The Role and Problem of Trust in Organ Transplantation and Donation

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DEDICATION

Eluwanaya, ọ were gị ndụ ọzọ, ma ị mere ya. Gwa ụmụnne gị nọ n'akụkụ ọzọ na ị gụsịrị akwụkwọ. Ị mere nke ọma

Eluwanaya, it took you a different lifetime, but you did it. Let your brothers beyond know that you completed your education. You have done well.

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Abstract

Although organ transplantation and donation (OTD) is sometimes described as dependent on trust, within policy discourse, clinical governance and bioethics, trust is often treated as an instrumental condition for public participation, cooperation and approval or for institutional stability rather than as a primary object of ethical analysis and structural and ethical reforms. So while it is true that trust is an instrumental prerequisite for the functioning of the OTD field, trust forms the moral foundation and organising norm of transplant and donation ethics; this thesis contends that trust is the normative foundation that renders transplantation and donation practices and policies morally intelligible. This thesis presents trust as a normative stance of hopeful dependence grounded in shared values and moral expectations maintained under conditions of vulnerability, uncertainty, limited time, and asymmetrical power; herein we entrust – counting on others to act with integrity and care in matters affecting life, bodily integrity and wellbeing.

This thesis develops a systematic philosophical account of trust tailored to the transplant context and suitable for application in transplant ethics. To this effect, trust is distinguished from mere reliance, prediction, or strategic expectation. It is this conceptual clarification that provides the basis for my analysis of organ transplantation as a network of reciprocal entrustments beyond procedural compliance, consent, and allocation rules.

Given this framework, the thesis maps trust relations within the OTD system through a stakeholder-centred analysis and identifies five core objects of trust that articulate the normative expectations that structure participation in OTD: Autonomy, Usefulness, Good Treatment, Appreciated efforts, and Fidelity to Shared Commitment. It is these objects of trust that clarify what is at stake when trust is invoked, and how failures – whether procedural, communicative or structural – undermine the moral integrity of the transplant system.

Introduction

Ethical inquiries in the transplant and donation field have been largely geared towards addressing moral issues that arise from the need to remedy the primary problem of matching the availability of organs (otherwise understood as the supply of organs) with the request for healthy organs (i.e. the demand for organs). While this thesis acknowledges the primary problems of supply and demand for organs, it identifies trust as another primary problem worth attention if we are to adequately address the issue of organ requests and availability. To this aim, this thesis advances a unifying claim: organ transplantation and donation (OTD) is primarily sustained not just by technical expertise, legal regulations, or public goodwill, but by morally fragile relations of trust between and among the stakeholders – donors, recipients, donor families, healthcare professionals and the public as potential donors and recipients. So, while organ transplantation is often praised and recognised as a triumphant biomedical innovation and the preferred treatment therapy for ailments involving dead or dying organs, this work argues that the ethical legitimacy and long-term sustainability of the transplant field and its practices depend on how trust is formed, acknowledged, distributed, enacted and even betrayed within the system. Rather than being a background condition for organ donation and transplantation, trust is the moral backbone of the transplant field. This becomes evident when we see that beneath the narrative of medical triumph and progress lies a fragile moral terrain of vulnerability, uncertainty, death, bodily integrity, existentiality, motivation, immortality, cultural and religious concerns, and profound dependence on others. Essentially, this work argues that the transplant field cannot function ethically, sustainably, or legitimately without a robust, morally responsive, intelligent, and committed trust relation among stakeholders, such that many of the field's deepest ethical problems can be best understood as failures or misarticulations of trust. When trust is breached, misunderstood, instrumentalised, or taken for granted, the transplant field risks becoming morally corrosive despite its efficiency and success; despite its capacity to save lives, transplant practices and policies may undermine the social, cultural, and ethical foundations that make transplant donations possible.

Against prevailing accounts that treat trust as confidence, psychological attitudes, reliance, predictability or institutional credibility, this thesis views trust as a normative stance of hopeful dependence, in which one counts on another to act with integrity and care in matters affecting one's good, without the assurance of control, and in light of shared or assumed moral expectations.

Applied to the field of organ transplantation and donation, trust is a morally attuned, domain-specific stance of ethically motivated dependence, whereby individuals, families, and communities rely on persons, practices, and institutions to act with competence, transparency, integrity, and care in matters concerning bodily vulnerability, life, and death – under conditions of uncertainty and without full control, but with an expectation of moral accountability and shared or acknowledged commitment to the good. With a principled, context-sensitive orientation, trust within the OTD field is marked by a morally grounded readiness to interpret the roles, actions, and decisions of actors as guided by shared commitments to care, respect for human dignity, and fairness, despite the irreversibilities, uncertainties, and asymmetries involved. Herein, trust is presented as a stance or orientation rather than just a feeling, belief or transaction. Instead of limiting trust to strategic reliance or affective hope, the moral expectations of trust are also captured: donors entrust their bodies, families entrust the dead, recipients entrust their survival, and transplant healthcare workers entrust their moral agency to institutional systems.

The central contribution of this thesis is fourfold: First, it shows that trust is not ancillary to transplantation ethics but is constitutive of it. Second, by focusing on a triadic framework involving trustors, trustees and the object of trust, it captures the moral complexity of the transplantation and donation field more accurately than dyadic models, revealing why policy reforms, technological efficiency, or even increased donor registration cannot resolve the transplant crisis unless the moral condition of trust is acknowledged and addressed. Third, it shows that many of the most demanding crises in contemporary transplant systems are best understood as failures in trust-responsiveness and moral recognition, rather than only as policy breakdowns or logistical issues. Fourth, trust in the transplant field is not limited to a single form; depending on the stakeholders involved and the object of trust, there can be multiple trust forms and relations.

Across five chapters, this thesis moves from the historical presentation and critical reconstruction of the transplant field and its narrative presentations, through an analysis of donation motivations and a philosophical account of trust, to an applied ethical analysis and mapping of trust relations in the transplant field using fictional examples and analogies as well as real-world failures in the field. The result is a theory that is both conceptually rigorous and ethically actionable, offering a lens for reimagining organ transplantation as a shared moral project rather than a purely medical field.

Chapter 1: This chapter presents organ transplantation within its historical, ethical and symbolic context, reframing the field as an ethical and existential crossroads, rather than simply a neutral medical solution. Expanding from its conception as a treatment of last resort to its conception as a routine treatment option for organ failure, the transplant field soon became increasingly oriented towards organ replacement, efficiency, and legality, but often at the expense of moral trust and reflections on meaning, vulnerability, cultural and religious significance and moral cost. As shown in this chapter, the expansion of the field has contributed to what I term the "paradox of infinite request," which states that the more organ transplants succeed, are normalised, and relied upon, the greater the demand for healthy organs for transplantation, to the point that availability is outpaced. This paradox reveals that organ scarcity is not a matter of insufficient donors or donor reluctance, and that it cannot be resolved by them. Rather, the paradox reflects deeper ethical and structural dynamics that reveal scarcity as a structural problem and the outcome of how organ transplantation has been depicted, promoted, and positioned within the medical field. Retransplantation, expanded eligibility criteria, institutional incentives, and the presentation of organ transplantation as a near-universal remedy have all contributed to a self-perpetuating shortage. This chapter essentially shapes and reaffirms our understanding of life, death, embodiment, altruism, and moral obligation. It is within these parameters and morally dense terrain that this chapter establishes the guiding insight of the thesis: once transplantation is understood as a morally saturated practice, trust is identified as a necessary condition of legitimacy and practice rather than a secondary concern. Trust, therefore, becomes indispensable, not optional, for sustaining practice and participation in the OTD field.

Chapter 2: In this chapter, I explore how beliefs and narratives about the body, death, and identity contribute to donation motivations. Drawing on philosophical, religious, and sociocultural perspectives, this chapter argues that humans are not merely owners of their bodies but are embodied selves whose bodily integrity carries deep symbolic and moral significance. As such, donation decisions are often about meaning, continuity, respect, and community, rather than just utility.

Analysing the moral narratives that structure donation practices – altruism, duty, reciprocity and solidarity – this chapter argues that donations may never be purely altruistic, given that such decisions are entangled with grief, reciprocity, existential meaning, social belonging, moral identity, social obligation, fear, care for loved ones, and selfish concerns, all of which contribute to having plural motivations. Examining various ethical narratives, this

chapter argues for a broader, more realistic framework that recognises the mixed motivations behind donation decisions. The chapter presents trust as the silent mediator between body, death and donation, securing genuine moral participation.

Chapter 3: This chapter provides the conceptual core of the thesis by developing a philosophical account of trust, which is soon tailored to the transplant context. Herein, I critique various conceptions of trust and identity various types of trust, some of which may exist simultaneously in the transplant field. This chapter develops an account of distrust and mistrust, showing how these relational stances may present within the forms of trust identified. Identifying trust as a normative stance of hopeful dependence and distinguishing it from reliance, prediction, faith, and confidence, trust is understood as being grounded in vulnerability, moral expectation, and the possibility of betrayal. Drawing on feminist philosophy, care ethics and relational theories of trust, this account emphasises that trust is more than just competence; it requires moral responsiveness – not mere reliability, which is particularly needed in transplantation, where stakeholders are exposed to asymmetries of power and knowledge.

Distinguishing trust from blind faith, this chapter argues for trusting intelligently, a form of trust that emphasises transparency, accountability and ethical scrutiny. Trust is presented as a morally demanding relation that must be sustained through visible commitment to care, respect, and honesty, and that structures ethical responsibilities in transplantation and donation.

Chapter 4: This chapter develops an account of trust in the OTD field. By offering a definition and characterisation of trust in the OTD field and identifying various types of trust, this chapter aids our presentation and understanding of trust in the OTD field. Trust in the OTD field is best understood through a framework comprising the following features and characteristics: (1) it is a tripartite attitude; (2) it is role-based; (3) it includes normative expectations from the trustor; (4) it entails the trustor's reliance on the trustee; (5) it involves the trustee's direct or indirect commitments to the trustor's well-being; (6) it is grounded in shared moral standards or, at the very least, the trustee's acknowledgment of the trustor's moral principles; (7) it is relationship-based; (8) it often involves the affective attitude; (9) it involves the participant stance, and; (10) it is domain-specific, allowing us to experience variations of trust rather than a simple static type for everyone involved. Applied to OTD, this conception explains why trust violations provoke moral outrage and moral injury rather than

disappointment. So, when organs are wasted, taken without consent, wishes ignored, or information withheld, what is harmed is not efficiency but moral fidelity.

Chapter 5: This chapter builds on the theoretical framework by examining real-life experiences of trust breakdown in contemporary transplant systems. Through investigative journalism and professional testimony, this chapter examines practices such as bypassing waitlists, opaque allocation procedures, institutional coercion of clinicians, pressuring healthcare professionals into silence, and erosion of informed participation. This chapter integrates my thesis's insights into a systematic mapping of trust relations in OTD, identifying multiple trustors, trustees and objects of trust – autonomy, usefulness, good treatment, appreciated efforts and fidelity to shared commitments. It argues that transplant ethics cannot be captured by a single trust orientation or an all-encompassing principle, nor by single policy fixes. Using a fictional analogy comparing transplant doctors to the Aes Sedai, this chapter explains how invisible constraints, opaque expertise, and limited truth-telling may undermine trust between transplant health professionals and the public, even when intentions are good.

In conclusion, this thesis argues that trust in the OTD field is neither automatic nor replaceable; the field's future depends not only on medical innovations and reform policies, but also on our willingness to acknowledge trust and treat it seriously as an ethical practice. Trust is what makes it possible for bodies to be given, for lives to be saved, and for deaths to be respected. It helps prevent the transplant field from being technically efficient yet morally hollow and ethically unsustainable. Trust in OTD is a moral stance that binds people – relations and strangers – together through vulnerability, solidarity and hope, maintaining the social fabric that makes donation possible.

Contributing to a philosophically grounded, ethically attentive and practical account of trust that clarifies why trust matters, how it fails and what it demands of those who engage in trust relations in the transplant and donation field, this thesis reframes transplantation as a shared moral project, proffering how it ought to be practised in a way that is worthy of the trust it requires.

CHAPTER 1

A FRAGILE CONTINUUM: ORGAN TRANSPLANTATION AS A CROSSROAD OF ETHICS AND EXISTENCE

Introduction

In this chapter, I will introduce the field of organ transplantation and donation (OTD) as a medical treatment and a phenomenon with ethical, legal, religious, cultural, and economic implications. Among the various perspectives on organ transplantation and donation (OTD) that can be understood, I will limit my scope to the ethical evaluation of the field, its practices, and policies. Accordingly, I will provide a preliminary overview of the ethical issues in this area. My discussions will contribute to considerations about the implications of existing practices and policies for the current development and future growth of the OTD field, the sustainability of OTD as a reliable treatment option for conditions related to failing or deceased organs, and society's understanding of OTD as an ethical domain concerning the movement of bodies, the health and well-being of recipients, respect for donors' bodies, consent, and wishes, as well as the enhancement of trust in the medical field as a whole.

I shall divide this chapter into two main parts. The first part will discuss the meaning and history of organ transplantation. Herein, my interest will include evaluations of what organ transplantation means and the implications of the presented conceptualisations on the acceptability of the field, trust in the field, and dependence on the field. By presenting various conceptualisations of organ transplantation, I also proffer answers to the question: 'Why should we increase the availability of organs?'[1]

In the second part of this chapter, I will present a preliminary and holistic analysis of the ethical issues in organ transplantation and donation (OTD), as well as an examination of

[1] Although some may observe that, based on the word choices used, the field of organ transplantation and donation is mainly economic, this is evident in the use of economic and market-related terms to frame the topic—such as "supply of organs," "demand for organs," "organ scarcity," etc.—which tend to evoke certain interpretations, both positive and negative. Regardless, for clearer understanding of the ethical issues involved, I will continue using these terms. Their use predates my research and helps facilitate a quick grasp of the ethical and medical issues in the field. Additionally, employing these terms does not, by itself, signify support for or opposition to any stance. Therefore, my use of these terms does not imply an economic perspective on organs or transplantation. Even when alternative words are chosen to replace the aforementioned ones, they are still open to being interpreted in an economic and market-related manner.

the motivations for donation. This section will discuss the ethical dilemmas in OTD and the plausible paradox that arises from the practices and policies in the OTD field. This section will introduce the role of symbols, images, and bodily rights in our conceptualisation of organs, bodies, and donation, providing insight into the acceptance of and trust in transplant medicine. I will present various motivations for donating, while also highlighting the limitations of altruism as the widely accepted criterion for organ donation. Herein, I argue for a shift in our ethical motivating criteria for donating organs, advocating for a broader conception of altruism that accounts for multiple motivations for a single act of donation, where one may have both egoistic and moral motivations to donate.

1.1 The History and Meaning of Organ Transplantation and Donation

Understanding the organ transplantation and donation (OTD) field requires an exploration into the conceptualisation of bodies, organs, donation and transplantation within the field. As such, a historical insight into the development of OTD provides a valuable introduction into transplant medicine as it offers insights into prevailing ideas, practices, assumptions and ideologies surrounding the body and transplantation. Accordingly, this section will offer brief accounts of the history of organ transplantation and examine the nature of the practice itself.[2]

As I will demonstrate, both the history and practice of organ transplantation make it quite unequivocally clear that the medical field has long been, and continues to be, "fully committed to full-scale organ replacement as a means for extending human life" (Sharp, 2006, p. 245, qtd. in Klinger, 2016, p. 4). In celebrating this medical achievement, we have at times minimised the ethical and social challenges it presents – particularly since most recipient narratives highlight the positive impact of transplantation on their health, quality of life, and survival. As a result, while transplantation has become normalised, and the extraordinary capabilities of transplant medicine, as well as the routine nature of its practices and policies, are often emphasised, we have simultaneously neglected some of the complex dilemmas it entails (Klinger, 2016, p. 4). This tendency is frequently reflected in both our understanding and historical interpretation of organ transplantation.

[2] While my discussions in this section will sometimes touch on arguments about imagistic, symbolic, or metaphoric classifications of organs, the discussions on the imagistic understanding and value of organs will be addressed in a different section.

1.2 A Brief History of Organ Transplantation: Religious and Mythological Inspiration, Contemporary Lore and Ethical Engagement

While it is widely accepted that organ transplantation is a revolutionary treatment therapy for end-stage organ failure, which allows survivors to have a second chance at improved quality and quantity of life (Wilkinson, 2011, p. 1; Laney, 2019; 1-11; Kunte, 2012, pp. 1-5), I posit that an analysis of the history of transplant medicine allows for a more grounded yet expanded view of what organ transplantation is, as well as the field's achievements, breakthroughs, and limitations. The examination of the history of transplantation, I argue, is not limited to the presentation of the field and its practices in the replacement of organs from donors to recipients or the triumph of contributing to recipients' quality of life through successful transplant procedures. On the contrary, the history of organ transplantation presents, among other things, (a) an understanding of the transplant field in terms of its medical relevance and development; (b) the complicated social relations which the field depends on for its continuity; (c) the symbolic, imagistic and narrative implications of the practice; and (d) the ethical dilemmas we are confronted with from transplant practices and policies.

Popularly understood and accepted as a successful life-saving and life-enhancing (in terms of quality of life after transplantation) treatment option for persons diagnosed with end-stage organ failure, for DeSpelder and Strickland (2005), "of all the innovative medical techniques for saving lives of patients who were once considered hopelessly ill, perhaps the most dramatic is organ transplantation" (p. 166 qtd in Aubrey, 2013, p 3). Given the scientific development of the field since the 1950s, when we consider the requirement of moving body parts from one person (usually the dead) to another, the social implications and public reactions to such a radical method of taking from the dead (and the living) to prolong the life of the dying, the ethical challenges of defining and accepting death and the many scandals that have come to the public's attention since the OTD field became an accepted treatment option for dead or dying organs, one would agree with DeSpelder and Strickland that the transplant field really is dramatic.

Even more dramatic are scientific and non-scientific historical accounts of OTD, some of which date back to surgical records from 600 BC and therefore disagree with the view that OTD is an achievement of the modern era, as Robert Troug notes when he states that organ transplantation remains "…truly one of the miracles of modern medicine" (1).

Other historical records date as far back as circa 1550 BC, when the "first written mention of transplantation is attributed to the Ebers Papyrus" on the transplantation of skin grafts for treating burns (Nordham & Ninokawa, 2021, p. 124). From such surgical records, we are also informed of donated tissues used for plastic surgeries (Hamilton, 2012, p. 4, cited in Aubrey, 2013, p. 3). Analysing how the uneasy relationship between medical science and societal values shapes regulations and attitudes towards the use of human remains in education and research, Ruth Richardson (2006) argues for a historical analysis of organ transplantation as one "rooted in the era of body snatching" (p. 163; qtd in Aubrey, 2013, p. 3).

Some non-scientific historical accounts of OTD present the field from a Christian perspective, drawing on biblical lore about Jesus Christ, his Eucharistic celebration, and one of his miraculous healing acts – the reattachment of a severed ear. To this end, one account of the history of organ transplantation can be dated as far back as the moment of Jesus Christ's arrest before he was arraigned before Pontius Pilate. During his arrest, the *Gospel of Luke* states that Jesus healed the ear of Malchus, the servant of the high priest, after it was cut off by St Peter (Luke 22:49-51; John 18:10, New Revised Standard Version; Kuss & Bourget, 1992, p. 10; Hamilton, 2012, p. 4). One may wonder how the supposed reattachment or healing of a servant's ear can be interpreted to contribute to the historical account of organ transplantation. What truly enables us to trace the inspiration behind such medical endeavours is not simply the lore itself, but an engagement with those who have drawn inspiration from it. By including biblical lore, we can underscore how stories have historically served as sources of motivation for and justification of medical pursuits. Through the juxtaposition of significant themes like healing, body restoration and integrity, improved quality of life, as well as moral considerations surrounding the body and its integrity, the story about this healing act Jesus performs highlights the ethical dimensions of organ transplantation, such as sacrifice, trust, and the moral duty to care for others.

To substantiate the above claim and for greater clarity, let us examine the details of the biblical lore interpreted as significant examples of transplantation. In the "healing of the ear," we see a thematic engagement with the restoration of bodily integrity as Jesus quickly heals the ear of the high priest's servant. In this story, Jesus not only presents himself as a pacifist by rejecting violence, but in healing the severed ear, he also restores the servant's body to wholeness. In the context of organ transplantation, this healing act can be said to equate the goal of medical healing, where recipients of organ transplants through donated organs are made whole again as bodily integrity is respected and restored through surgical

sacrifice and care. As such, this healing act is not just a miracle of physical restoration, but also a moral sign of care. Just as the servant, although not a supporter of Jesus and belonging to the company of those who sought to arrest Jesus, becomes a recipient of Jesus's compassionate care, this healing act reveals that trustworthiness and care transcend social boundaries and familiarity. Like the servant, transplant patients often show vulnerability, depending on the goodwill and competence of strangers (donors, donor families and healthcare professionals) with the expectation of healing and respect. In addition, when Jesus chooses to heal the servant in this moment of chaos, despite willingly accepting his arrest and being about to give himself up to suffering and death, we see the theme of sacrifice, which foreshadows the sacrificial dimension of organ transplantation, where the donation of one's body – in death or life – can lead to the restoration of another.

In the Eucharistic celebration, on the other hand, Jesus offers bread and wine as a symbol of his body and blood to his disciples, representing his complete self-gift and sacrifice. This resonates with the ethical imagination surrounding organ donation and the moral narrative that accompanies it, which is the view that one's body or parts of it can be given as a gift—a life-sustaining gift for the restoration of another and supporting their healthy living. Besides being about sacrifice, the Eucharist is also about building a community of trust—a space where people are united through shared participation in Christ's gift and a fidelity to their shared commitment to that gift. Similarly, transplantation connects stakeholders – donors, recipients, donor families, and healthcare professionals – into a community rooted in moral hope, interdependence, and moral responsibility, where trust is essential. In a sense, we can view the Eucharist as a ritualised celebration of care and ongoing life through sacrifice. From this perspective, I argue that the Eucharist reflects the moral call, moral duty, and camaraderie that underpin organ donation and transplantation – the duty to care for the lives of others, even when it involves cost, vulnerability, and deep trust. Just as we are called to see the Eucharist as an act of care and sacrifice that encourages us to remember Christ and his sacrifice, organ transplantation encourages us to view donation and transplantation as acts of care and sacrifice, and donors are to be remembered for their selfless gift.

These stories present an illustrative analogy that deeply resonates with discussions on organ transplantation. Building on the interplay between faith, ethics, and medicine, the story, in general, and the act of healing, specifically, emphasise the restoration and sanctity of

human life. This aligns with the modern goal of transplant medicine: restoring life and function.

Yet another noteworthy religious historical account of organ transplantation places the occurrence at the Eucharistic celebration. Jesus presents his body and blood to his disciples, saying, "Take, eat, this is my body which is broken for you… Drink from it, all of you, for this is my blood of the covenant, which will be shed on behalf of many for the forgiveness of sins" (Matthew 26:26-30, New Revised Standard Version). By giving his body and blood to his disciples, this eucharistic image exemplifies how gift-giving may be oriented toward saving the life of another, where the gift-giver seeks to improve the quality and quantity of the gift-recipient's life by giving a part of their self for the continued existence of the other (Gillet, 2000, p. 252).[3] This is further emphasised when we consider Jesus' instructions regarding the continuous performance of this eucharistic act in memory of Him. This metaphorical sacrificial transplantation ceremony, held countless times daily around the world, may perhaps be understood as aimed at giving people a second chance at living. The imagistic translation of the eucharist as a form of organ transplantation can also be captured in the declaration of Jesus Christ that he is the bread of life: "I am the living bread which came down from heaven: if any man eats of this bread, he shall live forever" (John 6:51, New Revised Standard Version). The Eucharistic celebration, the instruction to continue this practice in memory of Christ and His declaration that He is the bread of life, though metaphorical, captures the essence and practice of organ transplantation. Organ transplantation signifies (i) the gift given which saves life and explores the embodied experiences of man and organ transplantation as the movement of bodies to ensure continued existence and improved quality of life; (ii) the borderless boundaries of transplant medicine where organ transplantation is not to be limited to some select few based on race, social or

[3] Following this theme of seeing organ transplantation as giving a part of the self for the continued existence of the other, consider the biblical narrative of the creation of Eve from Adam's rib (Genesis 2:21–22, New Revised Standard Version). This narrative can be symbolically interpreted as an early example of bodily donation or surgical intervention – although not the consensual kind. While not medical in a literal sense, it inspires reflections on the body as something that can be shared or reconstituted for greater purposes. Similarly, in ancient Hindu mythology, Lord Ganesha's elephant head is often viewed as a symbolic tale of bodily transformation and restoration. Such myths have resonated with surgeons and medical students in regions where these stories form part of their cultural identity, often being cited in public addresses or discussions on medical ethics. Such lore provides a moral and imaginative framework that elevates transplantation beyond technical procedures into the realm of service, sacrifice, and healing, perhaps motivating people to view transplant work as a calling rather than just a career.

political position or economic position, and (iii) respect and memory of both the living and the dead for their sacrifice and gifts.

Nisha Kunte's historical account of organ transplantation shows the development of the field as essentially a medium for moving body parts. Her historical account recounts the first transplantation of a human body part, attributed to Saints Cosmas and Damian, which allegedly took place in a dream. What makes this transplant a remarkable surgery is the fact that it was executed nearly a thousand years after the deaths of the saints (Kunte, 2012, p. 1). Kunte's account of the Saints' miraculous transplant surgery shows the replacement of the contaminated limb of a church servant with the healthy amputated limb of a recently dead black Moor. According to her account, Nisha acknowledges the political and social gap that this transplant was able to close; organ transplantation is introduced as a bridge that connects people of every social background, race, or relationship. By Kunte's narration, organ transplantation is given the status of a "virtuosic and nearly unbelievable act of medical intervention," an act that articulates "the world of 'differences in unity'" (Edwards, 2013, p. 14, qtd in Kunte, 2012, pp. 3-4). It attempts to "create new forms of bodily union by moving parts across established corporeal, cultural, and social borders" (Kunte, 2012, pp. 3-4).

French physician Henri Dutrochet's historical account of organ transplantation dates to 1817, when he wrote a letter to the editor of the *Gazette de Santé* about a supposed skin transplant. This report was based on a story relayed by his brother-in-law, an army officer stationed in India. In the letter, Dutrochet recounts the experience of an army subordinate who sought out and asked to be operated on by the locals, well-versed in skin grafting and surgical nose reconstruction, after his nose had been cut off as punishment. As Dutrochet narrates, "[b]ecause the defect was already showing cicatrization, the wound edges were freshened. One of the man's buttocks, which was to be the donor site, was beaten with an old shoe until a substantial swelling was achieved. From this swollen area, a triangular piece of skin with subcutaneous fat was then cut and placed on the defect. It was fixed in position with adhesive plaster. The graft healed, and the man continued to serve in the brother-in-law's command" (Dutrochet, 1817, p. 91, cited in Nordham & Ninokawa, 2021, p. 124).

While these accounts may present as mere lore or myths, since they lack certainty and we are unable to ascertain the veracity and validity of these accounts, for Kristen Nordham and Scott Ninokawa (2021), the long-standing fascination with transplantation as moving bodies and the connection between humans as embodied beings is demonstrated by these

accounts (p. 124). This is because in these accounts, we see an interest in the restoration of bodily integrity, care, and the healthy continuation of life. Even if these ancient, mythical, and folkloric accounts of body restoration, bodily exchange, and transformation do not meet the standard account with historical certainty or empirical validity, they nonetheless reveal something quite enduring about human interest, imagination, and experience. These stories, whether the miraculous deeds of saints in dreams, mythic healers exchanging or constructing organs, or gods transplanting body parts, all demonstrate a deep and recurring fascination with the body's mutability and the possibility of reconstitution and restoration of bodily integrity. These stories demonstrate that interest in transplantation is not new, and transplantation has long been envisioned not only as a technical intervention, but also as a symbolic act connected to questions about bodily integrity, identity, embodiment, and relationality. By presenting the body as that which can be transferred, repaired, or even exchanged, these accounts recognise human beings as deeply embodied beings whose sense of self and connection to others can be inextricably linked to the integrity and transformation of their bodies. Hence, even when we are unable to confirm their truth or empirical validity, the persistence and recurrence of versions of these stories across cultures, religions, and time periods indicate that transplantation connects with fundamental human concerns such as the desire for restoration and healing, the hope that bodily integrity might be reconstituted through miracles, medical interventions or gifts, and the fragility of life. In the following paragraphs, I shall focus on scientific accounts of the history of the OTD field.

For Cammie Laney, the history of organ transplantation dates prior to the 17th century, with attempts at blood transfusion, first between animals and then between animals and humans. This skill was successfully performed between humans in 1818 and was made safe in 1940. These early tissue transfers mark the start of a growing medical revelation, which soon included skin grafting in 1868 with Jacques-Louis Reverdin's successful skin epidermic grafting and other solid organ transplantation (Nordham & Ninokawa, 2021, pp. 124-125). After this, there are records of successful kidney transplants between animals in 1902 by Abas Carrel, and the first successful human transplant in 1954 by Joseph Murray who bypassed the rejection barrier by transplanting donated organs from a patient's identical twin, helping the patient live for eight more years (Barker & Markmann, 2013, p. 8; Jonsen, 2012, p. 264; Centre for Bioethics, 2004, p. 10). Other notable historical developments of organ transplantation include: the first successful liver transplant in 1966 – the liver worked for over a year; the first successful heart transplant in 1967 where the heart worked for two

years and 6 months; the first successful heart-lung transplant in 1981 with the transplanted organs working for over five years; the introduction and approval of cyclosporine as an immunosuppressant in 1983; the transplantation of a baboon's heart into Baby Faye in 1986; the first successful living-related liver transplant in 1989; the first split liver transplant where one decedent liver donation was split into several pieces to help save more than one person in 1996, amongst others (Centre for Bioethics, 2004, pp. 10-11).[4]

1.3 What Organ Transplantation is

Given our limited understanding of the history of organ transplantation, it can be inferred that the transplant field traditionally involves the transplantation of solid organs (such as skin, eyes, and kidneys) to help save and improve recipients' quality of life. Apart from the transfer of solid organs, the field identifies other types of transplants, including (a) cell transplants such as stem cells, bone marrow, and pancreatic islet cells, and (b) tissue transplants such as skin, tendons, and bone grafts (Rease-Mackey, 2015, p. 18). Although I acknowledge the value of all these other types of transplant practices in saving recipients' lives, for my research, I will limit my consideration of organs to solid organs – specifically kidneys, livers, hearts, and lungs – and focus primarily on solid organ transplantation.[5] These solid organs are retrieved from two types of donors: living donors and deceased donors.

While donations from living donors are limited to kidney donations and liver lobes, decedent donations allow for the acquisition of all or some organs, depending on the donors' consent, the legal regime under which the donor died, and the organs' health. Decedent donations are ultimately donations from persons who have been declared dead either through

[4] It is pertinent to note that the development of immunosuppressants is closely related to the history and progression of organ transplantation. The introduction of immunological drugs to combat rejection not only enhanced surgical techniques but also expanded transplant donation activities beyond allogeneic donations between twins and related family members to encompass decedent donations from both related and unrelated donors, as well as donations from living unrelated donors. As Machado *et al.* (2007) aptly state, the success of organ transplantation "owes its development to advances in surgery and immunosuppressive treatment" (197). Considering the history and achievements of the transplant medical field, the remarkable successes of organ transplantation, despite its numerous challenges, can be attributed to (i) the introduction of immunosuppressants, improved to prolong the life of the transplanted organ (Watson & Dark, 2012, p. 40), and (ii) the reliance on and acceptance of the field by the public.

[5] To further clarify the scope of my research, I would like to note that my interest in solid organ transplantation acknowledges face and hand transplants, as well as larynx, uterus, and penis transplantations – which aim to improve the quality of life of the recipients – as other forms of solid organ transplantations (Caplan & Purves, 2017, p. 797). Irrespective, such examples of solid organ transplantation do not fall within the scope of my examination and analysis of organ transplantation, the ethics of organ transplantation, or my interest in examining trust relations in organ transplantation. Essentially, for my research, my conception of organs and organ transplantation is limited to the transplantation of solid organs like kidneys, livers, hearts, and lungs.

brain death or circulatory death.[6] Brain death accounts for the irreversible cessation of all brain activity, including the brainstem, irrespective of respiratory functions assisted by medical support (Spears, 2022, pp. 1-16). Donation after circulatory death occurs after the irreversible cessation of blood flow or circulatory function in the body, typically resulting from the heart not beating.

Regarding our understanding of organ transplantation, I argue that the transplant field relies on a set of premises for its justification and function. They include (i) the insistence that medicine progresses towards a world in which "the melding of disparate bodies" is natural; (ii) since transplantation has been given the status of a medical miracle – in the sense of us attaining and further developing and specializing this skill to help avoid death and promote healthy living which was once only ever imagined and fantasised about – its necessity has increased hence its development to the status of a competent skill; and (iii) there is a dependence on the brain death criteria while emphasizing nonmaleficence - this lacks public clarity (Sharp, 2006, p.8). Consider S. J. McNally *et al.*'s (2005) recognition of organ transplantation as "one of the great medical successes of our time"; for McNally *et al.*, organ transplantation is the medical treatment option which has revolutionised the treatment of organ failure, so much so that it often allows the recipients to resume a normal lifestyle (p. 631). For Robert Truog (2007) and C. T. Lazzaretti *et al.* (2004), organ transplantation is one of the miracles of modern medicine; a medical treatment option that improves the multidimensional quality of life (p. 1; p. 91).[7] For Lesley Sharp (2006), it is by relying on these and other assumptions that the transplant discourse asserts its usefulness (p. 9). This can be seen in recent expressions about "avoiding waste" and acknowledging organ transplantation as another form of recycling, where the object of recycling is biological materials. Associated with this growing sentiment of avoiding waste and recycling organs is

[6] When we consider the conditions of death and the organs eligible for transplantation, these are the two main types of death legally and morally recognised.

[7] It is worth noting that Truog and Lazzaretti *et al.* do not use the term "miracle" in any interesting sense; they rather use it to emphasise organ transplantation as something quite successful. While this may seem somewhat disappointing, considering what one would expect from the term 'miracle,' the emphasis on the success of the transplant field appears to be the primary reason why it is often considered a medical miracle. Essentially, the fact that organ transplantation overcomes past medical limitations and achieves scientific breakthroughs by offering a life-saving solution to end-stage organ failure, thereby transforming death sentences into opportunities for healthy living and improving the quality of life for patients, is what makes it a medical miracle. Its recognition as a successful way of preserving life and avoiding death makes it a miracle. As Grinyó (2013, p. 1) rightly posits, "organ transplantation may be considered a miracle of twentieth-century medicine. By increasing life expectancies and improving the quality of life, it remains the best therapy for terminal and irreversible organ failure." Grinyó, J. M. (2013). Why is organ transplantation clinically important? *Cold Spring Harbour perspectives in medicine*, *3*(6), a014985. https://doi.org/10.1101/cshperspect.a014985.

the belief that organs are essentially mechanical entities or parts, the value of which is not limited to only when one is alive; they can be used to replace bad or worn-out parts and should be used even after death (Klinger, 2016, p. 4).

Acknowledging that the OTD field requires and relies on radical shifts in our conception and value of the body, organs, and death, I opt for an understanding and conception of organ transplantation that captures not only the benefits of the field but also its limitations. As such, I see organ transplantation as primarily a medical treatment option that involves the replacement of dead or dying organs with healthy organs from living or recently dead persons.[8] Reiterating this view, the University of Minnesota Centre for Bioethics (2004) defines organ transplantation as "a surgical operation where a failing or damaged organ in the human body is removed and replaced with a new one" (p. 5).[9] For Margaret Horvat, organ transplantation is justified by the possibility of life it presents, despite the risks associated with the treatment (Catsanos *et al.*, 2016, p. 66, qtd in Horvat, 2018, p. 4). In the same light, The *Madrid Resolution* resulting from the 'Third World Health Organisation Global Consultation on Organ Donation and Transplantation' describes organ transplantation as a "cost-effective, mainstream, and a cardinal feature of comprehensive health services"; an effective treatment for irreversible end-stage organ failure (World Health Organisation. The Madrid Resolution on Organ Donation and Transplantation. *Transplantation* p. 91). I agree with Kunte's conception of organ transplantation as the physical reorganisation of the fleshy material of bodies; the material reconfiguration of the biological boundaries between bodies; and the reshaping of social and ethical possibilities of using certain bodies as resources for

[8] Horvat gives a similar definition when he states that organ transplantation occurs "when an organ or a part of an organ is removed from a donor, either from a living person or a recently deceased individual, and placed into another person whose organ is no longer functioning properly" (2018, p. 4). While this definition simply states what organ transplantation is – the movement of body parts – it gives a sense of the physical, social and ethical limitations of this practice in the definition. This can be found in the keywords used: *medical treatment, healthy organs, living, and recently dying*. Not only are we presented with beneficent ideals, but we are also made aware of possible maleficent actions.

[9] We must note that although my definition suggests that organ transplantation is the replacement of organs between humans, organ transplantation can also be interspecies, capturing the transplantation of organs from animals to human patients. While transplantation between humans is regarded as allotransplantation, transplantation from animals to humans is regarded as xenotransplantation. For the purpose of my research and to limit my scope of interest, I have chosen to focus on organ transplantation as the replacement of dead and dying solid organs from one human being to another human being. Although transplants from animals to humans can be regarded as organ transplantation, not all types of transplants fall into this category. While genetically modified porcine grafts can be regarded as organ transplantation in the form of xenotransplantation, bovine grafts (xenografts) do not count as organ transplantation because what is retrieved is a tissue not an organ, the tissue is non-living and only functions as a scaffold, so instead of replacing a body part, the processed bone is used as a framework that encourages the recipient body's own cells to grow and regenerate and overtime, the natural bone tissue of the recipient replaces the graft material.

the lives of others (2012, p. vii). Kunte's definition of organ transplantation situates the discipline strictly in the human domain, which helps limit our understanding and application of the concept. In addition, through Kunte's conception of organ transplantation, we are introduced to the two primary concerns that may limit the growth, success, and functionality of the field: the availability of bodily materials and the trust relations between stakeholders who comprise this discipline. From the first concern, we are led to wonder about ways to increase the supply of transplantable organs and donations. From the second concern, we are led to wonder ways to keep the transplant field dependable and committed to its goal while remaining available to all and devoted to the integrity of its stakeholders,[10] despite attempts at reshaping the social acceptability of transplant policies and procedures, as well as ethical possibilities of using certain bodies as resources for the lives of others. Organ transplantation "conjures up vivid associations and re-articulations of the relationship between self and other… of what it means to be and have a human body" (p. vii). It is the "profound transformation of bodies where the objectified other is the very thing that allows for the continued life of the self" (p. vii).[11]

1.4 Why Increase the Supply of Organs?

While there has been significant literature on the reasons for the increase in requests for healthy organs for transplantation and the reasons for the gap between these requests and the availability of healthy organs, relatively little has been written on the reasons why we should increase the availability of organs. Some of the notable reasons for the increase in the request for organs include: (a) the increase in persons with end-stage organ failures brought about by the increasing rate of obesity and comorbidities (like diabetes) associated with a higher incidence of end-stage organ failure;[12] (b) a larger proportion of the population being

[10] By the main players in the OTD field, I mean (i) the donors, (ii) the recipients, (iii) the families of donors and recipients, (iv) the public (as prospective donors and recipients) (v) transplant medical personnel, and (vi) the government – through the institutions and individuals responsible for regulating and developing rules and policies for organ acquisition and allocation (Laney, 1999, p. 14). The ethical issues that arise from the interplay of these players' roles in organ transplantation include, but are not limited to, views and beliefs about the body, death, symbolic interpretations about organs and transplants, as well as the practices and policies that encourage the growth and sustainability of the field in general.

[11] And understanding organ transplantation this way makes us aware of the ethical and social problems that arise and can be anticipated from this vastly praised yet problematic medical practice.

[12] The global increase in chronic diseases such as diabetes, hypertension, and cardiovascular conditions significantly contributes to the demand for organ transplants. For instance, over 34 million Americans are living with diabetes, a condition that significantly increases the risk of kidney and heart failure. Additionally, an estimated 129 million people in the U.S. have at least one major chronic disease, with chronic diseases responsible for seven out of every 10 deaths in the country. For further reading, see Reports, V. M. (2025). Organ and Tissue Transplantation and Alternative Market 2025 | Forecast, growth &

of elderly age and in need of healthy organs to ensure improved quality and quantity of life (Voo, 2014, p. 14; Wilkinson, 2011, p. 5); (c) technological advancements in surgical procedures and improved surgical minimally invasive techniques have enhanced transplant success rates and made patients more willing to opt for transplant surgery, resulting in higher demand; (d) the influence of government campaigns and policies aimed at increasing awareness and donor registries as well as the positive effect of successful organ transplant rates; and (e) the growing interest in conquering death rather than accepting it and the supposed possibility of a second chance at living (Walter, 2014, p. 13).

According to Martin Wilkinson (2011), whatever the identified reasons for the increase in organ transplants, it is impossible to quantify this increase, even with the available data. This is because while there may be a shortage of healthy organs for transplants, it is hard to define the shortage partly "because the statistics are either difficult to get or soft and partly because the concept of 'shortage' is itself open to interpretation" (Wilkinson, 2011, p. 3). Therefore, since we are unable to quantify this suspected increase, we inherently lack a method for calculating it. Following Wilkinson, this would mean that all that we are left with are data from organ regulatory boards which show the number of persons in need of organs as well as successful transplant surgeries, from which we assume that there has been a rise in the number of persons in need, based on the total number of patients yearly (Wilkinson, 2011, p. 3). While Wilkinson's view seems true in one sense, it seems less likely in another sense: although we are unable to have an exact calculation of the so-called increase in requests for organs, the available soft data have been quite useful in determining whether the need for organs is static, less, more, or even greatly less or more. Furthermore, if the need has clearly increased significantly, as several studies and data indicate, then perhaps that's all we need to know. After all, it is based on such soft data that Voo commits and defends the view that supply has been static. It is also such soft data that Wilkinson relies on in evaluating the reasons for the increase in organ requests and the limited available organs to match them (Voo, 2014, p. 14; Wilkinson, 2011, p. 6). While it is not the case that organs are failing us more now than ever (at least, I have yet to find literature and evidence for the claim), it is the

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Key Opportunities in the United States. In *Verified Market Reports*. https://www.verifiedmarketreports.com/product/organ-and-tissue-transplantation-and-alternative-market, and Maximize Market Research Pvt Ltd. (2024, January 11). *Transplantation Market: Industry Analysis and Forecast 2030*. MAXIMIZE MARKET RESEARCH. https://www.maximizemarketresearch.com/market-report/transplantation-market/187076.

case that more individuals are becoming receptive to the option of organ transplantation, thanks to the growing success of surgeries and survival rates of recipients and living donors.

Regarding the limited literature on the reasons for the increase in organ availability, I argue that this is partly because, among transplant doctors, researchers, and bioethicists, there seems to be an obvious practical answer. Since there is a need for organs, there are requests to match that need. While this may be the case, some readers might wonder if such a resolution is enough to increase the availability of organs, causing them to ask: Isn't this an oversimplification of why we should aim to increase the availability of organs? Although I hold the view that the need and request for organs justify our need to increase the availability of healthy organs for transplantation – mostly in consideration of the good that this act presents and promises – a better explanation resides first in the nature of transplant medicine as a preferred treatment therapy (for saving lives and improving the quality of life), and second, in the nature of organ transplantation as a medical field that creates a double-edged sword where its growth and dependence reflect its limitation as a result of the necessary materials needed for its success.[13] Hence, I argue that the reasons for increasing the supply of organs can be found in our understanding of organ transplantation itself. For example, I see organ transplantation as a good that helps us remedy the social ill brought about by failing organs. As a good, it transcends social identities, cultural backgrounds, races, and sexualities, binding us together through what we have in common and contributing to the overall health of the community. Understanding organ transplantation in this way and being aware that there are not enough viable organs to help everyone,[14] it becomes a given why we need more organs, and why we need to increase the supply.

In the same light, consider the view of Martin Wilkinson (2011), who states that organ transplantation is a "medium-scale branch of medicine" that involves replacing "patients' failing or failed organs with new ones from other people" (p. 1). Based on Wilkinson's understanding of organ transplantation, he argues that one reason to increase the supply of organs is to keep the option of organ transplantation open, as a routine and preferred treatment rather than merely an experimental therapy. Similarly, viewing organ transplantation as the "treatment of choice for most forms of organ failure," Maureen Martin

[13] Wherein, the 'necessary materials' depended on for its success are solid organs.

[14] There are not enough good to help remedy every social ill brought about by dead or failing organs. As a result we are challenged with limited organs to help save the 16yr old valedictorian who needs a kidney, the 35yr single father who needs a liver, the 57yr old grandmother who needs new lungs or the 25yr old college student who needs a cornea to regain sight.

(2000) suggests that increasing the supply of organs may help create a stable donor pool, which would also benefit advances in immunosuppression and transplant technology. Furthermore, Nisha Kunte (2012), who regards organ transplantation as a "virtuosic and nearly unbelievable act of medical intervention" that articulates "the world of 'differences in unity'" (pp. 3-4), believes that reasons for increasing organ supply include encouraging the creation of new forms of bodily union that transcend established borders (pp. 3-4). For Kunte, expanding the organ supply will foster solidarity in preserving the lives of fellow embodied beings by making the objectified other the means for the continued life of the self (p. vii). Additionally, another reason for increasing organ supply might be to improve population health and, in some respects, to demonstrate the public's interest, dependence, and trust in the transplant system.

1.5 Preliminary Understanding of the Problems and Motivations

Although the accomplishments of the transplant field have contributed to its recognition and appreciation, it is often argued that the OTD field is a victim of its own success. As there is an ever-increasing demand for transplants, a corresponding need arises for an increase in donated organs – both from decedent donors and living (related or unrelated) donors. This is a result of the fact that the OTD field depends on the willingness of people (living or dead) to donate their organs to people in need (Banner p. 133) and the status of the relatives of potential donors to "remain the critical link in maintaining organ supply" through their veto power and ability to influence the decision to donate (Sque *et al.*, 2005, p. 134).

To address the growing need for organ availability to meet demand, transplant teams have had to expand their criteria for accepting organs over time. These expanded criteria have enabled the inclusion of donors of advanced age, those with various medical and mental illnesses in a range of conditions, as well as the acceptance of organs that have been denied or rejected by other transplant centres. On one hand, this may be viewed positively, as broadening the acceptance criteria increases the donation pool. On the other hand, expanding the criteria for organ retrieval and donation raises ethical concerns that not only jeopardise the growth and practice of transplant medicine but also challenge social, cultural, religious, and moral beliefs. The consequence of these concerns is a growing scepticism towards transplant medicine in general and transplant doctors in particular, an increase in distrust

between the primary stakeholders in transplant medicine, as well as rising public anxiety regarding the scientific definition of death, which differs from the commonly held norm.[15]

In this section, I will attempt to introduce some ethical issues in OTD. To do this, I will first present the field of OTD as a moral dilemma and a paradox. It will be helpful to examine some of the ethical issues in OTD that will be discussed as this thesis develops. Considering the imagistic and symbolic effects of our understanding of OTD, this section will also explore the symbolic meaning of organs. Our motivations to donate will be evaluated here, with a focus on motives such as altruism, solidarity, and psychosocial interests.

1.6 Moral Dilemmas, Paradoxes and Lies: Reasons for Increased Organ Request

The field of OTD sometimes relies on paradoxical premises that seek to emphasise that the transfer of body parts to save lives is "normal", yet the field is dependent on the conceptualisation of transplantation as a "medical miracle".[16] This dual characterisation of organ transplantation can be seen as a genuine paradox because both frames – i.e., the normal and the miraculous – though logically incompatible, are both necessary for the transplant system to function. By a paradox, I mean two seemingly contradictory but true propositions that coexist simultaneously. In organ transplantation, a paradox may arise when society holds that both ideas are true simultaneously. Consider the following examples:

- For the growth of the transplant system and field, organ donation must be normalised and stripped of its supernatural mystique to encourage widespread participation.

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[15] For empirical research on this, see Irving, M. J., Tong, A., Jan, S., Cass, A., Rose, J., Chadban, S., Allen, R. D., Craig, J. C., Wong, G., & Howard, K. (2011). Factors that influence the decision to be an organ donor: a systematic review of the qualitative literature. *Nephrology Dialysis Transplantation*, *27*(6), 2526–2533. https://doi.org/10.1093/ndt/gfr683; Nayak, V. C., & Nayak, S. (2023). An empirical investigation on the impact of attitudes towards organ donation in India. *F1000Research*, *12*, 463. https://doi.org/10.12688/f1000research.131652.2; Russell, E., Robinson, D. H. Z., Thompson, N. J., Perryman, J. P., & Arriola, K. R. J. (2011). Distrust in the healthcare system and organ donation intentions among African Americans. *Journal of Community Health*, *37*(1), 40–47. https://doi.org/10.1007/s10900-011-9413-3; Ehtuish, Ehtuish F.A.; Baker, Abdalrazag. Understanding the Hesitancy: A Study on Reluctance Towards Organ Donation. Arab Board Medical Journal 25(2):p 53-61, May-August 2024. | DOI: 10.4103/abmj.abmj_3_24.

[16] For details about organ transplantation being a medical miracle, see Jonsen, A. R. (2012). The Ethics of Organ Transplantation: A Brief History. *The AMA Journal of Ethics*, *14*(3), 264–268. https://doi.org/10.1001/virtualmentor.2012.14.3.mhst1-1203; *Guest editorial: The hope and promise of transplantation | British Columbia Medical Journal*. (n.d.). https://bcmj.org/editorials/guest-editorial-hope-and-promise-transplantation?; Murray, J. E. (1990). *The first successful organ transplants in man*. (n.d.). Nobel Prize Lecture [Video]. NobelPrize.org. https://www.nobelprize.org/prizes/medicine/1990/murray/lecture.

- For the transplant field and system to be revered, and to retain the moral weight of acts of donations, it must be viewed as an extraordinary, miraculous gift of life.

The normal-miraculous paradox may arise in the nature of brain death, wherein people hold the following view:

- **Normalising view:** by defining brain death as the final biological death of a person, medical and legal professionals allow for increased organ procurement. As such, the retrieval of organs from brain-dead donors is presented as a routine, but sad medical procedure.
- **Miraculous view:** For grieving families, the image of their loved ones in the hospital beds with warm skin, beating hearts and chests rising and falling, indicating breathing – although attached to machines that aid respiration – contradicts this normal medical definition of death. They are asked to consent to a procedure which they recognise as part of a miraculous process that forces them to reconcile the finality of death with the continuity of their loved one's body in another person.

The paradox is seen in the inconsistency between the normalcy of brain death and the public's lack of clarity on how the retrieval of organs from brain-dead persons is not a maleficent act that causes the death of people. So, while some members of the public agree that brain death is death, and they agree that transplantation is a miraculous act where the organs of their loved one can be used to save lives, they are unable to reconcile these beliefs with the physiological state of their brain-dead loved one (Sharp, 2006, p. 8). Avilés, *et. al.* (2023) give examples of people who hold various forms of this paradoxical view; while some donor families express normalcy in death itself, and see donation as a miraculous way to save lives through the death of the loved one, others express normalcy in the act of donation itself, but consider the possibility of being given a second chance to life through the donated relative's organs a miracle (pp. 6508–6515).

The normal-miraculous paradox may arise in donation motivations:

- **Normal for public campaigns:** While public campaigns are designed to increase donor registration and encourage positive donation decisions for donor families in cases where the deceased did not previously give consent, they also portray donation as a normal practice. The decision to become a donor is presented as a simple,

straightforward, rational choice that requires a simple act: checking a box on your driver's license application or health card to show positive interest.

- **Miraculous for media and emotion:** The media, on the other hand, presents the transplantation as a dramatic, miraculous and heroic event – a last and altruistic effort to save a life. Media stories emphasise the extraordinary nature of the gift given selflessly and the miraculous recovery of the recipient. This presentation often tugs at the emotions of the public, creating anxiety for potential donors who want their organs to be treated respectfully, too, and be put to good use.

This paradox between the normal and the miraculous may also arise in the relationship between donors and recipients. While the normalising view shows how the transplant and medical system often see and treat organs as medical resources, intending to depersonalise the exchange such that most recipients do not know their donors, the miraculous view shows that the psychological and cultural narratives around donation and transplantation are highly personal. This is because donor families and recipients often view organs as living parts that carry the donor's identity or spirit, such that there have been anecdotes of and discussions about recipients who take on traits of their donors. This counters the medical view that organs are just normal tissues and cannot lead to such experiences as recipients claim. The situation is paradoxical because to tackle the problem of organ shortage, both narratives need to exist simultaneously. To maximise efficiency and maintain public trust, the medical system needs to treat transplantation as a normal (standard) procedure; however, the emotional, social and moral weight of the act ensures that it remains a miraculous and extraordinary event, most especially for the grieving donor families, living donors, grateful recipients and members of the public as potential donors or recipients.

While the OTD field relies on these and other assumptions to assert the usefulness and inevitability of the transplant field, for Alexandra Manzei (2015), it is such assumptions that are responsible for the ethical issues that the transplant field faces, as well as the feigned importance that the transplant field ascribes to itself as the preferred treatment option. As such, Manzei identifies other reasons for the increased request for organs other than (i) increased interest in the OTD field as a result of its success, (ii) increased rate of obesity and comorbidities associated with end-stage organ failure, or (iii) increased population of the elderly.

For Manzei, the reasons why the request for organs continually increases is a result of (i) the flawed conception and presentation of brain death; (ii) the fact that OTD is considered the most effective therapy for several diseases, replacing such other therapeutic approaches as the management of acute and chronic hepatic diseases; (iii) the fact that there are more organ rejections from unrelated donors than we are led to believe which result to people re-entering the transplant list; (iv) the fact that the number of multiple organ transplantations is also rising continuously like in patients with type-1 diabetes who, for a better chance of recovery, often receive new pancreas *and* kidney at the same time; and (v) the fact that transplant hospitals must carry out a minimum number of transplants to avoid losing the right to transplant organs (2015, pp. 134-135).

While Manzei's assumptions hold true in some cases, in other instances, he appears to have overgeneralized his fears and concerns, given his experience in the transplant field in Germany and the 2012 scandal.[17] More specifically, contrary to Manzei's view, rejections from unrelated donors are not as rampant as he would have us believe; this is a result of the development of immunosuppressants. We must note that, in addition to hyperacute rejections being rare due to reliable modern pre-transplant screening techniques, which help detect antibodies to prevent rejection early, there also exist effective immunosuppressive therapies that carefully monitor for early signs of rejection, as well as optimal strategies for improving the quality of grafts and reducing the risk of chronic rejection. Manzei's claim that transplant hospitals are required to perform a mandated number of transplant surgeries to maintain their license warrants further clarification. The requirement serves not only as a regulation but also as a mechanism for ensuring that hospitals and transplant institutions maintain and preserve the expertise necessary for surgical procedures and post-transplant patient care. With sustained experience and expertise in organ transplantation practices, care and surgeries, we can enhance and ensure positive surgery outcomes and patient care, thereby reducing

[17] The transplant scandal in Germany (2012–2013) involved the manipulation of organ transplant waiting lists at several hospitals – including Göttingen, Regensburg, and Munich – where physicians falsified medical data, such as liver function results and dialysis status, to give certain patients higher priority for transplants (Deutsche Stiftung Organtransplantation, 2013, p. 4). Although motivations varied from institutional pressure to improve transplant success rates to perceived moral obligations toward particular patients, the revelations severely undermined public trust in the German transplant system, leading to a more than 15% decline in organ donation rates (Deutsche Stiftung Organtransplantation, 2013, p. 5). The scandal prompted legal and regulatory responses, including stricter oversight by the German Medical Association and revisions to transplantation laws aimed at increasing transparency and accountability within the allocation process (Deutsche Stiftung Organtransplantation, 2013, p. 6; Stark, 2013, p. 9). While some physicians faced criminal charges, many were ultimately acquitted due to the difficulty of proving intent or direct harm, which further complicated public perceptions of trust and fairness in organ donation.

complications, preserving bodily dignity and respect, and improving overall transplant success rates. After all, hospitals and transplant centres that frequently perform transplant surgeries tend to develop well-established and valuable protocols, have more experienced surgical teams who are aware of the commitments expected of them and are dedicated to preserving the norms that their field of expertise requires, and a robust support infrastructure – all of which contribute significantly to minimising such risks as organ rejection and post-operative complications. This standard, therefore, aims not only to fulfil a licensing requirement but also to ensure that transplant centres are equipped to provide optimal care, informed guidance, and a safe, respectful experience for patients undergoing transplantation and donation.

Manzei's argument that brain death does not truly exist, and his resulting claim that it is inherently ambivalent, stems from a narrow focus on defining brain death as separate from other forms of "natural death" rather than examining the conditions under which brain death is legally and morally recognised. By doing so, he limits his understanding of brain death (2015, pp. 131-134). Despite evidence to the contrary, Manzei conflates the death of brain-dead donors with the act of organ removal, yet he paradoxically justifies it only in cases where individuals explicitly opted into donation before their death, rejecting it in opt-out systems (2015, pp. 132-133). This inconsistency suggests that his disagreement with brain death is not absolute but depends on consent structures – implicitly accepting brain death as "natural" when prior consent is given. Moreover, Manzei assumes a deep public misunderstanding of brain death, arguing that most individuals who are aware of brain death and post-mortem donation mistakenly believe they can donate organs days after their confirmed death. In other words, he suggests that prospective donors believe their organs remain viable for transplantation long after their bodies have been transferred to a mortuary (Manzei, 2015, p. 128, p. 134). However, his claim lacks substantial evidence, and existing research indicates that such misconceptions, if present at all, are held by only a small percentage of the public with limited knowledge of transplant systems, policies, and medical protocols. Contrary to Manzei's assumption, individuals who opt to be organ donors do not necessarily anticipate dying in a manner that results in brain death, nor do they explicitly foresee a death scenario that aligns with the clinical criteria for brain death.

While donors may hope that their deaths will ultimately enable them to contribute through organ donation, they are not, as Manzei suggests, blindly driven by a saviour complex that renders them oblivious to the specific conditions required for donation to occur.

Contrary to Manzei's pessimistic view, I argue that prospective donors who voluntarily choose to donate their organs do so with an awareness of the medical and ethical circumstances that make such a donation possible. The Dead Donor Rule (DDR) – which mandates that a patient must be legally declared dead before the removal of life-sustaining organs for transplantation (Truog & Robinson, 2003, pp. 2391-6) – exists precisely to safeguard individuals from being exploited as mere means to prolong the lives of others. Public awareness of this rule reinforces the moral principle (i.e. nonmaleficence) that it is fundamentally wrong to take one life to save another, *ceteris paribus*. While a very limited number of prospective donors are aware of the ethical safeguards and legal frameworks of OTD,[18] for persons who consent to be donors, it can be rightly assumed that their decision to donate does not stem from a naïve belief that their organs will be taken prematurely (even if some donors may be indifferent about such a possibility) while they are still alive or the belief that their organs will remain viable to be collected in a morgue, long after death has occurred, as Manzei wrongly assumes.

Although some aspects of Manzei's account of the rising demand for organs and the continued reliance on transplant medicine as the primary treatment for organ-related conditions may be problematic, I agree with both Manzei and Sharp that the ethical challenges within the organ transplantation and donation (OTD) field stem from the very nature of the field itself, along with its governing practices and policies. Beyond the concerns raised by Manzei and Sharp, I have identified additional ethical dilemmas and paradoxes that further complicate the landscape of organ transplantation and donation:

1.6.1 Dilemma 1 – *Acceptance and Scepticism*

I. Members of the public largely accept organ transplantation as a therapeutic method for prolonging life and health, and depend on this method.

II. Members of the public are sceptical about trusting some of the players in the organ transplantation field.

[18] In 2019, a survey by Canadian Blood Services found that while 90% of Canadians support organ donation, only 32% had registered their intent to donate. For this research, the gap between support for donation and registered donors suggests a lack of awareness or understanding of the processes and ethical considerations involved (Canadian Blood Services, 2019). Similarly, Kaitlyn Knickle *et al.* (2019) indicate that many Canadians are unfamiliar with the legal aspects governing organ donation. For instance, a study published in the *Canadian Journal of Kidney Health and Disease* found that only 20% of participants were aware of the laws governing organ donation in their province (Knickle *et al.*, 2019). Additionally, a study conducted in Ontario found that only 25% of respondents felt they had sufficient information to make an informed decision about organ donation (Trillium Gift of Life Network, 2018).

At the heart of many ethical challenges in the field of organ transplantation and donation (OTD) lies a fundamental moral problem: trust. The trust relations between members of the public and the transplant field (and by extension, the transplant system and medical professionals) plausibly present as one of the primary reasons for the persistent lack of transplantable organs. The Institute of Medicine emphasises that the success of the transplant field relies on public trust, as the public's perception of the transplant system as ineffective or unfair diminishes their willingness to donate. Focus groups and opinion surveys consistently identify distrust or mistrust as common reasons for non-donation, especially among individuals who perceive themselves as socially marginalised (Institute of Medicine, 2006, p. 82). Dubois and Anderson's (2006) empirical study found that public concern is linked to the fear that life-sustaining treatment might be withdrawn too early, underlining the relationship between trust in the transplant system and concerns about medical practices. For Dubois and Anderson (2006), specifically, 21% of respondents feared that a chance of recovery could be lost, and 20% thought the process resembled murder or suicide (as cited in Institute of Medicine, 2006, p. 82). Similarly, Ghoshal *et al.*'s (2022) cross-national study, which investigated medical mistrust in organ donation, found that higher levels of mistrust correlated with lower willingness to donate organs, with concerns including fears of premature organ retrieval and doubts about the fairness of organ allocation procedures (Ghoshal *et al.*, 2022, p. 5). In qualitative research, interview respondents often express worries that doctors will not do everything possible to save them and that donated organs will not benefit people in their own minority group (Ethics of Deceased Organ Donor Recovery - OPTN, n. d.). Research shows that many studies on deceased donation have identified common attitudes: increased distrust of the healthcare system overall and specific distrust related to organ donation. A scoping review analysing international data revealed that conflicts with healthcare professionals during hospital stays or distrust in those involved in the donation process accounted for 8.3% of reasons for opposition to organ donation (SciELO, 2024). Similarly, in China, public discourse on social media demonstrated that users with negative attitudes towards organ donation mainly distrusted the medical system, fearing improper trading of donated organs (Xiong *et al.*, 2021). Meanwhile, in Kentucky, a widely publicised incident where a man was mistakenly declared dead led to a significant rise in individuals revoking their organ donor registrations. This event highlights how medical errors can severely undermine public confidence in the OTD system (Associated Press, 2024).

