Contesting Normative Embodiment: Some Reflections on the Psycho-social Significance of Heart Transplant Surgery

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Abstract

What constitutes the normative body is always and everywhere open to challenge and disruption, particularly in the era of postmodernity when contemporary forms of technological practice intervene directly in our bodies. I shall focus on heart transplantation where, following the graft, the recipient’s sense of self as a bounded and unique individual is necessarily disturbed, and it is clear that an outcome favourable to extended life expectancy cannot be read through clinical measures alone. My speculative suggestion is that there are many other factors in play that might be most usefully interrogated through a variety of theoretical resources relating to the strand of cultural analysis that interrogates and rejects the modernist self-other paradigm. For the purposes of this paper, however, I shall largely restrict my comments to the phenomenology of embodiment as proposed by Merleau-Ponty.

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What constitutes the normative body is always and everywhere open to challenge, but it is perhaps in the era of postmodernity that the notion is most under threat of disruption. In his book, *Bodies in Technologies*, the phenomenologist Don Ihde makes the following claim:

> We are our bodies – but in that very basic notion one also discovers that our bodies have an amazing plasticity and polymorphism that is often brought out precisely in our relations with technologies. We are bodies in technologies. (2002: 137)

And what I shall address in this paper are some of the issues arising from a very contemporary form of technological practice that intervenes directly in our bodies.

The context of my theoretical approach lies in a current collaborative research project involving both empirical and theoretical elements that is exploring the significance of organ transplantation, and more particularly the question of why many recipients of heart transplants, which have been initially successful both clinically and physiologically, subsequently develop unexpected complications and may die ‘prematurely’. In the project, in which I’m one member of a team of five researchers, the empirical element consists of interviewing and videoing around thirty differential recipients over a three-year period to assess not simply their physiological well-being – which is already the...
focus of intense and ongoing scrutiny – but more importantly their psychic responses to the dramatic changes that are effected on their bodies. The speculative assumption is that the two elements are irreducibly linked. What is already apparent from existing research and scattered anecdotal evidence is that the ability of recipients to sustain and incorporate donated organs over time is at least correlative with their negotiation of questions of self-identity, bodily integrity and corporeal hybridity. Given that following transplant the recipient’s sense of self as a bounded and unique individual is necessarily disrupted, it is becoming increasingly clear that an outcome favourable to extended life expectancy cannot be read through clinical measures alone. My suggestion, which at this stage remains speculative, is that there are many other factors in play which might be usefully approached through a variety of theoretical resources relating to that strand of cultural analysis that interrogates and rejects the modernist self-other paradigm. Each will be investigated in the wider context of the project, but for the purposes of this paper, I shall largely restrict my comments to the phenomenology of embodiment as proposed by Merleau-Ponty.

My own starting point a few years ago, when I had been asked to speak on a symposium panel in Canada addressing the significance of the corporeal cut, is indicative of what is at stake. I approached the issue through my existing research on the ontological and psycho-social significance of conjoined twinning and the susceptibility of that condition to bio-medical intervention, and was surprised to find myself in a highly productive conversation with another panellist, a cardiologist, who is the clinical director of a major North American heart transplant unit. I say surprised because the cardiologist in question had given an entirely positivist presentation of the apparently unproblematic benefits of heart transplantation as opposed to other forms of therapy for end-stage heart failure, and had expressed frustration only insofar as there are not enough donor organs available. It all appeared to be a matter of supply and demand. Yet when I asked her over coffee what kept her awake at night, she replied without hesitation: “I worry about their identities”. The current project – provisionally named PITH: The Phenomenology of Incorporating a Transplanted Heart – emerged directly from that conversation and comprises input from the cardiologist, a medical sociologist who directs the ethnographic study, a psychologist, a social work academic, and myself, as a philosophically trained theorist.

