The Phenomenology of Organ Transplantation

How does the Malfunction and Change of Organs have Effects on Personal Identity?

FREDRIK SVENAEUS

INTRODUCTION
My inspiration for investigating the relationship between our organs and our sense of selfhood comes from the new possibilities opened up by certain medical technologies in saving and improving human lives—organ transplantation in particular. Organ transplantation not only offers ways of treating diseases, congenital defects, impairments, and injuries, it also influences processes of self-formation in different ways for the persons treated. The goal of this chapter is to better understand the ways of these identity-contributing processes by comparing and relating them to each other, and in this endeavor also to try to flesh out differences between the cases of transplantation of different kinds of organs. My chief examples will be brain (science fiction), kidney and heart. The analysis will be guided by the theoretical framework of phenomenology and it will be philosophical in character. This means that I do not claim the empirical examples I give to be typical for every case of organ transplant of the sort in question, but I am neverthe-
The Phenomenology of Organ Transplantation

less searching for and trying to map out characteristics of identity-changing processes and relate them to the different types of organ transplants listed above. The empirical examples I give will rely on stories told by persons who have gone through transplantation, but the stories in question have not been gathered by way of interviews or ethnographic field work. Instead, the stories have been picked up from novels and papers about organ transplantation.

Identity is a multifaceted concept. To begin with, it can mean identity over time, staying the same object, or, in the case of persons, staying the same person, in a process of change. This kind of identity is often called numerical identity. The alternative to numerical identity is qualitative identity. Two things can be qualitatively identical but still be two separate things, like two molecules of water. As things get more complex, qualitative identity becomes rarer, and in the case of persons it will, at least in the age preceding science-fiction technology, remain impossible. Even mononuclear twins, as we all know, are far from qualitatively identical.

The type of change in identity that will be of concern in this chapter is change in qualitative identity in preserving numerical identity; that is, the person who is transplanted does not believe herself to be (and neither do we believe her to be) another person, but a change in personal identity has nevertheless taken place, since important self traits have been changed. I will use the terms self and person interchangeably in this chapter,¹ and the changes in qualitative identity I am looking for will include what we normally refer to as personality changes, rather than personality disorder (which is, of course, also a possible, but rare, consequence
of having an organ transplant). Such changes of personal identity are certainly not restricted to the events of organ transplantation but also take place in other forms of life crises, such as severe illness or injury, existential crisis, and also by way of other life-turning events, such as falling in love, becoming a parent, or losing one’s job, if these events have deep-reaching effects on the persons we are. Our identities are constantly changing all through our lives as we grow older and experience new things. Some events, however, provoke more sudden breaks in identity, and organ transplantation is, in many, but perhaps not every, case, such an identity-breaking event.

THE BRAIN AND THE BODY
Organ transplantation could possibly lead to a change in numerical identity as well, but only, I think, in the case of the science-fiction scenario of brain transplantation. If I get a new brain I (at least possibly) become another person. In this sense, the brain is the only organ that cannot be donated; if you offer your brain to be transplanted into another body, you become a receiver, not a donor, of organs. That is, your brain gets a new body, and in this sense brain transplantation does not indeed lead to a change in numerical identity. However, it is actually highly doubtful if the brain transplanted into a new body would actually still be the same person as before the operation. As brain scientists have pointed out for quite some time now, what the brain feels and thinks is determined by the way it is connected to the rest of the body (Damasio 1999). This goes not only for feelings but also for thoughts, since thoughts are indeed made meaningful
by the feelings that precede and feed into them in various, bodily ways. The self becomes attuned through its bodily being, and such attunement is necessary for all forms of human understanding (that we know about). The brain cannot think in the vat, only in the body.

To sum up, what actually would happen if we were able to transplant a brain into a new body—what kind of identity changes it would lead to—we simply do not know at this point. The practical difficulties of such a transplant appear insurmountable at present, but doctors have done things considered impossible to do, before. The heart transplant was certainly considered to be impossible one hundred years ago, but it was still carried out sixty years later. Maybe the first brain will be transplanted in 2070 or so.

