Commodity Fetishism in Organs Trafficking

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For many years I have been documenting the violence of everyday life – the many small wars and invisible genocides – resulting from the structural violence of global poverty and the increasing public hostility to the bodies, minds, children and reproductive capacities of the urban and peri-urban underclasses (see Scheper-Hughes, 1996b). In this new multi-sited research project I am addressing an uncanny dimension of the usual story of race and class hatred to which we have become so accustomed. I refer to the covert violence occurring in the context of a new and thriving global traffic in human organs and other body parts for transplant surgery (Scheper-Hughes, 2000). It is a business that is justified by many – including a growing number of physicians, surgeons and bioethicists – as serving larger ‘altruistic’ ends.

In the rational-choice language of contemporary medical bioethics (see Roberts, 1999) the conflict between non-malfeasance (‘do no harm’) and beneficence (the moral duty to perform good acts) is resolved in favor of a libertarian sense of fairness (those who can buy should not be prevented from doing so). The resulting slide toward unrelated (i.e. paid) living kidney donation is constructed as a potential ‘win-win’ situation that could benefit both parties (see Richards et al., 1998). Individual autonomy – that is, the patient’s right to choose – has become the final arbiter of medical bioethical value (see Roberts, 1999). Social justice and notions of the good society hardly figure in these discussions, for bioethical standards have been thoroughly disciplined and brought into alignment with the needs and desires of consumer-oriented globalization.

The only dissident voices raised against the dominant narrative come from far...
afield and they express themselves in forms that are unpalatable and all too easily discredited (see Campion-Vincent, 1997). I refer to the alternative bioethical positions expressed, albeit negatively, even (some might say) ‘primitively’ in the fears, panics, dire warnings and opposition of the poorest poor and other socially marginalized groups. To those living on the edges and fringes of the new global dis-order the scramble for fresh organs for transplant surgery increases their already profound sense of ontological insecurity in a world that values their bodies more dead than alive, and as a reservoir of spare parts (Scheper-Hughes, 1992: Ch. 6; 1996a). Their fears, expressed in global rumors and urban legends of blood and body parts-stealing, have provoked popular resistance to new laws of presumed consent with respect to organs harvesting (most recently in Mexico and Brazil) and resulted, in the very worst instance, in attacks on foreigners suspected, in rural Guatemala and in Peru, of trafficking in children’s bodies and body parts (see Martin Medem, 1994; Radford, 1999). But these inchoate and chaotic acts of resistance are rapidly losing ground against the growing market in human bodies and organs as those on both sides of the transplant equation – desperate organ buyers and equally desperate organ sellers – are beginning to accept these still largely covert transactions, protected by transplant medicine’s coyly averted gaze, as normal and routine.

Following Bodies: Founding Berkeley Organs Watch

The following project, which I am about to describe, is a hybrid of experimental, muti-sited, ethnographic research (Marcus, 1998; Gupta and Ferguson, 1997) and medical human rights documentation and surveillance. It emerged out of the meetings and recommendations of the Bellagio Task Force on Transplantation, Bodily Integrity and the International Traffic in Organs (see Rothman et al., 1997) of which I was a member, and in response to the urgent need to consider new ethical standards for organs harvesting and transplant surgery in light of documented abuses in global practices of acquiring and allocating organs and tissues for transplant. The above mentioned Task Force,¹ consisting of a dozen international transplant surgeons, transplant professionals, medical human rights experts and medical social scientists, concentrated their efforts on exploring the rumors and allegations of organs and tissue theft; the extent of the global trafficking in kidneys purchased from living ‘donors’; and the use of executed prisoners in Asia as convenient and lucrative sources of organs and of foreign capital.

At its final meeting in Bellagio, Italy in the fall of 1996, the Task Force concluded that kidney sales were more prevalent and widespread than previously
suspected, and that the **move toward commodified kidneys and other organs was found in affluent as well as in poor nations.** The Task Force called for grounded ethnographic research to document the routine, as well as the deviant, practices of transplant harvesting and surgery world-wide. Second, the Task Force called for the creation of an international surveillance committee to serve as a clearing-house for information on global practices of organs procurement, and to explore allegations of ethical and medical human rights violations in organs procurement or transplant surgery. This clearing-house would also publish an annual review of declarations by international transplant and human rights groups bearing on organ donation. Finally, it would make recommendations to medical and human rights groups concerning strategies that might be used to enforce already existing, but ineffectual, international regulations and standards on organs procurement.

The Task Force has since disbanded and no such organization has been created, although a few proposals are being discussed within the international medical and transplant communities. Most initiatives seek to involve professional transplant organizations, like Eurotransplant in the Netherlands and UNOS (the United Network on Organ Sharing) in the USA, as key players on the rather dubious assumption that surveillance would best be carried out from within the transplantation profession. While these established and well-respected organizations have the expertise, power and resources to monitor a great deal of what transpires in normative transplant situations relying on cadaver organs, they have little experience or control over transplant practices outside the nexus of Western Europe, North America and a few well-known medical centers in global cities to the South and in the East. And such medical regulatory agencies have little control (or knowledge) of the activities of international transplant outlaws – doctors, brokers and patients – who seek to ‘opt out’ of organs waiting lists altogether in preference for illegal purchased organs from living as well as from cadaveric ‘donors’. These activities are, for obvious reasons, covert and they rely on false reports, forged medical records and, where necessary (as in the USA), on the willingness of kidney sellers to pose as relatives or as altruistically motivated friends and partners, and on the willingness of transplant coordinators and surgeons to ‘believe’ these sometimes outlandish stories. Some outlaw transplant operations are of the cloak and dagger type; others operate in a gray nether world of loopholes and soft corruptions of waiting lists for what are described as tightly regulated and carefully rationed cadaveric organs.

In the interim, and in light of these troubling conditions, it seemed advisable to form a small, free-standing, independent organization, that would be available,
as far as possible, to respond on the ground to allegations of medical abuses in the course of organs harvesting or distribution, or in the practices of transplant surgery itself. With this in mind, my colleague, Lawrence Cohen (in this volume) and I established ‘Berkeley Organs Watch’ in November 1999, with initial funding from a grant from the Soros Foundation and matching funds from the Center for Human Rights, the Vice Chancellor for Research and the Institute for International Studies of the University of California, Berkeley.

From this base we are coordinating research on transplantation practices world-wide and will make our findings broadly available on-line. This evolving archive will produce a changing map of the routes by which organs, doctors, medical capital and donors circulate. We see this organization as a stopgap measure in the absence of any other institution of its kind. It is our hope, given our status as full-time academics, and with limited funding, that the work we have begun will indicate a real need that can be filled by a larger independent and transnational Organs Watch Group. In other words, we eagerly look forward to being superseded.

