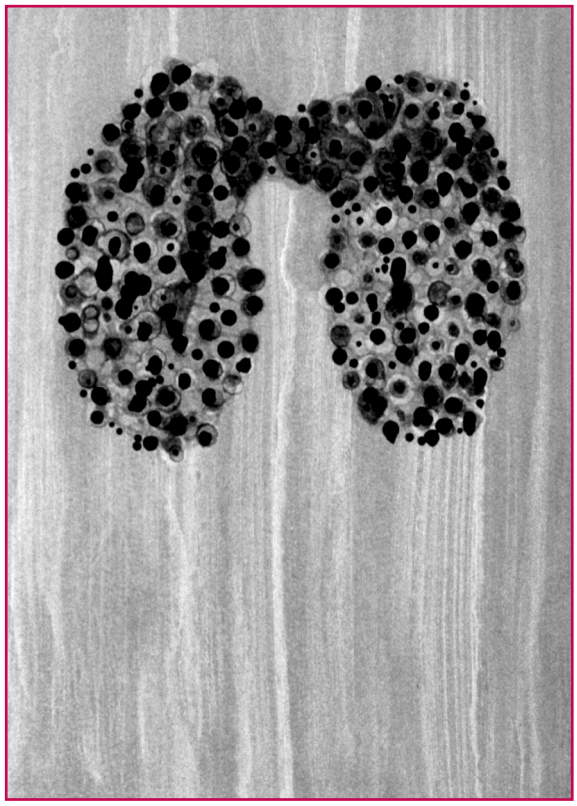


Untitled 94-07, by Brad Miller

Body Val-

by Donald Joralemon and Phil Cox

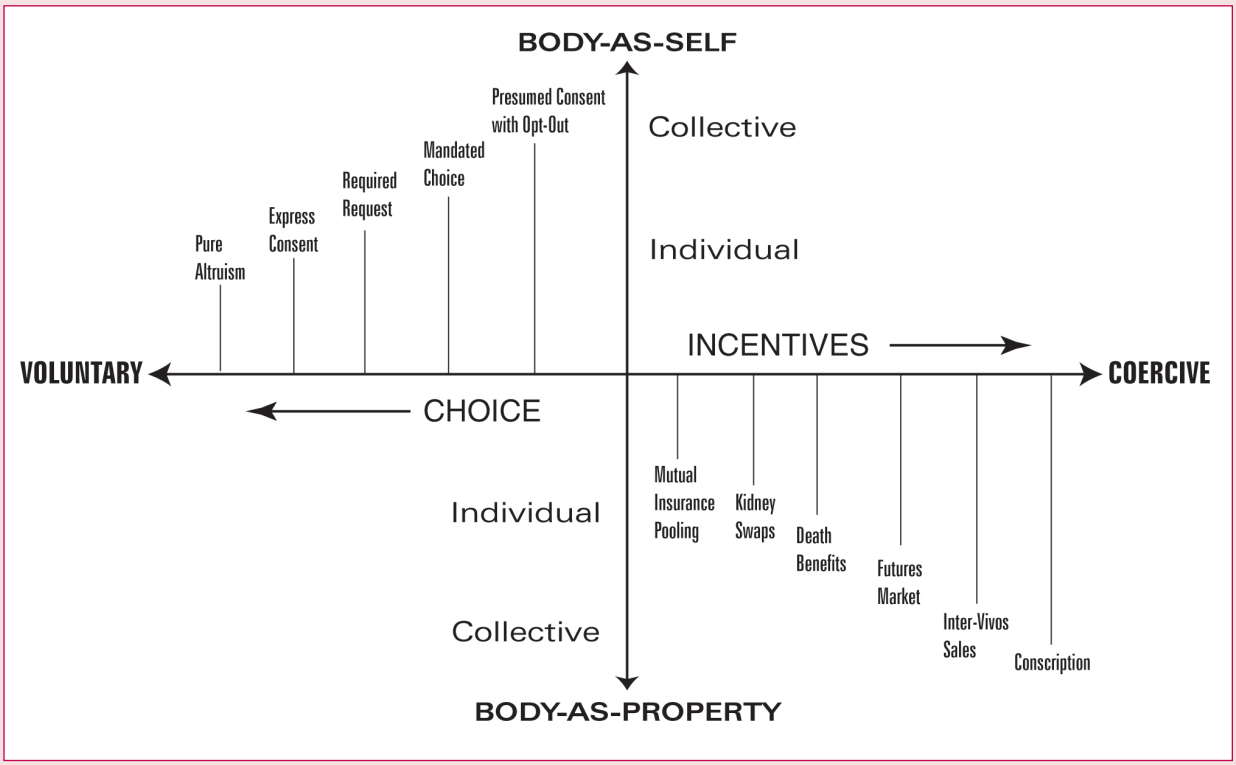
Proposals to compensate families for transplantable organs are gathering momentum. The proposals assume that the body is dissociable from the self and can be treated like property. But such a view is out of step with the rest of the culture.