However, this lack is not solely a matter of insufficient willing donors. There are two additional factors at play: (i) by its very nature, the material required for transplantation—human organs—is not readily available in sufficient quantities, given the current sources of donation, and (ii) not all donated organs can be successfully transplanted, regardless of the increasing willingness to donate. While an expanded donor pool may suggest greater organ availability, it does not necessarily mean that the need for organs will be met. The reality is that not every donor's organs will be viable for transplantation. The conditions and circumstances surrounding an individual's death determine whether their organs can actually be used, meaning that the mere increase in the number of registered donors does not automatically translate to an increased number of transplantable organs. The problem, therefore, is not simply a matter of having too few donors or, as Manzei argues, too few deaths, but rather that not enough donors die under the precise medical conditions required for successful organ retrieval and transplantation.

In *Acceptance and Scepticism*, we see how, despite widespread recognition of the benefits of organ transplantation, public trust in the system remains fractured. Many people remain unconvinced that the field adequately considers and respects the perspectives of donors, their families, and even recipients. I argue that this lack of trust indicates not only a problem within individuals who are sceptical of the system, but more importantly, a failure of healthcare institutions and professionals to establish themselves as trustworthy. "Mistrust" arises when individuals hold suspicions based on misinformation or misplaced trust, whereas "distrust" goes beyond suspicion to include active doubt, informed by scepticism, lived experiences, or specific concerns. While distrust may be fuelled by past organ transplantation scandals and fears of unequal or discriminatory medical care, a common source of mistrust is the belief that transplant physicians might not make every effort to save a potential donor's life or might declare death prematurely to obtain organs. Mistrust can also manifest as a form of blind trust, where a lack of transparency prevents individuals from fully understanding the implications of their consent. In contrast, distrust assumes harmful intent, leading people to take protective measures—such as refusing consent to organ donation or rejecting medical interventions they perceive as risky. Beyond these structural issues, other factors further contribute to the erosion of trust in organ transplantation, including cultural and religious beliefs, racial and socioeconomic disparities in healthcare, deep-seated myths about the body, and irrational fears of bodily mutilation after death.

1.6.2 Dilemma 2 – *Dead or Dying*

I. Organ transplantation requires that the donor must be dead.

II. Organ transplantation requires that the organ must be alive

In *Dead or Dying*, we face the issue of limited information and understanding about transplant practices, especially concerning deceased organ donations. This dilemma emphasises the confusion relating to the death states of brain-dead and circulatory-death patients, along with the ethical concerns associated with organ retrieval from decedent donors. The problem stems from misunderstandings about whether organ transplantation requires the organ to be "alive," raising moral questions about obtaining organs from those who have died. Decedent donors are individuals who have died either from circulatory death, where the heart irreversibly stops beating and circulation ceases, or from brain death, which occurs when all major brain structures, including the brainstem, sustain catastrophic damage, confirming permanent cessation of brain activity (National Kidney Foundation, p. 3; Spears *et al.*, 2022, pp. 1-2; Lewis *et al.*, 2020, pp. 299-309). Brain death can also be understood through the "higher brain" model, which concentrates on the destruction of the cortex and hemispheres. While this model is problematic—since patients with only higher brain function loss can still breathe—traditional criteria depend on the absence of brain activity, particularly the inability to breathe independently (Spears *et al.*, 2022, p. 2; Claassen *et al.*, 2003, pp. 2497–505).

Critics of brain death argue that patients diagnosed as brain dead are not truly dead but are in a state of dying. Manzei, for example, asserts that brain death is not the same as human death, as he claims brain-dead patients can survive for up to 14 years with intensive care (2015, p. 133). He argues that these patients are not dead but rather in a prolonged state of dying (p. 133). This perspective challenges the current understanding of brain death, which is based on the assumption that death occurs immediately after brain failure. For Manzei, while we have a small group of people who can donate organs, none of these categories include individuals who can donate organs after death, because that category only consists of people who are dying but still have well-functioning organs – specifically brain death patients (p. 130). As such, perhaps "the actual number of brain-dead patients who are not really dead is much higher since, of course, only those cases can be reviewed in which no organs were removed after the diagnosis of brain death [since] the removal of a vital organ foregoes the possibility of any result other than death" (Manzei, 2015, p. 133). By this, Manzei reiterates

the accusation of the American President's Commission on Bioethics (p. 42) that the brain death concept is "a self-fulfilling prophecy" and therefore rejects the assumption that the brain controls the body's functions such that death must occur immediately after total brain failure (Manzei, 2015, p. 133).

The ethical dilemma in *Dead or Dying* emerges when the Dead Donor Rule (DDR) clashes with the need for healthy organs. The DDR requires that a patient must be declared dead before organ removal, ensuring that the act of organ retrieval does not directly cause death. However, for organs to be healthy, they must be alive at the time of retrieval, which conflicts with the notion of organ donation from deceased individuals. Critics argue that organs retrieved from "dead" people would not meet the criteria for being healthy, as they would have undergone ischemic damage prior to retrieval.[19] For such critics, decedent donations do not exist; what we rather practice is the retrieval of organs from dying donors. However, this argument does not hold when we examine the process of organ retrieval from circulatory death and brain-dead patients. After death is declared, a 5-minute waiting period is observed to ensure that no signs of life remain (Canadian Institute for Health Information, 2014, p. 5).[20] Organs retrieved after this period have been shown to pass the ischemic rule, making them viable for transplantation. Therefore, despite the moral and ethical concerns surrounding decedent donations, the process aligns with established protocols, ensuring that organs retrieved for transplant purposes meet health requirements and allow recipients to lead healthy lives.

1.6.3 Paradox of Infinite Request

1. As the number of organs procured increases, so does the number of individuals on the waiting list (Annas, 1988, p. 621).

The paradox of infinite requests can be understood in two ways: first, as a problem arising from the transplant field's success and sustainability as the preferred treatment option, and second, as an internal structural issue within the organ transplantation and donation (OTD) field itself. As Manzei suggests, the infinite request for organs is "brought about by

[19] Essentially, the ischemic rule states that an organ is considered healthy and viable for transplantation when it has the necessary functional capacity expected of such said organ, is free from structural damages or deformities, has an adequate blood supply to maintain its function, is free of pathological disease, and can withstand a limited period without blood flow (ischemia) during its retrieval and transplantation since prolonged ischemia can lead to irreversible damage in organs.

[20] For further readings. See Canadian Institute for Health Information. (2014). Deceased Organ Donor Potential in Canada. In *Canadian organ donor statistics: 2000 to 2009*. [Report]. Retrieved September 12, 2025, from https://secure.cihi.ca/free_products/OrganDonorReport_ENweb.pdf

intrinsic problems of the transplantation system itself" (2015, p. 128). At the core of this paradox lies a contradiction in our beliefs about organ donation. On the surface, it is believed that after death, people can donate "tissue or an organ that they are willing to give or can no longer benefit from to another person who needs that organ to live" (Gillet, 2000, p. 239). This belief leads to the assumption that increasing the pool of registered donors will ultimately reduce the waiting list. However, this assumption is flawed. The paradox of infinite requests exposes the mistaken belief that patients on the waiting list die solely because others refuse to donate organs at the end of their lives. As Manzei argues, "waitlist patients do not die because other people did not donate their organs when they died, they die because of disease or old age, or both in some cases" (2015, p. 130).

This paradox highlights deeper moral, legal, and medical dilemmas within the OTD field. The uncontrolled dependence on organ transplantation as the primary treatment for a wide range of ailments—including diabetes, obesity, cardiovascular diseases, and substance abuse-related organ failure—has led to an overstatement of its effectiveness. From being an effective treatment for End-Stage Renal Disease (ESRD), allowing patients to regain their independence from dialysis, organ transplantation has expanded to the point where the transfer of extra-renal organs has become routine. As a result, "organ transplantation became the miracle cure for every patient suffering from chronic and terminal illnesses" (Klinger, 2016, p. 68). For George Annas, the paradox of infinite request shows that "an uncontrolled proliferation of transplant programs and an undisciplined patient selection criterion will always maintain the shortage of organs" (Annas, 1988, p. 621). Arguing similarly, Manzei identifies four key factors sustaining this paradox: (1) Not all donated organs can be used when one dies, so an increase in willingness to donate organs does not always mean an increase in the healthy organs retrieved for transplantation. (2) Since the preferred medical solution to most ailments is the replacement of organs, some recipients end up receiving multiple organs. (3) Since some recipients experience rejection, they have to undergo re-transplantation – we cannot ask them to give up and leave after the first transplant fails, after all, it was not their fault. (4) Since transplant hospitals have a quota to meet to retain their license, doctors in such hospitals will most likely suggest organ transplantation as the best medical treatment option, increasing the waitlist number.[21]

[21] I have already examined these assumptions and will not be revisiting the details of my disagreement with some of Manzei's view here.

Ultimately, the paradox of infinite request reveals the structural and ethical challenges of the OTD field. The assumption that more registered donors will resolve the demand for organs oversimplifies the issue, ignoring the deeper medical and institutional factors that drive the continuous expansion of transplantation as the go-to treatment.

Conclusion

As I have argued in this chapter, organ transplantation is not just a matter of technical triumph or medical efficiency; it is interwoven with ethical, cultural and symbolic significances, thereby making its history more than the mere replacement of failing or dead organs with healthy ones. Within the transplant field, we witness the reconfiguration of social relations, the shaping and reshaping of moral horizons, as well as an expression of what it means to live, die, and remain embodied within the communities to which we belong. Hence, to treat the transplant field as an economic enterprise is to willingly ignore the fragility of the human experiences it encounters, which shape it.

Hence, understanding the organ transplantation and donation (OTD) field goes beyond examining technical procedures, it requires engaging with the ethical dilemmas, recognising the lived experiences of donors, recipients and families, paying attention to the prominent social and cultural narratives about death, the body and organs, and being aware of the circumstances and norms on which public trust is built, required and broken. As we shall see in the coming chapters, trust in the OTD system is a necessity. It is the bond that clarifies, upholds and strengthens the conditions in which life, death, bodies, and organs may be given, received and respected.

CHAPTER 2

BODY, DEATH AND MOTIVATIONS TO DONATE: AN OVERVIEW OF FACTORS INFLUENCING TRUST IN THE OTD FIELD

Introduction

The ethical issues in the OTD field reflect and engage with fundamental moral, religious, social, and cultural beliefs about human beings as profoundly embodied beings (Gillett, 2000, p. 239). As William May asserts, "[a] man not only has his body, he is his body" (May, p. 3, cited in Aubrey, 2013, p. 5). This embodied nature establishes connections between donors (both living and deceased), donor families, recipients, and, in some cases, the transplant team.

It is within the engagement with the body and the moral, religious, and sociocultural dimensions of organ transplantation and donation (OTD) that perceptions about the body, what it means to have a body, and our relationships with our bodies begin to shape various conceptions of the body. We have come to recognise these conceptions as symbolic narratives of the body which influence how we value the body, how we situate the body within the transplant field and our interpretation of that value within the OTD field.

At a surface level, organ transplantation appears to involve the willing donation of organs from individuals who no longer need them or who wish to help another survive, to another person. However, the field is fraught with dilemmas regarding the meaning and significance of the body, body parts, and their transfer. These dilemmas contribute to confusion about identity, phobias, bodily respect, property rights, and body integrity. Given this complexity, it is unsurprising that contributors and critics of the OTD field engage in a "deeply challenging mixture of images and arguments that concern life, death, [bodies] and what is essential to being an intact [i.e., whole] human being" (Gillett, 2000, p. 239).

In this chapter, I will examine symbolic conceptions of the body and their influence on body integrity rights and motivations to donate. I will begin by analysing the relationship between death and the body, showing how perceptions of the body shape motivations to donate – whether driven by altruism, solidarity, duty, or self-interest. Following this, I will explore symbolic narratives of the body as property, gift, and biological material.

2.1 Death and the Body

Across disciplines, scholars and researchers have long been concerned with the body's actions, intentions, language, and gestures, its health status and social significance, its interaction with other bodies, and its potential for immortality or reincarnation (Nettleton, p. 106, cited in Aubrey, 2013, pp. 35-36). Although contemporary shifts in Western ideologies have generated renewed discussions about the body, these are not indicative of an absence of prior sociocultural, religious, or economic conceptions of the body. The increasing focus on the body – particularly within medicine and its attempts to preserve life and resist death – is shaped by the interplay between death and the body. Advances in medical research and technology continue to reshape how we perceive the body, even during the process of dying. Applying Emily Martin's perspective to the OTD field, when a donor dies, and their body is used for transplantation, what "we are seeing [is] not the end of the body but rather the end of one kind of body and the beginning of another kind of body" (1992, p. 121).[22] I argue that this transformation of the body from one categorisation to another is strictly symbolic. It applies only to the bodies of the deceased, and is not to be understood literally – although I posit that there can be literal understandings when we interpret Martin's distinction to mean the living body (the one that ends) and the dead body (the one that begins), or when we identify the body that begins as a body preserved for the preservation of other lives. Not only does the medical field contribute to the creation of bodily constructs or subject formations, but it also generates new possibilities for thinking about how bodily constructs relate to human existence and difference (Kunte, 2012, p. 7). According to Kunte, the OTD field "radically reorganises how bodies relate to one another in the materiality of their flesh" (2012, p. 6). This reconfiguration not only enables the continued existence of another but also dissolves the boundaries between bodies, reshaping the ethical and social meanings attributed to them (Kunte, 2012, p. 5). Through this process, the body is rearticulated – conceptualised in terms of self and other – capturing "what it means to be and have a human body" (Kunte, 2012, p. 5).

If we accept, as Martin claims, that in decedent donations alone, the donor's body marks not the end of the body but the end of one kind of body and the beginning of another kind of body, then we must ask: what kind of body "ends", and what kind of body "begins"?

[22] For Martin, there are essentially two coexisting bodies: "a body organised as a global system with no internal boundaries and characterised by rapid, flexible response, and a body organised around nationhood, warfare, gender, race, and class." (1992, p. 129)

It is essential to clarify that my distinction between a "body that ends" and a "body that begins" is essentially symbolic and not an ontological examination of the metaphysics of bodies. It is thus intentionally situated within the context of dead human bodies, given the complex cultural, social, and moral meanings they uniquely embody. One might object that this distinction seems arbitrary or unremarkable when compared to analogous scenarios involving the exchange or replacement of parts in non-human entities – such as transferring car components, computer hardware, furniture materials, or even biological grafts among plants. If such substitutions are considered morally and ontologically insignificant in these domains, the argument might go, why should the human body be treated differently?

On a surface level, this analogy appears plausible: if the exchange of parts between mechanical or organic entities does not necessitate ethical reflection on the nature of the "whole" to which those parts belong, one might infer that the same logic should apply to human beings. However, such reasoning fails to account for a fundamental distinction – the human body is not just a sum of its functional parts. The human body is not reducible to its materiality; it is rather imbued with symbolic, existential, and normative weight and significance, which makes it categorically distinct from other objects or living organisms.

While the mechanical parts of cars, computers, or the organic parts found in plants may be replaced without raising social or ethical concerns, the transplantation of human organs inherently invites moral scrutiny. This is because it implicates profound questions about personhood, mortality, and identity. The distinction between "a body that ends" and "a body that begins" is not a trivial metaphysical gesture – it is central to how we symbolically conceptualise the status of the decedent body post-mortem, and how we ethically frame the meanings attached to it. These conceptualisations influence whether organs are viewed as gifts, resources, or commodities, each of which carries different normative implications. While it may make no moral, cultural, or social difference when parts from one car or computer are sold, gifted, or used to replace the parts of another car or computer, this is not the case with the transplant of bodies.

As Childress (2001) insightfully notes, "the human body evokes various beliefs, symbols, sentiments, and emotions as well as various rituals and social practices" (p. 2). These dimensions are absent in our engagement with most non-human objects. Therefore, to ignore the unique moral and symbolic salience of the human body in the context of organ

transplantation is to risk impoverishing the ethical discourse that surrounds it, and to obscure crucial issues that demand sustained philosophical attention.

Since we are interested in the symbolic understanding of bodies within this categorisation, we can further ask: Is the delineation of a "body that ends" and a "body that begins" simply the end of the living body and its beginning as a mere biological material? Does the ending body signify the embodied identity of a once-conscious self, while the beginning body identifies spare parts or commodities for medical use? Should this new body be regarded as a resource material, or is it more accurately understood as a gift? Essentially, our conceptualisation of this "new body" is subtly shaped by our understanding of death. Symbolically, the body remains after death not only because it is useful for transplantation – whether as a gift or medical resource – but also because it holds significance for the family, serving psychological, cultural, religious and even personal roles. As Aubrey (2013) notes, "the usefulness and importance of the body lasts until the body is no longer seen as a person," and this transition occurs at different moments across cultures, religions, and disciplines (p. 42).

This view resonates with Fredrik Svenaeus' phenomenological reading of Heidegger's conception of the body. Given the etymological meaning of an organ – i.e., a tool or instrument – the body, too, may be seen as a tool, but it is unlike other tools (Svenaeus, 2010, p. 168).[23] Unlike lifeless instruments,[24] the body has patterns of action, thought, feeling, and communication, forming the basis of human connection and shaping our very being-in-the-world (Svenaeus, 2010, p. 168). Thus, we are not merely bodies; we are fellow beings existing in relation to others. As Heidegger argues, the body "is not to be understood as lifeless matter but is part of that domain that cannot be objectified… …a being able to encounter significance, which our entire being-there (Da-sein) consists in" (Svenaeus, 2010, p. 168).

Regarding death, scholars such as Zimmermann and Rodin (2004) put forth the "denial of death thesis," which argues that medical advancements have led to the increasing

[23] The word "organ" originates from the Ancient Greek term *organon* (ὄργανον), meaning "tool," "instrument," or "implement" – a term that reflected its usage in both philosophical and medical contexts as a means of performing a function (Harper, 2023; Liddell & Scott, 1940, p. 1247). The word was transmitted through Latin (*organum*) and Old French (*organe*), eventually entering Middle English as "organ", signifying both a bodily part with a specific function and a musical instrument (Oxford English Dictionary, 2024). The Greek root *organon* is derived from the Proto-Indo-European root *werǵ-, meaning "to do" or "to work", emphasising the organ's role as a functional entity (Watkins, 2011, p. 96).

[24] Possibly with the exception of Artificial Intelligence.

medicalisation of death, with contemporary Western societies seeking to "deny" death altogether (p. 121). This view argues that medical advancements have contributed to the societal denial of death by encouraging the notion that death is a problem to be conquered. The view posits that medical and technological advancements made between 1955 and 1985 – which was the period the denial of death first arose – shifted (some kinds of) death from being a natural event to a medical failure. As such, this period contributed to the development of new drugs, medical equipment and surgical techniques, all aimed at saving more lives, deterring death and possibly postponing it. For Zimmermann and Rodin (2004), by transferring the dying process from the home to the hospital – an institution that focuses on diagnosis and cure, death became medicalised, hence the redefinition of death and dying as technical or clinical problems to be managed by the medical profession (p. 122). For Zimmermann and Rodin (2004), with the medical focus on cure and the postponement of death came the societal and institutional denial of death through practices like the "conspiracy of silence," where doctors withhold information about a terminal diagnosis to maintain a false sense of hope, thereby avoiding the confrontation of the reality of death. This presents the institutional manifestation of the denial as the medical system unconsciously tries to eliminate death. Although this seems like an oversimplification of death, the contribution of Zimmermann and Rodin is significant when we examine society's interest in medical advancements that help sustain life, promote healthy living and minimise death. While the denial of death may be an overstatement, the reality of our interest in postponing death through surgery and medications presents the idea that death is being avoided or combated even if not denied.

Others, like DeSpelder & Strickland (2005), contend that this trend stems from an obsession with controlling death through medical technologies (p. 5). Tony Walter (1994) observes that medicalisation has reframed death as a natural process governed by doctors, stripping it of its spiritual meaning. In his view, not only are dying bodies medicalised, but dead bodies contribute to the medicalisation of the living (pp. 12-13). Walter's argument holds weight: our growing reliance on medicine to prolong life and manage death has positioned medical professionals as arbiters of the dying process. While the recognition of death as a natural process is not new – many cultures and religions have long accepted it as part of the natural order – Walter's claim that doctors now mediate this process is significant. Western medicine and technological advancements have made medical professionals central not only to the declaration of death but also to overseeing the dying process itself.

Just as “life” eludes precise definition, so too does “death.” It is difficult to conceptualise “death” beyond describing its process or occurrence. Given its complexity, I align with Gardiner *et al.* (2012) in asserting that understanding death requires medical, legal, ethical, societal, cultural, and religious perspectives (p. 14, cited in Aubrey, 2013, p. 38). These perspectives, in turn, influence how we conceive of the body after death.

The Canadian clinical guideline defines death as “the permanent cessation of brain function as defined by the absence of consciousness and brainstem reflexes, including the ability to breathe independently” (Canadian Blood Services, 2019; Shemie *et al.*, 2023, pp. 483-485). Similarly, the UK Academy of Medical Royal Colleges (AoMRC) states that “death entails the irreversible loss of those essential characteristics which are necessary to the existence of a living human person and, thus, the definition of death should be regarded as the irreversible loss of the capacity for consciousness, combined with irreversible loss of the capacity to breathe” (p. 11). According to these definitions, the body that ends is the conscious body – but the more complex question is: what kind of body begins?

It is important to reiterate and clarify what I mean by the terms “bodies that end” and “bodies that begin.” This conceptual distinction should not be misconstrued as implying that a person’s body (a recipient) ontologically transforms in some fundamental way as a result of organ transplantation. Such an interpretation would be inaccurate. For instance, in the case of Omelogor, who receives a kidney from her cousin Chiamaka, it would be misleading to suggest that Omelogor undergoes an experience of bodily discontinuity – wherein one body “ends” (with the removal of the failing kidney) and another “begins” (with the incorporation of the transplanted organ). That interpretation misapplies the intention and scope of the classification. If eating a range of foods or receiving skin, tissue, or bone grafts from animals does not lead us to conceptualise ourselves as transitioning between distinct bodily identities, then it is philosophically and empirically inconsistent to impose such a model on the lived bodily experience of organ recipients. The notion of bodily replacement or transformation, when applied in this way, risks flattening the complex phenomenology of embodied selfhood and intersubjective recognition.

Thus, my delineation of “bodies that end” and “bodies that begin” refers solely to the context of decedent donors. In death, especially within the legal and ethical frameworks of opt-in and opt-out donation systems, the body of the deceased is subject to various interpretations depending on the perspectives and roles of those involved. These differing

perceptions often produce a functional dichotomy: the "body that ends" is linked to the deceased's personal identity, memory, and relational meaning, while the "body that begins" – once donation is permitted – is redefined as a resource, gift, or instrument of healing. This transformation in meaning is poignantly illustrated in the narratives of donor families. Consider the reflection of a bereaved family member: "I tell my grandmother to think about the ones she has helped. And that the organs donated were just interiors and not really a part of our grandfather we relate to, and my grandmother then says I am probably right" (Berntzen & Bjørk, 2014, p. 269; Orøy *et al.*, 2011, pp. 1–11). Here, we witness the attempt to reconcile grief with altruism by identifying the new body not as a site of enduring identity, but as a moral repository of transferable value. In this sense, the conceptual framework of "bodies that end" and "bodies that begin" is not a metaphysical claim about somatic changes, but rather a symbolic and ethical lens for interpreting how the deceased's body is culturally and morally reconstituted in the process of organ donation.

With evolving definitions of "death" and advancements that sustain bodies on ventilators, diagnosing death has become increasingly complex. The ability to preserve bodies of the dead raises difficult questions about their state and transformation. Are we keeping alive a human being, or is what remains something else entirely? As Gaylin (1974) puts it, we are forced to decide "whether that which we kept alive is still a human being or, to put it another way, whether that human being we are maintaining should be considered 'alive'" (Gaylin, p. 23, cited in Aubrey, 2013, p. 38). More broadly, we must determine whether the body that begins in this preserved state is to be recognised as a commodity, biological resource, spare part, or a gift that enables the continuation of another's life.

2.2 Symbolic Narratives, Ownership and Bodily Integrity

Within the context of organ transplantation, various symbolic narratives have been employed to justify and influence decisions regarding organ donation. Paul Ricoeur refers to such symbolic narratives as the "narrative identity," encompassing metaphors, symbolic expressions, and stories that make organ transplantation not only biologically possible but also ideologically, socially, and morally conceivable (Kunte, 2012, p. 30). Organ transplantation breaches bodily boundaries, uniting disparate identities through the removal and reinsertion of body parts (Kunte, 2012, p. 29). However, the way donor bodies are framed in these symbolic narratives influences our motivations to donate and reflects three key things: (i) our relationship with our own body, (ii) our relationship with others as fellow

embodied beings, and (iii) our perception of what the body becomes at death and through donation.

As such, the dominating symbolic narratives of the body and, by extension, organs, at least include presentations of organs as (1) Gifts, (2) Biological materials/resources, and (3) Resource commodities. Seeing the body as one's property enables its conceptualisation as a gifted possession, a biological resource for those in need, or a commodity exchangeable under particular conditions (Svenaeus, 2010, p. 165). Accordingly, the body can be perceived as: (i) a gift freely given in life or death, (ii) a biological material valuable in preserving life but purposeless to the dead, or (iii) a resource commodity to be bought and sold, compensating donors for their sacrifice. Although these narratives arise from interactions with the medical and OTD fields and are shaped by notions of bodily ownership, value and integrity, my interest in the symbolic narratives of organs centres on the gift narrative.

Regardless of how we present the symbolic narratives, an evaluation of OTD practices reveals the body as a site of complex cultural, historical, and medical entanglements. It carries layers of "beliefs, symbols, sentiments, and emotions, as well as various rituals and social practices" (Childress, 2011, p. 2). Hence, an overly rationalistic approach to symbolic narratives risks undermining public trust in transplantation, as it fails to account for the complex, affective dimensions of bodily identity (ibid). A rationalistic account may, at the expense of emotional, religious and cultural meanings, prioritise reason, empirical data, logic and efficiency, while plausibly recognising such meanings. An overly rationalistic account, on the other hand, would mean examining and justifying organ transplantation solely on purely technical, utilitarian, or biomedical grounds, thereby ignoring the emotional, sociocultural, and religious symbolic meanings people attach to their bodies and their parts. A good example of such an overly rationalistic account will be the narrative that sees organs as a resource/medical material. Such accounts describe the body as a machine made of interchangeable parts, focus on the availability of organs in such economical terms that present the field like a marketplace, separate identity from organs and the body, and fail to adequately acknowledge the sentiments around death, as well as the spiritual beliefs around death and donation. While some may critique symbolic narratives for embedding ethical biases that shape debates on commodification, donation obligations, and policy frameworks, I argue that ethical neutrality is an impossible ideal. The body, being the subject of analysis, is inextricably tied to moral, religious, socio-cultural, economic, and political values.

Grant Gillett (2000) posits a similar view when he observes that ethical evaluations of transplantation are "sensitive to our basic emotive and value commitments and not restricted to a 'purely rational' analysis" (p. 240). This is evident in the public acceptance of the gift narrative, the reluctance toward organ commodification, and the conditional approval of organs as biological materials – permissible only when framed as gifts rather than spare parts. Childress concurs, arguing that transplant policies often fail because they are "too rationalistic, individualistic, and legalistic," neglecting deep-seated social and emotional beliefs (2011, p. 1). These ethical concerns "plunge us into mythical and imagistic territory," shaping how societies morally identify with organ transplantation (Gillett, 2000, p. 251). They influence views on identity, posthumous existence, commodification, solidarity, altruism, and even xenotransplantation, where sanctification rituals mitigate associations with the donor animal (Ibid).

2.3 Gifts, Resource Materials and Commodities

In a highly specialised field like transplant medicine, it is not surprising that human organs, tissues and cells are often classified as "biological materials" or "material resources." Although quite precise for clinical purposes, as they reflect the role of organs in the transplant process, such terminologies carry profound and often unsettling symbolic weight. The symbolic understanding of organs as "biological resources" views them not simply as physical parts, but as carriers of meaning, function, and identity. It can be seen as a reductionist perspective necessary for the operational logic of transplantation, while also challenging the opposing ethical frameworks that present organs as "gifts." Viewing organs in this symbolic form, as biological materials, serves a vital dehumanising function for clinical efficiency and a controversial philosophical function in legalising the management and distribution of life-saving resources. It presents a complex cultural construction that mediates how societies understand embodiment, personhood and the moral significance of bodily exchange. For organs to be successfully retrieved, preserved, transported, and transplanted, organs must be functionally depersonalised and treated as pieces of medical equipment rather than vestiges of a self.

Nonetheless, disagreements with this presentation of organs arise from concerns about the potential medical treatment of the body if we view it solely as biological material, overlooking the social and cultural meanings that this understanding may ignore or deny. This is because modern biomedicine has come to conceptualise the body as divisible and

manipulable, and this presentation allows organs to be detached, classified and circulated as medical resources. For Margaret Lock (2002), the reduction of organs to biological resources signifies an objectification of the body which arose from the medical capacity to maintain life artificially and define death in terms of brain function, thereby transforming organs into potentially exchangeable parts (pp. 1-31). With such reconfiguration of the symbolic relationship between the body and personhood, the once assumed indivisible unity of the body and self gave way to viewing the body as a system of replaceable biological materials. Thus, organs became both material resources for sustaining life and objects of biomedical control (Lock, 2002, pp. 1-31). This medical configuration of the body as "resources" is ethically problematic because it presupposes an instrumental reasoning in which human bodies become subjects of regulatory and productive practices, serving the biopolitical logic of health optimisation and population management. Although ostensibly a biological entity, the organ is made a site of governance, where moral and political values intersect.

In presenting organs as "biological materials," we experience a disruption of the integrity of the lived body, distinct from the objective body. By the lived body, I mean the subjective first-person experience of the body, which recognises how we experience our bodies as ourselves. Here, the body is not something we have; it is rather something we are. The lived body captures an embodied consciousness, as we are not separate from the body in experience but come to live through it. It is through the body that we feel pain and emotions, experience agency, and express various degrees of orientation. The objective body, on the other hand, is the third-person external view of the body. It sees the body as an object among others and is thus measurable, analysable, and visible as bones, organs, tissues, and neural signals. Herein, the body is that which can be observed, diagnosed and manipulated. A good example of this view is a surgeon's likely conception of the body during surgery, viewing it as tissues, organs, and blood vessels rather than as a patient's subjective experience.

This is because, in understanding the body as not merely an object in the world but the subject through which we experience the world, we live in the world, and we come to know the world, when organs are isolated as transferable materials, they are abstracted from this lived dimension and stripped of their embodied significance. In this sense, the donor's organ ceases to be an expression of embodied subjectivity and becomes a technical object, a neutral biological resource, detached from personal meaning. It is this abstraction that allows for arguments about organ trade and donation to be promoted while using the language of medical necessity, yet concealing the symbolic problems that the transplant field experiences

and creates. We can thus say that this presentation of organs, as "biological materials," is a double-edged sword: while it enables life-saving interventions, it also risks reducing persons to aggregate medical and biological entities. By symbolically disembodying organs from the body, this narrative transforms human tissues into morally ambiguous objects, oscillating from the sacred, other-directed, and generous gift to the profane commodity. But if, despite the medicalisation of organs and the body, organ donation is often narrated through metaphors of generosity, relational continuity and selfless gifts, rather than material exchanges, then this symbolic narrative resists total commodification by rehumanizing organs. As such, organs are not to be symbolically understood as merely biological fragments, but as vessels of moral meaning and socio-cultural significance.

The phrase "organs are gifts" extends beyond a sentimental expression that highlights altruistic aims and interests in organ donation. It has become the foundation of the legal, ethical, and social framework that governs OTD. Ensuring that the transfer of life-saving organs operates on a principle of altruism rather than commerce, the gift narrative mandates that organs cannot be bought or sold legally, thereby upholding the donor's intrinsic human dignity and protecting the integrity of the transplant and medical systems. Hence, it is not surprising that the gift narrative holds a positive stance amongst members of the public as the most viable motivation for organ donation and the success of the transplant field (Gillett, 2000, pp. 251-253; Hurley, 2011, pp. 217-231; Svenaeus, 2010, pp. 166-171; Childress, 2001, pp. 1-16). The gift narrative informs the virtuosic act of living donations despite a recognition of the possible health risks and harm one faces upon donation. For Hurley, the recognition of the body as "given" indicates the ideal recognition of the body as taking the form of a gift(s) rather than the form of a potentially exploitative sale, where this recognition of the body as "given" is, in turn, a prerequisite for any real sense of organ gift after death (230).

The significance of the gift narrative can be captured across three main dimensions: (i) its moral role in promoting altruism; (ii) its function within the complex medical structure and social infrastructure required for transplantation; and (iii) its role in preserving trust in the transplant field. Proponents of the gift narrative associate "gifts" with acts of altruism, which they argue, hold the fundamental ethical image that endorses organ transplants (Gillett, 2000, p. 252; Voo, 2014, pp. 16-18). Hence, the moral language of organs as "gifts of life" has been effective in emphasising the voluntary and generous acts of donors and donor families, thereby promoting the value-laden role of the transplant field. By relying on and upholding the altruistic ideal, we, in turn, uphold the ethical ideal that the human body and its parts

possess a sacred or inherent value that should not be reduced to a price tag. The gift status is essential to preserving the transplant system's moral high ground amid the pressures of demand and supply.

For advocates of the gift symbol, the ethical acceptability of "gifting" is often associated with the sacrificial gift tradition found in religious teachings and cultural values.[25] Unlike other forms of social transactions, advocates argue that the concept of "altruistic gifting" underpins many aspects of collective human life that we value most (Gillett, pp. 251-252; Murray, 1987). While the understanding of organs as "gifts" and donations as "gifts of life" may be the standard for many, existing views on "gifts" and "gifting" lack the holistic understanding needed to make this imagistic symbol the standard by which people view it. This is partly due to the varying notions of "gifts" and "gifting," and their implications when applied to organs and the transplant system. Although the ability to gift an organ has been taken by many to be the clearest sign of the execution of one's property rights, since without prior ownership entitlement to the organ, one is not authorised to give it away, upon examination of analogies from everyday life, we are made aware of the implications of a gift (Hausleben, 2013, p. 5). As Heather Hausleben argues, "[i]n practice, gifts of all types are rarely entirely voluntary as they often stem from obligation and the threat of social consequence" (2013, p. 5). In addition, as Hausleben argues, since legal gifts are "examples of exchanges of the bequest for lifetime care or attention, the same considerations that allow people to donate organs support allowing the sale… Similar to a bequest in a will, all exchanges, including the exchange of an organ for money, contain an element of a gift" (Hausleben, 2013, pp. 5-6; Munson, 2002, p. 122). Hence, the gift narrative does have its limitations: one may criticise the gift narrative for its idealism and potential misrepresentation of donation realities, just as one may criticise medical and legal framings that reduce transplantation to mere individual choices, treating organs as exchangeable biological materials while disregarding reciprocity (Pfaller *et al.*, 2018, pp. 1329-1330). Irrespective, the strength of the gift narrative lies in its recognition of the enduring social and emotional

[25] Gillett gives the example of the Christian Eucharistic ceremony where Christ gives his body and blood to his disciples, saying, "Take, eat, this is my body which is broken for you". For Gillett, this eucharistic image, like organ donation, focuses on gift-giving, where one person seeks to improve the quality and quantity of life for another by giving up part of themselves for the other's sake (p. 252).

dimensions of donation, aspects that are often overlooked in purely commodified or biomedical perspectives (Pfaller *et al.*, 2018, p. 1330).[26]

As such, while I hold that the gift metaphor offers the best narrative for understanding the body, organs, donations, and transplants, there is a need to reformulate the gift narrative. This is because the gift narrative can accommodate a broader understanding of body and organ donation and transplantation, while promoting ethical justifications for both cadaveric and living donations. It can also facilitate the ethical justification of both altruistic and non-altruistic motivations for donating, thereby expanding the ethical justifications of a broader range of potential solutions to the organ shortage problem.

Since a re-evaluation of the gift narrative is essential, not only to highlight the freedom this form of donation implies but also to reflect the trust involved in gifting what is itself a gift, I posit that understanding organs as "gifts" essentially aims to acknowledge self-trust on the part of donors – both living and decedent – manifested through presumed and explicit consent as well as interpersonal trust among donors, recipients, families, and the transplant team. By conceptualising organs as "gifts," we foster a communal, relational, and interdependent view—viewing organs not merely as biological materials or spare parts but as virtue-filled gifts that embody our solidarity as fellow embodied beings committed to preserving each other's lives. These virtue-laden gifts, I argue, signify respect and dignity for the deceased and their bodies; merit for recipients as deserving of the gift; decency from recipients, families, and the transplant team in recognising and respecting the gift; integrity on the part of transplant professionals and policymakers to preserve the gift's identity; and the overall integrity of the transplant system to uphold trust in the gift and its allocation. Recognising organs as gifts transcends our differences and borders, fostering trust in the system that sustains life through transplantation.

My symbolic conception of organs as "gifts" invariably views the body as a "gift given." As an advantage, this conception of organs and, by extension, the body, accommodates secular as well as religious and cultural views that can be used to support and promote donation and even nudge people into becoming donors. Following the teachings and

[26] It seems the case that it is for reasons as this that Shaw emphasizes the need to expand the "conceptual toolkit of organ donation to include the unconditional gift, the gift relation, gift exchange…" (p. 952). Doing so, I believe, ensures that transplantation discourse remains attuned to the moral, emotional, and social realities that shape organ donation practices, while focusing on viewing the donated body as a gift, thereby sustaining trust in the field while fostering ethical and inclusive policy frameworks.

worldviews of some religions and cultures, the body may be seen as a "gift given" by and from a deity, allowing us to share similarities not only with other humans but also with the deity (at least, depending on the religion and culture). This symbolic narrative of the body as a "gift given" allows for a broader application of the gift narrative that does not limit the gift to body parts but the entirety of the body: while organs are gifts given to save lives, they are first a part of a larger gift – the body – through which we have our subjective experience of the world, our interaction with the divine and spiritual, and our relationship with others. As a gift given, the body, whether while living or immediately after death, can be offered through donation, thereby continuing social belonging and moral identity.

A secular interpretation of the body as a "gift given" retains the moral and existential focus of the gift narrative without invoking a deity, while also promoting nonreligious cultural ideals such as solidarity, interdependence, and humanity. Essentially, the gift narrative is captured in the social, relational and existential conditions of embodiment. As that which is given rather than a possession of our own making, the facts of our embodiment, the biological capacities of our organs and the social conditions which our bodies are born into, are not of our own choosing. Our bodies are shaped by genetics, education, care, medicine, financial status, the labour of others, etc. Hence, rather than being simply owned, our embodiment is received through the outcome of biological possibilities and social investments. Our bodies are relational instruments that encourage participation in shared social life, allowing our continuous involvement in actions and bodily functions that sometimes depend on the support of others, such as working, loving, communicating, social interaction, etc. Understood as a "gift" in the secular sense, the body is embedded in a network of interdependence in which organ donation allows the continuation of the relational structure as a way to "pass forward" – through gifting – what we have received without individual merit. Through this secular interpretation of gifting, the idea of donation is presented as an act of solidarity rather than a sacrifice; donors need not see themselves or their donation as a relinquishment of something strictly theirs. Rather, donors are able to understand that through organ donation, bodily capacities that once enabled one's own life can be transferred to sustain the life of another when it is no longer needed by the original bearer – in the case of decedent donation at least. The secular gift narrative sees organ donation as a morally intelligible response to shared vulnerability, promoting mutual dependence and does not claim that individuals owe their bodies to others.

My understanding of organs as "gifts" allows for the inclusion of trust as a constitutive element in this specific type of gifting, which differs from other forms of gifting due to the nature of the gift involved. This is because, upon understanding the body as a "gift," the vulnerability involved in organ donation and the existential force of that gift, the inclusion of trust cannot be avoided. More specifically, the inclusion of trust aids the presentation of organ donation not just as the transfer of bodily parts, but as a morally loaded extension of bodily vulnerability and relational dependence. In gifting our bodies to others, we entrust them with parts necessary for their survival. This act of entrusting through donation is not limited to the donor alone, but also to other parties that are depended on and entrusted to care for, handle, allocate and transplant the donated organ. Hence, gifting presupposes the trust that these agents will respond with competence, integrity and moral regard to the vulnerability expressed in the gift. In cases where donations are made after death and are at risk of violation – symbolic and physical – or misrecognition and mistreatment, gifting introduces the belief that rules will be followed and an expectation that the trusted parties will recognise the content of the trust placed on them to act accordingly and the expectations to recognise the moral significance of the gift. In addition, just as "gifts" and "gifting" generally presuppose shared understandings about meaning, respect and appropriate responses, trust operates on the normative ground of a shared moral framework and values. So when donors offer organs as gifts, they trust that the shared values and moral standards – such as dignity, fairness, respect, non-commodification, non-instrumentalisation, and care – will influence the allocation process and the treatment of the body during and after donation. It is also important to note that the gift narrative suggests a forward-looking and anticipatory trust relation, in which the trustee is treated as trustworthy, thereby motivating and inspiring trustworthy actions from them in return. This is because, amid uncertainties and irreversible vulnerability, gifting here involves calling recipients, family members, the transplant system, and doctors to be trustworthy and to act morally despite the uncertainties the donor may have at the time they made their donor decision.

Reciprocity, understood as a "mutual exchange or giving back of what one has received" (Mauss, 1954, p. 3), broadens the moral horizons of organ donation. While some models suggest non-financial rewards or priority schemes favouring donors and their families, my notion of reciprocity, rooted in the concept of gifting, treats organ exchange as an ethical means to increase organ availability. Although modern transplantation ethics often resist notions of reciprocity due to concerns about and a desire to avoid commodification, and

although there are connections among reciprocity, exchange, and market dynamics, I argue that reciprocity, as an altruistic form of donation, should not be reduced to commercial transactions or barter systems. Rather, we can understand reciprocity here to be the indirect kind: a diffuse, social form of giving and receiving that sustains solidarity and communal welfare (Titmuss, 2019, p. 227).

Understood in this form, my conception of "reciprocity" aligns organ exchange with the moral logic underpinning social institutions as systems such as taxation, public healthcare, and pensions – all of which seem to rely on the ethical principle of giving without expecting direct returns, yet depending on the assurance that one's giving contributes to a shared good. In addition to being far from reducing donations to transactions, such reciprocity also reinforces the trust-based solidarity that upholds social systems of care. When we view organ donation as an act of indirect reciprocity, we, in turn, open space for ethical responses from recipients and their families to engage with the gifting process by making donations too to persons who are a better match for the recipient family's organ. To receive an organ is to recognise not only the material benefits of the gift but also the moral weight of the gesture: recipients bear a responsibility to honour the gift through ethical comportment, gratitude, and respect for the donor's legacy – acts that symbolically complete the cycle of giving and trust. Recipient families, on the other hand, have the opportunity to gift organs to other recipients whose family member has agreed to be their donor. Thus, reciprocity becomes a moral exchange rather than a market exchange —an ethical rhythm of giving, receiving, and giving back, thereby sustaining communal life.

Whether in the form of direct donations or indirect reciprocity, gifting remains a complex social network that mediates freedom and obligation, generosity and self-interest, and is an act devoid of coercion (Kunte, 2012, p. 36; Mauss, 1954, p. 69; Tsai *et al.*, 2011, pp. 11-13). Unlike other forms of gifting, this type of gifting is not merely a private exchange but a communal endeavour that positions the donor's autonomous decision alongside the shared values of society and the policies in the transplant system.

2.4 Property and Ownership

The concept of "property" has evolved across legal, economic, and historical[27] and philosophical domains to encompass a wide variety of entities ranging from objects like land and cars to intellectual creations and even human bodies and body parts. But unlike the philosophical perspectives that tie property to moral agency or alienation, the legal and economic theories provide (arguably) more structured criteria for what can be recognised, owned, transferred, or even regulated as property. These conceptions of "property" from the legal, philosophical and economic perspectives are beneficial, offering critical insights into how human bodies and their parts may be understood as properties within the OTD frameworks. This is because the increasing reliance on organ transplantation as the preferred treatment for organ failure, along with rising demands for viable organs, underscores a fundamental assumption about ownership, autonomy, and consent. This assumption holds that individuals possess their bodies in a dual sense: as an integral part of their lived experience and as an object they own.

This understanding of the body as a "property" informs arguments and assumptions about the body as a gift, as well as arguments against the commodification of organs. This becomes evident when we consider "traditional" philosophical views on property by Locke and Marx. For Locke, we own our bodies by virtue of being rational agents endowed by God with reason and free will: "every man has a property in his own person. This nobody has any right to but himself" (Locke, 1689/1988, p. 287). This statement is foundational in constructing a liberal argument for bodily autonomy as ownership of the self naturally extends to ownership of the products of one's labour, thereby justifying the acquisition and control of external goods. Following this framework, the body can be seen as legitimate property, and an act of organ donation becomes an expression of moral agency. As such, if a person consents to donate an organ, either as a living or decedent donor, their donation is consistent with Locke's 'labour-mixing' principle and his respect for voluntary action. I posit that Locke's philosophy may be interpreted to suggest that the value of the body is not purely instrumental but resides in the moral significance of free, self-directed giving, which is often

[27] Historically, the idea of property has shifted depending on cultural norms, legal traditions and economic structures. While humans were excluded from being property in principle, the existence of slavery demonstrates the extent to which bodies could be objectified under prevailing legal orders. In medieval and early modern Europe, the body was closely associated with the divine and sovereign, but not considered as property in the individualistic sense, and was subject to the authority of the church or monarch. The body was a sacred vessel, not a commodity, until the development of liberal legal and economic frameworks that recognised bodily autonomy and ownership.

presented as altruistic organ donation and gifting. Marx's view, on the other hand, highlights the risks incurred when we transform altruism into a transaction. This is because Marx, through his critique of property and labour, casts a sceptical light on the implications of treating the body as property. In the *Economic and Philosophic Manuscripts of 1844*, Marx identifies how capitalism alienates people from their labour, the products of their labour and ultimately, from themselves (Marx, 1978, p. 74). This critique is further extended, in *Capita*l, to the commodification of human life and capacities, noting how the body itself can become a site of and for economic exploitation (Marx, 1978, p. 320). As such, for Marx, the commodification of the body – which can be in the form of paid donation or coercive transplantation practices – captures a profound moral failure on our part. Such a commodification, for Marx, transforms persons into instruments of profit, obscuring their intrinsic worth and relational identities. The fear and danger – which is often reiterated by most critics of the organ commodification view – is that what should be a gift, offered voluntarily within ethical bounds, ends up becoming a commodity, subject to market dynamics and economic coercion, leading to the alienation of the donor and the recipient (though potentially, given the possibility of their struggle with the implication of having acquired a body part through exploitative means).

Ownership of the body is both enabling and restrictive. It provides autonomy to preserve, protect, and enhance the body, but also imposes legal and ethical limits, such as prohibitions against selling body parts, relinquishing bodily autonomy to another, or consenting to harmful treatment. Within this framework, organ donation – for both living and deceased donors – is morally and legally justified, provided that consent is given freely and with psychological clarity to avoid undue self-harm. The relationship between ownership of bodies and organ donation can be expressed thus: granted that we cannot give what we do not own or what is not ours (in a manner of speaking), how can we speak of donors giving organs to people in need if such donors do not hold any form of ownership over their bodies and the parts they choose to give?

The legal definition of "ownership" reinforces this perspective. According to the Legal Information Institute of Cornell Law School, "ownership" entails "the legal right to use, possess, and give away a thing." Black's Law Dictionary defines property as "the right to possess, use, and enjoy a determinate thing" (p. 1335). Property rights, as described by Hausleben, include possession, control, exclusion, enjoyment, and disposal, allowing for one's body to be viewed as the property of oneself (p. 5). Honoré (1961) shares this insight,

as for him, property is a "bundle of rights" that may include the rights to possess, use, and manage, and the duty to prevent harm from others (pp. 113-119). But these legal understandings of property are context-dependent and do not always apply fully to every form of property. For example, human bodies in many jurisdictions exist in grey areas of legal theory, and most legal systems do not grant full property rights over one's body or body parts, particularly after death. Consider English common law, which holds that there is "no property in a corpse," a principle derived from cases like Doodeward v Spence (1908). Despite judicial reluctance to classify body parts as property in some cases,[28] the law allows for the body to be treated as such in certain contexts (Andrews, 1986, p. 30). As such, Lori Andrews further argues that individuals can have property-like interests in their bodies and even the bodies of others, given legal provisions for recovering damages in cases of harm to family members (1986, p. 29). As I have earlier noted, and as Hausleben argues, the very act of gifting organs presupposes an entitlement to them, thereby affirming a form of ownership (p. 5).

Legal interpretations of "ownership" primarily emphasise protection against harm, yet the ethical dimensions of bodily ownership extend beyond mere defence. Key philosophical questions arise: How should we treat our bodies if they are considered our possessions? and are there limits to this ownership? To the second question, I agree with Plato and Locke that ownership does not grant unchecked freedom. Plato, in *Phaedo*, asserts that human beings, as "chattels of the gods," lack the authority to end their own lives, as the duration and condition of life are determined by a higher will (p. 62b-c, in Plato 1914, cited in Steinmann pp. 82-83). Locke, too, maintains that while individuals own their bodies, this ownership does not include a license to destroy the self (1689, p. 9; Steinmann, p. 84). Apart from Plato and Locke's theistic accounts of the limits of bodily ownership, other nontheistic accounts argue that the body, as the medium of experience and interaction, is not merely an object but an entity with intrinsic duties of care (Steinmann, pp. 85-86). Phenomenological and existential accounts see the body as the condition for our being in the world and thus reject the view that the body is simply a property we own. Rejecting the view that the body is merely an object owned in a detached sense, for Maurice Merleau-Ponty (1945/2012), the body is a medium of existence, our general medium for having a world (pp. 166-170). As such, Merleau-Ponty argues that rather than "I have a body", "I am my body" because since the body is

[28] Exceptions have been carved in cases involving reproductive tissue, hair and blood, where property-like treatment is allowed.

constitutive of subjectivity and not separable from it, one cannot have unlimited ownership of the body. Rather than being a thing, the body is a situation, our grasp on the world. The body is not a tool we possess; however, it is constitutive of our subjectivity, and there is no detached owner that oversees the body in an unrestricted way (Merleau-Ponty, 1945/2012, pp. 166-170).

Others, like Margaret Jane Radin (1987), Onora O'Neill (2002), Iris Young (1990) and Jennifer Nedelsky (1989, 2011), emphasise the communal dimensions and implications of the body that limit its ownership and what we can do with it. For Radin (1987), "ownership" is incomplete and morally restricted; hence, "ownership of the body" does not mean that body parts can be treated as commodities, as doing so undermines personhood. For O'Neill (2002), considering how bodily rights and autonomy are bounded by our duties to ourselves and to others, the body is a site of moral responsibility, not pure choice. As such, freedom must be exercised within a framework of trust and moral accountability. For Iris Young (1990), since social norms and structures shape bodily existence, our ownership of our bodies is mediated by power and culture, which limits our freedom because it cannot be detached from these relational constraints. In *What Money Can't Buy: The Moral Limits of Markets,* Michael Sandel (2012) argues for a limited ownership of the body. For Sandel, treating the body as a property to sell or modify at will erodes the moral meaning of personhood and community. This is because the ownership of one's body or bodily capacities does not mean unrestricted freedom to do absolutely anything with them, as some uses may be morally impermissible even if one consents to them, especially when such uses degrade aspects of dignity, commodify morally salient capacities or violate obligations to others. Like Young and O'Neill, Sandel's critique suggests that the notion of self-ownership becomes problematic if it implies that there are no external or communal constraints to limit our freedom. While bodily autonomy is morally important, it must be balanced with reflections about the meaning of the body and the impact on human dignity and communal values.

From an economic standpoint, properties are defined by their utility and transferability. As such, economists will regard properties in terms of resource allocation, incentive structures and market efficiency. Herein, property becomes a mechanism for organising and enabling access to scarce resources and maximising social welfare. Within the OTD context, the economic question and concern are often directed at the possibility of alleviating organ shortages through the introduction of market mechanisms; organs are presented as resources that can be understood in economic terms and property language, in

the conventional sense, enables the creation of market-like institutions that align incentives (Becker & Elias, 2007, pp. 3–5). The commodification of bodies is ethically and socially fraught, such that treating bodies as economically transferable property risks reducing persons to the status of repositories of saleable goods. The idea is that the solid organs, which are the object of our discussion here, are not the kind of things that should be commodified, as doing so would risk the objectification of persons and their bodies as means to ends, which will, in turn, lead to more cases of distrust towards the transplant field. Although one may argue that even in systems where payment for organs is rejected, economic logic still applies to the system and permeates policy: for example, the cost of procurement, storage and transplantation, as well as the salaries of transplant doctors, are central to national healthcare planning and can portray the OTD field economically.[29] Though economical in the broadest sense, this cannot be equated with propositions for the commodification of organs and bodies. While the economic logic that applies to the system is necessary for logistics and the functioning of the transplant field in terms of wages and manpower, it differs from the economic logic that would apply to the transplant field if the commodification of organs were accepted at this time.

Separate from the legal and economic presentation of "property" and "ownership" and the body being a property to the one who possesses it, I posit that the OTD field and the medical field requires an understanding of the body as property which emphasises an ownership context and relation that may accommodate some features of conventional property rights and ownership, but need not depend on the legal and economic justification of such rights for the presentation of the body as a kind of property. In view of this, I consider the philosophical contributions of Fiona Woollard on the difference and relationship between property ownership and genuine ownership, and Judith Jarvis Thomson's idea of bodily self-ownership. In *Doing and Allowing Harm* (2015), Woollard presents a nuanced distinction between "property" "ownership" and what she terms "genuine belonging", a category that aids and clarifies our understanding of how individuals relate to things – especially their own bodies – without the invocation of legal or economic terms, insights, and weight of ownership as classically defined. For Woollard, while we often use the language of "ownership" to describe our relation to our bodies, such usage is primarily metaphoric and not always helpful. "Genuine belonging," on the other hand, refers to a form of intimate and morally

[29] In some sense, one may even argue that opt-in systems reflect an economic model that centres on altruism and voluntary exchange, even when no financial incentive is involved.

significant relationship with something that is "not easily alienable" and whose significance is shaped by personal identity, bodily integrity, and agency (Woollard, 2015, p. 99). In this sense, "genuine belonging" differs from "property," which is typically alienable, transferable, and subject to legal rights and economic transactions, as the given legal definitions assume.

Woollard illustrates this difference between "property" and "genuine belonging" with the example of one's place in a queue: a space in a queue 'belongs' to a person in a morally important way. The space can be violated (if someone cuts in), restored (if a friend holds a place), defended or honoured. Yet, the space is not a "property" in the conventional and legal sense, as it is not sold or leased without violating and disrupting the moral logic that sustains the queue and the very norms that give it meaning (Woollard, 2015, p. 98).[30] Similarly, for Woollard (2015), our relationship with our bodies reflects a deep moral belonging that goes beyond legal ownership, such that while we may have control over our bodies and organs and consent to donation, our control over our bodies does not allow for aspects of property rights which traditional legal understandings of property accept (pp. 100-102). Essentially, the analogy is essential for understanding that just as one's spot in a queue belongs to them without being their property, so too do our bodies belong to us in a special and inviolable way that doesn't align with or allow full property rights. For Woollard, speaking of the body as being "owned" like a piece of land or clothing would risk reductionism, overlooking the depth of attachment, identity, and the non-transferability involved in bodily relations.

Woollard's framework would suggest that treating organs as "property" might obscure the more ethically salient notion of "genuine belonging." Put differently, when we consent to organ donation, especially posthumously, where we may raise questions about families consenting to donations in the stead of the deceased, for Woollard, the donation is not merely a transfer of property but a disruption or transformation of something that belonged intimately to someone in a non-proprietary but deeply moral sense. As such, for Woollard, ethical frameworks, symbolic narratives and transplant policies that encourage organ donation must recognise the unique personal and symbolic status of bodies and not treat them as alienable properties to be handed off at will. The idea is that since the consent of living donors often arises from an exercise of control over what belongs to them in a fundamentally personal way rather than from abstract ownership rights, then it must not be different for

[30] I do wonder if Woollard would accept that the space, though it cannot be sold, can be gifted to another. This may be controversial for some on the said queue, but I would like to think that a space on a queue is something that can be gifted or transferred without disrupting the norm of having a space on a queue. For example, I have given my space in concert queues to many strangers before.

decedent donations. Hence, policies and ethical frameworks for donation must consider more than just voluntariness; they must account for the emotional, existential and identity-related aspects that donation entails (Woollard, 2015, pp. 100-103).

Woollard's concept of "genuine belonging" provides a valuable corrective to overly legalistic or commodified views of the body. It affirms that while we can consent to donation and have control over our bodies, this control is not equivalent to the right of disposal typically associated with ownership. Irrespective, Woollard's concept of "genuine belonging" is lacking in the normative clarity that conventional property language provides in the legal, economic and policy context. For example, in a bid to protect donors and their bodies and prevent exploitation, we often rely on property language like rights, consent and even control. While these terms are well supported by conventional presentations of property, they do not adequately apply to the fuzzier notion of "belonging." As such, while the idea of "genuine belonging" may be ethically rich, it may be challenging to implement structurally in medical-legal systems that require enforceable standards. Nonetheless, Woollard's view can be valued as a contribution that deepens arguments for why the body resists commodification, as well as arguments against the commodification of organs – even when such market transactions are voluntary.

Judith Thomson, on the other hand, presents her view of property in her essay "A Defence of Abortion" (1971), where she invokes the idea of "bodily self-ownership" in the famous violinist analogy. While Thomson allows for persons to have rights over their bodies akin to property rights in the legal sense – such that one can refuse to allow another to use their body for the preservation of life – her framework does not treat the body as alienable in a market sense. As such, she parallels Woollard's distinction that control and moral entitlement over one's body do not necessarily entail commodification. Although Thomson's idea of "bodily self-ownership" is presented in the context of abortion, it has significant implications for understanding the moral contours of bodily rights, bodily ownership and genuine belonging.

In Thomson's violinist scenario, she encourages us to imagine waking up and discovering that a famous unconscious violinist has been medically attached to our body without our consent. The violinist's life depends on remaining connected to our kidneys for nine months. The Society of Music Lovers did this because you alone have the right blood type. The main question then arises: are you morally obligated to remain connected even

though you did not consent? For Thomson, “if you do allow him to use your kidneys, it is a kindness on your part, not something he can claim from you as a right” (Thomson, 1971, p. 56). By granting personhood to the individual in need (or in her case, the foetus), one’s right to life does not grant a right to use another person’s body without consent. Applied to organ transplantation, this idea that donors and potential donors must not be viewed or used as means to ends for transplant recipients is reinforced. The fact that a donor is in a life-threatening medical condition does not mean that transplant doctors are permitted to let them die so their organs can be harvested. Similarly, family members do not possess a right to life that would justify manipulating or forcing another family member to donate their body to save one's life or that of another.

Thomson’s view presents a robust assertion of “bodily self-ownership”: you have a right to decide and determine what happens in and to your body, even when another life is at stake. This right, rather than being about property in the conventional legal or economic sense, is about the moral sovereignty of the person over their body, which cannot be commandeered or grabbed for the benefit of others without consent.

While Thomson does not explicitly use the term “genuine belonging” as Woollard does, her position aligns with Woollard's view that our bodies are not mere possessions, but constitutive of our personhood. So unlike “property” in the legal and economic sense, which can be transferred or alienated without the loss of or alteration of identity, the body is intimately and inalienably bound to the self. This is what Woollard means when she claims that our bodies “belong to us” in a morally significant way akin to a place in a queue: while we have a claim to them, they cannot be commodified or transferred without undermining the very thing being claimed and the meaning of that claim (Woollard, 2015, pp. 98-99). As such, for Thomson, our bodily rights are not grounded in ownership in the sense we typically understand “ownership” in “property,” especially the legal and economic sense. Bodily rights are rooted in something deeper, namely, the personal, non-transferable relationship every person has with their own body. Essentially, even though organs can be separated from the body, the act of doing so must respect the non-proprietary, inalienable nature of the body’s belonging to the self. Based on this view, compulsory organ harvesting and conscription, even though they save the lives of recipients, would violate the principle of “bodily self-ownership.” Voluntary donations, on the other hand, though seen as permissible and laudable, are encouraged in Thomson’s idea to be viewed as a moral act of generosity rather than the alienation of a piece of property. It follows that policies and practices in organ transplantation

must respect not just consent, but also the deeply personal and symbolic nature of bodily integrity.

The concept of "bodily self-ownership" therefore shapes notions of bodily integrity, which in turn influence symbolic narratives surrounding organ donation and the body. While the dominant narrative – gifting – aligns with "ownership" by emphasising the voluntary and altruistic transfer of organs, whether in life or after death,[31] the perspective that organs are biological materials frames "ownership" from the viewpoint of the medical establishment and state authorities, wherein the body functions as a resource for treating those with organ failure (Svenaeus, 2010, p. 163).

