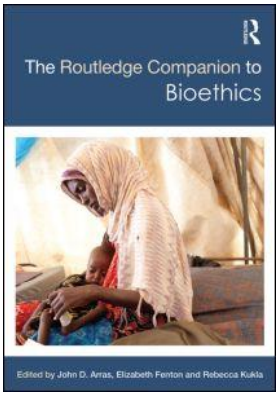

The Routledge Companion to Bioethics

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Organ Transplantation Ethics from the Perspective of Embodied Personhood

Publication details
https://test.routledgehandbooks.com/doi/10.4324/9780203804971.ch43
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Published online on: 12 Dec 2014

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ORGAN TRANSPLANTATION ETHICS FROM THE PERSPECTIVE OF EMBODIED PERSONHOOD

Fredrik Svenaeus

Transplantation Ethics

Organ transplantation is a medical procedure that presents stunning possibilities in saving and improving the lives of people who are ill and suffering (Tilney 2003). Although organ transplantations in this sense are ethically commendable things to do, the procedure has presented doctors, the law, and policy makers with a series of problems that have engaged medical ethics ever since the first transplants were carried out about half a century ago (Munson 2002). The ethical issues can roughly be grouped under four headings.

First, there are questions about the form of consent required from donors of organs. These questions regard both living donation—primarily kidney transplantations—and donation after death. Should consent be explicit or may it in cases of dead donation be presumed? What say should relatives have in the case of dead donation? How well informed must a donor be and what risks should he or she be allowed to take in the case of living donation? Should any form of compensation for the gift of organs be permitted?

The issue of compensation brings us to the second heading, namely questions regarding the buying and selling of organs. Should trade in human body parts be permitted? In nearly all countries of the world it is forbidden to buy or sell human organs, but the black market is large and growing. Kidney trafficking is a big business and the reason for this is the shortage of organs available for transplantation in rich parts of the world. Those in favor of lifting the ban on organ trade point out that legalization would improve the situation of vendors in poor parts of the world (Radcliffe-Richards et al. 1998). Under a legal organ trade vendors would receive a bigger share of the money that now ends up in the hands of organ brokers and they would presumably receive better medical treatment if selling was made legal. In addition to this, legalization would increase the supply of kidneys for transplantation in the world to a point at which the present lack would possibly cease. Costs for dialysis and other health care measures for people with kidney failure could be reduced, and the patients in question could live much better lives with

a new organ in their body. In many cases a new organ would mean life rather than death to these patients (Tilney 2003).

Arguments against a legal organ trade can be made in different ways. The claims that trade would lead to better consequences for everybody involved can be challenged. Would donation rates not fall if people expected to get paid for their organs instead of giving them away for free? Will poor people not be forced to sell their organs, having no better options to relieve their present misery, especially if they are in debt to unscrupulous profiteers who could now make use of this new opportunity of income (Wilkinson 2003)? Another way of defending a prohibition on selling and buying body parts is to point towards ways in which legalization of an organ trade would expand market behavior into yet another zone of human interaction (Waldby and Mitchell 2006). To give an organ—or several organs if we are talking about posthumous donation—is a way to contribute to the life and welfare of other human beings without profiting from it. It is a commendable act that serves as a model for how we should live together in a society (Campbell 2009).

The third heading involves questions about when persons are dead and/or when they have any interests that could be violated by letting them die by way of removing their organs. Most countries in the world have changed their legal definition of death (primarily, though, admittedly, not only) as a consequence of the new opportunities of treatment with which organ transplantation presents us. The brain has succeeded the heart as the organ that needs to be functioning if the person should be considered to be alive. Presently it is the functions of the whole brain that should be determined absent and beyond chances of recovery for the person to be proclaimed dead in the legal definitions of most countries (Russell 2000). But the possibilities of keeping patients alive (or dead) on respirators have also raised the question of whether persons who are beyond hope of regaining consciousness (although parts of their brains are still functioning) should not be considered to lack any interests to be kept alive, whereas their organs could be used to favor the interests of many other persons who are presently conscious and suffering (Singer 1995).