The issue of financial compensation for organ donation is back on center stage as a result of legislative proposals in Congress and recommendations adopted by the American Medical Association, the United Network for Organ Sharing, and the American Society of Transplant Surgeons. Recently introduced Congressional bills relating to organ donation include two that would authorize tax credits for cadaveric donations.[1] Another bill, by some readings, would grant authority to the Secretary of Health and Human Services to override the prohibition against donor compensation in the National Organ Transplantation Act of 1984 so as to support pilot studies assessing the impact of moderate incentives (such as funeral benefits) on donor rates.[2]

The AMA's House of Delegates, at its Annual Meeting in June 2002, approved a recommendation from the organization's Council on Ethical and Judicial Affairs to encourage pilot studies of compensation for cadaveric donations.[3] The studies would have to include consultations with the population affected, their methods would have to

Donald Joralemon and Phil Cox, "Body Values: The Case against Compensating for Transplant Organs," *Hastings Center Report* 33, no. 1 (2003): 27-33.

Figure 1. Body, Self, and Organ Acquisition



The major alternatives for acquiring organs

The horizontal axis distinguishes plans based on "choice" from those that assume "incentives" are required to get persons to give up their organs, or those of their deceased relatives. The axis is meant to indicate a continuum between two extremes. The vertical axis distinguishes plans that view the physical body as integral to the self from plans that view the body as property. Both conceptions of the body's relationship to the self range from individualistic to collectivist conceptions of personal identity.

"Pure altruism" characterizes the present system, in which a person's organs may be taken only if prior consent had been expressed or if the relatives agree after the person's death. In a system that relied on "express consent," the next of kin would not be able to override a deceased's documented wish to donate. "Required request," also already in effect in the United States, requires doctors to request organ donation in every suitable case. In a "mandated choice" system, all persons would be required to indicate on some common official document (such as a driver's license) whether they wished to donate. If we adopted "presumed consent with opt-out," agreement to donate would be a default assumption, but individuals could express disagreement.

Six proposed plans involve incentives to varying degrees. In "mutual insurance pooling," individuals who had signed an organ donor card while healthy would be given preference when they need an organ. In "kidney swaps," if a relative of someone on a waiting list for a kidney donates a kidney to another patient, the person on the waiting list is given a higher status. Kidney swaps may be employed if the relative and the person on the waiting list are not histocompatible.

Incentives would shift from quid pro quos to cash if "death benefits"—payments to defray funeral costs—were made to relatives who agree to donation. In a "futures market," contracts for organs would be written for healthy persons, to be activated should that person die in a fashion that makes the organs useful for transplantation. The contracts could be sold and purchased on a secondary market, and the owner of the contract would then sell the organs to people in need of them. Kidneys are available in some countries through inter-vivos sales. In a system that relied on conscription, incentives give way altogether; the state assumes ownership of bodies after death and does not have to solicit consent to salvage organs.

pass scientific muster and be approved by oversight bodies, and they could use only "incentives of moderate value and at the lowest level that can be reasonably expected to increase organ donation."[4] The studies would involve only cadaveric donations, not donations from live donors, and they would not sidestep the present organ allocation system (as governed by UNOS). UNOS and ASTS quickly responded to the AMA action with

supporting resolutions.[5]

The AMA proposal is based on a utilitarian ethic that is especially clear in the following passage: "Whether or not [incentives] are ethical depends upon the balance of benefits and harms that result from them."[6] A number of opponents agreed with past AMA President Lonnie Bristow when she said, "Please do not be seduced by the idea that the ends justify the means."[7] Rex Greene, an oncologist and a delegate to the AMA's House of Delegates from California, made a similar point when he said, "I would state that, no matter what the outcomes of these studies, it does not answer ethical questions."[8] Despite this strong opposition and in the face of a negative recommendation from the Reference Committee on Amendments to Constitution and Bylaws, the proposal passed.

