

<http://somatosphere.net/2014/08/how-the-face-became-an-organ.html>

How the Face Became an Organ

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By Samuel Taylor-Alexander

On July 3 of this year, the face became an “organ”. Changes to US Federal health policy came into effect, moving face transplantation into the jurisdiction of medical procedures governed and administrated by the agencies that oversee the US national transplant system – the Organ Procurement and Transplant Network (OPTN) and the United Network for Organ Sharing (UNOS). This policy introduced into the world a new type of thing: the “VCA organ”. The term refers to vascularized composite allografts, complete sections of tissue that are procured for transplantation. The most common VCA procedures are face transplantation and hand transplantation. My research to date has examined how the former has introduced new institutional and epistemic understandings and practices into world of biomedicine. In my book [*On Face Transplantation: Life and Ethics in Experimental Biomedicine*](#) (Palgrave Macmillan 2014), I argue that what is being remade in face transplantation is not only the lives of patients, but also the very ways in which state institutions, surgeons, and families make sense of rights, claims for inclusion, and life itself in the contemporary world.

In this post I want to shift focus a little to think about how the ontological status of body parts in technomedicine are shaped vis-à-vis regulatory practice. One of the most well known examinations of ontology in medicine is Ann Marie Mol’s [*The Body Multiple*](#) (Duke 2003), in which the author masterfully demonstrates how “medicine enacts the objects of its concern and treatment,” that is, how it “attunes to, interacts with, and shapes its objects in its various and varied practices” (vii). While it isn’t yet possible to show in detail how the face for transplantation is enacted in light of this policy change, its new status as a VCA organ has been cause for deliberation by the agencies that until now have been responsible for administrating the procurement and allotment of body parts such as the heart, kidney, and liver.

Recently I have been reading through the minutes of the OPTN VCA Committee, which was established to review agency policy in light of the aforementioned changes to the Federal health law. This has made me consider whether something is missing from those hospital-based accounts of ontology and medicine. Are we leaving anything out if we begin our analysis in the present by looking at how the body is

experienced and enacted in and through clinical practice? The deliberations of the VCA committee suggest that we should take more notice of the background work that implicitly shapes the clinical space – that we should examine how ontology in medicine is constituted in/by practice *and* policy.

In this short post, I want to examine this idea. The changes to national transplant law and the redefinition of an organ to include VCAs mean that the face for transplantation now has a rather peculiar ontological status. It is never just a face and never fully an organ; it is only an organ once it is removed from the donor and transplanted to the recipient, at which point it straightaway becomes a face; as a VCA the face extends past the immediate area of the face to include veins, nerves and extra tissue that would aid operative outcomes. The ontological status of the face in this form of medicine is thus both fluid and fractured. This echoes Mol's account of how medicine shapes its objects. Let's have a look then, at how such shaping is mediated by policy and broader sociopolitical concerns.

The Federal changes to the definition of an "organ" sought to standardize clinical practice for VCA procedures and, in doing so:

...ensure equitable access for those awaiting VCA transplantation, [as] there is a need to provide for consistency in allocation processes and reliable outcomes reporting on a nationwide basis. Appropriate Federal oversight of a national allocation system can increase safety of such transplants and provides equitable and consistent national access to such transplants while also conveying to the public that donation for such purpose will serve an essential medical need, ([OPTN, Notice of proposed rulemaking](#)).

Contained within the above is an implicit understanding of what both VCA procedures and the US state are about: ensuring equitable, safe and essential biomedicine. In making the face an organ, the Federal government has nationalized face transplantation in two interrelated ways: by standardizing disparate practices and by encoding them with values of what it stood for. From the get go, then, we see that normative sociopolitical concerns have been embroiled in the shifting status of the face for transplantation.

The piece of law that governs organ transplantation in the USA is referred to in short as the OPTN Final Rule. The modifications to this law were made in late 2013 and required the national transplant agency to develop policies for VCA transplant before July 3. Following amendments to the

Final Rule, now “Organ means a human kidney, liver, heart, lung, pancreas, intestine (including the esophagus, stomach, small and/or large intestine, or any portion of the gastrointestinal tract) or vascularized composite allograft.” Accompanying the classification of VCAs as an organ are nine criteria. For a graft to be considered a VCA, it must be something:

1. That is vascularized and requires blood flow by surgical connection of blood vessels to function after transplantation;
2. Containing multiple tissue types;
3. Recovered from a human donor as an anatomical/structural unit;
4. Transplanted into a human recipient as an anatomical/structural unit;
5. Minimally manipulated (i.e., processing that does not alter the original relevant characteristics of the organ relating to the organ’s utility for reconstruction, repair, or replacement);
6. For homologous use (the replacement or supplementation of a recipient’s organ with an organ that performs the same basic function or functions in the recipient as in the donor);
7. Not combined with another article such as a device;
8. Susceptible to ischemia and, therefore, only stored temporarily and not cryopreserved; and
9. Susceptible to allograft rejection, generally requiring immunosuppression that may increase infectious disease risk to the recipient, ([OPTN Policy Notice 7-1-2014](#)).

