Sapienza
Università Editrice

L'Uomo, vol. XIV (2024)
n. 1, pp. 113-138

E-ISSN 2465-1761

The Diffuse Person: the Moral Worlds of Organ Transplantation

Luigigiovanni Quarta
Università di Bergamo

Abstract

In addition to the issue of the coherence of the Maussian model of gift practices in the context of the body donation, further crucial questions for anthropology sharply emerge. What symbolic role does the harvested and donated body part play? What kind of relational effects does it produce, circulating in the social body? Which discourses surround this experience? What kind of practices do they produce? In this article, on the basis of two ethnographic fieldworks on organ donation carried out in recent years (2018-2022), I intend to address this question by showing how we can interrogate not only the practice of donation but a multiplicity of notions involved in it. The aim will therefore be to show how, according to the social actors concerned with the organ donation, at least two notions of person – the Cartesian person and the diffuse person – operate. Depending on which notion the social actors refer to, different constructions of the world are revealed, different local knowledge is produced, and, above all, a different set of ethical practices is constructed, which we can reinterpret and understand from the perspective of care relationships.

Keywords: organ donation; medical anthropology; care relationships; personhood; moral anthropology.

La persona diffusa, ovvero i mondi morali del trapianto di organi

Al di là della domanda sulla coerenza del modello maussiano delle pratiche di dono nel contesto del dono del corpo, altre questioni centrali per l'antropologia emergono con forza. Quale ruolo simbolico riveste la parte di corpo prelevata e donata? Che tipo di effetti relazionali produce, circolando nel corpo sociale? Quali campi di discorso avvolgono questa esperienza? Che tipo di pratiche producono? In questo articolo, a partire da due lavori etnografici sulla donazione degli organi svolti negli ultimi anni (2018-2022), intendo affrontare la questione mostrando come si possa interrogare non solo la pratica della donazione ma una molteplicità di nozioni in essa coinvolte. Si tratterà quindi di mostrare come, a seconda degli attori sociali interessati dalla donazione degli organi, operino almeno due nozioni di persona – la persona cartesiana e la persona diffusa. A seconda di quale sia la nozione cui gli attori sociali fanno riferimento, si mostrano al nostro sguardo costruzioni del mondo diverse, si producono saperi locali differenti e, soprattutto, si costruisce un diverso panorama di pratiche etiche, che noi possiamo rileggere e comprendere secondo la prospettiva delle relazioni di care.

Parole chiave: donazione degli organi; antropologia medica; relazioni di *care*; persona; antropologia della morale.

Introduction

The domain of organ donation, and body donation more generally, has been approached in anthropological and sociological terms from a two-fold perspective. On the one hand, the relevance of the general model of gift practices conceptualised by Mauss has been discussed in relation to these new contemporary social institutions, which are considered «forms of the gift» by the actors who are involved in it[1]; on the other hand, several social scientists have tried to reinterpret it in moral terms. Essentially, the classic

---

[1] This model proposed by Marcel Mauss is a threefold one – giving, receiving, and reciprocating – which takes place between two subjects who are in a close relationship with each other and who foster their relationship through the practice of giving. In contrast, legislation on post-mortem organ donation prevents any contact between the donor's family and the recipient. This element of anonymity has long been the subject of anthropological debate, appearing as a factor that prevents any overlap between Mauss's model of the gift and so-called body donation: see, among others, Steiner 2010; 2012; Quéré 2010; Scheper-Hughes 2007; Lock 2001; Fox & Swazey 1978. I have recently attempted to address and solve this problem by drawing on some of Marcel Mauss's lesser-known reflections than the *Essay on the Gift* and offering an emic interpretation of the institution of body donation; cf. Mauss 1931; Quarta 2023. However, it is not the aim of this paper to pursue this debate and, in this context, I simply refer the reader to the bibliographical references in this footnote.

works by Titmuss (1970) on blood donation and by Fox and Swazey (1978; 1992) on organ donation can be fully included in the tradition of studies that have sought, more or less implicitly, to reconceptualise the gift of the body within the framework of moral practices. The same can be said of more recent studies, such as those by Jensen (2016; Hoyer & Jensen 2011) and Heinemann (2014; 2015) which aim to shed light on the elements that permeate and construct the experience of the donation of the Self, such as hope in the former case and caring relationships in the latter.

The purpose of this article is to provide a further understanding of the phenomenon by exploring the moral dimension of organ donation through an examination of the ethical stances of care. I propose to show how that there are at least two different models for social actors faced with the consent or rejection of organ donation to deal with this issue. These models depend on the sets of representations through which subjects relate to the concept of person. What I mean by person is the patchwork of histories, relationships, and affects that come together in an active self-consciousness that, phenomenologically, we call the Self. Analytically, then, I will use «person» as a synonym for the notion of *presence* introduced by the Italian anthropologist Ernesto de Martino (1988; 2023).

Thus, the first model, based on the notion of the «Cartesian person», is essentially biomedical, or at least inherited from biomedicine, and establishes an indissoluble relationship between what we consider to be the «human person» and the threshold between life and death. Once the frontier of life is crossed, the relationship between cognitive activity and the integrity of the body dissolves, and with it the person disappears. The second model, on the other hand, which is based on the notion of the «diffuse person», emerges from the analysis of the motivations and experiences of some of the social actors involved in the context of donation and constructs the possibility of thinking about the presence of the person beyond the threshold of death[2].

---

[2] I postulate that there is a third model, also grounded in the notion of the «diffuse person», which helps us to understand the reason for some forms of opposition to donation, mainly linked to the desire not to «dismember» or «butcher» the body (Waissman 1996; 2001), because of the representation of a person who survives biological death in the body. However, as I do not have any ethnographic material on the opposition dimension and can only refer to secondary sources, I prefer not to develop this argument, which would have a merely conjectural value.

Drawing on the concept of local moral worlds, introduced in particular by Arthur Kleinman (1999; Keinman & Van der Geest 2009), I will show that there is an intimate relationship between ontology, morality, and epistemology. If the set of representations to which I have just referred gives rise to an articulated series of statements about what a «person» is and, secondly, about what kind of events can lead to the end of the «person», it is precisely on the basis of this ontological structuring that subjects develop a spectrum of moral values, on the one hand, and of possible ethical choices, on the other. And vice versa.

Some conceptual and methodological clarifications need to be provided as a preliminary step.