In the meantime, however, and with the assistance of graduate, law and medical student interns, and local field assistants in the countries where we are conducting field research and investigations (see below), we will continue to serve as front-line workers responding to allegations of irregularities in organs and tissues harvesting and allocation. We are concerned about violations of the near-dead and brain-dead patient; about the just and humane treatment and disposal of donated bodies, organs and tissues; and about the handling of so-called unidentified cadavers in medical morgues and police mortuaries. We are exploring the social and medical effects of kidney sales and of transplant tourism within the context of a global economy that produces the miseries and the incentives that precede and often force the sales. And we are trying to define the lines between ethical transplants and those that are exploitative and corrupt, and from those which are merely troubling and warrant further scrutiny and public discussion.

Above all, we are trying to pierce the secrecy surrounding organ transplantation and to ‘make public’ all practices regarding the harvesting, selling and distribution of human organs and tissues. These transactions have been protected by the invisibility and social exclusion of the population of organ suppliers, living and brain dead, many of them poor and socially marginal, and by a unique assumption of the unquestioned moral, medical and social ‘good’ of transplant medicine. Our task requires that we forge a language unencumbered by the medical rhetoric of scarcities, gifts, altruism and life-saving, and that will allow us to think in fresh and uninhibited ways about the bodies of those presumed dead, or presumed ‘unidentified’ and ‘abandoned’ public cadavers, or presumed to have
given consent, or presumed to be ‘donors’ engaged in presumed acts of altruism. In other words, we are calling for a long overdue and healthy skepticism.

Rather than views from the library or the office chair, our research reports views from beside and around the operating table and mortuary slab. In bridging normally discrete boundaries between research in elite medical centers and fieldwork in shantytowns and back alleys, our simple mandate and dictum is to ‘follow the bodies’. Many problems remain, of course, with respect to the incompleteness of evidence based on ‘soft’ rumors and whispered innuendoes as well as on ‘hard’ medical records and transcripts, x-rays and sonograms, in addition to thousands of hours of audio-recorded and only partly transcribed interviews from dozens of research sites in several countries. Multi-sited research like this runs the risk of being too thinly spread, but the alternative is unclear given our mandate and our limited funding. This research project also demands a sacrifice of the normally leisurely pace of traditional ethnographic fieldwork. We have to respond, move, reflect and write more quickly than we are accustomed.

Our initial forays have taken us into alien and, at times, hostile and dangerous territory, where we are exploring some of the backstage scenes of organ transplantation. Operating in these back ward-to-back alley contexts, we sometimes feel that Oliver Sack’s notion of the ‘anthropologist on Mars’ is apropos. We began our work by raising seemingly ‘foolish’ but necessary ‘first’ questions: What is going on here? What truths are being served? Whose needs are being privileged? Whose voices are being silenced? What invisible sacrifices are being demanded? What secrets are being concealed in the transplant rhetoric of gifts, altruism, scarcities and needs?

Working in various sites in Argentina, Brazil, Cuba, Ecuador, India, Israel, the Netherlands, South Africa, Turkey and the USA, we have identified the following issues: (1) race, class and gender inequalities and injustices in the acquisition, harvesting and distribution of organs; (2) widespread violation of national laws and international regulations against the sale of organs; (3) the collapse of cultural and religious sanctions against body dismemberment and commercial use in the face of the enormous market pressures in the transplant industry; (4) the emergence of new forms of debt peonage in which the commodified kidney occupies a critical role; (5) the coexistence of ‘compensated gifting’ of kidneys within extended families and ‘coerced gifting’ of kidneys by domestic workers and by hopeless prisoners in exchange for secure work and reduction in prison sentences; (6) popular resistance to newly mandated laws of presumed consent for organ donation; (7) violations of cadavers in hospital morgues and police mortuaries in which organs and tissues are removed without consent for barter or sale; (8) wasting of viable organs in the context of intense competition between public and
private transplant units; (9) medically substantiated allegations of ‘kidney theft’ from vulnerable patients, mostly poor and female, during routine surgeries.

In its odd juxtapositions of ethnography, fact-finding, documentation/surveillance and human rights work, the project blends genres and transgresses cherished distinctions between anthropology, political journalism, scientific report, moral philosophy and human rights advocacy. These *newer ethnographic engagements* require the anthropologist to enter spaces where nothing can be taken for granted, and where a hermeneutics of suspicion replaces earlier fieldwork modes of bracketing, moral relativism and suspension of disbelief. That these transgressive uses of anthropology make some of our colleagues uneasy or angry is understandable. Neither are we entirely comfortable with what we have taken on. But we wonder if any other discipline is better suited or situated than anthropology to interrogate values and practices from a position of epistemological openness, and to offer alternatives to the limited pragmatic utilitarianism that dominates medical bioethical thinking today.

**Stranger than Fiction**

What follows are a few scenes plucked from my field research in Argentina, Brazil, Israel, South Africa and the USA, to give a sense of the range of ethical dilemmas produced by the commodification of organs, tissues and body parts.

During the summer of 1998 I was sitting at a sidewalk cafe in downtown São Paulo with Laudiceia da Silva, an attractive young mother and office receptionist who had agreed to share her bizarre medical story with me. She had just filed a legal complaint with the city government requesting an investigation of the large public hospital where, in June 1997, during a routine operation to remove an ovarian cyst she had also ‘lost’ a kidney.

The missing kidney was discovered soon after the operation by the young woman’s family doctor during a routine follow-up examination. When confronted with the information, the hospital representative told a highly improbable story: that Laudiceia’s missing kidney was embedded in the large ‘mass’ that had accumulated around her ovarian cyst. But the hospital refused to produce either their medical records or the evidence – the diseased ovary and the kidney had been ‘discarded’, she was told. When I called on representatives of the São Paulo Medical Council, which investigates allegations of malpractice, they refused to grant an interview. A representative of the Council said that there was no reason to distrust the hospital’s version of the story and they had no intention of launching an independent investigation.

Laudiceia insists that she will pursue her case legally until the hospital is forced
to account for exactly what happened, whether it was a gross medical error or a criminal case of kidney theft. To make matters worse, Laudiceia’s brother had been killed in a random act of urban violence several weeks earlier and the family arrived at the hospital too late to stop organ retrieval based on Brazil’s new ‘presumed consent’ law. ‘Poor people like ourselves are losing our organs to the state, one by one’, Laudiceia said angrily.

Laudiceia’s is but one of several credible stories of ‘kidney theft’ that Cohen and I have encountered in Bangladesh, India and South America. For the past several months I have been communicating by phone, fax, and e-mail with Mrs Liliana Goffi (her real name), a middle-class, educated woman from Buenos Aires, and with her personal physician, who are both trying to get to the bottom of her strange medical case and to prove, without a doubt, that her kidney was illegally, surgically removed during minor surgery at a prestigious private hospital several years ago. In July 2001 I flew to Argentina to meet with Mrs Goffi and her doctors and lawyers, all of whom confirmed their distraught client’s suspicions. Mrs Goffi has pursued her grievance through two law suits. She lost her first suit against the hospital when state forensic experts testified that Mrs Goffi had an atrophied kidney on her left side that rendered the organ ‘invisible’ on many of her sonograms. Her second, and ongoing law suit, is against the state forensic specialists, charging them with falsifying her medical records and lying under oath. The civil law suit is still pending.

