Med Health Care and Philos (2014) 17:559–571
DOI 10.1007/s11019-014-9553-1

SCIENTIFIC CONTRIBUTION

The donor organ as an 'object *a*': a Lacanian perspective on organ donation and transplantation medicine

Hub Zwart

Published online: 15 March 2014

Abstract Bioethical discourse on organ donation covers a wide range of topics, from informed consent procedures and scarcity issues up to 'transplant tourism' and 'organ trade'. This paper presents a 'depth ethics' approach, notably focussing on the tensions, conflicts and ambiguities concerning the status of the human body (as something which constitutes a whole, while at the same time being a set of replaceable elements or parts). These will be addressed from a psychoanalytical (Lacanian) angle. First, I will outline Lacan's view on embodiment as such. Subsequently, I will argue that, for organ recipients, the donor organ becomes what Lacan refers to as an object *a*, the 'partial object' of desire, the elusive thing we are deprived of, apparently beyond our grasp. Within the recipient's body an empty space emerges, a kind of 'vacuole', once occupied by a faltering organ (now removed). This space can only be filled by a 'gift' from the other, by an object *a*. Once implanted, however, this implant becomes an 'extimate' object: something both 'external' and 'intimate', both 'embedded' and 'foreign', and which is bound to remain an object of concern for quite some time, if not for life. A Lacanian analysis allows us, first of all, to address the question what organ transplantation has in common with other bodily practices involving bodily parts procured from others, such as cannibalism. But it also reveals the basic difference between the two, as well as the distance between the 'fragmented body' of Frankenstein's 'monster'—as an aggregate of replaceable parts—and the multiple organ recipients (the 'puzzle people') of today.

H. Zwart (✉)
Department of Philosophy, Faculty of Science, Radboud University Nijmegen, P.O. Box 9010, 6500 GL Nijmegen, The Netherlands
e-mail: h.zwart@science.ru.nl

Keywords Organ donation · Transplantation medicine · Embodiment · Psychoanalysis · Jacques Lacan · Thomas Starzl · Cannibalism

Introduction

Bioethical discourse on organ donation covers a wide range of topics, from informed consent procedures and scarcity issues up to 'transplant tourism' and 'organ trade'. Over the past decades, it evolved into a stream of documents of bewildering proportions, encompassing thousands of books, papers, conferences, blogs, consensus meetings, policy reports, media debates and other outlets. Beneath the 'manifest' level of discourse, a more 'latent' dimension can be discerned, revolving around issues such as the experience of embodiment, the status of the human body, and the notion of bodily integrity.

In this paper, these more 'basic' issues will be addressed. What I envision is a 'depth ethics' (the moral equivalent of a 'depth psychology') focussing on the tensions, conflicts and ambiguities at work in these more latent layers of bioethical discourse, although they evidently influence and co-determine the viewpoints articulated on the more manifest levels as well. Notably the status of the body (not only as something which we 'have', but at the same time 'are'; but notably as something which constitutes a *whole*, while at the same time being a *set* of elements or parts) is a highly relevant issue in this respect. Moreover, these issues will be addressed from a psychoanalytical angle. Notably, the work of Jacques Lacan (1901–1981) will be used to highlight some of the contradictions and tensions of bodily existence resurging in the contemporary transplantation debate.

This attempt to approach organ donation from a Lacanian perspective will cause some eyebrows to frown, I

guess. To begin with, besides the interpretative difficulties that are raised by the obscurity and idiosyncrasy of his work, Lacan has never systematically addressed topics such as organ donation or transplantation medicine himself, so that the idea of 'applying' his views to such topics seems a hazardous one indeed. Moreover, Lacan even explicitly seems to discard the feasibility of 'applied psychoanalysis', calling it a silly 'deviation'.[1] And yet, as I will demonstrate in this paper, his work teems with insights that may significantly deepen our understanding of the various ambivalences entailed in the transplantation debate, so that it would be an intellectual waste to use his work as a resource for academic 'author studies' only. Moreover, from a depth ethics perspective, organ donation is a rather 'fundamental' issue. In fact, in one of his seminars, bearing the telling title *D'un Autre à l'autre* ("from an Other to the other"), Lacan approximates the issue rather closely, as I will show (Lacan 2006). Nonetheless, since bioethical quandaries are hardly (if ever) addressed by Lacan directly, a quick introduction into his views on embodiment as such seems an indispensable preparatory exercise. Subsequently, I will elucidate these views with the help of a bodily practice that is abundantly present in psychoanalytical discourse in general, and in Lacan's writing in particular (and which, like organ donation, involves 'gifts of the body'), namely sexuality and love. Finally, I will consider in what manner and to what extent a Lacanian view may facilitate the development of a 'depth ethics' approach to transplantation medicine, supplementing my conceptual analysis with a concrete case study.

The real, the imaginary and the symbolical: Lacan's understanding of human embodiment

Before addressing organ donation proper, the Lacanian understanding of bodily existence in general will be briefly outlined. Lacan distinguishes three realms (or: registers) of bodily experience, three basic ways in which the human body comes to the fore and may be encountered in various practices, namely the 'real', the 'imaginary' and the 'symbolical' body (Cf. Zwart 1998). As far as the *real* body is concerned, the human body is basically experienced as a fragmented body: a composite aggregate of organs, fluids, processes and products. The *imaginary* body, by contrast, refers to the body as a meaningful whole. Now, the body is envisioned in terms of integrity or wholeness, and seen as an integrated unity. Finally, the *symbolical* body is the body as it emerges in modern scientific research practices. It is brought to the fore through technology and science: the body as it is being measured, qualified and quantified with the help of biomedical equipment. Allow me to develop these three registers/dimensions of human bodily experience somewhat further, with the help of a few examples.

In everyday adult life, we are hardly ever directly confronted with the real, fragmented body any more. Rather, the fragmented body ('corps morcelée') is the body as it is experienced by very young children during early stages of development, although it continues to emerge in the folds and margins of bodily experiences later in life.[2] The real body is that which resists our efforts towards idealisation (scientific, artistic, religious, or otherwise) of the human body: it is the unclean rather than the clean, the damaged rather than the unviolated, the destitute rather than the wholesome, the eerie rather than the familiar body.

A first effort to turn the fragmented body into a stable, coherent unity or whole is brought about by the so-called mirror stage (Lacan 1966, p. 93 ff.). By recognising their image in a mirror, Lacan argues, very young children for the first time learn to see themselves as complete individuals. This triumph over fragmentation gives rise to an experience of "jubilation". Yet, this newly acquired sense of unity is dependent on an external image: the *Gestalt* or *image* as reflected in the mirror, and therefore remains highly vulnerable and image-dependent ('imaginary').