These are only the most recent episodes in a two-decade-long discussion about whether organs and money can ethically be mixed.[9] The combination of legislative proposals and aggressive support from medical societies indicates that proponents of incentives believe the time is right to move the discussion from the pages of bioethics journals to the public arena. In doing so, they seek to inoculate their proposals against attack by claiming the moral high ground—they ostensibly seek only to advance the interests of desperate patients on waiting lists—and by minimizing the scope of the actions proposed—they propose "incentives," not payments, and only "pilot studies," not policy changes.

This paper responds to the most frequent criticisms of the present altruism-based system, and elaborates on the case for keeping the cash out of transplantation. The arguments canvassed here refer variously both to the cadaveric organ acquisition addressed by the AMA proposal and to the use of live donors—or vendors—which is known as "inter vivos" donation. Although the AMA proposal is only for cadaveric organ acquisition, a natural next step is to consider employing financial incentives for inter vivos donation.

The major alternative schemes proposed for organ acquisition range from fully voluntary to coercive, where "coercive" plans are those that attempt to encourage or force people to do something that they would not otherwise be inclined to do. (See the accompanying figure.) Plans also vary in terms of what they posit about the relationship between physical bodies and the 'self' or 'person.' Some treat the 'person' as having a necessarily embodied existence. In these, 'I' am not distinct from my physical being; body is understood *as* the self. Others treat the body as property, as something distinct from the self that is "owned" by a disembodied (or at least anatomically localized) self. Both of these conceptions range from individualistic to collectivist understandings of identity. For example, the property conception can justify an individual's rights to dispose of his or her body parts ("I own my own body"), or it can be generalized to legitimate disposal by some collective entity ("The State owns my body"). Likewise, "embodiment" can be seen in purely individualistic terms or in reference to a shared identity with some larger social group.

Commodification

Proponents of incentives have repeatedly advanced several critiques of the current altruism-based approach to organ procurement. Three critiques seem to be especially significant: (1) that compensating for organs is no different from many other permissible forms of body commodification; (2) that it is hypocritical to prohibit an activity that you would wish to engage in were you in a similar situation; and (3) that it is unethical not to do everything possible to increase donation because so many die for the lack of an adequate supply of organs.

The worry about commodification is that the buying and selling of human organs would lead to an increasing objectification of the human body. Commerce in organs would encourage people to view individual human beings as saleable commodities and would to that extent compromise and denature human dignity, so the argument goes.[10] Other forms of this concern are voiced in discussions of surrogate motherhood, cloning, genetic testing and therapy,

The key point of contention, in courts of law as well as at the bedside of patients, is whether death immediately ends the body-as-self connection and opens the door to the application of property concerns and the logic of commodities—since the "person" is no longer there, who owns the material body and how much may they profit from its disposition?

and some other topics in biotechnology and medical research.

Yet commercialization advocates have a ready rejoinder: Selling an organ is not different in kind from selling one's labor in other, often quite legal, ways—commercial surrogate motherhood, choosing to work a very risky job, and in some jurisdictions, the sexual service industry. Physical risk, exploitation, or commodification are arguably a matter of degree rather than of kind, and one cannot consistently deny the "choice" of engaging in these other activities while exceptionalizing organ commerce.

However, admitting the similarities (or even ethical identities) between, say, the presumed exploitation of prostitution and the exploitation of organ selling should not be taken as an argument for legally, socially, or ethically embracing all kinds of exploitation. Working as a diamond miner in South Africa is demonstrably dangerous to life and limb; selling the right lobe of one's liver, or a lung, is also demonstrably dangerous.[11] Both force a devil's bargain on the economically desperate of trading life and limb for sustenance. Yet admitting the exploitative and hence ethically objectionable nature of highly dangerous working conditions is not an argument for *expanding* the range of dangerous occupations or risky labor-body exchanges. Rather, objecting to such kinds of exploitation or to the selling of one's labor or physical well-being should be taken as a reason for working to *reduce* the kinds of work or exchange that are so risky.