Incensed by what she and her private doctor perceived as an official cover-up of the theft of her kidney, Liliana traveled with her medical records to Johns Hopkins University Medical Center in Baltimore in 1999, where three independent specialized medical examinations verified that Liliana’s kidney had most certainly been surgically removed. ‘Why?’ I asked Dr McGinnis, one of the specialists consulted. ‘I haven’t the foggiest idea’, he replied during our telephone conversation. ‘I am a doctor, not a private eye.’ The specialist refused to become further involved in the case, on the advice of his university’s lawyers. Meanwhile, Liliana continues to pursue her case armed with dozens of contradictory medical tests and files, enough to drive any sane individual to distraction. And death threats continue to come to her home along with advice to drop her case.

Across the globe at roughly the same time Lawrence Cohen (1999 and this issue) sat in a one-room flat in a municipal housing-project in a Chennai (Madras) slum in South India talking with five local women each of whom had sold a kidney for 32,500 rupees (about $1200 at the time of the sale). Each had undergone their operation at the clinic of Dr K.C. Reddy, India’s most outspoken advocate of the individual right to sell a kidney. Unlike the more seedy ‘organs bazaars’ of Bombay, Dr Reddy prides himself on running an exemplary clinic: his kidney
sellers are carefully screened, fully informed about the medical risks of the operation, and they are followed for two years after the nephrectomy (kidney removal) and receive free health care at his clinic. Reddy avoids contact with semi-criminal intermediaries and serves as his own organ broker. The women Cohen interviewed were mostly low-paid domestic workers with husbands in trouble or in debt. The kidney sale was usually preceded by a financial crisis: the family had run out of credit and could not get by. Friends had passed on the word that there was quick money to be had through Dr Reddy’s clinic. Did the sale make a difference in their lives, Cohen asked. Yes, for a time, but the money was soon swallowed by the usurious interest charged by the local money lenders and the families were all in debt again. Would they do it again? Yes, the women answered, what other choice did they have, with the money gone and the new debts piling up? If only there were three kidneys, with two to spare, then things might be better.

Several months later, I sat next to Mrs Rosemary Sitsheshe on her black plastic sofa in her small but neat concrete-slab house in Guguletu township outside Cape Town, South Africa. On her other side sat a next-door neighbor, a powerful woman, who sustained her friend as she retold the painful story of how the body of her only son, 17-year-old Andrew, had been mutilated at the police mortuary in Cape Town, his eyes and possibly other body parts removed without consent and given to doctors to transplant into other people’s affluent and white bodies. Andrew was caught in the crossfire of township gang warfare during the extremely turbulent and dangerous period just before the end of apartheid. Badly wounded, he was taken to the local police station where Rosemary found him lying on the floor with a bleeding chest wound. By the time the ambulance attendants arrived, late as usual, Andrew was close to death and the police advised Rosemary to go home until the morning when she could claim her son’s body for burial. She was reluctant to leave her dying son and she begged to be able to travel with him in the ambulance, but she was rudely sent home. As she tried to reassure her son, Andrew raised his arm from under the sheet that was covering him. Before leaving Rosemary registered Andrew’s name and herself as next of kin. She left her home address and the telephone number of a neighbor in Guguletu.

The next day she was told by police that Andrew’s body had been taken to the Salt River mortuary and could be claimed there. But functionaries at the police mortuary turned Rosemary away saying that her son’s body was not yet ready for identification and viewing. Two days later, when the family was finally allowed to view Andrew’s body they were shocked at what they saw: the blanket covering Andrew’s body was covered with blood and his head had two deep holes on either side of his forehead ‘so you could easily see the bone’. Rosemary protested at her son’s condition, saying he had been killed by a single, clean bullet to his chest.
Why was his face swollen and what was wrong with his eyes? But when Rosemary questioned the state pathologist in charge he denied that anything was wrong and treated Rosemary and her husband abusively. Rosemary became emotional and threatened to take her complaint to the African National Congress (ANC). The pathologist laughed at her threat.

Later, accompanied by her own private pathologist, paid for by the African National Congress, Mrs Sitsheshe learned at the morgue that her son’s eyes had been removed and that the organs inside his abdominal cavity had all been severed and carefully replaced for viewing. ‘But were those my son’s organs?’ Mrs Sitsheshe asked. ‘I know my son’s eyes but not the color or shape of his heart or kidneys.’ At the nearby local eye bank Rosemary was told that her son’s corneas had been ‘shaved’ and given to two ‘lucky patients’ at the nearby academic hospital. The remains of Andrew’s eyes were being kept in the refrigerator and the director refused to return them to Rosemary for burial. And so, with his mother unwilling to argue any further, Andrew Sitsheshe was buried without his eyes.

But Rosemary could not bury her anger. ‘Although my son is dead and buried’, Mrs Sitsheshe said, with tears freely coursing down her cheeks, ‘is it good that his flesh is here, there and everywhere, and that parts of his body are still floating around? Must we Africans be stripped of every comfort? How could those white medical doctors know what was most important for us?’

Mrs Sitsheshe has since taken her complaint against the police mortuary and eye bank to South Africa’s Truth and Reconciliation Commission. She asked that her case be treated as one example of a practice that was widespread in police mortuaries under apartheid and which continues in some instances even today, out of habit, in the new and democratic South Africa. In September 2000 Rosemary told her story to participants at the international ‘Who Owns the Body?’ conference that was held at the University of California, Berkeley, co-sponsored by Organs Watch. Mrs Sitsheshe has transformed her grief and her ‘symptom’ into a larger political commitment. She offers counsel and physical and emotional support to the parents of youth killed in the continuation of violence and mayhem in Cape Town’s still de facto segregated and impoverished townships. She accompanies relatives to the Salt River mortuary to make sure that the bodies of their loved ones are not subject to further violence at the hands of pathologists and their medical assistants.

Younger and more educated township residents are less suspicious of medicine but are equally critical of transplant practice which they see as a legacy of apartheid medicine. ‘Why is it’, I was asked on many different occasions, ‘that in our township we have never met or even heard of such a person who received a new heart, or eyes, or a kidney? And yet we know a great many people who say that the
bodies of their dead have been tampered with in the police morgues? (Body parts harvested at the police mortuary include eyes, heart valves, skin and bone.)

Township residents are quick to note the inequality of the exchanges by which organs and tissues are taken from young, productive, black bodies – the victims of excess mortality caused by the legacy of apartheid’s policies of substandard housing, poor street lighting, bad sanitation, hazardous transportation, and the political and criminal violence that arose in opposition to white control – and transplanted to older, debilitated, affluent, white bodies.2

Then, in what was undoubtedly the most bizarre fieldwork expedition of my anthropological career, in January 2000 I went under cover to the grounds of Montes de Oca state mental asylum near Lujan in the province of Buenos Aires, accompanied by a private detective.3 We went there to see what, if anything, we could discover about the persistent reports of blood, tissue and organ stealing from the bodies of profoundly mentally retarded, but otherwise physically healthy, inmates.