A good guess is that the brain-transplanted person will feel to some extent like the same person he was before the operation. Especially if he has memories of the time preceding the transplant (which, indeed, appears to be necessary if he is even to understand the question we are confronting him with). Maybe he would say that he is the same person as before the operation, but also different in many important ways (consider, for example, the possibility that he was a she before her (his?) brain was transplanted). He would also, I think, say that these ways of being-the-same-and-yet-different are new to him in an important way. To get one’s brain transplanted into a new body will probably be a different kind of personality change than going through an existential crisis. Maybe puberty, or pregnancy, could be helpful as comparisons when we consider what getting a brain transplant (getting your brain a new body) would be
like, but these real-life examples will not get us very far. We simply have to wait for the event to take place to be able to answer the change-of-identity question.

The brain transplant case is different from the prospect of getting, not a whole new body (except for that body’s original brain), but one or two new organs: perhaps a new kidney, or a heart and a pair of lungs. These cases differ not only according to how many new organs one gets but also depending on which types of organs are replaced. Different organs seem to be of different importance to the identity of the person. This is true not only concerning which organs you could dispense with and still go on living without, but also concerning other aspects of personal identity (see Malmqvist this volume).

PHENOMENOLOGY AND THE MULTILAYERED SELF
A founding hypothesis in this chapter will be that identity, in the case of persons, is provided through several layers of processes constituting the self. I will not argue explicitly for this position here, but merely develop it and then depend on it conceptually in the subsequent analysis of organ transplantation as an identity-influencing process. This will take us into many of the deepest corners of phenomenology and philosophy of mind, as well as the hot spots of social construction, but for obvious reasons of space, I will not be able to do much more than point towards most of the problems and dissidences as we pass by them. The focus of the chapter will be the relationship between selfhood and organ transplantation.

The identity-forming processes of the self include pro-
cesses of the body, processes of the mind, and processes of social and cultural origin and nature. The processes of selfhood start with meaning formation that takes place on preconscious embodied levels, but the processes in question attain a different quality on the conscious level of self-reflection. This happens when I understand, and not only feel, that I am a *something*, which, in the experiences I am having, is encountering other things. This type of self-understanding means that I become able to attain an epistemological stance in which I direct my explicit attention to my very self in having the experiences, a procedure that allows several ontological as well as existential questions to set in. The processes of self-constitution, by yet another layer, also extend into the cultural world of language in which the person’s identity, her personality, is shaped by stories told with others.

The multilayered makeup of the self should not be understood only in an evolutionary or developmental way. It is certainly true that the preconscious level of self-awareness preceded the phenomenon of reflective self-awareness in the evolutionary process of life on earth, and it is also true that it does so in the individual life of a child, but the crucial point is that the different layers (when they have all been put in place) coexist and interact with each other. The narrative-social self never leaves the embodied (or the self-reflective) self behind, since they are all part of the *same* process (the same self). They are different aspects of what it means to be a self (a person).

Several disciplines and fields of knowledge are essential for understanding these self- and identity-forming processes—medicine, psychology, sociology, ethnography, aesthetics
—but my focus in this chapter will be mainly philosophical. As mentioned above, phenomenology will be my main theoretical platform, but the kind of phenomenology I will put to work also includes the tradition referred to as hermeneutics. Identity, in the sense that I am analyzing it in this chapter, is thus tied to the question of person- or selfhood: that is, it is tied to the question of the multilayered phenomenology of the self. This, I think, has the advantage of not leaving the silent, embodied aspects of a person’s identity behind, a risk we are running in highlighting the concept of identity, which is often interpreted to concern mainly our cultural belonging. At the same time, the link to hermeneutics (phenomenological hermeneutics) will make us able to preserve our sensitivity to the meaning-making of selfhood that goes on at the cultural level by way of the phenomenological analysis in question.

