

Facial Transplantation and Self-Identity

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Persons with severe facial deformity, whether congenital or acquired, frequently testify to enduring their own via crucis.¹ No matter the etiology, persons with extensive facial injuries confront and cope with their psycho-physical agony in one of two ways: Either they learn to live with and accept their facial anomalies, maintaining at least a semblance of normal social interaction in the process. Or, unable to achieve even a minimal sense of normalcy and positive self-image, they opt to have their facial appearance improved surgically.

Until recently, improving facial functionality and aesthetics meant one thing. Persons with major facial deformities needed to undergo conventional plastic and reconstructive surgical techniques: skin grafts, transplanted autologous tissues, and facial prosthetics. This reconstructive odyssey, requiring hundreds of surgeries over an extended period of time, often yielded less than satisfying, and sometimes completely unsatisfactory, results.²

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¹Facial deformities can be congenital, from birth defects, or acquired from severe burn injuries, facial cancer, or other catastrophic injuries. The French woman Isabelle Dinoire, who received the world's first partial face transplant in May 2005, suffered devastating facial disfigurement after being mauled by a dog.

²Despite international debate about the procedure's ethics, Dr. Bohdan Pomahac, the plastic surgeon who heads the face transplant program at Brigham and Women's Hospital in Boston, is driven to go forward with it by the fact that his burn and cancer patients continued to

Determined to realize better outcomes for their patients, a cadre of reconstructive surgeons have set their sights on a more radical treatment option for facial disfigurement.³ Toward that end, these surgeons have conducted the requisite preliminary research by performing facial transplants on animals and human cadavers. Their years of intense planning and ambitious research have earned them the appropriate medical and ethical clearance for an experimental alternative for persons with severe facial deformity—specifically, facial (allo)transplantation. With this option, affected individuals would receive a partial or whole face graft from a cadaveric donor.⁴

In this essay I will prescind from an examination of the chief medical and health risks of facial transplantation, which include graft rejection and adverse health sequelae from indefinite immunosuppression.⁵ I will focus instead on what has been described as the procedure's primary psychological risk: the emotional

look disfigured after traditional facial reconstruction involving tissue grafted from other parts of their bodies (Liz Kowalczyk, "Brigham Doctors Will Do Rare Face Transplants," *Boston Globe*, July 29, 2007, http://www.boston.com/yourlife/health/diseases/articles/2007/07/29/brigham_doctors_will_do_rare_face_transplants/). Dr. Maria Siemionow, head of the Cleveland Clinic's face transplant program, has been looking for the past three years for the correct donor for a patient who needs a full face transplant. Her experience doing hand transplants taught her that with improved microscopic and microsurgical techniques and instruments, "connecting the tiniest blood vessels and nerves is now possible" (Miriam Falco, "The Next Step in Face Transplants Being Planned," *CNN*, December 30, 2006, <http://www.cnn.com/2006/HEALTH/12/29/face.transplant/index.html>).

³Two U.S. medical centers have petitioned and been approved to perform facial transplants. Cleveland Clinic will offer full face transplants, whereas Brigham and Women's Hospital will specialize in partial face transplants (Kowalczyk, "Brigham Doctors").

⁴Finding face transplant donors is proving to be a daunting task. Not only must the donor and recipient have the same blood type, they must also match in race, gender, and general age. The New England Organ Bank is creating a special consent process and form for the families of potential face transplant donors. Anyone signing up for organ donation when they receive a driver's license will not automatically be considered for face transplant donation. Instead, the organ bank will contact the family of a deceased person who is already donating other organs for special permission to donate their loved one's face (*ibid.*). In a partial face transplant, the surgeons remove only part of a cadaver's face—nose, upper lips, and cheeks, for example—and "painstakingly attach the tissue, blood vessels, and nerves to the disfigured patient" (*ibid.*). In a full face transplant, "the entire skin flap of a patient and possibly part of the scalp, ears, and neck would be replaced" (Falco, "Next Step"). Either form of face transplant involves routine microsurgery: "One or two pairs of veins and arteries on either side of the face would be connected from the donor tissue to the recipient. About twenty nerve endings would be stitched together to try to restore sensation and movement. Tiny sutures would anchor the new tissue to the recipient's scalp and neck, and areas around the eyes, nose and mouth" (Associated Press, "Preparing for the World's First Face Transplants," *MSNBC*, November 21, 2005, <http://www.msnbc.msn.com/id/9397182>).

