In 1973, Barnes published an essay which explores a fundamental issue in kinship studies. As in his earlier debate (cf. Barnes 1964) with Ernest Gellner, he seeks ways to clarify both what we can ask and what we can say about the relation between biology and culture in the construction of human identity and kinship links. In his 1973 paper, Barnes discusses interesting differences between maternity and paternity in this context, but I want here to discuss some of the broader issues arising from his paper. In its most general form the question is disarmingly simple: what is the connection between who we are and what we are? Yet answers range from all to nothing. Sociobiologists tell us what we are our genes strategically pursuing their own survival (cf. Smith et al., 1987). Beattie (1964) tells us that biology is just an idiom we use to ascribe socially and culturally constructed roles and statuses to one another. As tempers and patience fray, we can turn with some relief to Barnes' analytical precision and his talent for asking questions which are both interesting and answerable.

This said, I am conscious that the present paper asks more questions that it answers, and that it takes me into territory with which I have had little previous familiarity. It arose out of a casual discussion with a surgeon who mentioned to me that transplant operations commonly involve a rather special set of strains for the individuals and families concerned. One aspect of this which he touched upon was the various pressures which a person could feel under to donate a kidney to a sibling or other close relative. For reasons which I hope will become clear, I was reminded of some features of leviratic institutions in traditional societies, whereby a man donates his reproductive powers to the maintenance of the descent line of a dead kinsman. This led me to consider the possibility of exploring such a theme in a contribution to this volume. It soon became clear, however, that the links of medical transplantation to kinship issues are much more wide-ranging than this. In addition to the implications for existent kinship ties, there appears also to be some potential to create them through organ donation; and broader questions of the definition, termination and perpetuation of an individual's identity also emerge in a variety of contexts.
In trying to explore such questions, I have received much valuable help from several sources. These are acknowledged mainly in the notes and bibliography, but I should make clear at once my debt to two particular texts, *Gift of Life* by Simmons, Bush and Klein, (1977) and *The Courage to Fail*, by Fox and Swazey (1978). These imaginative works examine a number of the social implications of transplant surgery, and provide a large body of case material in addition to substantial bibliographies. In some ways comparably with Tittmuss’s earlier study (1970) of blood transfusion, *The Gift Relationship*, both texts pay a great deal of attention to the possible applicability of classical ‘gift theory’ as set out by Mauss (1925). They also provide, however, a considerable body of material which relates closely to my own rather different point of focus, and I need only say that this paper would have been impossible without them. My own aim is a modest one. I hope to show that transplant surgery, as new technology, generates a variety of questions which are both new and old at the same time. As Riviere (1985) has elegantly demonstrated in the comparable and in some ways complementarily opposite context of *in vitro* fertilisation, and as my own reference to levirate suggests, such issues can emerge in other societies in what might seem at first sight quite unlikely places.

In the sections which follow, I first outline some of the main aspects of transplantation which are relevant to my discussion, and also some of the main forms of social interaction it entails. I then examine some of the more important areas where issues of kinship and identity appear to arise. The division of material into sections is more a matter of convenience of focus than of rigorous logic. It will be readily apparent that there are many different aspects to a situation where, for example, the relatives of a cadaver donor wish to establish links with the recipient in whom they see the donor as, in some sense, living on. Old and new relations are mixed up together, and issues of identity and immortality are also clearly relevant.

**Donors and Recipients**

I have already noted the attention paid to ‘gift giving’ in the literature on transplantation. Although this approach is somewhat different from my own, it is partly related to it, in as much as forms of reciprocity have long been recognised as significant markers of kinship relationships and of the nature of the boundaries between individuals in society. Such a focus also highlights several important features of different transplant situations, including some of their more paradoxical qualities, and it thus provides a useful starting point for the investigation of a range of connected issues.

Transplantation in the commonly accepted sense takes place in two main types of situation. The recipient is always alive, but often in a life-threatening situation. The