The concern about commodification takes on additional considerations in the context of cadaveric donation—the sort of donation that the AMA proposal addresses. Most commentators agree that as a matter of law and common morality, inter vivos donations should rely on noncoercive, voluntary organ acquisition plans that endorse what we refer to as the "body-as-self" view. When cadaveric donations are considered, however, commentators differ. Some still prefer voluntary, body-as-self organ acquisition, but some argue for using incentives to encourage donation, and they favor the "body-as-property" view of the organ.[12] The key point of contention, in courts of law as well as at the bedside of patients, is whether death immediately ends the body-as-self connection and opens the door to the application of property concerns and the logic of commodities—since the 'person' is no longer there, who owns the material body and how much may they profit from its disposition? Even scholars sensitive to the significance of body-self integrity seem prepared to accept that death means instant disembodiment of the person and transformation of the body to property, or at least a circumscription of the continuing right of the deceased to have his or her wishes honored in respect to the treatment of the corpse.[13]

We know from a massive ethnographic record that the cessation of biological functions is rarely seen as being commensurate with the separation of the self from the body.[14] The distinction made by social scientists between social and biological death captures the undeniable fact that a person's identity is commonly thought to remain with the body for some time after physical death has occurred. The cultural work achieved by mourning rituals is to complete the disconnection that biological death initiates. This is not, as Margaret Radin would have it, an example of fetishism—a superstitious belief that rational thought ought to banish.[15] Rather, it is a basic human recognition that our 'self', our identity, exists in the space of social relations, and that the ongoing flow of social life necessitates a gradual disaggregation of the deceased from the ties to the living that constituted the social self.[16]

These observations help explain the moral intuition some feel that the commodification of cadavers is abhorrent. It is this intuition that causes medical staff to hesitate when called upon to request a donation, that explains the fear felt by kin that their loved one's body would be mutilated during organ removal, and that makes understandable the reservations felt around the world to declaring a person dead at brain death and permitting cadaveric organ transplantation. The claim that dead bodies "are no longer inextricably intertwined with a person," and are therefore only protected as property,[17] may capture the direction of recent legal interpretations, but it is badly out of sync with the real world and the way families actually respond to the death of relatives. It would be wise to assess plans for acquiring organs against a real world standard, rather than by legal or philosophical reasoning alone.

Reason and Rescue

Inter vivos sales have also been promoted by what could be called the "reasoned ideal" argument. In response to anti-incentive critics, some ask, "But what would *you* do if your child's life depended on your selling one of your kidneys? How can you deny to others a choice that you yourself might make if you were in their circumstances?" This claim often invokes an example of a parent in the developing world who has already lost some of her children to malnutrition or preventable disease. The sale of a kidney can generate the equivalent of ten years' wages for, say, an itinerant Indian worker (although the promised financial gain often fails to materialize, and serious long-term health problems are common).[18] Isn't this just the kind of sacrifice that we generally applaud in developed countries, when a loving parent gives up a kidney to save a child with a life threatening kidney disease?

There is often something to this charge of hypocrisy. However, philosophers who make this charge should take more care to distinguish the arguments that might incline one to sell an organ—such as Kantian notions of a duty to family—from the utilitarian argument that enfranchis-

ing the practice would lead to the greater social acceptance of similar transactions. By way of analogy, consistency does not require that entertaining the proposition, "A parent may save the life of her child by cutting off a leg or selling herself into slavery," commits one to accept an effort to legalize, let alone facilitate, dismemberment or slavery. Two different questions are being asked here: What actions are morally understandable under conditions of desperation, and what social institutions or policies might be ethically justified to accommodate "choices" made under such desperate circumstances.

clearly: "We all have a moral duty to do everything we can to give the living the best possible quality of life.[21]

What's wrong with this claim? First, there is precious little legal or custom-based support for an obligation to rescue those whose organs have failed. Courts in the United States, for example, have repeatedly found that there is no duty to aid a person in need: "The common law has consistently held to a rule which provides that one human being is under no legal compulsion to give aid or rescue or to take action to save another. . . . The rule is founded upon the very essence of our free society."[22]

there are immense numbers of other persons whose lives could more easily be improved or saved with the financial resources required for organ replacement. Even as strong a defender of organ transplantation as Richard Evans must admit that "from a public health perspective, more harm than good has already been done [by organ transplantation]"; in the United States "nearly $6 billion is spent [annually] on a handful of solid organ transplant recipients."[23] We might contrast this expenditure, for example, to the $0.26 per vaccine to immunize against measles, which kills 900,000 children around the world.[24]

The mandate that organs may be removed for transplantation only with consent—expressed or presumed—suggests that even after death there is no presumptive obligation to rescue. Indeed, it is precisely the absence of an obligation to rescue that gives the decision to donate organs its positive moral weight.