What had immediately sprung to mind in listening to my now colleague talking about heart transplant was that issues of intercorporeality were just as relevant to her concerns as they were to my own previous research in the area of conjoined twinning. That work concerned the contestation of the Western imaginary’s investment in notions of bounded individuality, where I’m defining the imaginary in Catharine Waldby’s terms as “the deployment of, and unacknowledged reliance on, culturally intelligible fantasies and mythologies within the terms of what claims to be a system of pure logic” (2000: 137). And what is notable is that Waldby catches precisely the contradictions that underlie the whole enterprise of biosurgery, especially insofar as it is dedicated to producing normative bodies.
As I understand it, the extra-ordinary embodiment of conjoined twins raises the acute question of whether such human forms should be treated as one or two autonomous persons. This highly modernist concern has superseded an earlier historical anxiety about the location of the soul, and of course the whole point of contemporary separation surgery is to override hybridity and to establish separate personhood. In short, it is clear to see that the existence of conjoined twins deeply contests the normative status of the split between self and other, but might it not be equally disruptive, and indeed productive, to start as it were from the opposite position of a pre-existing split that is then troubled by the process of in-corporation? My proposition is that the cutting apart of concorporate bodies is paralleled in its theoretical implications by the stitching together of previously separate body parts. In both instances the verb “to cleave” – which has the double meaning of “to divide by force” and “to closely unite” - would be highly appropriate. One can imagine Derrida seizing on the richness of that indication of différence, for it is undoubtedly that sense of hybridity, of in-betweeness, that is at stake whichever morphology provides the substantive base. Both corporeal conjunction and organ transplantation speak to a sense of “the body which is not one”, to use Irigaray’s phrase (1985), and that very notion has been the motivating force equally of recent feminist theory that insists on the fluidity and intercorporeality of all embodied being, and of the earlier strand of phenomenology that stresses self-becoming as a matter of living-in-the-world-with-others. In place of the rigid and normatively framed sovereign self for whom the body is a possession that gives rise to property rights and questions of alienability, the phenomenological self is inseparable from, and indeed only exists in virtue of, her others. Her parameters are provisional and to an extent fuzzy, for as Donna Haraway notes: “even the most reliable Western individuated bodies…neither stop nor start at the skin” (1989: 18).

My focus here is on the strand of phenomenology developed by Maurice Merleau-Ponty whose deployment of certain major concepts in relation to the body is highly relevant to the current project. The most important factor is the phenomenological insistence that the self is always embodied – indeed that embodiment is the continuing condition of being a self at all. This contrasts strongly with the mainstream and broadly Cartesian Western tradition in which mind and body are separated, and the self is deemed to have an independent existence that is unchanged by even violent transformations to the body, so that if someone were to lose a leg, say, she would still be the same person with the same core identity. For phenomenologists, however, the self necessarily changes as the body changes, and just as importantly that embodied self is in a mutually constructive relationship with both other selves and the material environment. The self-other distinction can never be assumed. As Merleau-Ponty (1968) understands it, every one of us is embedded in the “flesh” of the world, that is, in a living web of dynamic connections that constantly shapes and reshapes who we are. And despite the strength of the quasi-Cartesian split between mind and body, most of us do on an everyday basis acknowledge the significance of our embodiedness, as is evidenced in the operation of whole industries like cosmetic surgery or dieting which rely on an appeal to our sense that an altered body will in fact result in a new ‘me’. Paradoxically, however,
biomedicine in general, and surgery in particular, rely on the notion that the body can be remoulded either without consequences to the embodied subject, or at least in the case of some aesthetic procedures, with only controlled consequences. In operations like both the separation of conjoined twins and gender reassignment surgery, the incursion of the knife intends to cut apart or cut away, in the putative interests of ‘uncovering’ the underlying true self. In transplant surgery, by contrast, the whole point is to replace some intrinsic part of the bodily interior with living organs or tissue taken from the body of another, but with a similar aim: that of the continuance of the existing and unchanged self. If the question with regard to the excision of body parts is how far can the process go before it radically diminishes embodied selfhood, then the pertinent concern in the context of transplantation is the very opposite: to what degree is the self altered, or become hybrid, as a consequence of the assimilation of ‘alien’ body parts?