The reports first surfaced during the early 1990s (see Sdrec, 1986; Bonasso, 1998; Romero, 1992; Ventura, 1992) following the kidnapping and ‘disappearance’ of a young psychiatrist, Dr Giubileo, who had lived on the grounds of the institution. It was said that she was on the verge of revealing the illicit and unethical practices by the director of the asylum, a psychiatrist who also practiced ‘surgery’ on his mental patients. A court-ordered search of the grounds of Montes de Oca by members of Argentina’s celebrated anthropological forensic team,4 did not turn up the body of Dr Giubileo, but did recover a few bodies of unidentified (‘NN’, no name) missing patients, found in a swamp and a water tower belonging to the institution. The only witnesses to Dr Giubileo’s kidnapping were two asylum patients who said they saw their doctor and friend being taken by force and pushed into the back of a van belonging to the asylum. But, declared mentally incompetent, the witnesses could not give testimony in court. The allegations of other nefarious goings-on at Montes de Oca led, ultimately, to the arrest of the charismatic medical director, Dr Sanchez, followed by his unexplained death in his prison cell the day before he was to give testimony in court. Following the death of Sanchez, who remained a key suspect in the abduction of Dr Giubileo, and in the selling of blood, tissues and organs of asylum patients, the case was closed and the asylum placed under federal receivership, where it remains to this day.

The asylum remains a frightening place, grossly understaffed, and the inmates, many of them naked and emaciated, wander the grounds unsupervised. A night nurse, who agreed to an interview at her home, explained the regime of blood-lettings from the living and cornea removal from the deceased inmates, without
consent, as legal and justified – a payment for their care at the public expense. ‘Isn’t that the way it is done everywhere?’ I was asked by the nurse, who in fact, was not really a ‘nurse’ at all, but a local telephone operator who, after losing her job, accepted, ‘out of necessity’ the highly stigmatized position of nurse attendant to the insane of Montes de Oca. The only scruples she had about the institution concerned the discipline used at night to control the agitated or unruly patients – whippings with wet bed sheets and the use of brutal physical restraints. ‘Was it true that Dr Sanchez allowed female patients to become pregnant by other inmates?’, I asked. ‘Yes’, the nurse replied. ‘Since the time of Dr Sanchez, this [i.e. sexual license] is considered “the right” of the patients. Dr Sanchez was considered a very progressive doctor’. The progeny of such unions, she told me, were offered for adoption through the good works of an order of Catholic nuns. Her story was verified in an interview with one of the sisters from that same religious group.

The human strip-mining of the dead for their skin, bone, cornea, heart valves and other usable parts is not limited to former police states in Argentina, Brazil and South Africa. Similar practices can be found in one of the wealthiest communities of the USA. In the spring of 2000 I first encountered Mrs Linda Schuringa, a handsome middle-aged and remarried widow from affluent Orange County, California.

When her husband suffered a stroke and died on Thanksgiving evening in 1997, Mrs Schuringa was contacted by a local tissue bank and pressured to donate cornea, then skin, then (in a subsequent phone conversation) bone of her husband. Three years later she learned from an investigative reporter that her husband’s bone had been ‘processed’ in Germany and sold commercially as a dental implant product. Though Mrs Schuringa was distressed when the information was verified, she remains committed to organs and tissue ‘gifting’, but she wants the designation of tissues to be explicit on the consent forms that are signed by relatives.

The Brokers

In the fall of 1999 I sat nursing a cherry Coke in a dilapidated Denny’s Restaurant on Sunset Boulevard in Hollywood. Across from me sat a tall, extremely thin, middle-aged man with intensely blue eyes and a nervous, tentative manner. He gulped frequently and seemed ready to flee from our booth at the slightest provocation, thus ending the strange ethnographic interview. Jim Cohan was a notorious ‘organs broker’ who solicited international buyers and sellers from his home office using the telephone, Internet and fax. No, I could not tape record our conversation, Jim said, though he was willing to be interviewed about his
activities on behalf of ‘matching up people in need’. ‘There’s no reason for anyone
to die in this country while waiting for a heart or a kidney to materialize. There
are plenty of spare organs to be had in other parts of the world. One can’t be
choosy. One has to play by my rules and go where I say. And one has to move
quickly.’ Though Jim is trying to operate in a gray nether world, he insists that
what he is trying to do is not illegal. In fact, he was proud of his newly invented
profession. ‘Don’t think of me as an outlaw’, he said, ‘think of me as a new version
of the old-fashioned marriage broker. I locate and match up people in need,
people whose suffering can be alleviated by the other.’

An outlaw or a revolutionary, Cohan was caught up in a police sting and was
arrested in Italy in the fall of 1998 soon after he had arrived there expecting to
meet patient for whom he had planned to broker an organ transplant. An Italian
doctor with whom he was communicating through the Internet reported him to
the Italian authorities and to the FBI, Cohan says. He was kept in solitary
confinement, beaten and relentlessly interrogated for 5 months before his case
finally got to the courts and was thrown out for lack of evidence. ‘I had done
nothing wrong,’ Jim maintains. ‘But the Italian newspapers had turned me into a
monster, an “organs eater”. They accused me of killing black people and poor
people to get their organs. A priest came into my cell, but once he discovered who
I was, he walked out without touching me or speaking to me.’ Now safely back
in Hollywood, Jim is more interested in brokering experimental genetic therapies
that can only be found outside the United States. ‘The bottom line,’ says Jim
Cohan, ‘is that the body belongs to the individual.’

The Last Commodity

I am willing to sell any organ of my body that is not vital to my survival and which could help
save another person’s life in exchange for an amount of money that will allow me to feed my
family. (Ad placed in the Diario de Pernambuco, Recife, Brazil, by Miguel Correia de Oliveira,
age 30)

Please, I need money to get dentures, and am a senior desparate [sic] for money. Want to sell a
very good kidney. Am desparate for money for teeth. Am senior citizen in excellent medical
shape, but need $ for dentures. My husband and I have no dental plan. (E-mail from E.B., Oak
Hills, California, to N.S-H @ Organs Watch, 26 January 2001)

George Soros (1998), legendary both in the world of finance as a maker and
breaker of national currencies and global financial systems and in international
human rights as an advocate of open and democratic societies, recently analyzed
the deficiencies of the global capitalist economy. It is a fairly elementary exercise
in microeconomics, but coming from a person in his privileged position, one tends to take more than passing notice. The benefits of world capitalism, Mr Soros cautions, are unevenly distributed. Capital is in a better position than labor. And it is better to be situated at the center of the global economy than at the peripheries. Given the instability of global financial systems, busts will inevitably follow booms and capital will flee to its centers leaving bit players in secondary or tertiary global cities (such as São Paulo, Mexico City and Buenos Aires) high and dry. Meanwhile, the growth of global monopolies has compromised the authority of traditional states and weakened their regulatory functions.