The imaginary body can also be encountered, moreover, in works of art, notably in ancient Greek and Roman sculptures (and their neo-classicist equivalents). An artistic rendering of the human body may present it as an integrated unity, as something admirable, stable and whole. Moreover, through various body practices, such as bodybuilding for example, athletes (male or female) may sculpt their bodies into living pieces of art, thus mimicking or mirroring examples (either in marble or in the flesh) presented by others. Ancient Greek statues were basically the statues of athletes or of gods (but that amounted to the same thing, as gods were regarded as athletes and athletes as gods). Moreover, as Lacan explains, statues of human beings, erected alongside major roads in ancient times, conveyed the idea of humanity: the concept of a human being, with integrity and dignity as its basic normative attributes (Lacan 1981, p. 328; Cf. Zwart 2000). Thus, statues of heroes, emperors or other 'exemplary' humans (both physically and morally) spread the ancient gospel of human dignity, of *humanitas*. They incorporated an idealised view of what embodied human beings should aspire to become. These statues were erected alongside public

[1] "Cette déviation bouffonne que j'espère barrer, qui est déjà étalée de longues années sous le terme de psychanalyse appliquée" (2006, p. 66).

[2] "Die Pathologie lehrt uns [Fälle] kennen, in denen uns Teile des eigenen Körpers … wie fremd und dem Ich nicht zugehörig erscheinen" (Freud 1930/1948, pp. 423/4).

roads by way of ethical propaganda. They functioned like missionaries in stone, whose silent sermons made a definite impact on anonymous masses of travellers and passers-by (Cf. Sloterdijk 2009, p. 37 ff.). The 'idea' of human dignity (as well as the commandment to respect and admire it) was thus carved into stone. In psychoanalytical language, human physical perfection was a result of artistic 'sublimation', turning flesh into marble. It was the celebration of the imaginary body: of a particular (normative) image of what our bodies ideally should look like. Turn thyself into a work of art! Ancient statues propagated a basic *idea* of what human bodies essentially *are*. Michelangelo's *David* may stand out as an early modern counterpart.[3]

This beautified body was not only endorsed by pagan (Greco-Roman) artistic representations (and their early modern equivalents), but also by Christian views of embodiment, although here a dramatic historical dimension is added. According to Thomas Aquinas for instance (1922, Pars Ia, Q 96–97), the human body once (*in statu innocentiae*, i.e. in Paradise) was beautiful and whole, but we damaged and corrupted this beautiful work of art, this gift from God. And now, it is our duty to restore our body to its state of original splendour, although this calls for divine support, a combination of human virtue and heavenly grace. Meanwhile, our earthly frame remains constantly under siege. Corruptive forces surround it, and its fragile, vulnerable wholeness can never be taken for granted. Bodily existence entails a continuous struggle, as it were, between good and evil, consolidation and fragmentation.

The body as a *fragmented* body is played out in a highly provocative manner in Mary Wollstonecraft Shelley's novel *Frankenstein*, published in 1818 (not coincidentally during the gestation period of modern medicine). A science student named Victor Frankenstein (whose mother had died during delivery) decides to find out whether deceased human bodies can be brought to life again with the help of modern science. Thus, we see him roaming cemeteries and mortuaries at night, looking for suitable bodily parts, notably organs and tissues. And from these collected parts, an organic amalgam is composed. Subsequently, by exposing it to high voltage electricity, this aggregate of organs is revivified, and the famous 'monster' is created, whose gimpish, distorted torso suddenly starts to breathe and move. In other words, in Mary Shelley's novel, the body emerges as an *aggregate of replaceable parts*. This break-down of the unified, integer body into detachable, semi-autonomous bodily parts arouses in us a particular experience, which Freud refers to as 'the uncanny' (1919/1947) and which constitutes a typical ingredient of horror stories.

To a certain extent, the ground for this Frankensteinian experience of embodiment had been prepared by early modern anatomists: notably pioneers such as Vesalius. Through dissection, the human body was opened up, so that the various parts and organs were exposed and presented as more or less separate entities. And indeed, in plastic anatomical models produced for educational purposes, heart, lungs, liver, kidneys and other organs can easily be removed: they can be taken out, and subsequently placed back again. The organs involved are allowed to stand out, as it were: they have become distinguishable, in principle, from the body as a whole. Whereas modern anatomy breaks down the body into constituent parts, Victor Frankenstein rather worked the other way around: his aim was to reassemble the body from dispersed fragments.

Developing along these lines, modern science gradually opened up a new and unprecedented experience of bodily existence, distancing itself both from the chaotic and uncontrollable 'real' body (of early childhood and of the distant, mythological past) and from the idealised and beautified 'imaginary' body (reflected in the mirror experience as well as in classical sculpture), namely the 'symbolical' body. Now, the human body is measured, for instance in terms of height and weight.[4] Gradually, notably in the nineteenth and twentieth century, a plethora of measurement practices emerged, establishing 'normal' standard values for various bodily functions, such as oxygen saturation in the blood or systolic and diastolic blood pressure (120/80 mmHg). Outcomes of such measurements are represented with the help of specific 'symbols' (kg, lbs, meter, cm, mmHg, and the like). Speaking about blood, an important step towards blood transfusion (as a preliminary form of transplantation medicine) was the discovery of blood types by Karl Landsteiner in 1900, describing blood samples in terms of (the presence or absence of) antigenic substances on the surface of red blood cells, represented by a minimal alphabet of symbols (A, B, AB and O). These myriads of symbols and numbers thus produced, moreover, can be employed in mathematic equations: notably by presenting one series of measurements as a function of another—for instance, by using weight and height to determine the body-mass index (BMI), as a way of describing, in short-hand as it were, the basic condition of a particular human body. All these numbers, units, symbols, technical terms and acronyms constitute what Lacan refers

[3] Cf. Cassell (1992): "Michelangelo's statue of David … evokes in all the essence of human form and purpose"" (p. 248). .

[4] This register of bodily experienced was opened up by Sanctorius (1561–1636), the founding father of iatrophysics, whose notes on medical statics—*De Medicina Statica Aphorismis*—were published in 1614, after having spent no less than 30 years of his life in a weighing chair, carefully measuring the effects of food intake and other daily habits on body weight, and comparing it with the weight of waste products (urine and faeces). .

to as the 'symbolical' order. It fosters particular ways of presenting the body, allowing it to emerge in a certain manner. Various technical instruments have been designed, ranging from standard medical equipment to fairly advance high-tech devices, to support this ongoing 'symbolisation' of the body (also known as biomedical science). And this is what critics of contemporary techno-medicine have in mind when they claim, for instance, that biomedical technologies endanger the dignity and integrity of the human body. The imaginary body (the body as a meaningful unity or whole) is disrupted by these powerful symbolical representations of the body, opening it up to calculated interventions and effective manipulations.

It goes without saying that this not only affects the way we actually see and experience our bodies, but entails far-reaching normative implications as well. Whereas a traditional (Greco-Roman or Christian) ontological evaluation of the body will emphasise its unity, wholeness and integrity, the sway of modern science inevitably disperses the body into fragments once again. Organs emerge as *partial objects* (as Lacan, building on previous authors such as Freud, Abraham and Klein, phrases it); detachable from the body as a *Gesamtbild*—as a coherent, integrated whole. It is the return of the Frankensteinian vision of the body, but now under hyper-modernistic scientific conditions. Indeed, in this new scientific version, the fragmented body is no longer experienced as chaotic, incontrollable and unclean. Quite the contrary, it is meticulously described and analysed, and even sterilised, cleansed and purified by techno-science.