The fourth heading concerns what we *owe* to people who are ill and suffering. The concept of justice is, indeed, central to all questions of organ transplant ethics, since the question of whether anybody *deserves* to be in need of a new organ (being ill and facing death) is a pressing one. Does the principle of justice not oblige us all to give the needy organs we could dispense with and still go on living a good life (i.e., one kidney)? Does it not oblige us to give them that which we do not need ourselves once we are dead (i.e., all our viable organs)? Whether people are obliged to become organ donors as a matter of justice is a central ethical question in the organ transplant literature (Fabre 2006).

Embodiment and Selfhood

The ethical questions grouped under the headings above all touch upon the relationship a person (a self) has to his or her body. It seems to be presumed by most philosophers that organs are something that *belong* to each person respectively. That is presumably why the persons must always consent to their organs being removed, although they may not be allowed to do *anything* they like with their organs for various reasons—consider the prohibition against selling. The two latter headings—the questions regarding when a person is dead and if we are obliged to give away our organs when we do not need them

anymore—also concern issues of what belongs to the self. Can ownership rights be overruled in certain situations when the person is no longer there and/or parts of his or her body can be used to save the lives of others? These are the fundamental questions of transplantation ethics as it is currently pursued.

But what if our organs—kidneys and hearts will be my main examples in what follows—are not things that belong to us as commodities, but instead are to be looked upon as something that we *are*? How would such a *phenomenological* view upon selfhood, as fundamentally embodied, change our views on the ethics of organ transplantation? This is the question I will explore in this chapter, introducing some concepts from phenomenological philosophy and giving detailed descriptions of two cases of kidney and heart transplantation, respectively. Phenomenologists take their starting point in the first-person perspective when exploring an issue and I will try to stay true to this ideal in what follows (Zahavi 2005). This first-person perspective includes the second-person perspective (the dialogue with other persons), but it is to be contrasted with taking an impersonal third-person perspective of science as our philosophical starting point.

At first it may look as if the phenomenological view on the body would weaken the incentive or duty to give away one's organs when one can dispense with them, because it would equal giving away something of one's *self* instead of merely giving away one or several *things* that belong to you. However, as I will attempt to show, an embodied account of organ transplantation will rather make apparent that although different organs contribute to our embodied selfhood in various ways, this essential belonging of the person to his or her organs—rather than the other way around—shows us that our embodiment *connects* us to the lives and sufferings of other people in a fundamental way (Leder 1999).

The connectedness by way of the body goes back to the way we are delivered to the world as fundamentally *dependent* on other persons, a predicament made obvious in situations in which we become ill or disabled in various ways and need the support of others (Mackenzie 2010). We share the same fundamental needs and desires as human beings because we are embodied in similar ways. This does not mean that we are unable to, or should not, care about other embodied creatures than humans, but our particular form of embodiment is an essential part of the life form in which we develop an ethics of human interaction. The "face of the other," as the phenomenologist Emmanuel Levinas puts it, is the basic source of ethical obligation, and it is not by accident that this metaphor is connected to embodiment (Diprose 2002). I encounter the other person by seeing, hearing, touching, even smelling him or her, and by this bodily encounter our belonging together is made possible. If not embodied, we would not desire and fear things that may happen to us; as a matter of fact, in order to have any kinds of feelings at all, we need to be embodied (and not just "embrained") (Damasio 1999). It is doubtful whether radically enhanced, post human persons, who have left the current limitations of human embodiment behind, will ever come into being, but if they do, they will probably not have an ethics that is similar to ours (Agar 2010).