Although it is perhaps not widely known, many organ recipients have multiple transplants and the most ‘heroic’ procedure of a heart graft not infrequently involves a combined heart-lung transplant. In addition, as a result of the body’s response to transplantation and to the exacting drug regimes that follow the initial operation, some patients may require at later points kidney and/or liver grafts, effectively replacing a whole set of major organs with non-self material. In the context of the ongoing project into the significance of heart transplants, I have personally observed, for example, a recipient of four different organ grafts – who had also suffered amputation of some digits due to kidney failure – expressing a desire for a second kidney transplant. Clearly, the will to live on is extraordinarily persistent, but who is the ‘I’ who makes the demand for continuing surgical intervention? In such circumstances, only the most committed Cartesian could fail to ask what has become of the embodied subject. That both additive and reductive surgical processes are surely acts of self-creation is, however, strongly denied. In the biomedical and public narrative alike, separation surgery and gender reassignment procedures, for instance, are deemed to liberate an essential self from a contingently anomalous form, while organ transplantation is understood to give renewed life to an existing self threatened with imminent death by the failure of specific bodily components. It seems to be the case that although our everyday understanding of ourselves is broadly phenomenological - we do live through our bodies and not just in them - it is only because of an underlying retreat to the notion that the body consists of a conglomeration of individual and/or replaceable parts that such surgery becomes acceptable. Indeed, the metaphor of the body as some kind of machine that is either in good working order or malfunctioning is particularly clearly deployed in the context of biomedical interventions that may be essentially violent in nature. Whether that takes the form of drug regimes, radiotherapy, the setting of bones, or cutting the flesh, the clinical care of the body frequently entails what in other circumstances would constitute the legal category of battery, and yet we implicitly contract and explicitly consent to such assault in the provisional and convenient artifice that our corporeality has no bearing on our selves.

Now this may sound entirely at odds with the phenomenological account of the embodied subject, but as Arthur Kleinman (1988) and Drew Leder (1990) have
indicated, even when we do have an integrated everyday understanding of the relation between mind and body, the onset of bodily breakdown or disease is likely to precipitate a newfound awareness of the body, not as an intrinsic element of the self, but as an alien other threatening to the self. At such a moment, the machine model that treats the body as any other utility allows for a range of reparative interventions that may include both the corporeal cut and the incorporation of spare parts. Many transplant recipients do explicitly refer to their operations as though they were repair jobs of no more consequence than replacing the clutch in a car. And there is growing anecdotal evidence to support the observation that patients who adopt a machine model approach display both faster clinical recovery rates and, initially at least, less psychic disturbance following transplant. It is, however, little surprise that complications should arise subsequently, for where the spare parts rhetoric would appear to refer to inanimate interchangeable objects, the reality of transplant surgery is that what is cut from one body and grafted into another is a living organ. And although I’d want to say that from a phenomenological point of view all changes to corporeality are significant to the self – including things like acquiring an artificial prosthesis such as the LVAD (left ventricular assist device) that some subsequent recipients use prior to transplantation - the incorporation of a living body part that has been an element of an other is substantially more likely to provoke anxiety. In heart transplantation, the organ by necessity comes from what is called a ‘living cadaver’ - a term that refers to a fully non-sentient, brain-stem dead yet still organically functioning body, and it is precisely at this point, where the parameters of life and death are to a degree uncertain, that the vital organs of heart, lungs, kidney and liver can be optimally ‘harvested’ for transplant.

Most current literature surrounding the transplant procedure tends towards a bioethical slant that poses the question of what is biomedically permissible, or to a psychological analysis that seeks to understand the hopes and fears of each recipient almost as though the body itself were self-contained. In contrast, the more phenomenological analysis I use takes seriously the current thinking about the nature of the embodied self. Aside from the obvious fact that for the majority of potential transplant patients what matters initially is the preservation of life in the face of imminent and certain death, it still makes sense to ask what it means for a recipient to assent to a procedure that at the most fundamental and symbolic level disrupts the integrity of the ‘I’. At the North American centre where the PITH project is situated, all potential recipients are provided with an extensive manual that outlines in more or less detail the practical social arrangements and adjustments that patients must negotiate, the rigour of the post-operative regime for recovery that will continue throughout life and the clinical context and biomedical explanation of the operation itself. All patients have a compulsory psychiatric consultation, but they are nowhere alerted to, nor encouraged to reflect on, the half-hidden anxieties and fears that many of them falteringly express with respect to the incorporation of what is essentially an alien organ. All will be told again and again that they will have to take immuno-suppressant drugs for life in order to circumvent rejection, but neither the reality of incorporating the DNA of the other, which will always remain clinically alien, nor the much-reported experience of psychic alterity, is explained. When I discussed the
issues with the chief clinic nurse of the transplant unit, she confirmed that recipients are encouraged to think of the transplant organs as their own from the start, and commented that she had never thought about the persistent DNA aspects herself. From a bioethical point of view, this evasion on the part of transplant professionals at least raises serious questions, as Koenig and Hogle (1995) note, for the notion of informed consent which must supposedly encompass an acceptance of all significant side effects. As a non-physician, the clinic nurse was nevertheless often the first person to whom patients turned with their doubts and anxieties, and she provided me with some rich anecdotal insights into the way in which individual recipients negotiated their transformed and essentially hybrid states.