First of all, despite the wide-ranging debate that has recently developed in the anthropological sphere around the themes of ethics and morality[3], it is useful to provide a clear framework for how I make use of these two concepts, which in turn refer to historically layered fields of Western philosophical reflection, as well as to the common use of social actors. In referring to morality, I am talking about a *corpus of* meta-practical, culturally situated values and assertions that offer social actors points of reference to guide their action. This *corpus* encompasses the range of socio-cultural precepts that distinguish the good from the bad, the just from the unjust, the legitimate from the illegitimate, etc. I see ethics as synonymous with morally informed praxis: that is, the vast field that includes the practices of subjects, reconceptualised according to their moral dimensions. In this sense, giving, caring, and educating, as well as stealing, killing, and in-

---

[3] Since at least the beginning of the 21st century, anthropologists have turned their attention to the domain of ethics and morality, producing a number of often discordant interpretative models of what we consider «moral» and what we consider «ethical». Recently, Csordas (2013) has grouped these different approaches into four clusters. The first, mainly related to the work of Didier Fassin and Richard Rechtman on trauma, is presented as an attempt to rethink morality and moral action as specific fields of the social (Fassin & Rechtman 2007). The second reflects on the socially instituted ways in which morality acquires practical value through ethical attitudes (Robbins 2004; Zigon 2008). The third responds to the concept of «local moral worlds», i.e. spaces of meaning within which moral constructions allow subjects to project themselves onto a meaningful horizon and thereby find resources to relate to their suffering (Kleinman 1992; 2006; Parish 1991; 2014). The fourth one aims to grasp the agentive dimension of the subject as an autopoietic form implemented through systems of practices that constitute the specific ethicality of ordinary human life (Faubion 2001; Laidlaw 2013; Lambek 2015; Das 2006; 2020). For an analytical and in-depth presentation of the various approaches that make up the so-called ethical *turn* in anthropology, see Urbano 2020.

sulting, are ethical practices because subjects can more or less reflexively produce a moral evaluation of them.

Second, a clear definition of what, in this context, is to be understood by care is useful. The way I use it follows closely from the works of Tronto and Fisher, who proceeded to highlight the most relevant analytical aspects of this notion. The two authors state that care is «a species activity that includes everything that we do to maintain, continue, and repair our «world» so that we can live in it as well as possible. That world includes our bodies, ourselves, and our environment, all of which we seek to interweave in a complex, life-sustaining web» (1990: 40). This conception of care appears extremely intriguing because it relates action to something more specific, namely the need to work on and preserve «our own» world. Thus, in order to reason about care, the effects, intentions, and practices have to be related to an image of the world, to a worldview, which brings us towards a double dimension of analysis – ontological and epistemological. Moreover, this worldview finds ample manifestation in intersubjectivity (the «complex, life-sustaining web» of which Tronto and Fisher talk about), which obliges us to consider not only individual patterns of action and cognition but also the way in which subjects co-construct them through negotiation or conflict[4].

Third, from a methodological point of view, this article is based on ethnographic research on organ donation carried out within the context of an applied anthropology project financed by the Organizzazione Toscana Trapianti (OTT). Conducted by a multidisciplinary team consisting of two anthropologists, two nurses, and a psychologist, the project aimed to reconstruct the donation process through follow-up interviews with the families of potential donors. The aim was to understand whether there were any events related to the hospitalisation of a family member eligible for organ donation that could influence the decision to donate[5]. My re-

---

[4] The issue of care relationships, particularly when they directly involve two subjects, entails a careful consideration of multiple aspects such as relational asymmetry, power gradients, inequalities, and micro- and macro-forms of violence. An extensive literature has been produced on the ambiguities of care relationships, especially by feminist epistemologies. Here, however, I will confine the analysis to Tronto and Fisher's definition, considering «care» a kind of *vox media* – a quasi-neutral category – that expresses a multiplicity of possible ethical attitudes related to meta-practical *corpora* within the framework of a given inter-subjective worldview. For an in-depth discussion of the care dimension debate, see at least; Buch 2018; Glenn 2010; Ibos 2019; Tronto 1993; 1998.

[5] The title of the project was «Collaborative interventions for the humanisation of

search lasted from December 2018 to March 2020, when the Sars-Cov-2 pandemic made it impossible to continue the ethnographic work taking place in the Transplant Centre of the «Careggi» Hospital in Florence. During the sixteen months of ethnography, we interviewed about 30 families involved in the donation process. All but two had given their consent to organ procurement.

As the pandemic developed and it became impossible to continue the ethnographical work, I focused my attention on four Facebook groups, two Italian and two French. The purpose of these Facebook groups was to allow members to share information and experiences related to organ transplantation and to enable those who wished to do so – both the recipient and the donor's family – to try to find and get in touch with the other person. This second line of research is still ongoing.

This article is based on some of the data collected in the course these two enquiries.

The notion of Cartesian person

What follows is part of an interview with Antonia[6], the daughter of a 75-year-old woman who had died of a brain haemorrhage and whose liver had been harvested and subsequently transplanted into a 58-year-old man. At this stage of the interview, we were discussing Antonia's memories of the time when she had been offered the possibility of donating her mother's organs. The woman was expressing a favourable evaluation of her relationship with the medical staff. However, when recounting the moment when her mother's body was returned after the procurement of the organs, she said:

> I can only say... that it was not clearly explained to me... We were very committed to the display of the body. We agreed to the procurement of the organs and tissues and we were not told that the corpse would have to be closed immediately, to prevent the blood and other fluids from flowing out of the body. This was a problem, because it was important for us to be able to display the

---

care: anthropological analysis of the cultural implications in organ donation»; see Di Pasquale 2019; 2022 for a more systematic reflection on the theoretical and applicative goals of this project, as well as the methodological difficulties it presented.

[6] In order to protect the privacy of my interviewee, people's names and contextual elements – such as the name of the Facebook group discussed in the next section – are fictional.

> body and hold a wake for mum. I was very upset about having to close the coffin immediately because I am not very spiritual but very concrete, and I wanted to see her still there, you know? Well, I was told that the procurement would not at all affect what we needed to do afterwards and the viewing before the funeral. But actually, the people in charge of the corpse then said: «No, you see, we have to close casket right now because soon it won't be possible to show it anymore»[7].

The theme of the restitution of the body and the impossibility of carrying out a complex funeral ritual involving the display of the beloved one for several hours recurred, albeit in a more nuanced way, in many of the interviews we conducted. The decision to donate was taken by Antonia, as well as by other people interviewed, in the awareness that all the rites of passage associated with death could be performed, whether secular or religious. In particular, open casket viewing is a ritual component that is often precluded by organ donation because the exudation of bodily fluids makes the display of the body unpleasant or impossible. Healthcare professionals are well aware of this, as Marinella, a nurse in her 50s, told us. She had lost her 83-year-old mother-in-law, who had died of a cerebral haemorrhage and whose liver had been removed and then transplanted into a 66-year-old woman.