1. I would like to thank the following for their generous help in my search for information on this topic: A. Angilley, Dr and Mrs J. Evans, Christine Hiley, M. Riggselsford, M. Rose, K. Tillet, Dr P. Barron and other staff at Addenbrooke’s Hospital, the staff at Cambridge University Medical Library, Moorfields Hospital Eye Bank, The Iris Fund for the Prevention of Blindness, Beat Magazine, and my wife Eeva Abrahams. Simon Coleman, Malcolm Ruel and Alan Thorold kindly read the manuscript and made valuable suggestions. Responsibility for any errors in my presentation is of course my own.
donor, however, may be alive or dead. Live donors of non-regenerative tissue occur principally in kidney transplantation, which is thus in some ways similar to the gift of such regenerative substances as bone marrow and blood. Cadaver donors occur in all forms of organ transplantation including kidneys. In the case of cadaver donors, their next of kin and other close relatives are normally consulted even though a hospital might in strict legal terms be justified in going ahead with organ removal for transplantation without such consultation, for example if the deceased had carried a donor card. The fact that organ donations do not meet demand, and that those involved in transplantation are keen to encourage donors by maintaining and developing an image of benevolence and unquestionable probity, may be one factor which inhibits doctors from testing their rights in such cases. More generally, great pains have been taken to ensure that all sensible precautions are taken before organs are removed. The fear that they might be taken before a person is truly dead has haunted public images of transplantation, and the situation has not been helped by at times ill-informed media coverage. Recent survey work suggests that such fears are common and that they may constitute a significant impediment to donation.²

The relatives of a recipient may also be significant in some contexts, and of course in situations like the live donation of a kidney, the donor and recipient are often very closely related to each other. Even in the case of kidney transplants, however, the general trend, at least in Britain, appears to be towards cadaver donation. In 1988, there were 1650 transplants with cadaver kidneys, as against perhaps 100 from live donors. It appears that one cause of this is a growing reluctance on the part of surgeons to employ live donors since they are placed at some risk, albeit small, by the operation, and they have become less essential for success, as tissue matching techniques and powerful immuno-suppressive drugs have been developed.³

As I have mentioned, there are a number of paradoxes within transplantation practice which an approach through reciprocity reveals. One is that 'the gift of life' which the donation of transplanted body substance involves may be felt to create a debt which can not really be repaid. There is some parallel here with the debt for birth and nurture which a child is said to have to its parents in some cultures, and this is perhaps especially pertinent in the case of young recipients. Indeed the idea of 'rebirth' through transplantation is reported to be often voiced both by recipients and live donors.⁴ But the fact that the majority of donors have to die in order to

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3. I am grateful to Myc Riggsford of the United Kingdom Transplant Service for the quoted figures. There is some evidence of international and possibly regional variation in live/cadaver donor ratios and in attitudes concerning the desirability of live donation, cf. Seils et al. (1986:257), Morris et al. (1987), and Rapaport (1986).

4. Cf. Simmons, Klein and Simmons (1977:64, 188, 439, 448) and, also in that volume, Bernstein (1977:143-4) and Simmont, Schilling and Kamstra (1977:326). Not surprisingly, donor mothers seem especially ready to draw the parallel with childbirth. For a wider range of suggestive ethnographic parallels in ritual and ritual kinship cf. Shapiro (1988) and also Bloch and Parry (1982).
donate is a complicating factor in the situation. In addition, there is the main
difference that whereas parenthood is seen to constitute the basis of close and
ineluctable relationships between kin, this potential in the transplantation process
tends to be suppressed. The suppression is partly achieved through careful
gatekeeping procedures in which strict control is normally maintained over the
transmission of information about the identity of donors and recipients and their
close families. There is also some tendency to mark the distinction between an
organ, almost as a 'spare part', and the identity of its original or new user. This is
not wholly inconsistent with more general medical usage, where the linguistic focus
is on a disease or on a damaged part of a patient rather than the person themselves
as an integrated being, but it is clear that the maintenance of such distinctions
serves important social ends in the present case. There is then an odd mixture of
component elements in such situations. People are brought together through the
extraordinarily intimate medium of shared organs or other bodily substance which
in everyday life is the bias of some of our most highly charged relationships to
others. Yet the idea that transplantation might create such relationships is normally
played sharply down, and not altogether without reason, as I shall discuss. People
are thus involved in sharing with strangers what they would 'normally' expect only
to share with some of those who are most close to them. I say 'some of those'
because there is, as we shall see, a further paradox that whereas spouses are
expected to be specially close in our society, they are rather unlikely to be able to
serve as transplantation donors for one another.

More generally, transplantation is an area peculiarly replete with complex and
often emotionally laden boundaries between categories. The situation is partly
complicated by the fact that there are different zones or levels of conceptualisation
involved. Medical professionals operate in terms of a 'scientist' framework of
findings and concepts about death, organs, suitable and unsuitable tissue matches,
and so on. No doubt there is room for some disagreement among them on the basis
of the evidence which is available on such matters, but however this may be, it is
also true that doctors, nurses, and other hospital staff are not without their own
powerful and by no means uniform emotions on such sensitive issues. In addition,
there are the often rather different ideas, values and emotional perspectives of the
donors, patients, and their families, and there is considerable variation here both
between individuals and between different cultural and religious groups.