2.5 Bodily Integrity and Bodily Integrity Rights

I have hinted that our conception of what the body becomes after death, and the symbolic narratives we have about the body and its organs, influence our notion of bodily integrity and the type of rights we have regarding our bodies in OTD. With more attention being given to the body and its physical and symbolic integrity, several considerations have been raised about what the body's physical integrity is to be understood as and how this must be reflected in transplant and donation policies and practices. Consider the following conceptions: Bodily integrity "is a claim against the invasion of the body" (Wilkinson, 2011, p. 16). Body integrity aims at "protection against unwanted physical intrusion [and] safeguards the physical parameters of a person… [it is] against intentional interference with one's body or certain kinds of such interference" (Neff, 1991, pp. 338-340). Bodily integrity holds that "every human being of adult years and sound mind has a right to determine what shall be done with his own body" (Justice Cardozo in Schloendorff v. Society of New York Hospital, 105 N.E. 92 (N.Y. 1914), 93).

From these conceptions, several suppositions can be identified: (1) Body integrity is more than one notion, and each instantiation tends to reflect a different use. (2) When we use the term "body integrity," we tend to refer to different concepts like ownership, property, body autonomy, privacy, body dignity, body respect, body wholeness, etc.[32] (3) There is no single right to bodily integrity but a series of rights concerning the body encompassing bodily

[31] This narrative underpins the opt-in donation system, which values autonomy, consent, and the moral significance of gifts.

[32] For example, while bodily integrity is understood in terms of privacy in the USA, self-determination in Germany and dignity in South Africa, in Canada, it is understood in terms of security according to section 7 of *The Canadian Charter of Rights and Freedom* (Viens, 2020, p. 373).

autonomy, property and ownership, bodily privacy, bodily dignity, bodily well-being, etc. Hence, at best, what we may have is a collection of bodily integrity rights that seek to protect and preserve various related but unidentical aspects of the body. It is in this sense that the idea of property as a bundle of rights can be best presented in relation to the body (Viens, 2020, pp. 369-375).[33] Based on the aforementioned, it can be said that bodily integrity is manifested in terms of the preservation of functionality, wholeness, and inviolability, where the transgression of bodily integrity could lead to physical harm, devaluation of the human person, defilement, and deprivation (Viens, 2016, p. 20).

Bodily integrity significantly influences organ donation and transplantation, affecting both living and deceased donations. People are psychologically inclined to resist practices that violate their bodies' or loved ones' physical integrity (Berntzen & Bjørk, 2014). In this way, bodily integrity can act as a barrier to organ donation, as perceptions of physical wholeness strongly influence one's willingness to donate (Viens, 2016, p. 21). In this context, bodily integrity functions as both an empirical and a normative barrier to donation.

As an empirical barrier to organ donation and transplantation (OTD), concerns about bodily integrity contribute to distrust in the field, particularly through fears of body mutilation and religious or cultural objections. These objections often originate from beliefs that organ transplantation disrupts the passage into the afterlife or permits unethical organ retrieval by medical professionals. Religious critics contend that the body, as a divine gift, must be returned whole, with bodily wholeness ensuring recognition and resurrection in the afterlife (Berntzen & Bjørk, 2014, pp. 266-274; Shewmon, 2004, pp. 76–78; Dorff, 2008, pp. 201–204; Zhai, 2000, pp. 324-325; Sharp, 2006, pp. 32-35). Non-religious critics, meanwhile, raise concerns about burial practices, such as the possibility of an open-casket funeral (Irving *et al.*, 2012, pp. 2526-8; Davis *et al.*, 2004, pp. 548-552; Sharp, 2006, pp. 36-38; Sque *et al.*, 2008, pp. 290-291; Siminoff & Lawrence, 2002, pp. 10-11). Other objections point to visceral

[33] Henry Sidgwick, in *Elements of Politics* (1891), identifies three components of ownership that reflect rights to bodily integrity: the right of exclusive use, the right to destroy, and the right to alienate (70; Bjorkman and Hansson 210-211). Tony Honore gave a more comprehensive list well used in legal discussions on the right to property and ownership: they include the rights to possess, use and manage; the right to income, capital and security; the incident of transmissibility and absence of term; the duty to prevent harm, etc. Depending on how these bundles of rights are interpreted, they can be used to justify narratives of bodies and organs as gifts in the form of biological materials that can be freely given by the living or dead to persons in need, as resource commodities owned by persons who, given the right circumstance and legal approval, may choose to bequeath them to another person through sales with financial compensations or barter systems. See Honoré, Tony. "Ownership." *Oxford Essays in Jurisprudence: A Collaborative Work*, edited by Anthony Gordon Guest, Oxford University Press, 1961, pp. 107–147.

emotions—fear, distress, disgust, and repulsion—that organ removal may provoke, reflecting anxieties about body mutilation or the potential for personality contamination from receiving another's organ (Viens, 2020, p. 22). Whether or not these concerns are rational, they shape real psychological states and influence decisions against donation.

Lucien Lévy-Bruhl characterises this fear of mutilation and dismemberment as mystical thinking, an ancient cultural belief that the body is required in the next world. Because this mode of thought is rooted in subjective reality, it is strongly felt but remains resistant to education or logical contradiction (Lévy-Bruhl 1980, cited in Verble and Worth, 1999, pp. 54-55). Another viewpoint links this fear to animal learning, an evolutionary remnant embedded in our primate history. As Edward Wilson states, such fears are irrational and emotionally intense, arising from the brain's lower, non-intellectual regions (Wilson 1978, cited in Verble & Worth, 1999, pp. 54-56).

A. M. Viens (2020) challenges the consistency of these attitudes, questioning whether the transgression of bodily integrity is truly as impermissible or undesirable as claimed. A striking asymmetry emerges: concerns about bodily integrity serve as grounds for rejecting organ donation but rarely hinder the willingness to receive a transplant.[34] As Viens observes, "when it comes to receiving organ donations, the possibility that a donor's bodily integrity will be transgressed to procure the organ – as well as the bodily integrity of the recipient to receive the organ – does not produce similar beliefs or attitudes of apprehension, revulsion or disapprobation" (2020, p. 22). This inconsistency reveals a form of hypocrisy that warrants scrutiny, as a principled rejection of organ donation on the grounds of bodily integrity should logically extend to the refusal to receive an organ.

Although it is argued that such fear, like most phobias, cannot be eradicated through education and information dissemination, public information campaigns aimed at correcting underlying beliefs about bodily integrity should be promoted by religious and cultural authorities with interfaith support.[35] Additionally, further education from religious leaders should clarify how donating organs does not prevent following traditional burial rights or violate religious requirements. Furthermore, individuals experiencing a fear of bodily mutilation may benefit from sensitively guided exposure to accurate information about the

[34] For further analysis on this, see Irving, M. J., *et al.* "Factors That Influence the Decision to Be an Organ Donor: A Systematic Review of the Qualitative Literature." *Nephrology Dialysis Transplantation*, vol. 27, no. 6, Dec. 2011, pp. 2526–33. https://doi.org/10.1093/ndt/gfr683.

[35] Like the assumptions that OTD treats the body of the dead with disrespect and that organ removal is an impermissible transgression of bodily integrity.

donation process, which can help reduce feelings of helplessness by fostering understanding, informed agency, and a sense of participatory clarity. This allows them to take part in the transplant and donation process, helping to alleviate their fears and demystify their thinking. As another possible solution to the fear of mutilation, Verble and Worth argue that depersonalising the bodies of the deceased when requesting donation consent from family members could be a helpful strategy (Verble & Worth, 1999, pp. 55-56).

Beyond its psychological impact, bodily integrity acts as a normative barrier to organ donation by fostering distrust in the transplant system. While increasing organ availability could save lives, deeply rooted beliefs about bodily integrity impose ethical limits on how this goal should be achieved. These limits are designed to prevent disrespect towards both living and deceased donors. Organ transplantation inherently involves transferring body parts across social, cultural, and geographical boundaries, but it must do so in ways that preserve the dignity of the body and avoid ethical violations (Veins, 2020, p. 24). This is why narratives portraying the body as a biological resource, spare parts, or a commodity are widely rejected. Even arguments that endorse posthumous organ retrieval without prior consent – on the grounds that saving lives outweighs bodily integrity – are flawed. As Fabre (2006/2008) states, while prioritising the sick extends lives, it also raises concerns that living individuals may be reduced to mere means for an end, undermining trust in medical professionals and transplant policies (p. 73). This fear fuels the belief that doctors could prioritise saving a transplant candidate over giving a potential donor a fair chance at survival in critical moments. To address these concerns, the "gift" narrative remains central to organ donation discourse, shaping policies that present donation as a voluntary, altruistic act.

For my thesis, I define bodily integrity (in relation to the field of OTD) as the enduring moral and/or legal claim of a person – whether living or deceased – to the inviolability, boundary, and uncoerced authorship of their body,[36] understood not merely as a biological structure but as a unified moral, existential, and symbolic locus of selfhood that resists fragmentation, instrumentalisation, or the deliberate posthumous incorporation into others without voluntary, informed, and role-sensitive consent.[37] It affirms the individual's

[36] This refers to the idea that people should have sovereign control over what happens to their bodies – in life and after death - through informed directives, explicit consent, and family members' assumption of their will. It implies one's agency in making choices and moral commitments, one's free and informed consent, as well as the resistance to coercion and any intrusion into the body.

[37] While there may be a few exceptions to this view, my presentation of bodily integrity here is only directed at the field of organ transplantation and practices that may encourage the movement of bodies and organs without showing adequate respect for the bodies. Unlike property or commodities, the body is

autonomy, dignity, and agency by opposing certain intrusions, divisions, or appropriations of the body that occur without informed, voluntary, and context-sensitive consent, or that go against social and cultural values and standards for respecting the body, preserving it, and preparing it for burial rights. This right stands as a safeguard against coercion, violence, commodification, and non-consensual medical interventions, protecting the body from being used as a mere means – whether in life or in death – and upholding its status as an integrated, dignified, and non-transferable embodiment of the person. While bodily integrity rights affirm an individual's authority over their body, I argue that the relation of bodily rights to property rights should not be overstated, nor should bodily rights be reduced solely to property rights. Within this framework, I adopt some of Bjorkman and Hansson's (2006) principles of bodily rights: (1) Organs may be taken from a person's body with that person's or a member of their family's informed consent or their acknowledgement in the case of routine organ harvesting. While one may argue that saving or improving lives is more important than kinship relations, I posit that emphasising the role of kinship relations in connection to bodily integrity serves not only legal and moral roles but also emotional, cultural, and religious roles. The inclusion of family in consent and in resolving issues related to bodily integrity holds an essential symbolic, cultural, and social role in medical practices. It affords respect and recognition to the living family as surviving kin with a say in the loved one's life and death. By including family members, one's bodily autonomy at death does not have to end legally. Through the inclusion of family, the body, even at death, retains the status of personal ownership, even when this ownership is transferred to family members. Furthermore, when no explicit consent is left, the legal right is transferred to the family to make informed decisions on one's behalf – as observed in present opt-in and opt-out systems. Culturally, because family members can be regarded as stewards who ensure the dead are treated with dignity according to tradition and/or religion, the family plays a vital role in upholding bodily integrity. The inclusion of family in bodily integrity recognises and positively contributes to the grieving process: while the deceased may no longer experience pain and suffering, the grieving families still do.[38] (2) Where one has given consent, the

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not composed of substitutable parts that can be seamlessly exchanged without leaving an ethical residue. As such, transferring organs without due regard for the body's narrative and symbolic wholeness disrupts its moral coherence. In addition, bodily integrity resists being weighed against utilitarian ends without residual moral loss. The body is not a reservoir of parts whose value can be fully subsumed under the aim of saving others; even lifesaving aims are constrained by the demand for bodily respect.

[38] In addition, based on practical reason, since the body, after death, is often treated as part of the estate – in legal terms, decisions about burial, cremation and donation (which fall under the scope and interest

removal of organs should be permitted to obtain significant therapeutic advantages for the donor (living) or their families (in the case of deceased donors),[39] provided that the removal does not cause disproportionate or serious harm to the donor.[40] This principle is compatible with cultural and religious ideals about the wholeness and sacredness of the body, as well as fears around body mutilation. The disproportionate and serious harms may relate to concerns about not being buried whole or not experiencing certain religious and cultural burial rights and experiences due to the decision to donate. (3) If the practices and policies for retrieving organs pose significant risks of exploiting human beings, then such policies and practices must be disallowed or modified to prevent or cease exploitation. This principle for bodily rights aligns with my aim to secure and enhance trust between the public and the transplant field. Since the body is viewed as a morally charged site of identity and personhood, not merely a neutral or interchangeable vessel, respecting bodily integrity means recognising individuals' unique embodied presence and ensuring they retain autonomous control over their bodies, free from coercion or reduction to means for others' ends. Prospective donors can trust the transplant team to prioritise their health, dignity, safety, and to respect their donation wishes (Bjorkman & Hansson, 2006, pp. 212-214).[41]

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of bodily integrity) may fall under inheritance laws. Hence, attaining medical consent from families will help avoid legal backlash.

[39] This principle is compatible with living and decedent donations where one declares consent to donation prior to their death, as well as cases of consent from family members based on knowledge of the supposed donor's principles, and their interests towards the OTD while alive.

[40] These therapeutic advantages are well documented in interpretative research on the motivations of donors and families of donors who acquiesced to donating organs. They include interests in saving lives through one's death or sacrifice, interests in keeping loved ones alive, interests in doing something good before one dies, interests in partial forms of immortality where one's body lives on through another, as well as interests in knowing a terrible incident or experience led to the preservation of life and opportunities for another. See Berntzen, Helene, and Ida Torunn Bjørk. "Experiences of Donor Families After Consenting to Organ Donation: A Qualitative Study." *Intensive and Critical Care Nursing*, vol. 30, no. 5, 2014, pp. 266–274. http://dx.doi.org/10.1016/j.iccn.2014.03.001. Irving, Michelle J., *et al*. "Factors That Influence the Decision to Be an Organ Donor: A Systematic Review of the Qualitative Literature." *Nephrology Dialysis Transplantation*, vol. 27, no. 6, 2012, pp. 2526–2533. *Oxford Academic*, https://doi.org/10.1093/ndt/gfr683.

[41] Bjorkman and Hansson's presentation of the bundle of principles is geared towards the right to commodify one's organs where their 5 principles of bodily rights are to be applied and evaluated in agreement with their identified 7 major components of bundles of rights to biological materials. I have adopted some of their principles of bodily rights with the goal of presenting an understanding of bodily integrity and bodily rights that places emphasis on respecting and protecting the body rather than selectively understanding geared towards the moral commodification of the body. For further examination see Björkman, B, and S O Hansson. "Bodily rights and property rights." *Journal of Medical Ethics* vol. 32,4 (2006): 209-14. doi:10.1136/jme.2004.011270.

2.6 Motivations to Donate

To improve donation interest and encourage positive donation decisions, G. M. Abouna (2008) identifies two key strategies: promoting a general system for altruistic donations and introducing financial appreciation for living donors (pp. 34-38). Given that living donations from family, friends, and even strangers via the internet are widely accepted, Abouna argues that nondirected donations from anonymous individuals who pass psychological evaluations should also be encouraged. Additionally, since living donors may already receive benefits such as paid leave and public recognition for their sacrifice, financial appreciation—rather than direct compensation—could further incentivise donation (Abouna, 2008, p. 37). The proposal to enhance donation rates through altruism and financial incentives is not a novel concept. Many scholars, bioethicists, and policy analysts have explored similar approaches. For instance, Dr Arthur Matas, former president of the American Society of Transplant Surgeons, has advocated for a regulated system of living kidney sales, emphasising that the ethical mandate to save lives outweighs concerns about commodification. Similarly, Dr Richard Fine, former president of the American Society of Transplantation, argues that rigid prohibitions on financial incentives should be reconsidered. Fine suggests that long-term medical insurance coverage for donors could serve as a potential incentive, emphasising that ensuring donor well-being can be a legitimate motivation for donation (Abouna, 2008, p. 37).[42]

Conversely, advocates of altruistic donation argue that donors and their families must be protected from institutional, social, or undue pressures – something financial incentives fail to ensure. They emphasise the importance of informed consent, which allows donors to fully comprehend the risks, benefits, and consequences of their decision (WHO, 1991, p. 47, cited in Cherry, 1999, p. 9). While they acknowledge that psychological, emotional, and medical considerations, as well as the desire to help others, may influence donation decisions (Cherry 1999, p. 9), they maintain that financial incentives create inappropriate pressures. However, as noted in the U.S. Office of Technological Assessment Report, even altruism is not free from problematic influences. Individuals may feel compelled to donate to meet social expectations, avoid confrontation, or fulfil family and cultural obligations. In some cases, the desire to save a loved one's life may override personal reservations about donation (ibid).

[42] For further reading, see Warren, J. "Time Has Come to Cease Being 'Pious About Equity' in Organ Acquisition." *Transplant News*, vol. 16, no. 17, 2006.

In this section, I examine various motivations for organ donation, including altruism, self-interested love, duty, and solidarity. I also consider psychosocial perspectives, which suggest that donation decisions arise from a complex interplay of motivations, with certain factors becoming more salient than others. By clarifying the degrees and modes of these motivations, I argue for the possibility of mixed motivations in organ donation, challenging the notion that a singular, isolated cause drives decisions.

2.6.1 Psychosocial Motivations

The psychosocial motivations for organ donations encompass both empirical and philosophical justifications for the social, cultural, and ethical acceptance of living donations (Wilkinson, 2011, p. 124). The psychosocial aspects of living donations capitalise on the psychological, physical and health-related well-being of the family members and friends of patients. The idea is that the loved ones of patients, oftentimes, suffer greatly at the loss of their friends, children, partners, etc., and more so if they are prevented from saving their lives by donating organs. In addition, not only does donation avoid and prevent the tragedy of death and grief, but it also helps reduce the burden of taking care of a sick relative and watching them die (ibid). Adopting a fairly standard view of harm as a setback to interest, we can argue that the refusal of living donations creates a setback to the interest of being living donors, which in turn causes harm to the living family members and friends of patients. Broadening the argument philosophically, the claim is that since philosophical views on well-being allow for vicarious interests, which demonstrate our concern for the well-being of others, then parents have vicarious interests in the welfare and well-being of their children; spouses have vicarious interests in the welfare of their partners. Ultimately, the harm the sick patient experiences causes harm to the living family members of the patient as well. And as Wilkinson holds, such harm to family members and friends is not limited to mental suffering (2011, pp. 124-125).[43]

These psychosocial motivations can be categorised as non-altruistic motivations, as donation motivations cannot be limited to altruistic gifting. While it is less likely that an

[43] To back this up, Wilkinson recounts the experience of a living donor who describes her willful organ donation to her husband as one that was done for her benefit, to prevent grief, death, and regret. As Wilkinson recounts, the woman said “I did it for selfish reasons. I didn't want to lose my playmate” (125). In the medical television series, *House*, we see Max who presents her motivation to donate her kidney to her partner, Hannah, in her need to stay married to her and the possibility of being together in their old years: “I just want me and Hannah to lie in bed together as old ladies, compare scars” (See "Sleeping Dogs Lie." *House*, season 2, episode 18, directed by Daniel Attias, written by Sara Hess, Fox, 2006; Kunte 58-59).

action can be purely altruistic, it is possible for an action to have more than one motivation. Even more importantly, one can share their altruistic motivations with other kinds of psychosocial and non-altruistic motivations, albeit to varying degrees, and at the same time or at different times. As such, while one may be ethically justified in donating altruistically, this does not limit, negate, or cancel other possible motivating interests that contribute to their decision to donate.

2.6.2 Altruism and Solidarity

Several studies on the ethics of OTD discuss the need for and place of altruism in hopes of attaining more organs from living and decedent donors; encouraging the symbolic narrative and interest to save more lives through selfless sacrifices; and promoting the aim of respecting the bodies and integrity of donors. Gaining momentum as the go-to socially accepted, encouraged and expected motivation for positive donation decisions, altruism is heavily backed up by and tied to the gift narrative. Although such social articulation of the altruistic ideal does not determine practice, it influences OTD practices such that the act of gifting organs provides a "social texture that sustains relationships between people, institutions, and the communities they live" (Jensen & Hoeyer, 2021, p. 27). In the same light, Lesley Sharp (2006) notes that the rhetoric of altruism is created and used to prescribe and encourage the view that organ donation and transplantation are unselfish, generous and devoid of any form of reciprocation (p. 365). Just as the rhetoric of gifts has been shaped by the notion of altruism, such that it is employed as the go-to lingua for OTD-related activities, policies and campaigns, in relation to altruism, the gift narrative is presented more in its normative capacity to influence the meaning of donation and donation decisions than the anthropological theory of gifts and gifting (Jensen and Hoeyer, 2021, p. 27). The idea is that since the body is an end in itself, and thus a gift given for the benefit of the other, this act of kindness – from experience, is selfless and aimed towards the recipient with no expectation or desire for payment. As a result, altruism in OTD has become commonsensical, such that we conceive its meaning even before understanding what is at stake in the decision to donate. Altruism aims to promote gift-centred policies and practices, and based on awareness, information and campaigns about recipients in need, altruism influences policies that promote positive donation decisions (ibid).

Generally, the widely applied meaning of altruism connotes that altruistic motivations often lead to sacrificial acts, but more importantly, since they are aimed at the other's welfare,

they beget acts of selflessness. This is evident in Kristen Monroe's definition of altruism as "behaviour intended to benefit another, even when this action risks possible sacrifice to the welfare of the actor" (1996, p. 6). Such altruistic ideals can also be traced back to August Comte.[44] In reaction to his fear of the negative influence of individualism and egoism on solidarity in modern society, Comte identified our capacity for an unselfish desire to live for others as our highest ethical duty aimed towards social cohesion, progress and collective welfare (Piliavin 2001, cited in Jensen and Hoeyer, 2021, p. 26). I argue that this unselfish desire aimed towards the other has not only empirically and anthropologically challenged the gift exchange theory,[45] showing that there is no such thing as a purely altruistic act or pure altruism, but the unselfish desire towards another also need not be directed towards specific individuals (Jensen and Hoeyer, 2021, p. 26).

In OTD research on ethical donation practices, while advocates may not always clearly define their use of the term, the meaning of altruism is often deduced based on their usage in arguments and discussions - donating organs (whether through living or decedent donations) is a selfless act. By altruistic, I mean behaviour undertaken deliberately to help someone other than the agent for that other individual's sake, in part; acts motivated in part by a desire to benefit someone other than oneself for that person's sake. Having said this, my understanding of altruism is not only inclusive of actions where self-interested motives are absent, but it also encompasses both generous and ungenerous actions that accommodate mixed motives for these actions.[46] It recognises that not all pure altruistic acts may involve self-sacrifice;[47] some altruistic acts can be motivated by self-interest.[48] So while a single motive may not be characterised in two ways, a single altruistic act can be undertaken from more than one motive – i.e. the act may involve motivations from self-interest and selflessness; self-sacrifice and social recognition, etc. Although altruism may serve as an explanation for donors' motives, it does not always connote a duty to donate, nor is it the

[44] See Comte, Auguste, *et al. System of Positive Polity*. Longmans, Green and Co., 1875.
[45] Mauss argues that gifting is engrained with a threefold obligation of giving, receiving and reciprocating. See Mauss, Marcel. *The Gift: The Form and Reason for Exchange in Archaic Societies*. Translated by W. D. Halls, W.W. Norton, 1990.
[46] See Nuffield Council on Bioethics, *Human Bodies: Donation for Medicine and Science*, p. 145 – 175 for the report on mixed donation motivations, with and without altruism.
[47] As seen in the cases of some people who happily declare interest in decedent donations, when asked about their views on donation, this category of donors states that their decision to donate their organs cannot and should not really be considered an act of sacrifice because not only have they enjoyed a fulfilled life, they would already be dead and the dead do not have any sacrifice to make.
[48] An example will be the wife who chooses to donate her kidney to her husband because she isn't ready to be alone, does not want to take care of the kids alone, or does not want a life where he is not present to share in her burdens and joys.

moral norm for allowing donations, especially living donations, since “a misanthrope who wants to become a donor is as acceptable as a philanthropic superstar” (Munson, 2002, p. 224).

For Wilkinson (2011), altruistic motivations to donate organs should not be limited to the idea of pure altruism, as expressed through instances of selflessness. This is because not only has the traditional presentation of altruism in OTD given an inaccurate perception of the moral value of giving, but an examination of said altruistic motivations among donors will show that altruism does not account for generosity for persons who have agreed to be donors. As Wilkinson states, since “many donors do not care what happens to their organs after they die”, their donations barely involve any sacrifice (2011, pp. 149-150). Arguing a similar view, Saunders (2012) suggests that since people have little to no use for their organs at death and since decedent donations require little to no sacrifice, this serves as a reason to question the authenticity of altruistic motivations to donate (Saunders, 2012, p. 378). Defining altruism as “a non-self-interested concern for the interests of others”, Wilkinson states that: “a wide variety of other-regarding motives can be described as altruistic, such as a special concern for children, or the deaf, or the poor. “Altruism” does not have a specific application. It does not require, for example, that actions be motivated out of adherence to a greatest happiness principle or, saliently here, a greatest needs principle. Consequently, there need be nothing non-altruistic about conditional donation…” (2011, p. 163).

Claims of pure altruistic donations suggest an account of industrialised altruism that permeates the transplant and medical community. Given the need to ethically increase the number of organs available, altruism (in this pure form) is treated more as an ethical resource extraction means (Healy, 2006, p. 44) that capitalises on body autonomy, body protection, and consent while refuting other possible donation motivations and means of increasing the supply of organs. Expressing his disagreement with the view that gifting expresses a complex network of social ties, Kieran Healy (2006) argues that rather than an assurance against coercive forms of procurement, or claims of rejecting incentivised and non-incentivised rewards, altruism imbues the process of organ acquisition with a form of righteousness at the expense of avoiding unsavoury acts like organ sales and body objectification (p. 44). According to Chuan Voo (2014), most altruistic justification projects have an improper understanding of how altruism functions as a moral motive, leading to misguided approaches that limit its understanding and application (pp. 1-50).

Favourable attitudes towards donation show positive correlations with other prosocial attitudes, such as voluntary work and charity work, feelings of gratitude, solidarity, and general altruistic values (Falomir-Pichastor *et al.*, 2011, p. 208). These prosocial attitudes are often understood as altruistic since they involve people engaging in actions geared towards the safety, health and welfare of the other. However, as one would observe, the motivations for engaging in prosocial activities like voluntary and charity works are not always purely altruistic – students think it will be great for their college application, repentant persons see it as a way to make up for lost time or past misdeeds, and some others see it as a way of getting in good terms with their religion's God. Whatever the other motivations were, they do not diminish the altruistic nature of their engagement with such prosocial activities. Consider the case of Kochouseph Chittilappilly and Zell Kravinsky. While both men have been praised for their heroic acts and considered purely altruistic, details on their donation motivations reveal that, although Chittilappilly and Kravinsky were both motivated by altruistic ideals in the basic sense, they experienced other motivations for their altruistic giving.[49] Chittilappilly hoped his example would lead to a chain of donations, considering the circumstances of his donation.[50] In contrast, Kravinsky seemed to be motivated by his sister's death, the guilt of not being able to help her and the overwhelming need to see himself as a good person. In his interview with Ian Parker, Kravinsky admits: "I used to feel that I had to be good, truly good in my heart and spirit, in order to do good. But it's the other way around: if you do good, you become better. With each thing I've given away, I've been more certain of the need to give more away. And at the end of it, maybe I will be good. But what are they going to say – that I'm depressed? I am, but this isn't suicidal. I am depressed because I haven't done enough" ("Zell Kravinsky's Extreme Acts of Philanthropy").

Another way to understand altruistic motivations is in their relationship with solidarity motivations. While I agree that altruistic motivations generate positive emotional reactions towards organ donation, which could be exemplary in prompting others to behave similarly, altruistic motivations lack concrete effects on facilitating emotional integration

[49] For further reading, see Parker, Ian. "Zell Kravinsky's Extreme Acts of Philanthropy." *The New Yorker*, 26 July 2004, www.newyorker.com/magazine/2004/08/02/the-gift-ian-parker. And Karmali, Naazneen. "Asia's 2018 Heroes of Philanthropy: The Mogul Who Gifted His Kidney to Save a Stranger's Life." *Forbes*, 21 Nov. 2018, www.forbes.com/sites/naazneenkarmali/2018/11/12/asias-2018-heroes-of-philanthropy-the-gift-of-life/#:~:text=Chittilappilly%20had%20agreed%20to%20donate,long%20chain%20of%20kidney%20donors.

[50] The wife of the recipient wasn't a match for her husband, so when Chittilappilly donated his organ, she donated hers to another recipient in need.

among citizens. Solidarity motivations, which account for social integration of the affective kind, have this effect. They recognize that not every act of giving implies an altruistic motive and therefore acknowledge that irrespective of the various mixed motivations we may possess for giving, an ethical rationale binds most givers: the "high sense of social responsibility towards the needs of other members of the society" (Titmuss, 2019, p. 236, cited in Voo, 2014, p. 89). This is evident in Titmuss' account of the motivations of people who choose to donate blood, where their motivations range from care for others to structural motivations about maintaining the donation system, as well as reciprocal benefits and non-financial incentives such as free health checks. For Titmuss, while none of these donors had pure altruistic motivations, since none of them expressed complete, disinterested, and spontaneous altruism, their motivations expressed some sense of obligation, approval, and interest, as well as feelings of inclusion in society. After all, for Titmuss, it is the individuality and diversity of motivations that add life and sense to the community (2019, 235; cited in Voo, 2014, p. 88). It is therefore in both these senses - as an altruistic and a solidarity motivation - that the gift narrative is promoted because it "structures the phenomenology of pursuing the good as the phenomenology of acting from obligation towards others," which in some sense is based on reciprocal rules depending on the form of gift relationship practised (Voo, 2014, p. 89).

Since positive attitudes towards donation tend to increase with social support, social interaction and inclusion, the feeling of involvement in society's collective organisation and welfare fosters a sense of social responsibility towards organ transplantation and donation, captured in the solidarity motivation. Put differently, the feeling of being part of a group (or society) could enhance donation tendencies as "ingroup categorisation is likely to increase perceptions of similarity and closeness, as well as a feeling of responsibility for the other group members' welfare" (Dovidio *et al.* 1991, cited in Falomir-Pichastor *et al.*, 2011, p. 207). Considering solidarity as a limited form of altruism, for Saunders, most donations are motivated by solidarity rather than altruism since donations are geared towards the needs of persons we share a community with – this is evident in living and decedent donations; donations are made to families and friends and in cases of anonymous donations, such recipients are members of the larger community. Since donations are made to persons, we feel in-group identities with, such donations are "more restricted forms of other-concerns, limited to members of a particular group" (Saunders, 2012, p. 377; cited in Voo, 2014, pp. 102-108).

2.6.3 Duty

I have stated earlier that the conception of death and the body held by people contributes to their motivation to donate. This is particularly evident when we consider reactions to conceptions of the body as a machine or the 'influenced body', where persons who see the body as a machine tend to be more positive of donation because they see the body as "the physical container for, but not a part of" the self (Pfaller *et al.*, 2018, pp. 1330-1331). On the other hand, those who conceive the body in the second category "consider body parts as an entity essential to the person as a 'being in its total'" and hence, are more prone to reject donation ideas (Pfaller *et al.*, 2018, p. 1331). Nevertheless, within these two categories of body conception, for some of those who are positive about organ donation, there is a sense of duty to organ recipients in need. Introduced and understood in the prescriptive capacity, in some cases, this duty may be promoted by patriotic ideals, and in other cases, by the sheer love for humanity and the preservation of life. As such, it is possible that for some donors, their motivating duty to donate may sometimes overlap with altruistic and solidaristic motivations, thereby increasing the likelihood of positive donation decisions.

Yet another way of understanding this notion of duty is through an application of Kant's categorical imperative: 'act only according to the maxim whereby you can at the same time will that it should become a universal law' (Jensen & Hoeyer, 2021, pp. 27-28). In a sense, this imperative suggests a universal duty towards organ donation, organ recipients and reciprocity in the form of a social obligation. Examples of donation being a social obligation abound in the mindset that helping persons in existential need is a duty to humanity; hence, donation is encouraged based on this narrative. This universal law formula introduces two types of duties: perfect and imperfect duties. Perfect duties are those that admit no exceptions and must always be done (like not lying or killing), while imperfect duties include ideals and general moral requirements that allow flexibility, such as beneficence. Unlike perfect duties, imperfect duties like beneficence, when omitted, do not always result in a moral failing, and there is a positive obligation to promote the welfare of others. Organ donation falls under such imperfect duties – while donation is an ideal and is encouraged, one is not required to make a donation in every case, as doing so may impose grave risks and costs. Nevertheless, in ordinary cases, where risks are low, donation becomes morally important: we ought to give when we can, especially to people in dire need. If one were to make a maxim that says: *"I will not donate an organ to save a person's life if doing so imposes a modest cost on me,"* then universalising this maxim will yield notions like: *"no one will donate an organ to save*

another's life if it imposes a modest cost." If this view becomes universal, it will mean that when someone requires a transplant, there will be no available organ because no one would donate. Since this will undermine one's well-being, creating a contradiction in will, as one could not rationally will that proposition to be a universal law because we would want people to help us when the time comes, refusing to donate organs is therefore seen as immoral. Hence, although an imperfect duty, we do have a duty to help organ recipients.

Suppose one makes a positive version of the earlier maxim*: "I will donate an organ to save a person's life when doing so does not harm me (i.e. decedent donation) or only slightly harms me (i.e. living bone marrow, liver or kidney donations)."* If universalised, this would suggest a world where, when feasible, people are willing to help one another and save lives through organ donation. Unlike the earlier maxim, this maxim does not create a contradiction in will; as such, it seems quite consistent with reason and does not conflict with one's rational ends because one would want the same standard if one were ever in need of organs for transplant. Hence, despite being an imperfect duty, Kant's formula for universal law proposes (when feasible) a duty to donate organs, a duty to organ recipients, and reciprocity.

Just like the duty to donate, the duty of reciprocity is embedded in the maxim itself because if the maxim states that *"one should contribute to organ donation systems if one wishes to benefit from them,"* when universalised, it promotes the willingness to give and receive organs, and as such, promotes reciprocity. As previously mentioned, this form of reciprocity can be seen in the idea of social obligation towards organ donation. Considering existing systems for organ acquisition and donation, the opt-out system, also known as presumed consent, exemplifies the general social obligation to donate and presents as a duty of reciprocity.

Presumed consent is a routine method for procuring organs, which requires individuals to opt out of the donor system if they do not wish to donate their organs when they die.[51] This view justifies acquiring organs without explicit or direct permission, since, under certain conditions, we can presume that the decedent donors would have consented to

[51] Strictly, "presumed consent" is the combination of a method of routinely procuring organs after death, plus a rationale for this: that silence, in given social conditions at least, implies consent to such procurement. Since one may endorse a policy of routine procurement without accepting or even doubting the rationale, this can be taken as a version of presumed consent, given that the central theme of routine organ procurement is shared. This is the sort of position Sneddon (2009) endorses: the routine procurement of organs without the presumption of consent as a rationale.

donation, having never indicated otherwise. Put simply, the "absence of explicit indication to the contrary indicates actual consent" (Sneddon, 2009, p. 56). Reiterating these same ideas, the World Health Organization defines presumed consent as a system that permits the removal of bodily materials for transplantation, anatomical study, or research, unless the person has previously expressed objections with an identified office or informed party who conveys such objection (Colarusso, R. (n.d.) ("Who Guiding Principles On Human Cell, Tissue And Organ Transplantation"). Advocates of presumed consent argue that the policy is most effective in preserving autonomy, altruism, and utility through the donor's consent. This is based on the logic that if anyone had no wish to donate, they are free and have the right to refuse donation; if anyone wishes to donate, they can express such altruistic need by consenting to donate; and if it is presumed that the organs are to be donated since there are no objections, it increases utility, maximizes happiness, enforces community solidarity and saves lives (Veatch and Ross pp. 118-124; Alwehaibi, 2017, p. 14). These perspectives express the idea of a duty to persons in need of organs as a social obligation.

The effect is discussions about how opt-out systems help to avoid 'freeloaders / free riders' who are willing to receive organs but not accepting of being donors themselves, hence the expression 'if you want to receive, you have to be willing to give' in some donation campaigns (Jensen & Hoeyer, 2021, p. 28). Nevertheless, another way in which donation can be regarded as a duty towards recipients is the effect it has as a motivating reason to save the life of a family member in cases of direct donations; aside from altruistic ideals, some persons may feel a duty to save the life of a family member by making a donation. As such, duty influences the possibility of motivations from moral positions, as well as felt obligations towards family members and expected obligations regarding appropriate behaviour towards family members and other members of society (Lock and Crowley-Makota, p. 154, cited in Pfaller *et al.*, 2021, p. 1330).

Conclusion

In this chapter, I have briefly introduced the field of organ transplantation and donation (OTD), including its history, role in medicine and human health development, and some of the ethical issues that arise in the field. I have also highlighted the prominent areas where trust relations are most paramount and threatened: the understanding of the body and death, bodily integrity, and motivations to donate.

CHAPTER 3

TRUST

Introduction

In the previous chapters, I introduced the field of organ transplantation and briefly hinted at how trust influences individuals' motivations to donate – or not to donate – organs. I also briefly noted how trust may intersect with cultural and religious beliefs that shape people's attitudes toward the body and its symbolic meanings. These symbolic perceptions, in turn, can profoundly impact trust relationships within the transplantation system, including those between donors, recipients, donor families, medical professionals, and broader institutional frameworks.

This problem of trust affects the main players in the organ transplantation system – i.e., donors, families of donors, recipients and healthcare workers – in three main ways: the expression of autonomy, the usefulness of donated organs and the good treatment of donors, recipients and family members (Martínez-López *et al.*, 2023). For donors, the problem of trust reflects their concern for fair distribution and unwasted organs; their uncertainty about how their bodies are viewed and handled, their doubt about whether their wishes and decisions will be respected; or their fear that their lives may not be prioritised as individuals worth saving rather than as mere sources of organs for others. In similar ways, the problem of trust for donor families reflects their concerns for the respect of wishes – both theirs and the dead donor's; the dignified treatment of bodies; prioritising saving relatives' lives; good communication; fair allocation, etc. In the case of recipients, the trust problem is captured in their concerns for optimal treatment, good communication, and follow-up care, as well as the fair distribution of organs. For healthcare workers, the trust problem captures their concerns about recipients' optimal treatment of organs received, priority for informed decision-making, and fair allocation of organs, among other issues.

Before I go further into examining the trust relations in the organ transplantation field, the problems that arise from existing trust relations between the main players in the transplant field, or how trust can be improved and the effect of such improvement, I find it pertinent to first examine what I mean by trust in this research and how my understanding of trust may differ from or be similar to others especially when applied to the OTD field. As such, my aim in this chapter is to examine trust and identify my conception of trust.

To do this, I shall first present an array of definitions of trust available in the existing trust literature. This presentation will capture the contributions of philosophers, sociologists, and ethicists, highlighting various elements of concern and priority in the conception of trust and how it can be differentiated from similar yet distinct concepts, such as reliance, faith, and conviction.

My identification of instances of trust and distrust in the previous chapter has hinted at how the problem of trust persists in the OTD field, such that it can be identified as a primary problem in the ethics of organ transplantation. As I hope to demonstrate, trust has a significant impact on the growth of the transplant field, particularly in terms of creating, improving, and increasing positive donation decisions. The role of trust is evident in our conception of the organ transplantation field as a medical field that enables the literal and symbolic fusion of disparate bodies for continued existence. Trust informs our perception of organ transplantation as the empathetic union of body parts, identities, and beliefs, aimed (in part) at the survival of the other and sometimes at the reassurance of the self. By this expression, I posit that the element of trust frames organ transplantation as an act that transcends medicine. This is because the transplant field forms an existential bridge between life and death, the self and other, as well as individual survival and collective well-being. Through trust, we acknowledge that while transplantation ensures the recipient's continued life, it may also serve some donor's deeper need for meaning, continuity and moral fulfilment. I acknowledge that this is not a general experience for every donor as in some cases where donation decisions are made on behalf of the deceased wherein the deceased may not have explored or entertained the need or desire for deeper meaning in any interesting way, or the cases of persons who have no further interest in their bodies after death and are as such fine with donating their bodies if the need arises. Irrespective, research shows that, compared to the former, a larger population is interested in the meaning, moral fulfilment, and existential continuity that their donation promises.[52] It is partly for this reason that organ

[52] For further reading on this, see Papachristou, C., Walter, M., Dietrich, K., Danzer, G., Klupp, J., Klapp, B. F., & Frommer, J. (2004). Motivation for living-donor liver transplantation from the donor's perspective: an in-depth qualitative research study. *Transplantation*, *78*(10), 1506–1514. https://doi-org.proxy.bib.uottawa.ca/10.1097/01.tp.0000142620.08431.26; Łuków P. (2020). Pure Altruistic Gift and the Ethics of Transplant Medicine. *Journal of bioethical inquiry*, *17*(1), 95–107. https://doi.org/10.1007/s11673-019-09951-z; Dicks S. G., Northam H., van Haren F. M., Boer D. P. An exploration of the relationship between families of deceased organ donors and transplant recipients: A systematic review and qualitative synthesis. *Health Psychology Open*. 2018;5(1). doi:10.1177/2055102918782172; Carola, V., Morale, C., Vincenzo, C., Cecchi, V., Errico, L., & Nicolais, G. (2023). Organ donation: psychosocial factors of the decision-making process. *Frontiers in Psychology*, *14*, 1111328. https://doi.org/10.3389/fpsyg.2023.1111328; Laskowski, N. M., Brandt, G., Tigges-Limmer,

transplantation is framed as a deeply relational act, involving more than the physical integration of organs; it also carries emotional, cultural, and even spiritual significance, highlighting the moral and social dimensions of transplantation, where giving and receiving become acts of shared human experience.

3.1 Understanding Trust: Conceptual Clarification and Historical Contributions

We use the word "trust" in varying ways. We use it to show confidence or to ascribe moral worth, to show reliance and dependence or to express commitment, to show faith or to encourage good behaviour; and in many ways, to express our belief states and emotional stance within a domain of action and/or testimony even when evidence counters such a stance. Sometimes our use of the word and its intended meanings are clear – like when Aladdin asks Princess Jasmine, "Do you trust me?" or when Jack Sparrow, in *Pirates of the Caribbean: The Curse of the Black Pearl* (2003), says, "You can always trust the dishonest man to be dishonest." Other times, they are less obvious but carry the supposed weight of intentionality geared towards the other – like when in *Harry Potter and the Deathly Hallows* (Book 7) Snape casts a Patronus charm, which takes the form of a doe (the same as Lily's). Surprised, Dumbledore asks, "After all this time?" and Snape replies, "Always." With that single word, Snape encapsulates not just his love for Lily, but his undying loyalty and trustworthiness, despite appearances of betrayal. Similarly, in *The Hunger Games: Catching Fire* (2013), Haymitch Abernathy, urging Katniss to distinguish between those she can trust and the enemies manipulating her situation, says to her, "Remember who the real enemy is." With this strategic expression, Haymitch relays a calculative trust relation that clarifies to Katniss that he trusts her to realise that he is worth trusting and to trust him in turn, not only to be committed to her cause but also to be willing to see it through.

Just as the word, "trust" can be used in the positive sense, encouraging the act of trusting, it can also be used to deter or warn against the possibility of betrayal and failed expectation of competence – like Joker's cynical take on such themes in *The Dark Knight* (2008) when he says "You can't trust anyone these days; you have to do everything yourself." Without clearly using the word "trust", we can also infer its usage to warn against blind trust,

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K., Halbeisen, G., & Paslakis, G. (2023). Donor and Donation Images (DDI)-A Scoping Review of What We Know and What We Don't. *Journal of Clinical Medicine*, *12*(3), 952. https://doi.org/10.3390/jcm12030952; Hogan, N. S., Coolican, M., & Schmidt, L. A. (2013). Making meaning in the legacy of tissue donation for donor families. *Progress in Transplantation*, *23*(2), 180–187. https://doi.org/10.7182/pit2013862; Quintin J. (2013). Organ transplantation and meaning of life: the quest for self-fulfilment. *Medicine, health care, and philosophy*, *16*(3), 565–574. https://doi.org/10.1007/s11019-012-9439-z

like in *Frozen* (2013), when Elsa tells Anna, "You can't marry a man you just met," reminding her that trust, in some instances, is supposed to be built over time, not assumed.

Other high culture examples can be found in *All's Well That Ends Well* and *Julius Caesar* by William Shakespeare, *The Histories* by Herodotus, *The Odyssey* by Homer, and others. In *All's Well That Ends Well*, the Countess of Roussillon, in advising Helena on how to navigate court life, says to her, "Love all, trust a few, do wrong to none." By this statement, she presents a very pragmatic view: be universal with your goodwill, but be cautious with trust. She distinguishes between affection for all and trusting everyone, while still emphasising the moral balance. While prudence and kindness in relationships are encouraged, trust must be reserved. Julius Caesar's expression "et tu, Brute?" is another notable example, identifying the ultimate effect of betrayed personal trust. In *The Histories*, when the narrator asserts, "The best man is he who realises, when he is trusted, the full depth of that trust," we see the honour and sense of awareness and responsibility that come with being trusted, as well as the moral implications of being trustworthy. Put differently, with trust presented as an ethical responsibility, character is tested through it. As such, from Herodotus, we learn that trust isn't just given; it imposes moral obligation(s) on the trustee. And in *The Odyssey* (Book 19), we read about Odysseus, who, disguised as a beggar, probes Penelope's loyalty and feelings while he hints at the importance of hidden truth. By telling her to "trust not in appearance", we can infer that genuine trust requires discernment and not just surface judgment. We can also infer that while trust can be tested, like when Odysseus probes Penelope's fidelity, trust is not reliant on appearance alone – especially in a world where men use disguise and deception. As we shall soon see, this is what I mean when I say that transplant donors, family members and recipients trust transplant doctors. The trust here goes beyond the general sense of reliance that patients often place on doctors due to their profession, similar to how we rely on pilots when we fly or on bus drivers and Uber drivers.

In examining what trust is, this section will also canvass some extant characterisations of trust. This will help illuminate the dynamic nature of trust, as I identify the existing characteristics that will be accepted, modified, or rejected for my presentation, definition, and application of trust. In addition, by examining various existing conceptions, definitions, and characteristics of trust, this will be beneficial in identifying and differentiating the various types of trust.

3.2 A Brief History of the Philosophical Contributions to Trust

Trust is not a new concept. Although not a virtue in itself, trust is closely connected to virtues, playing a vital role in our moral and social lives and interpersonal relationships. Trust is a learned capacity or disposition associated with our social development with other humans in general and with the particular communities and groups we form or belong to. Trust connotes a normative capacity expected and strived for to attain growth, stability, mutual welfare and concern (depending on relationships and roles) while also strengthening relationships and improving traits and values that inform the character to trust. Theorizing reasons for trusting and the impact of trust on social relations, psychologists (Worchel, 1979; Kramer & Tyler, 1996; Waytz, 2023; Lalumera, 2024), sociologists (Luhmann, 1979; Gambetta, 1988; Robbins, 2014; Eyal, Au and Capotescu, 2024), economists (Axelrod, 1984; Fehr, 2009), anthropologists (Coates, 2018; Storer & Simpson, 2022), and philosophers (Baier, 1986; Hertzberg, 1988; Jones, 1996; McLeod, 2002, 2004) have presented trust as an important element for healthy relationships and personality. Given the influences and interests of these fields, trust is employed by various persons to explain reasons for and the lack of cooperation, reliability, human relations and emotional development, economic growth, political stability, war, credibility, harm and even death. Often deployed in conversations about relations, roles, expectations, and commitments to persons in specific domains, trust has a subtle way of emerging as the most important moral disposition while relegating other values to a lesser status (Simpson, 2012, p. 550).

Given the aforementioned, it seems quite unequivocally clear that trust, rather than just being a mere abstract philosophical and sociological concept, is an emergent property of social life embedded in and personally experienced by people in their daily lives and engagement with friends, family members, healthcare providers, politicians, coworkers, media figures, etc. The value of trust is not limited to cases of money or possessions with market value; it includes cases where the lives of individuals are at stake, as well as the dignity of persons. It is partly for this that trust is appreciated within the relationships we form, despite the risks involved and the possibility of betrayal and deceit (Robbins, 2014, p. 12).

Trust is not only a key moral value or a normative good, but also essential for maintaining social order, given the situation and relationship in which it is applied. It helps to smooth the process of cooperation and interaction between people, allowing society to

function effectively and enabling individuals to thrive; it plays a crucial role in both personal growth and community development (Putnam, 1993, p. 171). Trust encourages people to rely on one another and make commitments, often without fully knowing the outcomes or stakes involved (Robbins, 2014, p. 12). It is central to creating a shared sense of norms, i.e., the normative expectations that trust entails, such as depending on others, keeping promises, showing genuine dedication and commitment, and upholding common values. Additionally, trust supports progress across various social spheres. It drives collaboration in fields such as science and technology, fosters economic stability, and helps people come together to pursue common goals. Without trust, these collective efforts would be difficult, if not impossible, to achieve.

Although trust is widely acknowledged as a fundamental normative value – something that everyone should both give and receive or be gifted and burdened with – and has been of interest for centuries, philosophical discussions on the history of trust remain relatively sparse. For Simpson (2012), this is partly because the concept of trust is so vastly applied that there is an invisible assumption of what it means, which is supposedly well understood by all who use it in the context they do. As a tacit confirmation of this, the philosophical literature on trust remains slim compared to other philosophical insights into other moral virtues and concepts such as knowledge, truth, and justice (Simpson, 2012, pp. 550-551). As a result, understanding the key elements or components of trust often requires us to carefully examine the works of ancient philosophers, extracting insights on trust from their broader contributions. These historical texts don't always explicitly focus on trust, so it's up to modern scholars to piece together the relevant ideas and concepts scattered throughout ancient philosophy.

For example, although Plato does not explicitly address trust or trustworthiness in his exploration of the great virtues of justice and the relationship between rulers and the ruled, it can be inferred that the idea of "leadership" he refers to carries an implicit trust. In *The Republic*, while discussing the role of philosopher-kings, Plato suggests that these rulers can only govern effectively if the majority of citizens trust that they will rule wisely. Plato captures the critical importance of trust among the ruling class for the stability and success of the state; he highlights the advantage of trust, noting that if the philosopher-kings fear betrayal – such as the poisoning of their wine by their subordinates – then the very foundation of the republic will crumble under mutual suspicion (Plato, trans. 2007, Book III, pp. 414d–

415d).[53] In essence, Plato seems to consider trust as vital for both social and political stability. Not only is trust essential for effective governance and leadership, but it is also advantageous for political systems where rulers can rely on the commitment and cooperation of their subjects, with expectations that the subjects will fulfil their responsibilities and are committed to the leader's goals and rule (Robbins, 2014, p. 13). In his work *Politics*, like Plato, Aristotle implicitly recognises the vital role of trust in maintaining social harmony by condemning tyrants for fostering an environment where the people, instead of distrusting the ruler, direct their distrust toward one another. He highlights how trust within a political structure can be easily undermined by a ruler's abuse of power, leading to division among the people and a loss of social cohesion (Aristotle, trans. 1998, Book V, 1313b). The lesson here is clear: trust is not only fundamental between rulers and the ruled but also among the people themselves (Robbins, 2014, p. 13).

In Aristotle's *Nicomachean Ethics*, although trust is not discussed in the modern sense of the term, it is a crucial element in his broader teachings on friendship and virtue. Aristotle's ethical framework focuses on the cultivation of virtuous character traits (arguably traits of trustworthiness), which are foundational to his understanding of social relationships and, by extension, trust. Key elements of trust in Aristotle's *Nicomachean Ethics* can be drawn from his discussions on the nature of friendship and virtue (Aristotle, trans. 2009, Book II, 1103a–1105a; Book VIII, 1155a–1158a; Book IX, 1165b–1166b). From his presentation of friendship as utility, we see first, the kind of trust we place in people on first acquaintance as members of our society – what Horsburgh terms innocent trust; we trust them to behave rightly and civilly towards us, and we owe them that much in return. In another sense, since friendship here is based on mutual benefit, the trust component is aimed towards mutual concern for the other's well-being, but not necessarily with a commitment towards them. Trust here is built around the broad sense of the reliability of the other party to fulfil

[53] One may argue that there is the possibility of the king having subjects who love and trust him but will – for whatever reason – betray him. While I agree with this possibility, it seems to me that Plato is more concerned with emphasising the advantage of trust and the result of unchecked distrust. Quite similar to Plato's implementation of trust in politics, in 1990, after the "Velvet Revolution", Vaclav Havel, the newly elected president of Czechoslovakia, in an emotional speech, pleaded with his people: "we have to trust one another." This plea was aimed at fighting and ending fifty years of oppression and exploitation, which had led to widespread distrust and paranoia among the populace. The request to trust was also a plea to set the precondition for a functioning social and economic system, to promote free enterprise rather than a suffocating one. Instead of just being another political ruse or speech, Havel's speech carried with it his belief that trust and cooperation, rather than fear and control, lead to prosperous societies. See Flores, F., & Solomon, R. C. (1998). Creating trust. Business Ethics Quarterly, 8(2), 205-232. https://doi.org/10.2307/3857754

specific needs or interests. In the treatment of friendship as a virtue, we see a more foundational, virtuous and normative presentation of trust, as in this friendship type, trust is built upon the shared commitment to moral excellence. Trust for Aristotle may be intrinsically linked to virtue, integrity and character since virtuous people can be relied upon to act in morally acceptable ways in the domains they are trusted; they not only fulfil promises and act justly, but they honour their relationships and are committed to the roles and actions expected of them in such relationships. Given his view on friendship as a key element in promoting social harmony and cooperation, it can be argued that trust is necessary for creating a stable and virtuous society, geared towards the common good and extending beyond personal relationships to shape the broader community. In addition, Aristotle's view of reciprocity in friendship can be considered an essential element of trust. Just as true friendship promotes the exchange of goodwill measured by mutual concern for each other's welfare, there exists a reciprocal element of trust where, in trusting you, and making it known that I trust you, I seek also to be trusted by you. This reciprocal trust sustains friendship over time, encouraging each person to trust the other to act in good faith and be committed to their welfare, even without direct rewards.

For Robbins (2014), the concept of "trust" further emerges in the works of early modern moral and political philosophers such as Immanuel Kant, David Hume, John Locke, and Adam Smith, all of whom address elements of trust through concepts like promise-keeping, fidelity, and character (pp. 14-15). For Kant, promise-keeping is a perfect duty that binds individuals in moral communities.[54] He argues that the act of keeping promises creates a cohesive, solidaristic group in which mutual respect among members is essential (Kant, 1998). For Hume, promise-keeping is one of the three artifices of society that allow individuals to extend commitments beyond family and friends to others with whom they share no direct ties.[55] Hume ([1740] 2000) sees trust as an artificial construct that enables society to function beyond small, intimate groups. Locke, too, ties trustworthiness to the very foundation of a society, suggesting that a society cannot be formed or sustained without respect for agreements and promises (Locke, [1689] 1988; Robbins, 2014, p. 14). Adam

[54] Perfect duties are duties that are binding, strict, and can be clearly and consistently enforced. These duties must always be followed, without exception, and include duties such as the duty not to lie or the duty not to commit murder. These are considered absolute, and failure to fulfil them is morally wrong in all circumstances. See Kant, I. (1998). *Groundwork for the metaphysics of morals* (M. J. Gregor, Trans.). Cambridge University Press. (Original work published 1785)

[55] See Hume, D. (1739–1740). *A treatise of human nature* (L. A. Selby-Bigge, Ed.; P. H. Nidditch, Rev.). Oxford University Press, 2000. (Original work published 1739–1740)

Smith emphasises the role of self-interest in maintaining one's character, arguing that people are motivated to uphold their trustworthiness not just out of altruism but because they fear losing their reputation and, thus, their ability to engage in profitable transactions (Smith, [1763] 1978). According to these philosophers, trust, manifesting as promise-keeping and moral character, is not just a social nicety but a fundamental element for the existence and functioning of society (Robbins, 2014, pp. 13-15).

Also worth mentioning is the contribution of Georg Simmel (1978) to the trust literature, where Simmel explains that trust emerges as a necessary force that enables social interactions, even when people know little about each other. For Simmel, without trust, the social fabric would unravel, as few relationships are based purely on factual knowledge or direct experience. Trust allows for cooperation in a world where most interactions are based on limited information (Simmel, 1978, pp. 178-179).

It wasn't until Annette Baier's "Trust and Antitrust" (1986) that we were provided with a detailed philosophical account of trust. Baier's contributions to the trust literature focus on the moral, social, and relational aspects of trust. She conceptualises trust not only as a social and psychological phenomenon but as a moral virtue essential for ethical relationships. In her view, trust is integral to moral communities, fostering cooperation, empathy, and mutual respect (Baier, 1986, pp. 233-235). Baier argues that trust is inseparable from vulnerability, where individuals open themselves to potential harm or disappointment when relying on others. This inherent risk, she suggests, is essential for the formation of meaningful social bonds. Trust, therefore, is not just about predictable behaviour, but about having moral faith in others, especially when risks are involved (Baier, 1986, pp. 236-238). Baier emphasises the role of trust in social life, asserting that it is foundational for social order and cooperation, and that it is critical for the functioning of societies and institutions, as individuals depend on each other for collective well-being (Baier, 1986, pp. 239-241). Furthermore, Baier explores the relationship between trust and justice, arguing that for trust to thrive, individuals must perceive the systems they are part of as fair and just. Without justice, trust cannot be fully realised, as perceived fairness underpins the possibility of being able to rely on others (Baier, 1986, pp. 239-245). Baier also brings a feminist perspective to the literature, critiquing traditional theories of trust that often overlook power dynamics. She emphasises the need for a more inclusive, context-sensitive approach to trust, acknowledging that social positions influence individuals' ability to trust (Baier, 1986, pp. 240-247). Baier's

work shapes a deeper, more ethical understanding of trust, highlighting its moral foundations and its central role in creating just cooperative societies.

3.3 What is Trust: Contemporary Conceptual Contributions

While the historical philosophical contribution to the trust literature suggests the view that trust arises from features related to humans being social beings, living socially and depending or relying on one another to act cooperatively to foster growth and stability, the concept still fails to have a single, unanimously accepted definition (Simpson, 2012, p. 550). From my analysis so far, it can be deduced that, depending on the meaning one holds, trust may acquire resonances of threat and hope that may be applied differently in various situations and contexts (Simpson, 2012, p. 550). As I have indicated earlier, the concept "trust" can be applied to our interactions with non-animate things, amoral beings like pets and toddlers, or to describe dependability when delegating tasks or confidence in outcomes. Respective examples of these ways of using trust include: saying I trust my phone battery to last until I am done writing this chapter; saying I trust my cat to wake me up at 6 am every morning, mostly for her sake, to get her breakfast; when I tell a younger colleague that I am entrusting them to a getting task done – proactive trust based on authorization; or when I say to a student during office hours that I trust they will ace their following assessment – reactive trust based on expectation. While "trust" has been used in all these cases, it has been employed in various capacities, not the one I am interested in for this research.

In this section, I present and critique contemporary conceptions of trust. By critiquing various conceptions of trust, I intend to attempt a presentation of the characteristics of trust and further engage with the various types of trust that may be identified. In one sense, this method will make for an easier understanding of what "trust" is, how we use it in this work and what we mean when we talk about "trust" in the medical field and more specifically in the OTD field. In another sense, this method will emphasise my view that there is no one perfect or all-encompassing way of understanding "trust". This is because the contexts and ways "trust" appears and can be used have informed and acquired a rhetorical potency which has, in turn, allowed for nuances of meanings (Dasgupta, 1988, p. 53; Gambetta, 1988, p. 234; Pettit, 1995; Jones, 1996, p. 22). By saying that "trust" has acquired a rhetorical potency, I mean that "trust" has become such a powerful tool for communication, morally duty and persuasion that it is often applied in public spheres on issues related to politics, health, religion, finance, economics, public discourse, etc., as a compelling and

persuasive tool for influencing opinions, shaping behaviour, gaining support and emphasizing reliance and fidelity. With an increased prominence among the populace, "trust" not only evokes emotional reactions but also establishes credibility and influences decision-making processes in various ways. The rhetorical potency of trust gives it emotional appeal, since trust is inherently tied to emotions such as safety, fear, reliability, and security. The emotional aspect of trust captures the vulnerability and desire for reliance and dependability in relationships. The rhetorical potency of trust captures its cultural and social relevance, as well as its universal value in affirming legitimacy and shaping perceptions. By invoking the rhetorical context, trust can frame debates and shift public opinion on related issues – as is the case in the organ transplantation field.

For Thomas Simpson (2012), "trust" is often "used in contexts different but analogically related to the generative conditions. Its use in these contexts is so apposite that, by repetition, variegated derivative forms of trust arise" (p. 551). As such, rather than having a simple definition or understanding of the term, we have multiple definitions; "trust" is then essentially "an umbrella term under which plural notions cluster" (Simpson, 2012, p. 551; Hollis, 1998, p. 10). Since understanding "trust" as an umbrella term avoids the regimentation of meanings to one definition, this results in conceptions where trust is naturally understood as an affective attitude ("I will trust my wife, she is faithful, I will not be jealous");[56] a conative attitude ("No matter what happens, I will always trust you"); a cognitive attitude ("I know you are honourable, so I trust you'); an action ("I followed the bus driver, because I trusted he knew the way"); and in some situations, it may be used to dramatically motivate trustworthiness through acts of love, mutual gain or moral considerations, where such motivations may count as reasons not to betray the trustee. (Simpson, 2012, pp. 553-554).

Consider the following conceptions of trust:

***A Primitive Attitude and Concept*:** "trust is a general outlook on human nature that does not necessarily depend on personal experiences or the assumption that others are trustworthy" (Uslaner, 2002, p. 10).