Having worked in operating rooms for most of her career, Marinella was very familiar with the practices of corpse manipulation by medical staff[8]:

> In the days of her intensive care unit hospitalisation, the announcement of her death, and the donation proposal, we always felt supported. By contrast, when Tatiana [her mother-in-law] entered the operating room for the procurement, and also in the later stages, we didn't hear anything. We saw her again at the morgue. No one told us how the organ procurement had gone. Not a single person got in touch with us. My brother-in-law noticed that her blouse was buttoned up to the neck and wanted to unbutton it to see how she looked. I told him: «I think they opened her sternum and abdomen. They opened them all up! You can't make a subcostal cut». In short, we saw her again at the morgue, dressed, with no one to help us, no one to tell us anything. We had to do

---

[7] Project «Collaborative interventions for the humanisation of care: anthropological analysis of cultural implications in organ donation», 23/01/2020.

[8] In this regard, see also the invaluable works of Claire Boileau (1997; 2002), which offer insightful ethnographies of body management and surgical practices related to organ procurement.

> everything quickly! When she comes out of the operating room, she is dead, I know it. However, the hope is that even at that stage someone will tell you: «Look, we were able to do these things, to harvest these organs». Sure, you tell yourself that you will receive the letter at home. But it's not the same thing. On the other hand, I thought: «What was the surgeon supposed to tell us? Or the transplant coordinators? Maybe it's better for ordinary people not to give details, not to say anything». I remember a friend who worked at the DEAS[9] once told me: «I don't know... if something happened to my son, I would never give consent for donation because l see what happens in the operating room»[10].

In Marinella's statements the emphasis is more on the technical aspects of managing the body and the lack of communication with the family, apart from obtaining consent for organ procurement. Again, there is a mismatch here between the way the deceased is treated by the medical staff and the affective, cultural, and ritual needs of the family members. The remark «We had to do everything very quickly!» indicates the impossibility of reconciling the temporality of certain funeral ritual practices with the technical temporality of organ donation. This runs parallel to the expression that is evoked and which is part of a colleague's experience: «I see what happens in operating rooms». The semantic domain covered by such an expression remains strongly linked to the processes of objectification of the body by the medical staff, as Sharp (1995; 2006) has clearly demonstrated[11].

This is confirmed by the conversations between the hospital staff. I vividly remember my first visit to the Centro Regionale Allocazione Organi e Tessuti [Regional Organ and Tissue Allocation Centre] (CRAOT). The place consisted of a few small rooms with doctors and nurses running around frantically. Voices overlapped. And then, on a wall, I saw a large bookshelf with dozens of green and blue binders. Each had the name of an organ and a date written on it: liver 2015, liver 2016, kidneys 2018,

---

[9] The DEAS is the Emergency Department of the Careggi Hospital; cf. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.aou-careggi.toscana.it/internet/images/docs/file/ServizioCivile/documenti/progetti/17_SCR_Prog_DEAS.pdf.

[10] Project «Collaborative interventions for the humanisation of care», 30/05/2019.

[11] Although I cannot discuss the issue in depth here, it is important to emphasise that medical staff are not subject to a single homogeneous representation of the suffering body, even though processes of objectification of the body are often observed in practice – linguistic and otherwise. On the forms of representational resistance to the sick body as body-object by healthcare staff, see Jensen 2016.

hearts 2010, corneas 2013, lungs 2017, and so on. Each of these binders contained countless papers: the clinical histories of donors or transplant recipients. Usually, in a hospital ward, there is an archive of medical records: huge piles of files, each with a person's first and last name, at most the date of birth. Instead, in the CRAOT, people's names dissolve into the organ that represents them. As I looked at these binders, I thought, as I wrote in my diary a few hours later: «If I died today, as an organ donor, tomorrow I could be renamed "liver 2018"». As I gazed at this hustle and bustle, a nurse answered the phone and, at the end of the call, addressed her colleagues: «There was a car accident a few hours ago. We may have a heart, lungs, and kidneys». Another, smiling enthusiastically, exclaimed: «Wow! A complete one,» meaning that a complete procurement of organs and tissue could probably be achieved. Such interactions were certainly not infrequent. The standard vocabulary used by health personnel consisted of a transition from the person to the organ. Rarely did I hear descriptions of the person that, in some way, drew attention to the history of the deceased. Generally, the donors referred to were defined by the organ of donation. «Today we did two kidneys»; or, «in intensive care unit we have one at risk of brain death. If his family donates, tomorrow we should have a liver and two lungs». Those kidneys, liver and lungs, together with some biographical and historical data of their previous owner, then went to compose the materials collected in the binders.

Certainly, there are legal and bureaucratic reasons for this sort of practice. The anonymity of the donor, not least for the respect due to his family context and his person, must be preserved. Therefore, the transfiguration of the person – with his history, his affections, his memories, his relationships – in the donated organ meets a criterion of protection. However, both the facility and the flippancy of healthcare personnel talking about kidneys, livers and lungs, instead of «a man of 40, a woman of 60, a child of 10» also show us something different. In fact, it demonstrates a process of embodiement, not only linguistically, of a far more materialistic and organicist worldview than we are given to suppose.

These ethnographic vignettes, apparently unrelated to each other, share a common thread: a specific conception of the person that I would like to call «Cartesian». The Cartesian person underlies the representational system embodied by healthcare workers and is based on the inseparable connection between the concept of person and the unity established between mind and body, with a certain pre-eminence of the former. Such a representation – usually called biomedical – places the possibility of the person's existence exclusively on the side of life. The moment life vanishes, through cardiac arrest or loss of brain activity, the person vanishes with it. This notion places the person within a discrete temporality (in the mathematical sense): just as life is clearly separable from death, so the person's presence is clearly separable from his or her absence. What remains of the person at the moment of death is only matter – *res extensa*, as Descartes puts it. Organs and tissues, to put it in medical language. At most, a corpse.

The disregard in the restitution of the corpse, in Antonia's case; the lack of management of communication and information, in Marinella's case, as well as the statement of her colleague who affirms that, knowing what happens in the operating theatre, she would never give consent to the procurement in the case of a loved one; the expressive ways in which the health personnel indicate the donors, through a reduction to the organ-object; all these evidences could be interpreted in terms of poor deontology, of inexperience. Or, they could be reduced to individual, personal faults for the doctor or nurse. On the contrary, these attitudes, these postures are deeply rooted in the way a certain practice and a certain discursiveness (the medical one, in particular) construct a vision of the world. They provide a specific status to certain fundamental notions, first and foremost that of person. This Cartesian notion of the person makes it possible to produce a series of representations that shape the actions of subjects, particularly physicians, but not only. First, linking the disappearance of the person to the precise moment of death makes it possible to transform the «who» into a «what». The person gives way to a mass of organic substances: blood, organs, tissues. The second implication, which is also conveyed by the concept of brain death, leads us to consider the «mechanical remains» of what was once a person as a fundamental therapeutic resource for other patients (Steiner 2001; 2004; see also Lock 2001). Faced with the remains of a person who can now only exist as a memory but whose presence has no relationship with the material support to which he or she was attached (the body), there are only two alternatives: either leave this organic material to putrefy and decompose, or resignify it, converting it into a kind of organic matter with therapeutic utility. A final implication concerns the relational scheme involving the deceased: insofar as it is a dead body and no longer a person, a mere corpse, it can no longer be considered a patient, and the relationship that health professionals establish with it is one of pure utility. This corpse is a reservoir of resources that enter into a wider social circulation and that, from this moment on, involve other dying patients whose lives can be saved or prolonged thanks to a transplant (Potts 2007; Grafiteaux 2009). The person who until recently was a patient is transformed into a dispensary of therapeutic opportunities, whose protection is necessary for the sole purpose of making such resources available to those in need. It is still a logic of care that is established, but it no longer concerns the one who is dead, but the one who is about to die. An Other, unknown to the doctors themselves, whose situation imposes itself as a priority.