⁵Although most clinicians agree that acute and chronic rejection together with the adverse health effects of immunosuppressive drugs are the principal health risks of facial transplantation, a recent report by John H. Barker and his colleagues at the University of Louisville, Kentucky, explains why, in the past, those risks may have been exaggerated. See

upheaval caused by an “identity” change—specifically, the prediction that a facial graft recipient will, post-transplant, experience a virtual emotional tsunami from the realization that their new face transforms them into a new person.⁶

“Identity Change” Predictions

Such predictions of identity change—change involving a person’s very substance or self—are based on two alleged needs of transplant recipients: (1) the need to incorporate the “non-self” of the transplanted organ into the recipient’s own self, and (2) the need to accommodate the “living on” of the donor in the transplanted organ. The following passages are fairly representative of such predictions. The first citation pertains specifically to facial transplant recipients:

D. Vasilic et al., “Risk Assessment of Immunosuppressive Therapy in Facial Transplantation,” *Plastic and Reconstructive Surgery* 120.3 (September 2007): 657–668. Having collected new data on risks of facial transplantation from current clinical transplantation experience that more closely approximates facial transplants, Barker et al. conclude that “data on immunosuppression regimen, recipient health status, and condition of the transplanted tissue revealed a substantially lower risk of acute rejection, acute rejection reversibility, chronic rejection, cytomegalovirus disease, diabetes, hypertension, and renal failure” than was previously estimated (Charles Bankhead, “Immunosuppression Risks of Face Transplants Overstated,” *MedPage*, August 29, 2007, <http://www.medpagetoday.com/Surgery/PlasticSurgery/tb/6532>). Barker et al. counsel that the new statistics regarding the medical and health risks of facial transplantation should be made available to and used by “facial transplant teams, institutional review boards, and potential recipients when considering the immunologic risks associated with facial transplantation” (Vasilic et al., “Risk Assessment”).

⁶The September 2004 issue of the *American Journal of Bioethics* is dedicated to the ethics of facial transplantation. The first target article, “On the Ethics of Facial Transplant Research,” by Osborne P. Wiggins and colleagues at the University of Louisville and the University of Utrecht, The Netherlands, introduces the notion of identity change: “Moreover, the recipient of a new face must deal with a new appearance, but to some extent this resembles the risk of receiving a new hand, which also reshapes one’s sense of one’s appearance. What is unique to facial transplantation, however, is that facial appearance is intimately and profoundly associated with one’s sense of personal and social identity. Therefore, the recipient of a face must adapt to his or her own responses to this new ‘identity’ as well as to other people’s response to it” (5). Response articles in the same issue criticize Wiggins et al. for paying scant attention to the psychological risks connected to changes in facial appearance. In “A Face Is Not Just Like a Hand: *pace* Barker,” Françoise Baylis, for example, argues that “recognition of the self is key to identity formation and this recognition is mediated, in part, through the face. To quote James Partridge, founder of Changing Faces (a charitable organization in the UK that helps people with facial disfigurement): ‘Even for those like myself with severe disfigurement, the face carries a lot of identity, the sense of self.’ A similar perspective can be found in the Royal College of Surgeons of England report on Facial Transplantation (2003): ‘The face is central to our understanding of our own identity. Faces help us understand who we are and where we come from.’ For these reasons, the face is not fungible in the way that other human organs and tissues used for transplant might be. As Linda Hogle, a medical anthropologist, writes about facial transplantation, ‘You’re really transplanting more than the tissue itself. You’re bringing someone else’s identity and overlaying it on the recipient’s body. . . . The face is the most intimate, most individual characteristic of your body. It’s who you are’” (31).