Not surprisingly, post-transplant patients most usually ask for what they consider relevant details such as age, sex, ethnicity and so on of their donors, but staff are bound by confidentiality to strictly limit the amount of identifying information that can be given on either side of the transplant relationship. Apart from the usual protocols governing confidentiality, there are very good reasons specific to transplant for imposing this impersonalisation on the process. As many previous studies have recorded, recipients frequently seek out their donors, or vice versa, (or in the case of cadaveric donation, their families), to claim a kind of kinship (Sharp 1995, Younger et al 1996, Potts 1998). The encounter – if it occurs – may be disturbing for all sorts of reasons and might even amount to a form of harassment. What is clear is that many recipients – in defiance of the objectified machine model - both experience and seek to realise a psychic bond with the other, or their proxies, whom they now feel to be part of themselves. Even in the absence of actual identifying information, the normative divisions between self and other are elided in a highly personalised way. Moreover, as the clinic nurse told me, recovering recipients may characteristically claim to be ‘not feeling like themselves’, or to experience themselves as alien and unable to relate to family and friends, who are in turn said to have difficulties with recognition. Several previous studies report similar findings, and although immuno-suppressant drugs are known to cause changes in personality, the empirical evidence speaks to how recipients themselves may explicitly attribute their feelings of strangeness to having taken on elements of the personality and habits of the donor. A substantial number report unanticipated feelings and emotions, unexplained changes in dietary preferences, and even new attitudes and values. It might be thought that such accounts should be consigned only to The National Enquirer or Sunday Sport, or the countless horror and science fiction movies and stories that have exploited such notions, but before we dismiss them too hastily as mere fantasy, we should consider briefly both the status of the biomedical imaginary and the tenets of phenomenology.

My first point is that to call something a fantasy tends to imply that it stands in opposition to some truth, or at least a superior state of things as they really are, but as postconventional thought makes clear, that is far too simplistic. The context in which such donor-recipient accounts circulate and gain credibility is one in which the normative expectations of biomedicine are themselves discursive constructions that serve to facilitate a shared understanding of a putatively secure and well-ordered world.
Where medical science may make claim to pure objectivity, it is nonetheless irrevocably part of a wider culture that makes sense of bodies through an array of representations, metaphors and displacements that shape the very language in which knowledge is expressed, thus introducing a tension and ambiguity into the apparently certain. The resulting imaginary derives its impetus, as Catherine Waldby puts it, “from the fictitious, the connotive and from desire” (2000: 137), and I would suggest that the very concept of heart transplant, with its promise of extraordinary corporeal control and the overcoming of death, places that procedure at the centre of the fantasmatic. Right from the start ambiguity is apparent, for although it is supposedly death that gives rise to the possibility of life in another, the donor heart is always alive at a cellular level, and as the recent breakthrough of so-called beating heart transplant (Randerson 2000: 12) shows even more clearly, it is not certain where the boundaries lie. In consequence, both the concept of the living cadaver and the notion of organs as simply spare mechanical parts are difficult to encompass. The transplant organ, moreover, is already what sociologists call a boundary object in which the relative restraint of clinical discourse meets with popular representations. The process does not simply celebrate an heroic triumph over nature – which is characteristic of the way in which the first heart transplants were greeted – but also highlights certain anxieties about what constitutes life or death, and about the integrity of embodiment. The point, then, is not whether the accounts of transferred personality have any truth value, but that they feed into an existent structure in which the apparent objectivity and impartiality of the biomedical system is already shot through with – indeed relies on – fantasy.