If we place this notion of person within a broader and more articulated worldview, grounded to some extent in webs of concepts, in paradigms (such as materialist positivism), in values, we see how it works perfectly. It allows doctors to get out of the impasse of the non-curable sick person. It ensures the permanence of their practice in the register of care, addressing the curable sick person. It is a game of gazes and depends on where we turn ours. In this case, the sick person who dies is no longer a person and becomes a therapeutic resource; the curable sick person can receive an organ and the doctor holds firm to the ethical value of his practice, which is that of taking on the suffering of others by trying to heal them. At the centre of this game, of this social scene, the Cartesian notion of the person plays a pivotal role. Noticing this element of care is crucial to understanding how reductive, at the very least, are the narratives that tend to fixate on the role of transplantologists as mere organ harvesters, insensitive to the suffering of others[12]. Indeed, they fail to recognise that it is within a specific ontological construction of the social notion of the person that the moral possibility of «caring for» someone else, that is of fulfilling the assigned social mission, opens up – in this case, no longer caring for the *potential donor*, but for the patient awaiting a specific therapeutic technology: the organ transplant. This ethical stance of physicians and transplantologists has frequently been criticised by scholars (see also Potts 2007; Grafiteaux 2009; but also Quéré 2010; Basualdo 2010), who see in it only the utilitar-

---

[12] This kind of stance is frequently observed among those who reject organ donation, as Waissman shows in his ethnographies (1996; 2001). See also the documents and bulletins produced by national and international associations fighting against organ donation, such as the *Lega Nazionale Contro la Predazione di Organi e la Morte a Cuore Battente* [*National League Against Organ Predation and Beating Heart Death*] and the *Pro-vita e Famiglia* [*Pro-Life and Family Movement*], which deserve in-depth analysis: see http://www.antipredazione.org/; https://www.provitaefamiglia.it/blog/predazione-degli-organi-apriamo-gli-occhi.

ian interest in a dead person. However, it becomes more comprehensible when one considers that the medical interest in the procurement of organs from a corpse is associated with the impossibility of identifying the presence of a person within that cadaver. The whole clinical and ethical focus therefore shifts elsewhere, to a living patient who is still a person, meaning someone to be cured.

The notion of the diffuse person

Although the scientific and materialist notion of «person» that I have just discussed seems to be the dominant one in our historical and cultural context, the ethnographic evidence that has emerged in recent research makes it possible to argue that, among the notions of person that are mobilised by social actors within local forms of epistemology (but also ontology), there is a very different one: the notion of the «diffuse person».

The analysis of the Facebook groups mentioned in the introduction offers several important supporting elements. These Facebook groups were created to allow donor families and recipients to contact and meet each other, since in Italy, as in many other countries, donors and recipients must remain anonymous. The virtual community, on the other hand, offers the possibility of bypassing the constraint of anonymity, if the parties involved are interested in doing so and are lucky enough to find each other in the same virtual reality. The function of Facebook groups, however, has changed: nowadays, it seems that these communities are mainly structured around the sharing of stories and experiences, creating a relatively large mutual aid community[13].

I would therefore like to analyse some of these shared experiences, in which we can glimpse specific constellations of concepts and notions that animate, albeit often implicitly, the logics of organ donation.

November 2021. Facebook group *Dalla sofferenza alla vita. Il dono di organi*. 2.37 a.m. A young woman, whose child has received a liver transplant, writes:

> Tomorrow it will be thirty days since my baby was called to receive a new liver. You are always in my thoughts [to the donor] and I thank your family who, despite the pain, have gifted us a new life. You will always be with us!

---

[13] Here is the number of members for each Facebook group: *Donare e ricevere,* 3,800 members; *Dalla sofferenza alla vita. Il dono di organi,* 6,000 members; *Le don d'organes. Rencontrons-nous*, 2,000 members; *Les amis du don d'organes*, 4,500 members.

At 4.12 a.m., another mother, who often intervenes in the Facebook group, replies:

> So much courage and immense strength and love in these people who have chosen to let their child live on in yours.

When I first came across such a post, I had only been observing these Facebook groups for a few days. At that time, I was mainly interested in trying to reconstruct the formation of gift relationships in a context rendered apparently aseptic by a regulatory system that is designed precisely to break these socio-relational ties. I was aiming to investigate these aspects through the words of donors and recipients who spoke openly because of the form of cultural intimacy (Hertzfeld 2016)[14] produced in a closed social context geared towards a common object. However, I was drawn to the many religious images that users attached to the Facebook groups and the emphasis on the angelic (for the religious) and heroic (for the secular) dimensions of the donors (Quarta 2023). In trying to trace these narrative processes of donor representation, I began to pay attention to the question of the donor's survival beyond death, precisely through his or her permanence in the form of the donated organ.

One of the first messages I read about this phenomenon in that Facebook group was a post from a middle-aged man, who left a message thanking a donor on 15 February 2020:

> It was five years ago today that we received the call for my wife's lung. I thank and embrace those Sicilian people who chose to donate and let their loved one live on. Francesca is well and we love you.

---

[14] Although the concept coined by Herzfeld is designed to help understand certain processes of identity construction on a political and geopolitical level, I find that it can be well applied, albeit with some strain, to a context such as the one examined in this article. These communities are very closed, as their members identify themselves with the *exemplary* value of an experience that sets them all apart from the outside world. As a young member of the Facebook group *Dalla sofferenza alla vita* put it: «I am glad you have taken me in, because you are the only ones who can understand me, and I feel at home with you». It is therefore the experience of donation or transplantation that binds the members of the Facebook group together, offering them a safe space, ideally free of misunderstanding, since the meaning and significance of the words and experiences shared are immediately understood by the others right on the basis of this common identity – being an active subject in the world of organ donation.

A few days later, on 24 February of the same year, in the *Donare e ricevere* Facebook group, I found another post, this time by a mother who had lost her son and who wrote:

> My little boy, my Paolo, died of a brain haemorrhage in 2015. Initially, I wanted to refuse organ donation but, faced with so much pain, I decided to donate everything. The heart was transplanted into a 16-year-old girl who, I was told, was dying. My greatest wish is to feel my Paolo's heart again. Whoever you are, please give me the chance to look into your eyes and hear that heart beating again!