Kidneys, hearts, and other types of organs, according to such an embodied view, are not just functional parts of the biological body; they are parts of what the phenomenologist calls "the lived body" (Zahavi 2005). The lived body is the body as it appears from the first-person perspective of the person *being* it, enabling the person to encounter and understand things around her in the world as meaningful for her in various ways. Our "being-in-the-world," as the phenomenologist Martin Heidegger puts it (1996), is consequently basically a bodily phenomenon, an insight elaborated by yet another

influential phenomenologist, Maurice Merleau-Ponty (1962). The body to a large extent organizes my experiences already on a preconscious level by way of neurological systems centered in the brain that coordinate my movements and perceptions (Gallagher 2005). To the ways of the lived body also belong the processes of my biological organism: Breath, digestion, blood flow, etc., which are mostly absent from my awareness but nevertheless provide the backdrop for my intentionality—my being directed towards different things that I engage with (Leder 1990).

Normally, when we engage in the world, busy doing various things, we do not pay much attention to our own bodies. They perform their duties inconspicuously in the background and make it possible for us to encounter things and other persons in the world around us, a world that we share as embodied, human beings. Sometimes, however, the lived body *shows up* in resisting and disturbing our efforts to do things. It "dysappears," rather than disappears, to use a term coined by Drew Leder (1990). The body plagues us and demands our attention by revealing itself, not only as our home, but as an *alien* creature. Organ transplantation, and also the process of falling ill, which in most cases (if one does not end up in the operating room because of an accident) precedes the transplantation, to a large extent inflicts such changes in self-being when our bodies display an unhomelike character. As phenomenologist Richard Zaner writes in his study *The Context of Self*:

> If there is a sense in which my own-body is "intimately mine," there is furthermore, an equally decisive sense in which *I belong to it*—in which I am at its disposal or mercy, if you will. My body, like the world in which I live, has its own nature, functions, structures, and biological conditions; since it embodies me, I thus *experience myself as implicated* by my body and these various conditions, functions, etc. *I* am exposed to whatever can influence, threaten, inhibit, alter, or benefit my biological organism. Under certain conditions, it can fail me (more or less), not be capable of fulfilling my wants or desires, or even thoughts, forcing me to turn away from what I may want to do and attend to my own body: because of fatigue, hunger, thirst, disease, injury, pain . . . .
>
> (Zaner 1981: 52)

I will now proceed to a more direct phenomenological analysis of organ transplantation in developing examples of what it is like to have a kidney and a heart transplant, respectively. In the examples, I will attend to the ways the body shows up as "other" (unhomelike, alien) in situations preceding and following transplantation and the way these different types of otherness should be understood. The phenomenological analysis of organ transplantation situations will then be reconnected to the ethical issues concerning the relationship to one's body and the bodies of others surveyed above.

The Kidney Transplant

In the book *Holograms of Fear*, Slavenka Drakulić tells the story of her first kidney transplantation, which takes place in Boston in 1986 (Drakulić 1993). Drakulić has left her homeland of Yugoslavia, her family, friends, and even her young daughter, in order to live in New York as a journalist. This radical decision is forced upon her not by political oppression but by a genetic disorder affecting her kidneys: Polycystic kidney disease. The medical care she is getting in Yugoslavia is not sufficient (she watches her fellow patients

in the dialysis ward deteriorate and die), and she has poor chances in Yugoslavia of getting the transplant she needs to survive. In the book she tells how the disease and her dysfunctional kidneys force her to undergo dialysis every second day in the hospital for several hours:

> I had no choice. Every other morning at five o'clock I went for my dialysis at the hospital on 72nd Street. I didn't consider the possibility of not going. The healthy can choose. Life is simple when you're sick, as it is for people in jail or in the army. There are rules that are more than rules because breaking them can only mean one thing. At first this is non-freedom but later, it is just certainty . . . Here the blood flows in streams: in veins, capillaries, pumps, rubber hoses, in clear plastic tubes, in cylindrical dishes with filters. As if the white room was woven with a red web. Everyone is quiet, deathly tired. They communicate in code, in subdued tones.
>
> (Drakulić 1993: 3–4)