[56] I am also interested in an affective approach to understanding and conceptualising trust. As Karen Jones argues, the affective attitude allows us to argue for and explain three obvious facts about trust: (i) that trust and distrust are contraries rather than contradictories; (ii) that trust cannot be willed, forced or enforced; and (iii) that trust can give rise to beliefs that are abnormally resistant to evidence (Jones, 1996, p. 15).

Framing trust as a primitive and foundational attitude towards humanity, Eric Uslaner (2002) describes trust as a "general outlook on human nature that does not necessarily depend on personal experiences or the assumption that others are trustworthy" (p. 10). Uslaner's definition views trust as an ingrained belief or disposition that influences human behaviour at given times, regardless of specific individual experiences. As such, trust is presented more as a primitive moral attitude – an ingrained predisposition to view strangers with benevolence, and less as a reaction to the behaviour of others. Being a primitive attitude, trust is presented not as a learned response to specific experiences or interactions but as a deep, intrinsic aspect of human nature. Uslaner's conception of trust challenges the traditional view of trust, which often posits that trust develops from human interactions, human experiences and by extension, human relationships. By his framing of trust as a general outlook on human nature, Uslaner means that individuals' predisposition to trust others is largely shaped by their overall perception of humanity and not any specific evidence or personal history. As such, trust is not contingent on people being trustworthy but is rather rooted in the belief that, in general, people can be trusted. This perspective aligns well with theories of generalised trust, which emphasise the societal level of trust rather than focusing on personal relationships (Putnam, 2000).

Uslaner's broad conception of trust is ingrained in a moral psychology which allows him to view trust as a stable, enduring attitude. By this, he sees trust as a general faith in the goodwill of others that individuals learn early in life from parents (2002, pp. 17-18). He calls this type of trust "moralistic trust," viewing it as a form of "generalised trust" directed at both known and unknown individuals. Unlike "strategic trust," which is rational and conditional, or "particularised trust," which is reserved for in-groups, "moralistic trust" is universal and not derived from specific experiences, but rather reflects a belief in the inherent decency of human beings. This view resonates with the moral sentimentalist tradition in Rousseau's idea of natural human goodness and in Aristotelian notions of ethos as habituated virtue. Uslaner's view is advantageous in redefining trust from a mere tool for managing risk to a moral orientation—a sort of ethical infrastructure that shapes how individuals and societies function.

By stating that trust does not depend on personal experiences or past interactions, Uslaner (2002) distinguishes between two types of trust: "generalised trust" and "particularised trust." "Generalised trust" is a broad, often subconscious belief in the goodness of people at large, while "particularised trust" is more context-specific, based on

direct experiences with specific persons and groups. Following Uslaner, one can argue that generalised trust suggests that the belief in human goodness can influence cooperation and altruism, even when personal experience or specific evidence of trustworthiness is missing.

Uslaner's conception of trust is advantageous in its capacity to explain how social cohesion and civic participation can be maintained in the absence of personal familiarity since moralistic trust applies to both strangers and institutions, forming a bedrock for social capital – a vital resource for public health, lower corruption, democratic governance and economic prosperity (Putnam, 2000; Uslaner, 2002). By removing trust from direct experiences, Uslaner offers a model of trust that is robust, pre-reflective, reciprocal and wide-reaching. Uslaner's view of trust has normative appeal, especially when interpreted as an ethical imperative to remain open and benevolent toward others, especially the unknown and vulnerable. As Baier (1986) suggests, trust is a moral sentiment that reflects not only judgment but also hope – an investment in the moral integrity of the social world.

Despite its advantages, Uslaner's conception of trust has serious limitations. A primary flaw is inherent in its epistemological looseness: if trust is not grounded in the actual behaviour or the trustworthiness of others, then what justifies it? The problem is that Uslaner's view can border on naivete, promoting the act of trusting blindly and leaving individuals vulnerable to manipulation, exploitation or systemic injustice (Hardin, 2002). Following this, trust as presented here can be identified as uncritical optimism – a stance detached from the demands of moral discernment and contextual sensitivity. In addition, viewing trust as a fixed disposition learned early in life raises concerns about inflexibility and moral stagnation. Viewing trust as a general outlook to human nature reflects an overreaching idealism about humanity. Uslaner may have overlooked the realities of human behaviour, such as deceit, betrayal, self-interest, etc. Critics such as Fukuyama (1995) argue that trust is not inherently part of human nature but is instead a product of social, cultural, and institutional factors. If trust is impervious to later experiences, then those raised in mistrustful environments may remain locked in cynicism, regardless of changing circumstances, and those who maintain trust despite betrayal may fall prey to people who take advantage of such a trait and may fail to hold others accountable. By oversimplifying the complexities of trust, Uslaner's view overlooks the nuanced and context-dependent nature of trust; a generalised outlook may obscure the precise factors that influence trust in particular situations. Trust is not always a monolithic construct; it varies depending on the persons involved, the specific situation and field applied, as well as the perceived benefits and risks of trusting. Trust must

rather be understood in more specific, relational terms while taking into account factors such as previous interactions, the nature of relationships and the level of risk required (Mayer, Davia & Schoorman, 1995). Finally, empirical research suggests that "moralistic trust" correlates strongly with socioeconomic privilege, such as stable income, parental education, and neighbourhood safety (Uslaner, 2002, pp. 63–70). This raises concerns of structural bias: if trust is portrayed as a moral virtue, what does that imply about the moral standing of marginalised groups who – justifiably – distrust institutions or strangers? The risk here is of pathologizing justified mistrust, thereby obscuring the social conditions that erode trust in the first place.

***A Biological Desire*:** "trust is an adaptive neurological mechanism hardwired in human brains that promotes cooperation and arose because of biological evolutionary kin-selection and reciprocal altruism mechanisms" (Kurzban, 2003, p. 106).

Robert Kurzban's assertion emphasises the neurological basis of trust, despite the fact that empirical evidence supporting specific neural correlates of trust is still developing. While research by Bechara *et al*. (1997) indicates that areas such as the prefrontal cortex and amygdala are involved in trust-related decisions, the extent to which these neural circuits are "hardwired" as Kurzban holds, remains a subject of ongoing research. Kurzban's conception of trust aligns with the theories of kin selection and reciprocal altruism. As proposed by Hamilton (1964), kin selection proposes that individuals are more likely to perform altruistic acts for those with whom they share genetic ties, promoting the survival of shared genes. Reciprocal altruism, on the other hand, was introduced by Trivers (1971), and extends altruism to interactions among non-relatives, where individuals help others with the expectation of future reciprocation. Kurzban's view that trust evolved through these mechanisms implies that humans are neurologically predisposed to cooperate with both kin and non-kin, facilitating social cohesion and mutual benefits.

As an advantage, Kurzban's inclusion of evolutionary theories provides a compelling framework for understanding the origins of trust. His integration of trust with kin selection and reciprocal altruism offers a biological basis for why humans may be predisposed to cooperate and trust in the most general sense – like trusting the sun to rise tomorrow if nothing goes wrong or trusting a bus driver to know the route to your destination. It also explains variation of trust behaviours based on relatedness, memory capacity (in terms of remembering one's past deeds) and reputation. Irrespective, trust can't simply be a

neurological switch; it emerges through cognitive heuristics and social norms and is influenced by social norms and cultural factors. Kurzban's conception of trust ignores the role of beliefs and attitudes in trusting as trusting someone involves believing they are trustworthy and expecting their future behaviour to align with that understanding (Jones, 1996, pp. 4-6). Kurzban's view reduces these intentional and epistemic components to an automatic neural function hardwired by evolution, hence, disregarding the trustor's perspective and their ability to reflect upon, revise, suspend or even withdraw trust. In addition, contrary to Kurzban's view, we frequently trust people who are neither kin nor expected to reciprocate – such as trusting doctors, civil institutions, and strangers under a shared moral framework (Hardin 2002, p. 129; Putnam 1993, p. 169). Kurzban's view fails to account for the normatively enforced, institutionally supported or civic form of trust which operates without direct incentives or reciprocation.

The moral thickness of trust allows for the recognition of vulnerability, moral expectations and an intentional recognition and acceptance of the object of trust and concern. Considering this, trust cannot be a hardwired mechanism; rather, it involves normativity, interpersonal relationships, and the moral significance ascribed to the motives of the trustee (Baier, 1994, pp. 133-135). Kurzban's view disregards the moral depth of trust and the interpersonal significance of trust, reducing it to a mere mechanical adaptation. Considering the dynamics of trust in relationships – i.e., the breach of trust and the possibility of moral repair and reconciliation – we find that trust is not hardwired, it is a process that involves dialogue, promises, apologies and policy mechanisms (O'Neill 2002, pp. 169–177; Hardin 2002, pp. 129–133). As another limitation, Kurzban's view cannot account for the repair of trust, nor can it explain the transformation of interpersonal relationships after the violation of trust; both of which may require moral reflection, the re-evaluation of motives and the renewal of interpersonal understandings. Simply put, Kurzban's definition overlooks the role of moral responsibility and interpersonal transformation in rebuilding trust.

As yet another disadvantage, Kurzban's definition of trust is too broad. By defining trust as "an adaptive neurological mechanism hardwired in human brains that promotes cooperation," his definition allows for the replacement of the subject matter (which in this case is "trust") to a number of other socially approved behaviours, actions and values such as love, friendship, altruistic motivations, and solidarity. All of which can also be argued from the standpoint of kin-selection and reciprocal altruistic mechanisms.

***An Expectation*:** "trust is the expectation of (1) the persistence and fulfilment of the natural and moral social order, (2) technically competent role performance from the trustee, and (3) the trustee to carry out their fiduciary obligations and responsibilities" (Barber, 1983, p. 133).

Articulating this definition of trust in *The Logic and Limits of Trust* (1983), Bernard Barber's nuanced conception of trust presents a tripartite framework which emphasises trust as a complex phenomenon, an expectation embedded within social structures, role-specific duties and moral obligations. As an advantage, Barber's definition of trust offers a comprehensive framework: it shows that institutions and moral standards support trusting relationships. This framework accounts for the fact that trust is not solely based on competence but also on shared societal norms and ethical conduct – this aligns with Luhmann's (1979) view that trust functions to reduce complexity in social systems by providing a framework for expectations. For Barber, for trust to flourish, there is a need for a moral social order that guides behaviour, ensures competence within the person acting in and holding a particular role, and a clear understanding that the person will fulfil their responsibilities with fairness and care. Emphasising the moral obligation of trust alongside the technical competency, Barber's view underscores the moral dimension of trusting relationships and trust in relationships, which is often neglected by perspectives that view trust as purely pragmatic or strategic. Situating trust within social structures and roles, Barber's view highlights the relational and institutional dimensions of trust. This sociological approach moves beyond individualistic interpretations, recognising that trust is often placed in systems and roles rather than individuals alone (Barber, 1983, pp. 5-6).

Additionally, Barber's view is advantageous in its application to institutional trust, i.e., trusting doctors, lawyers, judges or financial institutions. Such trust cannot rest solely on interpersonal relationships and is instead anchored in a framework of routines, roles, moral obligations, expectations, competency and institutions that collectively enable individuals to be trustworthy. Not only does this view of trust emphasize policy mechanisms designed to protect and foster civic trust in terms of the credibility of institutions to deliver their respective services, it also allows for a nuanced understanding of trust that acknowledges individuals being trusted for their expertise in certain areas while also being expected to act in the best interest of others, as in professional or fiduciary relationships (Barber, 1983, pp. 13-15; 132-134).

Despite these advantages, critics argue that Barber's framework is too idealised and overlooks the complexities and imperfections inherent in social systems (Zucker, 1986, p. 58). Barber's framework assumes that individuals and institutions will act in accordance with moral and social orders, but normative assumption may not account for instances where orders are violated, leading to a breakdown of trust. As an additional limitation, by focusing on roles and structures, Barber's view runs the risk of placing trust in individuals or systems without sufficient scrutiny of their actual behaviours or intentions, especially the moral dimension of such behaviours and intensions – trusting someone involves not just expecting their role performance, but believing in their intent and character (Jones, 1996, pp. 4-25). This may lead to misplaced trust, in which individuals are trusted based on their roles rather than on demonstrated competence or ethical conduct (Gambetta, 1988, pp. 213-237). Lastly, while Barber adequately shows the place of roles, routines and institutions in fostering civic trust, he fails to account for interpersonal relationships that arise outside institutional structures, such as trusting a friend, a sibling, a romantic partner or colleagues who operate outside a well-understood policy framework. For Hardin (2002), this forms an inability to account for forms of trust that emerge between individuals in a context of vulnerability and uncertainty (p. 129).

***A Strategic and Social Orientation*:** "trust is a calculative orientation toward risk and a social orientation toward other people and toward society as a whole" (Kramer & Tyler, 1996, p. 17)

Roderick Kramer and Tom Tyler's conception of trust in their seminal work, *Trust in Organisations* (1996), encapsulates trust as both a rational assessment of risk and a relational commitment to others. As such, trust is presented as being a rational, forward-looking evaluation of vulnerability and risk as well as a moral and interpersonal orientation toward relationships and institutions. Kramer and Tyler's perspective is advantageous in its balanced view of trust, which integrates both rational and social elements. For Kramer and Tyler, people do not trust blindly but weigh incentives, track records and vulnerability alongside their understanding of interpersonal relationships and social institutions (1996, p. 17). This resonates with real-world experience, in which trust typically involves careful consideration of both interpersonal motives and contextual safeguards. In addition, their view highlights the role of institutions and shared norms in fostering interpersonal trust, because, for Kramer and Tyler, trust is not an isolated, atomistic decision but occurs within a social framework consisting of routines, moral standards, incentives, and mechanisms for redress (1996, p. 17). Kramer and Tyler's view shows how vulnerability and risk are inherent in trusting

relationships, showing that trust involves placing oneself at the discretion of another (1996, p. 17; Baier, 1994, pp. 131-134). Hence, viewing trust as a calculative orientation toward risk, Kramer and Tyler account for the realistic, pragmatic judgments people make when extending trust.

A major shortcoming is that Kramer and Tyler's view reduces trust to a form of calculation, disregarding its moral depth and vulnerability to betrayal. As Baier (1994) notes, trust involves open vulnerability and a moral understanding that cannot be fully captured by a pure calculus of incentives (pp. 131-135). By framing trust in this forward-looking strategic way, Kramer and Tyler understate the significance of loyalty, care, and moral character – elements that influence interpersonal relationships (Jones, 1996, pp. 4-24). In addition, Kramer and Tyler's definition primarily focuses on cognitive and social aspects, potentially underrepresenting the emotional and cultural dimensions of trust. Emotions and cultural norms play significant roles in trust formation and maintenance, and their exclusion may limit the definition's applicability in emotionally charged or culturally diverse contexts.

***An Affective Attitude*:** "trust is an attitude of optimism that the goodwill and competence of another will extend to cover the domain of interaction with the truster; this optimism is couched not in beliefs about the trustworthiness of others, but rather in accordance with affect and emotions" (Jones, 1996, p. 5).

Karen Jones' distinctive view of trust emphasises its emotional and optimistic dimensions. The definition situates trust in the realm of emotions, suggesting that trust is more than a cognitive assessment but also an emotional stance influencing our engagement with others. Herein, trust is framed as a form of optimistic vulnerability that cannot be fully explained by pure beliefs or incentives. By this, it is meant that trust involves more than just cold calculations or a set of beliefs about someone's reliability. Instead, trusting someone involves choosing to make oneself vulnerable – open to potential harm or betrayal – with a hopeful or optimistic attitude that the other person will respond positively or responsibly. Consider the example of a patient trusting a surgeon. The patient might know the surgeon is well trained (a factual belief) and that incentives align for the surgeon to perform their best (self-interest). However, trusting the surgeon also involves a kind of vulnerable optimism – a hope or affirmation that the surgeon will care for their well-being and do their best, even when there's a chance something might go awry. This cannot be fully explained by incentives or beliefs; it involves an interpersonal leap of faith.

Jones' view is advantageous in accounting for the moral and interpersonal texture of trusting relationships (Jones, 1996, pp. 4-7). For Jones, trusting involves an affirmation of vulnerability and an openness toward the motives and character of the trustee (Jones, 1996, p. 5). This resonates with Annette Baier's (1994) philosophical view, which highlights vulnerability, reliance and interpersonal understanding as essential components of trusting relationships (pp. 131-134). By framing trust as an attitude stemming from emotions instead of pure beliefs, Jones presents a realistic view that resonates with ordinary experience, where much trusting occurs at a pre-cognitive or affective level (Jones, 1996, pp. 5-6). Jones' definition also accounts for trusting relationships where there might be limited information or unwillingness to compute incentives. For Jones (1996), we often trust without extensive reflection or clear cost-benefit analysis. We rather open ourselves to trusting people in ways that cannot be fully explained by pure calculation (pp. 5-7). This resonates with Thomas Hardin's (2002) observation that interpersonal trust frequently involves taking a moral risk in a context of uncertainty (pp. 128-131).

Irrespective, Jones's account shows significant limitations following criticisms from Hardin (2002) and Barber (1983) that trusting purely on the basis of emotions disregards the role of incentives, institutions, routine and mechanisms for verifying trustworthy behaviour (Hardin, 2002, pp. 128-133; Barber, 1983, pp. 131-134). Jones' view presents the danger of trusting in a naïve or unfounded way, which may foster vulnerability to abuse and betrayal, especially in relationships with a clear imbalance of power or knowledge. There is also the concern that this view disregards the role of rational reflection and judgement in trusting relationships. By tying trust to an attitude or feeling, this view may undermine the normative significance of trusting, that is its role in honouring moral relationships and moral responsibilities toward both the trustor and the trustee (Baier, 1994, pp. 131-133). Without a clear moral framework, trust may become a form of wishful thinking instead of a moral affirmation of someone's character. The emphasis on emotions and optimism may introduce ambiguity in applying the definition across different contexts. For example, in professional or institutional settings, where trust is often evaluated based on performance and reliability, the affective dimension might be less applicable or harder to measure. In addition, by downplaying the role of beliefs about trustworthiness, Jones's definition may neglect the importance of evidence and past experiences in forming trust. This is because in situations where individuals have limited emotional engagement, cognitive assessments of trustworthiness are crucial. Against Jones' view, trust based on emotional optimism may face

challenges in justification, especially when the trustee's actions do not align with the trustor's expectations. Without a cognitive basis, it may be challenging to rationalise or defend the decision to trust, potentially leading to vulnerabilities.

Yet another notable disagreement is the view that when we trust, others' goodwill will extend to us. While this may seem to be the case for some trust relationships, it is not a universal notion that applies to all forms of trust. Requiring the goodwill of others as a necessary condition for trust will be too demanding and will limit the instances of trust, given our trust relations with people who are indifferent to us. This is because goodwill alone is insufficient for trust; I could trust my hair stylist to braid my hair well, but that is not because they care about me. Similarly, trusting strangers and institutions does not always require their goodwill towards us. Ideally, goodwill is not a necessary condition for trust. I will discuss this further in chapters 4 and 5.

A Belief about Another's Trustworthiness: "trust is a belief and expectation held by one party that another party will behave in a trustworthy manner with respect to an uncertain issue or risky matter; that is, X believes that it is in Y's interest to behave in a trustworthy fashion with regard to uncertain matter Z" (Hardin, 2002, p. 8).

Russell Hardin's definition emphasises two principal components: (i) the trustor's beliefs and expectations, and (ii) the trustor's understanding that the trustee's incentives align with honouring that trust. Hardin's realistic and pragmatic framing of trust gives merit to his view. This definition posits that trust arises when one party believes that the other has an interest in maintaining a trustworthy relationship, particularly in situations involving uncertainty or risk. Hardin's perspective aligns with the "encapsulated interest" model, which suggests that individuals trust others when they believe that the other's interests are aligned with their own, thereby motivating trustworthy behaviour. Hardin's view also shows the significance of dependence and vulnerability in trusting relationships (Hardin, 2002, pp. 7-9). The person extending trust is vulnerable because their well-being depends on the judgments and incentives that guide the trusted person's choices.

Hardin's definition can be criticised for placing too much emphasis on self-interest, potentially overlooking other motivations for trustworthy behaviour, such as moral obligations or emotional bonds. For example, in a familial or altruistic context, people may act in trustworthy ways with no direct personal gain. While Hardin focuses on cognitive assessments, his view may neglect the emotional and social dimensions of trust, as trust often

involves feelings of affection or shared identity that are not fully captured by purely rational frameworks. Hardin's view falls short in addressing the normative significance of trusting – its role in fostering moral community, interpersonal solidarity, or civic institutions (Baier, 1994, pp. 129-134). Without accounting for these moral dimensions, his view cannot fully encapsulate the rich, interpersonal character of trust as something more than a pragmatic calculus. Lastly, while it may seem like Hardin's view on trust is such that exists in trusting relationships where both parties are aware of the trust dynamics and expectations, he fails to make this explicit. As such, we can consider situations in which one may believe another is trustworthy (e.g., a celebrity) but has never had the chance to interact with them. In such a case, the right kind of trust will emerge within the relationship one would have with that person, in their interactions, shared beliefs, and interests. That way, their trust in the person who displays trustworthy behaviours is brought to life rather than just imagined or anticipated.

A Response to Ignorance: "trust is a tentative and intrinsically fragile response to ignorance, a way of coping with the 'limits of our foresight'" (Shklar, 1984, p. 6).

Judith Shklar's (1984) definition of trust situates it within the realm of human limitations, highlighting the fragility of trust and its reliance upon the limited knowledge we have. Shklar emphasises the provisional and delicate nature of trust in the face of uncertainty, reflecting the pragmatic understanding that we cannot fully know or control the future actions of others. As an advantage, Shklar's view is a realistic acknowledgement of uncertainty and vulnerability, and it resonates with Hardin and Jones' view that trust is a way to cope with interpersonal uncertainty (2002, pp. 128-131; 1996, pp. 4-6). Shklar presents trust not as an absolute or unwavering certainty, but as a response to the inherent uncertainties of human existence. Her framing of trust as "tentative" and "fragile" captures the importance of humility and caution in human relationships and interactions. Shklar's view captures the adaptive role of trust, given our inability to account for all future contingencies. Nonetheless, by emphasising fragility and ignorance, Shklar disregards the moral depth, loyalty and care that can underpin trusting relationships and gives way to a pervasive scepticism or cynicism that may lead to one becoming overly distrustful (Baier, 1994, pp. 130-134). As such, Shklar's view may be too restrictive, reducing trust to a mere pragmatic response to uncertainty instead of a rich moral affirmation of vulnerability and character. By presenting trust as a way to cope with limited knowledge, Shklar overlooks cases where high knowledge and familiarity foster strong, robust trusting relationships that cannot be explained by mere

uncertainty, such as marriages and longstanding friendships. In addition, Shklar's view gives trust a pessimistic outlook by viewing trust as fragile and conditional, thereby disregarding the way trusting relationships can grow and consolidate over time, developing resilience and depth, in spite of uncertainty. Viewing trust as primarily a pragmatic response to vulnerability instead of a moral enterprise may further undermine incentives for moral character, loyalty and fairness and undermine the role of institutions, norms and interpersonal mechanisms – like promises, which people use in managing vulnerability – in strengthening and stabilising trust (Hardin, 2002, pp.127-130).

A Willingness to Vulnerability: trust is "the willingness to be vulnerable to the actions of another party based on the expectation that the other will perform a particular action important to the trustor, irrespective of the ability to monitor or control that other party" (Mayer, Davis, & Schoorman, 1995, p. 712).

This definition of trust presents it as a volitional act of vulnerability where trustors consciously expose themselves to potential risks, relying on trustees' expected behaviour. This definition captures the interpersonal understanding of trust in relationships, capturing vulnerability as a defining feature of trust as argued by Baier (1994) and Jones (1996). By emphasising the role of expectation, captured in the forward-oriented view about the trustee's future action without the need to control behaviour directly, the moral dimension of trust in trusting relationships is reflected. This view introduces three key elements of trust – ability, benevolence and integrity – essential for the development of trust and providing a framework for assessing trustworthiness. This view captures the healthy balance between vulnerability and confidence, showing the balance in healthy interpersonal relationships. It resonates with empirical and philosophical perspectives which show that relationships of trust enable greater creativity, adaptability and interpersonal coordination (Hardin, 2002, pp. 128-130).

Irrespective, this view is limited in its primary focus on vulnerability and expectations, disregarding the emotional and affective aspects of trust, as well as the character of trustees in terms of their motives, interests in the care of the vulnerable party, or moral commitments. This view may not account for cases where trust is fostered by loyalty, affection or deep moral understanding, independent of vulnerability. In addition, this view may be too unidirectional, focusing only on the trustor's perspective and overlooking the

reciprocal nature of trust. Lastly, in cultures and contexts where trust is more implicit and less contingent on explicit vulnerability, this view may not fully capture the dynamics of trust.[57]

3.4 Trust as a Plural and Context-Dependent Concept

From the above-presented definitions, it can be deduced that while trust may be applied to several, if not all, spheres of human social existence, interactions and relationships, there is no unanimous foundation for what we may hold trust to be, what trust addresses or what it is concerned with. We are rather presented with plural and context-specific conceptions of trust: some hold that, depending on the field of inquiry and the kind of relationship examined, trust is concerned with risk calculations, beliefs and expectations; others maintain that trust is concerned with an attitude, an emotion, a moral action, or a commitment (Robbins, 2014, pp. 19-21).

From these definitions, it becomes evident that trust can function both as a ground for cognitive decision-making, a ground for affective and relational attachment and as an internalised value. As a basis for cognitive decision-making, trust involves the formation of beliefs and expectations, which may evolve with personal experience, the acquisition of information, shifts in incentives, or the observation of others' trustworthiness. As a ground for affective relations, trust encourages and enables the cultivation and reinforcement of emotional bonds. Thus, it allows for the creation of relationships by establishing an initial position of openness and goodwill as experienced by some who engage in trust instinctively; it sustains relationships through the recognition of mutual vulnerability and reliability; and it strengthens relationships by transforming repeated acts and instances of trust and trustworthiness into enduring affective ties (Jones, 1996, pp. 4-6;; Baier, 1986, pp. 234–235). As Jones holds, “because it is affective, trust can generate and sustain relationships of intimacy and cooperation. To trust is to place oneself affectively in another’s hands, thereby creating a moral and emotional bond” (1996, p. 6). In this sense, trust functions not merely as an epistemic or moral orientation but as a dynamic affective resource that shapes the texture of human relationships.

[57] For example, in many indigenous communities, trust is inherited through familial or tribal lines, reinforced by collective memory, shared rituals, and identity, not through assessment of another's competence or personal risk-taking. Also, in some Asian business settings, Japanese and Chinese professionals often build trust over informal interactions, social harmony, and long-term relationships rather than through contractual or explicit vulnerability-based agreements.

Conversely, as an internalised value, trust appears as a biological or sociological disposition: an orientation of openness or confidence toward others that may operate independently of calculated reciprocity, explicit motivation or particular experience (Robbins, 2014, p. 21; Dinesen, 2009; Almond & Verba, 1963; Banfield, 1958). This internalised function of trust can be ingrained in cultural, moral or institutional structures, influencing both how individuals perceive others and how they comport themselves within social relations.

My presentation of trust thus far reiterates an earlier stated claim: "trust is an umbrella term under which plural notions cluster" (Simpson, 2012, p. 551). These plural notions of trust, though each (arguably) defensible within its specific domains of inquiry and application, do not capture the same phenomenon nor address the same relational issues, structures, or experiences. No single conception of trust can therefore claim universal application across all fields and problems.

While I agree that "trust" functions as an umbrella term for several notions and applications, I do not think this plurality warrants an unscrutinized acceptance of all perspectives. Simply put, I do not agree that 'anything goes' when defining trust. I rather posit that within this umbrella term, there exist some common cores, which, though instantiated differently depending on context, keep trust grounded such that it remains recognisable as the same phenomenon irrespective of how it is applied, where it is applied and the persons in such trust relations. I identify three common cores: Directed Vulnerability – when the trustor renders themselves vulnerable to a specific other in a specific domain; Normative Expectation – when the trustor holds an expectation the trustee ought to act in a certain way, different from a prediction or mere expectation; and Responsiveness to Being Trusted – the trustee's recognition that trust has been placed in them and letting that recognition shape their conduct. I shall speak more on these as my research progresses.

In light of this plurality, the following section presents several types of trust. While the list is not exhaustive, it will be beneficial in illustrating the diversity of trust relations relevant and existent in the medical field in general and the transplant field in particular, thereby clarifying the conceptual foundation of my analysis of trust in the organ transplantation field.

3.5 Types of Trust

So far, I have argued that there exist various interpretations, understandings, applications and contexts of trust, trust relations and the act of trusting. I have argued that the contexts in which "trust" is used lead to rhetorical potency, allowing the term to acquire nuances of meaning based on the generative conditions of its usages. Hence, the derivative forms we have come to understand and apply the word. Presenting trust this way shows that it is a "focal point for issues that arise for specific perspectives on human agency" (Lagerspetz, 2015, p. 11), of which organ transplantation and donation are a part. The various nuances of understanding, presenting, applying and conceptualising trust have shown that the definitions we have of trust have been developed in response to particular challenges and are in relation to interests and issues in specific domains. As such, what "trust" is, and what it is expected to accomplish, is dependent on the needs of the referenced or applied theoretical frame (Lagerspetz, 2015, p. 11).

It is based on the above understanding that I argue that it would be counterproductive to seek a unanimous definition of "trust" or to insist on an unequivocal agreement on what trust as a moral principle is and what it can be applied to. Nevertheless, this does not mean there is nothing common in most of these definitions of trust; quite the contrary. The many definitions and nuanced understandings of "trust" point to some core features it possesses, allowing us to speak of trust in the many ways we do. These features include the tripartite nature of trust; the fact that trust is often domain specific and acknowledged within a system of shared moral standards; the reliance placed on the trustee and the anticipated trustee commitment to fulfilling or meeting the object of trust; the affective attitude; the fact that trust is often relationship-based where the nature of such relationship differs ranging from close familiar relations (i.e. friends and families) to unfamiliar relations (i.e., strangers on the street or between pilots and passengers) and less familiar social relations (i.e., some business partners or doctor-patient relationship) and; normative expectations and the fact that trust is essentially self-concerning as much as it is other-concerning, capturing the foundations of beliefs, affect, and trustworthiness. By being self-concerning, I mean that trust reflects who we are and our values, not just what we think or expect of others towards ourselves; trust expresses our moral commitments, our vision of how people should relate and our ethical aspirations. This is because when we choose to trust people, we do not just make judgments about them; we also reveal something about ourselves, such as our willingness to be vulnerable, our belief in their competence, reliability, and goodwill, as well as our sense of

what is reasonably expected of them. Let us relate this to the types of trust: In affective trust, the self-regarding dimension is evident in the expression and reaffirmation of the trustor's emotional integrity and openness. In therapeutic trust, the self-regarding dimension is reflected in the healing of the self's capacity to trust after moral or emotional betrayal; it is self-regarding because it reflects one's internal process of healing, self-restoration, and the reaffirmation of moral hope. The self-regarding dimension in role-based and relational trust is evident in the demonstration of one's moral character and identity through responsible vulnerability; in strategic trust, the self-regarding dimension is evident in the reflective acknowledgement of one's epistemic limits and calculated dependence; and in wishful and fragile trust, we can ascribe it to one's self-recognition of emotional need and their hopeful projection despite uncertainties.

As such, to understand trust, one need not engage in criticising one theory, definition or presentation of trust with another. This is because such a method risks failing to appreciate the nuances of trust, the intriguing application of the subject to actions, behaviour, strategy, moral principles, institutions, and policies, as well as "the concerns behind the theory originally under scrutiny" (Lagerspetz, 2015, p. 12). When presented with examples of trust cases, what should be evaluated are the kinds of relationships such trust originates from, as well as the kinds of commitment, suspicion, tasks, complexities, etc. that are invoked by such cases. As such, in addition to the question "is this an adequate case of trust?" we can also ask "what kind of worries and type of trust are presented from this case?" This allows for context-sensitive and domain-specific issues and understandings about trust (Lagerspetz, 2015, p. 11). Irrespective, this does not mean that we may accept every definition of trust given or accept every instance of dependency and reliance as adequate examples of trust.

The definitions of trust presented earlier foreground particular modes of trust, and together they reveal a complex landscape of trust relations shaped by affect, belief, risks, social norms, expectations, commitment and moral engagement. They include:

Instinctual Trust – This is the evolutionarily grounded kind of trust we have based on evolved heuristics rather than conscious reasoning. This can also be identified as a form of general trust because it captures the kind of trust we form without dependence on strong personal relationships. An example of this trust is how children cling to and seek comfort from their caregivers, displaying basic trust skills (if we can really call that trust) even before

any explicit evidence and understanding of reliability or care. Trust here is not reasoned or belief-based.

Role-Based or Institutional Trust is the type of trust we form based on one's expectations about role performance, professionalism and social norms. It is often directed towards systems with structured relationships, such as doctors, teachers, and judges. Trust here is less personalised and more predictable across large-scale social systems based on the role and professionalism. For example, patients trust surgeons to perform scheduled operations competently, not because of their familiarity, but because surgeons are part of a licensed medical system governed by professional standards and rules. Trust here is directed at roles, not persons, and depends on expectations about technical competence and adherence to institutional norms.

Strategic Trust is the kind of trust we have based on tactical beliefs, incentives and risk assessments; it often exists in economic, political and contractual relationships, providing a clear framework for accountability, but reduces trust to a form of mere reliance or rational prediction, neglecting the moral and emotional dimensions of trust. Trust here is calculated and conditional, based on beliefs about incentives and outcomes. An example will be when Ronke, an entrepreneur, decides to rely and partner with Latifa, a software developer, after viewing successful past projects and calculating that Latifa's interest, reputation and business growth align with producing quality work.

Affective Trust is trust that is constitutive of close personal relationships and is based on emotional commitment and goodwill rather than calculation. It captures the warmth and moral richness of genuine interpersonal trust, explaining virtues such as forgiveness and loyalty, and even promoting the endurance of trust after failure. Since trust here is based on emotional commitment rather than evidence or rational probability, it may be overly idealistic, naïve and prone to abuse or manipulation in asymmetrical relationships. An example is a friend confiding personal secrets to another despite a recent disagreement, because they believe in the friend's goodwill and emotional concern for them.

Fragile Trust is grounded in necessity and provisional hope rather than in belief or emotion, often arising from the need to act amid ignorance and uncertainty. This type of trust captures the role of trust in existential uncertainty and tends to appear pessimistic or minimalistic. Take, for example, a citizen voting for a political candidate not because they are

fully convinced of the candidate's skill and capability, but because they feel they must act in the face of incomplete knowledge and the uncertainty of political outcomes.

Relational-risk Trust is trust as active vulnerability based on belief in other people's competence and benevolence. It blends the affective, cognitive and normative features of trust. It captures emotional openness and realistic risk-taking and is applicable in medical settings. It assumes that trustees will always choose vulnerability, which may not hold in dependency relations. An example of this trust can be captured when a team leader delegates a presentation to a junior employee, fully aware that they cannot monitor every step, but believing in the person's ability, competence and integrity. Another example is when a patient agrees to undergo a major surgery, despite knowing they will be unconscious and entirely dependent on the surgical and anaesthetic team. The patient entrusts their life to the competence and integrity of the professionals.

Save for these types of trust presented based on my earlier examination of conceptions of trust, consider the following other types, which identify other nuanced aspects and modes of trust and trusting.

Therapeutic Trust

Adam Carter (2024) introduces the concept of therapeutic trust and identifies two subtypes: *default therapeutic trust* and *overriding therapeutic trust*. In one sense, default therapeutic trust arises when a trustor treats a trustee as trustworthy by default, even when there is no evidence regarding their character. In this sense, it is used at the beginning of relationships to set a positive moral baseline, whereby extending trust this way provides the necessary social and psychological space to develop a sense of responsibility, moral and self-worth. In another sense, default therapeutic trust arises when an individual, due to certain limitations, cannot engage in standard trust practices. For instance, a patient with cognitive impairments may still be trusted in a therapeutic sense, acknowledging their agency within their capacities.

Overriding therapeutic occurs when a trustor chooses to trust a trustee even when there is contrary evidence pointing to and suggesting that the trustee is currently untrustworthy. Here, trust occurs when standard trust is overridden to support the individual's well-being, even if they might not meet typical trustworthiness criteria. An example is trusting a recovering addict to make decisions, fostering their autonomy and recovery. Carter emphasises that therapeutic trust is not merely about the trustee's past behaviour but involves

a commitment to their potential growth and rehabilitation (Carter, 2024, p. 16). Save from Carter's (2024) classification of therapeutic trust, since it generally refers to forms of trust that are intentionally cultivated or sustained for the sake of healing, psychological recovery, or moral repair – especially in relation to vulnerability, trauma or relational breakdown, therapeutic trust can also be restorative, proleptic, rehabilitative and ethical. This seems to be the case between the public as potential donors and the transplant system in Germany after the transplant scandal, where public members are now seeking reasons to trust the system. Cultivated to repair fractured relationships or to rebuild moral bonds, the therapeutic trust of the restorative form plays a key role in reconciliation in cases where trust has been violated. It is worth noting that, in this case, the trustor does not extend trust out of full confidence in the trustee's trustworthiness; rather, the trust extended is a hopeful, forward-looking gesture to rekindle moral connection and responsibility (Carter, 2020, p. 240). An example will be the patient who, having previously felt dismissed by the healthcare system, decides to engage with a new physician, motivated by the hope of recovery and care.

In another sense, therapeutic trust may call one to action and to trustworthiness when the trustor treats the trustee as already trustworthy, to encourage moral or relational development (Carter, 2020, p. 244). This seems to be how most trust relationships start; trust here seems anticipatory as it aims to create trustworthiness through the act of trusting. In yet another sense, therapeutic trust may be grounded in moral or emotional hope, especially when rational justification is absent, yet the potential benefits of trust (i.e., healing, reconnection, restoration) are considered worth the risk (Hieronymi, 2008, p. 222). An example will be when a transplant recipient chooses to trust the healthcare team after a history of medical trauma and bias, hoping the new care relationship will be different. In situations where one isn't sure whether to trust, the therapeutic attempt to trust may be taken as an ethical stance, taken to preserve human relationships or fulfil a moral ideal (Horsburgh, 1960, p. 344).

Wishful Trust

Wishful trust is trust grounded more in desire and emotional hope than in the necessary evidence or the trustee's actual trustworthiness or instances of it. Wishful trust reflects an optimistic projection of a sort, placing trust not because one has good reason to, but because one wants to, given the motivating belief that the trustee will act well, where the motivating belief is often out of personal need or longing for a better outcome. Pamela

Hieronymi (2008) discusses scenarios where trust is extended based on the desire for a positive outcome rather than evidence of trustworthiness. This wishful trust is characterized by the trustor's hope that their trust will lead to improved behaviour or outcomes, even in the absence of supporting evidence. As Hieronymi (2008) rightly notes, wishful trust can be seen as a hopeful stance where trust is extended in the absence of good reasons or against evidence, motivated by a desire for repair, connection or transformation (p. 228). What Hieronymi has termed "wishful trust," Horsburgh identifies as "guilty trust," i.e. trust extended despite evidence of untrustworthiness, perhaps due to necessity or hope of change. For Horsburgh, guilty trust requires careful moral consideration, balancing the potential for harm against the possibility of rehabilitation (Horsburgh, 1960, p. 343).

Wishful trust argues in favour of a non-doxastic account of trust,[58] given its compatibility with knowing that the trustee is not trustworthy, but the trustor is motivated to trust. As such, while trust here can be motivating, it may not always be rational or justified. The trustor's reasons are rooted more in the perceived value or necessity of trust rather than the trustee's demonstrated reliability (Hieronymi, 2008, p. 215). In examples of wishful trusting, A trusting B to C does not require believing something related to B's trustworthiness, as the trustor may know that the trustee cannot be counted on to perform C or is otherwise not trustworthy. An example is a person who repeatedly trusts a neglectful sibling because they deeply wish for familial closeness, despite a history of irresponsibility, noncommitment, and betrayal.

[58] The doxastic definition of trust centres around belief. In this framework, to trust someone is to believe that they will act in a way that is beneficial or at least not harmful to you. Specifically, it involves the belief that the person you are trusting intends to act in your best interests or will fulfil their commitment to you. A doxastic account sees trust as being tied to a belief (or set of beliefs) about the trustee's reliability, honesty, and ability to deliver on promises. The trustor's mental state in this view is essentially a belief that the trustee will act as expected. For instance, according to philosophers such as Baier (1986), trust involves a "belief in another's goodwill" (p. 235). In this view, it is the doxastic element – belief in the trustworthiness of the other – that forms the core of trust. Similarly, Hardin (2002) describes trust as involving the expectation that another person will behave in a reliable and dependable way, which inherently involves some level of belief about their future actions (p. 23).
In contrast, the non-doxastic definition of trust emphasizes a more pragmatic or behavioural understanding of trust that is not solely based on belief. From this perspective, trust is not about having a belief that the other will act in a certain way but rather about the willingness to act in a way that reflects trust, often despite uncertainty. This account of trust is often linked with Raz (1986), who suggests that trust can be understood as a commitment or a choice to rely on someone without necessarily having specific beliefs about their future behaviour. In a non-doxastic view, trust is often understood as an act of engagement or behavioural disposition, rather than a cognitive state of belief. For example, Baier (1986) contrasts trust with "blind trust" or trust based on irrational faith, suggesting that non-doxastic trust involves actions taken based on evidence and prior experiences, not just belief (p. 242). In essence, the doxastic approach ties trust to belief in a person's behaviour, while the non-doxastic approach emphasizes the actions or decisions involved in trusting, often under conditions of uncertainty.

Blind Trust

Blind trust refers to unexamined, unquestioning and uncritical trust, extended without scrutiny, scepticism or any regard for signs of one's trustworthiness – the trustee's character, motives, or history of behaviour. Implying a lack of discernment or critical awareness, blind trust may involve ignoring red flags, contrary evidence and past harms. While similar to wishful trust in some aspects, it differs from wishful trust: while the motivation for wishful trust is often hope or emotional longing, the motivation for blind trust is unquestioning faith and passivity. In relation to evidence, while wishful trust is often contrary to evidence, blind trust disregards or avoids evidence altogether. Based on ethical evaluation, while wishful trust may sometimes be ethically complex and reparative, blind trust is seen as irresponsible and risky. In addition, while the trustor is aware of the risks but hopes for a better outcome in wishful trust, the trustor is unaware or indifferent to potential risks in blind trust.

Unlike normative or "intelligent" trust, which is built on discernment and moral evaluation, blind trust is typically grounded in assumption, dependence, or emotional vulnerability, and may persist in the face of contrary evidence or unresolved doubt. In both interpersonal and institutional settings, blind trust poses ethical risks, not because trust itself is unwarranted, but because it suspends judgment and responsibility where they are most needed. H. J. N. Horsburgh, in his seminal essay "The Ethics of Trust," criticises blind trust as morally problematic, particularly because it reflects a failure on the part of the trustor to engage in rational and moral evaluation of the trustee (1960, p. 344). According to Horsburgh, trust ought to be responsive to the realities of the trustee's actions, character, and reliability. Where this evaluative function is suspended, the trustor does not merely risk disappointment or betrayal; they also abdicate an important moral responsibility. The problem, then, is not that trust is extended, but that it is extended in ways that ignore the normative significance of being trusted and the real consequences that can follow from misplaced confidence.

Blind trust is often associated with asymmetric power relationships, such as those between patients and healthcare professionals, children and parents, or citizens and public officials. In these contexts, trust may become blind when one party – typically the less informed or more vulnerable – places unqualified confidence in the other without sufficient understanding, evidence, or accountability. This is particularly concerning in domains like organ transplantation and donation, where decisions are high-stakes, and consequences are

irreversible. If patients or donors blindly trust transplant teams without a proper understanding of risks, policies, or alternatives, the result may be not only disillusionment but a fundamental breach in the moral purpose of trust-based medicine.

Moreover, blind trust lacks what Pamela Hieronymi calls "the reasons of trust," a justificatory framework grounded in evidence, mutual regard, and the expectation of care and commitment (2008, pp. 228-230). Trust, in its morally robust form, presupposes that the trustee is responsive to the fact of being trusted, and will act accordingly – not just out of competence, but out of a sense of responsibility to the trustor. Blind trust ignores this reciprocity, treating trust not as a normative stance but as a default attitude, thereby hollowing it of its ethical depth. Importantly, blind trust should not be mistaken for loyalty, forgiveness, or hopeful trust. One may forgive or continue to trust someone despite their failings, but still do so with eyes open – recognising the risk, affirming the values at stake, and holding the trustee morally accountable. Blind trust, by contrast, refuses to acknowledge or engage with potential risks or past failures. It denies the trustor's agency and awareness, and in doing so, compromises the integrity of the trust relationship itself.

Blind trust is a morally deficient form of trust that neglects the normative, evaluative, and relational dimensions which make trust meaningful. While it may arise from necessity, dependence, or cultural expectation, its uncritical nature renders it ethically problematic, particularly in domains like medicine, where lives and dignity are at stake. As Horsburgh reminds us, true trust demands attention to character, conduct, and the moral weight of dependence (1960, pp. 343-344). A culture of trust must therefore be one that cultivates responsible, informed, and reciprocal relations, not blind faith.

3.6 Distrust, Mistrust and the Moral Topography of Trust

So far, I have discussed trust as being predominantly moral or having a moral expectation, motivation, effect or result. I have done this with the field I intend to apply trust to in mind. But I find it quite pertinent to make an important clarification here: trust is not always moral, nor does it necessarily have moral effects, motivations or results. It is possible to have trust devoid of morality, so to speak of trust is not essentially to speak of moral trust – I will explain.

To place trust in someone, or to be trustworthy ourselves, while it may help to be morally conscious persons, we do not necessarily have to be moral persons. To state it differently, trusting people does not require us to ascribe moral qualities or moral motivations

to them; what is rather needed is ascribing some form of normative expectations to them. These normative expectations may range from specific commitments, to norms of action and reactions, or even a reason-governed disposition, and in all of these possible cases, the trustee is answerable to the normative expectation(s). so rather than moral expectations and motivations being necessary, it is normative expectations that are necessary for trust to hold.

Bennett, M. (2021), Amy Mullin, (2005), D'Cruz, J. (2018) and Misztal, B. (1996) share this view of the importance of normative expectations to trust but characterise their understanding of what this normative expectation is differently. Bennett rejects the "Moral-motivation theories of trust" which argue that trusting someone to do something requires confidence that they will be moved by moral qualities or motivations. Arguing against the necessity and sufficiency of moral motivations to trust, he argues that such understanding of trust limits its extension to many common instances where trust dwells, like a chess opponent's commitment to fair play or a civil adversary's commitment to norms of politeness. His proposal therefore states that "when we trust a person to F, we are confident that they will be motivated to F by a commitment we ascribe to them," where the commitment may be normative (like a promise or contract which generates obligation) or psychological (i.e., an internal motivating attachment to an action, a goal, value, project or even persons) (Bennett, 2021, pp. 527-529). For D'Cruz, the normative dimension of trust is not about being moral, virtue-tracking or commitment-tracking (2021, pp. 41-42). Adopting Hawley's commitment-based formula for trusting, D'Cruz argues that "to trust someone to do something is to believe that she has a commitment to doing it, and to rely upon her to meet that commitment. To distrust someone to do something is to believe that she has a commitment to doing it, and yet not rely upon her to meet that commitment" (D'Cruz, 2020, p. 44, quoting Hawley, 2014, p. 10).

Arguing for the non-moralising requirement as a methodological commitment, Mullin states that "a good theory of interpersonal trust should not moralise trust. It must be possible to understand that trusting another and being trustworthy are not always morally good, and that distrusting another and betraying someone's trust can sometimes be morally good" (Mullin, 2005, pp. 316–317). For Mullin, rather than a moral commitment, when we trust people, we assume that they "share our commitment to a particular social norm which we take to govern the trusted one's behaviour in some specific domain. We further assume that the trusted one's commitment to that norm is to at least some degree intrinsic rather than instrumental" (Mullin, 2005, p. 316). Mullin's example of the company-loyalty case makes

her view about trust not always having moral motivations and commitments better understandable: a supervisor can trust an employee not to report environmental violations despite the fact that both the trustor and the trustee feel "that the company activity is immoral, as long as both are thought to share a commitment to such loyalty" (Mullin, 2005, pp. 320–321). As Mullin notes, this example counts as trust rather than reliance because the trustor believes that the trustee is internally committed to the relevant norm – the company norm – which itself is not good (Mullin, 2005, p. 322). The idea is that while moral content can inform and influence trust relations, it is not a necessary condition for trust, because often retaining normative expectations such as commitment, reason-responsiveness, or shared social norms does the work morality is meant to do.

In addition, although trust is often mistakenly treated as a singular attitude or a binary condition which may either be present or absent, justified or unjustified, betrayal-inclined or not, harm-inclined or not, I argue that such treatments of trust, following the various types of trust we have examined thus far, tend to obscure the moral intricacy of the stances various persons adopt when they render themselves vulnerable to the agency of others when trusting. In this section, I shall continue my discussion of trust through an examination of distrust and mistrust as related stances, where distrust and mistrust are not to be misunderstood as mere failures or deficits of trust, but are morally intelligible reactions and responses to perceived risks, uncertainties, or clashes and breakdowns in shared values and moral principles. By turning to the obstacles and problems of trust, I hope to show how trust may be open, withheld, suspended, or refused, arguing that these stances – distrust and mistrust – express a form of moral judgement and psychological hesitation based on experience, uncertainty, expectation, and clashing values. Herein, distrust and mistrust are identified as active and discerned stances that exist in the same moral landscapes and domains as trust; they play important and critical roles in regulating vulnerability, promoting moral responsibility, moral values and judgements, signalling moral protest, and shaping the various conditions under which trust may be repaired, extended or declined across various social relationships and institutional contexts.

3.6.1 Distrust

Although distrust is often described as the absence of trust, it is more than that. The relationship between trust and distrust is one of contraries; hence, they cannot be reduced to contradictories. The fact that trust and distrust can exclude each other does not mean that they

exhaust all other possible stances; other possibilities include the suspension of judgement, withholding commitment or being indifferent or uncertain, as evident in cases of mistrust, agnosticism or non-engagement (Hawley, 2014; Almassi, 2014). Like trust, distrust is a domain-specific, emotionally and normatively charged *protective stance* in which a distrustor, shaped by a perceived or experienced moral disalignment or betrayal, refuses to expose themselves to the agency of a potential trustee – anticipating that the trustee will likely act without concern, integrity, or commitment, or may exploit the trustor's dependence for ends not aligned with the trustor's good. Rather than representing a simple absence of trust, distrust involves a counter-expectation grounded in suspicion, protective attentiveness, or a defensive attunement to perceived risk within the moral fabric of a specific relationship or role-based interaction.

This aligns with Karen Jones's argument that distrust is not merely the absence of trust, but an *active orientation* that involves the presence of negative affect and judgment: Distrust is a distinct stance, one that registers others as threats rather than as potential cooperators (Jones, 1996, pp. 10-15). Like trust, distrust is relational and value-laden, but whereas trust opens one to moral vulnerability, distrust functions as a self-protective posture against perceived threats (e.g., moral, physical, emotional, psychological, financial, etc.) or unreliability.

Recalling the other types of trust we have identified and explained above, we can identify several forms of distrust: Just as instinctual trust is pre-reflective, evolutionarily grounded in our ability to attach and depend, instinctual distrust portrays an equally primal and affective disposition towards caution, the result of which is withdrawal, unexplained scepticism, and defensive self-protection as a response to the perceived threat or unfamiliarity. As one would think, this form of distrust is neither reason nor evidence-based, but rather reflects an adaptive heuristic for survival, which may manifest as an automatic and sometimes involuntary wariness towards strangers, foreign systems and unknown procedures – e.g., the suspicion towards organ donation systems in communities that have been historically marginalised by medicine. This form of distrust can be morally ambiguous, making it problematic because, while it functions well as a survival instinct or mechanism in the face of genuine and perceived risk, it may enable bias and prejudice when applied indiscriminately.

Role-based or institutional distrust is directed at structures and authorities and manifests when one's confidence in professional roles, systems, or regulatory norms is eroded. Obvious examples of such distrust include cases of corruption, discrimination, and medical scandals (e.g., the German transplant allocation scandal) that emerge when institutional reliability, transparency, and moral accountability are questioned. This form of distrust is often justified and can even be found morally justified, functioning as a form of civic virtue that promotes institutional and systemic accountability and reform. Irrespective, when this form of distrust is cynicised or overly generalised, it may demoralise collective action and undermine public goods. Hence, there is a need to differentiate between critical distrust of this form, which is ethically protective and cynical distrust, which tends to be morally corrosive.

Strategic distrust mirrors the calculated nature of strategic trust but turns it into suspicion grounded in self-interest and rational prediction. This form of distrust is marked by the presumption that others primarily act from instrumental motives. As such, it is not always emotional or moral but often based on fear, and is rationally motivated and risk-averse. This form of distrust often instrumentalises human relationships and erodes the moral and affective basis of human cooperation, seeing people as strategic agents to be managed rather than moral agents to be engaged with. A good example is when a patient demands multiple second opinions after a diagnosis or before surgery as a result of systemic failures, or when a business partner insists on detailed contracts due to fear of exploitation.

Affective distrust, on the other hand, arises from emotional hurt, betrayal or moral disappointment in some cases. As the emotional inverse of affective trust, it is laden with fear, resentment, or moral pain. Rather than the absence of trust, it is an emotionally charged moral stance that registers a sense of violated care or relational breakdown. Given its moral depth, affective distrust signifies moral protest, exposing the vulnerability and ethical expectations built into trust relations. An example will be a patient who, after being discriminated against or dismissed by healthcare providers, becomes emotionally guarded toward future medical professionals.

In *Fragile distrust*, we see a parallel of fragile trust, as this form of distrust arises from uncertainty and limited information. Characterised by hesitant doubt, where one wants to trust but cannot confidently do so due to a lack of information and uncertainty, fragile distrust often reflects epistemic humility and interest in the face of incomplete understanding.

While it doesn't outrightly reject trust, it does not accept trust blindly either; this form of distrust often leaves room for moral repair, marking a liminal space between hope and scepticism. An example will be a patient who is uncertain about proceeding with an organ donation or transplant due to the opaque institutional communication.

Relational-risk distrust would occur when one's vulnerability is perceived as too dangerous to expose, even when the trustee appears competent, skilled and well-intentioned. Put differently, this form of distrust reflects an evaluated withdrawal of openness based on the trustor's judgement that the relational risk involved in trusting exceeds the moral or practical benefits. An example will be when a transplant candidate refuses to share full medical details for fear of discrimination or loss of control.

In *therapeutic distrust*, we could see distrust as being a deliberate and constructive scepticism maintained to protect or even heal oneself or relationships. Rather than hostility, it encourages maintaining a careful distance to prevent further harm or manipulation while remaining open to the possibility of repair. Distrust here becomes a step towards moral restoration, as it allows the injured party to renegotiate the conditions of trust. An example will be when a recovering patient questions medical advice after previous trauma, as a way of reasserting autonomy and agency.

Wishful distrust may reflect the tragic moral psychology of distrust, that is, the conflict between hope and caution, blending emotional hope with defensive withdrawal. Wishful distrust is rooted in emotional investment yet directed toward protective doubt; hence, it occurs when one wants to trust but, due to past harm, convinces themselves not to, out of fear of vulnerability. An example will be a person who, desiring reconciliation with a family member or institution, suppresses trust to avoid renewed betrayal.

In *blind distrust,* we experience an unexamined, reflexive and uncritical refusal to trust. Sustained without regard for counter-evidence or moral nuance, blind trust may manifest as cynicism or paranoia. Since blind distrust denies the possibility of moral responsiveness and rational discernment, it is ethically corrosive, foreclosing the normative potential of trust to restore shared moral life. An example is a patient who refuses medical advice simply because it comes from a surgeon, irrespective of the doctor's competence or empathy, or one who rejects all government aid and initiatives on the presumption that they are all corrupt by default.

As seen, these forms of distrust capture various modalities of moral withdrawal or protection, so while some may be ethically constructive (e.g., therapeutic and relational-risk distrust), others undermine moral communities – e.g., blind distrust. Recognising these nuanced types of distrust may help distinguish between protective scepticism and destructive cynicism, as they appear in feelings of distrust towards the organ transplantation system.

3.6.2 Mistrust

Similar to trust and distrust, mistrust is also domain-sensitive, but unlike trust and distrust, mistrust is often affectively charged ambivalent stance, wherein a mistrustor experiences uncertainty or cognitive dissonance regarding the trustee's capacity or willingness to act in accordance with expected moral standards – wavering between recognition of the trustee's role-based obligations and scepticism about their fulfilment. Unlike distrust, which forecloses openness, mistrust reflects a hesitant withholding of trust that may emerge from a breakdown in shared understanding, incomplete information, or historical/systemic disjunctions in the trustor-trustee relationship.

Mistrust can be subtle, context-dependent, and episodic. It may not always involve a complete refusal to engage but rather a suspended posture, shaped by conflicting cues regarding the trustee's moral and professional reliability, accountability, and integrity. In this sense, mistrust is often epistemic and cautiously evaluative; at other times, it can be affective even when not decisively protective. Essentially, mistrust is best understood as an ambivalent, suspended, or evaluative stance— a position of cognitive and emotional hesitation that neither fully withdraws from trust nor fully commits to it. This stance occupies an intermediate moral and epistemic space between openness and closure, confidence and rejection, trust and distrust. Its engagement with conflicting attitudes— a mixture of belief and doubt, recognition and scepticism— makes it ambivalent. The ambivalence arises from mixed experiences and evidence wherein the trustee may demonstrate reliability and failure, goodwill and negligence, sincerity and manipulation at various times, causing the mistrustor not to be entirely closed off as distrust would suggest, nor fully open as trust encourages. The ambivalent nature of mistrust reflects the tension between moral hope and cognitive caution, recognising that one may desire to trust but be hindered by past experiences, inconsistencies, or uncertainties. Since mistrust involves withholding full commitment to the trustee's moral reliability, it remains suspended. Instead of displaying moral confidence, the mistrustor refrains from vulnerability as they evaluate the moral and evidential grounds (in some cases)

for trusting. This suspension allows for future reconciliation and moral repair; in medical contexts, this may be seen in the public's hesitation to re-engage with a medical practice, institution, or policy after a scandal. While they refuse to trust outright, they await credible reforms, transparency, accountability, and renewed signs of integrity. The evaluative element of mistrust represents the active moral and cognitive assessment of the trustee's behaviour, intentions, or institutional structure; hence, rather than being a purely emotional withdrawal, it is a critical discernment that seeks to align moral commitment with evidence, accountability and trustworthiness. In this sense, we can say that mistrust is reflective rather than reactive. As such, mistrust is not merely negative as widely assumed, but rather it promotes moral responsibility, prompting us to trust intelligently rather than blindly. Moreover, mistrust exists in various forms and can even be expressed in very subtle forms wherein the trustor may not be entirely aware; for example, the patient who insists on understanding the allocation process and criteria before consenting to surgery may be expressing evaluative mistrust – a morally attentive stance grounded in the responsibility to protect one's own integrity and ensure fairness.

To further understand mistrust better, consider the following forms of distrust: *Instinctual mistrust*, being a kind of innate vigilance, given its pre-reflective nature, arises as an evolutionary adaptive caution or protection reflex when faced with unreliability or perceived danger. Like in the case of trust, this form of mistrust precedes reasoned judgement, presenting as a gut feeling of unease, hesitation and withdrawal before any rational justification can be made. An example in the medical context is when a patient may feel uneasy around a healthcare professional who seems dismissive and hostile, long before any explicit violation occurs.

In *role-based or institutional mistrust*, the mistrust emerges when institutional actors or structures such as hospitals and transplant organisations fail to meet their professional standard of fairness, transparency or moral accountability, causing a pause in reliance but still allows the citizens to participate in the said field, but with caution or conditions. Since mistrust functions here as a normatively alert form of vigilance, it demands accountability from said institutions without collapsing into cynicism and often prompts reforms. For example, even after transplant scandals in Germany, the UK and the USA, the public has not entirely withdrawn from organ donation, but has expressed sustained scepticism towards the transplant system's governance, policy and practices, demanding stricter oversight, transparency and accountability. Mistrust in such instances has served a reparative moral

purpose, forcing the system to restore credibility and fairness. Strategic mistrust, as the calculative counterpart of strategic trust, captures the mutual cautiousness of both parties as they monitor, evaluate and assess each other's compliance and motivations. One could liken this form of mistrust to Hobbesian realism about human motivation in the state of nature: it treats others as potentially self-interested agents whose reliability must be continually verified. An example may be when procurement organisations and for-profit tissue banks collaborate under contractual regulation but maintain a stance of strategic mistrust where they both ensure that ethical, legal and medical standards are upheld through monitoring and audits.

In *affective mistrust*, mistrust develops within personal and emotionally charged relationships involving dependence and love. It arises when perceived betrayals, affective inconsistencies, or past failures impact the emotional aspect of trust without completely destroying it. This type of mistrust is morally significant; it indicates a tension between vulnerability and self-protection, meaning the struggle between the moral desire to connect and the fear of further betrayal. For example, a patient who was previously neglected by a doctor, feeling emotionally betrayed, may feel anxious yet compelled to engage with a new doctor, swinging between scepticism and hope. Here, the mistrust is affective (although there could be epistemic reasons in similar cases) because it reflects an emotional residue from prior relational setbacks.

Relational-risk mistrust fosters cautious withholding of trust, prompting individuals to stay observant, reserved, and self-protective within the trust relationship. Since this form of mistrust occurs when vulnerability is unavoidable, the trustor experiences concern over whether their vulnerability will be exploited or respected. It captures the asymmetries of power and dependence fundamental to moral life, showing that trust and mistrust can coexist dynamically within relationships that demand both caution and openness. For instance, a patient undergoing surgery might recognise the healthcare professionals' competence but still feel uneasy about whether their dignity, concerns, integrity, and voice will be respected. Although their feeling of mistrust does not block their participation, it heightens their awareness of signs of moral recognition and care. When rebuilding trust after betrayal or trauma involves deliberate scepticism or caution as part of healing, this can be described as therapeutic mistrust. This type of mistrust acts as a moral safeguard, preventing premature, wishful, or blind trust that could cause the vulnerable person to be hurt again; it blocks moral coercion and forced trust, and allows healing through careful and restrained engagement.