The role of the VCA Committee was to assess OPTN policy in light of the new status of composite allografts as organs, making suggestions as to additions to and deletions from previous guidelines. In making policy suggestions to the agency’s board of directors, it was able and required to engage with the interpretive flexibility of the above nine criteria. Until July 3, there were no formal guidelines for performing the procedure, and the three active teams that since 2008 have completed seven such operations did so with the oversight of their respective hospital IRBs. The protocols established and used by these individual teams brought together longstanding organ transplant guidelines with specific measures developed to ensure the success of the operation, such as more rigorous candidate selection to minimize the risks and increase the benefits of the operation (Taylor-Alexander 2014). And while these teams had been gaining “extra” consent from donor families for the use of VCAs from the face, there was no national mandate for them to do.

How Committee members understood the new definition of a VCA organ, and its ramifications for clinical practice, was mediated by their own backgrounds and what they considered to be broader sociopolitical concerns. During six months of contemplations and information gathering,

VCA committee members came to tackle a number of related issues that emerged with the introduction of this new kind of organ. These ranged from: ‘what kinds of VCA should be regulated by the OPTN?’ and ‘how should consent for procurement be obtained?’ to concerns that people would be less likely to go on the organ donor registry if they thought it possible that their face or hands would be transplanted. Reading over the meeting minutes, it is possible to see how these issues were settled in tandem; in the process questions of knowledge were coproduced with questions of politics, of social order.

For the purpose of this short post, I will take a look at the above three questions to show how the Committee worked within a broader frame that paralleled federal concerns with equity, safety and public regard for biomedicine. In its first meeting, a teleconference on January 22, the issue of what VCAs should be regulated by the OPTN was raised alongside the question of what exactly a VCA is: Is the recovery of extra vessels/tissue/nerves for the purpose of an enhanced outcome allowed? Members debated whether to employ an encompassing definition with broad guidelines for all composite allografts or to produce specific measures for each kind of VCA – i.e. separate protocols for face, hand, limb, etc. The Committee Chair, UCLA transplant specialist Dr Suzanne McDiarmid, [emphasized](#) that one of her aims was to “move relatively quickly into discussing specific elements necessary to better facilitate, and thereby maximize VCA procurements...” She recommended that the Committee therefore focus on face and hand transplantation, as they are the most common VCA procedures performed.

In subsequent meetings, the Committee made a number of policy decisions that simultaneously introduced standardized clinical practice while stabilizing the meaning of Vascularized Composite Allograft. Additional informed consent procedures for harvesting faces and hands for transplant was made a requirement, while the Committee thought it reasonable to work with the same framework established for solid organ procurement when deciding what exactly could be taken from a donor body under the label of VCA. The issue of access was addressed by producing national waiting lists and, in the future, recipients will be allocated organs through updated OPTN/UNOS software, which uses an algorithm to rank patients based on criteria such as patient need. While this bureaucratization of face (and other VCA) transplantation is yet to be explored on a clinical scale, I think it tells a story about how policy influences medical practice and thus the ontology of the body.

The nine criteria that define VCA organs were implemented to secure the status of medicine and the values of the US state as equitable and necessary organizations that exist to protect the health and safety of the population. These policies were introduced on the back of the emergence

of new types of medical procedures – face and hand transplantation – which arguably introduced public concern about the limits of biomedicine and the role of the state vis-à-vis the bodies of citizens. The resulting changes at the level of OPTN/UNOS policy have standardized and altered how the face for face transplantation will exist in the clinical space.

Unlike solid organs – kidneys, hearts and livers – the face is not considered an organ until it is harvested and transplanted for therapeutic purposes. There are a number of clinical practices that are necessary for this to take place: how the face is enacted, how it exists in networks of clinical practice is mediated by its new classificatory status. A number of practices must be put in place for this to be possible. Alongside new procedures for informed consent and allocation, how the face is treated in the clinical space has also been standardized. It must be labeled in a new way, travel accompanied by paperwork, not be combined with “another article or device”, and used solely for replacing a person’s body part. (If the procedure does not conform with the last two criteria, it would likely fall under the regulatory authority of the FDA.) What the face is, how it is understood and constituted and the clinical arena, has thus been altered through the implementation of new regulatory policy.

In this short post I have aimed to draw attention to the role of medical policy in the making of clinical practice. In debasing established practices and calling into questions longstanding accounts of what society stands for, emerging technomedical fields often become the site of intense scrutiny and political oversight. The result is what Sheila Jasanoff has termed “[constitutional moments](#),” instances of sociotechnical work that reorder both the social and natural world – medicine and its objects, in this case. Examining the background work that goes into the shaping of clinical practice in such a way, I suggest, is important because it allows us to better grasp how emerging technomedical fields become imbued with understandings of what a nation stands for. “How the Face Became an Organ” is thus a story of how the classification and enactment of the body in biomedicine is shaped vis-à-vis particular conceptions of how the US state should act vis-à-vis its citizens.

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