To be in dialysis treatment means that your life becomes *regimented* in a new way. This concerns not only the hours you have to spend connected to the dialysis machine but also the way you have to watch and regulate your body, considering diet, how much to drink, sleep, exercise, etc. to keep the disease under control. But the most thoroughgoing effect of the kidney disease is that the body shows up in new and disconcerting ways that become central to your everyday experience, self-reflection, and life story:

> The thing moved from person to person like bad luck. No one could tell who it would attack. It attacked my father. It attacked me. It left my brother unharmed. We almost thought that it had skipped us, too, that those ancestors who had died in the past had nothing to do with us. But at the first signs—nausea, vomiting, tiredness—I knew that it had come. The doctors didn't tell me right away although they suspected it. I was already pale, my pulse was fast and every time I lay down I thought I might not be able to get up. Later my father came down with it as well. They told us that these days it was possible to live with it, that there were machines, kidney transplants. Various deals could be struck with the sickness, negotiating with bad luck.
>
> (Drakulić 1993: 6–7)

The uncanniness of such experiences is hard to deny. The body reveals itself as incorporating alien, unhomelike elements in illness (Svenaeus 2000). The uncanniness concerns the way the body becomes an obstacle and a threat, instead of my home territory and basic affordance, but in this (and most other severe) case(s) of illness it also concerns the ways I address the meaning of my life and my relationship to others. Bodily connectedness is made even stronger in cases of inherited diseases in which the family bonds are not only the source of security, joy or annoyance, but of a possible deadly curse.

Waiting for the transplant, knowing that you are on the waiting list but with no knowing when, if ever, the doctors will find a suitable kidney for you, is a vexing experience in itself. So is the fear of pain or dying as a result of the operation. You long desperately for a life with more freedom and fewer symptoms, but at the same time, the regime of dialysis might become a habit and a kind of security you are afraid of leaving for the uncertainty of the operation, which is, certainly, a dramatic event:

> "Breathe, breathe." An English voice penetrates the darkness in which I'm floating . . . Terrified I try to suck in air, catch it with my open mouth, but something is inside, something is inside. It is smothering me, I have to retch it out. They are pulling out a long tube with a sudden jerk from my throat, tearing the membranes. A deep sigh. Then a sharp pain under my stomach cuts me in half. "Your kidney is functioning."
>
> (Drakulić 1993: 42)

Only slowly does Drakulić recover after the operation; it takes hard exercise and a lot of time to be able to sit up, stand, walk, eat, etc. Even the routine of going to the toilet is an effort and, in the specific case of kidney transplants, also a new and remarkable experience for the patient, since the kidneys have not been producing any urine for a long time.

Even in the successful cases, when the new kidney works properly and is not rejected by the immune system, life after a transplant is not like life before the onset of disease. To suffer from a disease that destroys your kidneys and to get a new kidney means that life becomes prolonged and normalized, but it does not mean that life becomes the way it was before the onset of the disease, since you are at constant risk of renewed kidney failure. To live with a foreign kidney in your body means to lead a life that is extremely regimented regarding the relationship to your body. It often means a more anxious life, in the sense that the basic trust in the body is gone, but it could also mean a more self-reflected life, in the sense that the finitude of your life and the question of what is of real importance in it have come to the surface (Frank 1995). Finally, it will lead to thoughts about the life of others and how they are connected to you, particularly the person whose death (in the case of cadaveric transplant) and generous gift means life for you:

> "Her kidney came from a woman," the doctor said to someone. He was leaving the room. He thought I was asleep . . . I don't care who it belonged to, I am not curious. I think of it as an organ, not as part of a person. I must not be sentimental. My life is on the line. But the picture reappears. Her smiling face, gone forever. A lot of time will pass, then in a subway somewhere, a tall man will stop me . . . "Excuse me, I couldn't help myself, but you look so much like my late wife." I'll stare at him, indifferent at first. I'll pretend that I have no idea what he is talking about. Perhaps I'll say I don't know any English. But something will force me to change my mind and I'll say: "Yes. Yes, I probably do look like her. We are sisters, almost twins—you didn't know that she had a sister? You see this thin scar? It has almost disappeared, but this is where she moved in. We live well together, the two of us. Sometimes she gets a little obstinate. I can't keep her from spreading. Sometimes she chooses a smile, other times a gesture, or a walk—to show that she is here, that I am in her power. I think perhaps she wants to make me feel grateful. It's not my fault that she was killed."
>
> (Drakulić 1993: 73–4)

To sum up, already the kidney *disease* leads to experiences of bodily alienation—the body behaving in painful ways that I cannot control—which have implications for the way I think about myself and my life in relationship to others. However, the otherness displayed by my own body in severe disease has repercussions for my entire life, making it hard, sometimes impossible, to be at home in the world in carrying out everyday activities. It also affects my relationship to other persons and sometimes the way I think

about my entire life and its purpose. Why did this happen to me? What kind of a person am I and who do I want to be? After having the transplant this reflection in many cases leads to feelings and thoughts about the origin of the new kidney I now bear in my body (Sharp 2006). The scientific attitude to my new organ as a thing among other things, an attitude that will be encouraged by the doctors, can easily be conquered by an attitude in which the kidney of the other person harbors his or her identity in some way that has now been transposed to me. It might also lead to a thankfulness that becomes transformed into guilt. (How have I earned this life that was made possible by the other person's death?)

The Heart Transplant

In the case of the heart, things are slightly different, not only when it comes to the symbolic character of the heart (life, love, goodness) in comparison to the kidney (what, really, is a kidney symbolic of?) but also regarding the extent to which the heart *shows up* to me, in illness, and also in health. In contrast to the case of the kidney, it is possible to direct one's attention to the activity of one's heart at any time, and in situations that make us react strongly emotionally it is almost impossible *not* to notice one's heart pounding in association with other bodily processes, such as blushing or sweating. In exercise, the heart (together with the rest of the body, of course) sets the limit for what we are able to accomplish, and these limits are clearly *felt* on the embodied level as intense heart and lung activity or pain and weakness of muscles when, for example, I run fast for a long time.

Heart disease does not always make itself known through the experience of pain in the heart itself; a heart attack is experienced as a chest pain radiating out through chest and arms, for example. But the possible irregularity in the rhythm of the heart's beating, which can be a very powerful and frightening experience, nevertheless marks out the heart as something that appears in a more singular manner than the kidney does, in at least some cases of heart disease.

Human hearts have been transplanted since the late 1960s while the history of kidney transplantation dates back to the 1950s. A heart transplant is an even more dramatic and difficult operation than a kidney transplant, and it was not until the 1980s that surgical techniques and new immunosuppressive medications made it possible for patients to survive a heart transplant for a longer time (Tilney 2003). To find a new heart for a dying patient is even harder than finding a new kidney, for two simple reasons. Each person only has one heart, which makes living donation impossible (as long as we do not allow killing one person to let another live). Furthermore, hearts deteriorate much faster than kidneys outside the body, which means that we have only a very limited time in which to carry out the transplant (kidneys last much longer if they are kept the right way). Hearts for donation will most often come from patients who have been put on respirators as the result of accidents or sudden occurrences of disease (stroke) and have then been declared brain dead while they are still connected to the machine that assists the breathing and the circulation of the blood that keep the organs of the deceased person fresh.

