ORGAN TRANSPLANTATION AND (DIS)EMBODIMENT

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ABSTRACT

This paper argues that cadaveric organ transplantation offers new insights into the sociology of the body. It suggests there exists ambivalence about the nature of ‘embodiment’ due to differing perceptions of the relationship between personal and corporeal identity; whether individuals ‘have’ a body or ‘are’ a body. Although Cartesian Dualism is compatible with the rhetoric of transplantation, a holistic, integrated view also exists leading to difficulties in organ donation and integration. Organ transplantation also illustrates that although it is important to examine individuals’ experiences of being embodied it is also equally significant to consider beliefs about (dis)embodiment. An overview of the social, political, legal and medical definitions of brain death (including a comparative analysis of Denmark, Japan and Britain) is given including an analysis of the obstacles brain death can pose in donation. The discussion ends with a proposal that biological and social death are not necessarily co-existent; a person may be biologically alive, but socially dead or although a person may be biologically dead, they can continue to be socially “alive” in their previous social world. I argue that this affects 1) the decision to donate 2) the interaction between medical professionals and bereaved relatives and 3) post-donation a desire to contact the recipient.

KEYWORDS: organ transplantation, (dis)embodiment, social existence, Cartesian Dualism, brain death.

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INTRODUCTION

She was dead. Her consciousness was destroyed. But not her life ... that delicate life had merely stopped, it floated, filled with unechoed cries and ineffective hopes with sombre splendours, antiquated faces and perfumes, unforgettable and self-subsistent, more indestructible than a mineral, and nothing could prevent it from having been, it had just undergone metamorphosis. ‘A life’, thought Mathieu, is ‘formed from the future just as bodies are compounded from the void’. J. P. Sartre The Age of Reason (quoted in Lamb 1985: 83)

Since the 1980s, along with a rise in sociological interest in the living body, there has occurred a congruent rise in interest regarding death, dying and bereavement (Seale 1998; Hallam, Hockey and Howarth 1998). Yet despite this there is little dialogue between theorising death and theorising the dead body (Hallam et al., 1998: 1) and little attention given to dis-embodiment therein. The central claim of this paper is that examining organ transplantation allows the sociologist a valuable and unique opportunity to discover more about people’s beliefs concerning their own and others bodies, both living and dead.

In order to be successful organ transplantation depends on the willingness of individuals to consider donating organs after their death and the preparedness of their kin to agree to this. They are encouraged to do so through a discourse of giving “the gift of life” which is promoted via the ideologies of altruism and voluntariness. Yet because the ultimate aim of donation is the removal of body parts from one human being in order to be transplanted into another, studying organ transplantation permits insights that contribute to sociological theorising regarding the body, its constituent parts and eventual demise. Donating organs, for instance, raises questions about the nature of our “embodiment” a term that signifies the relationship between mind/body, or more commonly, person/body (Lambeck and Strathern 1998: 6).

The conceptual axis around which this discussion revolves is “embodiment,” referring to the person’s experience of their own body. Recently, the “body” as a subject for social theorising has received increasing attention within the social sciences (cf. Shilling 1983; Synott 1993; Turner 1996) although Turner (1996: 37) complains about the lack of
embodiment occurring in sociological discourse and argues that academics should recognise that people both “have” and “are” bodies.1 “Having” a body, is a perspective inherited from the Cartesian Dualist version of a mind/body split. Accordingly, the body is a material, mechanical entity, separate from what Descartes terms a “soul.” This is a conception of the body quite compatible with organ transplantation and one promoted by the medical profession, whereby removing body parts is the equivalent of stripping parts of a car.

Yet, as Turner also suggests (1996: 37) we are our bodies, the person is the body. Yet if the person is a body, nothing more or less, what then of donating body parts? By definition, a holistic integration of person and body implies that donating parts of the body is donating parts of the person. This offers an explanation as to why a small but significant number of donors and donor families qualify a donation by refusing to allow certain organs to be donated (Fulton, Fulton and Simmons 1977). Further, these two views of having and being can have unintended consequences for the interaction between medical professionals and bereaved relatives at a crucial juncture of the procurement process, the donation request. For does a person’s experience of embodiment necessarily agree with the medical discourse of organ transplantation?

Beside from the embodiment debate, organ transplantation also raises questions about a person’s dis-embodiment. That is, what happens when a person is no longer embodied? This paper will argue that 1) the dead body and its parts can symbolise the person that once was, thereby continuing the personification of the body even after death and 2) that the person continues to be socially represented despite being dis-embodied (as the opening quote exemplifies). In other words regardless of what one believes about the nature of embodiment whilst alive, personal identity continues to be represented at the moment of death and indeed sometime thereafter.

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1Turner argues that individuals are referred to euphemistically by sociologists as “social actors” located in their “social location” and “structure” (1996).
In support of such a claim, evidence suggests that biological and social death need not occur at the same time and a person can become detached, or dis-embodied, before death (Glaser and Strauss 1965; Sudnow 1967). Therefore if a person can socially die prior to biological death, then the converse is also true -- a remnant of the person can continue to be socially present after (Klass et al. 1996; Mulkay and Ernst 1991). In the context of organ donation this lingering personal residual can effect the relative’s decision to donate or not as statements such as “it’s what they would have wanted” imply. Post-donation the deceased’s continuing social presence can lead to a desire on the behalf of the bereaved to contact the recipient; a desire to join the social representation of the deceased with a physical closeness.

Theoretically, I will argue, that the definition of death, as well as the dead body and its organs, although biological events and entities, are socially constructed through differing social practices, discourses and beliefs surrounding them; for instance the medical profession may view the body as the equivalent of a car or a machine, the bereaved as the site of personhood. Simply put, the former may pronounce biological death, the latter social death. Nevertheless it is not the position here that language or culture alone somehow “constructs” the body, death or organs. On the contrary, as Craib suggests (1995: 152):

I cannot talk about my liver without language, but it does not make sense to say that my liver is constructed by language or culture ... different societies might have different conceptions of the liver and its function and one might surmise that modern science has a very sophisticated conception of the liver -- much more sophisticated, for example, than classical Greek society. However, it does not follow that my liver is more sophisticated than was Plato’s liver. Nor does it follow that people who live in cultures that have no conception of internal organs are people without livers (or hearts or kidneys).

Here, the biological basis of the body is not denied (nor the claims for its social construction exaggerated). To a degree, this may be “essentialist”, but as Craib (1995: 152) asks is it “any more essentialist than saying that nearly all human beings have two arms, but what they do with those arms varies culturally and historically?” On the other hand the
body, is not just a given biological entity, but is also understood through a cultural and social lens. “Human beings do not simply apprehend the natural world as a given, since nature is always mediated through culture” (Turner 1996: 61).

**ORGANS AND EMBODIMENT: IDENTITY OR POSSESSIONS?**

*Organs and Embodiment*

What is the nature of the relationship we have with our bodies? For instance how does a person experience their body? Do they feel that they have a body or are a body? Turner (1996) takes-for-granted that both can simultaneously co-exist; we *are* a body and *have* a body at the same time. To a certain extent this may be true and there is no intention to confuse the issue but Turner assumes rather than demonstrates and fails to recognise that individuals can be subject to a great deal of confusion about the nature of their embodiment. As far back as the nineteenth century William James described his uncertainty between whether the body is an essential part of the person or alternatively whether it is something that is owned or possessed:

> Our fame, our children, the works of our hands, may be dear to us as our bodies are, and arouse the same feelings and the same act of reprisals if attacked. And our bodies themselves, are they simply ours, or are they us? Certainly men have been ready to disown their very bodies and to regard them as mere vestures, or even as prisons of clay from which they should be glad to escape” (William, J. 1890 quoted in Belk 1990: 140).