One of the most symptomatic implications of this transition is the contemporary discussion over ownership of the body and of its multiple fragments. Whereas we can no longer claim ownership over a human body as a whole (as in the case of slavery), the ownership of bodily parts and fragments (of 'partial organs') has increasingly become a matter of dispute (ten Have and Welie 1998). A world-famous, highly symptomatic example is of course the dispute over the ownership of the so-called HeLa cell lines (Skloot 2011). There is evidently something uncanny entailed in the idea that human cells or tissues can be cultivated, analysed and owned, even immortalised, in a laboratory environment while the person from whose body these cells were originally procured (Henrietta Lacks) died more than 60 years ago (in 1951). But also the individuals themselves, rather than the biomedical institutes that cure them, care for them and study them, may claim ownership over bodily parts (tissues, fluids, DNA, extirpated organs, etc.), for instance in the context of biomedical research (Dekkers and ten Have 1998). Thus, the symbolisation of the body in the epistemological sense (as described above) inevitably calls for a concurrent symbolisation of the body on the governance level as well, in the form of laws, regulations, stipulations, ownership contracts, transfer agreements, informed consent procedures and so on. Not only the physiological, endocrinological, anatomical and genetic features of bodily existence must be minutely described, also its legal parameters must be documented and ascertained as meticulously as possible.

Let this suffice as an account in outline of how the human body tends to be seen from a Lacanian perspective. In the next section, I will focus on a particular type of bodily experience, paving the way as it were for the discussion on transplantation medicine, namely the body as it functions in sexuality and love.

Love and the idealisation of the body

It is well-known that, from the very outset, there has been a strong emphasis in psychoanalytic discourse on sexuality and love. Therefore, before turning to organ donation proper, the function of the body in sexuality will be given some attention.

Love and eroticism often involve an element of over-estimation, investing the body of the beloved Other with 'surplus value', transforming it into a unique, almost supernatural, imaginary body. And this idealised and elevated body tends to play a prominent role whenever sexual relationships are concerned. In narcissism (the love of self), for instance, a substantial amount of libido is invested in one's own body, so that our bodily self becomes the object of love, care and desire, turning it into a living work of art, through diet, life-style, exercises, and so on. Satisfaction may be derived from touching and caressing one's own body, or from viewing its reflection in a mirror. To the extent that others are involved, these others become a second self: an exemplification of what we ourselves aspire to be, the (in vivo) paradigm of our (unconscious) ideal of human embodiment in its most impeccable fashion, and this may well explain our erotic devotion. Thus, narcissism is closely connected with a celebration of the 'imaginary' body as a perfect *Gesamtbild*.

But we may also see the beloved other really as *other*, that is: as significantly different from ourselves. Such an 'other' seems to provide the very thing we lack or seek. For instance: someone whose bodily and mental features compensate our own inferiorities, our weaknesses and flaws. The Other (the erotic object) now emerges as our 'complement'. We experience our body not in terms of wholeness (A), but rather in terms of deprivation ($\not A$). We are yearning for a desirable, indefinable supplement which may make us whole again.

Erotic desire thus may be triggered by rather specific bodily features, and we may invest our libido in particular parts of beloved bodies (valued as particularly fascinating

and intriguing) rather than others. This may involve body parts such as breasts, phalluses, eyes, hands, muscles, buttocks or earlobes, although desire may also be aroused by the other's voice, gaze or smile, or even by specific ornaments or garments (such as high heels or pearl earrings) as symbolic equivalents of 'partial organs'. It is not in the beloved other *as such*, but rather in specific bodily parts that we suddenly seem to discern what we have been (unconsciously) looking for: the emblem of human perfection, the lost object of desire, which suddenly seems to resurge before our very eyes, which suddenly seems to be there, presenting itself to us, invitingly. Lacan uses the term object *a* to refer to partial objects (breasts, hands, feet,[5] voices, etc.) that may function as (lost) objects of desire. Moreover, he expresses its function with the help of a mathematical formula, where $ represents the (divided) subject (the subject of desire, yearning for wholeness), while *a* refers to the desirable object (the missing piece, so to speak), and ◇ represents the function of desire:

$$\$ \diamondsuit a$$

The partial object, as object of desire (object *a*) may also play a role in art. That which, in normal life, remains concealed, may certainly protrude, may unexpectedly emerge. Lacan (2004) discusses two paintings by Francisco de Zurbarán (1598–1664), for instance, depicting female saints, female martyrs, namely Sainte Lucia, carrying her severed eye-balls on a plate, and Sainte Agatha, carrying her severed breasts on a similar plate. These parts had been violently removed in the context of religious persecutions to which they had been subjected. In normal life, we see the gaze, the pupils, but not the eye-balls of the other, and we see the outward shape and nipple, but not the internal tissues of the breast. Separated from the body, these organs constitute something rather "uncanny", as we have seen (Freud 1919/1947). The same goes for hands, or the intestines (or even the complete skin, as in the case of Saint Bartholomew) or any other organ that is violently separated from the body as a whole. All of a sudden, the object of desire (object *a*) becomes a 'partial object', disconcerting rather than alluring.[6] To use another Lacanian formula: the integrity of the body (A) is fundamentally damaged (Ⱥ). Its dignity and wholeness (1) must somehow be restored (if this is still possible) through the recovery of (and reconnection with) this object *a*:

$$Ⱥ + a = 1$$

Let this suffice as a brief introduction into the Lacanian understanding of embodiment and love. I now will turn to the subject matter of this paper, namely organ donation.

A Lacanian depth ethics of organ transplantation in outline

In everyday experience, human beings tend to perceive their bodies as an integrated whole, as we have seen: we basically experience a sense of wholeness. The various sections of our body are all part and parcel of what we are as *individuals* (literally: 'indivisible beings'). The body's wholeness seems the primary experience, preceding our awareness of specific components or organs of the body, which are normally not regarded as separate entities.

This may dramatically change, however, in the case of illness. When specific organs (heart, lungs, kidneys) or other constituents (joints, bones, tissues, etc.) suddenly fail, they seem to stand out as it were, they become separated more or less from the body as such, the body as a (wholesome) whole. The failing part or organ becomes our primary focus of attention. It may even become an obsession. Moreover, it will serve as point of access for processes of symbolisation. Because of this affected organ, the body will be subjected to all kinds of measurements and inquiries. Contrivances and high-tech equipment are brought into bring the faltering organ into view, and to compare its functionality, it performance (in terms of quantitative values) with normal values (with normality: with that what is to be expected). To the extent that the disrupted/disruptive organ endangers the well-being or functionality of the body as a whole, we may even consider the option of removal. All of a sudden, the body becomes an aggregate/composite of organs once again. If other treatment options fail, we may indeed decide that one of our organs must be expelled, or has to be replaced.

From that point onwards, attention may turn towards the bodies of other persons: potential donors; not to their bodies *as such*, of course, but rather to specific parts or organs (such as a kidney, a cornea or a uterus[7]). In other words, attention is turned all of a sudden towards a *partial*

[5] In the novel *Gradiva*, as analysed by Freud (1907/1941), desire is aroused by the singular shape and movement of the heroine's feet that comes suddenly into view.