In the early 1990s, the French philosopher Jean-Luc Nancy underwent a heart transplant after a period of severe illness. He wrote about this event and the cancer that he was subsequently taken with—probably as a result of the heavy doses of immunosuppressive medicines that post-transplantation patients have to take to prevent rejection of their grafts—in the essay "The Intruder," which I will make use of in what follows

(Nancy 2008). Nancy's main figure for understanding the process he is undergoing is found in the title of his essay:

> The intruder introduces himself forcefully, by surprise or ruse, not, in any case, by right or by being admitted beforehand. Something of the stranger has to intrude, or else he loses his strangeness. If he already has the right to enter and stay, if he is awaited and received, no part of him being unexpected or unwelcome, then he is not an intruder any more, but neither is he any longer a stranger . . . To welcome a stranger, moreover, is necessarily to experience his intrusion.
>
> (Nancy 2008: 161)

This way of conceptualizing the *intruder* (as a person, but also, as we will see, as a thing that intrudes in me, such as an organ) is very similar in structure to the analysis of bodily *alienation* I have developed above. When Nancy's analysis is coupled to the experience of illness and transplantation, the overlap becomes almost total:

> If my own heart was failing me, to what degree was it "mine," my "own" organ? Was it even an organ? For some years I had already felt a fluttering, some breaks in the rhythm, really not much of anything: not an organ, not the dark red muscular mass loaded with tubes that I now had to suddenly imagine. Not "my heart" beating endlessly, hitherto as absent as the soles of my feet while walking. It became strange to me, intruding by defection: almost by rejection, if not by dejection. I had this heart at the tip of my tongue, like improper food. Rather like heartburn, but gently. A gentle sliding separated me from myself.
>
> (Nancy 2008: 162–3)

In comparison with the kidney failure experienced by Drakulić, we can see that the failing heart penetrates the experiences of Nancy to a far greater extent regarding the perception of the organ itself. But the alienation is also driven by the unique symbolic quality of the heart as the essence of life, goodness, and personal identity (Lakoff and Johnson 2003). Despite living in a scientific age, it is almost impossible to view the heart as a pure biological entity among others, a "pump" only, rather than the center of our emotional life. The heart is loaded with meaning and identity; therefore the intruding heart (still his old one) separates him from himself.

A new heart (the transplanted heart) is certainly also an intruder, but it is an intruder that we would like to welcome. This is possible, however, only by "experiencing his intrusion," as Nancy writes (2008: 161). This means the pains and plagues following the procedure of having the sternum cracked and the chest cut wide open in an operation that lasts for several hours and during which the blood is circulated and oxygenated by way of an external device, a heart–lung machine. It also means suppressing the body's immune system to prevent it from attacking and rejecting the graft, something that will otherwise happen immediately after the operation or in due time. The graft is foreign, an "intruder" in the body, which we have difficulties welcoming. But the immunosuppressive actions taken mean that other intruders (bacteria, viruses), lying dormant in the body or entering from outside, become a major threat. It also means that the regular outbreaks of uncontrolled cell division in the body, which otherwise are dealt with by the immune system before they grow and spread, can now lead to cancer diseases. Nancy

describes this multiple intrusion by organs, viruses, and cancerous cells, but also by medical technology and therapies. The latter make him *objectify* his own body, and in this way he becomes alienated from it in a way that aggravates the physical suffering (Nancy 2008: 169).

To sum up, the heart is "mine" in a way that the kidney is not, despite their both being hidden under the skin, rarely visible, except in the extreme situations of accidents, operations, and autopsies. This is probably due to the heart's being an organ that can be *felt* to a greater extent than the kidney can, and also due to the symbolic connotations of the heart in comparison with the kidney. Heart transplants may therefore evoke questions of identity in an even stronger way than kidney transplants will sometimes do (as in the case of Drakulić). Two good illustrations of how such questions of identity surface and lead to new bonds being formed between people as the result of heart transplants are the movies *All About My Mother* by Pedro Almodovar (1999), and *21 Grams* by Alejandro Gonzales Innarritu (2003). In both movies, stories are told about heart transplants and the attempts made by patients and family members of donors to find out more about the identity of donors and recipients of hearts, respectively. In these interactions new connections and relationships between persons are formed as a result of the transplant.