Then are our bodies “mere vestures” or vessels in which the non-material, intangible source of personhood is housed? The same question vexed Descartes who concluded that:

> ... I possess a body with which I am very intimately conjoined, yet because, on the one side, I have a clear and distinct idea of myself inasmuch as I am only a thinking and unextended thing, and as, on the other, I possess a distinct idea of the body, inasmuch as it is only an extended and unthinking thing, it is certain that this I [that is to say, my soul by which I am what I am], is entirely and absolutely distinct from my body, and can exist without it (Wilson The Essential Descartes 1993: 214). “This I” is separate from a body that is merely a vehicle for the intangible, non-material
substance of self.2 The body as a machine and therefore a conglomeration of disparate, interchangeable body parts is a view quite compatible with organ transplantation and one generally advocated by certain groups such as the medical profession.3 Organ transplantation is therefore akin to stripping parts of a car and the organs can be considered in light of this (i.e. the heart is the “engine” or the “pump” etc.) However this reductionist view of the body as mere machine is not the only one available (and as we shall see in a later discussion of countries such as Japan, an implicit cultural rejection of Cartesian Dualism, has contributed to controversy regarding the introduction of organ transplantation). As Belk (1990) suggests another metaphor may also exist, a view also alluded to previously by James; that is the body is central to our identity, the person is the body.

Modern symbolism and effects on donor families

Indeed, studies have shown that the more important and integral body parts are to ideas of personhood, the more sacred they are considered to be and less likely to be donated to others. Fulton, Fulton and Simmons (1977: 338 - 376) reported that American families were least likely to object to the removal of the spleen, pancreas, liver and kidneys of their loved ones and more likely to object to the removal of the eyes and heart. Wilms et al. (1987: 340) in a survey of 78 undergraduates tested the knowledge and psychological impact of differing organs and the relationship to willingness to donate. Their results showed that those subjects unwilling to donate a particular organ, understood its functioning less well and perceived it as more mysterious, sacred and emotional. On the basis of such findings, Belk (1988: 157) suggests that individuals are psychologically more likely to “cathect” (charge matter with emotional energy) those things that are considered important to identity, such as eyes and the heart. Yet, as Belk himself admits, not all

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2 Descartes was apparently loath to equate the brain as the site of self, saying that “One thing is certain: I know myself as a thought and I positively do not know myself as a brain” (quoted in Manning Stevens 1997: 277). In part, this is why when speaking of embodiment, it is necessary to look beyond brain/body interactions to what people themselves experience as “embodied” and like Descartes most people do not experience themselves as a brain, but as having an identity as a person or self.

3 For simplicity I have used the terms “medical professionals,” “transplant community” and “lay public” while realising that these are artificial constructs and do not take into account differences and hierarchies therein.
people view their bodies as equally central to their identities and not all organs are treated with the same symbolic importance.4

“BEING” A BODY -- REPERCUSSIONS FOR DONOR AND RECIPIENT

Nevertheless, throughout history one organ above all others are thought to be the vehicle of identity and enduring symbol of personhood. The heart continues to have powerful resonance today as a symbol for emotion, love, will and courage. It is used widely as an idiom, for instance “to love with all my heart”, a “heart to heart talk”, to be “heart broken” and “to take heart.” Why might the symbolism of the heart endure in the face of scientific and physiological explanation to the contrary? Manning Stevens (1997) suggests that because it is now known that the brain is the site of consciousness and this can be explained in purely physiological terms, the heart is therefore free from any “scientific” discourse of the self and can be allowed to remain in its metaphoric space, “symbolising the conjunction of body and soul” (1997: 276).

Indeed the first heart transplant caused immense media attention because, as Helman (1991: 3) states, “for the first time one of the most important metaphors for personhood had been cut out, handled and cleaned, and then placed inside the body of another individual. In a few historic moments, the borders of one human body had been breached by the symbolic core of another.” Consequently, this caused concern for the wife of the first heart recipient, Louis Washkansky:

It started with “The Man With The Golden Hands”, which is how Louis Washkansky, chatting in Yiddish to his wife, describes Christiaan Barnard who performed the world’s first heart transplant on Louis. He died a couple of weeks later ... At first Louis seemed to be doing wonderfully well. She was not allowed to see him until three days after the operation ... ‘I was very apprehensive because I thought his personality might have changed, not realising that it is the brain that makes the person. I was happy to see he was the same Louis’” (My emphasis, A Knife To The Heart” BBC1; 31. 4. 96):

Organs are not just biological entities but are surrounded by a host of cultural beliefs

4 For instance, women, suggests Belk (1990: 143) are more likely to cathect objects than men and although he quotes studies to validate his argument, does not offer an explanation as to why this might be the case.
regarding their relationship to personhood. Lamb suggests “[C]riteria for personal identity, unlike the criteria for life, can be based on either fictional or real concepts of bodily image and organic continuity” (1985: 89). That is, identity is, in part, based on how we view our “body image” which may not necessarily have any relation to biological facticity but can be influenced by history, tradition and custom. Unintentionally this can have worrying repercussions, for instance, the heart, as a source of personal identity, can affect relatives of the recipient who may be concerned about a personality change, but occasionally these type of beliefs can complicate the recipient’s physiological and psychological acceptance of the organ.

**Psychological Effects on Recipients**

Recent evidence suggests the existence of a “confusion of personal identity, implicit in the thought of walking around with someone else’s liver or heart” (Kass 1992: 74). Indeed some recipients are affected by what can be termed a “psychological transplant” existing alongside the physiological one. These are documented, but not well-researched incidents and as yet unknown is to what extent the phenomenon of psychological transplants occurs.

In the formative years of organ transplantation, Castelnuovo-Tedesco (1973: 350) reported that a much higher level of psychosis occurred after transplantation, heart or otherwise, than any other major surgical operation, including those operations where amputation had occurred. Findings which suggest that an organ gain is more traumatic than an organ loss. A study quoted by Castelnuovo-Tedesco, conducted in the early seventies, found that all two hundred and ninety-two recipients developed episodes of reactive depression, two of which committed suicide post-transplant. This was a much higher figure for psychiatric complications after major surgery -- roughly, at that time, post-operative complications occurred about one out of every fifteen hundred cases (Castelnuovo-Tedesco 1973: 350). However, this was a period when organ transplantation was in its infancy. There was little

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5 Some recipients, for instance, anthropomorphise the organs they receive; in one of the first studies conducted into the psychological effects of receiving an organ transplant, Castelnuovo-Tedesco (1973) discusses how one of his patients called the kidney he had received, “Clarence.” Clive Sinclair (1996: 16) writing an amusing personal account of his kidney transplant (describing himself as a “kidney wimp” as opposed to the *nouveau* lion-hearts) describes his kidneys as “back-stabbers, conspirators and would-be assassins” adding that he found it relatively easy to incorporate “another’s body part when you already consider your own innards to be strangers, if not mortal enemies. The doctors, however, insisted upon referring to them as my “native organs”, as in Native Americans” (1996: 19).
known about the effects of receiving a transplant, not only psychologically, but also physiologically. These studies may therefore not be representative and can be considered a reflection of the uncertainty at that time.6

Other studies conducted thirty years later showed that results from interviews with forty-four heart recipients found that thirty-six of the recipients did \textit{not} have any problem with accepting the transplant and did \textit{not} perceive it as having anything “foreign” within them (Bunzel et al. 1992). That said, four of the patients, who had received female hearts, were concerned about whether receiving an organ from a different sex would have any repercussions (1992: 1153):

Yes, that stubborn woman, she didn’t want to subordinate herself but now it seems that we have worked it all out between ourselves

My heart is my [female] slave. I am mainly interested in her performance.