If nature, as Lucretius claimed, does not make leaps, it is clear that here, as in
the partially linked fields of food and sexual taboos, human beings make them in
abundance - and often more sharply than objective differences in the array of
classified phenomena might, at least at first glance, appear to merit. Most human
beings ingest and metabolize the flesh of certain other animals as food, while other
creatures including almost always our own species are taboo. Sexual intercourse
implants male semen and contributes to creating a new person in a female womb,
and this is permitted only with our fellow humans whom we cannot eat. Heart surgery has made use of pig and baboon tissue in addition both to plastic and to spare parts from other humans. At the same time, the heart appears in the popular mind to be a more significant organ than the kidney, which lacks its symbolic content. Turkish peasants may be willing to sell their kidneys, (see below) and in many countries individuals sell their blood, but neither form of transaction appears to be favoured in our own society though they are by no means equally distasteful. In this and some other cases, 'real' distinctions such as that between regenerative and non-regenerative substances throw some light on the attitudes expressed. Nonetheless this seems to be a field in which the salience of categories is generated as much by emotion as by logic, and one moreover in which new developments sometimes have to be absorbed before their predecessors have been adequately digested. The boundary between quick and dead is one highly emotive area in this context, with medical conceptions of 'brain death', and more recently 'brain stem death', commonly at loggerheads with ordinary perceptions of a breathing body with a beating heart, which many would prefer to see as comatose or 'sleeping'.

The Effects on Existing Kin Ties

The physical suffering and anxieties surrounding any form of major surgery are naturally likely to have serious repercussions on relations between patients and those close to them. In many cases the relationship will be strengthened, but the crisis and its aftermath can also sometimes create strains between the parties. Organ donation between close kin has some special features, however; and although we are dealing here with a high technology development in modern Western medicine, its implications are, as I have noted, reminiscent of some kinship institutions which are spatially and, in some cases, temporally very different from our own.

I particularly have in mind here the well known institution of levirate which I have discussed in some detail in an earlier paper (1973). So called 'true levirate' involves the inheritance of a widow by her deceased husband'skinsman, with special condition that children born of the new union are ascribed to the dead man. In some societies, we also find an institution of 'ghost marriage', classically described for the Nuer by Evans-Pritchard (1951), in which a younger sibling marries a woman to the name of his dead brother, to whom the children of the marriage will 'belong'. In my own discussion of these customary forms I laid much emphasis on the element of 'self-sacrifice' which emerges in the literature in a number of contexts. Evans-Pritchard (1951:110-1) notes how a young man who marries in this way may not find the wherewithal to marry 'for himself', and may have to rely on yet a further kinsman to marry and have offspring for him. In the Old Testament (Genesis, 38:6-11), we find Dnan actually refusing to enter a leviratic union with his brother's wife 'because he knew the issue would not be his', and God strikes him down for his impiety. I also noted how levirate appears essentially to be an institution whereby the identity of an individual is perpetuated

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beyond his natural life-span by such self-sacrifice on the part of another. Moreover, in some contrast to Radcliffe-Brown's (1950:64) simplistic assertion that the institution illustrates the principle of the 'equivalence of siblings', it seems clear that it complicately embodies a duality of opposing principles. In this 'ambivalence of siblings', equivalence is both asserted and denied, and the identities of those concerned are to some degree in conflict.  

It is readily apparent that kidney transplantation may involve some comparable problems to those outlined, despite the radically different social and cultural settings involved. The continued existence of a person is threatened by the collapse of their kidneys. A human being normally has two functioning kidneys, but can cope in most circumstances with only one. Questions of tissue matching tend to make blood relatives the most obviously suitable donors, and this is especially the case with full siblings since they share a higher degree of common substance than other kin. At the same time, the situation is fraught with problems. Although a person can hope to manage well with only one kidney, nephrectomy is an inconvenient and painful process. The surgery involved is not without its dangers, and the donor's post-operative life chances are slightly diminished. It appears that the danger from disease is not greatly if at all increased, since both kidneys, when present, are likely to be damaged by such causes, but there is some risk of accidental damage. Overall, it is clear that an element of self-sacrifice is involved, and in this case in a much more literal sense than in ghost marriage. Not surprisingly, the literature reports a number of cases where the request for a kidney creates tensions and mixed feelings of reluctance and guilt in potential donors. The situation is especially complicated, it seems, when those asked are married. Then, the threat to them is also a threat to spouse and family, who may react in a more straightforwardly negative way to the request or suggestion. This is of course connected with the way in which an individual's marriage and the creation of a family of one's own is customarily accorded high priority over other ties in our society. Indeed, in some reported cases, the potential donor is unmarried but considers that donation may impair the ability to fulfill responsibilities to a spouse and children in due course. On the other hand, it is interesting that despite these aspects of the situation, many siblings do come forward and agree to serve as donors. Indeed, it appears recusants are less common than one might at first expect.

