Sanner illustrates the differences in opinions expressed over the appropriateness of receiving tissues and organs from other human and non-human sources. Regarding xenotransplantation, one interviewee posed the question, “Would I become half a pig, if I got an organ from a pig?”, another queried whether he or she “would start grunting?”, while another opined that “At least 5% of me would become animal”.<sup>30</sup> Clearly, for these individuals at least, receipt of an animal organ would somehow impinge on their pre-existing notions of personal identity. As Sanner summarised, “It was less a feeling of influence and more a fear of having the sensation that the body would not be itself, it would be ‘wrong’”.<sup>31</sup> There is equally compelling evidence that some individuals fear the effects on their identity of receiving an organ from another *human* body. Another of Sanner’s interviewees asked, “If I exchange many parts, I wonder what’s left of me as a person?”<sup>32</sup> Such unease has even been cited in evidence before the English High Court. In *Re M*, reported in 1999, an adolescent was adjudged incompetent and in any case unable to refuse a heart transplant, which she urgently required.

Explaining the reasoning behind her initial refusal, M stated:

“I don’t want to die but I would rather die than have somebody else’s heart. I would rather die with fifteen years of my own heart. If I had someone else’s heart, I would be different from anyone else – being dead would not make me different from anyone else. I would feel different with someone else’s heart, that’s a good enough reason not to have a heart transplant, even if it saved my life.”<sup>33</sup>

There seems to be two concerns here: one, that she would differ from other people, the other, that she would somehow *be* a different person, at least in her own perception.

However, not everyone shares this unease. Another of Sanner's respondents referred to organs as "machine parts, in principle nothing strange", while others commented that "If you receive a new heart, it will become your own" and "What is me, is not depending on whose kidney I have received".<sup>34</sup> Xenotransplantation did not trouble everyone, either: "My body wouldn't feel different if I get an animal organ. I'm also a kind of animal".<sup>35</sup> "Special" tissues can also be accommodated: Lee Brash, who had received a heart and lung transplant as a teenager, understood but did not share M's resistance:

"I used to think that maybe I would be different. With a different heart I might feel different things – even fancy different girls. But I didn't feel any different at all. It doesn't affect the person you are."<sup>36</sup>

Opinion is therefore divided and, as the Nuffield Council has observed in relation to transplants from animal sources,

"It is difficult to predict what the effects of xenotransplantation might be on individual recipients and, in particular, how people's views of their body and of their identity might be affected by xenotransplantation."<sup>37</sup>

This is not to deny that some potential recipients can indeed predict the effects for themselves and accordingly stipulate what they are and are not willing to receive. For example, a Jehovah's Witness might oppose a blood transfusion and an Orthodox Jew might object to the use of tissues, valves and organs from pigs.<sup>38</sup> Gillett, albeit writing in a slightly different context, clarifies why such procedures can be seen as threatening. He essentially offers an argument as to why one's psychological "make-up" is the key to personal identity. For Gillett, one's personal identity – indeed, he suggests one's status as a *person* – is inextricably connected with one's narrative or life story. As he says,

"A *person* is largely the cumulative result of a conscious narrative of life... Once one realises this central role of narrative in human life, the insight soon follows that being a person *just is* an ongoing process of being inscribed in this way – by the world and the significations impinging on one – and living out the psychic effects of that cumulative inscription under the shaping influence of the values that guide one's self-creation."<sup>39</sup>

If we understand Gillett, he is suggesting that one's identity derives, at least in part, from one's values. Religious faith might occupy a distinctive part of my narrative and hence be to some extent constitutive of my identity. Thus, I might choose to forego a procedure that is contrary to my sincerely and strongly held beliefs on the basis that this would contradict something that defines me; in other words, "I won't have the blood; it's just not me". Gillett's observations therefore return us to the suggestion that we should turn the choice over to the recipient, making the conditions for autonomy provide our moral compass. But that will not eradicate the uncertainty: can

the individual predict what he or she is getting and whether this will be what he or she wanted? The recipient of the first hand transplant is a case in point as, although he evidently consented to the procedure, he reported feelings of foreignness towards his transplant which, combined with the side effects of the supporting drugs, eventually necessitated its removal.<sup>40</sup> How then could we predict the response of the recipient of a new face?