With the transplant of a visible organ, a deep identity split occurs, because one's self-image is modified substantially. Even if functionality is given to the grafter organ, the recipient still has to come to terms with this new organ—i.e., to recognize him or herself in the everyday use of the organ, which indeed is both self and different from self. . . . Every graft of a visible organ leads to an identity split, the consequences of which can be very serious if the recipient does not succeed in psychologically accepting the organ and in rebuilding its social expression in everyday life. Thus a transplant can be considered successful if it assures not only the function of the organ, but also the rebuilding of the recipient's identity. This difficult rebuilding work can be fruitful, because identity is characterized by a continuous evolution. The graft of a visible organ can lead to a full expression of one's identity, making the individual aware that to be oneself is to change constantly, and to accept oneself as changing.⁷

The second citation pertains to all transplant recipients: "In essence, then, the recipient experiences a reconstruction or transformation of the *existing self*. The donor's kin, in contrast, assert the existence of what Belk refers to as the *extended self*. . . . Appeals from donors' kin to establish and extend links of fictive kinship are satisfied, however, only in cases where transplant recipients feel they have successfully incorporated another's loved one as part of themselves."⁸

In what follows, I demonstrate that these predictions are based on an incorrect and misleading assumption about facial transplantation and identity. The Aristotelian distinction between substantial and accidental change reveals the error of thinking that facial transplantation represents a change in the recipient's very identity. Instead, a facial transplant recipient experiences what I will call a change in personality. Realistic assessment of this latter change will better equip recipients to meet the psychological challenges of facial transplantation.

The Error of "Identity Change" Predictions

First, as embodied persons, we human beings do not just have or use our bodies. We are our bodies. Hence, if a facial transplant is successful, the graft becomes a functional, i.e., living part of the recipient's (Mr. X's) embodied person. Conversely, since his facial graft is no longer alive or animated by the donor's soul, it ceases to be an integral part of the donor. Once the facial graft is animated by the formal principle of Mr. X and becomes an integral part of his body, it cannot be different from Mr. X's self or identity. A fortiori, the donor does not, in any way, "live on" in Mr. X through the facial graft, nor does Mr. X have an "extended self" from the donor. To encourage facial transplant recipients or donor families to imagine or act otherwise is to do both parties a huge disservice. It distracts Mr. X from getting on with the goal of protect-

⁷E. D. Carosella and T. Pradeu, "Transplantation and Identity: A Dangerous Split?" *Lancet* 368.9531 (July 15, 2006): 183.

⁸Lesley A. Sharp, "Organ Transplantation as a Transformative Experience: Anthropological Insights into the Restructuring of the Self," *Medical Anthropology Quarterly* 9.3 (September 1995): 379 (emphasis added).

ing his new facial graft so he can live a healthier, more normal life and prevents the donor's family from receiving closure about their loved one's death.

Second, the physiological datum of the systemic integration of the facial transplant also helps to bolster Mr. X's realization that the change that occurs in him is not the sort that transforms his substantial self or identity. Commonsense reflection tells Mr. X that he is the same person—the same self, the same substance—after the transplant that he was before. In other words, Mr. X is keenly aware that, although he may feel and look even markedly different after the facial transplant, his identity (that of an embodied, intelligent, free being) is completely unchanged. His challenge, then, is to consistently temper his spontaneous reactions to his changed appearance according to this truth.

The ontological reality of facial transplantation is also corroborated by the meaning of the English term *identity*. At its root is the Latin word *idem*, meaning “the same,” as in the “state or fact of being the same one.”⁹ So Mr. X is correct in reasoning that, throughout his life's many changes—to his facial appearance, location, or character—he continues to be the same embodied, intelligent, free human being. To put a fine point on things, Mr. X has, to date, undergone only one substantial or identity “change,” and that was at his conception, when his substance and identity came into being. And he has only one identity change yet to undergo, at his death, when his body will cease to be part of him, and only his spiritual soul will survive (although it will become empirically inaccessible to us). All other changes, including the admittedly traumatic one of a facial transplant, represent evident alterations to Mr. X's personality, that is, *accidental* modifications to his person.