\textbf{The Effect of Using the Dead to Live}

In general, Bunzel et al., (1992) found that the main difficulty respondents reported coming to terms with was the fact that they felt that they had benefited from someone’s death. Although some of the respondents never thought about the donor (n=15), and others declined further information, wary of the strain it might put on them (n=17). However there were also a few respondents who reported a close connection to the unknown donor because of the heart (n= 12). Two of this group acted as if the donor was still alive in them:

Sometimes I can’t really believe that I have another heart. I always say to it, this is my little lassie, and I have the desire to protect her. Somehow I feel as if she were not dead at all.

I’m thinking about learning how to ride a motorcycle. Now he has turned 19, he is allowed to. I’ll teach him that too. Now the serious part of life will begin.

6 However, the support group, the Transplant Support Network, also reports in its newsletter more recent research from the States, that demonstrates that patients can still expect to have some form of depression, both pre- and post- transplant (Issue 14, December 1999).
More recently Sharp (1995) has suggested that the integration of an organ into a recipient can result in a “transformative experience” that is, it can often alter the recipient’s sense of self with some individuals struggling to redefine their identities. Her evidence from an ethnographic study of twenty-six recipients showed that there was a “permanent sense of being renewed or healed [which] contributes to a sense of wholeness.” The majority of recipients stated that they experienced a “new lease of life” and felt much stronger and younger. One lung recipient told her:

I wasn’t myself before -- you get into your own little world. I couldn’t wash my hair, eat or even talk without losing my breath. My brain didn’t get enough oxygen so I couldn’t think straight (Sharp 1995: 372).

Sharp’s usage of such examples demonstrates the “depth to which transformations are felt” (Sharp 1995: 372). However precise numbers on how many recipients felt like this is not offered therefore it is difficult to gauge the extensiveness of such reactions. Neither does she suggest that such reactions, that is, “feeling stronger and younger” may be ubiquitous to any patient after a life-saving operation. It is normal, if not desirable, that patients will enjoy a significant increase in the quality of life (Lock 1995b: 394).

Arguably the integration of an organ does not cause difficulties amongst all recipients. Nevertheless this does not necessarily divert attention from the fact that some donor families and recipients may be affected by cultural beliefs regarding the relationship between personal and bodily identity, believing that vestiges of personal characteristics are “embodied” and carried within transplanted organs. More evidence regarding the nature of embodiment can be found in the reasons that donor families give for donation. By agreeing to donate some families believe that the act of donation can in a sense, allow the deceased to carry on physically living. Fulton et al. (1987) affirms this hypothesis in their study that found donor families donated as a means of allowing parts of the deceased to gain “physical immortality” (Fulton et al. 1987). On the other hand, it would not be unexpected to find that some relatives may object to donation for precisely the same reason, that is they do not want something considered sacred and integral to their deceased relative becoming part of another. In this understanding donation may be considered to have too high an emotional
This integration of personal and bodily identity and organ physiology as evidenced by the behaviour of both recipients and donor families is denied by medical professionals and may be symptomatic of more general differences in how the medical professional and patients’ view a person’s biological make-up:

Part of what makes the patient’s self-description unintelligible to the biomedical physician is the practitioner’s tendency to take the metaphoric construction of the illness experience for literal statements within the empirical world of biomedicine. Language is treated not as personal expression but as a transparent code. But ‘blood’ for the patient [who regards it as a carrier of possible character contaminants] is not ‘blood’ for the physician [who regards it as a neutral chemical cocktail]. The inability to see the metaphoric and contextual basis of discourse limits the physician’s comprehension of the patient’s life-world (quoted in Sinclair 1996:14).

Significant differences in medical professionals’ and patients’ discourse of the body, are arguably symptomatic of wider ontological questions about the nature of embodiment, personhood and corporeal identity. This is not to suggest that all medical professionals hold a Cartesian Dualist view of the body, and conversely all members of the public hold an integrated, holistic belief of body and person. Indeed, Barnard, the surgeon to carry out the first heart transplant when speaking of his extra-marital affairs suggested that “What the eye doesn’t see, the heart doesn’t grieve” (quoted in Birke 1999). Such metaphors are therefore “entwined” as health professionals themselves are “heirs to ... cultural tradition” (Birke 1999) just as lay people can and do learn the mechanistic language of medicine.

Nevertheless in an organ donation context, interactions between the two groups holding differing perspectives of the body can result in a source of tension at a crucial juncture -- the donation request. Indeed the evidence presented so far suggests that for some donor families and recipients, it is not merely a question of changing one organ for another. “[T]o change or to abandon an age-long idea [regarding organs] deeply rooted in religion, arts and poetry, which has become inert because of convention, requires more efforts than the intellectual understanding of anatomical and physiological conditions for the
transplantation of organs ... We are prisoners of our ancestors’ pictorial fantasy (quoted in Bunzel et al. 1992: 1151). In other words, cultural beliefs about parts of our bodies and their relationship to personal identity are not always amenable to modern medical and scientific re-conceptualisations.

**THE SOCIAL CONSTRUCTION OF DEATH**

*The Change in the Visibility of Death*

Seale (1998: 11) suggests “[O]ur bodies are the means by which we have life, vehicles for our communal sense of what it is to be human.” Forgiven for stating the obvious, we exist and interact with each other precisely because we have bodies to exist and interact with. It is important to examine the nature of embodiment, of experiences of being embodied, especially in relation to organ transplantation, however it is also equally significant to realise the meaning of dis-embodiment, of no longer *having or being* a body and to examine the conditions, practices and beliefs under which death occurs.

Organ donation depends on individuals being able to consider what will happen to their bodies after death is pronounced. By signing a donor card they have, in a sense, confronted their own mortality and eventual demise as a foreseeable event. Psychologically, organ transplantation forces us as individuals, to confront the meaning and eventual reality of death, a denial of which can have a negative effect on donation (Robbins 1990). Freud once observed that:

> Our own death is indeed unimaginable and whenever we make that attempt to imagine it we can perceive that we really survive as spectators. Hence...at bottom no one believes in his [Sic.] death, or to put the same thing in another way, in the unconscious every one of us is convinced of his own immortality (Freud [1925]: 304).