Embodied Selfhood and Transplant Ethics

Getting a new organ—a kidney, a heart, a lung, a liver, a pancreas, a hand, a face, or some other part of the body that the doctors are able to transplant—will help a patient to a better life in most cases, at least when the new body part is installed in the patterns of the lived body in a successful way. It follows from the phenomenology of organ transplantation, unsurprisingly, that donating organs is a good thing to do because it will help other persons to be more at home with their bodies, enabling them to live a richer life (and survive). To donate posthumously may even be an obligatory thing to do, at least in situations when the transfer of organs can be brought about without violating the dignity of the embodied self (Campbell 2009). To what extent a body with an irreversibly damaged brain, kept "alive" through artificial measures, can be violated depends on the cultural practices of caring for and taking leave of the dying (Lock 2002). Dignity is a tricky concept (The President's Council on Bioethics 2008), but in the situations of organ transplantation, to violate dignity would primarily mean to treat brain dead bodies as entities that are first and foremost useful things—or collections of things—instead of bodily traces of persons that are connected to family members and friends by histories of life-long interaction. Dead bodies, however, have been treated in various ways in different cultures throughout human history, all found respectful in their particular contexts, and it should not be impossible to successfully install practices that can be combined with donation of organs. Indeed, this is already happening in many parts of the world, but the issue of how and why the dead body is more than an organ bank needs to be addressed in bioethics rather than being hidden or dismissed as bad metaphysics or religious superstition (Svenaeus 2010).

The phenomenological idea that we in a fundamental way belong to our own bodies, rather than the other way around, can work as an antidote to the influential organ-commodity paradigm in contemporary bioethics. The phenomenological account can deliver an argument explaining why body parts are not just yet another type of things to be traded, but rather fundamental parts of our self-being. We are born *as* a body coming from *another* body. The body makes our existence and appearance as persons

possible and it does so in a way that is related to how we depend on each other as finite human beings fated to die. This explains why organs are not things that belong to us in the same way as outer things in the world do. Organs are identity bearing in the sense that they belong to the *processes* of selfhood—the lived body—rather than being things that the self (the brain) controls and makes decisions about. Therefore, according to an embodied, phenomenological view, organs should not be traded in, even though they can and should be shared by way of transplants. "Giving life," as the slogan for encouraging organ donation goes, is a *sharing* of life, not an offer of a valuable commodity. Rather than fearing that a view upon grafts as anything but useful biological material will create confusion and feelings of guilt in patients who receive new organs, health care professionals should perhaps to a greater extent acknowledge the bonds that are created between people and families by organ transplantation, also in cases of posthumous transplantation (Sharp 2006).

My attempt above to develop a phenomenological framework in which to place the ethics of organ transplantation is far from complete and the theses put forward here may not be directly applicable to the writing of ethical codes or guidelines. Many questions about the implications of a phenomenology of the embodied, interconnected self for bioethics in the case of organ transplantation have been left unanswered in this chapter. They concern the exact responsibilities embodied bonds put on individuals in different situations. Do I have the same obligations to all human beings in need? Are the obligations stronger in cases of people I connect to in my everyday life and meet face to face than in cases of people far away whom I hear of or watch on television? The phenomenological ethics to guide organ transplantation certainly remains to be worked out in more detail. Nevertheless, I hope to have shown that phenomenology is a viable way to go in searching for theories in bioethics to complement autonomy, welfare, and virtue-based approaches in an interesting way.

Related Topics

Chapter 8, "Medical Tourism," I. Glenn Cohen
Chapter 21, "Autonomy," Catriona Mackenzie
Chapter 35, "Brain Death," Winston Chiong
Chapter 44, "Body Integrity Identity Disorder (BIID) and the Matter of Ethics," Nikki Sullivan

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