Another objection to philosophical arguments concerns what might be called the "rescue obligation." Proponents of incentives—whether arguing for inter-vivos sales or for cash rewards for cadaveric organs (including tax rebates and funeral "stipends" as well as cash paid outright for each organ taken)—frequently argue that the number of persons who die before an organ is available for them presents a compelling moral case for shifting the burden of argument back onto those who support the preservation of the current altruism-based system.[19] Recitations of the statistics on the ever-increasing gap between those awaiting organs and the number of organs available typically preface rhetorical charges of avoidable tragedies, of life-saving body parts being left for the worms, and even of criminal liability for refusals to donate.[20] A letter to the *British Medical Journal* puts the underlying claim

This rule has traditionally been applied to living persons, but the mandate that organs may be removed for transplantation only with consent—expressed or presumed—would indicate that even after death the default assumption is that there is no presumptive obligation to rescue.

Indeed, it is precisely the absence of an obligation to rescue that gives the decision to donate organs its positive moral weight. If this presumption were reversed, say by conscripting cadavers for their organs regardless of dissent, then no moral value would attach to the persons from whom organs are extracted, or from their next of kin. This would introduce a crass instrumentality into organ transplantation that is directly at odds with its longstanding ethos.

The claim that society as a whole has a positive duty to rescue those on transplant waiting lists is actually weakened by utilitarian calculation:

In a world of finite resources for health care, it is hard to argue that the extraordinary expenditure associated with organ transplantation constitutes the best possible way to serve the needs of the living.

A third problem with the rescue claim is that organ transplantation is not the medical miracle it claims to be. Given the severity of the diseases from which transplant candidates suffer and the stubborn reality of organ rejection, many of those who die before receiving an organ might very well have died within several years even with a replacement organ. Survival rates vary significantly by the organ replaced, but the average 20 percent loss of life at the one-year point increases significantly after five years. Furthermore, the profession of transplant medicine has consistently overstated recipients' quality of life and understated the long-term toll of

powerful anti-rejection medications.[25]

A final problem with the "rescue obligation" is that high technology medicine is, more often than not, unavailable to persons whose bank accounts or insurance status are inadequate to the expense. In all of Africa, between 1978-1994, only 163 transplant surgeries were performed; during the same period, over 124,000 transplants were performed in the United States alone.[26] Even within developed countries, the "green screen" determines who gets to the waiting list for organs and who can afford the medications after surgery.[27] If society has a moral duty to rescue, the obligation surely is not limited to rescuing those of means.

Science and Superstition

Many medical professionals believe that the body-as-self conception—especially when it is extended to include the recently dead—is a superstition that must eventually disappear as "scientific" understandings of the body penetrate ever more deeply into the general culture. They point to the growing number of body fluids and parts that are openly marketed—from gametes to skin and corneas—as evidence that, at least in the United States, we are witnessing a shift toward property conceptions of the body and an acceptance of bodily commodification. If this is the case, then one could predict an inevitable trend toward incentives in organ procurement, first for cadaveric and then for living "donations." Indeed, advocates of commerce frequently claim that incentives would cross no new or substantially relevant threshold, since other body parts are already treated as commodities.[28]

But this modernist view of how medical science influences the general culture may be out of step. Physicians and other health professionals come to a disembodied view of the self—if they do—only after the desensitizing socialization of medical school, where the curriculum promotes a Cartesian distinction between mind and body that accords well with the objectification of organ systems.[29] Rather than treating this way of thinking as the inevitable endpoint of a progressive culture, it would be just as reasonable to see it as a clinically useful but culturally aberrant view.

This alternative interpretation is supported by evidence that even those most fully immersed in the world view of modern medicine appear to have difficulty reconciling their scientific understandings of the body with their intuitive responses. How else can one explain why physicians often do not sign organ donor cards,[30] or the ambivalent responses by health care staff to persons declared brain dead or in a persistent vegetative state.[31] The strong dissent voiced at the AMA over the incentive proposal might be taken as additional evidence that even doctors are yet to be fully persuaded by the body-as-property view.