As any phenomenologist will point out, such a study should not attempt to answer the question of selfhood from the third-person perspective of science only, but rather search out the basic experience we all share of being a self—the first-person perspective, which will also prove, by way of the hermeneutical extension of phenomenology, to be a second-person perspective. The fact that we are not sure if infants and chimps are persons should not fool us into assuming that we do not know what it is like to be a self. Neither should the often quoted remark by David Hume that nowhere in his experience has he come upon any entity which could be referred to as his self, fool us into assuming that the self is either a fiction or something we will have to leave to the brain scientists to determine if we really have. The is-
sue is in many ways a question of terminology, of course, but if we leave behind the rather naïve idea that the self would consist in some kind of separate physical or mental entity, we could at least agree that many of us are able to say “I” and mean something essential by it, and that the ones who are not able to do so can be taught to, or have at some earlier point in their life been able to do so.\(^7\)

Despite the claim that it is the basic belongingness to somebody of every experience in the streaming life of consciousness that is the ground of selfhood, it should be pointed out that this pre-reflectively embodied self is in a way exactly anonymous in character, since we do not control it, but are rather constituted by it.\(^8\) As pointed out above, the body to a large extent organizes my experiences on a preconscious level. Proprioceptively it makes me present in my own body, and kino-esthetically it allows me to experience the things that are not me: the things of the world that show up to my sensing, moving body in different activities through which they attain their place and significance (Gallagher 2005). Intentionality, as Edmund Husserl named it, our being-in-the-world, in the terminology preferred by Martin Heidegger, is consequently basically a bodily phenomenon, an insight famously elaborated by Maurice Merleau-Ponty (1962). To the ways of the lived body also belong the autonomous processes of my biological organism: breath, digestion, blood flow, etc., which are mostly absent from my awareness but nevertheless provide the backdrop for my intentionality (Leder 1990).

Normally, when we move around in the world, acting, speaking, thinking, and feeling, we do not pay any attention
to our bodies. They perform their duties silently in the background, not only proprioceptively and kino-esthetically but also as regards all the autonomic functions of our visceral life—breathing, our hearts beating, stomachs and bowels working, and so on. Sometimes, however, the body *shows up* in resisting and disturbing our efforts. It “dysappears,” to use a term coined by Drew Leder (1990, 83). The body plagues us and demands our attention by revealing itself, not only as our home, but also as an *alien* creature. Organ transplantation, and also the process of falling ill, which in most cases (if one does not end up in the operating room because of an accident) precedes the transplantation, to a large extent inflicts such changes in self-being (identity) when our bodies display their autonomous character. As Richard Zaner writes in his study *The Context of Self*:

> If there is a sense in which my own-body is “intimately mine”, there is furthermore, an equally decisive sense in which *I belong to it*—in which I am at its disposal or mercy, if you will. My body, like the world in which I live, has its own nature, functions, structures, and biological conditions; since it embodies me, I thus *experience myself as implicated* by my body and these various conditions, functions, etc. I am exposed to whatever can influence, threaten, inhibit, alter, or benefit my biological organism. Under certain conditions, it can fail me (more or less), not be capable of fulfilling my wants or desires, or even thoughts, forcing me to turn away from what I may want to do and attend to my own body: because of fatigue, hunger, thirst, disease, injury, pain, or even itches, I am forced at times to tend and attend to it, regardless, it may be, of what may well seem more urgent at the moment. (Zaner 1981, 52)
I will now proceed to a more direct phenomenological analysis of organ transplantation in developing examples of what it is like to have a kidney and a heart transplant, respectively. I will try to fit my findings into the phenomenological pattern of selfhood developed above. This will allow us to discern similarities, but also systematical differences, between the different cases. It will allow us to answer the question, How do different sorts of organs influence our ways of selfhood? through an analysis of the situations when organs are not doing their proper job and have to be exchanged.

**THE KIDNEY TRANSPLANT**

In *Holograms of Fear*, Slavenka Drakulić tells the story of her first kidney transplantation, which takes place in Boston in 1986. Drakulić has left her homeland of Yugoslavia, her family, friends, and even her young daughter, in order to live in New York as a journalist. This radical decision is forced upon her not by political oppression but by a kidney disease (PKD). The medical care she is getting in Yugoslavia is not sufficient (she watches her fellow patients in the dialysis ward deteriorate and die), and she has poor chances in Yugoslavia of getting the transplant she needs to survive. In the book she tells how the disease and her dysfunctional kidneys force her to undergo dialysis every second day in the hospital for several hours:

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

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

The disease suddenly appeared in my ancestors’ genes. Who was the first? Perhaps my grandfather. While still quite young, he stopped eating and would only drink. He grew paler and paler, his legs began to swell until his skin was so stretched that it began to crack. Then he vomited up a murky yellow liquid and the stench of urine spread from his mouth. He died exhausted, bloated, perhaps in sleep. His son remembered a high, moist brow and a smell that lingered in the house for days. The thing moved from person to person like bad luck. No one could tell who it would attack. It attacked my father. It attacked me. It left my brother unharmed. We almost thought that it had skipped us, too, that those ancestors who had died in the past had nothing to do with us. But at the first signs—nausea, vomiting, tiredness—I knew that it had come. The doctors didn’t tell me right
away although they suspected it. I was already pale, my pulse was fast and every time I lay down I thought I might not be able to get up. Later my father came down with it as well. They told us that these days it was possible to live with it, that there were machines, kidney transplants. Various deals could be struck with the sickness, negotiating with bad luck. (ibid., 6-7)

The uncanniness of such experiences is hard to deny. The body reveals itself as incorporating alien, unhomelike elements in illness. The uncanniness concerns the way the body becomes an obstacle and a threat, instead of my home territory and founding ground, but in this (and most other severe) case(s) of illness it also concerns the ways I address the meaning of my life and my relationship to others on a social and narrative level (the level Heidegger names being-in-the-world). It should be noted that the bodily experiences in question in this case do not specifically make the kidneys appear, the way, for example, my finger appears to me as painful and needing attention when I hit it by accident. Rather, in kidney disease, my whole embodiment becomes plagued and obtrusive through pain, nausea, and bodily decay.

Waiting for the transplant, knowing that you are on the waiting list but with no knowing when, if ever, the doctors will find a suitable kidney for you, is a pressing experience in itself. So is the fear of pain or dying as a result of the operation. You long desperately for a life with more freedom and fewer symptoms, but at the same time, the regime of dialysis becomes a habit and a kind of security you are afraid of leaving for the uncertainty of the operation, which is, certainly, a very dramatic event:
“Breathe, breathe.” An English voice penetrates the darkness in which I’m floating. . . . Terrified I try to suck in air, catch it with my open mouth, but something is inside, something is inside. It is smothering me, I have to retch it out. They are pulling out a long tube with a sudden jerk from my throat, tearing the membranes. A deep sigh. Then a sharp pain under my stomach cuts me in half. “Your kidney is functioning.” (ibid., 42)

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

Even in the successful cases, when the new kidney works properly and is not rejected by the immune system, life after a transplant is not like life before the disease entered the stage. To suffer from a disease that destroys one’s kidneys and to get a new kidney means that life becomes prolonged and normalized, but it never means that life becomes quite normal (the way it was before the onset of the disease), since you are at constant risk of renewed kidney failure (see Gunnarson this volume). This leads to a life that is very self-controlling as regards the relationship to one’s own body. It often means a more anxious life, in the sense that the basic trust in one’s body is gone, but it could also mean a more self-reflected life, in the sense that the finitude of one’s life and the question of what is of real importance in it have come to the surface. Finally, it will lead to thoughts about the life of others and how they are connected to me, particularly
The Phenomenology of Organ Transplantation

the particular other whose death (in the case of cadaveric transplant) and/or (in the case of living transplant) generous gift means life for me:

“Her kidney came from a woman,” the doctor said to someone. He was leaving the room. He thought I was asleep. When the doctor left the room, his words simply stayed behind. I couldn’t push them out with him. I didn’t want to hear them. I don’t care who it belonged to, I am not curious. I think of it as an organ, not as part of a person. I must not be sentimental. My life is on the line. But the picture reappears. Her smiling face, gone forever. A lot of time will pass, then in a subway somewhere, a tall man will stop me. . . . “Excuse me, I couldn’t help myself, but . . . you look so much like my late wife.” I’ll stare at him, indifferent at first. I’ll pretend that I have no idea what he is talking about. Perhaps I’ll say I don’t know any English. But something will force me to change my mind and I’ll say: “Yes. Yes, I probably do look like her. We are sisters, almost twins—you didn’t know that she had a sister? You see this thin scar? It has almost disappeared, but this is where she moved in. We live well together, the two of us. Sometimes she gets a little obstinate. I can’t keep her from spreading. Sometimes she chooses a smile, other times a gesture, or a walk—to show that she is here, that I am in her power. I think perhaps she wants to make me feel grateful. It’s not my fault that she was killed.” (Drakulić 1993, 73-74)