[6] In an intriguing analysis Iris Marian Young (1992) juxtaposes 'breastedness' with mastectomy (building on the work of Luce Irigaray, a critical follower of Lacan). In Western patriarchal culture, dominated by the masculine gaze, she argues, women's breasts easily become objectified into a fetish that can be handled, manipulated, even 'owned' by males as an object which is detachable (more or less) from her body, functioning as 'object of exchange' on the market of sexuality. This latent detachability is exemplified by breast removal in the case of malignancy, resulting in a breast-less or one-breasted ('Amazon') woman, who may replace her missing breast with a prosthesis, thus underscoring its apparent replaceability.

[7] http://www.cbsnews.com/news/nine-swedish-women-undergo-uterus-transplants/.

object encased within their bodies. A specific organ becomes the object of our desire, our object *a*. It is more or less set apart from the rest of the bodies of these others. It becomes an entity in its own right: the one thing we desire more than anything else:

$\$ \diamondsuit a$

The one thing that would compensate for our deficiency, our deprivation: that which would make our destitute body whole again:

$\not{A} + a = 1$

The transplant, although it is basically an organ (i.e. a part of someone's body) is not a natural entity. It is an artefact of transplantation medicine, made available by technical developments, and also (in the case of cadaveric organs) by the brain-death concept, in combination with a donor's will and other symbolical items. It is a rather intractable 'thing' that may be either present or absent, available or non-available, depending on biomedical supplies and tissue matching, but also on codicils and various other elements that foster the viability and legitimacy of the act of transplantation.

If we place ourselves in the position of the donor, rather than that of the recipient, we may discern in the suffering Other a gap or lack, a deficit we are called upon to fill with our 'gift', either as a living donor or, after (brain) death, as a cadaver, via organ procurement. As Lacan phrases it, in one of his seminars, the suffering other seems to utter a silent scream, like the one depicted in the famous series of paintings produced by Edvard Munch (bearing this title), awaiting the arrival of someone who may fill the gap and ease the discontent, the pain (2006, p. 225).

Inside the body of the suffering Other, there is a kind of anatomical emptiness: a gap, which Lacan refers to as a 'vacuole' (2006, p. 232), a term that is usually applied to the anatomy of unicellular organisms, but is here used to indicate this ambiguous, sinister, empty space that was once occupied by a dis-functioning, but now removed organ. This space can only be filled by a gift from the Other, by an object *a*.

Tissue matching and immune-repressive drugs, in combination with informed consent procedures, will determine the extent to which organs are actually available and transferable from one body to another. This involves measurements and calculations: a drastic symbolisation of the body and its tissues. The objective is to restore the recipient's body to *normality* (a symbolical concept that can be determined with the help of measurements and standard values) rather than *integrity* (a concept which is tangled up with the imaginary view of the body in terms of wholeness: the realm of the 'ideal', as Lacan explicitly points out (2006 p. 270). So, normality (as a 'symbolical' objective) rather than integrity (as an 'imaginary' objective) is the goal. In fact, the integrity of the body, in the form of the immune system, will put up resistance, may even 'reject' the implanted organ, and much effort has to be spent in counteracting this natural response of the body as a whole. Moreover, organ implantation is bound to leave considerable scars: the integrity of the body can perhaps be partially restored, but at the same time it is damaged forever, by implantation and everything this entails (invasive surgery, immune-repressive drugs, the use of various instruments, the introduction of 'foreign' tissue, the scars of the operation and so on).[8]

Thus, there is an intimate gap within the recipient's body, a kind of vacuole, as Lacan phrases it, which cries out to us, as it were, and wherein the lacking organ is to be implanted. A gift from an Other, from a 'neighbour', in the Christian sense of the term, is then inserted into this empty space. To explain what is entailed in such an event, Lacan introduces the term '*extimate*', a portmanteau word, blending two (apparently opposite) concepts, namely 'external' and 'intimate', into one neologism, specifically coined to stress the paradoxical nature of these kinds of events. The body's 'forbidden' intimate region is opened up, its integrity is disrespected, and an implant is inserted as a kind of boundary object: something in between the intimate and the external, the self and the other, the familiar and the foreign: an *extimate* object. The new organ's presence within the recipients' body will remain precarious, however, at least for quite a while, and it may never become wholly embedded once and for all, never become a completely integrated part of one's bodily self. This new 'extimate' organ may remain a matter of concern for life. It is, indeed, something 'extimate': something eerily strange (external) and profoundly intimate.[9]

Extimacy thus implies that something can be on the inside while remained stigmatised as different: an ambiguous invisible thing of whose presence and performance we will remain acutely aware.[10] The concept *extimacy* stresses

[8] Lacan also makes a connection with perversion. The perverse subject discerns that something is missing in the body of the other (for instance: the phallus). This is represented as $\not{A}$, the barred Other, who falls short of the imaginary ideal. This deficiency has to be restored with the help of a certain supplement, an equivalent for the missing object *a*, so that the Other can be brought back to his/her level of dignity again: $\not{A} + a = 1$ (2006, p. 19).

[9] "J'ai désigné comme la *vacuole*, cet interdit au centre, qui constitue, en somme, ce qui nous est le plus prochain, tout en nous étant extérieur. Il faudrait faire le mot *extime* pour désigner ce dont il s'agit" (2006, p. 224).

[10] The paradoxical concept of 'extimacy' may been seen as comparable to Saint Augustine famous phrase envisioning God as 'interior intimo meo', more interior than my innermost being (Bracher et al. 1994, p. 76). The new organ is inside the recipient, but he/she remains highly aware of its presence.

that, on the one hand, due to transplantation medicine, and everything it involves, the distance and difference between Self and Other has dramatically decreased, while at the same time, traces of distance or otherness remain, but are now transferred into the internal, most intimate environment of the recipient's body. In the next sections, the concept of extimacy will be fleshed out further with the help of two historical analogies to organ donation, namely cannibalism and the catholic devotion of the Sacred Heart of Christ.

Analogies to transplantation (1): cannibalism

To further develop our psychoanalytical 'depth ethics' in more detail, the next step is to compare transplantation medicine and organ donation with other cultural bodily practices.

As a first analogy, cannibalism[11] (or anthropophagy) may come to mind: the harvesting of bodily parts or organs from cadavers after battle; in other words, the posthumous procurement of organs by victors. In cannibalism, what is eaten is not the body of another person *as such*. Rather, specific organs are singled out for consumption: organs associated with specific psychic features, personality traits which man-eaters may wish to incorporate through the act of cannibalism, for example: courage, by eating the heart of a slain, courageous enemy.

In his ethnography classic *The Golden Bough*, which has had a profound influence on psychoanalysis, notably the work of Freud, Sir James Frazer (1890/1993) already emphasised that cannibalism (once widespread) had always been a highly symbolical practice. While referring to a specific tribe in Central Africa, bent on consuming specific organs harvested from the corpses of adversaries of favourable repute, he writes for instance:

> The flesh and blood of dead men are eaten and drunk to inspire bravery, wisdom or other qualities for which the men themselves were remarkable, or which are supposed to have their special seat in the particular part eaten … Whenever an enemy who has behaved with conspicuous bravery is killed, his liver, which is considered the seat of valour; his ears, which are supposed to be the seat of intelligence; the skin of his forehead, which is regarded as the seat of perseverance; his testicles, which are held to be the seat of strength; and other members, which are viewed as the seat of other virtues, are cut from his body, baked to cinders and … mixed with other ingredients into a kind of paste (p. 497)

Thus, flesh coming from humans is not regarded merely as food. Rather, specific parts or organs are 'incorporated', as it were, to enhance a particular virtue, to remedy a particular deficit.