That a major change in one's appearance can have a significant psychological effect and accordingly impact upon one's self-perception and identity is poignantly illustrated by the famous situation of "Dax". Don Cowart received second and third degree burns over two-thirds of his body in a gas explosion and was consequently hospitalised for 232 days. Despite Don's repeated requests that the painful treatment be discontinued, the health professionals persisted. Prior to the accident, Don had been handsome and athletic; following the accident, he was totally blind, barely able to use his hands, badly scarred, and dependent on others to assist him in performing personal functions. Don now re-named himself "Dax". As WF May has stated, the bodily changes in turn prompted an "interior transformation", in which "Don Cowart becomes Dax".<sup>41</sup> Don had worked as a pilot in the Air Force, and was working in real estate at the time of the accident. Dax married and became a lawyer. Evidently Dax felt sufficiently "other" to re-name himself. His "old" identity was not completely lost, however, since (for example) his ambition and mental fortitude were just as pronounced after the accident, as evidenced by his subsequent achievements and the fact that, if placed in a similar situation again, he would still decline the burns treatment he endured (don't think that adds anything.<sup>42</sup> But what if Dax was to receive a face transplant? Would he then assume a third identity and third name?

Of course, it is not only one's self-perception that needs to be considered. The human face is, as MacGregor et al. recognise, "the source of vocal communication, the expression of emotions, and the revealer of personality traits. The face is like the person himself".<sup>43</sup> This suggests that the defensibility of the procedure cannot be resolved by appealing to the individual and autonomy alone, since the impact on others seems also to matter. These others might comprise the loved ones of the recipient and, importantly, the loved ones of the deceased donor. Potential donors would, we assume, need to be tissue matched and of a similar age and ethnicity to the recipient. Furthermore, because the facial tissue will deteriorate fairly rapidly after death, the recipient and donor will probably need to be geographically proximate as well. There is therefore the prospect of a relative of the deceased being confronted by a familiar face. This might only amount to a recognisable mole or similar feature in the early phase, which might be troubling enough, but could then become an especially significant issue if the science developed to the wholesale assumption of another face.

It therefore appears that not only are we unable to predict the effects on the individual receiving the face transplant but also that the impact on others is also somewhat difficult to foresee. Individual choice may be an insufficient solution since the risks and benefits are hard to assess and, as Dax further exemplifies, the aforementioned Catch-22 of receiving the transplant still remains. We therefore need further engagement with the possible effects of receiving the procedure, by scientists, ethicists and, it would appear, society at large. Indeed, the role and influence of society is particularly important here and therefore forms the focus of our penultimate section.

### **7. Who is the Patient? (Part II)**

Having suggested that the effect on identity and self-perception might not be so obviously positive in nature, why offer a face transplant? This leads us to consider again the general question, who are we treating? Another of Sanner's respondents felt that "It doesn't matter what you have inside your body, it wouldn't be visible from outside".<sup>44</sup> Visibility and appearance seem to matter, as a respondent to an online BBC poll further suggests:

"There's a lot more to a person than their[sic] face – the person with the transplant will not become you [the donor]. I can see how psychologically it could be very difficult to wake up with someone else's face, but I'd think less difficult than waking up without a face you can show anyone."<sup>45</sup>

Christine Piff, of *Let's Face It*, acknowledges that facial disfigurement can be a major source of emotional distress and that a transplant could benefit those who have become "withdrawn".<sup>46</sup> But this should give us another reason to pause. Such withdrawal is surely due in part to the responses from other members of society. Piff herself has spoken of "people staring at me" and feeling both "awful" and in need of "every bit of courage" she could summon.<sup>47</sup>