What troubles Soros most is the erosion of social values and social cohesion in the face of anti-social, market values. While a market economy is generally a good thing, Soros still maintains, humans cannot live by markets alone. By their nature markets are indiscriminate, promiscuous and inclined to reduce everything, including human beings, their labor, their bodies, and their sexual and reproductive capacities to the status of commodities, things that can be bought, sold, traded and stolen. The dilemma, as Soros sees it, is one of uneven development. Open and democratic societies require strong social values and political institutions to serve such ends as social justice, political freedom and social equity. The evolution of the global market has far outstripped the development of a mediating global society equipped with necessary moderating and regulatory functions to preserve human dignity and basic human rights.

Amidst the neo-liberal readjustments to the global economy there has been a rapid depletion of traditional, modernist and humanist values. New relations between capital and work, bodies and the state, citizenship and social and medical inclusion (and exclusion) are emerging. A triumphant global neo-liberal capitalism has released a voracious appetite for foreign bodies to do the shadow work/dirty work of low-level production and to supply the ‘needs’ of domestic and international medical consumption (see Sassen, 1991, 1998).

Indeed, there is nothing fixed, stable or sacrosanct about the commodity candidacy of things (Appadurai, 1986). Nowhere is this more dramatically illustrated than in the new – and in some areas ‘booming’ – market in human organs and other body parts (from both living and brain dead donors) for transplant surgery and other medical procedures (see Scheper-Hughes, 2000). A confluence in the flows of immigrant workers and itinerant ‘kidney sellers’ who fall into the hands of unscrupulous and sophisticated, transnational organs brokers is a sub-text in this story of late 20th-century and early 21st-century globalization, one which combines elements of pre- and post-modernity. At times the scenarios are reversed, as in the case of unscrupulous ‘kidney sellers’, like Pettia, an undocumented worker from Bulgaria in Israel, who bilked several desperate dialysis
patients of thousands of dollars for a kidney that never materialized. And there are also cases of naïve, misguided, but well-meaning organs brokers, like Jim Cohan (above) of Los Angeles, who was entrapped by the Italian police in 1998 and thrown into jail for several months on trumped up charges of kidnapping and organs stealing.

Organs transactions today are a blend of altruism and commerce; of science, magic and sorcery; of voluntarism and coercion; of gifting, barter and theft. Transplant technologies have reconceptualized social relations between self and other; between individual and society, and among the ‘three bodies’ – the lived body-self, the body social, and the body politic (see Scheper-Hughes and Lock, 1987). And they have redefined the meanings of real/unreal; seen/unseen; life/death; body/corpse/cadaver; person/non-person; rumors/fact/and fiction.

To date, the commodified kidney is the primary currency in organ sales worldwide. In these bodily exchanges life-saving measures for the one demand a dangerous and unrecognized sacrifice from the other. In all these transactions ‘organs brokers’ – ranging from entrepreneurial doctors to criminal ‘body Mafia’ – are essential actors, inciting a new ‘body trade’ which promises to select individuals of reasonable ‘means’ living almost anywhere in the world a ‘miraculous’ extension in what Georgio Agamben (1998) refers to as zoé, brute or naked species life – as divorced from bios, the qualified life, the proper and ethical life of a citizen (see also Cohen, this issue).

The market in organs was first documented by transplant surgeons in the Gulf States (see Daar, 1989; Saalahudeen et al., 1990) who, beginning in the late 1980s, found themselves treating patients for follow-up after they had returned from India (Bombay and Calcutta) where they had arranged transplants with kidneys purchased from impoverished organ sellers. Soon after, there appeared a surfeit of media reports, some of them well researched and reputable, but a distressing number sensational and misleading. While these media reports were debated and a great many of them discounted, a real kidney trade quietly spread to or emerged full-blown in other areas of the world including Turkey, South-East Asia and the Southern Cone. Both China and Taiwan discovered the value of transplant tourism to their countries’ economies and began using executed prisoners to supply the demand for ‘fresh’ organs, but under pressure from international human rights organizations, Taiwan, gave up the lucrative practice (C.J. Lee, communication to the Bellagio Task Force). After the fall of the Soviet Union, Bulgaria, Croatia, Estonia, Moldova, Romania and Russia became active in organs sales in which the hand of an international ‘body Mafia’ (see Viviano, 2001) trafficking in people for undocumented labor, prostitution, child slavery, international adoption, drugs and arms, and even in kidneys and other body parts was identified.
The global traffic in organs follows the modern routes of capital and labor flows, and conforms to the usual lines of social and economic cleavage. In general, the organs flow from South to North, from poor to rich, from black and brown to white, and from female to male bodies. But there are some innovations that have disrupted the conventional divisions between First and Third World, North and South, East and West, based on the emergence of new forms of wealth and of new ‘global cities’ in the East and the South (Sassen, 1991).

Today, affluent transplant tourists from Argentina, Brazil, Hong Kong, Israel and Japan, as well as from the Gulf States, travel to select medical sites in Eastern Europe, Turkey, and even to Cuba, Germany and the USA in search of transplants that they cannot arrange quickly enough, or safely enough, at home. In some newly emerging sites of transplant tourism (for example, in Cuba, Estonia, South Africa and the USA, although in very different forms) transplant clinics in private hospitals, or private clinics in public hospitals reserved for medical tourists can resemble four star hotels or even (as in Cuba) health spas for the rich and famous.

In Cuba, medical tourism, including a limited number of cornea and kidney transplants, is public and relatively transparent. The operations are controlled and actively marketed through a formal arrangement between MINISAP, the Ministry of Health, CUBANACAN and SERVIMED, groups officially formed to actively promote medical tourism to Cuba, capitalizing on that country’s reputation for excellence in basic medical care and in highly specialized surgical and other medical procedures. I arranged an interview with a sophisticated marketing representative of SERVIMED, working out of a ‘medical tourist’ office – and that is what the sign above the door called it – attached to an elegant, if somewhat spartan, medical facility, the Clinica Central Cira García, located in a gracious neighborhood of Havana. This medical center was specifically designed by the Cuban government to cater to international patients, originally diplomats and foreign workers, but in recent years catering to a new class of medical tourists. The representative handed me several colorful, plastic-coated brochures detailing various tourist ‘packages’ for highly specialized treatments ranging from psychiatric problems and drug addiction treatments to surgical rehabilitation of damaged optical nerves to liposuction and plastic surgeries to cornea and kidney transplants. Cornea transplant, for example, including a cornea ‘con optimas condiciones’, thirty-five nights of hospitalization in a private clinic, access to the best available ‘high-tech’ equipment, the operation itself, and ‘pre-op’ and ‘post-op’ care cost $5,720, well below the cost elsewhere in Latin America let alone in neighboring Miami. In fact, I was told with a mischievous wink, many medical tourists now came to Havana from the Miami Cuban community. ‘Doesn’t that cause a certain consternation and outrage among Cuban citizens, not to mention...
the surgeons asked to operate on “the enemy”? I asked. ‘Not at all’, the savvy medical tourist promoter said. ‘In fact, we encourage any patients who need excellent medical care, and who cannot afford to get what they need in their home country, to take advantage of our remarkable system.’ Kidney transplants, however, require that the patient arrive in Cuba with a living donor, who is assumed to be a blood relation.