Some have taken Freud’s proposition further, arguing that most of Western societies are “death denying” and that death is a “taboo topic.” Aries (1974) in his erudite work spanning almost three decades, argued that the modern epoch is hallmarked by a fear of death, the dying hidden behind hospital walls and banished to the margins of social life. By documenting the slow almost imperceptible changes in social rituals accompanying
death over the past thousand years, Aries observed that in the middle of the nineteenth “a complete reversal of customs” occurred (1974: 562). Due to advances in medical therapies, the dying were removed to the sanitised place of the hospital where, not only could they be cared for, but also the new indecency of death could be concealed. Death, it is argued, has become invisible through the rejection and elimination of ceremony, ritual and public mourning:

Once, there were codes for all occasions, codes for revealing to others feelings that were generally unexpressed, codes for courting, for giving birth, for dying, for consoling the bereaved. These codes no longer exist. They disappeared in the late nineteenth and twentieth centuries (Aries 1974: 579).

For instance, the once traditional ritual of the “wake”, keeping the body in the home for a few days preceding the funeral, has become increasingly rare. Shilling (1993: 189) states that “when an individual dies it is likely that she or he will be isolated from families and friends and subjected to the professional control of medical discourse and practical expertise. Rather than being an open, communal event death is sequestered to the medical expert.” Indeed, at the end of the twentieth century, it is extremely rare for anyone to confront a dead body. Data shows that over 70% of people in Britain die in a hospital or in a similar setting (Mulkay and Ernst 1991: 173). And although there is growing demand for a representation of death, from war documentaries, to violent movies, to a hospital casualty ward, this may be considered an “anaesthized knowledge” of death (Shilling 1993: 190).

*Death Denial or a Change in Discourse?*

It is not considered an aim of this study to solve the debate of whether societies are death denying or not, although it does seem difficult to prove conclusively that in the past death was more visible and endemic, and therefore not as feared as it is now. To all intents and purposes, the high level of support for organ donation in the UK demonstrates that a significant number of individuals are willing to consider what happens to their bodies after death. It is how, and in what way, death may affect donation that is considered important in this context so as to reach an understanding of the medical professionals’ and the lay persons’ confrontation with death and the dead body.
Medical and Lay Perspectives

Undeniably, in most cases, death occurs within the medical sphere as opposed to that of the private family one. And as an object of medical practice, it may be dealt with in an objective manner, emphasising statistics, mortality, and causation. As far as the medical profession is concerned the body is where the investigatory and explanatory practices take place through an objective discourse, not one of personal meaning and sentiments (Prior 1989: 20). In contrast, as far as the bereaved are concerned, the body is the location where the person and the social being interconnect, therefore it is a site where people express their sentiments of love and loss, where the individual can articulate their subjective emotions, thoughts and practices about death. People for instance may not want to donate organs because this involves surgery to the dead body (MORI 1994: 19). In Britain, there is an apparent ethos of “non interference” with the body of the deceased and the corpse must be treated with respect and dignity. An indication of how strongly people may feel about the body parts of their loved ones is demonstrated in the recent case at Alder Hey Hospital. Organs, including over two thousand hearts were retained, after post-mortem examination without the families’ permission, with the subsequent outrage reported in the media testifies to the intensity of feeling attached not only to the organs, but to the integrity of the corpse. One father, condemned what he termed a “barbaric practice” and called an end to “unnecessary mutilation after death” (Independent: 1 Saturday 14 December 1999).7

Tension therefore is created in cadaveric donation because on the one hand, the dead body may be viewed as a “means to an end” by the medical profession. That is, it is an anonymous body from which organs can be sourced or post-mortem research conducted on. Yet for the relatives, because the dead body signifies the person that once was, and because this past existence is tied up with the lives of loved ones and family, it is left to the next-of-kin to decide the proper course of action. Their permission therefore must be sought before the removal of organs:

the common law properly mandates the body of the deceased to next of kin, in order

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7 An interesting parallel can be drawn with the reactions of those in the nineteenth century to the 1832 Anatomy Act, that allowed the bodies of the poor to be used for dissection. Richardson (1996: 73) suggests that “requisition promoted resentment and resistance. Dissection, which for centuries had been used to punish and stigmatise the worst of crimes, now did the same for poverty.” For a fuller discussion see Richardson (1996).
to perform last rites, to mourn together in the presence of the remains, to say ceremonial farewell, and to mark simultaneously the connection to and the final separation from familial flesh (Kass 1992: 74).

Both donor and non-donor families have strong beliefs regarding the integrity of the dead body and even in the enlightened age of science and reason, customs and traditions are still extremely powerful. There is a strong social and cultural significance attached to the body and its parts, as well as a concern regarding the appearance and integrity of the dead body. This belief is particularly strong when the families are planning a burial and are more likely to stress the integrity of the body, to have the person buried whole. Unsurprisingly those families who are intending a cremation are more likely to agree to donation (MORI 1994: 19). Yet although “custom may be king over almost all, [it is] not over all” (Kass 1985). For instance, when a father dies within the Melanesian Triobranders the sons have the important job of:

... sucking the putrefaction from the bones of his exhumed corpse and washing them of rotting flesh in the sea so that his spirit can travel back across the water and ultimately be reincarnated. The bones of the corpse are then shared out ... and may be made into ornaments to be worn ... A man’s skull may be converted into a lime pot for his widow and his long bones into lime spatulas (Barley 1997: 104).

This example is given as a reminder that the Western attitude to the dead body as “sacred” and as something which is not to be interfered with, is not necessarily a view that is shared by other cultures who may have very different beliefs regarding what the families role and the status of the dead body is.

Organ Donation, Autopsies and Dissection and Respect for the Body
The respect and symbolism shown towards the dead body can be linked historically to a fear of the dead, as is revealed by the persistence of myths about ghosts and vampires

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8 Interestingly from the 1950’s onwards, cremation rose in popularity: in 1995 71% of families planned a cremation compared to only 1% in 1900 (Brierley, Religious Trends 00/01: 4.8). This may be indicative of a watershed in societies view of the dead body. Although further research is required in pinpointing why this change occurred it is likely that a combination of the increasing expense of burials and a decrease in the influence of religion may have been important.
coming back to terrorise the living. In modern times, however, as Sanner (1994b) suggests “treating the dead body respectfully seems to take on the symbolic meaning of showing respect for the individual who once was” (1994b: 1148). Without such symbolic meanings of respect “progressive” practices such as the one Gaylin (1974) proposed may well come into being. We could use, he argues, brain dead individuals or “neo morts,” for beneficial medical procedures such as drug testing or for medical students to train on, and as an unlimited source of organs and tissue for transplantation. In these “body farms” would lie row upon row of pink, apparently breathing, individuals recognisable as the persons they once were. Although a hypothetical scenario, the reaction to initiatives such as this is likely to be similar to the public reaction when it was discovered that corpses were being used (with the families’ permission) in order to improve car safety. In 1978 a political row broke out in the United States pertaining to the usage of dead bodies in test designs for cars. The outrage that ensued led to such experiments being banned, and the development of the “crash test dummy.”

The question therefore is why does practices such as organ donation, autopsies and dissection not provoke similar reactions? Sanner (1994a) conducted a survey into the Swedish public’s reactions to these three procedures. Her data in rank order showed that autopsy was viewed as the most acceptable medical procedure, dissection as the least, with organ donation at a mid-point (1994a: 288). Those accepting the extreme procedure (dissection) were more likely to be favourable to the others. It is plausible to suggest, as Sanner does, that an autopsy has a more acceptable character in society -- it is not as new a procedure as organ transplantation, occurring routinely for at least the last two centuries, and has a more mandatory character to it (1994a: 287). Furthermore, it is possible that the information that results from the autopsy is more immediately beneficial to the family than organ donation. What appears to be at issue here is the “symbolism of different uses” (Feinberg 1985: 31) and the acceptable level of interference with the corpse. And although Western society is overcoming certain taboos, especially pertaining to the living body e.g. surrogate motherhood, sperm and ova donation, abortion, etc., beliefs about the way the corpse should be dealt with seem more ingrained in this societies psyche.