A man replied within a few minutes:

> You are a great mum: one day, hopefully very soon, you will be able to feel that heartbeat again. Thank you from all of us who have been transplanted.

A very long exchange of comments follows. Many users of the Facebook group, unable to relate to this representation of the relationship between donor and recipient, responded to the woman, in an increasingly aggressive manner, pointing out to her that this way of experiencing donation and transplantation is potentially very dangerous. One woman wrote:

> Calm down! She is a little girl and it must have been very difficult for her too. I am sure she gives thanks every day for this gift.

A man, who identified himself as the father of a donor, added:

> I understand your suffering. However, let us be careful what we write. There is a little girl on the other side who has suffered so much and to tell her that she has a life thanks to you is not a nice thing to do. I understand your pain and I thank you with all my heart for your wonderful loving act.

The last reply from Paolo's mother is surprising:

> But she does [have a life thanks to me]. I have given her back a life. If Paolo did not live in her, she would no longer be there.

The initial hypothesis, which leaned more towards a psychological approach, was that this imaginary survival of the person beyond death through the incorporation of body parts into a living «host» was a temporary response to the grief felt at unexpected and emotionally charged bereavements, such as the loss of a child at a young age. This reaction is more common among donor families. We must bear in mind that, in the case of transplants, exceptional conditions must be met in order for someone to be considered a potential donor, first and foremost that the deceased must be «healthy». This means that donors are often people who have been victims of accidents or sudden pathological events (such as a cerebral haemorrhage), but who are generally in good health. The death of these people is an unexpected event. I therefore thought that the idea that they could continue to live in the bodies of others was linked to the exceptional conditions of their death and, above all, to the possibility of donating organs with a high symbolic value such as the heart or the corneas: the heart, because it is often considered to be the receptacle of emotionality and, for centuries, was regarded as the seat of the soul as the principle of life; the corneas – considered synecdochically equivalent to the eyes – because they are linked to the gaze, and thus to the functions of sight. However, in the months and years that followed, ethnographic data led me to abandon this explanatory model – a little too functionalist – that focused on the phenomenon's elements of «exceptionality» and suggested a culturally oriented emotional response. Instead, there appears to be something far more relevant at the core. This is illustrated by some of the following posts.

Facebook group *Dalla sofferenza alla vita*. July 2022. An anonymous member writes:

> You are not gone, but live inside me.

A father immediately replies:

> Our son also lives. 10 years ago his organs were removed. I don't know where you are today, but I know you are still here, inside someone. Have a good life, my love.

And the anonymous person from the first message replies:

> I would be happy to know that he lives inside me. If so, know that I will always take care of him.

Another message, from the French Facebook group *Les amis du don d'organes*, left by a woman in her 60s. November 2022.

> My 82-year-old father suffered encephalic death and donated his liver. We hope that the recipient is well and are eager to meet him, to thank him. He keeps our dear and beloved father alive.

I would like to conclude this ethnographic section, to which hundreds of such posts could be added, with two more exchanges from the French Facebook group *Le don d'organes. Rencontrons-nous*. The first message is from an elderly woman, Léonie, who talks about her nephew's transplant:

> Yesterday, my nephew had a kidney transplant. He had been waiting for it for 4 years. He has 4 children. His little ones have never seen their father in good health. Everything is fine now. I wanted to express my boundless gratitude to the donor and his family for such a generous act. I think of you always.

A woman replies after about a day:

> I hope that the recovery after the transplant will be fast enough. I am the mother of a donor and I am happy that this choice is a rebirth for suffering people.

Léonie replies shortly afterwards:

> Thank you for your act. I hope that knowing that people like my nephew are alive thanks to your relatives will help you ease your pain. Your loved ones are not dead, they are not gone. They still live on in their hosts. And, on our side, there is and always will be infinite gratitude and care.

Another exchange of comments taking place on 2 November 2023, within the same Facebook group, illustrates my point even better. The author is the sister of a man who died in a car accident. Because of his young age and excellent health, he was able to donate all his organs and tissues. Isabelle, his sister, wrote the following message:

> I often think of the recipients.
> How are they?
> Are they taking care of my brother?
> Is my brother happy to be with them?

A few days later, among the many messages of solidarity and sympathy, there was one from Zoé, the mother of a transplanted boy:

> To answer your question, «Are they taking care of my brother?», the answer is no! They are taking care of their organ, not the donor's organ. The organ is inside them and it belongs to them. This is my point of view and that of my son who was transplanted 15 years ago, at the age of 18.

Isabelle, offended, replied:

> Bitch!
> If you have to answer with this bullshit, just shut up! I don't need a Ms. Know-it-all to come and kick my ass.

The idea of a psychological reaction to an «inconceivable» event gives way to a different perspective: a more transversal model emerges, which also involves the recipients or the sons and daughters of elderly donors, and which is more or less as socially acceptable as the altruistic model based on what I called the *Cartesian person*[15] in the previous section. In this model of donation, the choice is accompanied by the construction of a notion of the person that I will call «diffuse», in the sense that it is not related to an inseparable psycho-somatic unity that would constitute the

---

[15] I find it necessary to make a brief methodological digression in this section. Compared to classical ethnographic investigations, the purely textual ethnographic data extrapolated from exchanges of comments in a Facebook group can seem very reductive. Ethnographic research should provide for the possibility of direct interlocution with social actors and continuous observation of the context in which they are immersed, in order to be able to analyze in depth the issues at stake, the semantic layers, the cosmologies, and the everyday practices that construct the horizons of meaning and action of the subjects. This is largely impossible in the case of a Facebook group. However, anthropologists have long pointed out that social media are not just tools but real communities, with their own norms, codes, practices, forms of interaction, and construction of shared horizons (Miller 2011). Certainly, much of the ethnographic work done on Facebook has included a detailed analysis of the ways in which subjects used the digital tool within their own non-virtual worlds (Mod 2010; Miller *et al.* 2018). But if we assume that, in their evolution, some social media – particularly Facebook – have created digital communities that are no less real than their non-virtual counterparts (Hiltz 1984; Plant 2004), and that the dimension of textualization allows for an equally in-depth, if not exhaustive, analysis of the worldviews of the subjects interacting within such communities, then the Facebook groups considered in this article certainly shed some interesting light on a phenomenon such as organ donation. Through what they say, the way in which they say it, and the way in which they interact, we can begin to see the emergence of implicit cultural elements such as the notions of gift, identity, and person, all of which play out around the culturally established frontier between life and death.

individual. The person inhabits the parts, the material components of the body, which, although reduced to their purely objective and material dimension, inherit qualities and biographical paths that defined the subject before his or her death.