These ideas were taken up by Freud who argued that, by consuming specific body parts of defeated foes, particular characteristics were 'incorporated'. Again: cannibalism is not primarily about food, it is first and foremost about identification with the (idealised) other (1913/1940, p. 101, 172; Cf. 1905/1942, p. 98; 1921/1940, p. 116; 1923/1940, p. 257). Thus, a surplus of strength or courage (for instance) is added by procuring and consuming specific organs (guided by a particular theory of localisation). It is not the body as such which is consumed, but certain favoured parts. The cannibalistic desire may focus on a number of partial objects (such as heart, ears, testicles, etc.): bodily components which are set apart as especially valuable. What the man-eating subject is after, is a particular organ, hidden inside the other's body, which is now brought to the surface, ready for the harvest. In other words, the cannibal strides to battle armed with the Lacanian formula: $\$ \diamond a$.[12]

In contemporary culture, cannibalism (although not formally listed among the psychiatric conditions mentioned in the *Diagnostic and Statistical Manual of Mental Disorders*) is usually associated with serial killers and sexual perversions. A famous (albeit fictional) contemporary devotee is Hannibal ('the Cannibal') Lecter, a former (psychoanalytically oriented) psychiatrist and art connoisseur who becomes a wanted cannibalistic killer in a series of well-known novels and movies. Usually, his object *a* is the face of his victims: he preferably rips the flesh off their faces with his bare teeth, but he may also go for the intestines (such as happens in the case of the unfortunate police inspector Rinaldo Pazzi, who is disembowelled and hung from the balcony of the Palazzo della Signoria in Florence) or for the brain (as in the case of justice department official Paul Krendler, whose skull is lifted, and part of whose brain is eaten for lunch). Indeed, Lecter is portrayed as someone who becomes fixated on a particular part of the victim's body. In other words, his desire, reflected by the structure of these movies and novels, adheres to the formula $\$ \diamond a$.

Although the comparison between the procurement of cadaveric organs for transplantation and cannibalism may seem somewhat far-fetched, a structural similarity can nonetheless be discerned. Indeed, organ donation has been

[11] *Caníbales* was the Spanish name for the Carib people of the West Indies, notorious for their cannibalistic practices. Cannibalism is used here not to refer to man-eating a last resort to fend off starvation, such as occurred during the infamous 'Andes flight disaster' in 1972, but as a ritualistic event notably practiced by warriors and priests.

[12] *In the Merchant of Venice*, a similar formula is at work: the heart is set apart from the rest of the body. The question is, however, how to collect the heart without damaging the remainder of the body.

explicitly compared to cannibalism by a number of authors, including Leon Kass (1992). In his provocative paper, Kass endeavours to analyse the (unconscious) origins of his uneasiness with transplantation medicine. How can I, he asks himself, see organ donation (involving a life-saving gift to a lethally suffering patient) as an "impropriety", an "unsavoury practice"? What is causing my resistance? It amounts to a self-analysis: an ethicist placing himself on the couch while conducting a depth-ethical, self-questioning exercise, as it were. According to Kass, what is so impelling about organ transplantation is that the body is treated as "a heap of alienable spare parts" (p. 66) and this undermines the body's dignity. Due to the technical possibility of salvaging cadaveric organs, the human body has become a valuable resource of materials which we should not allow to go wasted, which we should not allow to be left unused. Therefore, he argues that "organ transplantation really is—once we strip away the trappings of sterile operating rooms and their astonishing technologies—simply a noble form of cannibalism" (p. 73).[13]

Analogies to transplantation (2): the catholic devotion to the Sacred Heart

Another cultural practice which bears at least a family resemblance to donation, and which may therefore be regarded as a preparatory precursor of organ transplantation medicine, is the Christian (Catholic) devotion to the Sacred Heart of Christ. This devotion can be seen as an acting-out of a basic ambivalence that runs through Christianity as far as the body is concerned. On the one hand, Christianity has emphatically committed itself to an understanding of human embodiment in terms of inviolability, unity and integrity, as we have seen. This poses serious obstacles to transplantation medicine, notably to salvaging of cadaveric organs for transplantation. We are not allowed to use or recycle the bodies of deceased persons, nor are we entitled to violate their bodily integrity. Piety towards human corpses has been instilled by Christianity into Western culture throughout the ages, and has solidified into a deep-seated moral intuition. Indeed, in late Roman and early medieval times, Christian propaganda effectively put a stop to ritual practice such as incineration, replacing funeral pyres with graves. This was closely connected with the dogma of the resurrection of the body: on Resurrection day, when the trumpet calls (as Saint Paul phrases it),[14] body and soul will be reunited into a transfigured, imperishable body and for that reason, the integrity of the body has to be preserved, even posthumously—although the widespread practice of harvesting relics from bodies of deceased Saints seemed clearly at odds with this principle of post-mortal inviolability.

And yet, on the other hand, there is the counter-acting idea of charity and love (in the sense of: agape), the virtue of self-sacrifice, as exemplified by the devotion of the Sacred Heart. During the Last Supper, Christ shared His own flesh and blood with His disciples.[15] In pictorial renderings of the devotion to the Sacred Heart, the love (i.e. the willingness to share, care and give) of Christ has become so overwhelmingly great that His heart almost seems to rise to the surface of His body. His (wounded) heart becomes visible, as if a kind of window is opened up, providing visual access into His thorax, which has become transparent all of a sudden, under the influence of burning compassion. That which is usually hidden, within the *camera obscura* of our body, suddenly seems to protrude, becoming visible and touchable. From the profundity if His chest, His love seems to radiate into the world. Christ is offering his Heart to suffering individuals; it has become the universal object *a* par excellence, the thing that may sooth our most yearning desires, our gravest deficiencies. Indeed, the very thing that we (as devotees) were (unconsciously) seeking, now suddenly reveals itself, in a phantasmagorical fashion. A similar experience may befall patients who are suddenly told that a donor kidney or liver is available at last. This tension between a duty to safeguard bodily integrity on the one hand and the eagerness to share and give, introduces a kind of normative split in Christian morality at a very fundamental level.

Alfred Adler's concept of organ inferiority

Although the work of Alfred Adler (1870–1937), one of the earliest 'renegades' of the Freudian psychoanalytic movement, is usually ignored by mainstream psychoanalysts, he actually devoted much attention to the (psychic) role and function of organs in his writings. Therefore, before turning to our case study, his work deserves to be briefly consulted.