(Re)Defining Death
Most of the organs procured for organ transplantation are taken from cadaveric donors,
diagnosed as “brain dead.” In general these donors are young people who have died suddenly and tragically, usually through an accident, suicide or by some other form of irreversible damage to the brain; a condition known as brain death. Brain death as a phenomenon arose in the 1950s as a by-product of new resuscitation technology, although it was also congruent with the formative years of organ transplantation. The French were the first to discover the condition, naming it “coma depassé” literally meaning “a state beyond coma” (Lamb 1985: 4). It became clear to many physicians around that time that some severely brain damaged patients, whose hearts and respiration continued, had little hope of ever regaining consciousness. Moreover, artificial ventilation could not be continued indefinitely -- with certain brain functions missing the organs would eventually deteriorate.9 As Lamb (1985) points out it wasn’t until later that brain death, as it came to be known, was a condition located in the brain stem and is synonymous with death of the individual.

The main concern during the following decades was to develop suitably robust criteria in order to establish that there was no possibility the patient would regain consciousness, thereby sparing relatives further emotional stress. In 1968 the Ad Hoc Committee of the Harvard School to Examine the Definition of Brain Death published its report, with a clear statement of what the committee envisaged as the problem:

9 Brain death is not to be confused with persistent vegetative state. The former is analogous to being decapitated and unlike PVS, heartbeat and circulation will stop. There are heated medical and ethical debates regarding brain death, although it is sufficient for the purposes here to consider brain death as a reformulation of the traditional concept. Accordingly loss of heartbeat and circulation may not be considered a state of death in itself but an actual indication of its imminence. For an outline of the approaches and debates regarding the (re)definition of death see Gervais (1986).
There are two reasons why there is a need for a definition: (1) Improvements in resuscitative and supportive measures have led to increased efforts to save those desperately injured. Sometimes these efforts have only a partial success so that the result is an individual whose heart continues to beat but whose brain is irreversibly damaged. The burden is great on patients who suffer permanent loss of intellect, on their families, on the hospitals beds already occupied by these comatose patients. (2) Obsolete criteria for the definition of death can lead to controversy in obtaining organs for transplantation (Quoted in Singer 1990: 25).

The committee specified a set of clinical tests that would determine brain death: 1) unresponsive and unreceptive; 2) no reflexes; and 3) no movement or breathing. Tests are carried out twice by two different physicians and if both are satisfied that the conditions have been met the person is declared dead.

**Appearance of the Brain Dead Body -- Lay Perspective**

However the appearance of brain dead individuals is very different from someone who has died from cardio-pulmonary causes. The heart continues to beat spontaneously and the body is still warm. Colour appears normal and all bodily functions such as digestion, metabolism and elimination continue. Unsurprisingly confusion regarding the appearance of the brain dead body caused trouble for some family members in the Fulton et al., study. As one woman related to the investigators, “[My husband’s] mother couldn’t get it through her head -- she felt that as long as his heart was beating and he was breathing, he was alive” (Fulton et al. 1987: 354). Further, not being present at the “instant” of death only serves to exacerbate the ambiguity of the situation:

For the most part, people said, “Well great.” They thought it was a tremendous thing to do. But I think the majority of them say this not knowing that you give up their organs before their heart has stopped beating. My mother died seven months before he [son] did and I stood at her bedside and felt her pulse until it was completely gone. It’s a different kind of thing when you walk into a room and see the kid is breathing. You know the difference (Fulton et al. 1987: 355).

Other relatives were more blunt about the decision they felt they had made, “I think the
hardest part is the fact that she didn’t die. I had to tell them to ‘pull the plugs,’ I willed her to die.” Another put it as, “[T]here he was, right around the corner, still breathing on a machine and we were signing his life away in here” (Fulton et al. 1987: 357). These comments demonstrate that for some relatives, they believe they played an active part in ending their loved ones life; they “pulled the plug.” Some relatives are not entirely convinced by the health professional’s diagnosis of brain death. Indeed the medical community are aware of the difficulties that brain death causes. One health profession related how:

_The public still have a problem with pink ventilated bodies ... they may understand what’s being said but the fact is that they do not look like a normal corpse. I don’t think that there would be half the refusals ... they perceive them as still being alive ... I think you know... organ donation from a conventional corpse. If we could do it. Take the organs two or three days later I think we would half the refusal rate._

**Historical Precedents “Are We Really Dead?”**

Corroborating evidence for the argument that the public may be ambivalent about brain death has been regularly found in both qualitative and quantitative studies regarding families experiences of an organ donation request (Fulton 1987; MORI 1992; Dejong et al. 1998). Sanner (1994) for instance found that those undecided about organ donation were more likely to state that this was due to a fear of not being actually dead.

Throughout history distrust of the medical profession and ambivalence about the diagnosis of death has not been unknown, and indeed accounts can be found from as far back as 1740, when it was suggested by a Jean-Jacques Winslow, that “putrefaction was [death’s] only sure sign” (quoted in Lamb 1985: 51). Pernick (1988) has given one of the most comprehensive accounts of the evolution in medical thought regarding the diagnosis of death. During the eighteenth to twentieth century as a result of new technologies, especially artificial resuscitation that demonstrated individuals previously thought dead could now be revived, led to an increasing uncertainty in the diagnosis of death. Yet it was not just a mistaken diagnosis of death that worried people, but the more specific fear that they would be _buried alive_. In the main this was due to the spread of epidemic diseases during the eighteenth and nineteenth century that involved the burial of the dead in remote cemeteries.
(Pernick 1988: 35). Such reforms interfered with specific death rituals and mourning practices such as “family wakes.” Thus as Pernick suggests “Hasty burials in far-away places contrary to tradition undoubtedly fed the fear of premature interment. The new burial practices also fed the fear of grave-robbery, as the lower classes suspected the reforms were designed to make it easier for doctors to obtain cadavers for medical schools” (Pernick 1988: 36).

Although the nineteenth century premature burial panic was ended by an unprecedented enthusiasm and lay deference to medicine this was an “historical aberration ... Lay mistrust of doctor’s definitions has been the historical rule rather than the exception, though such mistrust only periodically caused great alarm” (Pernick 1988: 61). The subsequent public disquiet and drop in donation rates in the eighties following the notorious BBC documentary *Panorama*, shown on Monday 13 October 1980, that suggested that people had recovered from brain death, attests to the fine line that physicians tread when dealing in the area of death.10

**Medical Ambivalence**

Yet what of the medical profession response to brain death? Is it that they are immune to the same doubts and uncertainties as some members of the public? Does such a tight dichotomy of medical objectivity and lay subjectivity exist? If we consider that in many respects, the medical personnel are instructed to treat these patients as if still alive: machines are not turned off, life functions are monitored and rather than going to the morgue the donor is sent to the operating theatre then it is unremarkable to find researchers such as Younger (1990) identifying ambivalence in those health professionals working with “heart-beating” [brain dead] donors. He found considerable misunderstandings about the correct clinical and legal criterion for determining death suggesting that the medical professionals involved are not dealing with death “in an objective manner, emphasising s

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10 Lamb suggests that cases that have supposedly “recovered” from brain death the criteria for diagnosing the condition had not been met (for a fuller discussion see Lamb 1985: 66).
Lynch (1990: 1016) also reported medical professionals’ statements such as:

I wouldn’t want my child’s dead body mutilated like that.

