The Transplantation Revolution: From Vital to Non-Vital Organs and Finally to Faces?

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The announcement that the first face transplant had been accomplished December 3 and 4 at Amiens University Hospital in Northern France was greeted by a healthy dose of criticism. This story has the making of a soap opera. Isabelle Dinoire, 38 years of age, sustained "horrific wounds from a dog bite in May . . . [that] left her largely unable to eat, drink, or talk."1 The circumstances of the injury itself are somewhat clouded, but the patient confirmed that it all began with a suicide attempt.2 Her surgeon, however, denied that the trauma was a suicide attempt. Seven months later, she became the recipient of a portion of a brain dead donor?s face (who did commit suicide) that covered the nasal, facial, and lip defects resulting from her trauma.

Why all the publicity, one might ask? Since hand and larynx transplants began a few years ago, transplantation has again entered unprecedented territory. Those transplanting hands, larynxes, and faces must now address recipient risk for organs that are important, but not essential to life. This is a completely different set of circumstances than encountered during the transplantation of kidneys, livers, and hearts. Is the uproar directed at the first face transplant valid? In order to answer this question, it may be pertinent rather to ask what unequivocal ethical constructs should be in place before proceeding with the transplantation of "non-vital" organs, especially one as prominent as the face.

First, the entire process, especially since it is experimental, has to be transparent?that is, never in isolation from approval and step-wise evaluation of the public and medical profession. In this regard, it is interesting that both the Royal College of Surgeons and French National Ethics Advisory Committee recently stipulated that a red light be given to face transplantation, at least at this time.3 The British and French opinions were both concerned over the potential adverse consequences of graft failure (10% in the acute period and another 30 to 50% over the ensuing 5 years). The groups left a yellow light for a later time, when immune-suppression would progress
to a stage wherein rejection would be less prohibitive. In contrast to the French enterprise, in 1997, the first International Symposium on Composite Tissue Transplantation was attended by experts in immunology, transplant, research, and ethics from all over the world. They were there to openly discuss any issue relevant to hand transplantation. Critical questions were debated such as has adequate animal research been performed to progress non-vital organ transplants to human subjects, for example. Unfortunately, in the instance of Isabelle Dinoire, the disregard for transparency? and healthy debate, as well as the impartial opinion of two respected professional organizations, is bothersome.

Next is informed consent. The informed consent process has to be iterative, comprehensive, and forthright about what is really unknown and unpredictable. Face transplantation may be accurately characterized as experimental. As an example, with the first larynx transplant, exhaustive efforts were made to inform the patient over an extended period (exceeding the 7 month duration in this instance) about the pros and cons of a revolutionary and risky therapy. Any coercion based on unrealistic expectations or reward has to be completely absent for consent to be authentic. Was only 7 months enough time for a woman who may have attempted suicide? Did she know about the risk of cancer from immune-suppression, or about a 10% risk of diabetes from her medications? Were alternative, approved treatments (grafting, flaps) tried so that transplant was a last resort? Furthermore, recent disclosure of substantial monies ($177,000) contracted to the patient and surgical team for a documentary, if true, is problematic.

In addition, how vulnerable will this particular individual become now that she is under the glare of inordinate publicity? A fragile psyche may lead to a discontinuation of anti-rejection medications and stimulate the disfiguring results of rejection. Severe depression will inevitably follow. Were even these basic requirements to proceed enforced by unbiased individuals (that is, people solely concerned about the patient?s welfare and reasonably independent of the surgical team and the profitable documentary) on an Institutional Review Board? Although there is more to examine on an ethical checklist, the aforementioned are essential.

The ethical issues that have surfaced after the world?s first face transplant are both substantive and valid. The red light recommended by expert consensus should be enforced for any future attempts that proceed in such a vacuum, immune from well-intentioned debate and genuine concern for the recipient. That the first face transplant occurred under the particular circumstances that it did is yet another black eye for Post-Hippocratic medicine. It appears, unless evidence surfaces to the contrary, that the proverbial foxes may have been caring for the chicken coop! Unfortunately, the recipient was a very vulnerable human being and the rest of her story may qualify as a tragedy.


5 Sage, "Face Transplant Woman To Profit From Picture Sales."

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