It should also be added, however, that unlike levirate and other forms of widow inheritance, kidney donation tends to favor the 'sacrifice' of the old for the young.

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8. This side of sibling relationships is also neatly illustrated in some Nilotic myths discussed by Lienhardt. In the common story of 'the lost bead', a man who has a favourite bead suspects that his brother's child has swallowed it while playing. He insists on its return, and as Lienhardt notes, his right to do this, unlike his moral wisdom in so doing, seems to be unquestioned. In the face of the owner's relentless demands, and after fruitless searches in the child's faeces, the child is killed and opened up. The bead is found and returned, usually at the cost of the relationship between the siblings. Similar stories are also told in these societies about the loss of a brother's spear when elephants attack their home in his absence, and his subsequent insistence that it be recovered for him.

rather than vice-versa. It would be very unusual to find a man's father inheriting his wife, and even elder brothers are sometimes forbidden from so doing, but it seems quite common for parents especially to wish to give a kidney for their child. Goody (1962:92, 193) has suggested, with regard to patterns of inheritance more generally, that time would appear to be put into reverse if a dead man's estate were to be passed 'up' to one of his seniors. The same logic appears to inform attitudes to kidney donation by the young. For the life of a person of the senior generation to be preserved at the cost of the risk to the life of a junior seems less acceptable than the reverse in the minds of those who lay the ground rules for such practices in our society. The apparent discrepancy in the direction of the 'sacrifice' in the two cases seems to turn upon the fact that in levirate the recipient of 'extended life' is physically dead, and that the burden of reproducing for them often has fringe benefits of which the dead are sometimes said to be jealous (Goody, 1962:193). In the case of live kidney donation, as my earlier comments on sacrifice imply, we are dealing with living and dying in a much more literal sense.

Before leaving this part of my discussion, I make brief mention of a further issue which arises in some transplantation cases. It appears that donation has sometimes created an especially strong sense of linkage between the donor and their sibling, and that this can have deleterious effects upon a recipient's other links. One example is reported by Fox and Swazey (1978:23-4). In this case, the donor was a sister who became extremely possessive of her brother, the recipient. This type of problem has led at least one expert in the field to suggest that, notwithstanding tissue matching benefits, there should be an 'incest taboo' on donation by close kin (reported by Fox and Swazey, p.386). As with the greater reluctance of married siblings to donate a kidney, so here it seems clear that this problem is likely to be especially pertinent in our own society. In this context, Fox and Swazey (1978:22) interestingly discuss Schneider's (1968:38, 50) analysis of marriage as the pivotal relationship in the American kinship system, and they note suggestively that the ideal donor in such a society would be a spouse. This point is partly reinforced by some of the detailed circumstances in which the pivotal nature of the marriage tie is realised. Kidney patients who are on home dialysis are typically looked after by their spouses, who have a taxing regimen of tasks to follow. In such circumstances donation might appear as a radical and desirable alternative to both the parties. The problem is, of course, that spouses tend by definition to be poor tissue matches for each other, but it is interesting that there have apparently been some cases of a spouse as donor. I have unfortunately not been able to obtain relevant material from other societies. It seems likely, however, that if kidney transplantation is extended to social systems like that of the Lozi of Zambia described by Gluckman (1950), where kin ties appear to be dominant over those of marriage, the reinforcement of kinship bonds through live donation might well be welcomed rather than feared.