I am very ambivalent about being an organ donor, given the rough handling of the cadaver I see in practice.

I am anxious about the donor’s family – do these people know what removal of all usable organs and long bones entails?

The effect of the health professionals’ knowledge about the process of organ retrieval, in some cases, leads to ambivalence and personal beliefs that are not necessarily entirely supportive of organ transplantation. Lynch suggests that “To be professional … is to be accustomed, if not inured, to the ambivalence experienced …[to develop] ‘detached concern’” (Lynch 1990: 1016). Yet not all of the health professionals in the aforementioned studies have become “desensitised” and are still uneasy about organ retrieval, despite their knowledge of the procedures and benefit to another patient. The concept of brain death therefore challenges both the public’s and the medical professionals’ understanding of death and can pose an obstacle to donation. Furthermore, it takes the public’s trust in the medical professional to the extreme, and may simultaneously stretch the health professionals’ belief in the diagnostic capacity of medicine. Caution however should be used when treating the health professionals as a homogenous group. There may be significant differences between the views of nurses, consultants, surgeons, co-ordinators etc. Whether or not this is the case, is difficult to gauge as most of the research does not draw comparisons within their samples.

Modern day Resistance: Denmark and Japan

Brain death is not without its medical, ethical and lay critics. One bioethicist insists that “[Brain dead bodies] appear to be alive because in fact they are alive” (quoted in Lock and Honde 1990: 103). Another critic suggests that “one can establish neither operational criteria nor valid tests unless one has agreed upon a working definition; a concept of what it means to die. This concept has to be societal [sic.] and not biological since ... it is the
permanent loss of personhood which is of central concern” (Younger 1988 quoted in Lock and Honde 1990: 102). This is a debate not likely to subside. For instance, authors employing Pernick’s work agree with his premise that “neither the controversy nor the process has changed substantially over the past 250 years ... in searching for death, or life, in patients. Further we suggest that our testing is no better able than that of our predecessors to measure that which is not solely a medical diagnosis” (Powner, Ackermann and Grenvick 2000: 1219).

Indeed although the criterion for brain death achieved eventual world-wide recognition, it met with some resistance both soon after it was introduced and later from countries such as Denmark and Japan (Ohnuki-Tierney 1994). During the 1970’s in Virginia, for instance, a jury rejected the claim of the family of a donor, that the transplant surgeon was responsible for the death of their relative (Lock and Honde 1990: 101).

Denmark was one of the last countries in Western Europe to accept the irreversible loss of all brain functions as a criterion for death. Rix (1990a) suggests that this is due to the importance that the Danish government places on public consensus and “that a public debate must precede legislation on the brain death criterion” (1990: 232). A report by the Danish Council of Ethics (DCE) asserted that “any change in the criterion of death is an event of such significance that it should not be permitted without a major public debate on the ethical questions involved” (Rix 1990b: 5). It was argued that first, this ensures a general basic knowledge in the population and second, that all advantages and disadvantages have been presented.11 This, it was thought would quell any potential disquiet and doubt, and lead to a more favourable attitude from the Danish population.

Yet in 1990 the seventeen member council of the DCE rejected the medical criteria for brain death as death. The council argued for a concept of death that is “the everyday experience of death common to individuals of a particular culture” (Rix 1990b: 6). This provoked strong reactions from both Lamb (1990) and Pallis (1990) (philosophical and clinical proponents of brain death respectively) who attacked the DCE’s decision -- Pallis asked “Which individuals are being referred to? And is consensus possible in this sort of

11 The importance of public confidence in diagnosing death has always been recognised in a country, that since the nineteenth century, included electric bells in their mortuaries so that someone who is not actually dead can call for help (Rix 1990: 235).
context? (1990: 11) and Lamb (1990: 8) suggested that:

...references to the ‘everyday life experience’ of death of ‘oneself or others’ and the experience of one’s own death ‘as the concrete process of dying’ raise intriguing images. Whilst it is possible to observe (and hence experience) the death of another, our own death as Wittgenstein so forcefully put it, is not an experience but rather the cessation of experience (1990: 8).

Inherent to the DCE’s decision, continues Lamb (1990), is an untenable contradiction, between cardiac transplantation and cardiac death. By definition, the two cannot be reconciled, although the DCE attempts to do so by “offering a curious notion of a ‘death process’ which begins with brain death and ends with the cessation of cardio-respiratory function, in the middle of which cardiac transplantation is permissible” (Lamb 1990: 8). In other words, it accepted brain death as the irreversible onset of death, and suggested that brain death is the beginning of the death process and cessation of cardio-pulmonary activity the end, with cardiac transplantation occurring somewhere in-between. Confusing the issue even further, the DCE recommended that once the tests for brain death are conducted, all respiration should cease. If this was the case then, cardiac arrest would occur within minutes, and the distinction between the beginning and end of the death process would lose its significance therein.

Without going into further detail regarding this debate (see however Journal of Medical Ethics (1990) for further discussion) it is sufficient to note that the DCE attempt to reconcile the ‘everyday perception’ of death as the cessation of heart beat with a brain oriented one, ended in confusion. The Danish government eventually accepted brain death and was to implement presumed consent legislation.

**Japan: Scientific Controversy**

As in Denmark, Japan also had the technology and knowledge of organ transplants available, but because brain death had not been widely socially accepted, transplants were limited to living donors only. For example, in 1990, nearly 2000 heart transplants took place in the States, whereas in Japan, none occurred (Lock 1995: 5). Japan now recognises brain death (the new law was passed on October 16 1997) and cadaveric donation is now
both possible and legal in that country. However as Lock and Honde (1990) argued before this change to the status quo could occur in Japan, there had to be public consensus. For the last twenty five years debates raged in Japan, with public opinion regularly monitored. In the media, the controversial nature of the scientific evidence presented meant that the issue revolved around the establishment of clear, valid criteria; the same debate regarding brain death that dominated Western literature thirty years previously. The exception was that in Japan, it mainly occurred in the public sphere.

**Cultural Construction of the Body**

Although similar debates may have occurred in both Japan and the West regarding the scientific criteria for brain death, culturally in Japan there may be significant differences regarding the relationship between the body and the person. Lock and Honde (1990) discuss how in cultures that have a strong emphasis on Cartesian Dualism (and therefore a distinct mind/body split) are more likely to accept the criteria for brain death (1990: 109). For instance, they quote the Law Reform Commission Report of Canada:

> There now seems to exist a recognition of the idea that death is the termination of individual and relational life, and that therefore there is no point in prolonging a merely biological existence once personal life, as such, has been irretrievably lost (quoted in Lock and Honde 1990: 109).