In psychoanalysis, as we have seen, the term 'partial object' refers to particular parts of the body (or their symbolic equivalents) that are seen as separable, to some extent, thus serving as a focus point, notably during particular stages of libidinal development. During the 'oral stage', for instance, the desire of young humans is focussed

[13] In this same vein, Voyeurism is defined by Kass as "cannibalism of the eyes".

[14] "The trumpet shall sound, and the dead shall be raised incorruptible, and we shall be changed" (1 Corinthians 15:52).

[15] Indeed, the Last Supper, and the sacrament of the communion (conducted behind closed doors) which builds on it, has been regarded as a (sublimated) remnant of cannibalism by critics of Christianity notably in Roman times.

on breasts and nipples: body parts which may be absent or present, offered or denied to us, and which are absent (less prominently visible) in adult males. Subsequently, excrements come to be seen as separable, detachable body parts. And finally, during the 'phallic stage', the focus shifts to the phallus as a genital appendage whose presence or absence allows us to distinguish between self and other, between male and female bodies. Thus, traditional Freudian psychoanalysis focuses on a limited set of 'partial organs'.

This limited set of objects was significantly expanded by Alfred Adler who coined the concept 'organ inferiority' ('Organminderwertigkeit'). To a certain extent, organ inferiority refers to the human condition *as such*. We are, as Arnold Gehlen (1940/1962) once phrased it, *Mängelwesen*, and Adler clearly adheres to this idea, seeing human feet, for instance, as stunted hands, and so forth. Our bodily deficiencies give rise to a chronic need for compensation, which can only be provided by culture and technology. For instance, pyro-technology (fire management) was developed to compensate for our lack of fur. We are technology-dependent to a high degree because natural environments are pitiless and expect the organs of organisms to be fully developed and well up to their tasks. With humans, however, this is not the case. Adler argues that the human mind as such evolved as a protective organ to compensate for the lack of protection offered by the various parts and organs of our bodies. It became our organ of adaptation par excellence.

Individuals who experience a particular type of organ inferiority, moreover, will feel even more restrained and 'curtailed' in comparison to others.[16] As a result, these individuals will try to compensate their deficits. This may well result in overcompensation, for example when a child suffering from asthma becomes a top athlete in adult life. Thus, as Adler sees it, organs (as partial objects) may include not only breasts, penises and testicles (as in traditional Freudian psychoanalysis), but also kidneys, lungs and muscles (1917/1927). While erotic desire tends to focus on a limited set of protruding organs (penises, breasts, earlobes and so on) which we in principle could do without (in terms of mere survival), Adler puts much more emphasis on organs that play a crucial role in vital processes, on which not only our physical survival (as individual biological entities) relies, but also our ability to withstand the competitiveness of modern societal existence: organs involved in basic physiology, metabolism and mobility. Thus, he discusses a number of organs (such as lungs, heart and kidneys) that have become focal points for transplantation medicine as well. For the individuals involved, the inferior organ is bound to become an obsession, like a shadow hovering over the story of their lives.

Thus, in Adler's work, the focus shifts from reproduction (as to biological end-point of eroticism and love) to downright survival, and from *love* to *labour*: to professional performance and social competition. Organ deficiencies hamper social mobility and productivity, and individuals respond to this through (over)compensation. Now that we have entered the era of transplantation medicine, organ and tissue transplantation may increasingly become a viable option in this respect: compensation through replacement. Instead of a life that is compromised by organ deficiency, an implant may enhance our waning abilities to compete (to which our will to power continues to drive us).

Thus, the bodies of others can become objects of desire for other reasons than erotic desire only. There are other ways in which bodily parts may help us to overcome our sense of deficiency and lack. Let this suffice as a concise review of the conceptual resources of psychoanalytic theory. The next step is to select a (well-documented) case study to see how this works out in practice. To do this, I will analyse the memoirs of Thomas Starzl (born in 1926), a prominent American transplantation medicine pioneer.

A case study: Starzl

> In seeking a purpose [in life] … something at a subconscious level seemed to point to the liver … an enormous and silent reddish-brown organ that had withheld many secrets of its own function and was hostile to surgeons (Starzl 1992/2003, p. 54)

So far, we have discussed the 'depth ethics' of organ transplantation predominantly on a conceptual level. The tested psychoanalytical technique for adding empirical material is by selecting a *case study*—one that optimally exemplifies the basic tensions, contradictions and ambivalences of transplantation medicine as fleshed out above.

I propose to use the memoirs of transplant surgeon Thomas Starzl (a highly 'visible' scientist, both famous and controversial) as our *Fallgeschichte.* I have opted for a surgeon rather than a patient first of all because my target of reflection is transplantation medicine *as such*, rather than the 'subjective' experiences of lung, heart or kidney failure (and subsequently, of lung, heart or kidney transplantation) from a recipient's perspective (although Starzl, as an exceptionally *committed* physician, tended to vehemently identify himself with the recipient's perspective throughout his life). Moreover, Starzl as a transplant surgeon devoted his whole career to one particular 'partial object', the

[16] As Adler phrases it, organ inferiority gives rise to a sense of being disadvantaged: a *Gefühl der Verkürztheit*, which literally means 'feeling shortened' (1927/2009).

object a of all his trials and tribulations, the one true purpose of his life (as is already indicated in the quote at the beginning of this section), namely the human liver. For Starzl, this organ seems to stand apart from the rest of the body. It is (for him) the surgical challenge par excellence. When opening up a human body in a dissection room, it is the liver which comes most prominently into view. It is the one organ that has intrigued and haunted him for life.

The title of his memoirs ('The puzzle people') refers to a question addressed to him by a journalist: "Do you think that in the next decade a puzzle man with a heart, liver and pancreas taken from other human beings might be feasible?" (p. 3). This question already seems to present the human body as an aggregate of replaceable parts, in a truly Frankensteinian fashion. Moreover, as Starzl explains, the acquisition of new 'parts' basically means that the rest of the body will have to change before the gift can be accepted. In fact, Starzl tells us, even surgeons are profoundly changed by the impact of such experiences (p. 4).

Starzl's father was the editor of a local newspaper in Iowa and author of science fiction stories about space travel and extra-terrestrial life. Thomas Starzl himself began his medical career as a student in Chicago, where he had his first Frankensteinian experiences in the context of anatomy lessons:

> Dissatisfied with my knowledge of anatomy, I bought a cadaver of my own during my senior year… an Indian lady, not to be shared with other students. Late at night and on the weekends I learned her body lovingly as if she were an old and dear friend, making amateur drawings as portions of her came off. She slowly disappeared. When she was gone, she had bequeathed me a knowledge of anatomy that I would carry for all my life (p. 26).

A first step on the trajectory towards transplantation medicine was setting up a vessel bank, removing blood vessels from corpses in a Miami hospital morgue (p. 48), which led to his first publication on transplantation issues. Subsequently he began to remove livers from dogs ('hepatectomy') in a garage (an improvised research facility) and installing new livers "in the empty space from which the normal liver had been taken out" (p. 57)—in Lacanian terms: he artificially created a kind of 'vacuole' in the test animals' bodies for implantation purposes. These operations, however, proved "far more difficult and bloody" than he had expected. In Lacanian terms: the 'real' body's presence was quite pervasive, and its resistance quite substantial. Repeated failure of liver transplants, first in dogs and subsequently in human patients, revealed a devastating conflict between medical dreams on the one hand and "harsh reality" (p. 63) on the other. His sole desire became to fathom the "mysterious" processes that destroyed transplanted livers. Jacques Lacan would have called it 'the real': an intrusive force that cannot be discerned directly, but flouts our expectations, something unknown and uncanny, depriving a suffering body of its newly implanted organ. Gradually, it dawned on him that what was at work here was actually the active striving of the body itself to safeguard its integrity with the help of the immune system. The patient's own body was acting as the surgeon's primary foe.