My second caution relates more clearly to phenomenology and to its claim that the body and the mind are inseparable, and mutually constructive. It is a claim, as I outlined above, that runs entirely counter to the Cartesian machine model of the body which would otherwise give credibility to the notion of corporeal spare parts that could be transferred without loss to either the donating or recipient ‘I’. Amongst the professionals involved in transplant procedures such a mechanistic view clearly serves the purpose both of reducing their own potential doubts about the procedure and of bypassing any ontological anxiety that patients might feel. If the body to be cut open is treated as an object, then metaphors of restoration and repair can take on a utilitarian slant that may well generate fears of pain, disability and even death, but are unlikely to directly engage with psychic unease or distress. In the unit where the PITH project is located, it appears that the initial recovery of patients who enter into the procedure of transplant with a machine model of the body in mind is significantly less compromised than for those who see it as an intervention into their selves. It might be expected, then, that the Cartesian model would be a major factor in professional–client interactions to the extent of shutting out alternatives, but surprisingly that is far from the case. Although on the one hand patients are tacitly discouraged from exploring the difficult questions regarding bodily integrity and self-identity, a silencing that implies that such concerns are not an issue, on the other, the privileged metaphor for the donor organ itself is “the gift of life”. The phrase is widely used throughout the whole system in North America: it heads up public campaigns to encourage people to sign donor cards; it is emblazoned
on hospital vehicles including those that actually transport the organs; it is the slogan of the biennial Transplant Games; and it is constantly on show within transplant clinics and their literature.

Contrary to the pragmatic imposition of a spare parts approach, what the relentless gift of life rhetoric stresses is a fundamental connection in which the donor has given some part of his or her living body to sustain the life of another. Not surprisingly, the recipient may feel some guilt that the acquisition of an organ that will likely prolong her own life relies on the death and evisceration of another. In cadaveric procedures where the donor is not organically dead and the transplant procedure may run the risk of being read as a form of cannibalisation, the stress on the organ’s status as a gift may have an equally pragmatic function in relieving that tension. At the same time other complexities emerge in that the designation signals both a phenomenological connection between individuals, and opens up the question of what is at stake in the sense of embodiment, when organs themselves are interchanged. Whatever the intentions, the gift of life discourse inevitably highlights many paradoxes, as for example, in the quasi-cadaver being treated on the one hand as a disposable source of transferable spare parts, and yet on the other being given the status of an altruistic subject, at least by proxy. Equally confusing is the question of who owns a transplanted heart. Does the act of cutting the organ from its originary body and grafting it elsewhere mean that it no longer belongs to the donor but has become an inalienable part of the recipient? The issue is not easily resolved and it is noticeable that patients may clearly slip between the two possibilities of ownership, referring to both his/her and to my heart. Even on the simplest reading, the gift of life is double-edged, and while patients may be expected to finally view the organ as their own, they are also implicitly reminded of its provenance. Despite the strict requirement of confidentiality preventing identification of individual donors, recipients are encouraged to anonymously write a letter to the donor family, and – in the jurisdiction where my own research is situated – to attend an annual cathedral service that brings together families on both sides of the transfer. In other words, the recipient is scarcely allowed to forget that the transplant organ is not simply a circulating spare part. Moreover, as I already indicated, the underlying reality is that the DNA of transplanted material remains unchanged in its new location to the extent that the receiving body perceives it throughout life as non-self material that should be ejected. Although very high doses of immuno-suppressant drugs serve to damp down that biological reaction, it remains the case that the ‘new’ organ will never be less than alien, whilst at the same time providing the sine qua non of the self that attempts to reject it.

For biomedical professionals too, the ambiguity of the gift of life rhetoric may both shelter and provoke their own anxieties. Although one leading transplant cardiologist told me that the phrase is useful in prompting more treatment-compliant behaviour in ‘grateful’ post-op patients – and there is no reason to doubt that outcome – it is unlikely that the effects of the phrase stop there. Transplant teams themselves are invested not only in the utility and altruism of the gift, but also in the implied transfer of what constitutes the extra-organic aspects of life. And that, I’d suggest, is why my colleague lies awake thinking about her patients’ identities. Moreover, if we are to take our own
phenomenological understanding of everyday embodiment seriously, then we must allow that a change in morphology inevitably will signal a change in self identity. We are used to thinking about the effects of visible differences – like the loss of a limb or the scarring of a face - but as Drew Leder (1999) suggests, isn’t the viscous interiority of the body just as important? And given that in other areas of biomedical concern, the contemporary deployment of a phenomenological framework has recently begun to engage with the notion of ‘body memory’ – as, for example, a way of rethinking the apparently lost subjectivity of Alzheimer’s patients – then what are we to make of transplant recipients’ stories of transformed affect?