In contrast, in Japanese culture, there is a widespread belief that the body and soul are integrated, the word *kokoro* is written with the character for the “heart” referring to the “spirit.” Hence presumably the individual cannot die until the heart has stopped, similar to the traditional Western conception of death that equates death with the cessation of heart beat. Further according to Buddhist beliefs, “for the first forty-nine days after death the spirit of the deceased remains in this world. It would be highly inappropriate and very troubling to many families to know that they had allowed parts of the body of a dead relative to be removed” (Lock and Honde 1990: 110).

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12 This is not to imply that Japan is not as “modern” as the West, or that as a nation it is held back by a “culture of tradition.” It is likely that a number of factors are at work (for instance, Lock suggests that the “politics and power relations among the professions, and between the medical world and the public, are implicated” 1995: 5).

13 Both Shinto and Confucian derived religions also prohibit any interference with the dead body. The former is concerned with pollution and ritualises any contact with the corpse. The latter teaches respect for the dead body including its care and treatment...
Even those who do not believe in Buddhism per se, still respect the Buddhist rituals pertaining to the belief that it takes the deceased relative thirty two years to “be at one” with the community of spirits and ancestors. This involves the carrying out of rituals. For instance, in many Japanese homes, a photograph of the deceased is placed in a butsudan (the family altar usually in the eldest son’s home). There, relatives “talk” with the deceased and food is, on occasion, offered (Lock 1995: 19). Although the deceased is biologically dead, they are very much socially “alive”, or to be more precise, continue to have a social presence for the relatives. Hence it is unsurprising that although Japan has legally accepted brain death, it has as yet made little difference to medical practice. However, is it just the East that places importance on the continuing social presence of the deceased, religious or otherwise?

SOCIAL PRESENCE AND BIOLOGICAL DEATH

Social and Biological Death

There is another conception of death rarely perceived and hardly ever discussed -- that is, social death (Mulkay and Ernst 1991: 172). Social death need not occur at the same time as biological death. In fact it may occur earlier or indeed later. As the discussion of Japan attests to, because a person is biologically dead, does not necessarily mean that they continue to cease existing socially. Two classic ethnographies (Glaser and Strauss 1965; Sudnow 1967) carried out in the United States examined dying and death in institutionalised settings such as the hospital and the residential home. Both groups found that people died socially before they died biologically. Goffman’s concept of a non-person defined as “standard categories of persons who are sometimes treated in their presence as if they were not there” (quoted in Mulkay and Ernst 1991: 173) was employed as a basis for social death.14 Both Glaser and Strauss (1965) and Sudnow (1967) highlight that within the hospital, social death can occur in conjunction with the realisation that the patient is clinically dying.15 This can vary, for instance, the nursing staff may treat the patient as

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14 Goffman used it to indicate how the social presence of some groups of people e.g. the old, sick, young, and the disabled, is implicitly denied. Moreover this denial can often be linked to their biological condition (such as age, illness or disability).
15 Sudnow (1967) also found that groups of people, perceived to have low social worth, were more likely to be treated as socially dead by health care staff. More alarmingly, however, was the fact that social death then became a predictor for biological death. Timmermans (1997) demonstrates that the legal mechanisms invoked in attempts to stop such health rationing based on social
socially dead, whereas the relatives do not. However, Glaser and Strauss (1965) and Sudnow (1967) assume, along with the medical professionals in their study, that once biological death occurred, so then did social death.

Indeed the termination of our social existence is usually linked to the biological cessation of life. However, as Mulkay and Ernst demonstrate social and biological death are not necessarily identical. Although more research is required, social death may not occur until sometime after biological death, if at all (Mulkay and Ernst 1991: 172). Such findings have been confirmed by Klass, Silverman and Nickman (1996) who also suggest that the bereaved continue to have a “relationship” with the deceased. For instance, they quote research that found in the first few years after a spouse’s death the bereaved still maintain an active connection to the deceased, dreaming and talking to them, and occasionally feeling “watched” by them. In other words, the relationship continues despite the absence of the other’s physical presence. It is not the case that the bereaved continue to pathologically live in the past (although one might expect this to happen in a minority of cases), but rather the recognition of past bonds informs present and future behaviour. Although requiring further research, it is likely that there will be a correlation between the nature, intensity and length of the living relationship with the continuing social presence of the deceased. The parallels with the Japanese bereaved hardly need drawn out further, except perhaps to note that this continuing social presence may not necessarily be informed by religious instruction or cultural belief. As the poet William Barnes wrote about the loss of his wife:

In every moaning wind I hear thee say
sweet words of consolation ...
I live, I talk with thee where’er I stray (Quoted in Klass et al. 1996: 37).

Continuing and Complex Bonds
Hence Klass et al., suggest that the standard psychological view of the bereavement process i.e. “the purpose of grief is to sever the bonds with the deceased in order to free the survivor to make new attachments” is misguided (Klass, Silverman and Nickman 1996: 3).

worth paradoxically reinforced such death inequalities.
Indeed it is a twentieth century phenomenon that deemed “maintaining an ongoing attachment to the deceased was considered symptomatic of a pathology” (Ibid.). They suggest this is a result of the modern understanding of the relationship between self and society which views individuals as individuated and autonomous actors bereft of interdependence:

Independence rather than interdependence, is prized ... There is little place in this model for any idea of individuals as interdependent and living in a web of relationships. In this modern view humans are understood to have a limited amount of energy for any one type of relationship. To have a new relationship we need to give up the old one (Klass, Silverman and Nickman 1996: 15).

As members of society we do indeed live in a “a web of social relationships,” and in part, the basis of such relationships is due to that fact that we are embodied. Our personal identity and social existence is inextricably inter-linked with our corporeality. It is therefore unsurprising that holistic views of personhood and the body persist into the twentieth century, despite opposing separatist accounts.

Yet although for the majority of the time our social and biological existence is inter-twined, to the extent that one may not be easily separated from another, paradoxically one can be biologically separated whilst still being socially connected with an (y) other. We are socially bonded and exist in society, because of our biological existence, yet we can continue to be socially bonded despite of this existence. An example demonstrates this best - the Queen exists socially because she physically exists. Personally I have never met her, yet this does not mean that I cannot imagine what she is like or feel that I may know her, or to base decisions, if I should want to, on what I would imagine she would do. Thus individuals can (or continue to be) socially present, and prescribed some form of agency, despite the fact that the person is not/no longer physically present. Although it may be argued this puts too much emphasis on the social interdependence of members of society, the argument I believe is a valid one, at least in that it draws attention to the fact that through existing in a society, we are therefore, ipso facto, social beings.

Ancestor Worship
The idea that a person may continue to be present in the social world previously occupied is neither a unique nor a controversial concept, especially in anthropology. Lloyd Warner, for instance, wrote sixty years ago that:

> Human culture is a symbolic organisation of the remembered experiences of the dead past as newly felt and understood by the living members of the collectivity. The human condition of individual mortality and the comparative immortality of our species make most of our communication and collective activities in the larger sense a vast exchange of understanding between the living and the dead. Language, religion, art, science, morality and our knowledge of ourselves and the world around us, being parts of our culture, are meaningful symbol systems which the living generation has inherited from those now gone ... Communication between living and dead individuals maintains the continuity of culture for the species (quoted in Davies 1994: 12).