With regard to the body donation, Jacques Godbout (2006) had recognised the formation of a *hybrid person* in certain transformative experiences of the recipient, thereby proceeding in the same direction as Sharp (1995; 2006)[16]. The condition for this to be possible is that, for some social actors, the person is not defined by the relationship between a spiritual (or cognitive) principle and a somatic unity (the body). The *Cartesian person* gives way to the *diffuse person*. As Kopytoff (1986) has clearly illustrated, objects have dense biographies that collect the qualities of those who have possessed, exchanged, or lost them. The same holds true for the object-organ, which, much more deeply, can embody the essence of the person it was part of and which, for this reason, allows it to survive in new forms within the body of a «host» that receives it[17]. The object-organ thus becomes a person-organ.

Concluding remarks

Before leaving the reader with some concluding remarks, I will briefly recapitulate what has been presented so far.

First, I have argued that there are *at least* two different models of the «person» in our contemporary cosmology. The first, the *Cartesian person*,

---

[16] Elsewhere, still on the basis of the ethnographic material presented here, I have had the opportunity to reflect on the ways in which the person is *hybridized*, starting precisely from the narrative of the transformative experiences of transplant recipients who, in this structural transformation of their Selves, recognize the action of the donor person, embedded through transplantation (Quarta 2023). These are profound and radical experiences: it is not uncommon for recipients to perceive a structural transformation of the Self, coupled with a change in their tastes, habits, and identity. The Self is made up of biographical elements supposedly belonging to the donor, whose permanence is guaranteed by the installation of the organ vector in a host body. For the Italian context, see, for example, Mitola 2011a; 2011b; 2012; fundamental, in this sense, are also the works of Sharp (2006; 2007).

[17] The topic of the permanence of the person in single parts of the body echoes anthropological reflections that are well established in the literature, the best-known example of which is certainly Marylin Strathern's work on the Melanesian person (1988), to which can be added the more recent work by Francesco Remotti (2019; 2021) on the composite notion of the person.

is strongly linked to an individualistic conception of life. The body and the cognitive faculties are closely intertwined. Their unity, which is materialized in the individual, would constitute the concept of the person. The cessation of one of these two elements leads to the definitive cessation not only of life but also of the person.

The second model is that of the *diffuse person*. The person, in this case, does not correspond to the singularity represented by the individual, but is literally and concretely *diffused* into the various somatic components. The person survives in the individual organs or tissues and lives on through the incorporation of the person-organ into the recipient's body[18].

Both models also deal with the temporality of life and death, understood as social processes that subjects approach from the perspective of their own cosmologies. The duration and rhythm of these two notions-boundaries (Grossin 1996; Sewell 1996; Bessin 2009) vary considerably from one model to the other. In the case of the *Cartesian person*, life and death are radically separated and develop in a discrete way: that is, it is possible to establish a clear break between what is life and what is death. In addition, life and death are regarded as two homogeneous and distinct temporalities. In other words, there is life here and now, with all its positive signs; a traumatic event – an illness, accident, haemorrhage – marks the end of life and establishes the temporality of death. Thus, the positive signs of death can be recognized here and now. In the case of the *diffuse person*, on the other hand, we are faced with continuous temporalities that are articulated one on top of another, making it very difficult to establish a real break, a clear discontinuity. Therefore, we do not refer to life and death as self-enclosed objects or social facts, but to living and dying as processes that unfold in a duration, according to a rhythm and in forms that cannot be unambiguously defined. Indeed, in the context of a diffuse person, when can one say that an individual is definitively dead? What are the definitive signs of the end of the person? If the self, with all its historicity and biographical capacity, survives in the organs, flows through them into the social body, and then installs itself in the biological body of the recipient, merging with the latter's self and producing a new person, how is it possible to conceive of a clear-cut, discrete, and definite idea of «death»?

---

[18] Interestingly, these kinds of experiences are also well represented in the medical literature on transplantation, particularly in the psychological literature, but are contrasted as psychopathological experiences that need to be suppressed in order to establish a healthy recipient psychism; cf. Bash 1973; Mai 1986; Rauch & Kneen 1989.

However, one element is even more relevant. Both representational models are simultaneously produced by and produce epistemologies associated with local ontologies that tend to be incompatible with one another. As I pointed out earlier, they combine to produce very different representational effects. These representational effects, however, do not exist only on the level of cognition, explanation, or theoretical reasoning. They exist, above all, on the level of praxis. They exist and produce effects in the field of morality, in the sense of a corpus of regulative values, and ethics, in the sense of a field of action in relation to which judgments can be made. In this sense, then, ontology should be understood as a derived domain: it is nothing more than the naturalized translation of epistemological and moral representations that produce representative effects in the imaginary. Well, these effects, once subjected to a naturalization process, are translated into local ontologies. However, these ontologies are extremely powerful from the perspective of both morality and epistemology, in the sense that they constantly inform the action and cognition of subjects. If the two notions of the person I have discussed are ontological notions, they entail, from the perspective of social actors, significant modifications in the choices and orientations of their actions: calling the person a «corpse», disregarding the funeral rituals of family members, and directing one's intentions of care towards the only «person» still present, on the one hand; searching for one's loved one in the body of another, choosing to donate in order to sustain life, and understanding care in terms of «caring» for those who survive in the body of a «host», on the other. These are all agentive possibilities that can be evaluated according to a specific moral code that places the fundamental value of care at the center. And they are provided by being located in that field of naturalized representations that we call «ontology».

Formally speaking, both models respond to the same pattern, the same mechanism. The initial event is a considerably traumatic one that produces a specific effect. In the model of the *Cartesian person*, this effect can be denoted by the term «death», whereas in relation to the model of the *diffuse person*, I think it is more correct to use a term that denotes the process: «dying». I have already illustrated the radical difference between these two forms of naming. In both cases, we are faced with an experience of crisis (de Martino 2023) or *moral breakdown* (Zigon 2007) that somehow compels action. It calls for the use of culturally oriented procedures that ensure that the subject can still conceive of himself in a possible world. This urge to act leads them to turn to their own moral imaginary, which in turn is closely linked to the possible structure of the world in which the social actor lives. Different structures provide for different moral imaginaries. Just as different moral imaginaries require different structures. Acting, in this case, means making a choice. In the first case, the choice will transform the person into a corpse, the primary source of therapeutic resources. In the second, by contrast, the choice will approach donation as a way of enabling the person to be able to continue their biological (and social) journey within the body of another. In the first case, care is directed towards the person who is still there. In the second, care is chosen so that one can continue to exist. In turn, those choices are generators of order, i.e. of meaning. In a constant form of circularity, the choices made test the moral imaginary in relation to a given local ontology and epistemology, confirming both. Both, moreover, manifest themselves to us in the lexicon of care. As Tronto states, there are two main ways in which care is declined: *caring about* and *caring for* (Tronto 1998: 16). In the first case, it is an attitude of recognition. This means perceiving and recognising the explicit or implicit need for care that comes from another. In the second, on the other hand, it is a matter of responsibility. In other words, making oneself actively responsible for taking care of the other. Both then have to find practical ways shared between the one who provides care (*caregiver*) and the one who receives it (*care reciver*).