Lastly, we have *blind mistrust*, which, like blind trust, is unexamined suspicion that appears as uncritical scepticism or reflexive disbelief. Often seen as a defensive generalisation, this type of mistrust stems from systemic injustice and past betrayals. *Blind mistrust* can be ethically problematic as it embodies a hardened form of cynicism, yet it often masks itself as prudence; it prevents moral repair and the possibility of trust because it fails to recognise moral agency and the potential for reform. An example of this type of mistrust is when, after several public scandals in the transplant field, members of the public may come to view all transplant professionals as corrupt, misleading, and unethical, thus refusing to believe in any reform efforts. This kind of mistrust weakens the collective capacity for moral reconstruction and institutional reform.

3.6.3 Trust and Trustworthiness

Based on the aforementioned, we can argue for a relationship between trust and trustworthiness, where trustworthiness primarily consists of a disposition to fulfil one's obligations. One may wonder whether, since being trustworthy is (in the simplest sense) to be worthy of trust, the disposition to fulfil one's obligation is central to being worthy of trust? To this, I would argue the affirmative, because if we are to trust intelligently and responsibly, then we must be willing and ready to place such trust in persons whom we deem dutiful or committed with a disposition to fulfil obligations towards us. As we shall see in subsequent paragraphs, this idea of being trustworthy as a disposition to fulfil one's obligations resonates with the types of trust I have earlier presented. Whether in cases where we must trust instinctively (*Instinctual trust*), cases where we place trust through a calculative method (*Strategic trust*) or through emotional commitments (*Affective trust*), as well as cases where we trust based on roles and institutional values or cases where we place trust with the hope that vulnerability will be met with competence and benevolence (*Relational-risk trust*), in all of these instances, the trustor finds the trustee trustworthy because they judge the trustee to have a disposition to fulfilling their goal(s). Nevertheless, I must note that there are exceptions to this, as noted in cases of Therapeutic trust, Wishful trust, and Blind trust, but this is to be expected if our aim is to trust intelligently and responsibly. In *therapeutic trust*, specifically *overriding therapeutic trust*, where standard trust is often overridden to support the trustor's well-being, even when the trustee might not meet typical trustworthiness criteria, we cannot say for certain that the trustee has a disposition to fulfil an obligation. The same applies to wishful and blind trust; since these other forms of trust lack the intelligibility

necessary for an adequate trust type, they count as exceptions to the evaluation of trustworthiness.

Presented this way, we can make sense of how we apply the term "trustworthy" to our actions, commitments, and relationships with people at various moments. In one sense, we tend to use "trustworthiness" to acknowledge our general feeling of trust towards a trustee. In another sense, we use "trustworthiness" to identify the specific domain and action in which we are assured of a trustee's obligation towards us. In the first instance, we may say: "Chimamanda is trustworthy"; and in the second instance, we may say "Chimamanda is trustworthy when it comes to keeping secrets and promises". In the latter, we may say that Chimamanda has the disposition to fulfil her obligation of keeping secrets and promises. In the former, we may say that Chimamanda has the disposition to fulfil her obligation in every instance it may arise. Since the view of trust we will be focusing on here involves a three-place relation rather than a two-place relation, I find it best to concentrate on the latter understanding of trustworthiness as the disposition to fulfil one's obligations regarding a specific goal, outcome or entity. So rather than giving an overly general understanding of trustworthiness as the disposition to fulfil obligations in the general sense, I see trustworthiness more as that disposition that makes one obligated to fulfil specific duties, commitments and expectations. Hence, while Nnamdi may be a trustworthy doctor, there is no guarantee that he is a trustworthy husband or father; applying the three-place relations makes our understanding of trust and trustworthiness better understandable and practical. In addition, it is advantageous for examining degrees of commitment to obligations and, by extension, trustworthiness. So, while it may be the case that Nnamdi and Chigozie are both trustworthy doctors, one can also make comparative statements about degrees of trustworthiness: Nnamdi is a more trustworthy doctor than Chigozie, as he has never been involved in a medical scandal or misconduct.

Given the case, the disposition could be behavioural, reputational or even normatively loaded, involving moral sensitivity, recognition of another's vulnerability and a sustained commitment to act from goodwill and/or integrity. We can further understand the disposition as having trigger and manifestation conditions: the trigger is having the obligation to *X*,[59] and the manifestation is fulfilling that obligation to *X* (Kelp & Simion, 2023, pp. 668-669). It is also worth noting that dispositions are relative to suitable conditions, which vary depending

[59] *X* here is the domain or act which one is entrusted with or deemed trustworthy for – like how we earlier said Chimamanda is trustworthy when it comes to keeping secrets.

on the *X* in question. So Chimamanda may have the disposition to fulfil her obligation to keep her friends' secrets, but not the secrets of strangers, acquaintances or people she considers enemies. Here, the suitable conditions for this disposition include the status of friendship. In addition, dispositions may vary in degree of strength as the higher the probability of manifestation given the presence of the trigger in a suitable condition, the stronger the disposition (Kelp & Simion, 2023, pp. 668-670). So, Chimamanda has a stronger disposition to keep her friends' secrets than we do because we are not friends with them; we lack the trigger and suitable conditions to manifest this trustworthy trait.

Let's relate this to the various types of trust: when one has a disposition to fulfil an affective obligation, we could say such a person is trustworthy in this sense. Such *affective trustworthiness* will rely on emotional bonds and goodwill rather than formal guarantees; it will involve a person's moral and emotional reliability in responding with care, empathy, and loyalty to a trustor's needs. The trigger is the presence of an affective relationship grounded in care, friendship, or emotional intimacy, and the manifestation can be identified in the trustee's acting with loyalty, empathy, and moral attentiveness to the trustor's needs or vulnerabilities. Grounded in moral emotions, this type of trustworthiness sustains personal and interpersonal bonds and affirms the moral worth of the trustor's vulnerability. So Chimamanda keeps her friends' secrets not out of duty, but genuine care for their emotional well-being. The trigger is the trust embedded in friendship, and the manifestation is her loyal silence.

In a *role-based or institutional trust* setting, trustworthiness may depend on one's conformity to professional norms and institutional standards; it concerns the trustee's commitment to act in accordance with the duties, policies, and ethical codes and conduct that define their role. The trigger here would be the adoption of a professional or institutional role, along with the specified ethical obligations and standards, while the manifestation would be the consistent, competent and ethically responsible execution of one's role-defined duties. Trustworthiness here depends on professional fidelity in the form of one's commitment to uphold the code of conduct, norms and shared principles and standards that justify the public's trust in the role one holds. A good example will be when one deems Nnamdi a trustworthy doctor because he reliably fulfils the professional duties of medical confidentiality, informed consent and non-maleficence. Herein, the suitable conditions are the professional contexts where competence, honesty and accountability are expected and displayed. A breach in such traits – say, mishandling a patient's information – would mark a

failure of role-based trustworthiness, even if Nnamdi remains trustworthy in other domains – for example, being a trustworthy husband.

One can also exhibit traits of *strategic trustworthiness*, which exists under conditions of rational calculation and expected reciprocity. Herein, one's trustworthiness may be identified in their disposition to keep agreements or to act dependably because of reputational or contractual incentives. Hence, in a business partnership, one may be considered strategically trustworthy if they consistently uphold agreements, not necessarily out of goodwill, but from a rational commitment to fairness, mutual gain and future cooperation and alliance. The trigger here would be the existence of a reciprocal or cooperative relationship sustained by rational incentives or reputational stakes, and the manifestation would be the reliable fulfilment of promises or agreements made for the mutual benefit of both parties or for other prudential reasons. Although the disposition here is mostly instrumentally motivated rather than being purely moral, it helps to foster stable cooperation. Take, for example, in a research collaboration, Chigozie consistently honours authorship agreements to preserve reputation and future partnership opportunities. His trustworthiness can be viewed as strategic, rooted in the alignment of incentives rather than affection or moral duties. In this kind of trustworthiness, the suitable conditions may include contexts of interdependence, where predictability and reciprocity sustain collective goals.

As is the case with many healthcare professionals in the transplant field, one may exhibit traits of *fragile trustworthiness*, a form of trustworthiness that emerges in contexts of uncertainty, limited knowledge and forced dependency. It can be identified as a provisional but earnest disposition to maintain ethical standards and expectations despite precarious conditions. In the transplant field, doctors, coordinators and policymakers exhibit fragile trustworthiness when they operate transparently and fairly despite the shortage of organs, systemic pressures, ethical tensions and past scandals, resisting bias or corruption and allocating organs fairly. Herein, the trustworthy agent's disposition is tested by advert and manifests as moral steadiness or reliability despite contextual fragility.

Relational-risk trustworthiness, on the other hand, identifies a trustee's disposition to accept and bear moral responsibility for one's dependence on them in specific matters. For example, a surgeon who communicates honestly with the patient about surgical risks, admits mistakes, and prioritises shared decision-making, demonstrates relational-risk trustworthiness. The trigger here is the mutual recognition of vulnerability and accountability

in a shared moral relationship, and the manifestation is the fulfilment of obligation with openness, moral responsiveness and accountability.

Conclusion

I have argued in this chapter that far from being a singular notion, trust is a complex, moral, affective and relational stance that expresses, sustains, binds and develops the moral life of relationships and human societies. From my analysis of trust here, I have argued that trust is not to be limited to a functional necessity of cooperation or an instrument for reducing uncertainty. Rather, trust is a deeply normative and affective orientation that defines how we relate with others, ourselves and the moral frameworks that bind us. In trusting, we are reminded of the ethical depth of human interdependence and the vulnerability that often accompanies it.

By examining the multifaceted nature of trust, I have emphasised that trust operates as both self-regarding and other-regarding, since to trust is to disclose who we are and what we value, especially when we open ourselves to the agency of others. Presented this way, trust is a moral act of hope and exposure, binding the epistemic, emotional, and ethical dimensions of human life. Hence, rather than being limited to calculations of reliability or institutional predictability, trust is a domain-specific moral stance through which we engage the world, grounded in shared expectations, vulnerability and the recognition of another's moral agency. Understood this way, within the OTD context, trust gains urgency as it mediates the most intimate exchanges between bodies and persons, life and death and between personal hope and public good. Trust influences how donors, recipients, families, and healthcare professionals navigate institutional structures, as well as the moral meanings of donating organs, receiving organs, and caring. It is for this reason that I insist that trust in the OTD field transcends procedural assurance, functioning as the moral and emotional bridge through which the act of transplantation becomes not merely a technical success, but also a shared human gesture of continuity, compassion and ethical recognition.

CHAPTER 4

TRUST IN ORGAN TRANSPLANTATION AND DONATION: CHARACTERISTICS AND CONCEPTION

Introduction

In this chapter, I present an understanding of trust in the field of organ transplantation and donation (OTD), examining my conception of its main characteristics and features. As an introduction, this first section presents a general account of trust in OTD, while more specific details on the complexities and varieties of trust issues will be addressed in the ensuing discussion. As will be seen, my identified features of trust are quite robust, making them widely applicable beyond the medical and transplant settings, with slight changes if needed. Although not all identified features may apply or be captured within certain other trust relations that we may experience, irrespective, these features are beneficial in describing nuanced trust relations that could exist, be formed, or be promoted in both the medical and transplant fields, as well as in other applied fields. While I acknowledge the possibility of "negative trust," i.e. trust relations in which trustors rely on the incompetence, lack of commitment and negative traits of their trustees in certain contexts and domains, this is not the sort of trust I seek to discuss or apply to the transplant field. Irrespective, this does not mean I do not agree that such a negative trust attitude can exist in the transplant field; I consider them trust anomalies and will not focus on them. I consider them trust anomalies because, as discussed in the following sections on the characteristics of trust, this type of trust lacks the emotional and psychological effects that occur when trust fails or is breached. In the strict sense, such attitudes cannot be taken as trust; they are rather instances of reliance or prediction. This is because, unlike trust, these examples lack the normative dimension, vulnerability, and moral exposure, and do not entail a sense of betrayal when broken. In such instances, the trustees have no awareness of the object of the trust, nor of the trust placed on them, and therefore have no disposition to respond with obligation or goodwill. Hence, such examples do not count as trust under my definition.

As I have discussed in chapter 3, while trust does not necessarily involve a moral commitment and expectation, in the specific domain to which I intend to apply it, I see it as necessary to emphasise the value of moral commitment and the expectation of trust. In the transplant and medical fields, which are unavoidably moral given the issues and concerns at hand, trust will always involve concerns about moral conduct. Hence, arguing that trust in

OTD involves moral expectations does not mean that I am importing morality into the general concept of trust; it rather means that I am making a domain-specific claim grounded in the nature of the OTD field itself: bodily vulnerability, life-and-death stakes, power asymmetries, and the irreversibility of decisions. So, the moral weight is not in trust as such, but in the domain. While normative expectations focus on, address and govern appropriateness within the role or practice, moral expectations govern conduct towards persons as such. The OTD field is morally saturated such that failures have irreversible consequences for persons in their most vulnerable states; hence, this often collapses the normative and moral distinction in this domain, as every normative expectation carries moral weight.

I view trust as a normative stance of hopeful dependence, in which one counts on another to act with integrity and care in matters affecting one's good, without the assurance of control, and in light of shared or assumed moral expectations.[60] Like Jones (1996), Baier (1986), O'Neill (2002) and Potter (2002) argue, trust is the belief or hope that others will act with care, fairness, and responsibility, especially when we depend on them in important and uncertain situations.[61]

Applied to the field of organ transplantation and donation, trust is a morally attuned, domain-specific stance of ethically motivated dependence, whereby individuals, families, and communities rely on persons, practices, and institutions to act with competence, transparency, integrity, and care in matters concerning bodily vulnerability, life, and death – under conditions of uncertainty and without full control, but with an expectation of moral accountability and shared commitment to the good. My definition of trust includes a normative stance, showing that trust is not just a feeling or prediction; it involves a moral

[60] Do recall that my inclusion of the moral expectation of trust in my definition is geared towards the application of trust to the medical and transplant field. If one chooses to adopt my definition to understand trust in domains where moral expectations and motivations are unnecessary, that characteristic of trust can be easily replaced by normative commitments alone.

[61] As previously stated, for Jones, trust is an affective attitude in which the trustor expects goodwill and responsiveness from the trustee within a particular domain. My conception of trust reflects this through its emphasis on care and responsibility, as well as the hopeful orientation embedded in uncertainty. Just as Baier emphasizes that trust often involves being vulnerable to the goodwill of others, especially when we are reliant and cannot easily monitor or compel behaviour. My conception of trust, which retains this notion of depending on others in uncertain situations and hoping they act with fairness and care, draws from this. O'Neill's introduction of responsibility and accountability in institutional trust, particularly in healthcare and public systems, informs my perspective on trust; the language of acting fairly and responsibly in high-stakes domains echoes her work. However, another influence is Potter, whose contributions from writings on trust in therapeutic and clinical relationships emphasise moral care, obligation and the importance of trust for healing and dignity, especially under conditions of vulnerability and dependence.

orientation or an evaluative posture, which makes it different from mere reliance. The emotional and ethical orientation of trust emphasises that it is not just rational and strategic calculation; it also accounts for hopeful dependence. Within the transplant domain, trust involves acting with integrity and care, centring on morally significant actions that may go beyond competence; sometimes, trust includes attentiveness to the trustor's wellbeing in moments of vulnerability, uncertainty, and moral hopefulness.

I have stated that trust involves the trustor's dependence on the trustee as well as the trustor's vulnerability and the trustee's recognition of it, but there's a need to clarify what I mean by these terms – dependence and vulnerability. By dependence, in one sense, I mean simply depending on others, a universal feature of human existence; it is a condition in which the achievement, protection, or preservation of something one considers important, valuable, or beneficial is contingent upon the actions, decisions, or conduct of another. As such, we can say that it is a condition of vulnerability in which one must look beyond oneself to another person, institution, or group for the protection, advancement, or fulfilment of what one considers important, valuable, or beneficial. Rather than being an exceptional state that applies only to a select few, dependence is a feature all humans experience at various points in life – at birth, as children, teenagers, and adults, in old age, and even after death. It is not exceptional; it is the condition. I do not view dependence as simply a deficiency of an idealised, self-sufficient trait we have, or as a weakness. I see it as being relational and socially constitutive because, as humans and social beings embedded in communities of mutual vulnerability and care, we all depend on one another. Our dependence is what connects us all; it is a natural moral expression of our condition as interdependent beings who genuinely need one another. Vulnerability, on the other hand, is the condition of being genuinely exposed – physically, emotionally, morally, or socially – to harm, loss, or exploitation in ways one cannot fully control, and that generate moral obligations in those who have power over that exposure.[62] This includes the recognition of *inherent, situational* and *pathogenic* vulnerabilities. *Inherent vulnerabilities* include the universal ontological condition of embodied, finite, interdependent beings, such that every person in the OTD field is inherently vulnerable simply by being human, mortal, and dependent on others. This coincides with my framing of OTD as a practice of shared human significance rather than a

[62] I agree with Walter and Goodin's definition of vulnerability as "X is vulnerable to Y in respect to N when X is actually depending on or circumstantially dependent upon Y to secure or protect N because of the nature of their existing relationship, some prior agreement, a particular causal history, or the fact of Y's unique proximity and capability in light of X's extreme plight" (Walter, 2007, p. 90).

transaction between strong givers and weak receivers. *Situational vulnerabilities* arise from specific circumstances, such as the recipient's illness, the donor family's grief, the living donor's financial precarity, and the patient's linguistic or cultural distance from biomedical institutions. This is the vulnerability the trust framework must be sensitive to in practice, because it varies significantly across individuals and communities. Pathogenic vulnerabilities are the most critical and most neglected. They are produced or worsened by the very systems meant to help. Examples include opt-out systems that remove meaningful consent from marginalised communities, allocation criteria that compound existing disadvantage, clinical communication that assumes health literacy, as well as the vulnerabilities of marginalised races and communities who have suffered a history of moral wrongdoing from the medical field.

Being a principled and context-sensitive orientation, within the OTD field, trust is marked by the morally grounded readiness to interpret the roles, actions, and decisions of actors as guided by shared commitments to care, respect for human dignity, and fairness, despite the irreversibilities, uncertainties, and asymmetries involved. Herein, trust is presented as a stance or orientation rather than just a feeling, belief or transaction. Instead of limiting trust to strategic reliance or affective hope, the moral expectations of trust are also captured. Essentially, this understanding of trust supports ethical and philosophical inquiries and is suitable for both normative theory and applied research within and outside the medical and transplant fields, depending on its application.

Based on this conception of trust and its application to the OTD field, I am of the view that, rather than experiencing a uniform trust relation in the transplant field, the players in the OTD field experience a variety of trust relations depending on the context of their trust relationship and the desired outcome. Instances of intelligent trust, which is aligned with hopeful dependence and tempered by shared moral expectations and critical awareness, can be captured when transplant recipients, despite uncertainties, place their trust in a surgeon whose ethical reputation and clinical track record offer grounds for hope; or when families of decedent donors intelligently trust that their loved one’s organs will be handled with dignity, based on institutional transparency and past performance. As a paradigm of care-responsive, morally embedded trust grounded in vulnerability and shared norms, *affective trust* may be seen in familial decisions to consent to donations to save a loved one out of shared identity and love, or when donor families trust that the transplant team will honour the body and intentions of the donor with respect. *Fragile trust*, highlighting the importance of context,

history and relational repair in ethically grounded trust, may encourage communities with histories of medical racism to trust the transplant system delicately. However, even a minor failure in communication or transparency can result in profound distrust.

Instances of *therapeutic trust*, which exemplify care-based dependence under normative medical obligations, can also exist, given therapeutic trust's orientation towards healing, reassurance and ethical dependence (Carter, 2024). Here, we may find instances of living donors who trust that the transplant team will prioritise their health during and after the procedure, rather than focusing solely on the recipient. Given the role of trust in hopeful dependence in high-stakes, morally laden circumstances, *relational-risk trust* plays a central role in the types of trust relations that may arise in the OTD field, considering the emotional, physical and existential exposure. Instances of this trust type may include recipients trusting the medical team with their survival, families trusting procurement teams to honour death rituals, and donors trusting doctors to prioritise saving them and give them a fighting chance rather than pushing for them to become organ donors.

Since *role-based or institutional trust* is grounded in institutional roles and associated expectations of professionalism, ethics and accountability, role-based trust aligns with domain-specific moral expectations. However, it runs the risk of being degraded to mere reliance when trustworthiness is assumed and not earned. Instances of this trust may include public trust in a national donation registry and trust in hospital ethics committees managing allocation decisions.

Other possible trust types accommodated by my definition of trust in the OTD field include (i) *Ethical-commitment trust*, which emphasises the trustee's continuous commitment to moral responsibility beyond discreet tasks, such as the continued care of donors after surgery. This trust type typically arises in long-term relationships, such as those between transplant coordinators and donor families, where a sustained ethical presence is expected. (ii) *Proleptic trust*, a type of anticipatory trust that calls trustees into being trustworthy, like recipients expressing trust in under-resourced transplant centres, thereby motivating improvements, or donors and donor families expressing trust that the recipient will use the donated organ well, thereby motivating the recipient to live a healthy life and treat their second chance at life with determination and positivity. (iii) *Reparative trust*, which is captured in instances where trust is extended despite past betrayal, as is the case in Germany, and amongst Black and Indigenous families who participate in organ donation despite

colonial trauma and medical bias. Trust here is often morally courageous and relationally reparative.

While I agree that instances of *strategic trust, blind trust*, and *wishful trust* exist in the OTD field, they do not align with my definition of the appropriate kind of trust relationship one should have within the transplant scene. *Strategic trust* lacks the affective and normative elements essential to my view of trusting when it becomes too calculative; it may promote efficiency, but does not foster ethical care. *Blind trust* lacks the reflective and moral accountability that my understanding of trust emphasises; it is ethically risky in contexts of bodily vulnerability. *Wishful trust,* on the other hand, distorts hopeful dependence by disconnecting it from normative discernment and mutual accountability. Often, the ethical issues in the OTD field stem from such trust relations.

4.1 Trust In Organ Transplantation And Donation: Characteristics And Conception

While I agree with Thomas Simpson's (2012) view that there is no single definition of trust capable of accounting for all its diverse manifestations across human relationships and institutional contexts, it remains both necessary and productive – particularly for applied ethical analysis – to articulate a concept of trust that is context-sensitive and analytically useful as I have done. Simpson rightly observes that trust is a "normatively rich" and "highly variable" phenomenon, and that attempts to reduce it to a universal formula risk obscuring rather than clarifying its function in moral and social life (Simpson, 2012, p. 549). Nevertheless, to delimit the scope of my inquiry and provide conceptual clarity in the context of organ transplantation and donation (OTD), I have given a composite understanding of trust tailored to the ethical, institutional, and interpersonal dynamics specific to this domain. Hence, to better understand and situate the ethical issues in OTD practices and policies as issues of trust, this section will attempt to characterise and conceptualise trust in the OTD field.

I argue that trust in the OTD field is best understood through a framework comprising the following features and characteristics: (1) it is a tripartite attitude; (2) it is role-based; (3) it includes normative expectations from the trustor; (4) it entails the trustor's reliance on the trustee; (5) it involves the trustee's direct or indirect commitments to the trustor's well-being; (6) it is grounded in shared moral standards or, at the very least, the trustee's acknowledgment of the trustor's moral principles; (7) it is relationship-based; (8) it often involves the affective attitude; (9) it involves the participant stance, and; (10) it is domain-

specific, allowing us to experience variations of trust rather than a simple static type for everyone involved.

1. Tripartite Attitude[63]

The tripartite structure of trust, as conceptualised by scholars like Russell Hardin (2002), is crucial in capturing the full scope of trust within clinical settings. In this model, X (the trustor) trusts Y (the trustee) to do Z (a specific action), where the object Z is essential to understanding the relationship's context and risk (Hardin, 2002, p. 9). In the transplantation setting, for example, a donor family (X) may trust a transplant coordinator (Y) to handle the retrieval process (Z) with respect and ethical diligence. This tripartite framework helps clarify that trust is not an undirected attitude but a structured and contextually bounded orientation. This tripartite structure enables a more precise analysis of trust as a relational and domain-specific phenomenon. While the trustee in everyday usage may include both animate and inanimate entities – such as trusting one's car to function properly or a pet to behave in familiar ways – my interest here is more narrowly focused on interpersonal trust between human agents, particularly within the complex moral and institutional terrain of organ transplantation and donation (OTD).

In *therapeutic trust*, for instance, the tripartite element of trust is evident when the trustor (which may be the donor, recipient or donor family) trusts the trustee (depending on the stakeholders involved, could be the recipient, healthcare professionals or the transplant institution) to act with restorative concern, promoting healing or moral repair within a context of vulnerability. In contrast, *blind trust* emerges when the "Z" – the specific action in this triadic structure – is unreflectively or vaguely defined, thereby revealing a lack of normative clarity about what is expected of the trustee by the trustor. Similarly, in wishful trust, the trust arises when the trustor's affective hope exceeds epistemic and moral justifications, showing how epistemic asymmetries and/or emotional desperation can morally weaken the tripartite structure. It can thus be said that the tripartite structure of trust aids our differentiation of various forms of trust based on the moral intelligibility of their aims. This is because since trust in the OTD field is always the trust to do something – to allocate organs fairly, to treat

[63] I must note here that the tripartite nature of trust does not always require a direct relationship like in the case where I trust my friend to have my back if I get into a fight, trust relations can also be indirect: take Hawley's (2014, p.14) example of the mother who trusts her daughter's friend to drive her home safely. Other similar examples may include trusting my teacher to defend and protect the student who is being bullied or trusting my manager to defend the coworker who, with incredible evidence of the crime, has been sexually assaulted by the manager's friend.

donors' bodies with respect and dignity, to treat the gift given well, to carry out last wishes with respect, to act transparently, etc. – the action required or expected takes a distinctive moral weight, depending on the type of trust one aims for. This tripartite structure presents the possibility for authentic or inauthentic trust, depending on whether or not the trustee recognises and upholds the moral significance of the entrusted action.

Given the earlier-examined definitions of trust, it becomes clear that trust, understood as a three-way structure, entails not only actional dimensions such as reliability and competence, but also reactive dynamics, involving reciprocal attitudes of trust and trustworthiness, and crucially, normative expectations grounded in shared moral understandings. Trust in the OTD field, therefore, is not merely instrumental; it is morally inflected, institutionally situated, and often deeply affective.

Trust may be directed toward particular persons,[64] such as a transplant coordinator, ICU nurse, or surgeon, whose competence, moral integrity, and professional commitment are central to the trust attitude and relationship. Alternatively, it may be directed toward institutions, such as hospitals, regulatory bodies, or national organ allocation systems, where trust depends more on systemic reliability, transparency, and ethical governance. Importantly, this bifurcation between interpersonal and institutional trust reflects a broader philosophical distinction between particular and general trust. The trust placed on particular persons and institutions may vary significantly, influenced by factors like familiarity with the trustee – like when a patients may trust a known family physician more readily than a new specialist; the nature of the relationship – since trust is typically deeper and more affective in relationships marked by past care, personal vulnerability, or shared experiences; or the knowledge of the trustee and object of trust – but while trust may presuppose some degree of epistemic background, this is not necessary for full understanding or application of trust.

[64] We must note that "particular trust" does not suggest that you can trust only one person at a particular time; it is rather the view that trust is more direct in the sense that our trust is usually directed at specific persons or institutions rather than at every person and every institution. This is also not to negate the fact that some people are more trusting than others and experience trust towards a wider range of people and institutions than others do. In the case of those who are considered more trusting than others, research shows that this is either a result of their natural disposition to trust or an influence from their environment and upbringing to be trusting towards others, irrespective of the nature of their relationship with such persons. Research suggests that the propensity to trust may be influenced by genetic factors, and studies in evolutionary biology suggest that trust has been naturally selected as a mechanism that promotes cooperation in social groups. Oxytocin, often referred to as the "trust hormone," has been shown to increase individuals' willingness to trust others (Kosfeld *et al.*, 2005, p. 673). This is consistent with research indicating that trust is an evolutionary trait that enhances social bonding and cooperative behaviours (Brosnan & de Waal, 2002, p. 135).

Yet, trust may also take a more generalised form,[65] as when individuals trust members of society at large to act civilly and not pose threats of harm in public interactions. This background level of social trust – what Simmel (1950) referred to as "a presupposition of interaction" (p. 178) – is foundational to the functioning of modern societies. As Hardin (2000) notes, generalised trust sustains the "thin" interactions that allow strangers to cooperate in civic life without intimate knowledge (p. 34). Robbins (2014) similarly describes such trust as a "background attitude" essential to everyday moral life (p. 22). In the OTD field, particular trust is exemplified by the donor family's confidence in the surgical team to treat the donor body with dignity and by a recipient's reliance on the coordinators to ensure fair allocation. General trust, by contrast, is expressed in public support for organ donation systems, based on the belief that institutional processes are ethically sound, and that others in society will act in morally responsible ways when asked to donate.

Thus, recognising the influence of this feature of trust allows us to understand that trust in this field operates across multiple axes – it is particular and general, interpersonal and institutional, affective and epistemic, relational and normative. Recognising this multi-dimensionality is essential to both understanding and ethically engaging with the fragile but indispensable trust relations that undergird organ transplantation and donation.

2. Shared Moral Standards, Principles, and Ideals

As experienced in the medical and organ transplantation field, trust, at its deepest level, is more than a calculated confidence in competence or reliability. It is a moral stance embedded in shared expectations, principled relationships, and normative ideals. Within this high-stakes and emotionally charged domain, trust is not merely an epistemic or strategic matter. Above all, it is a moral and affective practice grounded in mutually acknowledged values and principles. The existence of shared moral standards, or, at the very least, a perceptive demonstration of the trustee's commitment to respect, accommodate, or understand the trustor's moral framework and values, is central to establishing and sustaining trust in OTD. This feature emphasises the interpersonal, ethical, and social character of the trust relationship, especially where vulnerability, dependency, and existential stakes converge.

[65] This notion of "general trust" differs from Uslaner (2000), who defines "generalised trust" as "the belief that most people can be trusted, [and] [p]articularised trust [as] faith only in your own kind" (p. 573). Herein, Uslaner conflates whom to trust with social identity, seeing particularised and generalised trust as trust in categories of people (Robbins, 2014, p. 22).

This is the case in instances of *instinctual, role-based,* and *intelligent trust*. The trustor and trustee share an array of values, principles, and moral standards that contribute to their trust relationship, allowing the trustor to depend on the trustee despite the vulnerability involved. This feature is evident when trustees actively engage with the trustors' moral worldview, accommodate cultural rituals and beliefs, clarify the criteria for death, and respect bodily integrity. It is such shared moral recognition that allows us to differentiate between intelligent trust and wishful trust or other manipulative forms of trust. In addition, when shared moral ideals and principles are ignored or absent, trust degenerates into various forms of blind trust, often marked by moral alienation. Essentially *therapeutic, affective, role-based,* and *relational-risk trusts* often depend on an overlap in moral understanding, ideals, and worldviews between trustors and trustees. Even when full agreement is impossible, given the nature of pluralistic societies, the responsiveness to moral diversity demonstrated by the trustee sustains the integrity of trust, so much so that *role-based/institutional trust* emphasises moral trust through the integration of competence and care.

It seems the case that trustworthiness is not exhausted by competence; it is also deeply tied to integrity and the recognition and respect for moral norms and principles (O'Neill, 2002, pp. 146-149). What this means is that trustworthy professionals in the OTD field must not only be technically skilled but also demonstrate sensitivity to and alignment with the moral expectations of those who depend on them. As such, transplant surgeons, nurses, coordinators, and institutions are to do more than to secure successful surgical outcomes; they must engage with the cultural, religious, ethical, and emotional values of donors, recipients, and families in ways that honour their moral agency. It is actions such as these that will deepen *role-based trust* or *relational-risk trust* in the transplant field, making them become not just forms of intelligent trust but also ethical trust. A transplant team that strictly follows protocols but ignores the cultural or spiritual significance of death and bodily integrity for a grieving family might meet the criteria of procedural reliability but fall short of moral trustworthiness. As O'Neill notes, integrity involves a commitment to principles that are recognisable and acceptable to others (2002, pp. 147-149). In the OTD context, this often entails making space for grief rituals, respecting culturally defined boundaries regarding organ removal, or offering transparent communication about the use of donated organs. For example, in cases where Indigenous communities have expressed concern that organ removal might interfere with the spiritual return of the deceased to the ancestral realm, trust can only be cultivated if transplant professionals are willing to engage with and accommodate these

deeply held beliefs, not necessarily because they share them, but because they recognize their moral weight for the trustor (National Academies of Sciences, Engineering, and Medicine [NASEM], 2022, pp. 58–60).

Carolyn McLeod extends this ethical dimension by grounding trust in the trustee's responsiveness to the vulnerability and dependence of the trustor. For McLeod, our attitude towards people we trust "targets both their moral integrity and what they stand for" such that what we ultimately want from the people we have trust relationships with "is not kindly feelings but a commitment to doing what is right in the circumstances… we want them to have an enduring commitment to acting in a morally respectful way toward us and we want their actions to accord with that commitment" (McLeod, 2000, pp. 466-468).[66] For McLeod, trust demands integrity from the trustees, where having integrity means integrating one's actions with what one stands for, and, in the case of moral integrity, with what one morally stands for (2000, p. 468). As such, in McLeod's account, trust entails the belief that trustees will not only act competently but also do so in ways that reflect moral concern, integrity, and ethical responsibility. It seems this is the problem for most people: They trust the OTD system to be effective to some extent, to have the safety and continued living of transplant patients as part of their goal, but they are unsure about what the transplant system stands for – the collection and transfer of organs, the continued living of transplant patients, the continued living of prospective donors? It seems like this uncertainty about where the moral integrity of transplant policy makers and healthcare workers lies is what causes the rise in mistrust; from stories of families who soon regretted agreeing to donate, having understood "better" what it means for them to donate when their loved one could have had a fighting chance. And in other cases, this uncertainty about where moral integrity lies creates a system and a feeling of distrust such that persons do not even expect individuals involved in the procurement and allocation of organs to have the best interests of patients at heart. This responsiveness, integrity and commitment are crucial in OTD where patients and families often experience extreme vulnerability, such as coming to terms with mortality, bodily violation, grief, or loss. In such states, patients and their families seek not merely competent care but morally engaged care. As such, I argue that McLeod's emphasis on the moral nature of trust implies that shared moral principles – or a recognised commitment to the trustor's moral framework –

[66] While this makes all the sense in personal relationship cases, or cases where the concerned parties are familiar with themselves, it is not the same with relationships between individuals and persons in professional positions, political positions and even institutions or systems. The idea is that the relationship differs so much so that we are unable to conceive of a relationship the way we can in the former cases

are not optional embellishments but constitutive elements of trust. A living kidney donor, for instance, may trust a transplant team not only because of their surgical skill but because she perceives them to be attuned to her moral and emotional needs, such as full disclosure of risks, sensitivity to her altruistic motives, or reassurance that her sacrifice will be ethically honoured.

For McLeod, since it is possible to disagree on what is right, despite having moral integrity, it is not just moral integrity that we expect from people when we trust; we also care about what they stand for. Since we usually need some sense of what people stand for to trust them, this helps us know whether they are likely to act in ways that we would expect them to if we trust them, and often, this depends on our perception of the morally acceptable ways of acting (McLeod, 2000, pp. 470-473). The presence of shared moral standards between the trustor and the trustee enables both parties to establish clear normative expectations, articulate moral sentiments, and evaluate trust-related actions and outcomes in a meaningful manner. Without some form of shared normative language or mutual ethical recognition, trust may become fragile, opaque, misplaced and easily fractured. This is especially true in culturally pluralistic contexts like OTD, where diverse conceptions of bodily integrity, death, reciprocity, and sacrifice intersect. Take, for example, the notion of "respect for the dead" in different cultures. For some families, removing organs without specific forms of postmortem care constitutes a violation of the personhood of the deceased. If clinicians disregard these moral sentiments, viewing them as irrelevant or impractical, they erode trust, even if their actions are legally and medically justified. On the other hand, demonstrating an openness to engage with and honour these values, such as inviting spiritual leaders or accommodating family rituals, can foster profound trust, even amid clinical complexity (Potter, 2002, p. 46).[67]

Trust in OTD cannot rest solely on procedural compliance. Ethical responsiveness, applying McLeod and O'Neill's views, requires recognising the trustor not just as a case or donor, but as a moral agent, a person whose values are meaningful and whose dignity must be preserved. This responsiveness reinforces the idea that trust is not simply a cognitive belief in

[67] But one may wonder, how much do we need to know about what the people we trust stand for, to be able to trust them? McLeod would argue that since we often trust people to act in certain ways only within specific domains, what is important is for us to know what they stand for in the domain we trust them in (2000, pp. 471-472). The first step to knowing what people stand for is to reasonably assume that they share at least some common social values with us (McLeod, 2000, p. 472). While this may be helpful in some cases, it can be said to be one of the assumptions that lead to cases of blind trust and mistrust where trustors were not critical and sceptical enough to inquire about the system, policies, practices and risks before engaging with the transplant system.

capability, but a moral attitude oriented toward relationship, accountability, and mutual respect. This is especially crucial in instances where shared ideals are aspirational rather than actual. In such cases, the trustee's demonstrated willingness to engage with the moral worldview of the trustor becomes the bridge upon which trust is built. This is evident in some transplant programs that partner with community leaders from historically marginalised groups (e.g., Black, Indigenous, or immigrant communities) to build culturally safe practices. These partnerships do not necessarily ensure complete agreement on all moral issues, but they reflect a shared commitment to ethical respect and trustworthiness (Siminoff & Chillag, 1999, pp. 34–35).

While this practice may be challenged by pluralism, which complicates the possibility of fully shared norms, it does not render shared moral frameworks irrelevant; instead, it underscores the need for ethical pluralism, where moral engagement occurs through deliberative respect and mutual understanding rather than assimilation. In addition, while institutional constraints in the OTD field, such as limited time for organ procurement and transplant, limited resources, available staff and training, may prevent transplant medical personnel from fully engaging moral ideals or showing and/or communicating where they stand, symbolic acts of recognition can be very useful to sustain trust by signalling moral attentiveness; for example asking families about their cultural needs, using respective language, explaining (brain) death and how the physiology of the dead body may not match their understanding of death or pausing before procurement. Even in cases where no moral standards are fully shared, trust can persist if trustees display an ethically appropriate orientation to the moral values of others – openness, humility, and a willingness to be morally accountable. As McLeod (2002) observes, trustworthiness is as much about how one engages moral difference as it is about the content of one’s own values (pp. 23-25, 72-73; 2000, pp. 470-473).

Nonetheless, there is the possibility that one may be mistaken about the depth or existence of such shared values and principles with their trustor, and this may lead to misplaced trust – i.e., trust extended based on falsely assumed moral alignment. This is inevitable and constitutes the hopeful character of trust. One way to resolve this is to treat the misplaced trust that arises in this instance as an epistemic failure caused by poor judgment, insufficient evidence, or miscommunication. As such, one may be tempted to say that the solution to this is to demand more information, transparency, or proof that morals and values are aligned before trusting, but this is not the moral character of trust. Trust is not fully

evidentially grounded as knowledge or some beliefs are; trust requires vulnerability – a leap into the unknown, an exercise of moral hope. If trust required certainty about people's values and motivations, then it would cease to be trust and become reliance or prediction.

The resolution, therefore, lies in seeing trust in such instances as a revisable and responsive moral attitude that can be responsibly extended when accompanied by moral attentiveness, i.e., the ability and openness to revisit and reevaluate one's stance in the light of new evidence, experiences, or failures of recognition. So we can avoid or manage mistrust after the mistake of thinking there were shared values and principles by reframing our trust attitude and being willing to revisit and reevaluate the principles and values we hold as trustors and trustees.

3. Role-Based Relationship

Another defining feature of trust in the medical and organ transplantation and donation (OTD) context is that it is frequently role-based, grounded in institutional functions and professional expectations rather than in personal relationships or familiarity. As Bernard Barber (1983) argues, trust in modern societies increasingly relies on the predictability and moral reliability of institutional roles, rather than the personal attributes of individual actors (p. 133). For Barber, trust is shaped here by expectations that individuals in these roles will act with both technical competence and moral responsibility, as prescribed by the norms of the role itself (1983, pp. 13, 133). In the OTD domain, this role-based trust is especially salient. The work of transplant surgeons, coordinators, ICU staff, and organ procurement organisations is guided by codified responsibilities, technical competence, and ethical obligations. Here, trust is invested not necessarily because the trustor knows the individual physician or coordinator personally, but because they are understood to inhabit roles that carry moral and professional commitments enforceable through systems of accountability and oversight. This role-based feature of trust reveals how institutional and strategic forms of trust emerge within the OTD field, as within this feature, trust is anchored both in personal familiarity and the moral expectations that are attached to professional and institutional roles. As largely experienced in cases of role-based and institutional trust, trust here is sustained through the perceived reliability of the system and institution rather than the character of the individuals outside the domain of trust. Put differently, transplant healthcare professionals, coordinators, and procurement organisations are trusted because they occupy roles defined by competence, accountability and ethical norms. In cases of strategic trust, the role-based

feature is reflected in the rational reliance that agents place on other agents and systems when they cannot personally verify trustworthiness but are positive that the incentives will align conduct and moral expectations based on the role each agent must play in the trust relationship for their benefit. Although generally less affective, strategic trust values and presupposes the moral frame of roles as without institutional integrity, strategic trust may devolve into mere reliance. Essentially, the role-based feature of trust translates abstract systemic expectations into situated moral relationships.

In role-based settings, trust becomes a functional response to complexity and vulnerability. As Russell Hardin (2002) notes, trust in institutions or roles often arises when personal verification is impossible, and actors must trust in the reliability of systems or procedures (pp. 51-54). The expectation is not that every individual will act virtuously, but that the role and the system that sustains it will constrain misconduct and reward moral competence. Given the asymmetry of knowledge and power that defines most clinical interactions – particularly in the high-stakes context of organ donation and transplantation – patients, families, and the public must often place trust in institutional agents whose competence and goodwill they cannot personally verify. Yet this trust is not blind: it is predicated on the expectation that those in professional roles will act in accordance with the values, norms, and duties associated with their institutional identities.

While the role-based trust relations between the transplant team and the broader public – i.e. donors, prospective donors, recipients, and families – are typically explicit given the institutional expectations, licensing standards, and professional codes that govern medical practice, the trust dynamics between donors, recipients, and families are less institutionally codified and thus more morally complex. Nonetheless, these relationships, too, often carry implicit role-based expectations, which shape ethical judgments and social perceptions; these actors often inhabit morally charged roles, which give rise to implicit expectations.

For instance, recipients are trusted to treat the received organ with care and reverence, acknowledging both the medical gift and the human cost embedded in the donation. This expectation is not simply personal; it is rooted in a broader social and moral role that recipients are seen to occupy – i.e., honourable stewards of life-saving gifts. Transplant ethics committees often deliberate on these expectations when considering listing criteria, thereby institutionalising judgments about recipient trustworthiness (Veatch & Ross, 2015, pp. 132–133). This expectation reflects Annette Baier's (1994) observation that trust often involves

entrusting something valued into another's keeping, with the expectation that it will be used rightly (pp. 100-102, 130-135). The recipient's trustworthiness, then, is not merely about compliance with medical regimens, but also about honouring the donor's sacrifice. Similarly, in instances of decedent donations, family members of deceased donors are often trusted to act as moral proxies, responsible for upholding the values, intentions, or prior decisions of their loved one. In such cases, their decisions are seen as morally representative – an idea reinforced by Barber's (1983) view that trust often depends on the fulfilment of fiduciary obligations, particularly in situations where the primary agent is unavailable (pp. 130-134). When they consent to donation on behalf of the deceased, their decision carries a moral weight, not only as a legal act but as an ethically significant interpretation of the donor's will.

Likewise, donors themselves, whether living or deceased, are implicitly entrusted with the role of altruistic agents, whose willingness to provide organs is expected to reflect a moral orientation toward the needs of others. Although Hardin (2002) distinguishes sharply between trust and mere reliance, he concedes that expectations about another's interest in acting for the good of others are central to relational trust, especially in vulnerable contexts (pp. 27–30). This role-based expectation, while not enforceable, contributes to the moral narrative of donation that sustains public trust in transplantation systems. In this way, the act of consenting to donation – especially when made explicit in life – becomes an expression of anticipated moral responsibility, thereby reinforcing the network of reciprocal trust among donors, recipients, and the community.

Thus, role-based trust in OTD operates on multiple levels: formal and informal, institutional and interpersonal, as well as normative and affective. It allows trust to function even amid anonymity and asymmetry by embedding moral expectations in the roles themselves, rather than relying solely on personal character or direct relationships. However, as with all role-based trust, it requires ongoing maintenance through transparent communication, ethical accountability, and cultural sensitivity, particularly when the moral meanings attached to these roles may vary across social and cultural contexts. Recognising these role-based dynamics not only clarifies how trust is distributed in OTD but also highlights the moral stakes of trust failures or breaches, especially when roles are misunderstood, neglected, or misused.

4. Trust is Domain-Specific

For clarity, I understand a domain to be an area of activity, expertise, or concern, such as medicine, finance, intimate relationships, or professional conduct, and is defined primarily by its subject matter and the kinds of competences, norms, and vulnerabilities relevant to it.[68] As such, trust is not a generalised or indiscriminate attitude. It is rather domain-specific, bounded by the particular contexts, fields and expectations within which trust relations unfold. As many scholars have emphasised, trust is often appropriately confined to specific domains of interaction, shaped by the norms, obligations, competencies, and vulnerabilities that are distinctive to those domains.[69] In high-stakes environments like organ transplantation and donation (OTD), where multiple actors – donors, recipients, families of donors and recipients, clinicians, coordinators, institutions, policymakers, and the public as prospective donors – interact within complex systems, recognising the domain-specific nature of trust allows for a more accurate, morally attentive, and practically useful account of how trust is built, maintained, and sometimes lost.

As Karen Jones (1996) notes, trust is an attitude of optimism that another will be morally competent and responsive within a given domain of interaction (p. 4). This qualification—that trust is limited by a specific "domain"—is not a minor caveat, but a vital aspect of understanding how trust operates. To trust someone does not necessarily mean to trust them completely or universally, but to trust them regarding a particular role, task, or context. For example, in OTD, a family might trust a transplant surgeon to perform a procedure with technical skill and respect for the deceased donor's body, while remaining sceptical of hospital administrators responsible for overseeing resource allocation or transparency in procurement practices. In such cases, the scope of trust is confined – it is aimed at a trustee's performance within a defined domain, rather than a full endorsement of their character or institution.

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[68] As such, a domain differs from a role. By role, I mean a socially defined position within a relational structure — such as a doctor, friend, teacher, or parent — that carries specific obligations, expectations, and permissions regardless of the particular domain of expertise involved.

[69] As D'Cruz rightly argues, domain-specific trust is explanatorily basic, but this does not preclude general trust. As a result of the domain-specific nature of trust, we can identify the trustor, the trustee, the specific domain of vulnerability, the normative expectations operative within that domain, and the conditions under which trust would be honoured or breached. The domain specificity of trust makes it structurally tractable because the domain defines the relevant competences, norms, and vulnerabilities, and the content and conditions of trust can be specified with precision. This is different from the general trust we may have towards people or specific persons. While general trust is real, it is less analytically tractable and often derives from a history of domain-specific trust interactions that have generalised over time.

This insight is supported by Russell Hardin (2002), who argues that trust is encapsulated in specific relationships and contexts; it is not a general disposition (p. 50). Hardin's "encapsulated interest" theory suggests that trust is established when we believe the trustee has a vested interest in meeting our expectations within the specific relationship or interaction. Applied to OTD, this indicates that a transplant recipient may trust a coordinator to act as a reliable liaison in the matching process without extending that trust to the broader national organ allocation system. The recipient's trust depends on what the coordinator is expected and empowered to do within the specific moral and institutional framework.

Carolyn McLeod (2000) echoes this concept of domain-boundedness, asserting that trust is influenced not only by the trustee's competence but also by their alignment with the moral values and expectations specific to the relational and institutional context in which the trustor exists. She notes that when we trust others, we want their actions to accord with an enduring moral commitment to do what is right in the particular circumstances we face (McLeod, 2000, p. 468). Therefore, the scope of trust is determined not only by the agent being trusted but also by the moral landscape of the interaction. In the context of organ transplantation, a living donor may trust a transplant team to honestly disclose medical risks, respond with sensitivity to her altruistic motives, and manage her postoperative care responsibly, without necessarily extending trust to policymakers who establish eligibility criteria for organ recipients. Her trust, consequently, is rooted in a specific moral relationship and set of expectations.

Through this feature of domain-specificity, we can explain how multiple types of trust coexist without contradiction. It explains how a donor family may have affective trust in the transplant surgeon's compassion, institutional trust in the hospital's competence, role-based trust in the transplant team and healthcare professionals, and fragile trust in the fairness of the transplant allocation system. All these forms of trust can be had within the same moral horizon. By recognising the domain-specificity feature, we are prevented from idealising or condemning trust in the transplant system wholesale. The domain-specificity reveals a layered system where trust is distributed across relationships, roles and institutions, and each is often governed by distinct moral expectations and vulnerabilities.

Recognising that trust is domain-specific also allows us to better account for how trust can coexist with scepticism or even mistrust across different roles or layers of a system: trust in clinicians does not automatically translate to trust in administrators or policymakers. By

differentiating trust by domain, we obtain a more precise understanding that avoids the false dichotomy of unconditional trust or total mistrust. A decedent donor's family may trust the attending nurse or social worker who provides emotional support and consistent communication, while expressing suspicion toward the hospital ethics board's involvement in determining the moment of death or consent protocols. Similarly, public trust in national donation campaigns may be high, while trust in how organs are allocated across regions (especially in contexts shaped by structural inequities) may be significantly lower. This underscores the value of a finer-grained, non-monolithic account of trust that is responsive to the nuances of role-based, domain-specific interactions.

Furthermore, recognising trust as specific to particular domains carries ethical consequences. It challenges the common view within institutional rhetoric that frames trust as a broad feeling to be cultivated in an abstract or unconditional manner. Instead, it requires institutions, practitioners, and policy designers to engage trust by paying attention to the specific areas where trust is asked for and potentially broken. Consequently, when trust diminishes in a particular domain, such as consent procedures or fairness in allocation, it should not be assumed that trust in the entire OTD system has disappeared. Instead, focused ethical reflection and structural changes are necessary in the exact fields where trust has been compromised. For example, the 1999 findings by Siminoff and Chillag (1999) showed that families who consented to donation often expressed strong trust in individual clinicians but also voiced concerns about how donated organs would be used or allocated, especially if there was limited transparency or perceived bias in recipient selection (pp. 34–36). These findings demonstrate that trust in competence (e.g., surgical skill) does not automatically lead to trust in systems of justice, distribution, or long-term care. This view has important ethical consequences. It requires healthcare institutions to actively promote trust in their specific areas by ensuring that clinicians not only possess the necessary skills but also demonstrate moral responsibility, clarify decision-making processes, and involve patients and their families in considering moral perspectives to influence practice.

5. Reliance on the Trustee

While trust presupposes a willingness to rely on someone, as Annette Baier cautions, what distinguishes trust from mere reliance is the moral and relational vulnerability that trust introduces, wherein we do not just count on others to do what they say, we further count on them to care about the fact that we are counting on them (Baier, 1994, p.131). Essentially,

reliance without moral expectation is insufficient to be understood as trust. As Baier argues, we rely on many people and things without trusting them. We rely on alarm clocks, streetcars, and indeed on people when we only expect mechanical or habitual performance from them (Baier, 1994, p. 131).

Mere reliance is mainly predictive and mechanical, based on habits, routines, or even institutional roles, such as when we depend on our baristas to make our coffee correctly or on the Cineplex to start the movie at 9 pm as scheduled. However, in these cases—and many similar cases of mere reliance—while failure may disappoint us, it is not usually the kind of situation that would cause moral betrayal. In contrast, trust introduces and involves vulnerability—both emotional and non-emotional; moral expectations that might include the implicit assumption that the trustee cares about our well-being, and the lack of control, where the trustor is aware of the power the trustee holds over her and her inability to constantly monitor and enforce control.

Being trusted means being entrusted with responsibility, not just expected to behave a certain way (Baier, 1994, pp. 131-139). Therefore, when trust is broken, beyond the failure of expectation, we suffer a moral wound caused by a betrayal of the belief that the trustee cared about us or our interests. This often results in feelings of resentment, hurt, and even damaged relationships, whereas a failed reliance might only cause inconvenience or a need for rethinking.

This distinction between trust and mere reliance is especially important in healthcare, particularly in organ transplantation and donation. While patients may depend on a physician to follow protocols, they trust that physicians will act with genuine concern for their life and dignity, especially when outcomes are uncertain or patients are vulnerable. It is no surprise, then, that breaches of trust in medical settings are experienced as ethical betrayals of patients' and/or family members' moral personhood, rather than just technical failures. As in OTD, we tend to trust only those whom we believe can care about us, and we grant them discretionary powers over us. Even when patients develop emotional connections with their physician, alongside their moral expectations, trust assumes that the trustee's actions will be guided not only by rules or interests, but by concern for the trustor's welfare. Essentially, although patients' reliance may be directed at the hospital to provide care based on recognised professional standards, when the care involves deeply personal decisions such as organ donation, end-of-life choices, or truth-telling in uncertain circumstances, the expectation

shifts to trust. Patients do not only expect physicians to follow protocols but also to act with integrity, empathy, and sincere concern for their well-being. These cases align with Baier's view that trust "depends on the belief in another's goodwill and not just on their reliability" (p. 133).

Following this link between trust, reliance, vulnerability and care, in instances of fragile trust, such as in cases where families consent to organ donation amid their feelings of uncertainty and scepticism, trust here embodies the moral exposure and vulnerability which Baier fondly speaks of, and informs the patient, donor family and donor's reliance on the transplant system and health professionals to care for the trustor in their moment of vulnerability. In understanding the significance of one's vulnerability, we see how trust is precarious because it goes beyond calculable reliability and depends on the moral and affective commitments of others. The commitment of those we trust to the object of our trust in them transforms reliance into ethically charged relationships where the trustee is not only expected to perform competently but to be moved by the trustor's vulnerability. This reinforces therapeutic and relational-risk trust where the vulnerability and exposure of trustors to moral, emotional and health risks are high and their need for moral reassurance through transparency, empathy, adequate information dissemination and responsiveness, is requisite, crucial even.

6. Trustee Commitment

Philosophical accounts of trust agree that trust requires both competence and moral responsiveness, as it is not enough that someone can perform the trusted action: they must also care about it in relation to the trustor (Baier, 1986, p. 234; Jones, 1996, pp. 4-5). Carolyn McLeod's concept of trust emphasises this moral dimension: a trustee must be responsive to one's dependence or vulnerability, not merely being instrumentally reliable. Here, the responsiveness is not incidental but constitutive of trust itself. As such, the trustee's commitment to the trustor's well-being is not merely beneficial; it is rather integral to being trusted, it defines what trust truly is, and separates it from mere reliance. This view aligns with recent frameworks developed in the field of transplantation ethics. A study published in *BMC Medical Ethics* identifies moral intent as essential in transplant relationships, describing trust as involving both autonomy support and a genuine orientation toward the patient's best interests (Martínez-López *et al*., 2023, pp. 1–2).

In the OTD field, examples include instances where donor families place moral trust not only in technical competence but also in promises of respectful treatment. They expect assurances such as: “We will treat your loved one with dignity” and “Organs won’t be wasted” (NASEM, 2022, pp. 58–60; Martínez-López *et al.*, 2023, pp. 4–5). A breach, such as mishandling or failing to maintain transparency, provokes not logistical concern but moral outrage, illustrating that the trustee's ethical orientation counts more than mere competence. Similarly, when a kidney donor trusts the transplant surgeon to disclose risks transparently and place her welfare as a priority, if later informed of risks withheld, this creates feelings of betrayal and moral injury; trust violations in transplant care spark profound emotional and moral responses (Brown, 2008, p. 353; Martínez-López *et al.,* 2023, pp. 3–8).

While trust grounded only in competence or system reliability remains functional, moral commitment elevates it into a genuine human encounter. The awareness of the trustee’s commitment enables trustors to be vulnerable, as without moral assurance, they cannot safely reveal their needs or dependence. Since public confidence in OTD systems depends on ethical integrity, not just on protocols, moral commitment translates abstract principles such as respect, justice, and fairness into everyday clinical actions, promoting healthier outcomes and emotional resilience (McGeer & Baker, as cited in Martínez-López *et al.,* 2023, pp. 3-5). In organ transplantation and donation, trust is inherently a moral concept. The trustee’s commitment to the trustor's well-being, through competence, empathy, transparency, and respect, is not optional but the essence of trust itself. Recognising this is vital for ethical clinical practice and preserving public confidence in life-saving healthcare systems.

7. Normative Expectations

Understood as fostering an optimistic attitude that the goodwill and competence of another will extend to the interaction with the trustor (Jones, 1996, p. 5), the optimism that trust brings is not only psychological but also normative, since it is fundamentally based on normative expectations. Therefore, trusting involves the belief that the trustee should act with care, regard, reliability, and ethical responsiveness. This suggests that donors and recipients might expect not only technical skills from physicians and the transplant team but also compassion, integrity, and moral judgment, considering the human costs of organ donation and transplantation. However, the normative expectation of trust is not uniform. As scholars such as Kölle and Quercia (2021) explain, normative expectations vary across domains, disciplines, and individuals, reflecting accepted institutional, social, or cultural standards of

behaviour associated with specific actions within a trust relationship (p. 691). Given the high-stakes decisions, emotional vulnerability, and socio-cultural complexities involved, especially in the OTD field, the normative expectations are diverse and context-dependent.

Since different aspects of trust foreground distinct normative expectations, consider the following possible normative expectations that may emerge in the OTD field:

- When moral grounding is the focus, Baier (1986) argues that trust requires moral regard and responsiveness, not just reliability (pp. 234-235). In this view, a donor's family expects the transplant team not simply to carry out procedures effectively but also to treat the deceased's body with dignity and respect, recognising its moral and emotional significance. This expectation could also be shared by the decedent donor prior to their death.
- With an emphasis on goodwill and reciprocity, trust involves mutual concern and the assumption of ethical engagement, which is evident when donor families hope that the organs of their loved ones are ethically distributed and put to good use, that their generosity will be respected through transparency and regard, and they will also be able to receive a donation if the need ever arises.
- Following Hardin's (2002) encapsulated interest, the normative expectation may be the belief that the trustee will act on the trustor's behalf because it aligns with her own rational interest (p. 9). As such, a transplant surgeon may be trusted to act ethically and competently, not just because they are morally obligated to, but also because it sustains their professional values and trustworthiness and sustains institutional legitimacy and dependability.
- When discernment and informed vulnerability are central, O'Neill (2002) emphasises that trust should be founded on rational principles, supported by transparency and understandable reasoning (p. 65). Since donor families who consent to organ donation are making themselves vulnerable to the medical system, their trust does not always presuppose blind faith but an informed and rational belief in the system's integrity. As such, there is an expectation of adequate communication to ensure informed decision-making.
- Introducing the element of accountability into the normative framework of trust, according to Pettit (1995), trust involves an expectation that the trustee is motivated by the right reasons and is answerable for their actions (p. 204). He notes that betraying trust is not just about disappointing expectations; it is about wronging

someone by violating a norm of respect (p. 202). Thus, when transplant teams act without securing informed consent, they are not only breaching protocol but also morally violating those who have trusted them.

- For Carolyn McLeod (2000), the normative expectations in trust are based on the moral and rational understanding of the domain, the shared values, and the informed goals of all participants (pp. 465–79). In OTD, this includes recognition of shared interests in preserving life, respecting bodily autonomy, and ensuring fairness in allocation systems.

In OTD, the relationships between trustors and trustees are role-based and morally charged, often involving asymmetries of power and knowledge. As such, the normative expectations are also diverse: Recipients may be expected to act responsibly by caring for the organ, adhering to post-transplant protocols, and recognising the gravity of what they have received. Donors and their families are often trusted to make decisions that reflect altruism and respect for life. They, in turn, expect respectful treatment, transparent procedures, and moral stewardship of the donated organs. Medical professionals, such as surgeons, ICU staff, and coordinators, are expected to fulfil institutional roles with ethical clarity, clinical competence, and moral sensitivity. Their trustworthiness hinges not only on performing tasks but also on understanding the ethical obligations associated with their role. The public, as a collective trustor, expects institutions to act with fairness, justice, and transparency, especially in procurement and allocation procedures. These normative expectations structure the relationships and guide decision-making processes in the field. As Baier (1986) and Hardin (2002) suggest, trust cannot be reduced to simple reliance; it involves a commitment to meeting expectations that are grounded in shared moral frameworks and the vulnerability inherent in the trusting relationship (Baier, 1986, p. 235; Hardin, 2002, p. 9).