Although the claim that cultural continuity is based entirely on relations between the living and the dead is a more ambitious statement than the one made here (and the implication that culture is a monolithic institution made only possible through death is deterministic) it does demonstrate that relations with the dead is an important area of cultural reproduction. Studies of other cultures show that “ancestor worship” is quite common and that these “ancestor spirits” coexist alongside the living, influencing and determining their behaviour. Opler’s study of death in the Chiricahua and Mescalero Apache cultures, for instance, highlights how living members of the group have ambivalent feelings regarding their deceased relatives, on the one hand grief and mourning and on the other fear and loathing (Opler 1972: 468).
Social Death/Existence and Organ Transplantation

It would seem, if the preceding argument is correct, that individuals do not need to be alive in order to continue to exert an influence in the previous social world they occupied. Studies (MORI 1994) have shown that the relatives of brain dead individuals are more likely to donate if they knew that that is what the deceased wanted. However, indirectly it is also possible for them to frame the decision to donate without knowing whether this was their relative’s wish. Rather by employing their knowledge of the deceased the family can say “well although s/he did not express their wishes regarding donation, from what we know of them whilst they were alive, that’s what s/he (the deceased) would have wanted.” In this interpretation the family bases their decision on the past actions and behaviour of the deceased. However, paradoxically, it is also possible for the family to re-interpret the past actions of the deceased whilst alive, on the basis of the donation decision. Organ donation, can then offer the relatives the opportunity to remember the donor in a more favourable light thereby aiding them in their grief. As I was told, some donors “got their tickets to heaven,” not because of anything the donor did whilst alive, but because something worthwhile came out of their death. Preliminary discussions with health professionals suggest that this is the case:

Those who haven’t made an expression to the relatives by having a donor card or I’d like to donate, the attitude largely is that ‘he [sic] was a good person, he would have liked to help someone, he used to go down in the morning and put the kettle on, that sort of thing. A general attitude to life. The other thing that comes to mind as well is that mm... in cases where the person has been a bit of a ‘monkey.’ Men, young men who have been in trouble a bit. Right? You know they’ve died in a stolen car whatever. The ability to donate then makes them ‘go to the angels’. Because instead of being remembered as a bad boy who having nicked a car and crashed it into the wall and died and injured his friends, he’s remembered in the family as the last thing he did was donate and help somebody else.

The above quote highlights how the internal representation of the deceased by the family highlights the altruistic nature of the deceased and plays down the actualities of their death. Thus although the continuing social presence of the deceased may correspond with the actual living characteristics of a person concerned, in other contexts the family can
“orchestrate” their memories of the deceased through the act of donation. By remembering the deceased as a donor arguably aids the family in their grief. If donation does occur, the continuing social residues of the deceased may lead to a desire on the donor families’ part to try and communicate with the recipient, thereby coinciding the person with the body again, as is normally the case if they were embodied. In Britain, as far as can be ascertained, the amount of information provided to donor families is usually limited to the age, sex and condition of the recipient, although this can vary from region to region. However, it is practice that in some parts of the UK., letters between the donor family and the recipient are passed on via the transplant co-ordinator. Cunningham suggests that transplant co-ordinators encourage recipients to write letters of thanks, but do not encourage meetings between donor and recipient within the first year of donation. Little is known about this practice or about donor and recipients responses to letters or meetings (1998: 18).

CONCLUSION
Organ transplantation allows the sociologist to discover more about people’s beliefs concerning their own and others bodies, both living and dead. For instance, transplanting organs from one individual to another involves a host of social and cultural issues that proves to be illuminating for those interested in the sociology of the body. The body, both living and dead, and its perceived relationship to the intangible facets of personhood affects the decision to donate organs in a myriad of ways, not only at the individual level but also at the macro-social level of a country’s acceptance of the procedure. Throughout this paper the emphasis had been on the cultural aspects of bodies, and how this inter-links with inherited ideologies from the past. This is not to argue that there is a simple causal relationship between cultural resistance and organ donation. Rather the modest claim is that is some cases (both donor family and recipient) belief systems cause concern when organs are taken from one body and placed in another. Taken as such, this is more about

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16 Bartucci and Seller’s (1996) American donor respondents (n=19) reported that, regardless of the amount of time that passed after the event, receiving the letter was a positive experience (1986: 403). Reasons given were, “it was gratifying to know that a part of our son lives on in her,” “it made me feel the first blessing in this tragedy had just surfaced,” and “it was reassuring to know that my son’s death was not a complete loss, that he did some good in dying” (1986: 402 - 403).
the experiences of donor families and recipients, and in turn what this can say to sociologists about a person’s lived experience of their body.

For instance, the discussion regarding the socially construction of organs highlighted the implicit existence of a holistic approach to our personal and corporeal identity. Indeed the experience of self is bodily incorporated, and to appear as a person is to give evidence of a “self in a body.” This may have contradictory effects on organ donation, as evidence suggests donor families may donate in the belief that they are gaining for the deceased a “physical immortality.” However, it is not unreasonable to suppose that because of the integral relationship between body and identity some families may not want to give parts of their relative to an anonymous another. In their eyes the personification of the deceased’s body means that they cannot consider the idea that that same body would be opened up and organs removed.

Not only do beliefs about the body and its parts influence whether or not they are donated but the environment under which they are donated can also have profound effects. Important changes have occurred over the last hundred years regarding death, one of the most significant being the shift from a traditional conception of cessation of heartbeat to one where irreversible damage to the brain, a condition known as brain death, has been introduced. Pernick (1988: 17) wrote that “Once upon a time, long before modern machinery, everyone agreed that death occurred when your heartbeat and breathing stopped.” This is no longer the case and the paradox is that accompanying the advancement of scientific and technological precision of defining death, comes doubts about its diagnosis.

Over the last hundred years the nature of biological death has altered dramatically. This not only raises interesting philosophical and cultural issues regarding the nature of our relationship to our bodies, but takes public trust in the medical profession in extremis. Brain death, moreover, also blurs the presumed dichotomy between medical objective diagnosis and public subjective emotion -- health professionals are not immune to doubts and debates about brain death and are susceptible to the same emotional “baggage” regarding death and dead bodies as the public are. Brain death has not only caused debates regarding the scientific criteria of death, but also wider social and cultural ambivalence
pertaining to the apparent “breathing corpse.” As Giacomini (1997: 1478) argues, brain death was not solely a clinical definition, but a socially constructed one. “Brain-dead bodies had to be created, recognised, and defined in the development of brain death criteria: brain death was socially as well as clinically constructed. The 1968 definition did not produce a more “accurate” description of death so much as mark new delineations between the living and the dead.”

Although medicine may declare that the physical life has ended, this does not necessarily mean that the person ceases to be socially present, the nature of our dis-embodiment, of how the person can continue to be socially present for others, without biological referent, (the adage to be with someone “in spirit but not in flesh” is testament to this) is largely neglected by authors more concerned with our living corporeal existence. Yet a person, who has died, continues to be remembered, and to influence present and possibly future behaviour of another, as statements such as “it’s what s/he would have wanted” imply. Moreover, by donating, the family can adjust their memories of the deceased; by focusing on the donation act itself allows the social presence of the deceased to continue in a more favourable light. Social presence can therefore transcend the “spatio-temporal existence of bodies” (Lamb 1985: 86). Yet for how long and in what form residues of the person continue for is as yet unknown, although work such as Klass et al., (1996) and Mulkay and Ernest (1991) are making significant inroads into what the repercussions of death are for past, and possibly future social relationships.
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