In recent years, Israel, which has its own well-developed, but under-used, transplantation centers (underused due to the low rates of voluntary organ donation) saw the development of an active underground economy of transplant tourism that promotes and arranges international transplant junkets from dialysis clinics in Jerusalem and Tel Aviv to medical centers in Bulgaria, Estonia, Latvia, Romania, Russia and Turkey. In the last year, however, a competitor to this growing market and the dominance of a particular ‘company’ working with a notorious transplant surgeon from Bellinson Medical Center in Petach Tikvah (near Tel Aviv) has been arranging transplant junkets to Europe and to the USA.

The post-operative international kidney transplant patient community in Israel is actively engaged in promoting transplant tourism. They have increased the ‘ante’ and are now demanding the ‘right’ of access to what some there described to me as ‘first-class’ transplants with trophy organs obtained at premier, First World medical centers. ‘Why should we Israelis be made to travel to Third World clinics in dangerous cities in Turkey, Moldava or Russia to get the kidneys we need to survive from the bodies of peasants, soldiers, or guest workers who may be in worse physical shape than ourselves?’, a 71-year-old ‘kidney buyer’ from Tel Aviv asked rhetorically in August 2000. ‘Why shouldn’t we have the right to travel to Berlin, Amsterdam or New York City for the operations, if we are able to pay for them? Organs should be seen as a human, not as a national, resource.’ It was good to see ‘Avirham’, an elderly, white-haired gentleman, alive and happy with his revitalizing 22-year-old ‘peasant’ kidney, and I hesitated, though I did eventually ask him to reflect on his living donor. ‘A peasant, without anything!’, he replied. ‘Do you have any idea what $1000, let alone $5000 means in the life of a peasant from the hills of [a rural part of Eastern Europe] today?’ As George Soros indicated, global social values lag far behind global economics.

Since the fall of 2000 dozens of transplant patients, like Avirham, a man of middle-class means and postmodern aspirations and imagination, have begun to travel from Israel to the USA where they have been able to locate both cadaveric organs (from the UNOS-regulated waiting lists) as well as organs purchased from living, unrelated kidney sellers who are US citizens, arranged by transnational corporations and paid for by Israeli medical insurance companies, acting as facilitators. This practice is justified (some government officials say) by the difficulties...
Israeli patients have in procuring cadaveric or living, related organ donors at home.

At present two prominent ‘firms’ in Israel are competing for transplant patients willing to travel overseas. One, Coby Dyan, is affiliated with a leading transplant surgeon from Belinson Medical Center outside Tel Aviv who travels with his patients to ‘oversee’ their operations (with locally purchased kidneys). Dr Shapira has worked primarily through his medical transplant associates in Turkey, Estonia and elsewhere in Eastern Europe. His package deal, arranged through a well-known business corporation, is now priced between $180,000 and $200,000. Most of this money is shared among the doctors and brokers. The travelling patients are described to the immigration officials as tourists. Under considerable pressure from transplant patients to develop links in more developed countries, the cost is rising.

The transplant ‘package’ covers: a private plane (to accommodate a group of six patients, each accompanied by a family member, the Israeli doctors and the business coordinator); the ‘double operation’ (kidney ‘extraction’ and kidney transplant); the kidney ‘donor’ fee (usually no more than $5000); the bribes to airport and customs officials; the rental of operating and recovery rooms and nursing staff; hotel accommodation for accompanying family members. The covert operation is usually accomplished in five days. Day 1: on site pre-operative tests and dialysis; days 2 and 3: the operations (two or three patients per night, depending on the size of the group); days 4 and 5: on-site recovery and the flight home.

The patients I interviewed explained that the specific country, city and hospital sites of the illicit surgeries are kept secret from transplant candidates until the day of travel. Meanwhile, the sites are continually rotated to maintain a low profile. The surgery is performed after hours, late at night. In the most common scenario, Israeli patients and doctors (a surgeon and a nephrologist) fly to a small town in Turkey on the Iraqi border where the kidney sellers are often young Iraqi soldiers or guest workers. In another scenario, the Israeli and Turkish doctors travel to a third site in Eastern Europe where the organ sellers are unemployed locals or ‘guest workers’ from elsewhere.

The passivity of the Ministry of Health in refusing to intervene and crack down on this multi-million dollar business, which is making Israel something of a pariah in the international transplant world, requires some explanation. In the absence of a strong culture of organ donation and under the pressure of angry transplant candidates, each person transplanted abroad is one less client to contend with. More troubling is the complicity and involvement of the Israeli Ministry of Defense. Among the patients who have traveled with the outlaw
transplant surgeon to Turkey and Eastern Europe, soldiers and army officers have been over-represented.

The second broker is an ophthalmologist, Dr F, who has developed connections with transplant surgeons and units in New York City and Boston, among other locations, to broker illegal operations using paid local, US donors who pose as ‘family members’ of the foreign transplant patient.

These transplant junkets from Israel to the US range from the legal but questionable to the criminal. In January 2000 I interviewed the vivacious mother of an adolescent boy who had just returned from a suburb in Dallas, Texas, where the mother had been able, with the help of Dr F (above), to obtain a cadaveric organ for their son without a long wait on dialysis at home. The transplant center in Texas was a new one and the medical directors there were apparently anxious to locate patients with sufficient insurance coverage to undergo the procedure. We have found that if transplant organs are a scarce commodity, and they are of course, patients with sufficient means to cover the cost of transplant are an even scarcer commodity in most parts of the world, including the US. In the case of the ‘Gruber’ family, their insurance covered only part of their expenses. The rest was raised through a private, but extensive, media campaign in Israel, which allowed this close-knit family of four to travel together to the USA for the duration of the eldest son’s kidney transplant.

One might ask how such a transaction is possible in light of the USA’s national program and system of surveillance for organ procurement and allocation under UNOS. UNOS does permit a small number of foreign patients to compete for scarce organs on altruistic grounds that they were unable to be transplanted at home. Officially, 5 percent of any transplant center’s patient list may be foreigners, but a center will only be audited by UNOS if more than 15 percent are foreign-born patients. Meanwhile, the business offices of many hospitals actively recruit foreign transplant patients who can pay in cash. But while the distribution of cadaveric organs in the US is regulated, local organ procurement programs are given a certain amount of ‘discretion’. And, as mentioned earlier, there is no national surveillance of living kidney donation. Individual transplant programs are often able to determine how rigorously they will enforce US laws against organ sales. Some transplant centers operate with a ‘don’t ask don’t tell’ policy and the corporate/business culture that pervades in US medicine at present encourages the same.