In an important sense, one must query whether the "patient" is actually society, and in particular image-conscious Western society. MacGregor et al. wrote that,

"Every culture has its own standards of attractiveness, and while an infinite number of physical divergences are possible which meet the aesthetic requirements, a certain conformity is demanded".<sup>48</sup>

This apparent obsession with beauty is probably one of the strongest reasons for permitting this procedure and also ironically one of the main reasons why it gives cause for concern. Ideally, of course, society would celebrate, rather than alienate, such diversity. There nevertheless lingers the suspicion that the influence of societal norms amounts to a form of coercion, which might again threaten the validity of any consent. In another parallel with the euthanasia and palliative medicine debate, we wonder whether alternative responses to disfigurement, such as counselling, would suffer once the

transplantation doors are opened. As Strauss points out, “when something is correctable, our willingness to accept it as untouched is reduced”.<sup>49</sup>

These concerns, particularly when considered alongside the risks of rejection, the risks associated with immuno-suppressants and the uncertain psychological effects of the procedure, combine to suggest that there is more work to do both with those with disfigurements and in this debate specifically. Certainly, the work of charities like the British *Changing Faces* needs greater recognition, particularly by health care professionals dealing with the disfigured. Although we do not oppose face transplants in principle, more can still be done to respond to the disfigured individual and to facilitate that individual’s flourishing in society.

### **8. Conclusion: Whether or When?**

We have focused on issues relevant to the recipients of face transplants, which we believe need further analysis and discussion before the procedure is attempted. Other issues that we have not addressed fully include the existence (or otherwise) of a pool of willing donors and the question of cost: would the recipient have to fund the life-long supply of anti-rejection drugs and if so would ability to pay become a criterion for inclusion? Until such questions (and doubtless more) receive defensible answers, we should not be forced into thinking in terms of “when?” but should instead continue to ask “whether or not?” In terms of this latter question, it is worth clarifying that (as our discussion of personal identity demonstrated) we have not found a problem with the procedure in principle, but we accept that such opposition may well exist. One might anticipate, for example, appeals to Caplan’s “yuk” factor and charges of meddling with nature. We are not convinced that such arguments will succeed but we are convinced that all such views must be aired at this juncture.

Even if there exists no principled objection to the procedure, there is still cause for concern and there remain questions to be answered. Who would be a suitable recipient of the transplant and can the Catch-22 of “need” and vulnerability be avoided? How can we predict the effects of receiving the donor face on the individual and, indeed, others, such as the loved ones of both the recipient and the donor? While slippery slope thinking sometimes prompts specious and deliberately extreme metaphors, might this not also be an area in which the potential for future abuse and move to elective transplants are sufficient to prevent the first steps being taken? Is this procedure at least in some sense motivated by society’s intolerance of disability? Should not greater efforts be put into other means of addressing the problems associated with and caused by facial disfigurement? Finally, and perhaps most importantly, will the anticipated benefits of receiving the transplant outweigh the risks? The Working Party of the British Royal College of Surgeons was most influenced by the risk of the face rejecting and the uncertain psychological effects of receiving a donated face.<sup>50</sup>

Notably, at a public debate hosted by the London Science Museum, Dana Centre, at least one of the report's authors did not otherwise object in principle to the procedure being undertaken. However, at the same event, the authors appeared to lack a clear view as to when the risks would be sufficiently minimised. We have suggested that this procedure must be viewed as experimental, and research will always carry risks. Should it therefore simply be left to the individual to decide whether or not to run the risks? Whilst mindful of charges of paternalism, we believe autonomy alone cannot govern here. The rights and wrongs of the procedure do not wholly lie in the realm of private morality, since it will surely impact on those close to the recipient and donor and it also involves, and is expressive of the values of, the societies in which the procedure is being contemplated. For these reasons we welcome further analysis and debate not least so that, in the drive to gain face, we do not overlook the risks of losing face.