There are other indications that the corpse continues to be treated as integral to the self. Consider the extraordinary investment of time and money in the recovery of the smallest of body parts from the ruins of the World Trade Center, or the public horror occasioned by news of bodies left uncremated at a Georgia facility. Persistent accounts of organ recipients who express concern about the identity and character of the donor, and of donor kin who believe that the deceased lives on in the recipient, also show how firmly rooted in common intuition is the idea that a person's identity is embodied.

Clearly, the AMA's proposal entails much more than an innocent experiment. Rather than doing ethics by pilot study, it would be better to reflect more deeply on where the "is" and the "ought" of incentives line up. There is more at stake than encouraging donation.

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1. H.R. 2090, Help Organ Procurement Expand Act of 2001 (U.S. Rep. C. Smith, N.J.) and H.R. 1872 Gift, of Life Tax Credit Act of 2001 (U.S. Rep. J. Hansen, Utah).

2. S.R. 1949, Organ Donation and Recovery Improvement Act (U.S. Sens. W. Frist, Tenn., and C. Dodd, Sonn.). The language of the bill is most clearly directed toward reimbursement for a wider range of expenses incurred as a result of cadaveric donations, but some believe that the bill would also permit waivers for studies of other forms of financial incentives. See A. Robeznieks, "Feds Have Final Say on Organ Donor Initiatives," Amednews.com, 22 July 2002.

3. As early as 1995, the AMA supported even more extreme proposals for compensating donors, specifically calling for future contracts. American Medical Association, Council on Ethical and Judicial Affairs, "Financial Incentives for Organ Procurement: Ethical Aspects of Future Contracts for Cadaveric Donors," *Archives of Internal Medicine* 155 (1995): 589-91.

4. CEJA Report 1:A-02, "Cadaveric Organ Donation: Encouraging the Study of Motivation," presented at the 2002 American Medical Association House of Delegates Annual Meeting, Chicago, Ill., June 15-20, 2002.

5. See A. Robeznieks, "Feds Have Final Say." By contrast, the American College of Surgeons released a statement in opposition to any financial compensation for organ donations (see "News in Brief," Amednews.com, 29 July 2002).

6. CEJA Report 1:A-02.

7. Quoted in A. Robeznieks, "Boosting Organ Donations Ultimate Focus of Initiative," Amednews.com, 8/15 July 2002.

8. Robeznieks, "Boosting Organ Donations Ultimate Focus of Initiative."

9. See D. Joralemon, "Shifting Ethics: Organ Transplantation and the Question of Compensation," *Journal of Medical Ethics* 27 (2001): 30-35.

10. See D. Joralemon, "Organ Wars: The Battle for Body Parts," *Medical Anthropology Quarterly* 9 (1995): 335-56; and "The Ethics of the Organ Market: Lloyd Cohen and the Free Marketeers," in *Biotechnology and Culture*, ed. P.E. Brodwin (Bloomington, Ill.: Indiana University Press, 2000) for reviews of the arguments of both proponents and critics of organ sales.

11. Admittedly the removal of some organs—most prominently, one kidney—is much less "risky" than is often supposed. Some pro-commerce advocates argue that selling such an organ ought to be placed *lower* on a scale of activities that are risky-but-legal. Of course, in assessing risk, a lot

depends on the economic and medical conditions surrounding the surgery, and advocates of organ commerce point out that these conditions would be less risky for the donor if the practice were legalized and regulated.

12. Thus organ acquisition plans tend to cluster in the upper left and lower right quadrants of our figure, suggesting a powerful connection between incentives and property views of the body. Plans in the other two quadrants are possible. For example, the donor's kin might be offered incentives directly by recipients in a form that builds on the often-stated idea that the deceased lives on in the recipient's body. This plan would fall into the upper right of the figure.

13. See R. Rao, "Property, Privacy, and the Human Body," *Boston University Law Review* 80 (2000): 359 and M.J. Radin, "Market-Inalienability," *Harvard Law Review* 100 (1982): 1849-937; See also the Uniform Anatomical Gift Act.

14. See M. Bloch and J.Parry, eds., *Death and the Regeneration of Life* (New York: Cambridge University Press, 1982), G. Howarth and P.C. Jupp , eds., *Contemporary Issues in the Sociology of Death* (New York: St. Martins, 1996), C. Seale, *Constructing Death: The Sociology of Dying and Bereavement* (New York: Cambridge University Press, 1998) and P. Metcalf and R. Huntington, *Celebrations of Death: The Anthropology of Mortuary Ritual* (New York: Cambridge University Press, 1997).