10. There is some variation in the ratios of donation by different types of relative in different centres, and this may partly turn on the age of recipients in the programmes concerned. Cf. Liouvis et al. (1988:436-7), Morris et al. (1971:2841), O'Donnell et al. (1986:175), and Simmons, Bush and Klein (1977:203 and passim).
I turn now to some aspects of donation between strangers. This mainly concerns the use of organs from cadaver donors, since there is a widespread opposition, at least in Europe, to live organ donation from people who are not closely related to a specific recipient. This situation has recently been documented and challenged by Martyn Evans (1989). He argues that the reasons which appear to underlie the opposition to more open patterns of donation - mainly fears that poor and other individuals will be exploited and that a commercial organ traffic will develop - are less sound than might appear at first sight. He notes that genetically close relatives can also be placed under objectionable pressure to donate, and he suggests that the way to prevent commercialisation is through policies which control the form of the collection and distribution system itself rather than the restriction of donors. He also argues that the failure of cadaver and close relative donation to meet the demand for organs means that a restrictive policy is causing a great deal of suffering. In the course of his discussion he raises a number of interesting points about the drawing of conceptual boundaries on the subject. He points out that there is typically no objection to the transfer of blood and bone marrow between strangers, and while he agrees that these are regenerative substances, he notes that kidneys are a problematic category of non-regenerative organ since most people can cope well with only one of them. He also draws attention to mixed feelings which have been expressed about the use of spouses as live donors since this is, as I have mentioned, a relationship where close ties of affection and responsibility do not coincide with close genetic linkage. He then goes on to query why a friend should not serve as a donor if the tissue matching were sufficiently good, and he might here also have added persons in close ties of kinship, e.g., through adoption, who are not genetically related to a recipient. Lastly, in this context, he suggests that the free donation of a kidney for a stranger is an act of true and extreme altruism which should be admired rather than prevented. His assumption here appears to be that there are sufficient numbers of such 'altruists' to make a significant impact on the shortage of kidneys through live donation, but there is reason to believe that not all his opponents share this optimistic view. He also does not mention what I understand to be a general medical preference for cadaver donation, whatever the source, because of the danger of imposing possibly quite fruitless pain and risk through surgery upon live donors.\footnote{Rapaport (1986) also makes a plea for a wider ranging system of donation by live 'emotionally related' donors. On cadaver versus live donor preferences see fn3.}

Evans' paper focuses largely upon legal regulations within mainland Europe, and it is perhaps worthwhile to add a little here about more recent developments in Britain where new legislation is in the pipe-line. The Human Organ Transplants Bill was introduced to Parliament earlier this year as a reaction to reports of sales of kidneys by Turkish peasants for use in transplants in Britain. The Bill is designed 'to prohibit commercial dealings in human organs intended for transplanting; to restrict the transplanting of such organs between persons who are not genetically related; and for supplementary purposes connected with those matters.' The Bill defines genetical relations in the following terms:
'For the purpose of this section a person is genetically related to -
(a) his natural parents and children;
(b) his brothers and sisters of the whole or half blood;
(c) the brothers and sisters of the whole or half blood of either of his natural parents; and
(d) the natural children of the brothers and sisters of the whole or half blood of either of his natural parents.'

The Bill runs along much the same general lines as the legislation criticised by Evans, but it is important to note that the word 'restrict' rather than 'prohibit' is used with regard to non-related donors. This point was emphasised in the committee debate prior to the second reading, when it was pointed out that the Bill provides that non-related donors might be permitted in some cases after scrutiny by duly appointed authority in accordance with specific regulations. In this context, however, it was stated by the Under-Secretary for Health that the Government has 'in mind the possibility of donations between spouses and between parents and their adopted children', and in a later gloss he said 'I wish to make it plain that we are not discouraging those who are not genetically related from considering voluntary donation if their relative, spouse or friend is suffering from renal failure'.

It appears that the government here recognises that there are close relationships, including some within the field of kinship, which are not based upon genetic relationship. Two important points are clear, however. Firstly, there appears to be a somewhat simplistic assumption that genetically close relatives are also likely to be socially close. The Under-Secretary made this point as follows: 'the Bill has been drafted to permit organ transplants between close relatives because there could be clinical advantages, that they are more likely to be compatible in a medical sense. Also the motives of a donor who is a relative are likely to be altruistic.' Secondly, there is an assumption that desirable non-genetically related live donors are likely to have a close personal relationship to the intended recipient. It should be noted that this seems to run against the grain of Evans' critique despite the element of permissiveness through the concept of 'restriction' in the Bill. For Evans appears to deny or at least play down the importance of the idea, which the legislation reflects, that the sharing of bodily substance is intimately related in our own and many other cultures to the recognition of close and highly particularistic social bonds which peculiarly entail what Fortes (1969:234) called an 'axiom of amity'. This is a difficult issue to assess. It is clear from the success of charitable exercises such as 'Bandaid' and 'comic Relief’ that large numbers of people are willing to collaborate in the donation of vast sums of money for strangers in need. It is also true that blood donation operates on a voluntary basis at least in Britain, and that many valuable social services are provided by volunteers. The question is, however, whether and

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12. The Bill itself is set out in HMSO (1980a) and the debate is recorded in HMSO (1980b). The concept of 'emotionally related' donors, noted above, also assumes a personal bond. Rapaport (loc.cit) suggests the exchange of such bonds of emotional relationship by those needing to receive new organs in cases where this would provide better tissue matching than would be possible through direct donation between the emotionally related pair.
what other forms of sacrifice can be elicited within a comparable framework of donation.13

The Creation of New Bonds

If some forms of transplantation can have significant effects upon existing kin
ties, there is also a potential for such surgery to create new ties between previously
unrelated donors and recipients.