Essentially, normative expectations are what give moral shape to the various types of trust we may experience. While affective trust grounds these expectations in optimism about the goodwill and moral responsiveness of others, in therapeutic trust, the expectations may be oriented toward moral repair and responsiveness to vulnerability. In fragile trust, they are oriented toward building trust and protecting vulnerabilities amidst uncertainties; in role-based and institutional trust, expectations are aimed at meeting role-centred commitments, role performance, professionalism and social norms. In blind or wishful trust, normative expectations, though present, tend to be distorted since they are either inflated beyond reason or are detached from shared moral standards. Normative expectations regulate how trust

operates across roles for the stakeholders in OTD: while donor families, recipients and donors expect compassion, honesty, respect and integrity, clinicians expect institutional support; policy makers expect public compliance grounded in belief of fairness and moral integrity, etc. when fulfilled, these expectations make trust become self-reinforcing and breeds distrust and moral injury when violated. Importantly, normative expectations are not static; they evolve based on knowledge, cultural values, and social positioning. For instance, a donor's family may prioritise bodily sanctity and communal honour, while a recipient may prioritise survival and fairness in allocation. These differences reflect not a contradiction, but a plurality of valid ethical commitments, each grounded in different aspects of trust. The moral specificity that each type of trust we experience in the OTD field avails us with can thus be traced to how its normative expectations are defined, presented, justified and enacted within the tripartite relation.

8. Trust Is Relationship-Based

Trust arises in the context of human interaction. Whether those interactions aim to achieve personal goals, fulfil social obligations, or secure emotional, physical, or economic needs, trust, while not always necessary, is often crucial. In this respect, trust is best understood as a relational phenomenon. However, it is not inherent to every relationship. There are many relational settings, whether familial, professional, or social, where trust may be absent, unnecessary, or even inappropriate. For example, in a purely transactional medical interaction – such as a routine walk-in for a vaccination administered by a healthcare worker one has never met before - trust may not be meaningfully present. The patient may comply not out of trust, but out of confidence in institutional routines, minimal expectations of competence, and systemic reliability. Since there is no deep, emotionally invested, or normatively expectant relationship in such instances, this distinction is critical: not all reliance or expectation is trust. Similarly, having a biological tie with a distant family member does not imply a trust relationship. Despite the shared history and social identity, if there is no exposure, engagement, or moral demand placed on one another, then trust need not materialise, even if certain expectations grounded in cultural or familial norms persist. Trust, in these cases, is absent not due to hostility, but due to the absence of emotionally and normatively loaded relational engagement.

In relationships where trust does emerge, it is often seen as a facilitator of relational efficiency. Efficiency here refers not merely to productivity, but to the ability of the

relationship to remain cordial, dependable, communicative, and mutually beneficial. Trust facilitates open dialogue, eases coordination, promotes emotional stability, and fosters deeper mutual understanding. This insight has led thinkers such as Fukuyama (1995) and Whitney (1996) to frame trust as a form of social capital —an invisible infrastructure that enables relationships and institutions to function smoothly.

Yet this instrumental view of trust as a mere enhancer of efficiency is inadequate and potentially dangerous. As Flores and Solomon (1998) argue, reducing trust to a mechanism of social efficiency strips it of its moral depth, turning it into a tool for manipulation (pp. 207–208). If trust is framed merely as a strategy to induce compliance or cooperation, then even coercive or exploitative scenarios can masquerade as trust relations. To illustrate this point, consider the following: (i) The armed robber who "trusts" me not to scream, (ii) The rapist who "trusts" his victim to keep his crime secret, (iii) The con artist who manipulates others by feigning trust, (iv) Even the unethical physician who assures a patient that their secrets are "safe," only to disclose private health information without consent later. While they all invoke the language of trust, what they actually employ is instrumental reliance. These examples reveal a hollow or inauthentic trust, rooted not in mutual vulnerability or moral obligation, but in manipulation, control, or strategic dependency. Authentic trust, by contrast, is not simply reliance or belief in someone's predictable behaviour; it involves an exposure grounded in a normative expectation of concern, commitment, and care. This is why trust must be understood as domain-specific and relationally situated. Baier's (1986) insight is critical here: we may trust someone in one role or context but not in another. One may trust a babysitter to care for their child, but not to conduct emergency surgery. A teenager may trust her friend with a secret, but not to cure her mother's cancer. The domain, context, and mutual awareness of the trust at stake are what give trust its relational texture.

In healthcare, particularly in organ transplantation and donation (OTD), the domain-specificity of trust becomes particularly acute. A transplant recipient may trust their transplant coordinator to communicate clearly and advocate on their behalf, but not to perform the surgery. A donor family may trust the hospital system to treat their deceased loved one with dignity, even if they do not trust the broader governmental healthcare policies.

Crucially, patients often trust clinicians not merely because of institutional assurances but because of the relationships they form, through compassionate listening, honest communication, and recognition of the patient's vulnerability. When a patient consents to

donate a kidney to a stranger or agrees to a high-risk transplant procedure, they are not simply relying on technical competence. They are exposing themselves to the moral and emotional agency of others, expecting clinicians, transplant teams, and even the recipient to honour that vulnerability with care and integrity (Hawley, 2014). Take, for example, the case of a living kidney donor who is fortunate to meet the recipient during the transplant process, or the case of a deceased donor whose family meets the recipient during the donation and transplant process. From such encounters, a brief but profound relational bond may emerge, marked by mutual gratitude and a shared moral understanding of what is at stake. Trust here is not simply about efficiency; it is rather about the ethical weight of one's life (the recipient) depending on the moral commitment of another (the donor/donor family). Even in cases where donors remain anonymous, reports have identified that they sometimes have an unspoken and probably imagined trust relationship with the recipient, a sense of moral connection that underpins their donation decision and motivation. Angelique Ralph *et al.* discuss such themes in their qualitative synthesis of 40 studies involving 1440 participants, in which they confirm this relational deepening: donors and recipients tend to strengthen their relationship after donation through increased closeness, empathy, shared meaning, and quality time (2017, pp. 602-616). From the review, we find that a large percentage of donors report having improved or unchanged relationships after donation, with many describing enhanced intimacy. It is such profound bonds that underscore my view that trust cannot be reduced to efficiency alone. Donors and recipients do not simply engage in smooth cooperation for the sake of transplantation; they instead engage in morally significant exchanges that involve vulnerability and ethical commitment. This is evident in how donors frequently report feelings of guilt, gratitude, obligation, and a sense of moral debt in both living and deceased donations (Ralph *et al.*, 2017, pp. 602-616; Gross *et al.*, 2013, pp. 2924-2934).[70]

[70] For further empirical and interpretative readings, see: Dew, M., Jacobs, C., Jowsey, S., Hanto, R., Miller, C., & Delmonico, F. (2007). Guidelines for the psychosocial evaluation of living unrelated kidney donors in the United States. *American Journal of Transplantation*, 7(5), 1047–1054. https://doi.org/10.1111/j.1600-6143.2007.01751.x Gross, C., Messersmith, E., Hong, B., Jowsey, S., Jacobs, C., Gillespie, B., Taler, S., Matas, A., Leichtman, A., Merion, R., & Ibrahim, H. (2013). Health-Related quality of life in kidney donors from the last five decades: results from the RELIVE study. *American Journal of Transplantation*, 13(11), 2924–2934. https://doi.org/10.1111/ajt.12434 Khidekel, M. (2010, February 23). Organ Donation: How Christina saved 11 lives. *Glamour*. https://www.glamour.com/story/organ-donation-how-christina-saved-11-lives MacFarquhar, L. (2009, July 20). The kindest cut. *The New Yorker*. https://www.newyorker.com/magazine/2009/07/27/the-kindest-cut Pistorio, M., Veroux, M., Trigona, C., Patanè, M., Lo Bianco, S., Cirincione, G., Veroux, P., Giaquinta, A., & De Pasquale, C. (2018). Psychological and emotional aspects in living donor kidney transplantation. *Transplantation Proceedings*, 51(1), 124–127. https://doi.org/10.1016/j.transproceed.2018.04.085 Ralph, A. F., Butow, P., Hanson, C. S.,

In other cases, families of deceased donors must trust the organ procurement team to honour the donor's body, respect family wishes, and ensure that the donation process is conducted with transparency and care. Here, trust is not just in individuals but in institutional character, a point Flores and Solomon (1998) emphasise. Trustworthiness applies not only to people but also to systems, processes, and the relationships they engender (p. 209). We also see instances of people placing generalised or blind trust in medical systems, such as trusting an unknown surgeon or believing that organ allocation is fair. While these forms of trust may lack relational intimacy, they are still relational in a broader, role-based sense. Patients often trust based on the assumption that others – clinicians, ethicists, administrators – are committed to upholding their professional and moral duties. So, when such trust is betrayed, the betrayal is not only epistemic but also moral, because a relationship of vulnerability and expectation has been violated.

Essentially, trust is not an abstract ideal or a spontaneous feeling. It is created through concrete interactions and embedded in the roles and relationships we inhabit. As Flores and Solomon (1998) argue, trust does not just "happen to us," it is actively built and sustained through engagement (p. 213). Even when we "find ourselves" trusting someone – say a surgeon, a pilot, or a priest – such trust often rests on a history of socially constructed roles, responsibilities, and moral expectations.

9. The Affective Attitude of Trust

The affective attitude captures the moral, emotional, and interpersonal depth of trust, illuminating its vital role in sustaining and enriching human relationships. Far from being reducible to strategic reliance or role-based expectations, the affective attitude reflects a trustor's emotionally invested and normatively charged stance toward a trustee. In this regard, it articulates not only an optimism about another's competence and goodwill but also a vulnerability to moral injury, manifested in experiences of betrayal, resentment, and disillusionment when trust is violated. As Karen Jones (1996) compellingly argues, the affective attitude is an attitude of optimism that the goodwill and competence of another will extend to cover the domain of our interaction with her (p. 4). It includes the expectation that

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Chadban, S. J., Chapman, J. R., Craig, J. C., Kanellis, J., Luxton, G., & Tong, A. (2016). Donor and recipient views on their relationship in living kidney donation: Thematic synthesis of qualitative studies. *American Journal of Kidney Diseases*, 69(5), 602–616. https://doi.org/10.1053/j.ajkd.2016.09.017 Tong, A., Chapman, J. R., Wong, G., Kanellis, J., McCarthy, G., & Craig, J. C. (2012). The Motivations and Experiences of Living Kidney Donors: A Thematic Synthesis. *American Journal of Kidney Diseases*, 60(1), 15–26. https://doi.org/10.1053/j.ajkd.2011.11.043

the one trusted will be directly and favourably moved by the thought that we are counting on her (p. 4). This definition reveals the complexity and ethical salience of trust as a practice embedded in our affective and moral lives.

To define the affective attitude more precisely, it can be described as an emotionally charged, socially expressive, and normatively important stance that a trustor takes towards a trustee within a specific domain of interaction. This attitude is characterised by a hopeful willingness to rely on another, based not only on predictive judgments but also on the belief that the trustee will be motivated by concern, respect, and responsiveness to one's dependence. It is not a passive or private feeling; rather, it is a meaningful and communicative attitude that both conveys the trustor's expectations and calls forth the trustee's moral agency. Consequently, the affective attitude does not merely reflect how we perceive others but also expresses how we believe they should act in accordance with our shared moral commitments (Jones, 1996, pp. 6–9). It is this expressive and evaluative quality that distinguishes genuine interpersonal trust from mere reliance or calculative risk assessment.

The importance of the affective attitude becomes especially clear when trust is broken. The affective stance makes the trustor vulnerable not just to disappointment but to deeper emotional reactions such as betrayal and moral anger. These are not merely responses to unmet expectations; they are responses to the breaking of a normative relationship in which the trustor felt ethically and emotionally involved. Holton (1994) emphasises this by describing trust as a reliance "regarded in a certain way," so that one is "ready to feel betrayal should it be disappointed, and gratitude should it be upheld" (p. 67; cited in Simpson, 2012, p. 552). This explanation reinforces the idea that trust involves a disposition to emotional responsiveness and moral judgment and decision, qualities that are missing in purely strategic or institutional trust models.

A critical distinction must be made here between two senses of affect in relation to trust. On one hand, there is the *affect that constitutes* trust – i.e., the optimism, hope, and emotional vulnerability that form the affective attitude itself. On the other hand, there is the *affect that results* from trust being either upheld or betrayed – namely, feelings such as gratitude or resentment. The former belongs to the structure of trust as an interpersonal and moral attitude, while the latter are its emotional consequences. This distinction is necessary to

avoid conflating the presence of emotional reactions with the existence of trust itself or mistakenly identifying any instance of emotional engagement as a manifestation of trust.

The affective attitude is, moreover, domain-specific. We do not trust others in all aspects of life or across every context. Instead, trust is often limited to specific interactions or roles. As Jones (1996) points out, trust is best understood as involving optimism about another's goodwill and competence "in a particular domain of interaction," rather than a general or global sentiment (p. 4). For instance, I may trust my business partner to manage our accounts with integrity but not to offer sound medical advice. This specificity ensures that trust does not overreach, and it anchors the affective attitude in concrete expectations appropriate to particular roles and relationships.

This domain-specific structure of the affective attitude becomes particularly salient in medical contexts, and especially in the field of organ transplantation and donation (OTD). In OTD, this domain encompasses not only medical aspects but also moral considerations, including respect for bodily integrity, dignity in death, equity in organ allocation, and empathetic engagement with grieving families and anxious donors. Trust in this field often transcends mere procedural or institutional confidence and takes the form of an affective relationship between trustors (donors, recipients, and families) and trustees (surgeons, coordinators, and institutions). For example, a family consenting to donate their deceased loved one's organs places affective trust in the transplant team, not only expecting that the organs will be allocated appropriately but trusting that the body will be treated with dignity, that cultural and religious rites will be respected, and that their grief will be met with compassion. This trust is not simply a belief in institutional competence; it reflects an emotional investment in the moral conduct and concern of the professionals involved (National Academies of Sciences, Engineering, and Medicine [NASEM], 2022, pp. 58–60).

Similarly, a living donor may trust the transplant surgeon to act with moral concern, disclose risks honestly, and respect their bodily autonomy. If they later discover that key risks were concealed, their sense of betrayal is not just about information asymmetry but about a breach of the emotional and normative expectations embedded in their trust (Brown, 2008, p. 353). Here, the affective attitude explains why such violations provoke moral outrage rather than mere frustration.

Philosophers, such as Nancy Nyquist Potter (2002), have echoed this affective model, arguing that trust is "emotionally embedded" and "identity-shaping" (p. 23). It is not only

about what the trustee does, but also about whom the trustee is perceived to be – a morally responsive agent who cares about and acts upon the trust placed in them. Annette Baier (1986) similarly portrays trust as a relational practice grounded in emotional vulnerability and moral dependence. For Baier, trust involves "accepted vulnerability to another's power" and is therefore emotionally risky (p. 235). However, Baier's emphasis on goodwill as a central feature of trust raises important limitations. As Onora O'Neill (2002) has argued, we may trust a professional (such as a doctor) to act competently and ethically even if they do not personally like us or feel goodwill toward us (p. 14). In such cases, the affective attitude is directed not toward personal feelings but toward the expected conduct within a specific normative role.

This clarification is critical in the OTD field, where trust often resides in the anticipation of professional responsibility rather than in interpersonal affection. For instance, the affective attitude of a donor or recipient may involve optimism about a transplant surgeon's moral integrity and commitment to ethical norms, regardless of whether the surgeon experiences personal warmth toward the trustor. Thus, the domain-specific affective attitude enables trust in emotionally charged settings that are not necessarily intimate. Moreover, in transplant contexts, the anticipated goodwill may be limited to specific actions, such as respectful treatment of the body and fair allocation of organs, rather than extending to broader evaluations of the trustee's character.

Karen Jones' (1996) formulation offers a more nuanced model than Baier's by incorporating the elements of competence, awareness, and normativity. For Jones, trust includes the belief that the trustee will be "moved by the thought that we are counting on her" (p. 4), thus grounding trust in an acknowledgement of moral responsibility and relational responsiveness. This model is particularly apt for the OTD field, where trust often involves hope that others will act not merely out of role obligation but out of a sense of ethical commitment to the vulnerable individuals who rely on them.

Nevertheless, one might object that not all trust in OTD is affective. Some forms of trust may be better described as strategic, role-based, or institutional. For example, a recipient might trust the organ allocation system because of its regulatory oversight, rather than due to emotional investment. Indeed, as Uslaner (2002) and others argue, trust is often portrayed as a rational strategy aimed at maximising outcomes, particularly in political or economic theory. In this model, trust becomes a form of calculated risk management rather than a moral

or emotional commitment. However, while such models may account for certain impersonal forms of trust, they fail to capture the relational and normative expectations that animate affective trust, especially in ethically fraught fields like OTD. This critique overlooks the fact that many decisions in OTD are not reducible to instrumental calculations. When a donor family chooses to donate organs amid profound grief, or when a recipient interprets a transplanted organ as a sacred gift, these are decisions imbued with meaning, not merely grounded in probabilistic expectations. The affective attitude of trust is therefore not an irrational surplus; it is an indispensable feature of moral engagement in such ethically weighty contexts. Furthermore, the affective approach to trust allows us to differentiate between trust and mere reliance. For example, a donor family might rely on the transplant coordinator to arrange transport but trust her to do so in a way that respects their cultural values about the body and death. The former is instrumental; the latter is affective and morally invested.

Still, limitations exist. Not all individuals involved in OTD share this affective outlook. Some living donors may act purely from familial obligation or religious duty, and trust may take a more duty-bound or procedural form. Others might base their confidence entirely on institutional reputation or legal frameworks – i.e., forms of role-based or systemic trust that are cognitively grounded rather than emotionally invested. Moreover, systemic inequities, such as racial disparities in access to transplant lists, can erode the plausibility of the affective attitude for marginalised groups, who may experience the system as indifferent or structurally unjust (NASEM, 2022, pp. 70–75).

Thus, while the affective attitude of trust captures a vital and often underappreciated moral feature of the OTD landscape, it must be recognised as domain-specific and contingent. The affective attitude is indispensable for understanding the moral, emotional, and relational dimensions of trust in organ transplantation and donation. It offers a richer framework than strategic models by accounting for the trustor's vulnerability, hope, and normative expectations. It thrives in relationships of mutual recognition and care but is undermined by opacity, bias, and depersonalization. While not all trust in OTD may be affective, the presence of affective trust among donors, recipients, and families reflects the ethical depth of the practice and highlights the importance of fostering morally responsive and emotionally intelligent relationships within clinical and institutional settings. The challenge, then, is to create institutional cultures and professional practices that can

justifiably evoke and sustain such trust, not by demanding it, but by being genuinely worthy of it.

10. Participant Stance

Following P. F. Strawson's seminal essay “Freedom and Resentment” (1962), the concept of the participant stance has become foundational in moral philosophy. This stance describes a mode of relating with others as morally responsible agents – individuals who can respond to moral demands, are aware of moral expectations from others, and are subject to reactive moral emotions such as resentment, betrayal, gratitude, trust, and forgiveness (Strawson, 1962, pp. 4–6). In contrast, the objective stance treats others as morally incapacitated or as objects of scientific observation and prediction, thereby depriving them of moral engagement. According to Strawson, the participant stance is our default relational orientation, embedded in the way we experience and structure interpersonal relationships through shared moral life (Strawson, 1962, p. 5). In the medical field, the participant stance is captured when patients treat healthcare professionals as agents capable of understanding and responding to moral obligations, not just functionaries. Patients expect empathy, honesty, and respect in the shared decision-making process. The objective stance, on the other hand, is captured when patients view doctors as medical machines, reliable in technique but morally neutral with no expectations beyond competence. By adopting the participant stance, we assign moral depth to the relationship – trust becomes relational and oriented toward moral recognition and accountability, not simply dependence.

Applying this concept to trust, particularly within the context of medicine, organ transplantation, and donation (OTD), offers valuable insights into the relational and moral nature of trust. Trust, under the participant stance, is not reducible to strategic reliance or instrumental predictability as we may experience in strategic trust. Instead, it is a moral attitude, an emotionally and normatively charged disposition toward another person who is perceived as capable of recognising and responding to our needs, vulnerabilities, and expectations in morally appropriate ways. The participant stance is quite essential for therapeutic, fragile, affective and relational-risk trust as they presuppose that trustees can recognise and respond to moral dependence. Since these forms of trust sustain trust by embodying moral agency and relational accountability, trustees are seen to act from the participant stance, being aware of their goodwill in the lives of others and their trust relationship with them. As Karen Jones (1996) writes, taking up the participant stance in trust

involves regarding the other as someone who is responsive to moral demands, including the demand that she takes one's trust seriously (p. 10). When we trust someone from this stance, we do not merely expect them to behave in a certain way based on statistical patterns or professional norms. Instead, we presume that they acknowledge and affirm the moral significance of our dependence. This explains why trust violations elicit emotions such as betrayal and resentment, which go beyond disappointment or frustration. As Strawson (1962) notes, reactive attitudes such as resentment are not merely psychological responses but signify a belief in mutual accountability (p. 6).

Annette Baier's (1986) account of trust closely aligns with the participant stance. For Baier, trust is sustained through shared values and emotional vulnerability. She highlights the importance of entrusting oneself to another's goodwill, noting that such vulnerability is central to the moral fabric of human relationships (Baier, 1986, pp. 231–235). This vulnerability is not imposed by ignorance or necessity alone; it is voluntarily embraced because the trustee is seen as a participant in a shared moral world. Baier underscores this in the medical context, observing that prospective organ donors, despite recognising the power differential between themselves and transplant professionals, still willingly enter into a moral relationship grounded in trust (p. 244). Nancy Potter (2002) further develops this line of thought by conceptualising trust as a virtue arising from mutual recognition and moral responsiveness. Trust, for Potter, is deeply relational and thrives within a "shared moral landscape" in which both trustor and trustee are emotionally and ethically engaged (p. 37). Margaret Walker (2003) echoes this in her claim that shared moral understandings sustain trust and are vulnerable to collapse when these frameworks disintegrate (p. 94). Similarly, Bernd Lahno describes trust as encompassing "a participant attitude and a feeling of connectedness grounded in shared aims, values, or norms," which produces normative expectations and moral risks (p. 183).

Carolyn McLeod adds a crucial dimension by linking trust to moral integrity. She argues that to trust someone, particularly in high-stakes domains like medicine, one must possess a "knowledgeable expectation" about the trustee's moral commitments and integrity. In OTD, this means trusting a transplant surgeon not just because of their technical skill, but also because of a demonstrated ethical stance in handling patients, organs, and decisions (McLeod, 2002, pp. 72-73; 2000, pp. 470-473).

Concrete examples in medical practice illustrate how the participant stance operates in trust relations. Consider a family that consents to donate the organs of a deceased loved one. Their trust in the transplant team is not merely a belief in surgical competence; it involves trusting that the team will honour their loved one's body, respect cultural and religious rituals, and communicate transparently. This trust is not merely procedural but moral, rooted in a shared framework of respect, dignity, and accountability (NASEM, 2022, pp. 58–60). The perspective of a living donor offers another compelling case. A woman who chooses to donate a kidney to her sister enters into a trust relationship with the medical team. Her trust goes beyond believing that the surgery will be successful; it is a recognition of the surgeon's capacity to act with moral concern for her well-being and dignity. If she later learns that risks were not fully disclosed, the breach she experiences is not just informational but moral, a betrayal of shared ethical understanding (Brown, 2008, p. 353). In institutional contexts, public trust in organ donation systems hinges on the perception that professionals and agencies operate not just efficiently but ethically. Following scandals involving organ trafficking or biased allocation, public trust erodes not merely because of system failure, but because of a perceived violation of moral commitments to fairness, transparency, and respect (Siminoff & Chillag, 1999, pp. 36–38).

Thus, understanding trust through the participant stance reveals that trust is a deeply relational and morally situated practice. It emphasises that trust is not simply cognitive or strategic; it is grounded in a commitment to see others as moral agents capable of understanding, responding to, and honouring our vulnerabilities and ethical claims. As Baier (1986) notes, our moral lives are emotionally entangled with each other (p. 244), and nowhere is this more evident than in the domain of organ transplantation and donation, where trust must navigate profound ethical stakes and emotional investments.

4.2 Trust and Trustworthiness

Although trust and trustworthiness are deeply interwoven moral concepts, they are distinct in their structure, function, and normative significance. As an affective and relational stance, trust involves the readiness to become vulnerable to another within a shared normative framework (Jones, 1996). Trustworthiness, by contrast, is a compound virtue – an evaluative quality that includes integrity, reliability, competence, consistency, responsiveness, and moral commitment within specific domains (Hosmer, 1995; Flores & Solomon, 1998). As such, while trust involves the willingness to expose oneself to another's agency,

trustworthiness involves recognising that vulnerability and a moral responsiveness to the demands it imposes. Jones (2012) articulates this clearly: trustworthiness entails being attuned to the dependence that trust embodies and being moved by that dependence in normative ways (pp. 62-65). For Onora O'Neill (2002), in some cases, trustworthiness permits reasoned judgements that justify our deliberate placement of trust – what she terms intelligent trust (p. 65). Following O'Neill's view, trust is framed not as blind or wishful trust, but as a responsible and discerning act, where the trustor evaluates whether the trustee possesses the competence, reliability, and moral integrity required to merit trust. The ethical discernment that trusting intelligently requires is particularly important in high-stakes and morally charged fields, such as organ transplantation and donation (OTD), where trust is not merely strategic or pragmatic, but existential and relational.

Nevertheless, we must note that while the perception of trustworthiness is normatively desirable, given the context of one's trust relations and the persons involved, trust does not always presuppose such perception. Stated differently, people can – and often do – trust without having full or even partial knowledge of another's moral character, competence or trustworthiness. As Flores and Solomon (1998) emphasise, trust is not necessarily limited to contexts where one has confirmed the trustee's worthiness; it can be extended to strangers, institutions, or even to those previously found wanting (pp. 210–211). For example, a parent might entrust their child to a new school teacher at the start of a term without any intimate knowledge of the teacher's past behaviour, relying instead on institutional guarantees or social norms. Similarly, in emergency healthcare situations, patients may trust a physician they have just met, driven not by a rational assessment of the doctor's trustworthiness, but by necessity, moral hope, or emotional vulnerability. These forms of trust highlight that trust can occur even in the absence of full moral evaluation, sometimes rooted in necessity, hope, or existential dependence – thus bordering on what has been described as wishful or blind trust (Flores & Solomon, 1998; Jones, 1996).

It seems that trusting one often involves the presumption or projection of trustworthiness; nevertheless, the mere act of trust does not ensure or validate that such worthiness exists. This point is particularly pertinent in cases involving trustees who are unaware of the trust relation or show no interest or intention of acting within it. For example, a transplant surgeon may be regarded as trustworthy in their clinical duties due to their demonstrated competence and commitment to ethical norms. However, if a transplant patient or family member begins to trust this surgeon with unrelated personal matters – such as

giving good financial advice or sharing family secrets – without any established trust relationship in those domains, the surgeon's unawareness or disinterest could render this a case of wishful or even blind trust. Essentially, these types of trust lack mutual recognition, normative reciprocity, and shared role expectations; thus, they may be said to fail to meet the ethical standards of a genuine trust relationship. Since trust and trustworthiness are domain-specific, I argue that they are not global traits – at least not in the sense that one may presume their unified application in every form of trust or trust relation. This domain-relativity affirms that trust and trustworthiness must be situated within specific social, professional, and ethical contexts, rather than being treated as universal qualities (Jones, 2012, pp. 62-67). As such, institutional trustworthiness in organ transplantation depends not only on individual virtue but also on the structural integrity, transparency, and moral consistency of the institutions and systems involved.

Similarly, trustworthiness is not to be conflated with mere reliability or predictable behaviour. A reliable person may fulfil certain expectations without any moral awareness or regard for the relational dynamics involved.[71] Trustworthiness, in contrast, includes an internal motivational structure – a recognition that being trusted imposes moral obligations, responsibilities, and normative expectations on one's actions (Jones, 2012). It thus exceeds strategic reliability, requiring not only competence but also responsiveness, sincerity, and care in fulfilling the trust that has been placed.

In addition to the relationship between trust and trustworthiness, consider the role of transparency in trustworthiness. In both ordinary and high-stakes contexts, transparency plays a pivotal role in cultivating trustworthiness, although it is not exclusive to these contexts. Transparency, understood as the accessible disclosure of relevant, accurate, and truthful information, helps facilitate judgments to trust intelligently. In this form, transparency is not a virtue in itself, but a means of making trustworthiness visible and evaluable, thus permitting O'Neill's "intelligent trust", i.e., trust placed with discernment and responsibility. Transparency supports trustworthiness by evidencing the trustee's moral recognition of their responsibility, offering the trustor grounds for an evaluative judgment. It allows the trustor to see whether the trustee is competent, honest, and consistent with previously made commitments. However, transparency is not coextensive with trustworthiness, and,

[71] I do think that in the broadest sense possible, when we speak of trustworthiness, we may be justified to include reliance as a type of trustworthiness, where reliance can be understood as one of the first or early forms of trustworthiness. This is because, before we include the elements of the moral character, awareness and normative expectation, being trustworthy basically invites one to be reliable.

importantly, it is neither necessary nor sufficient for it. Consider, for example, the decision of a grieving family in an unfamiliar healthcare setting to consent to the donation of their loved one's organs. They may not fully understand the procedures or trust the system, but a culturally sensitive physician who offers transparent explanations and respects their mourning practices may nevertheless earn their trust. In such cases, transparency plays a mediating role – not by proving trustworthiness, but by helping to signal respect, reduce epistemic asymmetries, and support the possibility of morally meaningful engagement.

This distinction is particularly salient in OTD, where layers of institutional, professional, and interpersonal trust intersect. A transplant surgeon may be transparent about surgical procedures, yet a patient might mistrust the allocation system or the ethics committee. This underscores O'Neill's point that trust must be placed discriminately – not in individuals per se, but in institutions, roles, and specific practices whose transparency may vary. Furthermore, transparency may coexist with a lack of care, or even with institutional neglect. A hospital may disclose high mortality rates in transplant recipients (this demonstrates transparency), but if the system lacks remedial action, moral accountability, or a genuine commitment to reform, trustworthiness is undermined. Transparency without moral engagement risks becoming performative – a pseudo-virtue that simulates openness without inviting responsibility. Equally, trust without transparency can manifest as wishful trust or blind trust, where the trustor projects hope or moral desire onto the trustee without sufficient basis (Flores & Solomon, 1998, pp. 210–211). This is particularly dangerous in OTD, where systemic inequities or historical injustices (e.g., racially skewed organ availability) may make uncritical trust an ethical liability, especially for vulnerable populations.

Understanding the relationship and difference between trust and trustworthiness helps illuminate the benefits, risks and failures of trust within the transplant domain. Breaches of trust may arise not only from betrayal or bad faith but from neglect, incompetence, or a failure to recognise the moral salience of another's vulnerability. A clinician who unintentionally breaches trust by overlooking a donor family's cultural or religious values, even if not acting maliciously, may still be seen as untrustworthy if they fail to appreciate the moral dimensions of their role. Hence, trustworthiness entails more than outcome-based success; it requires attunement to relational and moral expectations within specific domains of interaction.

4.3 Epistemic Aspect of Trust and Trustworthiness in Organ Transplantation and Donation (OTD)

I have hinted in my discussions so far that there is an epistemic attribute of trust embedded in the value of being trustworthy, an epistemic aspect that notes the place of truth, the value of adequate information dissemination and informed consent, and the worth of interpretative fairness. Put differently, I posit that trustworthiness possesses an epistemic element that prompts recognition when agents act competently and with goodwill, and when they communicate honestly and handle information in ways that respect those who trust them. As Parker and Chin (2020) note, "respecting patient autonomy calls for a physician to grant a patient a degree of epistemic authority regarding their claims of self-knowledge" (p. E408), making truthfulness and interpretive fairness central to trust.

Following my definition of trust as a normative stance of hopeful dependence, epistemic conditions function as the informational and justificatory substrate that makes such dependence reasonable rather than arbitrary. Simply put, it is the epistemic conditions that inform the intelligent element of trust, predicated on discernment, adequate information acquisition and dissemination, and even sceptical acceptance of knowledge claims to avoid blindly trusting. In the case of OTD, the epistemic condition required to trust is complicated by expertise asymmetries. One such asymmetry is technical opacity, which encompasses the various clinical, legal, and logistical processes of organ procurement, matching, and allocation. These technical aspects of the OTD field — including its practices and procedures — are so specialised that it makes it difficult, if not impossible, for patients and families to verify competence or fairness directly. This is what Alvin Goldman (2001) means when he notes that epistemic reliance is unavoidable when the relevant evidence is not directly accessible to the layperson, since in some domains, like the OTD, even the grasp of evidence and information may be out of reach (p. 94).

Another complexity may stem from distributed causation. As experienced in the OTD field, outcomes in transplant and donation practices depend on multiple actors – including surgeons, procurement coordinators, ICU staff, and organ transport teams – making it difficult for stakeholders to attribute success or failure to a single source. This further entrenches epistemic dependence and requires that those in epistemic authority positions exercise epistemic trustworthiness – the virtue of being a reliable source of information while fostering the trustor's own epistemic agency (Zagzebski, 2012, pp. 52-74).

Based on the aforementioned, I posit that the epistemic dimension of trustworthiness consists essentially of epistemic competence – focusing on skill, capabilities, and knowledge; epistemic honesty – focusing on integrity and the accuracy of the information presented; and epistemic diligence – focusing on the conscientious pursuit of reliable knowledge claims. Essentially, epistemic competence requires the possession of relevant medical, procedural, and ethical knowledge for safe and fair transplant practices; epistemic honesty is the accurate representation of facts without distortion, omission, or strategic misdirection, and epistemic diligence is the active pursuit of reliable information to guide decision-making. In the OTD field, these elements of the epistemic dimension of trustworthiness, together, enhance donors' and their families' awareness of trust in the transplant system and the trustworthiness of the other stakeholders; essentially, they contribute immensely to defining the trust relationships among donors, recipients, and the transplant medical team. As Jones (2019) argues, epistemic trustworthiness is not merely about possessing and sharing knowledge, but about being motivated to ensure that the trustor is not misled in a state of ignorance and vulnerability (pp. 66-69). This is crucial in OTD, where decisions about donation, consent, and organ acceptance often depend on the clarity and completeness of information.

Given the influence of expertise asymmetries, the epistemic dimension of the OTD field can be said to be aimed at reducing and avoiding epistemic vulnerability, which is often intensified by three main factors: (i) *Urgency* – where the time-sensitive nature of organ donation and allocation often pressures potential donors or their families to make decisions without exhaustive deliberation; (ii) *Information imbalance* – procurement agencies and medical teams often control the framing and interpretation of critical OTD information, influencing donor perceptions, and; (iii) *Moral–epistemic entanglement* – failures in disclosure, oversimplification, or selective framing impede informed consent, leading to what may be described as threats to the autonomy of donors, their relatives, and the nature of donation as a 'gift' given.

Various scenarios illustrate these concerns. For example, partial disclosure, such as omitting that certain patients are prioritised due to geographic proximity rather than medical urgency, can lead to feelings of distrust when discovered. Similarly, framing effects, such as the gift narrative, resource material, and commodity, may influence donation. While presenting donation exclusively as a gift may have its value in public perception and acceptance, the failure to present organs as essentially a scarce resource may subtly influence the willingness to consent to donation while obscuring systemic allocation realities.

Overemphasising the presentation of organs as simply resource materials may increase the fear of the medical gaze, where persons may only be seen as means to ends rather than as persons deserving of respect. Finally, systemic opacity in allocation algorithms, as seen in some U.S. and U.K. policies, forces trustors to rely on institutional assurances without the means to verify fairness, intensifying epistemic dependence.

These epistemic concerns are not peripheral but central to the ethical and functional legitimacy of OTD systems. As Parker and Chin (2020) caution, psychosocial assessments and clinical decisions made without robust, transparent evidence risk not only being wrong but also undermining trust in the fairness of transplant programs (pp. E408-E411). To address these issues, healthcare professionals are required to cultivate epistemic virtues such as competence, honesty, and diligence, while also actively supporting the epistemic agency of donors, recipients, and their families.

Conclusion

In summary, the conceptual analysis I have conducted so far aims to develop a strong and context-aware understanding of trust, particularly one capable of navigating the complex ethical landscape of organ transplantation and donation (OTD). By framing trust as a domain-specific, emotionally and normatively influenced relational stance rooted in role-based vulnerability and moral responsiveness, I have endeavoured to articulate what is often overlooked in more reductive or discipline-specific approaches: specifically, the moral importance of entrusting oneself to another within socially and ethically constrained relationships.

The tripartite framework I have adopted—comprising the trustor, the trustee, and the object of trust—has proven useful in highlighting and differentiating the various components that influence trust relationships. It enables us to examine the dispositional and relational qualities of those who trust and those who are trusted, as well as the systemic and contextual environments that affect the development, breach, and breakdown of trust. Notably, I have argued that trust in the OTD field cannot be sufficiently theorised without considering its moral, emotional, and participatory dimensions, which raise it above mere instrumental reliance or strategic calculation.

Drawing from interdisciplinary insights while remaining critically aware of their limitations for my application, I reaffirm Simpson's (2012, p. 551) observation that trust is best understood as a cluster concept that accommodates diverse interpretations without

descending into ambiguity. In this pluralism, my thesis presents a principled and structured articulation of trust that conforms to the ethical demands and relational asymmetries inherent in medical practice, particularly transplantation.

Ultimately, trust in this context is not merely a precondition for clinical success or procedural cooperation. Trust is an ethically charged stance of hopeful dependence grounded in shared moral ideals, emotional resonance, and a commitment to the integrity of human relationships. It is precisely because patients, donors, and their families open themselves to the care-responsive agency of transplant professionals that trust becomes not only desirable but indispensable. As such, a properly articulated theory of trust must illuminate not just how trust operates, but also why it matters, and for whom.

CHAPTER 5

MAPPING THE TRIADIC STRUCTURE OF TRUST IN ORGAN TRANSPLANTATION AND DONATION

Introduction

In the previous chapter, I have defined trust, tailored explicitly to OTD, as a normative stance of hopeful dependence, in which one counts on another to act with integrity and care in matters affecting one's good, without the assurance of control, and in light of shared or assumed moral expectations. I have also argued that this definition incorporates elements of intelligent trust, thereby avoiding blind trust and fostering stronger, more secure trust relations among the involved persons. Stated differently, trust is the belief or hope that others will act with care, fairness, and responsibility, especially when we depend on them in important and uncertain situations. Applying this to the organ transplantation and donation (OTD) field, I argue that trust is a morally attuned and domain-specific stance of ethically motivated dependence. Within the transplant field, the involved parties – donors, recipients, families, medical professionals, and the public – rely on individuals, practices, policies, and institutions to act with competence, integrity, transparency, and care in matters concerning bodily integrity and vulnerability, as well as life and death. This reliance is often exercised under conditions of uncertainty and without complete control, but with an expectation of moral and epistemic accountability, as well as a shared commitment to the good.

In this chapter, I shall examine some of the trust relationships that exist within the transplant field. Since trust is domain-specific, it follows that even within the transplant field, there is no unanimous way trust exists and operates, nor is there a single type of trust that can be identified. Instead, what we have are various instances of trust relations between the involved parties, aimed at different moral outcomes but geared towards the same goals: Autonomy, Usefulness, Appreciated efforts, Fidelity to Shared Commitments and Good Treatment – competence, integrity, respect, transparency, and care – in matters regarding bodily vulnerability, life, and death. In some ways, these goals can be revised to focus on three specific objectives: the preservation of life, respect for death, and honouring bodily integrity. Thus, upholding normative expectations that the involved parties are often aware of and committed to, or at least should be.

This examination will build upon Martínez-López *et al.'s* (2023) presentation and mapping of trust in the organ transplantation field. Martínez-López *et al.*'s presentation provides a detailed understanding of the subject matter. Rather than focusing on specific cases, Martínez-López *et al.* are concerned with general claims applicable to the transplant field as a whole. In addition, Martínez-López *et al.*'s presentation aligns with my definition of trust and its application in the transplant field: trust is presented as a domain-specific enterprise, a normative stance for hopeful dependence, considering shared or assumed moral expectations. While Martinez-Lopez *et al.* limit their identification of the object of trust to Autonomy, Good Treatment, and Usefulness, I identify two additional objects of trust among the main players in the transplant field: Appreciated effort and Fidelity to Shared Commitment. In addition, my examination of trust in the transplant field provides a more detailed mapping of the actual and potential trust relations in the OTD field.

5.1 Situating Trust within the Organ Transplantation and Donation (OTD) Field

Since trust is foundational, it serves as the ground upon which many other important values are built. As Sissela Bok (1982) rightly argues, trust is essential for human relationships to flourish, such that whatever matters to humans, trust is the atmosphere in which human relationships and interactions thrive (pp. 31-32; McMillan, 2022, p. 153). Recognizing this value of trust and including trust as an important element that influences the transplant and donation field, it is not surprising that trust is taken as a crucial element to attaining and maintaining not just public cooperation for the continued existence of the field, but also public interest, opinion and the moral acceptability of the field, as well as its practices and policies. Nevertheless, for Sarah-Jane Brown (2018), trust has not always been fully appreciated in the OTD field (p. 143). Considering the depth and concerns of available research on the role of trust in OTD, I agree with Brown on this. Empirical, sociological and philosophical research on the ethics of organ transplantation and donation (specifically research on the primary problem of organ availability, as well as influences and reasons for and against organ donation) often gives the impression that trust is a central interest in ethical issues in the OTD field. However, upon close examination of some such research, I find that the methods for understanding the ethical problems in the OTD field do not always include an interest in understanding and examining trust specifically or how trust is generated and maintained in the field. This does not mean that trust has not been a subject matter for analysis and examination in relation to the transplant field; the problem is that trust has been

mostly understood, presented, and examined as a secondary issue.[72] Trust is not given a foundational place in the OTD field or considered a primary concern; instead, trust is viewed and presented as one of many elements that explain negative reactions towards the transplant field – specifically, experiences of distrust and mistrust within the OTD field.

Similar to my conception of trust as a normative stance of hopeful dependence, counting on one to act with integrity in light of shared or assumed moral expectations, Martínez-López *et al.* (2023) view trust as being characterised by the belief that others – i.e., individuals and institutions – will act as expected, generating positive emotion linked to a sense of security (p. 2). As I have discussed earlier, trust in the OTD field lacks a univocal definition or presentation, given its domain-specific and relationship-based nature. While trust may generate positive emotions in some cases, as Martinez-Lopez suggest, this is not the

[72] See Truog, R. D., & Robinson, W. M. (2003). Role of brain death and the dead-donor rule in the ethics of organ transplantation. *Critical Care Medicine*, *31*(9), 2391–2396. https://doi.org/10.1097/01.ccm.0000090869.19410.3c. Manzei, A. (2015). Organ shortage as a structural problem in transplantation medicine. In G. Assadi, R. J. Jox, & G. Marckmann (Eds.), *Organ transplantation in times of donor shortage: Challenges and solutions* (pp. 195–206). Springer. https://doi.org/10.1007/978-3-319-16441-0_12. Sazonov, V., Asanova, A., Bolatov, A., Shaisultanova, S., Abdiorazova, A., & Pya, Y. (2025). Attitudes toward posthumous organ donation in Kazakhstan: a qualitative analysis. *Frontiers in Public Health*, *13*, 1602268. https://doi.org/10.3389/fpubh.2025.1602268. Sque, M., Long, T., & Payne, S. (2005). Organ donation: Key factors influencing Families' Decision-Making. *Transplantation Proceedings*, *37*(2), 543–546. https://doi.org/10.1016/j.transproceed.2004.11.038. Albert, C., Harris, M., DiRito, J., Shi, A., Edwards, C., Harkins, L., Lysyy, T., Kulkarni, S., Mulligan, D. C., Hosgood, S. A., Watson, C. J. E., Friend, P. J., Nicholson, M. L., Haakinson, D., Saeb-Parsy, K., & Tietjen, G. T. (2023). Honoring the gift: The transformative potential of transplant-declined human organs. *American Journal of Transplantation: Official Journal of the American Society of Transplantation and the American Society of Transplant Surgeons*, *23*(2), 165–170. https://doi-org.proxy.bib.uottawa.ca/10.1016/j.ajt.2022.11.015. McDonald, E. L., Powell, C. L., Perryman, J. P., Thompson, N. J., & Arriola, K. R. (2013). Understanding the relationship between trust in health care and attitudes toward living donor transplant among African Americans with end-stage renal disease. *Clinical transplantation*, *27*(4), 619–626. https://doi.org/10.1111/ctr.12176. Ralph, A., Chapman, J. R., Gillis, J., Craig, J. C., Butow, P., Howard, K., Irving, M., Sutanto, B., & Tong, A. (2014). Family perspectives on deceased organ donation: thematic synthesis of qualitative studies. *American Journal of Transplantation: Official Journal of the American Society of Transplantation and the American Society of Transplant Surgeons*, *14*(4), 923–935. https://doi-org.proxy.bib.uottawa.ca/10.1111/ajt.12660. Douville, F., Godin, G., & Vézina-Im, L. (2014). Organ and tissue donation in clinical settings: a systematic review of the impact of interventions aimed at health professionals. *Transplantation Research*, *3*(1), 8. https://doi.org/10.1186/2047-1440-3-8. Honarmand, K., Ball, I., Meade, M. O., Sarti, A., LeBlanc, D., Basmaji, J., Belley-Côté, E. P., Chassé, M., D'Aragon, F., Guyatt, G., Rochwerg, B., Shemie, S. D., Sibbald, R., Slessarev, M., Weiss, M. J., & Parsons Leigh, J. (2025). Perceptions of health care providers involved in organ donation or transplantation on cardiac donation after death by circulatory criteria: a qualitative study. Perceptions des prestataires de soins de santé participant au don ou à la transplantation d'organes sur le don cardiaque après décès selon des critères circulatoires : une étude qualitative. *Canadian journal of anaesthesia = Journal canadien d'anesthesie*, *72*(6), 986–999. https://doi-org.proxy.bib.uottawa.ca/10.1007/s12630-025-02979-3.

only type of trust relation that can exist within the transplant field. In addition, although we have a general understanding of what Martínez-López *et al.* mean by positive emotions, it remains unclear what specifically constitutes positive emotions generated from trust relationships.

Nevertheless, Martinez-Lopez *et al*.'s conception of trust in the OTD field shares similarities with mine. I agree with Martínez-López *et al.* (2023, p. 2) that trust is an essential condition and facilitator of social interaction and cooperation. Not only does it bring people to depend on one another, but it also encourages cooperation within groups, among individuals, and between institutions and individuals or groups. Although the OTD field is one that predominantly requires one to be vulnerable, by applying trust to the field and its practices, we introduce the element of moral hopefulness, which tends to give our vulnerability an ethical foundation as one hopefully depends on the trustee to remain committed to fulfilling the object of our trust (Martínez-López *et al.*, 2023, p. 2).

I have argued that trust has a moral dimension, which captures the asymmetrical bilateral relationship of power and vulnerability between the trustor and the trustee. Martinez-Lopez *et al*. also argue for this view. For them, an expression of the trustor's vulnerability inevitably makes the trustee morally bound by the trustor's expectations to use their power responsibly (Martinez-Lopez *et al.*, 2023, p. 2). This view is captured in my inclusion and evaluation of the normative expectation and participant stance in trust.

Trust within the OTD field may be between donors, recipients, families of donors, medical teams, and transplant institutions, where the category of trustors may be assumed to include individuals or groups of people (like donors, recipients, families of donors, the public as prospective donors and members of the medical team) and the category of trustees can include individuals, groups or abstract entities, like the transplant system or policy makers (Martinez-Lopez *et al*., 2023, p. 2). As such, I posit that trust is domain-specific, presenting differently depending on the players involved and, oftentimes, on the relationship the players have. Regarding the trust relationship between players, trust may vary in intensity and nature depending on the relationship between trustor and trustee (Martinez-Lopez *et al.*, 2023, p. 2). However, despite the numerous ways trust in the OTD field may manifest, given the peculiarities of the domain and the relationships among players, I agree with Martinez-Lopez *et al.* that certain trust relationships are inherent to trust in OTD. For example, donors need to trust that transplant doctors will follow their wishes to donate or not donate; members of the

public, as potential donors need to trust that transplant donors do not just see them as potential biological materials and as such, will treat their bodies with respect and prioritize saving their lives rather than rushing to making them donors; some donors may need to trust that their families will respect their donation wish after death; recipients may need to trust that the transplant allocation system is just and fair; families of donors may need to trust that the donated organs will be used to save a life/lives, and; doctors may need to trust that recipients will respect the donation given and treat it accordingly, etc.

In the OTD field, various influencing factors exist that can have highly diverse effects on the main players within the system, creating numerous potential dynamic relationships (Martinez-Lopez *et al.*, 2023, pp. 3-4). Essentially, as in many other fields where trust is relevant, trust relationships in the OTD sector are deeply shaped by personal, community, and relatable views, values, and beliefs, as socially constructed relationships. These influences determine what is important to trustors, whom they trust, and for what purpose, as well as the strength and significance of their relationship, and why they choose to trust – even when their trust appears blind, wishful, or therapeutic (Martinez-Lopez *et al.*, 2023, pp. 3-4).[73] Such influences range from media inputs about the OTD field to testimonies and narratives from survivors, recipients, and families of donors (including both positive and negative reviews and experiences), as well as the transparency and communication of the transplant system, policy, and healthcare professionals, social contexts and identities, the relationship between autonomy and the existing procurement system, and notions of reciprocity and solidarity towards the donation cause.

While trust within the transplant field involves a tripartite relationship among trustors, trustees, and the objects of trust, the trust relationship is not limited to dyadic interactions but often involves complex networks of interactions and expectations. As such, not only can one social actor assume the role of a trustor or a trustee depending on their relationship with other persons involved, but there may also be several objects of trust, each depending on the players involved, the trust relationship they may share or seek to build, and the domain of their trust (Martinez-Lopez *et al.*, 2023, p. 3). I argue that within the OTD field, (i) multiple trustees may share a single object of trust; (ii) a single trustee may be relied on to be responsible for multiple objects of trust; and (iii) the object of trust may vary depending on

[73] I agree with Martinez-Lopez *et al.* (2023) that although these features may be determinant and constituent, it is best to view them as influencing factors that exert various degrees of influence on the trust relationships within the transplant and donation field.

the context, needs, and interests of the trustor. A typical example of (i) is respecting donation decisions; this object of trust may depend on the family of donors, doctors, or even the government – depending on donation consent policies and regulations. An example of (ii) is when doctors are trusted to save lives, be impartial in treating potential donors first, as patients who need to be saved, respect human dignity and the body after death, honour the wishes of people about donation, etc. An example of (iii) is when a trustor may trust their family to fulfil their donation wish (in the case of decedent donations) or trust them for emotional and physical support, but not for medical guidance or medical skill. Another example is trusting the organ transplantation system for the fair and just allocation of organs, but not for a guaranteed successful transplant surgery (Martinez-Lopez *et al.*, 2023, pp. 3-4).

5.2 Mapping Trust Dynamics in OTD: Understanding the Objects of Trust

In chapter 1, I discussed various factors that contribute to the ethical issues encountered in the OTD system. Some of these I have recalled as either elements that influence the object of trust or as plausible objects of trust in the OTD field.[74] Since there can be numerous objects of trust among the main players in the transplant field, not all of which can be examined in this work, the selected objects of trust span the range of concerns for most — if not all — of the main players in the OTD field. Martinez-Lopez *et al.* identify these objects of trust in the OTD field as: (1) Autonomy, (2) Usefulness, and (3) Good Treatment. Although they identify a fourth object of trust – Rewarded effort (2023, p. 4) – they limit its application to healthcare professionals only. In addition to the three main objects of trust presented by Martinez-Lopez *et al.*, I identify two more: (4) Appreciated effort and (5) Fidelity to Shared Commitment. Unlike Martinez-Lopez *et al.*, my inclusion of Appreciated Effort as an object of trust applies to the experiences of donors, recipients, and donor families, and I have rephrased the object of trust from Rewarded Efforts to Appreciated Efforts. This is to avoid the possible affiliation with commodification of organs and the assumption that people who donate organs are entitled to some kind of reward.

Like Martinez-Lopez *et al.* (2023), I argue that although grouping ethical, cultural, and religious concerns and diverse realities into simple categories, such as objects of trust in OTD, provides a useful framework, the categories mentioned above are not intended to be an exhaustive list. Nor do they suggest that every trust relation within the transplant field functions or appears in the same way for all objects of trust or trust relations (p. 4). Instead,

[74] Examples include consent policies, practiced systems for organ donation – i.e., opt-in and opt-out systems, culture, religion and belief systems, bodily integrity, method of organ retrieval, etc.

these objects of trust aim to offer a holistic and simplified understanding of the subject, mapping/outlining the trust relations that may exist in the transplant field.

I have identified the trust agents to include both actual and prospective donors, recipients, families, healthcare professionals, policy makers, and society at large. The donors – potential and actual – are living persons capable of making donation decisions for either living or deceased organ donation. Recipients – actual and potential – are patients with terminal organ failure awaiting organ transplantation; recipients include transplant patients who are either on the transplant waiting list or considering registration for a transplantation programme. Families include individuals related to or close to the deceased person, who have the legal capacity to influence donation decisions through their reactions, acceptance, denial, or consultation. Families have the power to influence donation decisions even in cases where the deceased has previously declared a positive interest in donating. Healthcare professionals encompass medical workers directly involved in the donation process, including those who identify potential donors, collect information, make donation requests, procure organs, and perform transplantation surgery (Martinez-Lopez *et al.,* 2023, p. 4; Delgado *et al.*, 2019, pp. e112-118). Policy makers are tasked with facilitating successful transplantations; they are persons "involved in the creation and promotion of regulatory frames for transplant activities, including transplant laws, clinical protocols, algorithm design, communication strategy, public education, etc." (Martinez-Lopez *et al.*, 2023, p. 4). The society is inclusive of members of the public from various backgrounds, including potential donors, recipients, families, and healthcare professionals. It is worth noting that in some cases, individual actors may be required to play multiple roles simultaneously, such as when a family member is also a donor and a medical professional.

Autonomy, as an object of trust, involves concerns about decisions made with informed and voluntary consent regarding donations; it includes concerns about the self-preservation and self-governance of the agent; it refutes the limiting equation of autonomy (as self-rule) with voluntariness, given the possibility of choices that can undermine an agent's capacity for future self-rule (Sneddon, 2002, pp. 105-110). Although the most common and general view of autonomy holds that it is content-neutral, focusing on the freedom and voluntariness to make choices, and allowing for various autonomous actions irrespective of what such an action is, means, or ethically implies, I do not agree with this view of autonomy. As we shall see, rather than simply being the making of independent and voluntary choices/decisions, autonomy involves being an autonomous person; hence, it is not

content-neutral (Sneddon, 2001, p. 106). Under the general content-neutral view, selling oneself into slavery is deemed acceptable so long as it can be done autonomously – as long as the choice was made voluntarily, freely. Similarly, living persons can readily choose to give their organs – including their heart – to anyone who is in need, even to their own detriment, so long as they freely and voluntarily consent to this choice. But this is not how autonomy works; save for some exceptions, we do not typically condone committing self-directed harm or neglect in a bid to make an autonomous choice. The fact that some choices, given their content, are autonomy-destroying, regardless of how they were made, proves this point. Since self-rule is the value of autonomy and is best understood in terms of being an autonomous person rather than in terms of making autonomous choices, we see that voluntary choice-making is insufficient for autonomy if the choice made undermines the agent's capacity for self-preservation and self-rule (Sneddon, 2001, pp. 107-115; Sneddon, 2006, pp. 392-394; O'Neill, 2002, pp. 141-164).[75]

Against this view, I opt for a non-typical position of autonomy: autonomy is not simply about how a choice is made, but also what is chosen, and whether that choice can be situated within the moral architecture that gives legitimacy, meaning, acceptance and self-rule to agency. I opt for the version of autonomy that recognises the need to have and exercise control over one's life, where the control includes, at least in part, having a life-plan with thoughts and choices that are backed up by reflection, foresight, self-assessment, sensitivity to values that may be deemed important to structuring life, as well as knowledge of various kinds of life one is capable of pursuing (Sneddon, 2001, p. 107). As such, autonomy involves a normatively constrained form of agency, with conditions on what may permissibly be chosen, not just on how choices are made. It presupposes ongoing self-rule and evaluation, the ability to revise commitments and ensure continued standing as a moral agent (Sneddon, 2001, pp. 110-111; O'Neill, 2002, pp. 141-164)

[75] For further reading on autonomy, please see O'Neill, O. (2002). *Autonomy and trust in bioethics*. Cambridge University Press; Sneddon, A. (2013). *Autonomy*. Bloomsbury; Pugh, J. (2020). *Autonomy, rationality, and contemporary bioethics*. Oxford University Press; Childress, J. F., & Quante, M. (Eds.). (2022). *Thick (Concepts of) Autonomy : Personal Autonomy in Ethics and Bioethics* (1st ed. 2022.). Springer International Publishing. https://doi.org/10.1007/978-3-030-80991-1; Taylor, J. S. (2009). *Practical autonomy and bioethics*. Routledge; Paul, E. F., Miller, F. D., & Paul, J. (Eds.). (2003). *Autonomy*. Cambridge University Press. https://doi.org/10.1017/CBO9780511550119; Giovagnoli, R. (2007). *Autonomy: a matter of content* (1st ed.). Firenze University Press; McCarthy, A., & Watt, H. (2023). Double-Effect Donation or Bodily Respect? A "Third Way" Response to Camosy and Vukov. *The Linacre Quarterly*, *90*(2), 155–171. https://doi.org/10.1177/00243639231162436.

In the OTD field, the autonomy of living donors may be expressed through their awareness of themselves as autonomous persons whose choices must be geared toward self-preservation and self-rule; respect for autonomy may sometimes require refusing to honour certain choices, not because agents lack competence, but because such choices may negate their moral standing as autonomous agents. Hence, it is essential that they be reasonably and adequately informed about the risks, benefits, and alternatives to organ donation, to ensure that their thoughts and choices do not undermine their moral agency. Donors trust that institutions will not treat consent as sufficient when doing so would undermine their moral agency; while consent is central, it must be embedded within practices that sustain thick instances of autonomy rather than merely record agreements.[76] With insight from Sneddon's (2001;2006) treatment of autonomy as agency-preserving, normatively constrained, and future-oriented, we find that, for deceased donors in opt-in systems, since their death marks the end of the agent's capacity for ongoing self-rule and self-preservation, there is no destruction of future agency. As such, respect for autonomy takes the form of bounded authorship, moral authority, and consent. In this regard, respecting the deceased's prior wishes is crucial because autonomy is exercised prior to their death through decisions that author one's posthumous treatment in ways that are consistent with their values, commitments and self-conception. This shows that autonomy is not merely voluntariness or choice-making; it includes the normatively structured authorship of one's life and one's death (or ending). Under the opt-in system, the donor must provide consent through the donor registry or will, and, in some cases, family consent is also necessary. Transplant healthcare workers and institutions are then tasked with respecting such authorisation as an expression of the agent's moral authority.

For donor families, since autonomy cannot be transferred or alienated in ways that erase moral authorship, donor families do not inherit the deceased's autonomy. It is impossible for donor family members to autonomously decide in place of the deceased, as if the deceased's agency had become theirs. This is because doing so would fail autonomy, turning it into authority or even control. As such, autonomy for donor family members takes the form of interpretive moral agency, allowing donor families to fill the role of interpretive

[76] Andrew Sneddon argues for two classifications of autonomy, which in some senses can be likened to my classification of thin and thick autonomy. In a broad sense, my idea of thick autonomy can be likened to his notion of deep autonomy, while my idea of thin autonomy can be likened to his view on shallow autonomy. An application of his classification of autonomy to the field of organ transplantation and donation will yield similar results, with examples of thick or deep autonomy and thin or shallow autonomy.

agents rather than originators of decisions and choices. In this regard, the autonomous task for donor family members is the interpretation of the deceased's values, commitments, and prior wishes, deliberations on how best to honour those wishes and commitments, and functioning as and responding as moral agents rather than passive decision-makers or gatekeepers of prospective organs. Since autonomy is not just the making of choices under minimal coercion, when donor family consent is obtained under vulnerable conditions characterised by grief, time pressure, and moral shock, it may still be permissible as respecting autonomy as long as the autonomous agency of the deceased and the donor family is not ignored, giving way to the recognition of authorship and the demonstration of moral reflection. Herein, while the deceased's status as the primary autonomous author is preserved, the moral agency of the donor family members is established. Given the aforementioned, respect for the autonomy of donor families may take the form of accepting the donor family's interpretation of the deceased's decision, the engagement with the deceased's prior autonomous commitments, values and decisions (where stated/known), the preservation of the deceased's standing as a moral agent – even after death, and the transplant system's acceptance and adherence of the moral prohibition against treating the deceased as merely a means.

For recipients, respect for autonomy is demonstrated by providing information about the risks and benefits of transplant surgery, as well as the chances of success and post-transplant life. This would mean that recipients can make informed medical and surgical decisions about their health; they can choose the course of treatment they will follow and even accept or refuse donations. By respecting recipients' autonomy, recipients can, in turn, trust that their healthcare providers and the transplant system have their interests at heart rather than seeing them as a means to emphasise the importance and growth of the transplant field. Recipients can trust that they will not be treated as passive agents in matters related to their own healthcare and safety. Healthcare professionals exercise autonomy through professional freedom to make judgments based on medical ethics and evidence, free from institutional, political, or financial pressures. They should also have the liberty to raise ethical concerns and conscientious objections regarding new transplant techniques or allocation issues without facing reprisal. Fundamentally, autonomy for healthcare professionals requires protocols, policies, and audits that support their roles as moral agents rather than reducing them to mere medical technicians whose only use is their skill in advancing the transplant field.

Even in the unlikely event that healthcare professionals within a particular OTD system participate in designing protocols that, when implemented, reduce clinicians to mere technicians, such protocols cannot be regarded as compatible with either their autonomy or the relational trust that underpins and supports transplantation practices. This is because, considering the role of autonomy and the sense in which it is necessary for ethical healthcare practices, it cannot simply be understood as a procedural capacity to choose. While the common view of autonomy presents it as being content-neutral, capitalising on voluntariness and the making of choices freely, as earlier indicated, I opt for an understanding of autonomy that seeks to preserve the autonomous person even in the choices willingly made, such that the making of choices does not negate the autonomy and moral agency of the self, or threaten the self-rule and self-preservation of the agent.