However, in the above instance, the Gruber family decided to leapfrog the new national registry waiting list in Israel by putting their child down for various transplant programs in public and private clinics in Israel, as well as on waiting lists abroad. In fact, their son was on a priority list on the national registry and
was relatively well positioned to receive the kidney he needed. But there would be a wait. The anxious mother had, however, pursued other options with the help of her ‘medical intermediary’, and the clinic in Grapevine, Texas, came up first in this family’s private, international, transplant lottery. The transplant proved successful and the family was extremely appreciative of their good fortune. The gratitude was expressed, however, by ‘Mrs Gruber’ joining forces with transplant ‘activists’ who were trying to help other kidney and dialysis patients to ‘network’ with medical brokers involved in arranging international transplants using either cadaveric or living donor kidneys that are purchased. The rallying cry and the defense was always the same – ‘Yes [there are moral dilemmas], but it will save a life.’ With this, all debate and critical inquiry is cut short or silenced altogether.

More recently, in January 2001, I interviewed by long-distance cell telephone, a young man who had just returned to Israel from a kidney transplant in Brooklyn, arranged through an Israeli broker, in which his donor, an American citizen, was paid an unspecified amount. ‘It is not something I want to think about’, said ‘Ari’, a 24-year-old university business student. Although it was a highly constrained conversation, Ari was willing to say that he was happy, overall, with his transplant, which took place in September 2000, although he did not wish to dwell on the manner in which it was procured. ‘My parents were in charge of all the details’, he said. Nor would he share any information on the exact location of the medical center or the names of his broker or personal physician in Israel or the name of the surgeons in Brooklyn, although one of the doctors involved in his surgery was, he said, a military surgeon.

Invented Scarcities and Artificial Needs

The market in organs is driven by the simple calculus of ‘supply and demand’ and by the specter of waiting lists, organs scarcities and organs panics. But the very idea of organ or kidney ‘scarcity’ is what Ivan Illich (1992) would call an artificially created need, one that is invented by transplant technicians, doctors and their brokers, and dangled before the eyes of an ever expanding sick, aging, desperate and dying population. Newer and better technologies of organ retrieval and preservation and later generation immune suppression and antirejection drugs (see Cohen, this issue) promise an extension of life or an improvement in the quality of life through transplant surgery to an ever expanding pool of transplant candidates. In recent years, various transplant centers have begun to offer, on an experimental basis, transplants to populations of previously excluded patients – the elderly (over 65 years), the immunologically impaired, the difficult to match, HIV
seropositive and hepatitis C patients. These are high-risk, poor-outcome patients who were previously denied a place on organs transplant waiting lists in most countries. Now, ‘guardedly optimistic’ reports on the outcomes of such experimental programs in Western Europe were uncritically discussed at the annual meetings of Eurotransplant, which I attended in the fall of 2000 in Leiden, the Netherlands. There was almost no reflection on the effect that such marginal programs might have in inflating the demands for already ‘scarce’ organs. Instead, an ethos of rugged market individualism prevailed in place of a discourse on social medical ethics.

One hesitant pediatric surgeon raised a lonely voice from the convention hall. She rose to the microphone to ask the panelists the following question. Since the pool of available organs was finite, and given that donation rates were flat or even declining in some Eurotransplant countries, wouldn’t these experimental transplant programs further decrease the availability of organs for child and adolescent patients? The chair of the panel replied that the distribution of organs would continue to be monitored by Eurotransplant with attention to the constantly shifting priorities that are accorded to different classes of patients. ‘Yes, it is a bit like a balloon’, the chairman stated, ‘and demands and pressures from one group impact the expectations of other, previously privileged groups. But this is part of the democratic process through which organ allocations are made.’ Here ‘democracy’ has been redefined as the contestations among special interest pressure groups, which seems inappropriate in the medical context.

The Fetishized Kidney

The spread of transplant medicine to new patient pools and to new social and geographical contexts over the past twenty years has incited rapacious needs and desires for the body of the other. These are needs that can never be satisfied, for underlying them – as in the case of 71-year-old Avirham – is the quintessentially human refusal of mortal sickness and death at all or any cost.

For most bioethicists the ‘slippery slope’ in transplant medicine begins with the emergence of a black market in organs and tissue sales; for the anthropologist the so-called slippery slope emerges much earlier: the first time a frail and ailing human looks at another living person and realizes that inside that other body is something that can prolong his or her life. The desire is articulated: ‘I want that; I need that even more than you.’

Desperation on both sides and a willingness of the transplant doctors to see only one side of the transplant equation allows the commodified and fetishized kidney to become an organ of opportunity for the buyer and an organ of last resort for the
seller. Witness, for example, any one of the dozens of postings that come to Berkeley Organs Watch website from desperate people who are not clear about the concept of a Watch Group, thinking that we can perhaps serve as organs brokers. This message, for example, came to Organs Watch from Harry in Chicago:

I am a Caucasian male with O+ Blood, no family history of renal disease, in great health. I am a non-smoker and a non-drinker with low body fat. I have a kidney available for you [right or left, your choice] for the best price possible for you and for me. I have a wife and child and due to economic problems I am ready to do this and pray to God everyday for help in the moral and ethical dilemma that I face. Please allow me to help you and you to help me.

Or, consider this message from Bacliff, Texas:

If someone has two functioning kidneys and wants to sell one of them (since you really do only need one) ... what is it worth to you? Urgent – please reply, etc.

Or this one from south of the Texas border:

Hello, I am Art. I am 22 years old and I am completely healthy. The razón for this mail is that I am determined to donar one of my kidneys, but the thing is not so simple. I am Mexican, but I am willing to travel wherever be necessary. And this is not a donacion one hundred percent. I mean that of I can help in this way, why not help us both? Perhaps this sound a little cold and selfish, but it is a way that all we can all come out ahead. My economic situation is not the best. If someone is interested in obtaining the kidney that I am giving and he has the economic power to make this possible – enough money for me and my family – then, we can be speaking of a transplante immediate. . . . I am sure about one thing. This is a very good opportunity for both of us.

If Immanuel Kant could respond by e-mail to Harry, Art and the other would-be kidney sellers, he might caution them that to regard one’s own body as a property relation alienates one from the very basis on which humans can be said to enjoy a self, or to speak of one’s self, at all. But perhaps it is not, as Art (above) says, so simple. I think, for example, of the young Brazilian street child, a girl of 14, who once told me why she had ‘gone to the streets’ as a sex worker, after years of sexual abuse at home: ‘Nanci’, she said, ‘the first time I was paid to “put out”, I knew what it meant to be a person and to be the owner (dona) of myself.’