To sum up: already the kidney disease leads to changes in selfhood on the embodied level and the level of existential self-reflection. This, indeed, includes the social and narrative realms, since my life story, spun in the web of my relations to others, is exactly the place and structure in
and by which the existential reflection is carried out. This reflection, after the operation, also often leads to feelings and thoughts about the origin of the new kidney I now bear in my body. The scientific attitude to my new organ, an attitude that will be encouraged by the doctors, can easily be conquered by an attitude in which the kidney of the other harbors her identity in some way that has now been transposed to me. It might also lead to a thankfulness that becomes transformed into guilt: How have I earned this life that was made possible by the other person’s death? In the case of the kidney, however, this process is made weaker by the fact that I cannot feel the new organ in me. The kidney is buried in the depth of my body in a disappearing way.

THE HEART TRANSPLANT
In the case of the heart, things are slightly different, not only when it comes to the symbolic character of the heart (life, love, goodness) in comparison to the kidney (what, really, is a kidney symbolic of?) but also regarding the extent to which the heart shows up to me, in illness, and also in health. It is possible to direct one’s attention to the activity of one’s heart at any time, and in situations that make us react strongly emotionally it is almost impossible not to notice one’s heart pounding in association with other bodily processes, such as blushing or sweating. In exercise, the heart (together with the rest of the body, of course) sets the limit for what we are able to accomplish, and these limits are clearly felt on the embodied level as intense heart and lung activity or pain and weakness of muscles when, for example, I run fast for a long time.
It is true that a heart disease, just like a kidney disease, does not always make itself known through the experience of pain in the heart itself; a heart attack is experienced as a chest pain radiating out through chest and arms, for example. But the possible irregularity in the rhythm of the heart’s beating, which can be a very powerful and frightening experience, nevertheless marks out the heart as a phenomenon that appears in a more singular manner than the kidney does, in at least some cases of heart disease.

Hearts have been transplanted since the late 1960s (the history of kidney transplantation dates back to the 1950s) (Tilney 2003). A heart transplant is an even more dramatic and difficult operation than a kidney transplant, and it was not until the 1980s that surgical techniques and new immunosuppressive medications made it possible to survive a heart transplant for a longer time. To find a new heart for a dying patient is even harder than finding a new kidney, for two simple reasons. Each person only has one heart, which makes living donation impossible (as long as we do not allow killing one person to let another live). Hearts deteriorate much faster than kidneys outside the body, which means that we have only a very limited time in which to carry out the transplant (kidneys last much longer if they are kept the right way). Hearts for donation will most often come from patients who have been put on respirators as the result of accidents or sudden occurrences of disease (stroke) and have then been declared brain dead while they are still connected to the machine that assists the breathing and the circulation of the blood that keep the organs of the deceased person fresh.
In the early 1990s, the French philosopher Jean-Luc Nancy underwent a heart transplant after a period of severe illness. He wrote about this event and the cancer that he was subsequently taken with—probably as a result of the heavy doses of immunosuppressive medicines that post-transplantation patients have to take to prevent rejection of their grafts—in “L’intrus,” which was published in 2000. Nancy’s main figure for understanding the process he is undergoing is found in the title of his essay, in English “The Intruder”:

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

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

If my own heart was failing me, to what degree was it “mine,” my “own” organ? Was it even an organ? For some years I had already felt a fluttering, some breaks in the
rhythm, really not much of anything: not an organ, not the dark red muscular mass loaded with tubes that I now had to suddenly imagine. Not “my heart” beating endlessly, hitherto as absent as the soles of my feet while walking. It became strange to me, intruding by defection: almost by rejection, if not by dejection. I had this heart at the tip of my tongue, like improper food. Rather like heartburn, but gently. A gentle sliding separated me from myself. (ibid., 162-63)

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

A new heart (the transplanted heart) is certainly also an intruder, but it is an intruder that we would like to welcome. This is possible, however, only by “experiencing his intrusion,” as Nancy writes (ibid., 161). This means the pains and plagues following the procedure of having the sternum cracked and the chest cut wide open in an operation that lasts for several hours and during which the blood is circulated and oxygenated by way of an external device, a heart-lung machine. It also means suppressing the body’s immune system (if the donor is not an identical twin) to prevent it
from attacking and rejecting the graft, something that will otherwise happen immediately after the operation or in due time. The graft is foreign, an “intruder” in the body, which we have difficulties welcoming. But the immunosuppressive actions taken mean that other intruders (bacteria, viruses), lying dormant in the body or entering from outside, become a major threat. It also means that the regular outbreaks of uncontrolled cell division in the body, which otherwise are dealt with by the immune system before they grow and spread, can now lead to cancer diseases.