15. Radin, "Market-Inalienability."

16. Quoted in B. Conklin, *Consuming Grief* (Austin, Tex.: University of Texas Press, 2001), for a recent exploration of this theme in relationship to endocannibalism among an Amazonian people.

17. Rao, "Property, Privacy, and the Human Body," 459.

18. The case of India is instructive since it has been a major locale for kidney sales, which have continued despite belated criminalization. See L. Cohen, "Where It Hurts: Indian Material for an Ethics of Organ Transplantation," *Daedalus* 128 (1999): 135-65. However, many other countries either permit or fail to stop organ commerce. See a series of articles in the National Post Online (29 March, 30 March and 2 April, 2002) authored by journalist M. Jimenez and N. Scheper-Hughes (http://www.nationalpost.com/search/story.html?f=stories/20020329).

19. See J. Radcliffe-Richards et al., "The Case for Allowing Kidney Sales," *Lancet* 351 (1998): 1950-52; J.S. Cameron and R. Hoffenberg, "The Ethics of Organ Transplantation Reconsidered: Paid Organ Donation and the Use of Executed Prisoners as Donors," *Kidney International* 55 (1999): 724-32; and R. Sade, "Cadaveric Organ Donation: Rethinking Donor Motivation," *Archives of Internal Medicine* 159 (1999): 438-42.

20. See M. Lysaght and J. Mason, "The Case for Financial Incentives to Encourage Organ Donation," *American Society for Artificial Internal Organs* 46, no. 3 (2000): 253-56; L.R. Cohen, *Increasing the Supply of Transplant Organs: The Virtues of an Options Market* (New York: Springer, 1995) and R.W. Evans, "How Dangerous Are Financial Incentives to Obtain Organs?" *Transplantation Proceedings* 31 (1999): 1337-41.

21. S. Cansdale and R. Cansdale, "We Know That Our Daughter Lives On," *British Medical Journal* 318 (1999): 1490.

22. J. Rutherford-McClure, "To Donate or Not to Donate Your Organs: Texas Can Decide for You When You Cannot Decide for Yourself," *Texas Wesleyan Law Review* 6 (2000): 241. While U.S. common law has not given rise to any establishment of a "duty to rescue," most European countries have passed such laws. In the United States, five states have legislatively enacted related statutes, though in four of them "duty to rescue" simply means "duty to report a crime," if such can be done without risk to the reporter. Only in Vermont is a person obligated to provide "reasonable assistance" when another person "is exposed to grave physical harm," but again only if such can be done without danger or peril to self or others. See E. Volokh, "Duties to Rescue and the Anticooperative Effects of Law," *Georgetown Law Journal* 88 (1999): 105-14.

23. R.W. Evans, "How Dangerous Are Financial Incentives to Obtain Organs?" *Transplantation Proceedings* 31 (1999): 1337-41.

24. WHO/UNICEF figure cited in *Business Recorder*, 12 April 2001.

25. See D. Joralemon and K. Fujinaga, "Studying the Quality of Life after Organ Transplantation: Research Problems and Solutions," *Social Science and Medicine* 44 (1996):1259-69, for a review of outcome studies.

26. T. Harrison, "Globalization and the Trade in Human Body Parts," *Canadian Review of Sociology and Anthropology* 36, no. 1 (1999): 21-35.

27. For a discussion of post-surgical costs and variable ability to pay, see L. Sharp, "A Medical Anthropologist's View on Post-transplant Compliance: The Underground Aconomy of Medical Survival," *Transplantation Proceedings* 31, no. 4, Supplement 1 (1999): 315-35.

28. According to this claim, whatever justifies the selling of one's blood, for example, would also justify the selling of other body parts, unless these parts are different in kind. Some critics argue that solid organs are different in kind because they are non-replenishable (removal of a lobe of the liver is an exception, since the liver will restore the missing segment) and because their removal represents a greater risk to the donor.

29. The relevant literature is reviewed in D.E. Gordon, "Tenacious Assumptions in Western Medicine," in *Biomedicine Examined*, ed. M. Lock and D. Gordon (Dordrecht, The Netherlands: Kluwer Academic, 1988), 19-56.

30. Lock, *Twice Dead*.

31. See S.R. Kaufman, "In the Shadow of 'Death with Dignity': Medicine and Cultural Quandaries of the Vegetative State," *American Anthropologist* 102, no. 1 (2000): 69-83.