However, in this article I have argued that, beyond the formal definition, the practical content of care is not – and cannot be – independent of the way we think, want, understand and name the world. Local knowledge contributes to the construction of the worldview and the worldview shapes our local knowledge. On the other hand, the naturalisation of these worldviews constructs the world we inhabit in a real, empirical way. In this sense, epistemology and ontology intertwine. Standing at the intersection of these two dimensions of our presence, fundamental notions emerge that express within them, paraphrasing the Maussian notion of total social fact, a total worldpicture (*Weltbild*). One of these is the notion of the person. Alongside it, we can locate the practice of care. What is at stake is that it is precisely by analysing care practices that we can see the emergence of a specific notion of person and an entire world. If we wanted to suspend for a moment what I have called a form of circularity, we could inductively argue as follows: in the practices of care (in who we care for, why we do it, who is included in our care and who is excluded from it) we detect significant elements that allow us to understand what notion of person is operating; starting from the notion of person, then, a way of understanding the world (knowing-epistemology) and a way of constructing the world (entity-ontology) can be observed.

Of course, a reader who finds the two models incompatible, claiming the need for a single legitimate notion of person, body, life, and death, could claim the need to choose between the two: which of the two models is the correct one? Or rather, which is the true one? Or, again, which is the real one, using a strong notion of reality that involves a two-way correspondence between our representations and the objective construction of the external world?

I reject this objection on the grounds that I do not believe it is the task of anthropology to comment on issues that belong at most to the fields of physics, medicine, or philosophy. Rather, I am interested in pointing out how, even with respect to an apparently self-evident notion such as that of the *person*, there exist quite different representational schemes. They are the result of a reciprocal relationship between epistemological forms, ontological forms, and moral forms that give substance to the actions of social subjects. My aim in this article, therefore, has been to make a small contribution to a historicist anthropology capable of showing us, once again, that in different moral worlds (i.e. ontologies), even actions that may appear to be the same or motivated by identical reasons – as in the case of the affirmative decision to donate organs – reveal all the profound differences in the paths that human beings can take in their history.

References

Buch, E. 2018. *Inequalities of Aging. Paradoxes of Independence in American Home Care*. New York: NYU Press.

Basch, S.H. 1973. The intrapsychic integration of a new organ. A clinical study of kidney transplantation. *The Psychoanalytic Quarterly*, 42, 3: 364-384.

Basualdo, C. 2010. Quel don pour la greffe d'organes?. *Revue du MAUSS*, 1: 489-495.

Bessin, M. 2009. Parcours de vie et temporalités biographiques: quelques éléments de problématique. *Informations sociales*, 6: 12-21.

Boileau, C. 2002. *Dans le dédale du don d'organes. Le cheminement de l'ethnologue*. Paris: Éditions des archives contemporaines.

Boileau, C. 1997. Ethnographie d'un prélèvement d'organes. *Sciences sociales et santé*, 15, 1: 21-33.

Csordas, T. 2013. Morality as a Cultural System?. *Current Anthropology*, 54, 5: 523-546.

Das, V. 2006. *Life and Words. Violence and the Discent into the Ordinary*. Berkeley: University of California Press.

Das, V. 2020. *Textures of the Ordinary: Doing Anthropology After Wittgenstein*. New York: Fordham University Press.

de Martino, E. 1988. *Primitive Magic: the Psychic Powers of Shamans and Sorcerers*. Bridport: Prism Press.

de Martino, E. 2023 [2017]. *The End of the World: Cultural Apocalypse and Transcendence*. Chicago: The University of Chicago Press.

Di Pasquale, C. 2019. Il «caso» delle opposizioni alla donazione di organi e tessuti in Toscana: fare ricerca etnoantropologica in équipe. *L'Uomo. Società tradizione sviluppo*, 9, 1.

Di Pasquale, C. 2022, *Micro-etnografie nel sistema donativo. Gerarchie, dislivelli e «ordinaria» amministrazione,* in *Antropologia in cors(i)a. La professione dell'antropologo medico nella sanità pubblica italiana*, edited by M. Castaldo & M.C. Segneri, 197-234. Ogliastro Cilento: Licosia Edizioni.

Fassin, D. & Rechtman, R. 2007. *L'empire du traumatisme. Enquête sur la condition de victime*. Paris: Flammarion.

Faubion, J. 2001. Toward an anthropology of ethics: Foucault and the pedagogies of autopoiesis. *Representations*, 74, 1: 83-104.

Fisher, B., Tronto, J., Abel, E.K. & Nelson, M. 1990. Toward a feminist theory of caring, in *Family: Critical Concepts in Sociology, Volume II*, edited by D. Cheal, 29-54. London: Routledge.

Fox, R. & Swazey, P. 1978. *The Courage to Fail. A Social View of Organ Transplants and Dialysis*. Chicago: The University of Chicago Press.

Fox, R. & Swazey, P. 1992. *Spare Parts. Organ Replacement in American Society*. New York: Oxford University Press.

Glenn, E.N. 2010. *Forced to care: Coercion and caregiving in America*. Cambridge (Mass.): Harvard University Press.

Godbout, J. 2006. Le don au-delà de la dette. *Revue du MAUSS*, 27, 1: 91-104.

Graftieaux, J.P. 2009. Prélèvement d'organes et donneur potentiel. *Éthique & Santé*, 6, 3: 147-151.

Grossin, W. 1996. *Pour une science des temps. Introduction à l'écologie temporelle*. Toulouse: Octares.

Heinemann, L. 2014. For the sake of others: reciprocal webs of obligation and the pursuit of transplantation as a caring act. *Medical Anthropology Quarterly*, 28, 1: 66-84.

Heinemann, L. 2015. Accommodating care. *Medicine Anthropology Theory*, 2, 1.

Herzfeld, M. 2016. *Cultural intimacy: Social poetics and the real life of states, societies, and institutions*. London: Routledge.

Hiltz, S.R. 1984. *Online communities*. New York: Ablex Publishing.

Hoeyer, K. & Jensen, A.M. 2011. Organ donation and the ethics of muddling through. *Critical Care*, 15, 1-2.

Ibos, C. 2019 Éthiques et politiques du care. Cartographie d'une catégorie critique, *CLIO. Femmes, Genre, Histoire*, 49: 181-219.

Jensen, A.M. 2016. "Make sure somebody will survive from this": Transformative practices of hope among Danish organ donor families. *Medical Anthropology Quarterly,* 30, 3: 378-394.

Kleinman, A. & Van der Geest, S. 2009. "Care" in health care: remaking the moral world of medicine. *Medische Anthropologie*, 21, 1: 159-168.