There is an analogy here in traditional societies with the institution of friendship
through ‘blood brotherhood’. Evans-Pritchard’s (1933) classical analysis of this
practice among the Azande has raised questions which have never properly been
answered. In the Azande case, he argues, it would be mistaken to see the institution
as simply mimicking kinship since the people do not express actual kinship links
through idioms of ‘shared blood’. I should add that such a gloss on customs of this
sort would be much more justifiable in the Nyamwezi case which I have studied,
where kinship is sometimes expressed in terms of common blood. Nonetheless, the
fact remains that this is not the case for the Azande, at the same time as it is clear
that shared bodily substance creates a close link, in many respects analogous to
kinship, for the people. Strathern (1973) has usefully argued that kinship concepts
may also turn upon such substantial inputs as the food a child consumes, and
Barnes himself has discussed some of the customarily perceived implications of
wet-nursing in his 1973 paper.

The evidence which I have seen concerning matters of this sort in transplantation
contexts is quite complex. Firstly it may be noted that the medical ‘gatekeepers’,
who organise organ donation, tend to maintain a strict control over later
connections between donors (and/or their families) on the one hand and recipients
and their kin on the other. The literature I have been able to examine contains the
odd suggestive case, however. Fox and Swazey (1978:32) report a case where the
heart of a young boy who had died was given to a girl who needed it. The fathers of
the two children met and the father of the dead boy is reported to have said that
he had always wanted a little girl ‘so now we’re going to have her and share her
with you’. In another case which I have heard about, a girl in receipt of new heart
and lungs was able to donate her own heart to another child. The operations were
performed in the same hospital and the two children know each other and know of
the transfer. Apparently this has created a strong bond between them.14

Nonetheless, the general impression is that, at least for Western society, this
emphatic emphasis on relatedness is played down. This is of course the opposite of the policies
pressed in recent legislation about live donation. As we have seen, the aim there
is to restrict donation especially by those with whom the donor has a strong
attachment through close relationship. In the case of unrelated donors, who are
usually dead, the aim is to prevent the possibility of such relationship developing
tween the recipient and the donor family. There appears to be a range of factors

A further important question, which it would take me too far afield to explore here, is the
degree of cross-cultural variation which might be expected on this issue.

I am grateful to Myc Riggulsford for an outline of this case.
involved. I understand that it is especially donor families who would like to establish such links, while recipients and their families, although wishing to express their gratitude, are more ambivalent about the idea of a lasting bond. I shall discuss some detailed aspects of this in the following section, but it is worthwhile noting here that whereas the dead person whose organs have been transferred is typically designated as the ‘donor’, in practice the bereaved family typically play a major role, and often the decisive one, in the agreement or refusal to donate, and in any case they are the ones left trying to make sense of their loss and its consequences. Recipients and their families are in a very different position, and it seems that a variety of aspects of ‘indebtedness’ lie behind their attitudes. In some cases, this is expressed as a concern for the donors, who may have to undergo a second ‘mourning’ if the recipient dies.\(^\text{15}\) There also seem to be worries that the establishment of links might constitute an unwelcome intrusion into recipients’ lives. The case of the ‘new-found daughter’ which I cited earlier provides some clues to such concern. So too does what has been described to me as a ‘probably apocryphal’ American case. There, a rich businessman received a kidney from a young criminal who died in a road accident. He later agreed to a request for money from the donor family, who had discovered his identity and pointed out that his ability to continue making money turned on the death of their son. The risk of such requests is clearly seen as undesirable by those who tell the story. This seems likely to be closely connected with the nature of our kinship system, in which, for economic and other reasons, people generally appear keen to limit their kinship ties than to extend them. What the situation would be like in other societies where the opposite tends to be true is again a matter of some interest. Of course, it is not wholly accidental that the technological developments which have made transplants possible are found in a society such as our own, where kinship ties are relatively restricted in their range and salience. But once developed, technology is mobile and applicable in a wide variety of contexts, and its implications may vary strongly from one social environment to another.\(^\text{16}\)

One point which this raises is that new technological developments of this sort, and especially the ideas they generate, have a potential for exerting influence in society, but this potential will not always be realised. Of course, developments which have a serious structural and material impact on society - such as the effects of improved medical and related facilities upon demographic structure - are likely to encourage the growth and spread of new values and ideas. But this does not seem to arise in the case in question, where the wider social impact remains uncertain. Transplantation clearly provides the possibility for individuals to explore