The idea is that, even when made voluntarily, certain choices can be ethically self-negating, as seen in the example of the healthcare professionals presented above. Irrespective of how autonomously individuals may appear to consent, we do not permit individuals to enslave themselves, nor do we treat suicidal intentions as morally valid simply because they are self-originating and voluntary. This is because these choices deny the moral agency standing that autonomy presupposes, negate the continuation of a future self and condone committing an unjust act towards oneself. Put differently, the content of these choices undermines the agent's own good and welfare in a way that contradicts the normative conditions of autonomy. In the same light, the voluntary endorsement of protocols that instrumentalise healthcare professionals, reducing their moral contribution to mere technical efficiency, cannot be taken as an exercise of meaningful professional autonomy. This is because the ethical responsibilities of healthcare roles are defined by commitments to patient welfare, responsiveness to vulnerability, and the integrity of healthcare practices, rather than by service to a system's technological or institutional ambitions. Accepting such instrumentalisation would deny healthcare workers' moral agency, permit them to commit unjust acts against themselves, and negate their self-preservation and self-rule, since they will be unable to reevaluate, reexamine, and revise commitments and change decisions as needed.

It is in this sense that trust enters a crucial object of moral evaluation. Since trust, as I have formulated and defined it in the context of OTD, is a domain-specific, affectively and normatively charged stance where the trustor exposes themselves to another's care-responsive agency within a shared moral framework, this means that to trust healthcare professionals is to rely on their moral responsiveness to vulnerability, their integrity as well

as their commitment to act with concern and respect for those under their care, rather than to rely solely on their technical skill. As such, protocols that treat healthcare professionals as replaceable instruments, solely valuable for their operational contribution to the transplant field, actively erode the normative basis of this relational stance. Simply put, they negate the expectations of goodwill, integrity, commitment and moral recognition that trust requires (Baier, 1986; Jones, 1996). In addition, reducing or redefining healthcare professionals' roles to those of technicians is incompatible with their position as trustees. Since trust and trustworthiness involve the disposition to fulfil one's obligations in ways that respond to another's dependence and vulnerability, when the role of healthcare professionals is redirected from care-responsive agency and toward system-driven efficiency, the ability of healthcare professionals to act in the ways that make them trustworthy is compromised. We must note that, in this sense, autonomy and trust intersect; they presuppose a moral environment in which agents are recognised as responsible participants rather than as instruments of institutional goals. Hence, even if healthcare professionals were to design, support and implement such a protocol, the normative content of their choices would remain ethically unacceptable. Essentially, professional autonomy cannot be cited to legitimise decisions that undermine the conditions of moral agency and relational trust within the OTD field. To accept such a limitation of healthcare professionals to the status of technicians would be to prioritise the advancement of transplantation data and metrics over the safety, integrity, moral commitment and moral standing of those whose labour sustains the system.

While I may have a bias toward opt-in systems and donations with explicit consent, I am fascinated by the prospects and implications of how autonomy may operate in opt-out systems. This is because in such regimes, consent is not expressed through an active declaration of interest and approval, but through a legally constructed silence that conveys the meaning of autonomy through interpretations of solidarity, altruism, reciprocity, and acting for the common good. Irrespective, in order to positively depict autonomy as an object of trust within opt-out systems, we must focus on how opt-out systems and regimes can honour, rather than erode, the moral significance of individual agency. Despite presumed consent being criticised for stretching the meaning of autonomy, it can be understood as a system that creates a distinctive moral environment in which autonomy is trusted, respected, and relationally protected, even in the absence of explicit verbalised or documented decision, and the autonomous agent. This can be seen in how presumed consent embodies a morally

generous view of persons as agents embedded in shared ethical frameworks, rather than treating them as passive sources of salvageable organs and heralds of voluntariness.

By assuming that individuals are capable, responsible, and morally active agents – i.e. autonomous persons – whose dissent can be articulated when the need arises, the opt-out system is not just procedural but also reflects an expectation that the public can shape its own post-mortem commitments. Essentially, opt-out systems allow for substantive autonomy, in which individuals maintain genuine control over their bodies and postmortem decisions, and expressive autonomy, in which the articulation of refusal is socially respected and treated as morally and legally binding. We can thus say that opt-out systems implicitly assume that people are morally capable and aware of registering their disagreements when objections arise. While presumed consent operates on the premise that inaction can signify permission, and that silence within opt-out regimes can be treated as a communicative posture rather than as an absence of agency (Dalal, 2005, pp. 45-51; Saunders, 2010, pp. 84–87), the system treats autonomy as important and worth safeguarding in the sense that it assumes individuals (as autonomous persons) can own, shape, and express their bodily commitments at any given time. By treating silence as meaningful, individuals are trusted to signal their preferences – by registering their refusal, leaving the default intact, or discussing their wishes with family. Autonomy in opt-out systems is therefore not bypassed but presumed to be active and intact even when it is not outwardly expressed. This is because opt-out systems can be said to honour individuals' moral maturity, given their capacity to engage with their bodily rights and the actions they often take when moved by moral concern.

In addition, we can positively frame autonomy in opt-out systems when our understanding of autonomy is not limited to atomistic self-rule, but also encompasses a relational, socially situated capacity that may be intertwined with collective goods and values such as reciprocity, solidarity, and moral responsibility towards the vulnerable. In this sense, autonomy is regarded as embedded, shaped by communal norms that affirm giving one’s organs after death as an ethical commitment to saving lives and sharing bodily gifts for the sake of others. As such, autonomy is not just individualistic in this sense but also includes the presumed moral responsibility and responsiveness to participate in communal life, unless the individual explicitly says otherwise. So rather than override autonomy, the opt-out system assumes that autonomy already thrives within the existing system of mutual care. Within the opt-out system, autonomy can also be positively depicted as an object of trust when transplant systems, policies, institutions and healthcare professionals demonstrate

transparency and attentiveness to donor families through an efficient practice of the de facto family veto; even though the law in opt-out regime presumes consent, healthcare professions often defer to the family's knowledge of the deceased's values to make donation decisions (Rosenblum *et al*., 2011; Sque *et al*., 2005; Martinez *et al*., 2023; Verheijde, 2009; Dalal, 2015).

Following my examination of autonomy thus far, it is pertinent to note that not all forms of respect for autonomy are to be regarded as trust-supportive. While a merely procedural respect, which risks reducing autonomy to a bureaucratic artefact and choice-making system, may be taken as a form of respect for autonomy, it lacks a trust-supportive element, making this form of respect for autonomy less efficient. Here is what I mean: when we examine the process of formally recording donation consent while registering for a driver's license, we find that this process, despite promoting agency and fostering respect for autonomy and donation decision-making, can come off as being merely bureaucratic, as it fails to ensure understanding, communicative clarity, and does not clearly answer questions and concerns, nor does it promote voluntariness. One can even argue that this process treats persons as data to indicate donation decisions, instead of treating persons as morally recognised participants. As such, while some forms of respect for autonomy may promote trust in the transplant field (such as obtaining consent from living donors, donor families, and recipients and respecting the self-rule of such persons), others may exert less significant influence on the growth of trust in the transplant field. The idea is that substantive forms of respect for autonomy, which promote attentiveness to context, cultural meaning and the symbolic significance of bodily decisions, signal to donors that their moral and cultural identities are taken seriously, as well as their vulnerabilities. This fosters trust because donors are aware of the institution's recognition of and concern for their moral expectations and dependence, not just adherence to the rules. Such richer forms of autonomy secure the idea that the transplant system is morally reliable and ethically attuned, fostering a trusting disposition rather than mere strategic reliance. For easier labelling, we can thus differentiate between thin and thick accounts of autonomy: thin autonomy merely records consent, relies on presumed consent without public explanation, clarity, or information, and fails to ensure that families understand what is happening. It may also include lip service to the medical team, in which their autonomy is only promoted in theory and therefore has no significant impact on transplant practices or on the roles of transplant health professionals as trustees. Thick autonomy, on the other hand, will include recognition of agency and roles, voluntary

decision-making backed by understanding, clarity, and opportunities to ask questions and withdraw interest or consent, communicative clarity, culturally competent engagement, etc.

Since I will be using the categories of "thin" and "thick" to characterise and examine the objects of trust, I find it necessary to clarify what I mean by these terms. The "thin" account reflects the formal structure of a concept while remaining largely neutral regarding values, meanings, and lived experiences. As such, the "thin" account only captures the minimal conditions, the functional role, or the basic procedural experience. The "thick" account, however, incorporates normative substance, social meaning, and contextual detail. "Thick" accounts are concerned with how a concept is experienced, interpreted, and morally evaluated within specific practices and relationships. Therefore, while "thin" accounts may be sufficient for regulatory clarity and procedural governance, they often fail to encompass important aspects of moral vulnerability, relational dependence, and symbolic significance that characterise transplantation practices.

Based on this understanding, a display of thick autonomy will promote trust in the transplant system, allowing donor families to trust clinicians more when they see that the wishes of their loved one are discussed with concern and gentleness, rather than mechanically or in a detached way that seeks only to secure organ acquisition. Even in an opt-out system, the awareness and ability of a transplant coordinator to make it known to the donor family that their transplant practice includes ensuring that families understand the donation process and honour any known donation wishes, even though the system presumes consent, may promote thick autonomy. Nevertheless, I must insist that it risks belabouring the donation process for the families. Healthcare professionals will trust transplant institutions when recognition of their autonomy and respect are integrated into their workflows and job descriptions, so that these are not treated as administrative obstacles.

As an object of trust, the experience of mistrust or distrust when autonomy is breached is common among stakeholders in the transplant field. Mistrust may arise when procedures seem unclear, rushed, not well communicated or in some cases, mechanistic and overly bureaucratic, such as when donor families feel concerned, uneasy and begin to doubt their donation decision when brain death, presumed consent or the process of donation is not clearly explained. They may come to regret agreeing to donate, become unsure if they unknowingly permitted the death of a loved one or even become unsure whether the wishes of the donor were truly known or followed. On the other hand, distrust may arise, not from

uncertainty but from accusations of moral violation, like when families believe that transplant healthcare professionals will override, manipulate, or disregard donor wishes. An example is when a family refuses to consent to donation because they believe the hospital will harvest organs even without proper consent. Other instances of mistrust include when recipients do not feel that their opinions and concerns for self-preservation are being considered, or when communication about donated organs they may receive appears vague and inconsistent, thereby generating ambivalence about the legitimacy of the consent process or the recipient's recognition. Healthcare professionals, in turn, may develop feelings of mistrust when transplant administrators emphasise the documentation of consent, yet fail to provide adequate time and resources for clinicians to have meaningful, autonomy-supportive conversations with donors and donor families. They may also feel mistrust towards the transplant system when their concerns and input are taken at face value, with no further structural mechanisms to address and recognise their contributions. In terms of distrust, donors and recipients from marginalised communities affected by past consent abuses may distrust the system because they believe autonomy violations are systemic and recurrent. Recipients may feel distrust towards the transplant field if they believe the transplant system obtains organs from improperly obtained consent, believing that the system infringes on bodily integrity and autonomy and/or posthumous autonomy. Similarly, healthcare professionals may come to distrust the transplant field after experiencing cases where the procurement of organs was executed without explicit family consent or despite family objection.[77]

Usefulness, as an object of trust in the OTD field, refers to the utility and serviceability of donated organs. For my purpose, both utility and serviceability refer to the capacity to be useful, provide benefit, and, to some extent, be profitable. Specifically, serviceability relates to the technical aspect of donated organs – their ability to perform their intended function over time, such as prolonging the lives of recipients and promoting healthy living, all of which is presumably dependent on more specific functions like breathing. Therefore, concerns about serviceability include the maintenance, functionality, or durability of donated organs. Along with utility, they reflect the organs' adequacy as a purposeful and beneficial gift. Consequently, Usefulness, as an object of trust, highlights the concern and reliance of both (prospective) donors and (prospective) donor families on (prospective)

[77] For further reading on this issue, see *Liverpool Children's Hospital collects body parts without authorization | Research Starters | EBSCO Research*. (n.d.). EBSCO. https://www.ebsco.com/research-starters/law/liverpool-childrens-hospital-collects-body-parts-without-authorization#full-article

recipients and healthcare professionals, respectively.[78] Donors and donor families trust that recipients will use the transplanted organ(s) respectfully, honouring the gift and ensuring its usefulness by preventing waste. Similarly, healthcare professionals and the transplant system are trusted to use the donated organs efficiently, minimising waste whenever possible. Since the donated organ is a precious and scarce resource, it must be utilised properly. Healthcare professionals and the transplant system are responsible for facilitating this process through their procedures for identifying and matching recipients, retrieving and preserving organs, transplanting them, and developing policies to safeguard and promote their optimal use. Since some instances of Usefulness may build trust better than others, like autonomy, thick usefulness is deemed more trust-centred than thin Usefulness. More specifically, instances of thick Usefulness call for appropriate and transparent systems for organ distribution and allocation, the serviceability of donated organs to prevent patient relapse from unhealthy donated organs, the explanation of outcomes within limits of confidentiality, and the demonstration and recognition of every donation as a generous act that requires maximum respect and treatment. On the other hand, instances of thin Usefulness may include cases in which organs are lost due to preventable errors or when communication gives the impression that donations are routine and organs are easily replaceable, such that recipients can always get new organs when the transplanted ones become unhealthy as a result of their unhealthy lifestyle.

Through actions that promote instances of thick Usefulness, recipient trust in the transplant field is increased and maintained when the usefulness of organs is preserved through high-quality care and competence; health professionals trust the system they work for when they see that organisational structures and procedures support the effective use of donated organs and; donors and donor families may experience increased trust towards the transplant system and their health professionals when they learn about the lives that their donations saved. In contrast, if the stakeholders come to learn about how the donated organs were mishandled, this may raise mistrust towards the transplant field and the transplant system. For example, John Oliver, in December of 2023, gives a hilarious but insightful account of some of the trust issues that arise in the transplant field in the episode titled "Organ and Body Donations" in his show *Last Week Tonight*. In one of such examples, Oliver recalls the incident of the donated heart that was forgotten on the plane after being

[78] To avoid including "prospective" every time I speak about donors, recipients, families of donors, and healthcare professionals, please note that every time I mention the main players in the OTD field, I mean both the actual and potential players.

transported in the cargo compartment of a Southwest Airlines flight from Sacramento to Seattle (Kimberly Kindy and Lenny Bernstein, *The Washington Post; Last Week Tonight*. "Organ and Body Donations: Last Week Tonight With John Oliver).[79] Although real, traumatic, and aggravating, this example may be likened to the fictional one in the infamous episode of the TV series *One Tree Hill*, in which a dog eats a donated heart. In episode 18 of season 6, the main antagonist, Dan Scott, is awaiting a life-saving heart transplant in the hospital. An EMT carrying the donor heart in a cooler enters the emergency room and trips over a dog's long leash, causing him to lose balance, and the cooler falls to the floor. The heart tumbles out of the unlocked cooler, and the dog, which was brought in after eating marijuana-laced brownies, proceeds to eat the donor heart while Dan and his son, Lucas, watch in horror. While the fictional example may be overly melodramatic, what it shares with Oliver's actual example of a mishandled donation is the feeling of mistrust that arises from such scandals, among members of the public, donors, donor families, and recipients alike. The idea is that when a family is informed of how their loved one's organs helped save lives, they are more likely to trust the transplant system because the donated organs were put to good use as the donor intended, than when one hears nothing about the donated organs or learns through the media about wasted organs due to administrative and logistical errors.[80]

When reports about such scandals and logistics issues repeatedly surface, donors who read about such repeated incidents and preventive organ losses begin to have feelings of distrust towards the transplant field, whilst concluding that the transplant field does not care about the donated organs and does not use them responsibly. This is a similar experience for donor families and recipients as well, having indirectly experienced scandals which point to the misuse of organs, donor families tend to believe and fear that the same would have to their loved one's organs if they consent to donation, while recipients will continuously have

[79] For further viewing of this episode: Last Week Tonight. "Organ and Body Donations: Last Week Tonight With John Oliver (HBO)." YouTube, 4 Dec. 2023, www.youtube.com/watch?v=Tn7egDQ9lPg.

[80] For further insight on similar issues, read up on the body donation scandal, which involved the Biological Resource Center (BRC) of Arizona. Although not an instance of body donation for transplant activities, this example presents credible reasons from feelings of mistrust and distrust towards the donation system. This is owing to the fact that, contrary to what donors and donor families were told and their reasons for donations, the BRC sold donated bodies and body parts to the U.S. military for blast testing without the families' consent and, in many cases, in violation of their explicit objections. Not only were they lied to and deceived, but the donated bodies also were not used as the donors intended. See Sini, B. R. (2019, August 6). *A body donated to science - but used to test bombs*. https://www.bbc.com/news/world-us-canada-49198405 and O'Kane, C. (2019, August 1). *Stephen Gore, Biological Resource Centre: Man suing body donation company after mother's corpse was sold to the military for blast testing*. CBS News. https://www.cbsnews.com/news/man-suing-body-donation-company-after-mothers-corpse-was-sold-to-military-for-blast-testing/

doubts about the quality of organs, the reliability of the transplant team to preserve their lives by securing and delivering the donated organ as expected, and the storage of the donated organs to be healthy enough for transplantation.

As an object of trust, ***Good Treatment*** encompasses a range of ethical and social considerations that prioritise the respectful and dignified treatment and engagement of donors, recipients, and their families throughout the donation and transplantation process. McLeod (2002) emphasises that trustworthiness involves being attentive to vulnerability through competence, care, and communicative responsiveness (pp. 118–119). This object of trust covers medical, ethical, psychological, and social aspects within the transplant field, aiming to guide trustees in acting ethically, respecting and recognising the rights and dignity of all involved, promoting fairness and transparency, and supporting long-term health and well-being. Within Good Treatment as an object of trust, trust relations may include cases where trustors (donors, families of donors, recipients, and society) depend on trustees (healthcare professionals and the transplant system) to prevent exploitation of donors and ensure equitable access to organs based on medical need rather than socio-economic status, nepotism, or connections. Other examples of Good Treatment include dignified and compassionate care, which may involve, but is not limited to, recognising the dignity of the donor—whether living or deceased—and treating all parties involved with compassion, empathy, and respect. In some cases, providing psychological support for donor families and recipients can be seen as an aspect of dignified care. Considering the importance of medical transparency, integrity, and effective communication, it is unsurprising that these areas may also become objects of trust. Essentially, such trusts are held by donors, donor families, and recipients who depend on the transplant system and healthcare professionals to adhere to evidence-based practices that uphold high medical standards, ensure transparent, fair, and ethically guided allocation and procurement procedures, and communicate clearly to maintain accountability.

Furthermore, Good Treatment may also be identified in the promotion of confidentiality and privacy, where the identities of donors and recipients are typically kept confidential unless both parties mutually agree otherwise. This example of Good Treatment overlaps with autonomy and rightly so; the recognition of one's agency is not limited to their recognition as autonomous beings with meaning making abilities and moral responsibilities capable of making ethical decisions, the recognition of agency assumes the trait of treating persons as ends in themselves rather than as tools or means to further ends, hence sharing

overlapping values with the element of good treatment. An additional vital component of Good Treatment, as an object of trust, is the respect and sensitivity towards cultural and religious beliefs and values. Similar to concerns about bodily dignity and respect, respecting cultural and religious perspectives involves acknowledging and honouring beliefs related to the body, death, and donation, and incorporating these beliefs into discussions with donors, families, and communities. Besides these aspects, the long-term medical support provided to donors and recipients also contributes to Good Treatment as an object of trust. For trustors such as living donors, this may involve dependable lifelong health monitoring and access to care should complications arise. At the same time, for recipients, it means ongoing access to post-transplant care and medications essential for graft survival and overall well-being.

Like the previously discussed object of trust, some forms of Good Treatment may be more attuned to trusting than others. So while examples of Good Treatments, such as being polite with recipients and donors without showing genuine engagement, mechanical or systemic display of empathy and rushed or impersonal communication, may promote thin Good Treatment, a more robust form of Good Treatment that would promote and foster trust within the transplant field will include instances of emotionally attuned care, culturally appropriate communication and concern, the recognition of the symbolic and existential weight of donation and transplantation, recognition of bodily integrity and respect, humane treatment of loved ones, recipients and clinical staff, etc. the simple act of showing reverence for the donor's body like pausing before procurement commences, explaining the process with sensitivity and empathy, or momentarily just being present for a grieving family struggling with the donation decision may show one's value for relational dignity and in turn present them as being trustworthy. Other instances may include a dedication to the psychological, religious, cultural, and moral needs of recipients, rather than just their medical needs, as well as the institutionalisation of humane treatment and clinical procedures to reduce moral distress for healthcare professionals.

When we consider the donation scandal in the US surrounding how the rich and famous in need of transplants are treated differently from lay persons, and the impact this had on the trust relationship between recipients, donors and the transplant system, it helps one understand how Good Treatment, connotes a standard that must be fairly and ethically applied across board to everyone such that all donors are treated alike and all recipients are treated alike. Failing to achieve this will lead to mistrust and distrust within the transplant system. Consider the example of the alleged case involving Steve Jobs in 2019 and other

unnamed wealthy individuals who the public believes paid their way through the transplant system to get their transplants done on time. While one may argue that these privileged and wealthy individuals did not purchase the organs as often assumed, but instead engaged in multiple legal organ recipients' registrations across the country, we must note that this argument becomes problematic when we consider the fact that some of the conditions to make such multiple registrations are heavily dependent on one's financial status, given the need to travel around the country to be part of the multiple listing system. As such, one may argue that the option for multiple recipients' registrations reintroduces the problem of the commodification of organs. While the organs may not be commodified directly in this sense, the system for acquiring them imposes a financial burden that makes it seem like one is engaging in a transaction in which organs are offered as opportunities. In addition, many transplant patients are unaware of the multiple listing option, and even fewer of those who are aware can afford it. As an example, when *ABC News 10*, in 2013, made this option known to Claudia Chairez, a kidney dialysis patient awaiting a donation, her initial hope and enthusiasm were dashed when she realised the financial constraints of travelling around the country to be part of the multiple listing system. So while creating a multiple listing system for recipients may be seen as a (thin) form of Good Treatment, it soon becomes problematic and breeds mistrust when we consider what is required of recipients to be part of this multiple listing system and what category of people benefits most from the said system that is supposed to promote trust through Good Treatment. For donor families, knowledge of this multiple listing system may influence trust in the system as they begin to have the suspicion that perhaps the transplant system and health professionals only serve the interests of the wealthy and privileged. Not only will this affect the number of donated organs, but it will also reduce moral hope in the transplant field and the supposed good treatment it promotes.

Appreciated effort as an object of trust in OTD can be understood from the perspectives of healthcare professionals, donors, recipients, and donor families. Although Martinez-Lopez *et al.* limited their presentation of this object of trust to the perspective of healthcare professionals, I argue that it can be reasonably and ethically expanded to include the perspectives of donors, recipients, and donor families. In the case of healthcare professionals, Appreciated effort captures the trust relationship between the transplant healthcare workers and the transplant system, wherein the healthcare professionals trust that their labour and professional contributions are recognised by policy makers, well-

compensated for, supported by policy, and are protected by decent labour laws (Martinez-Lopez *et al.*, 2023, pp. 4-8).

I argue that as an object of trust, Appreciated Effort is a morally appropriate, care-responsive reciprocal act where transplant institutions and professionals recognise and reciprocate people's good-faith efforts with respectful practices such as expense reimbursement (rather than payment), honoured authorisation, and dedicated transplant care. Simply put, trustors can rely on the OTD system and its agents to (i) acknowledge good-faith efforts, (ii) respond to them in suitable, role-sensitive ways (e.g., support, fair processes, protections), and (iii) turn them into practices that prevent waste, indignity, or procedural arbitrariness. This directly connects to respect for persons and procedural justice in allocation and procurement ethics (OPTN Ethics Committee, 2024, pp. 16, 29). Appreciated Effort does not equate to the commodification of organs. It should be understood as ethically appropriate reciprocation that upholds the moral ecosystem of the OTD field by honouring first-person authorisation, providing living donor expense reimbursement, ensuring medical follow-up and bereavement support, and maintaining transplant-appropriate processes that value the labour of patients, donors, and their families.

For living donors, Appreciated Efforts may be understood as the trust that their donation efforts will be acknowledged and reciprocated, given the toll of invasive evaluations, lost wages, travel (and sometimes childcare) logistics, and long-term medical follow-up. For such donors, Appreciated Efforts might include legally permissible expense reimbursement or structured support that recognises these burdens without commodifying organs. For instance, in Ontario, the Program for Reimbursing Expenses of Living Organ Donors (PRELOD) explicitly permits reimbursement for legitimate costs such as loss of income, travel, meals, accommodation, and parking, up to a specified maximum (UHN Transplant Bioethics, 2016, p. 5). PRELOD's public brochure further clarifies that reimbursement covers eligible out-of-pocket expenses and lost income during assessment and surgery (Trillium Gift of Life Network [TGLN], 2023, p. 1). This is significant in fostering trust because, by reimbursing legitimate donor expenses as a policy, transplant institutions demonstrate recognition of donor efforts within a shared normative framework – "we asked, you bore costs; we will not leave you carrying them alone." This form of reciprocity is what some donors expect from and trust transplant institutions to uphold.

For decedent donors, efforts can be seen in their previous moral labour, such as registering to be donors or discussing their donation wishes with family and friends. At the end of their lives, this effort – namely, their donated body – is entrusted to family members, transplant professionals, and institutions. In such cases, the Appreciated Effort may take the form of honouring first-person authorisation, respecting autonomy, and maximising the use of donated organs within ethically accepted boundaries (OPTN Ethics Committee, 2024, p. 16). These efforts to appreciate help motivate potential donors by assuring them that registering as donors – an act of commitment and solidarity – will not be overlooked or exploited for unethical purposes. Essentially, honouring authorisations and direct gifting (in morally acceptable cases), as well as acting as stewards of the donated gifts, can be rightly seen as the transplant system's way of reciprocating efforts; a fair and moral appreciation for the donor's moral initiative.

For transplant recipients, Appreciated Efforts aims to ensure they are treated fairly and ethically, taking into account their efforts before and after the transplant. These efforts may include attending clinical appointments, adhering to medication, and making lifestyle changes. Appreciated Efforts may be reflected through procedurally fair allocation standards and policies that consider clinical benefit and stewardship without arbitrary or stigmatising thresholds – unlike what members of Black and Indigenous communities have experienced in the past; consistent and transparent application of ethically approved criteria; as well as efficient post-transplant support (OPTN Ethics Committee, 2024, p. 29). These transparency measures appreciated efforts by linking them to clear public standards rather than discretionary or subjective moral judgments. Essentially, recipients want to trust that their visible commitment to the transplant process – which may include, but is not limited to, treatment for substance use, attending education and therapy sessions, keeping appointments, vaccinations, etc. – will not only be acknowledged but also ethically recognised and consistently applied, rather than used punitively. This fair inclusion process will enable a just allocation of organs to recipients, thereby fostering greater trust in the transplant system.

Appreciated Effort for donor families manifests as the trust that their relational and decisional efforts will be acknowledged with respect and care. These efforts may include bedside advocacy for their dying loved one, making a donation decision, acknowledging the wishes of the deceased relative, bereavement, making sense of death, donation itself, the dignity of the deceased, and addressing cultural and religious considerations. As such, Appreciated Effort for them can take the form of providing clear communication, offering

bereavement support that affirms the donor family's efforts and the donor's gift(s) (UHN Transplant Bioethics, 2016, p. 13),[81] as well as endorsing practices that reduce – not remove – decisional burden in cases where first-person authorisation has already been given. For donor families, Appreciated Efforts are crucial for building trust because (i) they acknowledge the vulnerability of donor families; (ii) families often view donation as a final act of care that requires dignified treatment, respect, honouring of wishes, meaningful follow-up practices, and institutional care-responsive reciprocity.

While Autonomy and Appreciated Efforts share similarities, given that Appreciated Efforts often depend on adequate recognition of autonomy and agency, they function within distinct registers of moral evaluation, anchoring trust within the transplant field on distinct moral landscapes. So while *autonomy* seeks to identify the kind of agent one is trusting and the moral status of agents, Appreciated Efforts function as an object of trust in its capacity to trust the continuity and sincerity of agents' efforts as well as the willingness of agents to uphold their commitment, honour their roles and act with moral consistency. As such, trust in Appreciated Efforts includes concerns about whether agents will be diligent, attentive and show care when enacting their responsibilities; whether sustained contributions will be valued, recognised and reinforced, and the possibility that the transplant system will adequately respond to the moral motivations and efforts of recipients, donors, and donor families.

Based on my discussion so far, as an object of trust in the transplant field, Appreciated Efforts exist in both thin and thick forms, with the latter more likely to improve trust relations than the former. Thin Appreciated Efforts risk being perceived as procedural or indifferent; while they sustain basic formality and functionality of the transplant system, they do not help stakeholders reach the conclusion that the transplant system and institution understand or are willing to share responsibility for the burden borne by stakeholders. Essentially, thin forms of

[81] This can be integrated into institutional guidelines to ensure its practice. For example, the University Health Network (UHN) commits to providing bereavement support for donor families or candidates who die, recognising the moral significance of their role. This includes immediate emotional and practical support, such as reaching out to families of transplant candidates who have died to offer condolences, provide resources for grief counselling, or explain the medical events leading to death. In the case of donors, families receive structured follow-up meetings to inquire about the donation process, ensuring transparency and emotional closure. UHN also offers commemorative practices, such as holding annual memorial ceremonies, which symbolically recognise the donor's moral and communal contributions. Donor families also often receive letters of appreciation acknowledging their relative's role in saving or improving lives. When a child donor or transplant candidate dies, UHN provides tailored bereavement support that considers the unique grief processes of parents and siblings, often involving family-centred counselling and memorial resources for children.

Appreciated Efforts refer to formal, symbolic, and minimal recognition of efforts that satisfy basic expectations but fail to engage deeply with the lived experiences, burdens, and vulnerabilities of the stakeholders. Following such descriptions, it would seem that thanking donor family without providing follow-up on donated organs or bereavement support will count as thin Appreciated Efforts. Similarly, acknowledging a living donor's generosity without ensuring long-term medical follow-up or reimbursement for expenses may count as thin Appreciated Efforts. Thick Appreciated Efforts, on the other hand, capitalise on context-sensitive, role-appropriate, and substantial reciprocation, thereby reflecting an understanding of what stakeholders have endured and contributed. As such, thick Appreciated Efforts are characterised by institutional responsiveness, where the recognition and appreciation of efforts is translated into policies, practices and protections; care-responsive reciprocity rather than transactional exchange; moral consistency in ensuring that donations are not wasted or arbitrarily allocated. The difference between these two classifications is not about more versus less gratitude; rather, it is about the moral depth of the recognition and response to stakeholders' efforts. While thin Appreciated Efforts simply recognise that an effort occurred, thick Appreciated Efforts recognise what that effort cost, why it mattered, and what must follow from it.

However, one problem that may arise concerns how to clearly and accurately establish and distinguish instances of thick and thin Appreciated Efforts in some cases. For example, one may argue that offering generic gratitude without demonstrating an understanding of what the stakeholder has endured may be seen as a type of Appreciated Effort in the thin sense – i.e., the recognition of the donation effort itself. In contrast, thick Appreciated efforts (in addition to the examples discussed above) may include explicitly acknowledging sacrifice, emotional burden, labour, pain, mental struggles, or professional difficulties through the creation of processes that tangibly reflect this recognition. A concern may arise when we wonder who gets to evaluate and classify these actions as thick or thin forms of Appreciated Efforts. While some donors, recipients, and health professionals may be satisfied with a generic display of gratitude, others may require a more explicit show of gratitude to ensure the appreciation for their donation efforts, depending on each individual's knowledge of and expectations for the field. So while some donors and donor families may be fine with the transplant team acknowledging their sacrifice and generosity through oral recognition, showing concern and care during and after the surgery and being ethical in their actions, others may require public recognition, indirect financial relief, or even a chance to be

introduced to the recipients of their donation(s). Irrespective, it is clear that the stakeholders require actions, policies and procedures that aim at appreciating their efforts: donors and donor families want to see that their donations end up saving lives, that their donations were not made in vain, commodified or allocated with bias; donor families want to be sure that their emotional labour is recognised and put into consideration; recipients want to be sure that their effort to be part of the waiting list, to quit an unhealthy lifestyle and undergo regular medical examinations, both for the sake of the donation, will not be ignored when the time comes to be considered for transplant, etc.

Instances of distrust may arise from knowledge of the treatment of donors in black markets, like how the black-market scandals in India and Pakistan influenced the distrust members of the public began to feel towards the transplant institution, with the public believing that donations and bodies will be exploited if the transplant field gets the slightest bit of chance. Similarly, the knowledge of preventable procedural errors that lead to the loss of organs may lead to donor families believing that the system does not value their sacrifice; and when recipients hear of organs being given to people who are not on the list, people who are far down the list or wealthy and famous people while they remain unattended to on the list, they begin to feel like the transplant system is persistently ignoring their efforts, needs and condition, hence the feelings of distrust. For healthcare professionals, distrust may arise when the transplant system and institutional leaders treat burnout and moral injury as acceptable collateral damage.

Consider the fictional example of Granny June, a long-term patient who had been awaiting a liver transplant for 3 years and finally had a perfect match, only to be asked if she could give up her spot to save another patient, a younger 25-year-old woman with a liver complication who may not live to see the next day. In this episode of the 13th season of *Grey's Anatomy* titled "Back Where You Belong", after what seemed like emotional blackmail, prompting Granny June to give up her spot on the waitlist to save another person, the transplant doctors are met with surprise when Granny June replies to this request, saying, "screw her, no cutting the line." As is the case in many transplant examples from this fictional work, the medical facts are less important than the relational dynamics that unfold around them; however, this example gives an insight into how issues of mistrust and distrust can arise when efforts are not appreciated, in this case, the efforts of recipients. This example questions whether the transplant system and its medical workers can be trusted to act competently, respectfully, and with moral concern towards recipients whose lives are at stake.

By disagreeing to give up her spot for the liver transplant, Granny June insists on being appreciated for her efforts – waiting on the transplant list, taking her medications, changing her diet, etc. To ensure that her efforts are appreciated, Dr Bailey tries not to manipulate her patient to give up her spot on the transplant list; when approached by Dr Grey and Dr Webber, Dr Bailey expresses her distress and tries to advocate for her patient who had been on the waiting list for 3 years, while also being sympathetic and empathetic to the younger patient in dire need of a transplant. By reassuring her patient that it is up to her to make a decision, Dr Bailey reaffirms the respect for autonomy, showing her patient that her view counts. It is actions such as these that help patients trust their transplant doctors and hope their efforts will be appreciated when the time comes. Nonetheless, some moments in this example showed signs of impending mistrust towards the transplant doctors: the fact that Dr Bailey could make such a request of her patient, knowing how much she needed the transplant and the efforts put in by the patient; the fact that personal medical details about the other recipients were divulged to nudge Granny June into giving up her spot to save some else and the growing anxiety that the healthcare workers prioritised procedural efficiency over the life of Granny June.[82]

In the transplant field, stakeholders do not merely trust the competence of other stakeholders. In addition to relying on the competence, commitment and goodwill of others, they also believe these stakeholders will uphold a set of publicly shared commitments, such as safeguarding donor and recipient welfare, ensuring equitable and fair allocation, maintaining transparency, and adhering to accepted clinical and ethical rules and procedures (e.g., the established criteria that no organ must be retrieved before death). Philosophically, this can be understood within the concept of trust, rooted in the acceptance of vulnerability to others' goodwill (Baier, 1986, pp. 234–236), and in justified optimism about others' goodwill and competence within a specific domain (Jones, 1996, pp. 4–5). The idea is that when any agent reliably acts in accordance with these shared commitments, even under stress, they become trustworthy as custodians of those commitments.

From the above discussions, it may seem to some that there is no difference between Good Treatment and Appreciated Efforts, as some of the examples I have given of Appreciated Efforts could simply be seen as good medical treatment. While I sympathise

[82] For further insight, see Shonda Rhimes Productions. (2016, October 13). "Both sides now" (Written by Zoanne Clack; directed by Debbie Allen; Season 13, Episode 5) [TV series episode]. In S. Rhimes (Executive producer), *Grey's Anatomy*. American Broadcasting Company (ABC).

with that view, since I see how the confusion can manifest in that way, I think I can further clarify the distinction between Good Treatment and Appreciated Efforts for better understanding. While Good Treatment concerns the moral quality of how stakeholders are treated, Appreciated Efforts concerns the moral recognition and reciprocation of what stakeholders have contributed or endured. We can say the former protects dignity while the latter protects the meaningfulness of sacrifice. Hence, while Good Treatment asks the question: *"Will I be treated well?",* focusing on how people are treated as persons such that the object of concern includes *r*especting bodily dignity; compassionate and humane care; transparent communication; recognition and sensitivity of cultural and religious differences; fair allocation procedures; long-term medical follow-up, etc., Appreciated Efforts asks the question: *"Will my sacrifice, labour, commitment, or contribution be recognised and honoured?"* Since the focus here is on acknowledging efforts and responding appropriately to them, the object of concern may include reimbursing living donors for legitimate expenses; recognising the emotional labour of donor families; appreciating recipients' commitment to treatment and wait-list requirements; supporting healthcare professionals for their work and sacrifices; as well as creating policies that show that stakeholders' efforts mattered.

Fidelity to Shared Commitment can manifest in many ways for donors, recipients, donor families, and even healthcare professionals. As discussed with the other objects of trust, Fidelity to Shared Commitment may also manifest in thick and thin forms; in either case, it continues to matter because it structures and defines the conditions under which vulnerability is accepted. Thin forms of Fidelity to Shared Commitment show that commitments are acknowledged, yet in such cases, the operational force of the said commitments is weak. So while some transplant institutions may have statements of values, these institutions may lack consistent implementation; while policies may exist on paper, operational activities may show that the policies are not readily and actively enforced. In such cases, patients may be forced to depend wholly on professional goodwill, since there are no structural safeguards to rely on. Examples of thin forms of Fidelity to Shared Commitment for living donors include situations in which commitment is perceived to exist, but donors cannot reliably trust that the transplant system, institution, and healthcare professionals will protect them if the need arises. So while the transplant programme affirms autonomy (i.e., self-rule and voluntariness) and the right to withdraw, it may fail to actively check for relational pressures or leave the withdrawal decision to the discretion of the healthcare provider or transplant counsellor. For donor families, thin forms of Fidelity to Shared

Commitments may be experienced when fidelity is perceived as conditional rather than reliable. Examples include when transplant institutions and hospitals publicly affirm respect for donor bodies and bodily integrity, but inconsistently honour first-person authorisation, provide minimal family communication or lack clear protocols for resolving conflicts. Thin forms of Fidelity to Shared Commitments may exist when, although allocation fairness is affirmed, the allocation criteria are opaque, allocation exceptions appear discretionary, and allocation updates are not communicated consistently. For healthcare professionals, it may exist when transplant institutions endorse ethical standards for the smooth running of the transplant system (for instance, the dead donor rule), but provide insufficient ethics support, and prioritise transplant data showing the growth of the transplant system over ethical reflection. In such cases, healthcare professionals can sense that the transplant system's commitments are aspirational and not binding.

Thick forms of Fidelity to Shared Commitments, on the other hand, are characterised by readily available, structurally embedded implementations that are active in policies, practices, and safeguard rules; role-sensitive practices that recognise the transplant institution's obligations towards donors, recipients, families and healthcare professionals; transparency; responsiveness under pressure; and moral consistency even when fidelity conflicts with efficiency or outcomes. Essentially, shared values are transformed from moral aspirations to operational standards that are respected and adhered to. For living donors, thick forms of Fidelity to Shared Commitments involve trust that the transplant programme's stated commitments are structurally implemented and genuine, not merely rhetorical; that there is a sincere pathway to refuse donation, independent advocacy, and evaluation; and that bodily integrity and privacy protections will not be compromised for the recipient's interests. Essentially, transplant programmes build trust by implementing such commitments, such as separating donor and recipient teams, explicitly checking and avoiding stressors and pressures, and providing "off-ramps"— i.e., safe, genuine and ethically protected ways for potential donors to stop or withdraw from the donation process at any stage without pressure, stigma, or relational fallout. As a thick form of Fidelity to Shared Commitment, the University Health Network's (UHN) guidelines stands out in its detail and interest in autonomy of the self, voluntariness, safeguards against conflicts of interest, and the donor's right to withdraw, all of which can be understood to be shared commitments established in policies, procedures and rules (UHN, 2016, pp. 3–5, 10–14). Consider the example of a sister who begins the donor process to donate to her brother, but midway through, she informs the

independent donor advocate that she feels uncomfortable. Honouring the shared commitment to self-rule, self-preservation and voluntariness, the team halts the donation process and notes a neutral medical reason, thereby safeguarding the relationship between the siblings. In this example, by prioritising the autonomy through self-rule and voluntariness over throughput, fidelity maintains and secures the potential donor's trust (UHN, 2016, pp. 10-14). From Baier's perspective, we can say that the donor accepted vulnerability in the expectation of the programme's goodwill, concern, and care for them, and the transplant programme's fidelity to the donor confirms that expectation.

What is shared in the case of decedent donors and donor families includes respect for the deceased's documented decision, accurate determination of death, compassionate family care, and consistent, transparent protocols. Families grant access to the body and intimate information of their deceased loved one because they believe transplant doctors and healthcare professionals will follow the shared rules of the road, such as that death must be established by accepted criteria before procurement begins, that while the registered donation decision is honoured, care for the family will not be neglected, and that in cases where the donation decision is not stated prior to their demise, the donor family will be contacted and consent will be required from them. The aim is to respect, protect, and be committed to both the deceased donor and their family; contemporary policy statements emphasise respect for persons, transparency, and procedural justice as vital program-level commitments to maintain public trust (Anthony *et al.*, 2021, p. 611-621; Declaration of Istanbul Custodian Group, 2018, pp. 1–2).

For recipients, what is shared includes, but is not limited to, expectations of fairness in allocation, clinical integrity, non-commercialisation, and transparency about risks, etc. Many recipients agree to undergo high-stakes surgery and lifelong immunosuppression partly because they believe that transplant centres will uphold these shared commitments of fair allocation and clinical integrity. It is therefore not surprising that global statements, like the Declaration of Istanbul, exist to codify commitments to equity, fair treatment, and the prohibition of organ commercialisation, all explicitly aimed at maintaining trust from actual and potential patients (Declaration of Istanbul Custodian Group, 2018, pp. 1–3). An example of this is when a patient becomes a candidate for organ transplantation and is offered a graft through the standard allocation system that examines if the patient is a match for the donated organ. During this process, the donor and recipient risk factors, logistics and uncertainties are disclosed to the recipient by the transplant team. This transparent fidelity to fairness and

truth-telling mirrors Jones' account of trust, in which the recipient's justified optimism includes both the team's goodwill and their competence within the domain of trust.

For healthcare professionals and transplant programmes, what is shared is their commitment to adhering to professional and societal norms that safeguard respect for persons, transparency, and clear surgical limits, such as the dead-donor rule. Transplant teams earn trust from donors, recipients, families, and the public by institutionalising these values through written protocols, prospective ethical review, and auditability (both internal and external), so that fidelity is not merely asserted but also observable. Despite the evolution of transplant techniques, Fidelity to Shared Commitments, as reflected in policies, procedures, and practices, retains and establishes trust. As such, it is not surprising that, in ethically complex innovations such as normothermic regional perfusion (NRP), professional bodies explicitly emphasise respect, transparency, and procedural justice as essential commitments that should guide practice and public demonstration (Anthony *et al.*, 2021, pp. 611–621).

Essentially, fidelity functions as an object of trust because it structures the domain in which vulnerability is accepted, and goodwill is combined with commitment. In this way, commitments are not only moral aims (goodwill) but also operational standards (competence) that justify trust. Additionally, fidelity is transparent and repeatable, for example, when commitments are codified (e.g., non-commercialisation, living-donor safeguards, the dead-donor rule, transplant allocation lists, etc.). Fidelity can then be demonstrated, observed, criticised, and audited, thereby maintaining trust (UHN, 2016, pp. 4–5, 13–14; Declaration of Istanbul Custodian Group, 2018, pp. 1–3; Anthony *et al.*, 2021, pp. 611–621). The idea is that when the Fidelity to Shared Commitments takes the thick form, it captures communal recognition of moral work, dialogue and practices that link individual actions to collective purpose. It creates and maintains structures that embody invoked shared goals, moral values, and principles, and systematically actively prevents structural inequalities and clinical burnout while still promoting the idea of saving lives.

Instances of mistrust under Fidelity to Shared Commitment may arise when donors and donor families read about allocation errors, which makes them unsure about the transplant system's consistency in honouring commitments to accuracy (e.g. the Cleveland Clinic kidney mismatch case); the lack of timely follow-up as promised, causing feelings of doubt and condemnation; rumours about how waitlists are run and updated inconsistently, leading to feelings of uncertainty and bias for recipients; or when hospital management

occasionally suspends fairness protocols during emergencies, prompting feelings of uncertainty amongst healthcare professionals, recipients and the public as prospective donors and recipients. Other times, mistrust may arise when transplant staff are perceived as depersonalised, so that donors feel threatened by the possibility that their sense of shared values and commitments is being eliminated; when donors and recipients notice a big divide between deeply motivated healthcare professionals and those who are merely task-oriented, leaving them unsure who is committed to their concerns and whether there are shared values to begin with; or when healthcare professionals worry that the collective mission is being diluted or ignored by managerial pressures. Instances of distrust, on the other hand, will arise from new constructs and beliefs about the transplant system and team following direct, indirect, and repeated knowledge of scandals in the transplant field, such as falsified waitlists, preferential treatment, organ harvesting, disrespectful treatment of donor bodies, hidden error reports, etc.

5.3 Mapping Stakeholder-Centred Trust in Organ Transplantation and Donation: Donors, Recipients, Donor Families and Healthcare Professionals.

From my discussion thus far, I have argued that trust functions as a moral architecture that sustains and promotes the field and practice of organ transplantation and donation (OTD), showing its relevance as a constitutive ethical foundation that influences the system's ethical operation. Given that trust involves vulnerability, it is the case that donors, recipients, donor families and healthcare professionals share a similar but contextually distinct form of vulnerability, since within the OTD field, each group tend to entrust something of utmost moral significance, ranging from bodily integrity to life prospects, memories of loved ones and professional conscience and integrity, all of which is entrusted to a system that promises to act with competence, fairness, integrity and goodwill.

To show the dynamic trust relations within the OTD field, I have designed trust maps that articulate five main objects of trust – i.e., Autonomy, Usefulness, Good Treatment, Appreciated effort, and Fidelity to Shared Commitment – all of which function across various relational contexts within the OTD field and sometimes overlap in expectations and roles. The trust maps delineate not just what one stakeholder expects from others, but also what they morally rely on the others for, and how such expectations influence the ethical terrain of donation and transplantation. Essentially, I use these maps as normative guides to understanding trust in the OTD field. Considering the unique experiences of the main

stakeholders in the OTD field, the trust maps reveal where trust is upheld, strained, or absent, and where the transplant system must secure the moral commitments that make organ donation and transplantation ethically meaningful. In mapping a stakeholder-centred trust dynamics that applies specifically to the transplant field, I, in turn, reveal how trust binds the OTD system and how betrayals of trust can ripple across communities, identities, social narratives and institutions. Using these maps, I examine trust from the perspectives of donors, recipients, donor families, and healthcare professionals, showing that the transplant field requires recognition, reciprocity, fairness, integrity, and commitment to function optimally, rather than only technical success.

5.3.1 Donor-Centred Trust Map

Trust is the moral foundation on which organ donation and transplantation (OTD) depends. The trust of donors, both living and deceased, constitutes a foundational pillar of the organ transplantation system. Their trust is not reducible to reliance on medical or policy structures; rather, it is an affective and normative stance in which donors make themselves vulnerable by offering parts of their own body, or authorising donation after death, within a framework of shared moral commitments (Baier, 1986, pp. 234-239; Jones, 1996, pp. 4-8). Donors—both living and deceased—trust their bodies or parts of them to a system that claims to uphold dignity, reciprocity, and fairness. The trust map in *Fig. 1* illustrates how donors' moral expectations are organised into five objects of trust—Autonomy, Usefulness, Good Treatment, Appreciated effort, and Fidelity to Shared Commitment—and how these areas involve various stakeholders: recipients, donor families, healthcare professionals, policymakers, the transplant system, and society at large. The framework can be seen as an ethical map of the responsibilities that uphold trust in OTD.

Autonomy reflects respect for the donor's right to make voluntary and informed decisions regarding donation. This includes the right to withdraw, confidentiality, and the respect of relatives' wishes in cases of delegated consent. Trust here presumes moral recognition and non-coercion: to betray autonomy is to undermine the very relational foundation of trust. In OTD, protecting donor autonomy recognises the profoundly personal and symbolic significance of bodily integrity, ensuring that consent is never reduced to bureaucratic formalities. Trust also depends on confidence that donated organs will be used responsibly and meaningfully. This includes fair and efficient allocation, responsible clinical care, and recognising organs as vital gifts that save lives. Donors rely on recipients,

healthcare professionals, and the transplant community to use the organs ethically, with the aim of saving and improving lives while ensuring fairness and maximising benefit. Recipients and the public – as potential donors and recipients – are trusted to see the gift as valuable and to treat it accordingly. If the system fails to ensure that organs genuinely contribute to saving or improving lives, it damages the moral trust donors expect. Therefore, Usefulness underpins trust, guaranteeing that gifts are not trivialised, wasted, or misused.

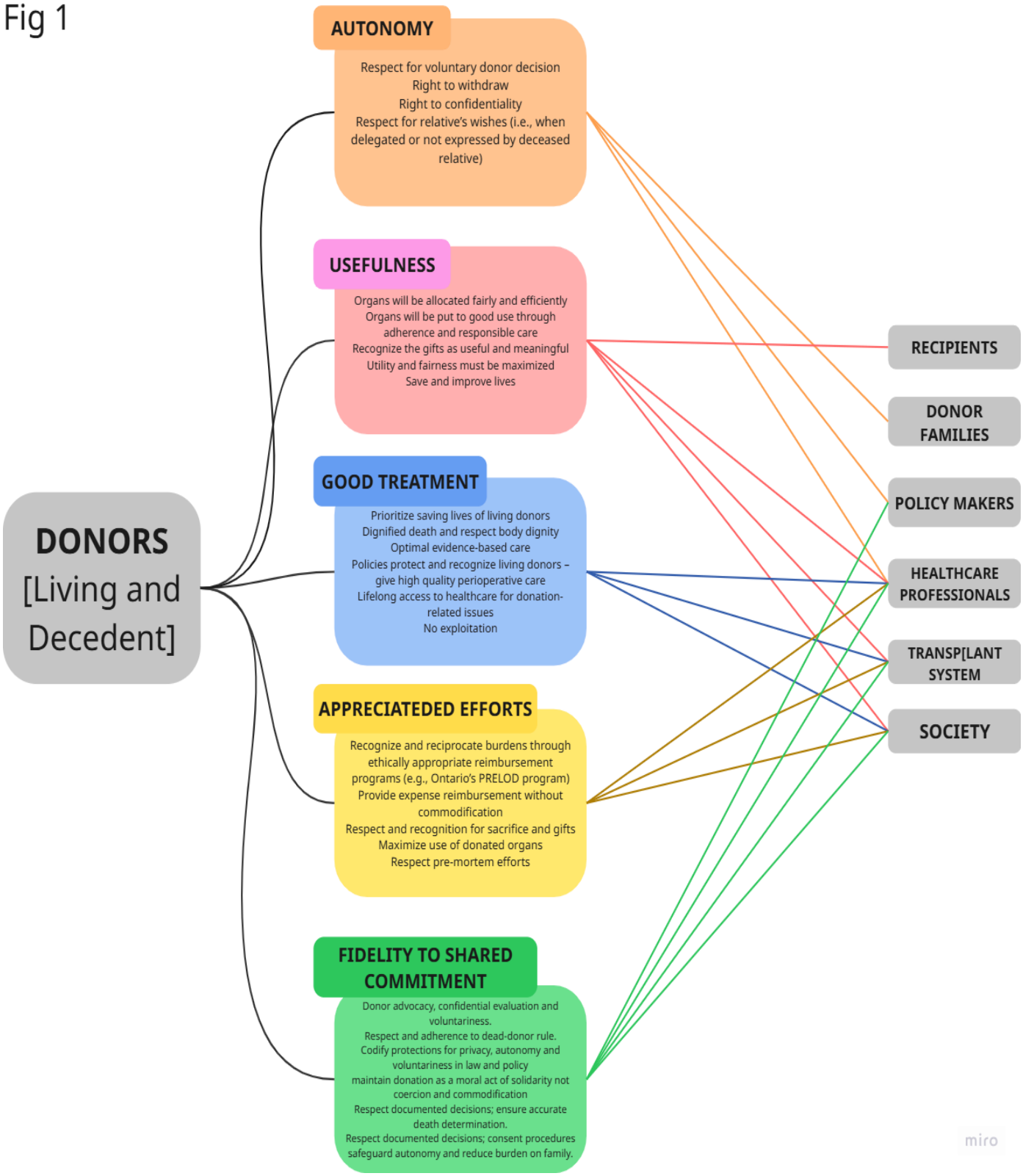
When they entrust their Good Treatment to the transplant system, healthcare professionals, and society, donors' trust relies on the assumption that both living and deceased donors will receive respectful, skilled, and compassionate care. This includes prioritising the health of living donors, ensuring a respectful death for deceased donors, and preventing exploitation. Karen Jones (1996, p. 5) describes trust as a practical attitude grounded in normative expectations of goodwill; here, goodwill manifests in the healthcare system's duty to provide lifelong aftercare for living donors and to respect the bodies of the deceased. Treating donors merely as resources would reduce trust to mere reliance, stripping away its moral and emotional core. Instead, trust involves care that preserves dignity and recognises vulnerability.

In trusting the transplant system, healthcare professionals and society to appreciate their efforts, burdens, and sacrifices, donors need ethical forms of recognition, reciprocity, and appropriate compensation. Therefore, programmes like Ontario's PRELOD initiative, which reimburses living donors' expenses without commodifying organs, exemplify this principle. Donors trust that their efforts will not be ignored but will be genuinely recognised, both symbolically (through social honour and gratitude) and materially (through supportive measures). A lack of reciprocity risks reducing donors to invisible labourers, which could undermine trust in the fairness of the system.

Finally, since trust depends on fidelity to shared moral commitments, donors entrust the observation, advocacy, execution, transparency, and implementation of these commitments through procedural justice, transparent and communicated transplant practices, and policies. Herein, policymakers, healthcare professionals, the transplant system, and society are entrusted with respect for the dead donor rule, donor advocacy, confidentiality, protections of autonomy, and solidarity against commodification. This reflects Baier's (1986, pp. 234-254) claim that trust thrives in moral communities sustained by shared values and norms. Fidelity means not only honouring legal protections but also upholding communal

narratives of gift, solidarity, and moral responsibility. Documented consent must be respected, processes must remain transparent, and burdens on families must be minimised. This map acts as a normative guide, ensuring that donors' trust—and that of all who rely on them—remains ethically secure.

Fig 1



5.3.2 Recipient-Centred Trust Map

Not only is the OTD field upheld by a fragile web of trust, but it also demands unique forms of trust relations, trust preservation, and commitment. For instance, while donors entrust their bodies as gifts, recipients entrust their lives to a system that promises fairness, competence, and solidarity. *Fig. 2* illustrates how recipients' trust is organised into five objects of trust — Autonomy, Usefulness, Good Treatment, Appreciated effort, and Fidelity to Shared Commitment — and how these domains involve direct clinical relationships as well as relationships with families, policymakers, the transplant system, and society. Trust here is not simply based on strategic reliance; it is a normative stance of hopeful dependence, characterised by vulnerability and expectations of moral responsiveness.

Fig. 2 shows that autonomy is not limited to donors and donor families; for recipients, trust begins with respecting their self-determination in treatment decisions and their acceptance or rejection of organ offers. As O'Neill (2002) notes, respecting autonomy is to respect others' capacities for self-government; it requires not the removal of all influence, but the assurance that patients can act from their own considered principles rather than being manipulated (pp. 84-85; p. 92). For recipients, this is reflected in their trusting donors, donor families, healthcare professionals, and policymakers not to override their treatment choices through paternalism or systemic pressures. Trust requires confidence that organs will be allocated and used efficiently, equitably, and with due skill. As such, in *Fig. 2*, we see an emphasis on fair access to donated organs, free from socio-economic barriers, on safeguarding organ quality, and on maximising survival outcomes. Here, Usefulness intertwines with fairness. As Rawls argues, just systems distribute benefits without arbitrary privilege or disadvantage (Rawls, 1971, pp. 83–90). In transplantation, inequities in access based on race, socioeconomic status, or geographic location erode trust; recipients trust that organs are not only useful in a technical sense but also meaningfully deployed in ways consistent with justice.

Recipients' trust in the OTD field partly depends on receiving continuous, dignified, and compassionate care. This includes transparency, clear communication, systemic and financial support, and equitable post-transplant follow-up. Applying Baier's (1986, p. 235) view that trust is accepted vulnerability to another's goodwill, in healthcare, this translates to reliance on professionals' competence and integrity, and in OTD, this further translates not only to competence and integrity, but also to reliance on healthcare professionals, the

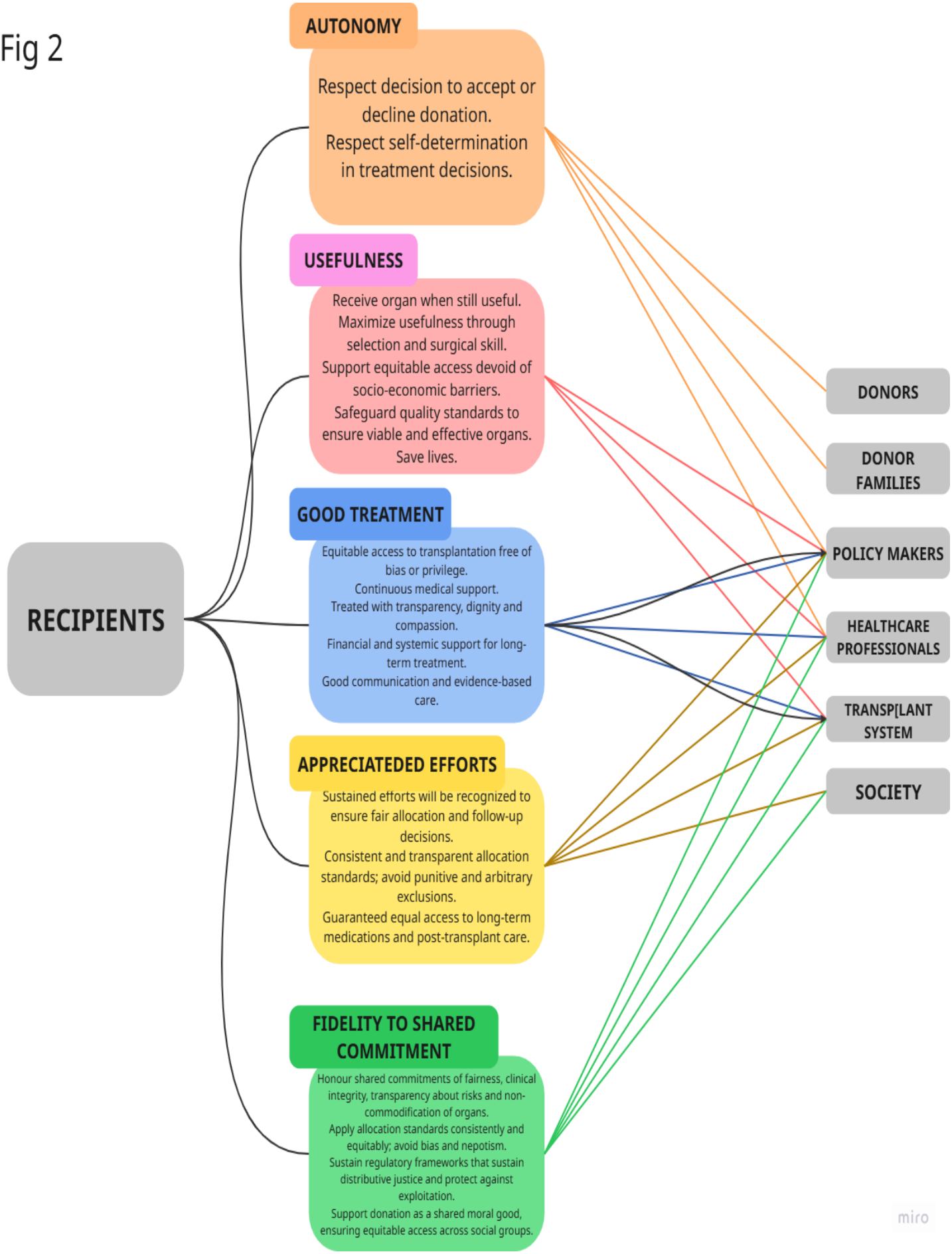
transplant system, and its policies to act positively and intentionally with integrity and respect towards recipients within the boundaries of Good Treatment. Similarly, just as Karen Jones describes trust as an affective attitude of optimism about another's goodwill, it can be inferred that recipients embody this stance when they enter transplantation programmes, given their profound dependence on transplant physicians, transplant institutions, and transplant policies. Trust is betrayed when treatment becomes impersonal, discriminatory, or exploitative, undermining the optimism necessary for patients to endure uncertainty.