Personality and the Nature of Accidental Changes

To better grasp how accidental changes determine Mr. X's personality, we first need to examine the different kinds of features common to human beings. Human features are of three types: properties, mere accidents, and modal differences.¹⁰

Properties naturally flow from the nature of the person's substance. Because Mr. X is substantially an embodied, intelligent, free being, he possesses certain properties, such as the need to eat, sleep, socialize, and communicate through conceptual language. In realizing these properties, Mr. X undergoes accidental changes, moving from being hungry to being sated or from being lonely to being sociable, for example. Another property is the general bodily appearance—an upright posture, smooth skin, and hair on the top of his head—that identifies Mr. X as a human being. That is to say, Mr. X demonstrates his substantial identity through intelligent and free behavior precisely because he has the radical capacity to carry his body in an upright, forward-looking manner.

⁹*Random House Dictionary of the English Language*, s.v. “Identity.”

¹⁰Aristotle discusses the difference between the substantial and accidental features of a human being in book I, ch. 7, of his *Physics*. In book I, lectures 7 and 8, of his *Commentary* on Aristotle's *Physics*, Aquinas takes up the same discussion.

Another feature of the human being's personality that accidentally modifies his properties is *virtue* or *vice* (acquired accidental features that are *perfections* of or *injuries* to the intellectual and volitional powers, properties of every human being). For example, Mr. X's acquisition of the virtue of prudence would perfect his intellect and will in making good decisions, while an acquired vice of imprudence would severely limit his freedom to consistently choose the good in his everyday affairs. Changes such as these are not the same as the change produced by facial transplantation, but they help us understand by contrast the nature of the alteration Mr. X does undergo.

The second kind of personality change that human beings undergo represents non-substantial modifications, called *mere accidents*. Strict accidents are personality changes that follow from merely accidental modifications. These do not originate from the individual's acquired virtues and vices, or from the realization of his other properties, but are brought about by external agents. Mere accidental changes are externally produced and modify the person's self in merely accidental ways—i.e., in ways that are relevant to his personality but irrelevant to his character and properties and, therefore, irrelevant to his substance.¹¹ So hair that is curled, skin that is shaved, or a posture that is stooped due to arthritis or osteoporosis are changes to the general bodily appearance of a human being that are irrelevant (i.e., accidental) to the person's properties.

Since Mr. X's face transplant does nothing to alter his character (his virtues and vices are unchanged by the procedure), nothing to modify the properties of having to eat, live in community, and search for the truth (Mr. X retains those needs after the facial transplant), and nothing to change the property of his general bodily stance (after the transplant, he retains the natural, radical capacity to walk around with the same upright, forward-looking carriage, performing the same kind of intelligent and free acts as he did before), it also does nothing to modify his substance. Mr. X's facial transplant modifies only his personality, more particularly, his facial appearance, one of the accidental features of his general bodily exterior.

The third kind of modification that affects an individual's personality occurs by a "mode" of human nature. Modal differences are accidental changes that are "proper" to an individual, in the sense of originating in his material cause (i.e., in his genomic or chemical composition). The white skin of person A, the black skin of person B, and the brown skin of person C represent differences that are mere accidents with respect to the substance of each person. Having different skin colors, in other words, does not change the species of persons A, B, or C. But since matter and form of a substance are co-relative, the modal (material) difference of skin color does affect the person's soul, not substantially, not by mere accident, but by

¹¹There are various ways that we can discover some kinds of internal or hidden changes. For example, to discover the bodily changes brought on by cancer, a patient can submit to an MRI or CT scan. In the case of a facial transplant, the recipient undergoes external changes—visible changes in his facial features—and internal changes that occur under the skin, which are manifest only through symptoms or, perhaps, on x-ray or ultrasound images.

way of establishing the “mode” of the individual’s human nature. Similarly, men and women differ, not by a property or a mere accident, but by a “mode” of human nature. Although modal differences do not apply to the change produced by facial transplantation, it is well to understand these accidental differences, since they have significant social justice implications.