\(^{15}\) Dr. Fox and Swazey (1978:29-30). Dr and Mrs Evans have provided me with interesting material on this issue. Their organisation BODY (British Organ Donor Society) has been established to try to provide help to donor and recipient families, and also to hospital staff, who find difficulty in coming to terms with the stresses of bereavement and donation. On donor attitudes cf. Fulton, Fulton and Simmons (1977:368ff). Mai (1986) has commented on the 'striking' incidence of expressions of 'denial' towards graft, donor, or both by heart transplant recipients, and he notes the possible positive value of such 'denial' for post-operative adaptation.

\(^{16}\) I had hoped originally to obtain information from southern Africa and elsewhere about such possible variation in attitudes, but I have not been able to do so.
the boundaries which we set to recognising kinship, and this potential appears to be acknowledged by the attempts to keep it under strict control. Overall, however, there seems insufficient incentive for most people involved to adopt new ways of thinking about kinship, even though some individuals may do so if their circumstances and their disposition favour such a shift.

Identity and Mortality

Along with its potential for the creation and recognition of new relationships, transplantation also offers some intriguing possibilities for changes in our conceptions of the nature of identity and mortality. At the same time, however, it is not surprising that the issues are far more than purely intellectual ones for those concerned, and that they are often fraught with intense emotion. There are, as far as I can tell, two main aspects to this situation. One is focussed on the issue of death itself, and on the donor’s side it is naturally often of most immediately pressing concern to the donor’s close relations. The donor is, or course, in most such cases only just dead or close to being so defined while in an apparent limbo state on ventilation in an Intensive Care Unit. The situation is complicated by the fact that such ventilation can in some circumstances constitute ‘life support’ whereas in others, and especially when ‘brain stem death’ has been confirmed, it involved no more than the preservation of heart action in a body which is permanently incapable of any form of self-support, and which most medical expertise would define as ‘dead’.

It need scarcely be remarked that all this can be excruciatingly distressing to those close to potential donors. Decisions may have to be made to switch off ventilation in situations where there are still superficial signs of life, and thoughts about the possibility of ‘organ donation’ and its various implications are in any case likely to appear secondary, if they occur at all, compared with their sense of loss of the individual. There have been some very sympathetic accounts of the difficulties of decision making which can be involved here, and of the process whereby a spouse or parents may come to agree to a donation. It appears that despite the shortage of donated organs, many medical staff may balk at the thought of asking for donation at such times, and there have been strong pleas from some quarters for the introduction in Britain of a law of ‘required request’ as exists in many parts of the United States.¹⁷ This would make it legally incumbent on hospital staff to make such a request, and it is argued that the legal requirement would make the task easier at the same time as it would help to increase organ supply. Among the difficulties which can arise, in addition to those touched upon so far, is the fact that taking organs for donation can readily appear as a mutilation of a loved one rather than in any sense a continuation of them. Moreover, it appears that such ideas of continuation are discouraged by those professionally involved in transplantation. It

¹⁷ For accounts of the stresses of decision making see Fulton, Fulton and Simmons (1977). A number of documents have been prepared for medical staff guidance in such situations, cf. Le Poidevin (1987) and Working Party (1983). The case for required referral has been strongly made by Taylor (1987). In Belgium and France an opting-out system has been Instituted, but this was not favoured by a recent British working party on organ supply (Conference of Medical Royal Colleges, 1987).
appears to be felt that they are likely to do more harm than good, and it is like
though I do not know for sure - that this view is connected with the emphasis
maintaining distance between donor and recipient families. At the same time th
is some evidence that the idea of, in some sense, 'living on' does occasion-
emerge and can be a comfort, if only a small one, to those bereaved.