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

I end/s up being nothing more than a fine wire stretched from pain to pain and strangeness to strangeness. One attains a certain continuity through the intrusions, a permanent regime of intrusion: in addition to the more than daily doses of medicine and hospital check-ups, there are the dental repercussions of the radiotherapy, along with the loss of saliva, the monitoring of food, of contagious contacts, the weakening of muscles and kidneys, the shrinking of memory and strength for work, the reading of analyses, the insidious returns of mucitis, candidiasis, or polyneuritis, and a general sense of being no longer dissociable from a network of measures and observations—of chemical, institutional, and symbolic connections that do not allow themselves to be ignored, akin to those out of which ordinary life is always woven, and yet, altogether inversely, holding life expressly under the incessant warning of their presence and surveil-
lance. I become indissociable from a polymorphous disso-
ciation. This has always more or less been the life of the ill
and the elderly: but that’s just it, I am precisely not the one or
the other. What cures me is what affects or infects me; what
keeps me alive is what makes me age prematurely. My heart
is twenty years younger than I, and the rest of my body is (at
least) twelve years older than I. (ibid., 169)

The heart is “mine” in a way that the kidney is not, despite
their both being hidden under the skin, rarely visible, ex-
cept in the extreme situations of accidents, operations, and
autopsies. This is probably due to the heart’s being an organ
that can be felt to a greater extent in its beating. Because of
this, we consider the heart to be the locus of our feelings,
a view that is upheld through a whole system of different
metaphors feeding our language with meaning (Lakoff and
Johnson 2003). The heart is considered the heart (!) of self-
hood and personality in many emotionally and culturally
inter-nested ways, and therefore the heart transplant evokes
questions of identity to a far greater extent than the kidney
transplant does.16

In the case of both heart and kidney, the organ is invisible
to its bearer. We all know what a heart or a kidney looks like,
but it is still hard to imagine that my heart (or kidney) looks
exactly like that right now when it is functioning within
my body. The inner realm of the body is a messy, foreign
zone with which we are rarely acquainted directly. It is for-
eign, despite its being closest, because we have only a lived,
subject-like experience of it and not, in addition to this, an
object-like acquaintance, as in the case of my hand, which I
can watch and touch from outside.
CONCLUSION
In this chapter I have attempted an analysis of how the malfunctioning and replacement of organs relate to our ways of selfhood. After first considering the borderland example of the transplanted brain (borderland because still unknown, and also because of its inverting the relationship of giving and receiving organs), I turned my attention to the examples of kidney and heart transplants.

In the case of the kidney transplant, the matters of selfhood involved were found to reside largely in autonomous processes of my own body that make themselves known to me in an alien, disconcerting way, in the illness preceding the transplant and in the recovery and control regime following the operation. Admittedly, the two other layers of selfhood—existential self-reflection and social-narrative identity—will also become involved in the suffering of grave, life-threatening illness, and in the experience of thinking about the fact that the kidney I now bear in my body has belonged to another person. The extent to which the processes going on in these layers of self-understanding are displaying a pattern of alienation, making the kidney appear as alien to the person, also in the sense of its being the kidney of another person, will vary from case to case depending on circumstances and the attitude taken to the new organ.

The example of the heart is different from the kidney because the heart makes itself more directly known (felt) to the person in the process of bodily alienation, and also because the heart is linked to selfhood by being traditionally considered as harboring the feelings and character of the person, a cultural factum that is heavily inscribed in hu-
man languages by powerful metaphors involving the heart. Because of this, the existential self-reflection brought about by a heart transplant is often more deep-reaching than it is in the case of kidney transplants. Hearts are not only more difficult, technically, to obtain and transplant than kidneys are, but they are also more personal in this symbolic way.