Informed Consent and the Accidental Change of Facial Transplantation

Because facial transplantation is an accidental change only, think what a difference it would make in Mr. X’s informed consent process if he were to receive counsel from a psychologist or psychiatrist who could, first, correctly articulate the kind of accidental change that is realized with a facial transplant and, second, predict by extension the intensity of the mental and emotional adjustments that Mr. X might need to make.¹² When it comes time for Mr. X to evaluate the psychological risks of an alleged identity change, how helpful would it be to hear something like this from his counselor:

“Your facial features will change and, if all goes well, could be dramatically improved. But you will continue to be the same person you were before the transplant. Don’t be fooled, then, by your reaction of ‘that’s not me’¹³ or ‘I don’t look at all like my old self’ when you look into the mirror the first few times after receiving your new face. You’ve done the groundwork, carefully examining the whole question of the kind of accidental change produced by a facial graft. So you will be equipped to consistently temper your initial reactions by the realistic understanding that the ‘you’ reflected in the mirror might have a new face but not a new identity.

“And with the assurance that you’re the same person, only better looking, you will gradually gain the courage and maybe even the eagerness to re-enter society—to once again mingle and interact lovingly and productively with family, friends, and coworkers. Resuming activities of a normal human life will slowly but surely boost your own self-acceptance and feelings of self-worth. I predict that you will rid yourself of the negative emotional baggage that you’ve carried with you for the past five years since your burn injuries. I am suggesting, then, that regaining the small but

¹²To execute a successful facial transplant, the leading reconstructive plastic surgeons are assisted by a formidable team of experts: a clinical research coordinator, a transplant social worker, a transplant dietician, nurses and clinical coordinators, a transplant infectious disease physician, surgeons who have done facial transplants in animals, and a transplant psychiatrist. Since the psychological risks—not just from the changes in facial appearance but also from the unsavory consequences of graft rejection—are frightening, it is critical that the psychiatrist gives correct and helpful information regarding these risks.

¹³Isabelle Dinoire, the partial facial transplant recipient, reported to the press that her initial reaction was, “that’s not me.” But the unease dissipated when she considered how fortunate she was to be able to get on with her life. “I have returned to the planet of human beings,” she said, “those with a face, a smile, facial expressions that let them communicate” (Kowalczyk, “Brigham Doctors”).

symbolically huge joys of being able to eat normally, talk, wink, blush, and smile will yield an enormous psychological harvest of joy, contentment, and healthy interaction with others. And the power of these positive emotions and behavior will not only dominate but perhaps eventually eradicate all traces of your former hopelessness, anger, and withdrawal. Your improved self-concept and reintegration into society will inevitably make you a happier, more fulfilled person, able to give yourself to others and to receive them as gift.

“That your facial transplant changes you in a strictly accidental way is underscored by another possible outcome. Reconstructive facial surgeons have suggested that, as your graft adjusts to the muscle and bone structure that you have retained, your new face will begin to shape itself around that structure. So, rather than looking completely unlike yourself, your new facial appearance could well turn out to be a cross between your uninjured face and that of your donor.”¹⁴

An Aristotelian Distinction

My contribution to the ensuing public conversation on the ethics of facial transplantation is to shine the light of the Aristotelian distinction between substantial and accidental change on the psychological risks of facial transplantation and the process of evaluating these risks during the recipient’s informed consent process. Here I defend a two-fold thesis: first, rather than causing a substantial change, i.e., an identity shift in the recipient’s person, facial transplants represent a change in personality, i.e., mere accidental changes in the facial appearance of the transplant recipient. Second, this realistic framework for understanding the psychological risks associated with these changes will, in turn, guide prospective facial transplant candidates toward a more accurate assessment of (a) how to evaluate those accidental modifications as well as (b) how to prepare for and cope with their related mental/emotional challenges.

¹⁴See Associated Press, “Preparing for the World’s First Face Transplants.”