In the face of horrendous drawbacks, rather than giving up, liver transplantation became an obsession. Starzl became a liver transplantation 'addict', as it were. He developed a habit of working excessively long hours, seven days a week, depriving himself of sleep, often reducing it to 2 h per day, sacrificing not only his marriage, but also his own health, until his heart began to fail. He underwent heart surgery several times during his life. Indeed, this is how the book begins: "The impulse [to record these memoirs] had become more insistent after I underwent two operations on my heart" (p. ix). In 1962, by the time he had reached the age of thirty-six:

> Life had become a round-the-clock nightmare. I operated early in the morning, beginning at 6:00 or 6:30 A.M., arrived at the experimental laboratory by 9:00 or 10:00 in the morning. Work there lasted long past dinner time so that evening rounds or examination of patients to be operated on the following day put off returning home even more. Knowing fatigue was my enemy, I learned to fall asleep in strange places. It was like self-hypnosis. I left home at 4:00 A.M, drove 100 or more miles a day and on lucky days returned home in time to hear the Star Spangled Banner at 2 A.M. after the last television movie finished (p. 80/1).

Following a self-imposed moratorium on liver transplantation, Starzl temporarily focussed on kidneys transplantation (as a surrogate) for some years. The use of captive donors (prisoners), of primates (chimpanzees) and of commercialisation (reimbursed living donors) was considered, but light at the end of the tunnel was primarily offered by two events: the brain-death criterion (allowing for the procurement of organs from bodies that were technically still alive) and the discovery of cyclosporine (to supress rejection). Meanwhile, the memoirs abound with stories of heroism and self-sacrifice, involving both patients and physicians. For example, Starzl tells the story of two young colleagues who, chronically fatigued, fell asleep at the wheel, crashing their car in a mountain pass. Although one of them miraculously survived, the other person died, whereupon his liver and kidneys were removed and transplanted (p. 171).

Yet, for a long time, the tension between "the perfect world of liver transplantation" as it was imagined, and the

"world as it really was" would remain seemingly insurmountable (p. 191). Resistance against liver transplantation was not only offered by the bodies of recipients, however, but also by growing numbers of physicians, scientists, politicians, journalists, insurance companies and others. In was only in the 1980s that Starzl managed to decide the "liver wars" (243 ff.) in his favour, with the help of a cohort of fresh young recruits (p. 257), adding more heroic stories (such as the one about an airplane that almost crashed in Nova Scotia, while passenger Starzl, on his way to remove a donor liver, continued to work stoically on an article that was overdue; in the end, the recipient was given the liver and survived, p. 262/3).

At a certain point, the string nonetheless "broke", as Starzl phrases it. Being completely exhausted after a 24-h liver operation, he received an emergency call from another hospital, jumped into a helicopter, and arrived just in time to save the life of a juvenile patient. From that day onwards, however, although the electrocardiograms continued to be seemingly normal for some time, he sensed "a strange presence" inside his chest (p. 311). Finally, in 1990, during his first vacation in 7 years, a mysterious fatigue came over him. Back in office, he suddenly found himself paralysed on the floor "like a statue". After an hour or so he recovered and managed to work himself through a pile of mail for another 12 h before returning home. He had finally become a patient (with a severe, angina pectoris-like heart condition) himself, although he decided to chair the biennial meeting of the Transplantation Society in San Francisco before allowing himself to be taken into the operation room.

From a Lacanian perspective, there is more to this than mere commitment and idealism. What is it that transforms a gifted physician into an obsessive workaholic?

Part of the answer is given by Starzl himself. Throughout his career, he suffered from a remarkable symptom, a strange anxiety, which was already noticeable at the very start (in 1958), namely an anxiety to operate, all the more remarkable in a hyperactive surgeon with a career path such as himself:

> I harboured anxieties which I was unable to discuss openly until more than three decades later, after I had stopped operating. I had an intense fear of failing the patients who had placed their health or life in my hands… the anxieties grew worse. Even for simple operations. I would go to the operating room sick with apprehension, almost unable to function until the case began. Later in life, when I told close friends that I did not like to operate, they did not believe me or thought I was joking (p. 59).

Apparently, his decision to become fixated on the liver, as a tremendous and apparently insurmountable surgical *challenge*, was a case of over-compensation, 'subconsciously' chosen to fight off a chronic phobia that threatened to hamper his budding surgical career. If he would be able to successfully transplant a liver, what would there be left to fear? But it took a whole career arc to realise this grand objective.

Thus, surgeon Starzl fell prey to the formula $\$ \diamond a$. The only way to pay back the recipients of liver transplants (whom he seemed to be constantly failing) was to work himself into exhaustion, so that he ended up being a patient himself, finally finding the time to recount the story of his life. And yet, strictly speaking, the liver as his object *a* remained beyond his grasp. Integrity, even normalcy cannot truly be restored. The object *a* will never become completely controllable. From the point of view of bodily integrity, every liver transplant remains a failure, to some extent, as the implanted organ remains an 'extimate' object of concern for life.

Conclusion

What is the difference between cannibalism and organ transplantation? Or, to put it somewhat differently, what is the difference between Frankenstein and Starzl, between the 'monster' of the former and the 'puzzle people' of the latter? The answer is that, although a particular organ (a kidney or a uterus) remains *materially* the same (in terms of organic matter), regardless of whether it is used as food or as an implant, in the latter case it has undergone a significant transition (a 'transubstantiation', to use a scholastic term) on the *symbolical* level. Due to the interventions (the procedures) of modern technoscience, the organ (until recently an intrinsic part of the donor's body) has suddenly become something else, something that can be legitimately transported and used: an organ transplant.

Allow me to illustrate this point with the following story. Some years ago, while sitting in a cab that was taking me to an airport, the taxi-driver told me what had happened to him earlier that week. Initially, I misunderstood him, so that it seemed that he had been asked to take a 'gentleman' to the hospital, which is not all that remarkable of course. But then he added that the entity that had been sitting on the backseat of his car (where I now found myself) had been carefully placed and wrapped inside a plastic, white, sealed box. In the dialect which he spoke, the world for 'gentleman' ('hier'; [hi:r]) happens to be almost the same as the word for 'kidney' ('nier'; [ni:r]). The difference is only one small signifier (*h* instead of *n*). And now it dawned on me that what he had taken into the hospital, driving at full speed, was not a person, but a sealed kidney, prepared for transplantation purposes.