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<sup>1</sup> BBC News Online Network. From Hand to Face. 30 September 1998. Available from: <<http://news.bbc.co.uk/1/hi/health/183870.stm>>

<sup>2</sup> The Royal College of Surgeons of England. 2003. *Facial Transplantation*. Working Party Report. Available from: <[http://www.rcseng.ac.uk/services/publications/publications/pdf/facial\\_transplantation.pdf](http://www.rcseng.ac.uk/services/publications/publications/pdf/facial_transplantation.pdf)>

<sup>3</sup> Comité Consultatif National d'Ethique pour les Sciences de la Vie et de la Santé 2004. *L'allogreffe de tissu composite (ATC) au niveau de la face (Greffe totale ou partielle d'un visage)*. Opinion 82: 1-20. Available from: <<http://www.ccne-ethique.fr>>

<sup>4</sup> O.P. Wiggins, J.H. Barker, S. Martinez, M. Vossen, C. Maldonado, F.V. Grossi, C. G. Francois, M. Cunningham, G. Perez-Abadia, M. Kon and J. C. Banis. On the ethics of facial transplantation research. *The American Journal of Bioethics* 2004; 4(3): 1-12.

<sup>5</sup> R. Nicholson. Editorial. *The Bulletin of Medical Ethics* 2002; 183: 1.

<sup>6</sup> D. Concar. The Boldest Cut. *New Scientist* 2004; 29 May: 32-37.

<sup>7</sup> Taipei Times Online. Face transplants Nearing Reality. 19 November 2003. Available from: <<http://www.taipetimes.com/News/taiwan/archives/2003/11/19/2003076393>>

<sup>8</sup> Op. cit. note 2.

<sup>9</sup> N. McDowell. Surgeons Struggle with Ethical Nightmare of Face Transplants. *Nature* 2002; 420(6915): 449.

<sup>10</sup> Ibid.

<sup>11</sup> NHS UK Transplant. *UK Transplant Activity Report 2003-2004 Summary*. 2004. Available from : <[http://www.uktransplant.org.uk/ukt/statistics/transplant\\_activity/transplant\\_activity\\_uk\\_2003-2004\\_summary.jsp](http://www.uktransplant.org.uk/ukt/statistics/transplant_activity/transplant_activity_uk_2003-2004_summary.jsp)>