Kleinman, A. 1992. Local worlds of suffering: An interpersonal focus for ethnographies of illness experience. *Qualitative Health Research*, 2, 2: 127-134.

Kleinman, A. 1999. Experience and Its Moral Modes: Culture, Human Conditions, and Disorder, in *The Tanner Lectures on Human Values*, edited by G.B. Peterson, 357-420. Salt Lake City: University of Utah Press.

Kleinman, A. 2006. *What really matters: living a moral life amidst uncertainty and danger*. Oxford: Oxford University Press.

Kopytoff, I. 1986. The cultural biography of things: Commoditization as process, in *The Social Life of Things: Commodities in Cultural Perspective*, edited by A. Appadurai, 64-91. Cambridge: Cambridge University Press.

Laidlaw, J. 2013. *The Subject of Virtue: An Anthropology Of Ethics And Freedom*. Cambrdige: Cambridge University Press.

Lambek, M. 2015. *The Ethical Condition: essays on action, person, and value*. Chicago: University of Chicago Press.

Lock, M. 2001 *Twice Dead: Organ Transplants and the Reinvention of Death*. Berkeley: University of California Press.

Mai, F.M. 1986. Graft and donor denial in heart transplant recipients. *American Journal of Psychiatry*, 143, 9: 1159-1161.

Mauss, M. 1969 [1931]. La cohésion sociale dans les sociétés polysegmentaires, in *Œuvres,* t. III, edited by M. Mauss. Paris: Minuit [e-book].

Miller, D. 2011. *Tales from Facebook*. Cambridge: Polity Press.

Miller, D., Costa, E., Haynes, N., McDonald, T., Nicolescu, R., Sinanan, J., Spyer, J., Venkatraman, S. & Wang, X. 2018. *Come il mondo ha cambiato i social media*. Milano: Ledizioni.

Mitola, M. 2011a. *Il corpo di Pandora. Storie di trapiantati di cuore tra attesa e dono*. Roma: Abilgraph.

Mitola, M. 2011b. Tra l'attesa e il dono. Una ricerca tra i trapiantati di cuore, in *La promozione della salute e il valore del sangue. Antropologia medica e sanità pubblica*, edited by M. Pavanello & E. Vasconi, 47-60. Roma: Bulzoni.

Mitola, M. 2012. L'altro cuore: il rapporto con il donatore nei pazienti cardio-trapiantati. *Trapianti*, 16, 3: 110-120.

Mod, G.B.B. 2010. Reading romance: The impact Facebook rituals can have on a romantic relationship. *Journal of comparative research in anthropology and sociology*, 1, 2: 61-77.

Parish, S.M. 1991. The sacred mind: Newar cultural representations of mental life and the production of moral consciousness. *Ethos*, 19, 3: 313-351.

Parish, S.M. 2014 Between persons: How concepts of the person make moral experience possible. *Ethos*, 42, 1: 31-50.

Plant, R. 2004. Online communities. *Technology in society*, 26, 1: 51-65.

Potts, M. 2007. Truthfulness in transplantation: non-heart-beating organ donation. *Philosophy, Ethics, and Humanities in Medicine*, 2, 1-2.

Quarta, L. 2023. Alcune considerazioni sulla donazione degli organi, in *La donazione degli organi. Prospettive antropologiche*, edited by L. Quarta, 9-52. Bologna: Il Mulino.

Quéré, R. 2010. Enjeux éthiques des prélèvements d'organes et de tissus: vers un utilitarisme de la mort?, in *Traité de bioéthique. II - Soigner la personne, évolutions, innovations thérapeutiques*, edited by E. Hirsch, 657-670. Toulouse: Érès.

Rauch, J.B. & Kneen, K.K. 1989. Accepting the Gift of Life: Heart Transplant Recipients' Post-Operative Adaptive Tasks. *Social Work in Health Care*, 14, 1: 47-59.

Remotti, F. 2019. *Somiglianze. Una via per la convivenza*. Roma-Bari: Laterza.

Remotti, F. 2021. Condividuo. Prove di fruibilità antropologica. *L'Uomo. Società tradizione sviluppo*, 11, 2: 61-86.

Robbins, J. 2004. *Becoming sinners: Christianity and moral torment in a Papua New Guinea society*. Berkeley: University of California Press.

Scheper-Hughes, N. 2007. The tyranny of the gift: Sacrifical violence in living donor transplants. *American Journal of Transplantation*, 7: 507-511.

Sewell, W.H. 1996. Three temporalities: Toward an eventful sociology. *The historic turn in the human sciences*, 98: 245-280.

Sharp, L.A. 1995. Organ transplantation as a transformative experience: Anthropological insight into the restructuring of the self. *Medical Anthropology Quarterly*, 9, 3: 357-389.

Sharp, L.A. 2006. *Strange Harvest. Organ Transplants, Denatured Bodys, and the Transformed Self*. Berkeley: University of California Press.

Sharp, L.A. 2007. *Bodies, commodities, and biotechnologies: Death, mourning, and scientific desire in the realm of human organ transfer*. Columbia: Columbia University Press.

Steiner, P. 2001. Don de sang et don d'organes: le marché et les marchandises «fictives». *Revue française de sociologie*: 357-374.

Steiner, P. 2004. Le don d'organes: une typologie analytique. *Revue française de sociologie*, 47, 3: 479-506.

Steiner, P. 2010. *La transplantation d'organes: un commerce nouveau entre les êtres humain*. Paris: Gallimard.

Steiner, P. 2012. Symbolisme et échange symbolique dans la transplantation d'organes. *Revue française de socio-économie*, 2: 29-48.

Strathern, M. 1988. *The Gender of the Gift. Problems with Women and Problems with Society in Melanesia*. Berkeley: University of California Press.

Titmuss, R. 2018 [1970]. *The Gift Relationship. From Human Blood to Social Policy*. Bristol: Policy Press.

Tronto, J. 1993. *Moral Boundaries. A Political Argument for an Ethic of Care*. London: Routledge.

Tronto, J. 1998. An ethic of care. *Generations: Journal of the American society on Aging*, 22, 3: 15-20.

Urbano, L. 2020. Una svolta etica. Prospettive e criticità dell'*ethical turn*. *Lares. Quadrimestrale di studi demoetnoantropologici*, 86, 1: 107-135.

Waissman, R. 2001. *Le don d'organes*. Paris: PUF.

Waissman, R. 1996. Analyse des acceptations et des refus du don d'organes; une étude de cas en France. *Sociologie et sociétés*, 28, 2: 109-118.

Zigon, J. 2008. *Morality: an anthropological perspective*. Oxford: Berg.

Zigon, J. 2007. Moral breakdown and the ethical demand: A theoretical framework for an anthropology of moralities. *Anthropological Theory*, 7, 2: 131-150.