This anecdote may well illustrate my point. The difference between a 'bare' kidney, removed from its body (as

an uncanny 'thing'), and a carefully prepared organ, ready to be transplanted, is precisely this white, sealable box, in combination with all the logistics that go along with it (the taxi, the operation room, the gloves, the high-tech equipment, the electrocardiographic monitoring of the recipient's heart-beat, and so on). Although one could argue that (on the ontological level) transplantation medicine has indeed redefined the human body into an aggregate of replaceable parts, there still is a significant difference between the body as it was allegedly sewn together by Victor Frankenstein, and the body of a multiple organ recipient inside an operation room. In the latter case, although it is indeed a 'composite' puzzle body, it has been reassembled *on a higher level of aggregation* as it were. The rituals, procedures and technologies of transplantation medicine make all the difference, as a bare kidney is 'transsubstantiated' into a transplant. In other words, the procedures of transplantation medicine add symbolical status and *surplus value* to what would otherwise be a horrid thing, symbolically cleansing it as it were, turning a tainted object into a highly valued one: an *object a*, on which someone's life and well-being depends, something that is to be handled with the utmost care.

At the same time, the anecdote underscores the extent to which such transplants may detach themselves from the body as stand-alone objects, comparable almost to the more usual passengers in a taxi cab, on their way to a hospital, occupying a seat, mistakenly taken for a human person (due to a slight misunderstanding of the dialect, because of just one tiny letter). Moreover, the transformation of an embedded kidney into a moveable, transferable transplant emphasises another dramatic change as well. Transplantation medicine has become a large-scale system, a highly efficient 'machine' for producing transplants of this type. And we (as potential donors, but also as potential recipients) are its raw materials (as living or cadaveric donors) as well as its consumers (as potential patients). Occasional, ritualistic instances of cannibalism, as documented by anthropologists such as Frazer, have thus become institutionalised into global, large-scale, costly endeavours.

Meanwhile, the *ethics* of organ donation is being subjected to similar processes of 'symbolisation'. The symbolic order is essentially a digital one. In the end, it is a matter of *Yes or No*; of *A or B*; of absence or presence, of *1 or 0*. During the past decades, there has been a growing pressure on citizens (in Western countries, but also globally), first of all pressing them to become a donor, but even more so to indicate *whether or not* they are willing to serve as potential donors in the case of sudden death. Various procedures (codicils, information campaigns, new legislation, etc.) have been installed to force individuals to come to a decision. Our answers must be processable: *1 or 0*; A or B; $+$ *or* $-$. Uncertainty (that is: a blank) disrupts the system and hampers the functioning of the global transplantation machinery. *Tertium non datur* ('no third (option) is available'), that is the ideal. There is a relentless drive to procure as many kidneys (or other organs) as possible, relying on symbolisation and digitalisation. It has become a kind of high-tech industry where organs represent value (whether donors are actually reimbursed or not). Not only codicils are part of this process, but the brain-death criterion belongs to it as well, allowing us to ascertain, in a digital, indisputable manner (*Yes or No*) whether a particular body has formally died and can legally be submitted to the harvesting of its organs: these highly valuable, life-saving *objects a* that are so carefully wrapped up inside our bodies, but at the same time seem to yearn to be procured and re-implanted, so that they may survive the irresistible decay of the remainder of our body as we die.

References

Aquinas, T. 1922. *Summa Theologica (6 volumes)*. Taurini: Marietti.

Adler, A. 1917/1927. *Studie über Minderwertigkeit von Organen*. Darmstadt: Wissenschaftliche Buchgesellschaft.

Adler, A. 1927/2009. *Menschenkenntnis*. Frankfurt am Main: Fischer.

Bracher, M., M. Alcorn, F. Massardier-Kennedy, and R. Corthell (eds.). 1994. *Lacanian theory of discourse: Subject, structure, and society*. New York: New York University Press.

Cassell, E. 1992. The body of the future. In *The body in medical throught and practice. Philosophy & medicine*, vol. 43, ed. D. Leder, 233–249. Dordrecht: Kluwer.

Dekkers, W., and H. ten Have. 1998. Biomedical research with human body 'parts'. In *Ownership of the human body. Philosophical considerations of the human body and its parts inhealthcare. Philosophy and medicine*, vol. 59, ed. H. ten Have and J. Welie, 49–63.Dordrecht: Kluwer

Frazer, J. 1890/1993. *The golden bough*. London: Wordsworth.

Freud, S. 1905/1942. Drei Abhandlungen zur Sexualtheorie. *Gesammelte Werke V*, 27–145. London: Imago.

Freud, S. 1907/1941. Der Wahn und die Träume in W. Jensens. *Gradiva. Gesammelte Werke VII* (Werke aus den Jahren 1906–1909), 29–122. London: Imago.

Freud, S. 1913/1940. Totem und Tabu. *Gesammelte Werke IX*. London: Imago.

Freud, S. 1919/1947. Das Unheimliche. *Gesammelte Werke XII*. London: Imago.

Freud, S. 1921/1940. Massenpsychologie und Ich-Analyse. *Gesammelte Werke XIII,* 71–162. London: Imago.

Freud, S. 1923/1940. Das Ich und das Es. *Gesammelte Werke XIII,* 237–289. London: Imago.

Freud, S. 1930/1948. Das Unbehagen in der Kultur. *Gesammelte Werke XIV,* 419–513. London: Imago.

Kass, L. 1992. Organs for sale? Propriety, property, and the price of progress. *The Public Interest* 107: 65–86.

Lacan, J. 1966. *Écrits*. Paris: Éditions du Seuil.

Lacan, J. 1981. *Le Séminaire de Jacques Lacan X: Les psychoses*. Paris: Éditions du Seuil.

Lacan, J. 2004. *Le Séminaire de Jacques Lacan X: L'Angoisse*. Paris: Éditions du Seuil.

Lacan, J. 2006. *Le Séminaire de Jacques Lacan XVI: D'un Autre à l'autre*. Paris: Éditions du Seuil.

Skloot, R. 2011. *The immortal life of Henrietta lacks*. New York: Broadway Paperbacks.

Sloterdijk, P. 2009. *Du musst dein Leben ändern. Über Anthropotechnik*. Frankfurt: Suhrkamp.

Starzl, T. 1992/2003. *The puzzle people. memoirs of a transplant surgeon*. Pittsburgh: University of Pittsburgh Press.

ten Have, H., and J. Welie (eds.). 1998. *Ownership of the human body. Philosophical considerations of the human body and its parts in healthcare. Philosophy and medicine*, vol. 59. Dordrecht: Kluwer.

Wollstonecraft Shelley, M. 1818/1831/1968. *Frankenstein; or, the modern Prometheus/three gothic novels*. Harmondsworth: Penguin.

Young, I.M. 1992. Breasted experience: The look and the feeling. In *The body in medical throught and practice. Philosophy & medicine*, vol. 43, ed. D. Leder, 215–230. Dordrecht: Kluwer.

Zwart, H. 1998. Medicine, symbolization and the 'real' body: Lacan's understanding of medical science. *Medicine, Health Care and Philosophy* 1: 107–117.

Zwart, H. 2000. From circle to square: Integrity, vulnerability and digitalization. In *Bioethics and law II: Four ethical principles*, ed. P. Kemp, et al., 141–153. Copenhagen: Rhodos.