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- <sup>12</sup> C.A. Erin and J. Harris. An Ethical Market in Human Organs. *Journal of Medical Ethics* 2003; 29: 137-138.
- <sup>13</sup> M.E. Tardy. Ethics and Integrity in Facial Plastic Surgery: Imperatives for the 21<sup>st</sup> Century. *Facial Plastic Surgery* 1995; 11(2): 111-115.
- <sup>14</sup> ????
- <sup>15</sup> J. Crace. Pushing Back the Frontiers. *The Guardian* 15 July 2003.  
Available from: <  
<http://www.guardian.co.uk/print/0%2C3858%2C4711861-103531%2C00.html>>
- <sup>16</sup> BBC News Online Network. Doctors Perform Jaw Transplant. 2 February 2003. Available from: <<http://news.bbc.co.uk/2/hi/health/2712767.stm>>
- <sup>17</sup> P. E. Butler, A. Clarke and R. E. Ashcroft. Face Transplantation: When and for Whom? *The American Journal of Bioethics* 2004; 4 (3): 16-17.
- <sup>18</sup> See *Re C (Adult: Refusal of Treatment)* [1994] 1 WLR 290.
- <sup>19</sup> University of Louisville School of Medicine Plastic Surgery Research Information for Potential Face Transplant Patients and Research Subjects.  
Available from:  
<<http://plasticsurgeryresearch.louisville.edu/news.htm#Cleveland>>
- <sup>20</sup> Op. cit., note 2, at p. 10.
- <sup>21</sup> Op. cit., note 16.
- <sup>22</sup> BBC News Online Network. Surgeon Agrees to Sever Transplant Hand. 21 October 2000. Available from:  
<<http://news.bbc.co.uk/1/hi/world/europe/982817.stm>>
- <sup>23</sup> Op. cit., note 11.
- <sup>24</sup> Op. cit., note 4, at p. ????
- <sup>25</sup> R. Fox and J. P. Swazey. 1979. *The Courage to Fail: A Social View of Organ Transplants and Dialysis*. Chicago: University of Chicago Press.
- <sup>26</sup> G. Foucher. Commentary: Prospects for Hand Transplantation. *The Lancet* 1999; 353: 1286-1287.
- <sup>27</sup> A. Caplan and D. Katz. In Brief: About Face. *Hastings Center Report* 2003; 33(1): 8.
- <sup>28</sup> D. Parfit. 1984. *Reasons and Persons*. New York: Oxford University Press.
- <sup>29</sup> E.g. M. B. Green and D. Wikler. Brain Death and Personal Identity. *Philosophy and Public Affairs* 1980; 9(2): 105-133.
- <sup>30</sup> M. A. Sanner. People's Feelings and Ideas about Receiving Transplants of Different Origins: Questions of Life and Death, Identity, and Nature's Border. *Clinical Transplantation* 2001; 15: 19-27, at p. 22.
- <sup>31</sup> Ibid.
- <sup>32</sup> Ibid.
- <sup>33</sup> C. Dyer and S. Boseley. A Matter of Life and Death. *The Guardian* 16 July 1999: 3.
- <sup>34</sup> Op. cit., note 30.

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<sup>35</sup> Op. cit., note 30, at p. 23.

<sup>36</sup> G. Davidson. New Life is Heart of the Matter. *Evening News* (Edinburgh) 19 July 1999: 15.

<sup>37</sup> Nuffield Council on Bioethics. 1996. *Animal-to-Human Transplants: The Ethics of Xenotransplantation*: para. 10.45. Available from: <<http://www.nuffieldbioethics.org/publications/xenotransplantation/rep0000000042.asp>>

<sup>38</sup> See e.g.

<<http://www.cmf.org.uk/index.htm?nucleus/nucoct93/jehovah.htm>>;

<<http://www.freeminds.org>; <http://www.ajwrp.org/index.shtml>>

<sup>39</sup> G. Gillett. You Always Were a Bastard. *Hastings Center Report* 2002; 32: 23-28: 26-27.

<sup>40</sup> Op. cit., note 22.

<sup>41</sup> W. F. May. 1991. *The Patient's Ordeal*. Indiana: Indiana University Press: 35.

<sup>42</sup> See further R. Cavalier, P. Covey and D. Anderson. 1996. *A Right to Die? The Dax Cowart Case: An Ethical Case Study on CD-Rom*. London: Routledge.

<sup>43</sup> F. C. Macgregor, T. M. Abel, A. Bryt, E. Laner, and S. Weissman. 1953. *Facial Deformities and Plastic Surgery: a Psychosocial Study*. Springfield, Ill: Charles C. Thomas: 65????.

<sup>44</sup> Op. cit., note 30, at p. 23.

<sup>45</sup> Katie, UK ????

<sup>46</sup> Op. cit., note 9.

<sup>47</sup> BBC News Online Network. I Would Consider a Face Transplant. 27 November 2002. Available from:

<<http://news.bbc.co.uk/1/hi/health/2518555.stm>>

<sup>48</sup> Op. cit., note 43, at p. 65.

<sup>49</sup> R. P. Strauss. Ethical and Social Concerns in Facial Surgical Decision Making. *Plastic and Reconstructive Surgery* 1983; 72(5): 727.

<sup>50</sup> Op. cit., note 2.