Since recipients invest sustained effort in their health by adhering to treatment, attending follow-ups, and enduring systemic burdens, they tend to entrust the transplant system, policymakers, healthcare professionals, and society with appreciating such efforts through fair allocation and adequate medical care. As shown in *Fig. 2*, recipients' efforts can be recognised through fair allocation, transparent standards, and guaranteed access to medications and post-transplant care. As Walker (2007, pp. 80-82) argues, responsibility within moral communities requires that vulnerabilities and sacrifices be acknowledged and not ignored; although this principle is well known among donors, it also applies to recipients. When allocation processes are opaque or follow-up care is unequal, recipients' trust is compromised. Essentially, the recognition of patient effort maintains trust not as a contractual exchange but as a mutual acknowledgement of responsibility and resilience. As shown in *Fig. 2*, recipients' trust depends on fidelity to shared values of fairness, transparency, non-commodification, and distributive justice. This extends beyond individual care to the societal level, so that policies must apply allocation standards consistently, protect against exploitation, and support donation as a moral good. Although Hardin's concept of "encapsulated interest" (2002, pp. 6-9) explains part of this trust, transplant ethics demand more; hence, the inclusion of care, solidarity, and communal fidelity is necessary. Recipients' trust relies on the assurance that the system will sustain these commitments not episodically, but structurally. For Russell Hardin, trust is not solely about moral goodwill or emotional bonds. Instead, it concerns rational expectations based on shared interests. According to Hardin, to trust someone is to believe they have valid reasons to consider one's interests because doing so aligns with their own. As such, we can argue that transplant doctors and the transplant system have interests that require prioritising the interests of recipients in order to achieve their own goals and interests. Such interests, which transplant doctors and the transplant system share, may include maintaining organ donation and transplantation as viable treatment options for some illnesses, promoting and advancing the transplant field,

securing funding for its growth and research, and acquiring viable organs for transplantation. Although Hardin's perspective can be partially applied to promote trust amongst stakeholders in the transplant field, it is insufficient as a holistic understanding of the trust dynamics in the sector, given that trust in the transplant sector exceeds the promotion of interests. Trust is also dependent on reciprocity, care, solidarity, and communal concerns; this partly explains why transplantation remains rooted in narratives of social responsibility rather than market exchange.

The recipient-centred trust map shows that transplantation relies not only on technical success but also on a moral framework of recognition, fairness, and fidelity. Trust remains strong when recipients' autonomy is honoured, organs are utilised effectively, care is provided with dignity, patient effort is acknowledged, and societal commitments are maintained. Each area is a potential point where betrayal can damage not just individual trust but also collective confidence in transplantation. As Baier warns, "We inhabit a climate of trust as we inhabit an atmosphere and notice it as we notice air, only when it becomes scarce or polluted." (1994, p. 98; 1986, p. 243); without this environment, organ transplantation cannot ethically flourish.

Fig 2


RECIPIENTS
AUTONOMY
Respect decision to accept or decline donation.
Respect self-determination in treatment decisions.
USEFULNESS
Receive organ when still useful.
Maximize usefulness through selection and surgical skill.
Support equitable access devoid of socio-economic barriers.
Safeguard quality standards to ensure viable and effective organs.
Save lives.
GOOD TREATMENT
Equitable access to transplantation free of bias or privilege.
Continuous medical support.
Treated with transparency, dignity and compassion.
Financial and systemic support for long-term treatment.
Good communication and evidence-based care.
APPRECIATEDED EFFORTS
Sustained efforts will be recognized to ensure fair allocation and follow-up decisions.
Consistent and transparent allocation standards; avoid punitive and arbitrary exclusions.
Guaranteed equal access to long-term medications and post-transplant care.
FIDELITY TO SHARED COMMITMENT
Honour shared commitments of fairness, clinical integrity, transparency about risks and non-commodification of organs.
Apply allocation standards consistently and equitably; avoid bias and nepotism.
Sustain regulatory frameworks that sustain distributive justice and protect against exploitation.
Support donation as a shared moral good, ensuring equitable access across social groups.
DONORS
DONOR FAMILIES
POLICY MAKERS
HEALTHCARE PROFESSIONALS
TRANSP[LANT SYSTEM
SOCIETY
miro

5.3.3 Donor Family-Centred Trust Map

The trust relationship of donor families reflects a complex set of moral, relational, and institutional expectations. Unlike recipients, donor families exist in a liminal space between grief, decision-making, and social solidarity. As depicted in Fig. 3, this multidimensional trust structure emphasises both the vulnerability of donor families and the ethical duties of institutions and professionals to uphold their role.

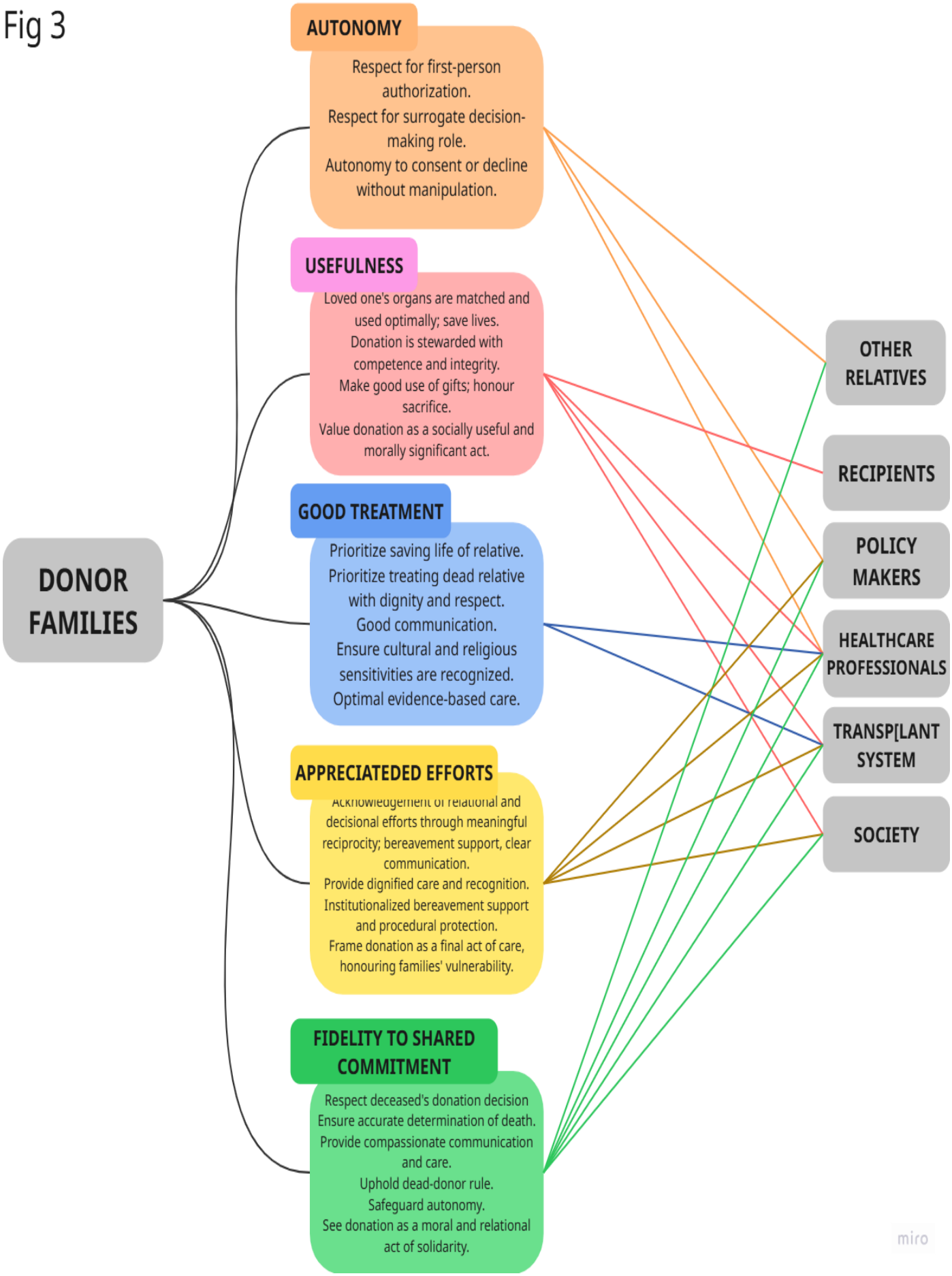
For donor families, autonomy encompasses two interrelated dimensions: respect for the deceased's wishes and respect for surrogate decision-making authority when no explicit donor consent was given prior to the death of the potential donor. If the deceased has explicitly authorised donation, families trust that the dead relation's consent will be upheld without manipulation or coercion (O'Neill, 2002, *Autonomy and Trust in Bioethics*, pp. 146–149; 159–161). In cases where the deceased relative has not made any explicit donor decision, surrogate decision-making becomes the locus of trust.[83] Families expect that their role in consenting or refusing is treated with integrity and not undermined by institutional pressures. Families are motivated not only by the clinical utility of donation but also by its moral significance, wanting to ensure that the organs of a loved one are used competently, meaningfully, and optimally. They seek to see their relatives' sacrifice honoured by saving lives and their donation stewarded with professional skill. Anthropologists and transplant-ethics scholars report that families find solace when organs are treated with competence and dignity, and when donation is framed as a meaningful social act and a morally significant act (Sharp 2006, pp. 116, 148-149; Scheper-Hughes 2007, pp. 507-508). Families trust transplant professionals and systems to prevent the gift of donation from being wasted or mishandled, but rather to integrate it into a broader narrative of social good.

[83] The idea is to not overwhelm family members with donation decisions during a time of grief and pain when it can be avoided. While it is the practice that even when deceased donors, when alive, have explicitly consented to be donors, their families are still asked to consent to donation, I find it quite disrespectful to the dead and an unnecessary burden to put on the living. If seeking consents from living relatives is more important than the explicit consent given by the dead while they were alive, then why do we ask people to register their donation decisions or become donors? If their supposedly well thought out decision can be easily changed by the momentary veto power of a living relative who is forced to make a decision at such an emotionally laden and critical time, then why request people to opt in and become donors? I posit that the task of requesting donation consent from families, should only come up when deceased relatives have made no explicit donation decision prior to their death, or when there was a change in their decision prior to their death. So while I encourage that family members should be told of their deceased relatives' donation decision – when one exists – I disagree with the view that families must always veto donation decisions, even when the deceased did make a decision before their demise. Upholding the deceased's donation decision counts as trusting and respecting them, and when family members maintain their deceased relative's donation decision, it shows that the trust the deceased has for them remains even after their death.

Donor families expect the dead relative to be treated with dignity and respect. This will require accurate and compassionate communication, culturally sensitive handling of the body, and scrupulous clinical practice during death determination and organ procurement. These expectations reflect the broader ethical demand that medicine combine technical competence with humane care — the same themes O'Neill links to institutional trust in medicine (O'Neill 2002, pp. 17-19). Families' preference for transparent, respectful clinical practice helps preserve trust in healthcare professionals and the transplant system. Although donation is typically framed as altruistic, families also expect societal acknowledgement and dignified follow-up, including bereavement support, clear communication about outcomes, and institutional protections that recognise families' sacrifice (for example, organised bereavement programs and non-diminishing procedural safeguards). Policy guidance from transplant programs stresses the duty to provide bereavement counselling and follow-up when a donor candidate or donor dies, and institutions such as major transplant centres include bereavement and follow-up explicitly in their guidelines (UHN Ethical Guidelines, p. 13).

Donor families seek fidelity to the "shared moral commitments" that underpin the donation process: that organs are not treated as commodities, that allocation is fair and non-exploitative, that the dead are treated with dignity and respect and not merely as resource materials; that their donation saves lives; and that the dead-donor rule and clear standards for determining death are consistently followed. When families see these shared commitments honoured, they interpret donation as a moral act of solidarity rather than an exploitative transaction. Critics have warned that breaches of these expectations — such as commodification or opaque practices — can cause distress and breed distrust (Scheper-Hughes 2007, pp. 507-509; Sharp 2006, pp. 115-117).

Fig 3


DONOR FAMILIES
AUTONOMY
Respect for first-person authorization.
Respect for surrogate decision-making role.
Autonomy to consent or decline without manipulation.
USEFULNESS
Loved one's organs are matched and used optimally; save lives.
Donation is stewarded with competence and integrity.
Make good use of gifts; honour sacrifice.
Value donation as a socially useful and morally significant act.
GOOD TREATMENT
Prioritize saving life of relative.
Prioritize treating dead relative with dignity and respect.
Good communication.
Ensure cultural and religious sensitivities are recognized.
Optimal evidence-based care.
APPRECIATEDED EFFORTS
decisional efforts through meaningful reciprocity; bereavement support, clear communication.
Provide dignified care and recognition.
Institutionalized bereavement support and procedural protection.
Frame donation as a final act of care, honouring families' vulnerability.
FIDELITY TO SHARED COMMITMENT
Respect deceased's donation decision
Ensure accurate determination of death.
Provide compassionate communication and care.
Uphold dead-donor rule.
Safeguard autonomy.
See donation as a moral and relational act of solidarity.
OTHER RELATIVES
RECIPIENTS
POLICY MAKERS
HEALTHCARE PROFESSIONALS
TRANSP[LANT SYSTEM
SOCIETY
miro

5.3.4 Healthcare Professionals-Centred Trust Map

Healthcare professionals, like donors, recipients, and families, hold a distinctly vulnerable yet influential position in the OTD field. They have the authority to make decisions that can save lives or, alternatively, seem to condemn someone to death. As trustees, their vulnerability is both personal and professional. They bear the weight of being responsible and accountable to various stakeholders—often without fully satisfying any of them—which adds to their sense of vulnerability. This includes moral and emotional challenges related to societal expectations around organ donation and transplantation. This vulnerability becomes especially clear when they face accusations of betrayal if they act in a manner perceived as coercive, indifferent, or harsh. Additionally, healthcare professionals are at risk of lacking institutional support, being forced to act against their conscience, or being abandoned by their institutions or the transplant system during controversies or accusations. Symbolically, they embody the trustworthiness of the OTD field, making them subject to moral scrutiny both as individuals and as representatives of medical ethics.

Recognising these vulnerabilities, I contend that healthcare professionals in the OTD field must serve as moral agents rather than just technicians. This means that their autonomy can take the form of professional sovereignty, granting them the freedom to apply professional judgement grounded in ethics and evidence, free from coercion, while still honouring the decisions of donors and their families. Such autonomy allows healthcare professionals to openly support or oppose transplant practices and procedures, trusting their colleagues to uphold or at least not betray them, such as risking their jobs. Ultimately, this system should enable healthcare professionals to perform their duties without undue pressure to participate in ethically questionable acts.

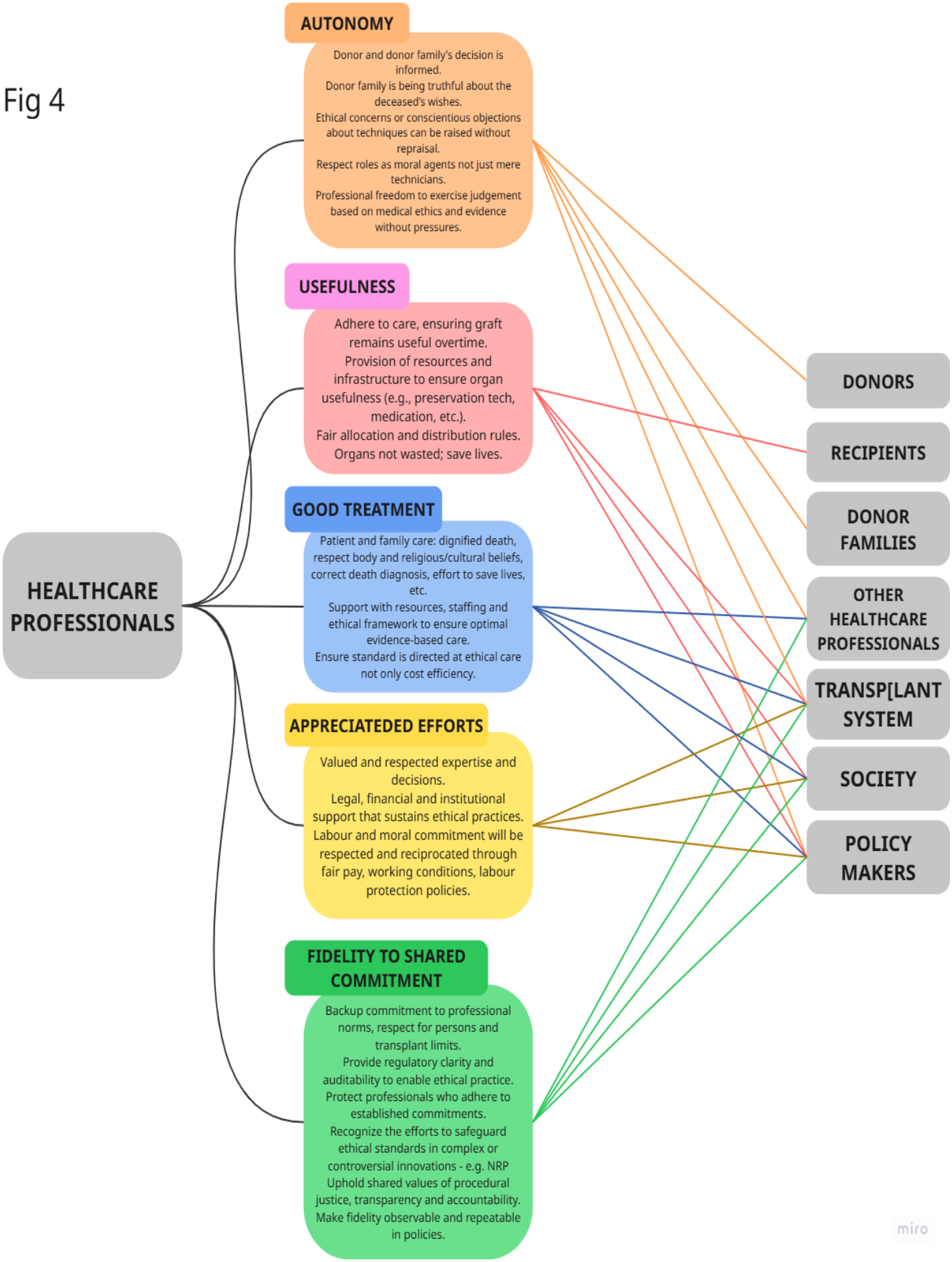
Healthcare professionals, as stewards of donated organs, often entrust recipients with the responsibility of properly caring for their transplanted organs to ensure long-term viability. This approach prevents organ wastage and avoids returning recipients to the waiting list due to neglect. They depend on the transplant system for resources and infrastructure – such as preservation technology, immunosuppressants, and ethical organ allocation frameworks- to preserve organ utility and maintain public trust in the OTD field. By delegating fair allocation rules to policymakers and the transplant system, healthcare workers can concentrate on their core duties: optimising organ use, respecting donation choices, upholding bodily dignity, and applying their skills to save lives. Stewardship encompasses

not only technical expertise but also maintaining transparent, fair systems that maximise benefits.

Healthcare professionals trust each other to adhere to the dead-donor rule, make efforts to save the lives of donors (both actual and potential), ensure a dignified death and accurate death diagnosis, and respect bodily integrity alongside religious and cultural beliefs about death and the body. They rely on the transplant system and policymakers to uphold high ethical and clinical standards, promoting evidence-based practices and transparent allocation processes. Additionally, they trust policymakers to prioritise ethical care over cost efficiency.

Trust for healthcare workers sometimes manifests in the recognition and appreciation of their professional expertise and labour. An example is when healthcare professionals trust that recipients, donors, families, and society value and respect their expertise, contributions and decisions. Another example is when they entrust the transplant system and policymakers to recognise their professional labour with fair compensation, policy support and legal protections (Martínez-López *et al.*, 2023, pp. 4–8). A growing object of trust in their relationship with members of society may be the need to be acknowledged for their role in sustaining the ethical credibility of transplantation, as well as the reliance on colleagues and institutions to reciprocate their good-faith effort with fairness and procedural justice. The aim is to uphold and institutionalise shared commitments, avoid the breakdown of the balance of interests, and prevent trust and trustworthiness from being undermined. This way, when novel and innovative methods for procuring organs emerge, healthcare professionals are aware of the trust placed on them to be ethical in their actions and decisions, so much so that members of society will recognise their efforts to safeguard ethical standards even in complex or controversial innovations and situations like the Normothermic Regional Perfusion (NRP). Healthcare professionals rely on institutions to uphold ethical norms and safeguard their ability to practice responsibly, whether through clear regulations and accountability or the protection of those who adhere to ethical standards. As O'Neill (220) rightly argues, trust is often well placed where others have made themselves trustworthy, and where institutions make that trustworthiness visible. Hence, Fidelity to Shared Commitments requires that professional norms and procedural justice are not merely aspirational but structurally supported and enforced, strengthening trust in the OTD system as well as trust within the system.

Fig 4


HEALTHCARE PROFESSIONALS
AUTONOMY
Donor and donor family's decision is informed.
Donor family is being truthful about the deceased's wishes.
Ethical concerns or conscientious objections about techniques can be raised without repraisal.
Respect roles as moral agents not just mere technicians.
Professional freedom to exercise judgement based on medical ethics and evidence without pressures.
USEFULNESS
Adhere to care, ensuring graft remains useful overtime.
Provision of resources and infrastructure to ensure organ usefulness (e.g., preservation tech, medication, etc.).
Fair allocation and distribution rules.
Organs not wasted; save lives.
GOOD TREATMENT
Patient and family care: dignified death, respect body and religious/cultural beliefs, correct death diagnosis, effort to save lives, etc.
Support with resources, staffing and ethical framework to ensure optimal evidence-based care.
Ensure standard is directed at ethical care not only cost efficiency.
APPRECIATEDED EFFORTS
Valued and respected expertise and decisions.
Legal, financial and institutional support that sustains ethical practices.
Labour and moral commitment will be respected and reciprocated through fair pay, working conditions, labour protection policies.
FIDELITY TO SHARED COMMITMENT
Backup commitment to professional norms, respect for persons and transplant limits.
Provide regulatory clarity and auditability to enable ethical practice.
Protect professionals who adhere to established commitments.
Recognize the efforts to safeguard ethical standards in complex or controversial innovations - e.g. NRP
Uphold shared values of procedural justice, transparency and accountability.
Make fidelity observable and repeatable in policies.
DONORS
RECIPIENTS
DONOR FAMILIES
OTHER HEALTHCARE PROFESSIONALS
TRANSP[LANT SYSTEM
SOCIETY
POLICY MAKERS
miro

5.4 Bound By Oaths, Seen With Suspicion: Transplant Physicians, The *Aes Sedai*, And The Moral Fragility Of Trust

Since trust is a central concept in moral philosophy, medical ethics, and social theory, I argue that prevailing accounts must not limit themselves to its cognitive and predictive aspects. Instead, they should embrace the full spectrum of its normative, affective, and relational nature. Therefore, when applied to medical and healthcare domains, we avoid reductionism that overlooks the lived experiences of trustors and trustees, as well as the moral reality of trust within these contexts.

In the most evident and widely understood sense, the triadic structure of trust in the OTD field comprises trustors and trustees—including donors, recipients, families of donors and recipients, the public as potential donors, medical professionals, institutions, and others—and the objects of their trust. Within this triadic framework, patients awaiting transplants, living donors, and families of deceased donors form relationships marked by deep vulnerability. Their trust goes beyond procedural efficiency to include being treated with dignity, respect, moral concern, loyalty, and fairness. Transplant medical professionals are entrusted not only with technical expertise but also with maintaining the moral integrity of the system; their perceived trustworthiness involves both competence and responsiveness to dependencies and moral responsibilities—saving lives, respecting bodies and donation wishes, and fairly allocating organs. As discussed in the previous chapter, since the transplant system is not merely a neutral domain but a moral landscape, trust is placed in the fairness of organ allocation, the transparency of donation and transplant decisions, and the symbolic respect for human life and bodies conveyed through organ stewardship. Examining trust in this field reveals a moral continuity across bodies, emphasising the unique nature of trust in transplantation—how it extends beyond individual identities. When people decide to become donors, they are not only entrusting organs but also conveying a moral hope—faith that the transplant recipient, medical professionals, and the system will honour their lives and gifts, respect and safeguard their bodies and wishes, and prevent wastefulness of their generosity. Trust in the transplant arena, therefore, transcends individual ethical agency, uniting key players—donors, recipients, families, medical professionals, and the public, who may also serve as potential donors and recipients—into a transpersonal moral community that is aware of, concerned with, and opinionated about transplantation and donation. Given the emotionally, culturally, religiously, and morally invested nature of these relationships, breaches of trust—such as exploitation, neglect, deceit, or inequality in donation and

allocation—elicit feelings of betrayal, grief, regret, and social fragmentation rather than mere disappointment. Such breaches threaten the collective trust that underpins public willingness to donate organs.

As my previous discussion indicates, trust relations within the field of organ transplantation are complex and ever-changing, with the roles of trustor and trustee often shifting depending on the context. For example, while family members of donors can be regarded as trustors when they entrust the donor's life and body to medical professionals involved in transplantation, to honour the wishes of the deceased or their wishes regarding donations, they can also act as trustees when the donor has expressed her feelings and consent about donation and entrusts her family members to adhere to such wishes or directives if the need arises and she is unable to make such declarations herself. Additionally, while transplant doctors are mainly seen as trustees in their relationships with donors, recipients, families of donors, and potential donors from the public, they can also serve as trustors to the families of donors and recipients, trusting them to uphold the wishes of the deceased regarding transplants; they may also trust recipients to value and respect the gift and to care for it properly – especially in cases where recipients have a history of alcohol abuse.[84]

In this section, I aim to explore possible reasons behind the public's scepticism towards transplant doctors, and more broadly, towards medical professionals. To do so, I introduce a comparative analogy between transplant doctors and the *Aes Sedai*, a fictional yet symbolically resonant group from Robert Jordan's *The Wheel of Time* series.

The *Aes Sedai* are powerful and influential figures bound by internal codes of conduct and ethics. Yet, outsiders often perceive them as secretive, manipulative, and institutionally self-serving – traits that, while not inherently immoral, foster suspicion. Similarly, transplant doctors often operate within a complex and opaque medical and ethical framework that is not easily understandable to laypeople. Their decisions involve layers of clinical discretion, institutional protocol, and ethical prioritisation, which, although understandable within the medical community, may appear alienating or even threatening to the public

The analogy is particularly potent because it highlights not an equivalence of intent but a similarity in perception. The public may not see transplant doctors as malicious, yet

[84] Nevertheless, as I have shown in the trust maps, a relatively fixed, institutionally sanctioned and publicly expected trust relation exists within the transplant field, whereby transplant physicians are required to play the role of and function as trustees – individuals entrusted with profound responsibilities over life-altering decisions and scarce medical resources.

they might project qualities onto them similar to those of the *Aes Sedai* – such as guardedness, strategic ambiguity, and a prioritisation on collective systems over individual transparency, which complicates affective trust. This dynamic is exacerbated by the emotionally charged nature of transplantation decisions, which often occur under conditions of extreme vulnerability and informational asymmetry.

To clarify, this analogy does not serve to impugn the moral character or expertise of transplant professionals. Instead, it highlights the symbolic and perceptual landscape where trust relationships are formed. Public scepticism, in this context, is not just a reaction to institutional failure but a sign of deeper concerns about epistemic access, moral agency, and institutional and professional accountability. Recognising this can help the medical community adopt practices that emphasise transparency, relational ethics, and open dialogue – qualities vital for building lasting and ethically based trust.

The Aes Sedai: Truth, Power, and Constraint

The *Aes Sedai*, whose name means "Servants of All" in the Old Tongue, are a group of women sworn practitioners of the One Power. Their abilities to heal, protect, and influence are constrained by three irrevocable oaths, taken upon the Oath Rod:

1. *To speak no word that is not true.*
2. *To make no weapon for one man to kill another.*
3. *Never to use the One Power as a weapon except against Shadowspawn, or in the last extreme defence of her life, the life of her Warder, or another sister* (Jordan, 1990, p. 211).

These oaths are designed to cultivate public trust in the *Aes Sedai's* moral integrity. However, within the narrative, they often have the opposite effect. Because the *Aes Sedai* are technically bound to truth, they develop intricate strategies of equivocation, specifically offering statements that are true but misleading. Their words, though technically honest, are frequently ambiguous, calculated, or incomplete, prompting the common saying in the world of the Wheel: "You can't lie, but you can mislead."[85] This strategic use of truth creates a

[85] For further philosophical research on this subject matter, please see Adler, J. E. (1997). Lying, Deceiving, or Falsely Implicating. *The Journal of Philosophy*, *94*(9), 435–452. https://doi.org/10.2307/2564617; Saul, J. (2012). Just go ahead and lie. *Analysis (Oxford)*, *72*(1), 3–9. https://doi.org/10.1093/analys/anr133; Rees, C. F. (2014). Better lie. *Analysis (Oxford)*, *74*(1), 59–64. https://doi.org/10.1093/analys/ant104.

persistent gap between how *Aes Sedai* perceive themselves and how others perceive them. While they see themselves as protectors and guides, outsiders often view them as manipulative, untrustworthy, and bound by internal rules that override common moral intuitions. They are, as one character famously notes, "truth-tellers who cannot be trusted" (Jordan, 1990, p. 456).

This paradoxical position – morally bound, yet epistemically alien – forms the thematic bridge to transplant medicine. Both the *Aes Sedai* and transplant physicians occupy roles that demand not only competence but also ethical restraint. Both wield power in the service of others, and yet are often perceived as distant, opaque, or even manipulative. Understanding this perception requires more than a critique of communication practices; it calls for an analysis of the underlying moral architecture of trust.

Transplant Doctors as Ethically Bound Agents

Like the *Aes Sedai*, transplant doctors are surrounded by and embedded within structures that demand moral commitment and institutional conformity, such that their decisions and actions must conform to national allocation guidelines, hospital protocols and the realities of limited resources. Irrespective, by virtue of their profession and their sworn oath, transplant doctors are called to act with care, transparency and moral responsiveness to patients – both the strong and the most vulnerable. Understanding the value and limitations of bioethical principles, such as beneficence, nonmaleficence, justice, and autonomy (Beauchamp & Childress, 2013), transplant doctors must navigate the tension between the duty to save lives and the constraints of fairness, transparency, informed consent, and procedural consistency. So, when a transplant candidate is deemed ineligible or when families are not told every detail of resource limitation and transplant procedure, this decision, which can be ethically justifiable, tends to appear callous, insensitive or even immoral to those affected and sometimes to members of the public.

This recalls Karen Jones' (2012) assertion that trustworthiness is not simply a matter of internal moral orientation but also of *manifested responsiveness* – an orientation to being counted on, seen, and morally understood (pp. 70-4). Where this responsiveness is lacking or obscured, trust falters – as seen in some of the reasons presented for the lack of trust in the transplant field[86] – not necessarily because of wrongdoing, but because the moral landscape

[86] These include fears of premature termination of life to retrieve organs, perceptions of unequal access to transplantation based on wealth or social status, and anxieties about organ trafficking or

becomes unintelligible to the trustor. As I have stated in previous chapters, while it is true that public mistrust of the transplant field may be traced back to the numerous wrongdoings that members of the public may have experienced directly or indirectly, it is also the case that we cannot simply link every form of the public's mistrust of the transplant field to instances of wrongdoing that occur in the field. On the contrary, public mistrust of the transplant field often arises from morally complex and emotionally charged dynamics and situations, which make it challenging to sustain trust even within ethically structured systems. One of such problematic situations is the affective tension that the idea and practice of brain death brings. This is because while brain death is medically and legally accepted, the idea can feel quite counterintuitive, if not unsettling, especially when we are met with the physiological problem of trying to see a body that appears physically alive as dead. In yet another way, the epistemic asymmetry that exists between members of the public and transplant professionals – an asymmetry manifested in the use of complex terminologies, unclear allocation systems and procedures, and depersonalised care – can leave patients and families feeling quite left out from the critical decisions, thereby nurturing a sense of alienation instead of feelings of shared moral engagement. The idea is that, given high-stakes, time-sensitive scenarios, even well-intentioned doctors may come off as being emotionally detached or overly procedural, thereby unintentionally diminishing the care-responsive stance needed to anchor trust. In addition, since the nature of transplant care suggests that patients encounter a rotating cast of professionals, this may limit opportunities for relational continuity and the deep, morally charged connections that trust depends on and can be built on. As I have argued, trust requires not only competence and reliability but also a care-responsive agency grounded in a shared normative framework. When this relational foundation is absent, though through structural and communicative gaps rather than through malice, public scepticism begins to reflect moral vulnerability rather than irrational fear.

A particularly rich comparison exists in the practice of truth-telling. In *Wheel of Time*, it is repeatedly said that the *Aes Sedai* never lie, yet viewers and readers repeatedly see that the *Aes Sedai's* words often conceal, mislead, or withhold information. This strategic use of honesty ironically fosters distrust and mistrust in them. Similarly, transplant physicians may

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commodification of the body. Historical injustices – particularly among marginalized communities – have left lingering legacies of distrust, exacerbated by opaque decision-making processes and ambiguous concepts such as brain death. Moreover, the epistemic gap between the public and medical experts fosters feelings of exclusion and vulnerability, while the fragmented nature of transplant care undermines relational continuity. When physicians are seen as acting more in service of institutional goals or abstract protocols than as care-responsive agents, trust erodes.

be mistrusted by donors, donor families, recipients and the public when they present partial truths – sometimes expressed in medical language – about transplant eligibility, prognosis, or risk. While such decisions are often made to protect the patient or adhere to professional ethics, they can undermine the emotional transparency essential for building trust. Essentially, this illustrates a broader challenge in the moral landscape of transplantation. If patients and families perceive information as being managed rather than openly shared, their trust may diminish, even if the physician's actions are medically justified and ethically sound. Just as those outside the White Tower misunderstand the Aes Sedai's oaths, so too are the ethical constraints guiding medical decisions often hidden from patients and their families. This lack of clarity invites suspicion and mistrust, and, in other cases, fosters detachment and breeds distrust.

There are several instances where partial truths are encouraged and provided during the course of administering transplant therapy as the desired treatment option; this may be due to the complexity of the transplant situation and ailment, or to protect the emotional well-being of patients and prevent further health deterioration. A common example is when transplant doctors discuss transplant eligibility with patients in need of a heart transplant. Although the doctors may tell the patients that they are under consideration for a transplant, which is true, technically, this statement avoids and omits other critical information, such as where the patient is placed on the waiting list, or even the truth about their prognosis being worse than the doctor is letting on. When doctors act this way and are not forthcoming or transparent about their patients' chances of being successfully matched and receiving a donation as a result of the lack of available healthy organs for transplant, this may cause recipients to mistrust the doctors and the transplant system when they do not receive the organs as quickly as they believe they should, based on the doctors information. A study by Jassal *et al.* (2010) reports that this is often the case for patients requiring kidney transplants; transplant doctors sometimes present partial information about the likelihood of long-term transplant success and complications from immunosuppressive therapy. Since patients are often given a more optimistic view of their condition, transplant success and long-term outcomes than was statistically warranted, the reality of failure rates in kidney transplant and the overwhelming reality of post-transplant care were downplayed. So while patients were informed about some risks like infections and organ rejection, they were often left blindsided on other risks like potential long-term lifestyle changes, as well as the psychological burden of life after transplant surgery. Most patients do not learn of these until after the procedure

has been carried out, leading to comments such as “I did not know it would be this intense… they did not prepare me for this part.” So while a doctor might say the transplant will significantly improve one’s quality of life, they do not always address the potential for complications like the patient's overall life expectancy post-transplant, chronic rejection or even organ failure. While such communication reflects the desire to protect patients from anxiety and worry, it may lead to situations where patients feel misled when the reality of their condition does not match what they had been told, hence their feeling of mistrust towards transplant health professionals and the system.

In addition to these instances of partial truth-telling, the process of facilitating consent from donor families who are often in states of profound shock when approached for organ donation may be seen as problematic. This is because, in their very vulnerable state, families are approached with donation requests in which donating is presented as noble, life-saving, generous, and altruistic. However, the distressing truths about how this donation is executed may be omitted or softened. These truths may include the invasive nature of organ procurement procedures, which may differ from what families have in mind – such as Normothermic Regional Perfusion (NRP), a technique used to retrieve organs in cases that fall under *Donation After Circulatory Determination of Death* (DCD); the ambiguity of brain death, which is further problematic for families with cultural and religious backgrounds that equate death with the cessation of cardiopulmonary activities; the possibility that donation will not lead to successful transplantation, or that organs would be used for other things not consented to, like research and training, rather than lifesaving transplant surgery; or the donor family’s lack of information regarding the donated organs, who received them or how the recipients are doing, which puts donor families in an incomplete narrative that may later breed regret, confusion and mistrust.

The Normothermic Regional Perfusion (NRP) method is used when someone chooses to donate after circulatory death. However, rather than retrieving the organs after the heart stops and circulation ceases, as is traditionally the case, the NRP allows the transplant medical team to re-establish oxygenated blood flow to the donor's organs after death has been declared and documented, but before the organs are removed from the body. This process avoids the problem of warm ischemic injury, which is organ damage caused by a lack of oxygenated blood. Once a patient has been declared dead under the circulatory criteria - i.e., the heart has stopped beating, and circulatory and respiratory functions have irreversibly ceased- the NRP method requires vascular cannulas to be placed into major vessels. After

that, circulation is regionally restored, either to the abdominal organs or to both thoracic and abdominal organs, using the extracorporeal membrane oxygenation (ECMO) machine, thereby pumping blood back into the donor's organs. All the while, blood flow to the brain is blocked by clamping major vessels or inflating balloons to prevent renewed circulation to the brain, to avoid resuscitation and restoring brain perfusion. Thereafter, the organs are perfused for a period (2 hours at most) to reverse some of the ischemic damage that may have occurred after death was declared and the 5-7 minutes wait was observed, the function of the organs is assessed, and then they are flushed with cold preservative solution and then removed for transplant. While this method is beneficial in retrieving organs in the best conditions for transplant, thereby increasing chances of organ utilisation while also increasing and improving the number of viable organs, it runs the risk of going against the Dead Donor Rule, as restoring regional circulation after death questions and challenges our understanding of death, even though the circulation to the brain is avoided. This method is not always well communicated to donor families, and as such, informed consent is not always obtained, as donor families are not aware of how the NRP method works or what it requires. An understanding of this process may lead to donor families denying consent for cultural reasons and even concerns about bodily integrity and dignity. Other concerns may revolve around fear of resuscitation and the possibility that the donor is still alive since blood flow to the brain had to be avoided. Issues like this can lead to mistrust and distrust towards the transplant field.

Kentish-Barnes *et al*. (2012) argue that regarding organ retrieval from brain-dead patients, some families felt misled and underinformed about the process and requirements. So while lies were not told, the information received from the transplant team was described by the donor families as selective and emotionally curated to nudge them towards donating. Hence, upon learning the facts of donation for brain-dead patients, some family members expressed distress, betrayal and disbelief: “They told us he was dead, but his body was warm, and he looked like he was sleeping. I did not know they would keep machines on him just to take his organs. I wish I had known more.” (Kentish-Barnes et al., 2012, p. 31)

Although few, trained in a distant and secluded tower, and rarely explaining the rationale behind their decisions, the *Aes Sedai* are viewed with reverence and fear, often perceived with awe, yet this fosters alienation. Transplant doctors share a similarity in that they are recognised as members of a highly exclusive profession, where they can make decisions that affect other people across a wide socioeconomic and cultural spectrum without

always explaining every detail behind their decisions. Given this outlook, patients may feel disempowered by the epistemic authority that doctors wield – a feeling not unlike the suspicion that the villagers have towards the *Aes Sedai* (Jordan, 1990, pp. 78–79). Such asymmetry generates informational injustice, in which unequal access to knowledge and decision-making power produces not only confusion but also moral distress. In transplant medicine, this dynamic is compounded by the irreversible and high-stakes nature of decisions for donors, recipients, and their families. The consequences of trusting the transplant medical team or the transplant system are enormous, and patients are keenly aware of the risks of misplaced trust.

Both *Aes Sedai* and transplant doctors carry the burden of saving lives within moral and procedural limits. The *Aes Sedai* are constrained in how they use their power: they cannot kill except under narrow conditions, and they are forbidden from creating weapons. These restrictions reflect a commitment to avoid causing harm, yet they also mean that they cannot always act freely to achieve what they believe is right. Similarly, transplant doctors operate under strict moral, regulatory and institutional frameworks: they cannot give organs to everyone in need, they must follow allocation criteria, they cannot consciously harm a patient to retrieve their organs for another, and they must often deny transplantation to patients based on comorbidities or resource constraints. This creates what we might call ethical triage—the necessity of choosing between lives within externally imposed rules. Like the *Aes Sedai,* doctors may appear detached or "cold" in the face of suffering, not because they lack compassion, but because their hands are tied by systems larger than themselves. The result, however, is a perception gap: the public sees arbitrariness or injustice, while the physician sees ethical necessity. This perception gap is one of the core challenges to cultivating trust in organ transplantation.

The core of the analogy is in viewing trust as a role-bound, care-responsive agency. Both *Aes Sedai* and transplant doctors are responsible for saving lives within certain constraints. However, to be trustworthy in such circumstances – in the OTD field – is not just about following rules or procedures; it involves embodying one's role with moral sensibility and responsibility, an awareness of trust relations, and a genuine interest in fulfilling commitments. It means acting in a way that makes trustors feel their vulnerability is acknowledged, their dependence is meaningful, and that the trustee is genuinely affected by that dependence, not merely compelled by rules. This is why, as I have argued, trust demands that the trustee recognise and be moved by the trustor’s dependence within the normative

framework of their relationship and roles. In transplantation, this implies that physicians must be more than just skilled clinicians; they must also be morally attuned and affectively responsive. Where this attunement is absent, trust may break down, not due to error or malice, but because of a lack of perceived care.

What the *Aes Sedai* teach us, albeit indirectly, is that trust cannot be secured by codes, rules, or institutional safeguards alone – trust is not always strategic and crafty. It must be relationally enacted, affectively perceptible, and morally intelligible. In recognising the symbolic and emotional weight of their roles as both gatekeepers and healers, transplant doctors can move toward a practice of trustworthiness that is not only procedurally defensible but relationally grounded. To be trusted in such a domain is to act competently and to embody a moral presence that responds to the lived vulnerability of those who trust. After all, trust is not granted to procedures, but to persons who make themselves trustworthy through care, clarity, and moral responsiveness.

Despite these similarities, there are notable differences between the *Aes Sedai* and transplant doctors, as well as how they are perceived as trustworthy. A significant and notable difference lies in the institutional and cultural visibility of their commitments and constraints. The *Aes Sedai* operate under a magically enforced code – the Three Oaths, sworn on the Oath Rod and visibly binding – that the public is aware of and knows cannot be broken. This ontological certainty offers the people a paradoxical mix of fear and trust: while *Aes Sedai* are often distrusted for their manipulation of truth and hidden agendas, people are nevertheless assured that they cannot lie, which supports a minimal threshold of trust (Jordan, 1990, pp. 147–149). By contrast, transplant doctors operate within a more complex ethical environment, governed by professional oaths, institutional protocols, bioethical principles, and legal obligations. Nevertheless, unlike the Three Oaths, these constraints are not inherently visible or enforceable to the public in the same direct magical sense. For example, the truth-telling of transplant doctors is subjected to judgment calls, risk-benefit assessments and institutional pressures that the public may interpret as evasive or paternalistic rather than care. The absence of visibly binding constraints contributes to a climate where patients and families question whether doctors act in their best interests alone, especially in the emotionally charged context of organ transplantation. Given the lack of a baseline for trustworthiness, as reflected in the visibly binding nature of the *Aes Sedai's* Three Oaths, public trust in the transplant field and her doctors must be cultivated through transparent

communication, consistent moral engagement, and demonstrable care-responsive agency, rather than through presumed moral codes alone.

5.5 Trusting A Failing System: An Example of Distrust in the US Transplant System

I have outlined a sample of the trust relationships that may exist within the transplant and donation field, showing how trust might be experienced by donors, recipients, families, and the transplant sector. I have also examined, through fiction, the public's perception of transplant doctors and why trusting healthcare professionals involved in the transplant system can be complex for some. In contrast, others may remain sceptical about the values, commitments, and ethics of transplant healthcare workers. In this section, I will present recent findings from investigative journalism that highlight the challenges faced by donors, recipients, families, and healthcare professionals in the transplant sector. These issues emphasise the importance of trust and the trust structure among the main stakeholders, as outlined earlier. From the stories shared, it is clear that just as donors and recipients feel betrayed when their trust is broken, healthcare professionals also experience this sense of betrayal.

In February 2025, *The New York Times* published investigative work by Brian Rosenthal, Mark Hansen, and Jeremy White on the recent cause of distrust in the field of organ transplantation and donation. As their title suggests, the transplant scene in the United States is in chaos, with waiting lists ignored, recipients disrespected and treated with "well-justified" bias, rules and practices being arbitrarily changed, and healthcare professionals being bullied into silence, disregarded and left dumbfounded and gaslighted.

To understand the problem and situate it within our discussion of trust in the transplant and donation field, we must first understand the norms and standards for organ procurement and allocation. Like many other countries, the United States operates a transplant allocation system that depends on a waitlist system. The transplant waitlist system is the nation's registry of patients awaiting organ transplants. It includes both persons with life-threatening conditions that require new organs and persons whose cases are not as fatal but still meet the specified medical criteria for a transplant. The purpose of the waitlist is to help match donated organs with recipients who need them the most and to ensure the fair and

ethical distribution of organs based on medical urgency rather than income, status, nepotism or favouritism.[87]

If a kidney were available for transplantation, it would mean that someone from the transplant list would receive it, assuming it was not a direct donation. At any given time, only some patients on the waitlist are considered active, as a result of having no disqualifying medical issues or paperwork problems. From the pool of active patients, an algorithm identifies those with compatible blood types and determines which patients have other matching traits, such as height and weight. The selected active patients are then ranked, with priority given to the sickest persons, who have been waiting longer and are nearby, among other factors. Next, since the algorithm cannot necessarily identify exact matches, but only possible matches, the procurement organisation is tasked with offering the organ to the doctor of the first patient on the list, who verifies if the donated organ is a good match for their patient. Possible reasons for a patient's doctor to refuse an organ may include the size of the organ, the donor's age, or the quality of the organ.

If the top recipient's doctor refuses the donated organ, the organisation is supposed to go down the wait list, asking the doctors of every patient on the list until the organ gets accepted. This process is intended to be the standard, repeating approximately 200 times a day nationwide, and is the same for every available organ to be transplanted. Until recently, transplant organisations have followed this system religiously, only deviating from it on rare occasions when they had to allocate an organ to someone else after the decision had been examined by the United Network for Organ Sharing (UNOS) and a peer review committee. While ignoring the list was only allowed as a last resort to avoid organ waste, recently, it has risen to the status of determining how organs are allocated in the US. With the rise in such occurrences, skipping patients has become so common that it threatens to be recognised as a norm. As a result, UNOS and the committee have been overwhelmed by its frequency and are unable to examine each case closely, resolve them, or adequately communicate with the affected stakeholders. (Rosenthal *et al.* "Organ Transplant System 'in Chaos' as Waiting Lists Are Ignored," 2025). In a desperate need to justify their actions while making no attempt to ensure trust through ensuring Good Treatment, Fidelity to Shared Commitment, Appreciated

[87] In the US, this process is managed by UNOS (United Network for Organ Sharing) under contract with the federal government and operates through the Organ Procurement and Transplantation Network (OPTN). In Canada, the National Organ Waitlist (NOW) is used for non-renal solid organ transplants, i.e., hearts, livers, lungs, pancreas, but not kidneys. The Canadian Blood Services operates the national registry and coordinates transplant programmes and donation organisations among provinces.

effort and Autonomy, the leaders of some procurement organisations acknowledge that their deviation from the waiting lists has always been for the greater good, to preserve the usefulness of the donated organ, and to save lives.

Examined through a simplistic and broad moral lens, this is indeed the case: organs are saved daily from being wasted or deteriorating in transplant value when they are quickly given to people who need them and are readily available to undergo transplant surgery. But upon close examination of the complaints, cases and results of the investigation, we find that often, these organs go to people who are far down the waitlist, while people at the top of the list are ignored and not considered for the donated organ. This has led to the assumption that perhaps there exists a different list, a privileged list – a list which accommodates certain people who, though they are not considered to be in life-threatening situations and therefore do not need the transplant immediately, still end up getting the donated organs in place of persons who are listed top of the transplant waitlist and have been evaluated to be in life-threatening positions and in dire need of a transplant.

Consider the example of Marcus Edsall-Parr, who had been diagnosed with kidney problems and developmental delays since infancy. As expected of a recipient, Marcus attends three dialysis sessions a week. He doesn't participate in sporting activities, eats a healthy diet, and avoids even foods he would like to eat. Marcus only hopes that his efforts will be appreciated when the time comes. After almost a decade on the transplant list, Marcus finally moves well up the list and is more hopeful for a match. This is affirmed when his doctor calls in the spring of 2025 to tell him that there's a perfect match, and since Marcus was at the top of the waiting list, he was first in line. But the donated organ didn't go to Marcus, nor did it go to the next person on the list, or the next person after that. The organ went to a middle-aged man, 3,557 spots further down the list. With experiences like this, the waiting list for many recipients is beginning to look more and more like a lie, or at least a formality used to deceive people while a few privileged others benefit from the deception. The American organ transplant waitlist system, which used to function on the standards and principles of fairness and justice, seems to have deteriorated into something immoral and untrustworthy. Officials charged with following the list and rules regularly ignore the list and rankings, leaping over hundreds or even thousands of deserving patients on the list when they give out donated organs. The organs go to patients, who, though deserving, are not as sick as persons who are top on the list, persons who have not been waiting nearly as long and, in some cases, as reported by Rosenthal *et al.* (2025), persons who are not on the transplant list at all.

In addition to skipping patients on the transplant list,[88] some nonprofit organisations in charge of managing donations routinely prioritise ease over fairness, using shortcuts to direct donated organs to selected hospitals they seem to have struck deals with, which compete to gain better access to donated organs than their competitors. Having benefited from the transplant system in this manner, these hospitals are at liberty to assign the donated organ to any patient of their choice, regardless of the patient's ranking on the transplant waitlist. Rosenthal *et al.* (2025) are convinced that some hospitals have quietly created separate "hot lists" of preferred candidates who benefit from this act.

From experiences like this, we find that just as recipients are rightfully becoming sceptical about trusting the transplant system, since their efforts are not being appreciated, nor are they being treated well, and the transplant system lacks Fidelity to Shared Commitments, healthcare professionals are also losing trust in the transplant system and fellow healthcare professionals. As Dr Sumit Mohan, a kidney specialist and researcher at Columbia University, notes, in acting this way, the transplant system and healthcare professionals make a mockery of the allocation system and encourage a system that will destroy trust in the transplant system (Rosenthal *et al.* "Organ Transplant System 'in Chaos' as Waiting Lists Are Ignored," 2025). Similarly, for Dr Nicole Turgeon, addressing a crowd at the most recent American Transplant Congress annual gathering, this new system of retrieving and allocating organs only proves that medical professionals and the transplant system have violated their own principles, violated transparency and violated trust in the system (Rosenthal *et al.* "Organ Transplant System 'in Chaos' as Waiting Lists Are Ignored," 2025). This growing system of allocating organs disrespects recipients and their doctors; it fails to recognise the efforts of recipients on the waitlist and does not treat recipients or their doctors with good intent or dignity. Doctors are forced by hospitals to follow this method of organ retrieval and allocation, and patients are kept in the dark about their fate on the transplant list, not knowing if they have been skipped or why the organ which they were to receive never came to them.[89]

[88] Rosenthal *et al.* further discovered that in 2024, of the total number of deceased donations received, nearly 20 percent of the donations went to patients down the list after officials skipped patients who were top on the list. This was six times as often as a few years earlier. It seems to have contributed to the profound shift in the trust placed in the transplant system, as the system which once promised equality and fairness has increasingly become wrapped by expediency and favouritism with little to no accountability and transparency for actions and decisions.

[89] Rosenthal *et al.* tell the story of Corey Field, a Minnesota grocer who was 10th on the list for a liver but was skipped in 2023. After being skipped, Corey didn't get another chance, he died two months later. On

While it is true that open offers to hospitals or other patients on the official waiting list speaks to the desperation of making sure that the donated organs remain in good condition for transplant and get transplanted into somebody, it is also the case that such expedited placements are problematic because by encouraging them more than necessary, we fail to follow the standard policy and procedure which donors, families, recipients and the entire public is aware of and believes we are following (Rosenthal *et al.* "Organ Transplant System 'in Chaos' as Waiting Lists Are Ignored," 2025). In addition, while it is becoming a widely held claim that ignoring the waiting list helps to avoid and reduce organ waste, there is no evidence to this, even if transplant doctors and researchers have been asked to study this practice, hence the federal Health Resources and Services Administration's (HRSA) interest in increased oversight to monitor procurement organisations more strictly to curb the practice of ignoring the waiting list.

Conclusion

From mapping out trust in organ transplantation and donation, it becomes clear that trust in the OTD is not a simple, one-directional relation. In addition to trust being a fragile and shifting fabric, woven from the hopes, vulnerabilities, and commitments of stakeholders, trust also encompasses the expectations and concerns that stakeholders carry, ranging from fairness to recognition, competence, fidelity, and care. Although these expectations give trust its moral weight, they also expose trust to betrayal. As such, the triadic structure of trust in the transplant field that I have described, is not an abstract model but a lived reality to donors,

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learning about the truth behind her husband not receiving an organ until his death, his wife, Laura expressed disbelief and pain as he husband, like many other recipients deserve a fair shot: "corey was not just a number in a database, he was a good husband, father, grandfather, son, brother and a friend. His life mattered." Consider another example: In 2023, OneLegacy, the procurement organisation in Los Angeles, learned of a donated heart and ranked potential recipients. Once allocation began, the heart was first given to the top patient on the list, but the patient's doctor declined because of the organ's size. The second patient's doctor declined due to specificities in the organ's test results. The third patient was not given the chance to receive the heart, nor were other patients on the list. Instead of following the list, One Legacy gave an open offer to Keck Medical Centre of USC, which meant that only patients on their hospital list were eligible. On their supposed list, Keck Medical Centre gave the organ to the 11th person on their list, a woman in her late 50s, despite records showing that she was "stable" and healthier than dozens of people higher on the original list, where she had been ranked 115. On learning about this occurrence, Jennifer Sakai, the fiancée of the patient who was 8th on the list but had died 6 weeks after being skipped, was stunned: "That's not fair... there is a system in place to ensure that people have that opportunity, and they're obviously failing." In a statement released, OneLegacy claimed the allocated organ had less than 12 hours to find a recipient and chose Keck Medical Centre because the hospital was already sending a doctor to collect the lungs. Keck Medical Centre, on the other hand, claimed the patients ranked higher in their hospital's list were not good matches for the heart. While this may be true, it is hard for some to believe, given the new occurrences experienced. While open offers used to make up only 2 per cent of allocation cases in the past, this is no longer the case as organisations now skip patients at least 10 per cent of the time, and almost always through open offers.

recipients, donor families and even transplant medical professionals: people who entrust their bodies, lives and the lives of their loved ones, often under conditions of deep uncertainty and vulnerability, relying on shared moral frameworks to sustain them.

Seeing trust in this way means acknowledging its necessity and fragility. Without trust, it would be a challenge for the OTD system to command legitimacy and to a large extent, participation; yet, once broken, trust is not easily repaired. This is because what sustains trust in the OTD field is not just policies and procedures, but the visible enactment of moral commitments – acts of respect, reciprocity, fidelity, care and transparency that reassure people that their vulnerability is not taken for granted or lightly. Through the Aes Sedai analogy, I have provided an important lesson: trust falters when rules or expertise appear opaque, manipulative or detached from the lived experience of those who depend on them. Trust endures when professionals, institutions and communities make their care-responsive commitments visible and credible.

Essentially, trust in OTD is not reducible to technical efficiency or procedural justice alone. At its core, trust in the OTD field is a shared moral project: it binds strangers together in acts of solidarity and reciprocity, demands ethical stewardship of the most intimate of gifts, requires that the vulnerable dependence of each be met with integrity, responsiveness and care, and protects the aim of donation and transplantation – the chance to life. Betraying this project not only fails the system but also harms and injures the community that makes donations possible.

Conclusion

So far, this thesis has been articulate about the role of trust in transplant ethics, policies, and practices. Moving past the instrumental use of trust to secure public participation, sustain professional legitimacy, or facilitate institutional stability, I have argued that trust is the moral foundation and the organising norm of the transplant system. I have shown this with examples – both fictional and real-life – how trust is a normative stance of hopeful dependence, such that when applied to the transplant and donation field, transplantation is presented as a socially sustained practice of reciprocal entrustment structured by shared and acknowledged moral values and expectations, and enacted under conditions of vulnerability, uncertainty, and power asymmetry.

This thesis has argued three main ideas and contributions that seem quite interrelated: (1) the moral significance of trust as a normative expectation of integrity, commitment, shared values, care, and goodwill is established, differentiating trust from reliance, faith, prediction, or strategic calculations. (2) The transplant system has been mapped as a dense network of overlapping trust relationships and normative expectations, thereby emphasising that trust in the transplant and donation field is not dyadic but systematic. It is to this effect that the erosion or reinforcement of trust in one domain reverberates across the practice, affecting policies, practices, and orientations in various ways. (3) By identifying five objects of trust, how various trust relationships may be formed within these domains, and by mapping out the trust relations between stakeholders based on these objects of trust, this thesis has shown what is normatively at stake in organ transplantation and donation.

As intended, the implication and application of this framework goes beyond theoretical classification; by articulating the structure, roles, and fragile nature of trust, this thesis in turn provides a normative and analytical foundation for engaging some of the most ethically and existentially controversial areas in transplant ethics, namely donations from medical assistance in dying (MAiD) patients, Normothermic Regional Perfusion (NRP) practices, and the very controversial proposals for the financial commodification of organs.

NRP debates centre around the determination of death, questions around the integrity of the dead donor rule, the idea of creating "zombie humans" perfect for organ retrieval, and the potential restoration of brain circulation. Since these concerns are evidently important, a trust-centred framework contributes to research by revealing the impact of NRP on public and stakeholder trust – a perspective that seems to be assumed but rarely discussed in the field.

Given that the NRP introduces a technologically complex, culturally abhorrent, religiously problematic, and symbolically sensitive intervention at the threshold of death, this disrupts not just social, cultural, and religious understandings of death and the body, but it also raises critical ethical questions about what it means to die and be dead based on clinical, social, and moral orientations of death. Based on the perspective this thesis develops, I argue that the ethical permissibility of NRP cannot be solely evaluated in terms of biological criteria or the procedural guidelines for carrying out NRP, especially when the practice may undermine trust and limit public participation in the transplant system. As such, the ethical permissibility of NRP must also be evaluated based on the possibility of preserving or undermining the objects of trust that structure such a domain. Hence, concerns may include questions about the respect of autonomy, consent, and the do-not-resuscitate advanced directive (irrespective of the various loopholes one may try to invent to override such a directive); the maintenance of fidelity to shared commitments about death; the continuous use of donated organs and the sustained confidence in the integrity of the clinical practice and the clinicians.

In MAiD-related organ donation, as organ donation permits have increased across jurisdictions, the focus of ethical discussions has been on voluntariness, autonomy, and the repair of decision-making processes to avoid overlapping pressures and undue influence. Again, these concerns are relevant, but in addition, we need to consider an ethical analysis of this domain and its practices and policies through the lens of trust. This, I believe, will reveal that the ethical stakes extend even further. This is because, at the intersection of MAiD practices and organ donation, there are unique morally charged discussions about ending life, donating organs, and consent, which in turn intensify discussions around vulnerability, responsibility, autonomy, and moral ambiguity. Herein, the trust relations are not limited to patients and healthcare professionals, but extend to healthcare institutions that regulate end-of-life care and transplant activities, family members, and the public at large. My thesis framework allows for nuanced investigations into the role of trust in MAiD donations. In particular, the objects of trust in this domain may include concerns about fidelity to shared commitments, the non-instrumental treatment of patients as means to ends, and the good treatment of MAiD patients, which may include the need to help them get off the MAiD list by addressing their limitations, assuming they're not type 1 patients. In addition, it shows how failures in one domain – for example, perceived pressure or a lack of transparency – may be problematic, affecting other domains of the transplant system, hence emphasising the need

for practices and policies that are not just ethically defensible but also demonstrably trustworthy.

In the domain of organ sales, while proposals to legalise or regulate the commodification of organs and organ markets are often framed in terms of efficiency, the reduction of organ shortages and autonomy, as proponents argue that allowing individuals to sell their organs could help increase the supply of organs and save more lives by reducing wait¬list mortality, critics raise concerns about exploitation, coercion, inequality, and the limits of autonomy. A trust-centred analysis of this domain raises questions about the prospects of this practice by situating it within the moral ecology of trust, questioning how such activities could jeopardise or sustain trust. Since organ sales risks transforming relationships of reciprocal entrustment into transactional exchanges, which are governed by market norms – private or government-controlled – such a shift has negative implications for the identified objects of trust and the stakeholders' trust relationships. Usefulness may be overshadowed and reframed in purely economic terms and undertones; good treatment may become dependent on purchasing power; rewarded efforts may be distorted by financial incentives; and fidelity to shared commitment may be weakened and limited to financial goals, as the practice has partly moved away from altruistic actions and a gift-based ethos. In tandem, the normative expectations of care, goodwill, integrity, and commitment that distinguish trust from reliance may be eroded and replaced by strategic calculation and contractual obligations. Essentially, this suggests that proposals calling for the commodification of organs must be critically evaluated to assess their impact on trust relationships and on the trustworthiness of the transplant field, institutions, and healthcare professionals.

Beyond the many ways and domains in which this thesis can be applied, it is significant in its reconceptualisation of transplant ethics as trust-dependent and fundamentally relational, calling for a shift in both theoretical orientation and practical concern. It suggests new avenues for empirical, conceptual, and normative inquiry into what trust is, how it is formed, sustained, and undermined in various contexts. It paints a broader picture of the various types of trust and domains of trust and provides a framework for evaluating the efficiency, fairness, and role of trust in policies and practices. It underscores the significance of stakeholders' roles as trustors and trustees in the shared practice of entrustment.

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