Some evidence on this is provided in an American study by Fulton, Fulton : 
Simmons (1977). In study of 15 cadaver donations, the authors report that 'feeli
about immortality sometimes made the decision to donate an easier one. At le
five of the survivors took comfort in the idea that part of the cadaver-patient wo
still be alive.' However, some of the feelings expressed were, not surprisingly, qu
complex. One still distressed mother said that she had agreed to donation beca
she wanted to do something to help her son. 'Perhaps he was alive as far as I con
cerned. So his death wasn't totally a death.' A father said 'Well, it's a fun
feeling. In a sense you think they're still around and yet they're not. [As long as
kidneys still function] he isn't dead down there'. Another mother, of a cada
donor daughter, reported that her teenage son had expressed the "beaut
thought" but there would be two transplants, one a physical operation performe
the doctors, and the other 'a psychological and spiritual transplant . . . we wo
live her joy and implant it in others.' The authors also note that feelings abou
donor's 'immortality' were somewhat frustrated by the lack of long te
information about the health of the recipients and the details of their p
operative lives. The donor families wished to know if the gift had been succes
and valuable. On the other hand there appears to have been reluctance to lear
the transplant had been unsuccessful. One or two other themes emerge from
slender information which I have at my disposal. It appears that some do
families are interested in the idea that an organ taken from a child should go t
child. One American father, who had been notified that one of his son's kidn
had gone to another boy while the other had gone to a married man with child i
is reported to have been much more anxious about the successful outcome for
youngster than for the adult recipient. There is also some suggestion that feeli
of involvement in the fate of a recipient tail off after a time, though this may pa
turn on lack of contact as well as the diminishing intensity of loss for the bereat
In one case, a son had died some years ago and his heart, liver, kidneys : 
pancreas had been passed to four separate recipients. The parents, who were k
enough to talk to me about this, told me that the recipient of the heart died sc
thirteen weeks after their son. Their emotions were, it seems, extremely comp
The mother was depressed for two days, whereas the father had taken a m
distanced stance. He, however, would have liked to go to the funeral, had
opportunity arisen, but the mother said that she would not have wished to go. I
son was really dead. They sometimes think about the other recipients, though t
do not know what has happened to them. They think more in terms of oth
benefiting from their son’s death, rather than in terms of his ‘living on’, though this idea seems to have figured in their thoughts at first.18

A further element in the situation appears to be the symbolic qualities attached to certain organs. As one might expect, at least in our own society, eyes and, especially, the heart seem to be more significant than other organs. They are thought of as being peculiarly part of an individual’s identity, and their donation and acceptance appear to be felt to be more significant. In one case British case which I have heard of, a young woman who needed a heart transplant was at first reluctant to go through with the operation because of such considerations. She was engaged to be married and she appears to have been deeply worried that the transplant, if successful, might turn her into a ‘different’ person and affect her love for her fiancé. In the study of 15 cadaver donations, referred to earlier, the authors report that two families in their sample specified that the heart of the deceased could not be used. This was particularly remarkable because heart transplants were not being done at the hospital in question and no request to use hearts had been made. Nonetheless ‘these families felt so strongly that the heart should remain with the body that they wrote in this qualification on the permission form themselves’. The authors also note that two families who had not realised that eyes might be taken were upset to hear that this had happened.19

Conclusion

The question of the symbolic meaning of the body and its parts, and their relation to identity, is clearly one on which much more research could usefully be done.20 Among other things, it seems likely that there are significant differences of viewpoint between different cultural and ethnic groups, and this is potentially of practical importance. It appears that at present there are particularly serious shortfalls in the supply of organs for members of ethnic minority groups in Britain.21 Partly this may derive from problems of communication, and of family structure and decision making, which are especially salient at the critical juncture when requests for donation are normally made. It is also possible that there are elements of mistrust on the part of some potential donor families. Nonetheless, cultural perceptions of the relationship between the body and identity may also be important, and there seems to be considerable need to study these along with the other factors I have mentioned. There is, moreover, reason to believe that such problems are not simply confined to minority groups. So far, studies appear mainly

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18. Dr and Ms. Evans (pers.comm.). The question of the bearing of religion on ideas of immortality in such contexts is intriguing, but I have found very little discussion in the literature I have examined.

19. See also Mai (1986:1159) and Fox and Swazey (1978:132).

20. There are clearly further complications in store for us. The Times for 26 July 1989 reports that the Polkinghorne Committee has pronounced in favour of the controlled use of human foetal brain cell transplants into adults. The report stipulates that only isolated brain cells or fragments of tissue should be used to ensure that no ‘personality transfer’ occurs.

21. Myc Riggulsford (pers.comm.). See also British Transplant Association Newsletter (1989:3) and Lewis (1987) Chinese and British attitudes are contrasted.
to have been carried out by psychologists, medical sociologists, and staff closely associated with transplanting itself, and I suggest that social anthropologists should also be encouraged to participate in such work.

I am thinking of much more than an expertise in cultural diversity. Transplantation is a field which offers the possibility of exploring a number of fundamental issues in the ideology and structure of kinship and the wider society. In addition to a potential to lay 'bare the microdynamics of entire families' (Fox and Swazey, 1978:24) in our own society, it appears to offer an opportunity both to apply insights from other areas of kinship studies and to provide new clues for the comparative understanding of familial institutions in a range of social settings beyond those of its immediate incidence.

References