One of the most sustained reflections on the personal significance of having a heart transplant comes in the essay L’ Intrus (the intruder) by the philosopher Jean-Luc Nancy who underwent the procedure in the early 90s. Nancy is explicit that his account cannot “disentangle the organic, the symbolic, and the imaginary” (2002: 3), and he opens with a highly Derridean deliberation on the in-coming of the stranger whom we suppose to be a metaphor for the grafted heart: “Once he has arrived, if he remains foreign…his coming will not cease; nor will it cease being in some respects an intrusion” (2000: 1-2). Right away, however, it becomes apparent that for Nancy, his own heart – once it had become a presence to him precisely through its impending failure – is the originary stranger. Nancy is not a phenomenologist as such, but his account here is entirely in line with the move that Leder (1990) tracks from what he terms the ‘absent presence’ that constitutes our awareness of the body in health to a sense of betrayal almost as corporeal breakdown forces itself on our attention. As the body ‘sickens’, the previous unity of the embodied subject is split apart, such that the self/other relation is exposed as an internal condition. Nancy’s heart, he says, becomes “an elsewhere ‘in’ me” (2000: 6). Interestingly, after the transplant, as his immune system attempts to reject the substitute organ, Nancy refuses “the gift of life” metaphor, with its intimations of self-other solidarity and connection. Instead, the meaning of l’intrus is rapidly multiplied and comes to figure equally his original heart, the graft, the various viruses and bacteria that inhabit any body, the workings of the immune system and the effects of the drugs that suppress it, the eruption of a cancerous tumour, and above all death itself. All of these are self-estranging, or more properly they expose the hybridity of all forms of embodiment. As Nancy concludes: “The intrus is none other than me, my self” (13), a multiple, excessive, and always transformatory state of becoming. His reflection moves much further than the alien experiences reported by other recipients, but it figures a life-long troubling of any normative account of embodied selfhood.

The question that remains is whether a phenomenological perspective brings anything positive to our understanding of the transplant experience, particularly if, as I’ve indicated, those who adhere to the machine model of the body seem better suited to the rigours of recovery. The long term effects of the quasi-Cartesian approach are, however, less promising for, as heart transplant professionals have consistently indicated, recipients inclined to think in terms of an exchange of spare parts may initially flourish but frequently deteriorate both physically and psychically after a couple of years, with up to 30% of the total showing signs of depression. We have yet to ascertain
in detail how recipients experience their conditions of being, and what explanations they give themselves, but I would provisionally suggest that a more adequate approach to lessening the dis-ease that many experience - both in their narratives and in their silences - could come from a rethinking of the phenomenological nexus as it relates to the nature of embodiment. Instead of covering over the anxieties that arise around the issue of hybrid bodies and hybrid identities, those concerns should surely be anticipated and acknowledged. In Western societies that, regardless of the Cartesian legacy, have an intimation of the necessary embodiment of self, and at the same time privilege identity as both unique and enduring over time, the responsibility is to reset the significance of taking in the organs of another. Where transplant recipients may conceptualise the necessary disturbance of self-other separation and distinction as at least an alien intrusion and at worst as figuring transference of identity, a phenomenological approach stresses that identity is always intercorporeal. If we acknowledge the normative body as an element of the modernist imaginary, then it is not that post-transplant identity should be restored to the impossible illusion of unity, as even some phenomenologists would argue, but that embodiment should be understood as always in a process of restructuring. The psycho-social message that might usefully be translated for recipients is that far from being a phenomenon unique to transplantation, the encounter with and incorporation of otherness within is the very condition – as Nancy indicates – of every embodied self.

References


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**Notes**

1 Average life expectancy one year after a successful transplant is around 10-12 years.

2 The other project members are Dr Heather Ross, Professor Patricia McKeever, Dr Susan Abby and Dr Jennifer Poole.

3 See in particular Grosz (1994), Shildrick (1997) and Merleau-Ponty (1962, 1968). Luce Irigaray (1985, 1993) was one of the first to bring the strands of phenomenology and feminism together.

4 The term is now being replaced by the supposedly more anodyne term ‘deceased donor’.


6 Lock notes that for donor families, donation may imply ‘living on’ and therefore the rhetoric of “the gift of life is effective in that it permits people to restore a modicum of order to their lives” (2004: 145).

7 In other papers I am developing the idea of reading the in-coming of the other through Derrida’s notion of the host and hospitality. See Shildrick (2008) for an initial sketch.