Into this highly emotional context, it is hardly surprising that that the transplant kidney has emerged as the ultimate fetish – promising to satisfy the most basic of human desires, the desire for life, vitality and elan. In this process the extraordinary has become routine, and what may have once verged on the fantastic has been ‘naturalized’. I asked Ari, the 24-year-old transplant tourist from Jerusalem to Brooklyn, why he chose such a risky, murky and expensive procedure over dialysis and the waiting list for a cadaveric kidney in Israel. He replied:

The waiting list is a joke. Who wants to be a prisoner of dialysis while waiting? Dialysis is a bore and very unaesthetic. Your skin changes color, you are tired all the time, and you are limited to eating only certain foods. Having a transplant is the most normal solution because
you don’t have to go to the hospital three times a week. It is liberating. Kidney transplant from a living donor is the best you can get. It is the healthiest and the most natural solution.

I hesitated to press Ari any more, or to ask him if he thought the surgical removal of a kidney from a living donor was also a normal and natural procedure. And I did not have an opportunity to pose the question to Ari’s paid donor, whose identity was concealed.

In conversations with living donors (paid and otherwise ‘compensated’) in Brazil and elsewhere, I encountered a strikingly similar tendency to normalize and naturalize the procedure. For example, a middle-aged teacher from an interior town in Pernambuco who had given her kidney to a relative for a small compensation, argued forcefully that the payment did not detract from the pricelessness of her gift, and equally forcefully and contradictorily that the gift was something she would assume anyone would not think twice about giving. ‘Oh Nanci’, she said, ‘wouldn’t you give something that you had two of to a needy person who didn’t have any?’ Here, too, the language of the normal, the routine and the natural replaced earlier sentiments, widespread in this same community, of horror at the thought of self-mutilation and dismemberment in the name of medicine.

The sale of human organs and tissues requires that certain disadvantaged individuals, populations and even nations be reduced to the role of ‘suppliers’. It is a scenario in which only certain bodies are broken, dismembered, fragmented, transported, processed and sold in the interests of a more socially advantaged population of organs and tissues receivers. I use the word fetish advisedly to conjure up the displaced magical energy that is invested in the purchased living and thereby strangely animate kidney. A kidney buyer who flew from Jerusalem to Georgia in Eastern Europe, where he purchased a kidney from a young peasant explained, for example, why he would never tolerate a cadaveric kidney:

That kidney is practically dead. It was probably pinned down under the wheels of a car for several hours and then it was put on ice for another several hours. Then you expect it to go right back to work for me? It’s really a disgusting idea to think about putting that traumatized dead man’s organ inside you. So I chose a better way. I was able to see my donor. My doctor pointed him out to me [it was in a small town in Eastern Europe]. He was young, healthy, strong. Just what I was hoping for.

In Brazil the refusal of the cadaveric kidney was equally strongly articulated. A nephrologist practicing in the area of Copacabana Beach said that most of his patients refuse to consider an organ from an ‘anonymous’ dead person. The public cadaver, he said, was described derisively as ‘the state’s body’, something to be avoided at all costs.
My patients do not trust the public health system. They fear that the ‘public’ organ will come to them full of pollutants and contaminants. They see it as a ‘diseased’ organ. Anyone who can afford to do so will find a living donor, whether from a relative or from an ‘acquaintance’ who is willing to sell. But, in that case, the buyer has the right to demand that the donor be carefully screened so that there are no mishaps later on.

In all, the ultimate fetish – as recognized many years ago by Ivan Illich (1992) – is the idea of ‘life’ itself as an object of manipulation, a relatively new idea in the history of modernity. The fetishization of life – a life preserved, prolonged, enhanced at almost any cost – erases any possibility of a social ethic. Often, when I speak of troubling issues in organs procurement, I am accused of risking or ‘taking a chance for life’ away from someone. But what I am trying to underscore is that there is another ‘body’ of patients whose needs are being ignored or violated in the panicky search for organs and other body parts.

To summarize: I am trying to make three points. The first point is about invented scarcities, artificial needs and the fetishization of transplant organs in the social imaginary of organs buyers and organs sellers. My second point concerns gifts versus sacrifice; and my third point concerns surplus empathy and the visibility and invisibility of two distinct populations – ‘excluded’ organs givers and ‘included’ organs receivers. Scarcity and need (along with fetishized notions of ‘saving’ or prolonging a ‘life’ at any cost) drive the transplant and harvesting ‘business’, while a single drug – cyclosporine – is the pharmaceutical engine that makes this all possible. If there were no cyclosporine there would be no story here at all.

Surplus Empathy and a Preferential Option for the Organs Donor

Dialysis and transplant patients are visible to us. We can see and hear their pain and suffering. Their stories are shown to us in the media. But while there is empathy – even a kind of surplus empathy – for one population – the transplant patient – there is a deficit or an absence of empathy for the groups we cannot see, those whose lives and suffering remain largely hidden from view – the population of organs and tissue donors, living and dead.

We might ask why so many transplant recipients are so ready and willing to accept the enormous human costs of these procedures? Few organ recipients know anything about the kinds of demands that are made on the bodies of ‘the other’, living or dead. They recognize, of course, that their good fortune comes out of the tragedy of another and they pass along the transplant folklore of the permissible guilt and glee they experience on rainy nights when traffic accidents rise. Donor anonymity prevents scruples in the organ recipient population, although transplant patients often do try to learn something about their donors, living and dead. But
they are never privy to the secret negotiations and sometimes the psychological manipulations of the cadaveric donor’s family members while they are in shock and deep grief. Meanwhile, kidney buyers engage in a kind of double-think, double-speak in which they discount living donation within the family, while recruiting organs from living strangers who are believed to ‘benefit’ enormously from the transaction. Here were some contradictory explanations from Israeli kidney buyers:

I wouldn’t think of asking a family member to make such a sacrifice for me.

Kidney removal is a perfectly safe procedure.

Nature has endowed us with two kidneys including one to share . . . or to sell.

It is better to buy from an outsider than to take from another Jew.

The world owes us at least 8 million hearts and 16 million kidneys.

Meanwhile, organs brokers – like any other brokers – try to keep organs buyers and sellers apart. But even when live donation is transacted within families, recipients can be protected from knowing the human cost of donation. In Brazil, for example, kidney donors are cautioned by their doctors that it is wrong, after donation, ever to bring the subject up in front of the recipient. Their act, they are told, must be completely ‘forgotten’. This mandate alone is a burden that forces the donors to carry within themselves a deep ‘family secret’. If the medical and psychological risks, pressures and constraints on organ donors (and their families) were more generally known, potential transplant recipients might want to consider ‘opting out’ of procedures that presume and demand so much of the other.

Human Sacrifice in the New Millennium

At the heart of this project is an anthropological analysis of postmodern forms of sacrifice. Though it bears little resemblance to the burnt offerings of the desert Hebrews, or to the agony of Christian martyrs thrown to lions, human sacrifice in the form of living organ donation is still with us. Indeed, organ harvesting carries some trace elements of Aztec hearts ripped – still beating – from the chests of state-appointed ritual scapegoats. Global capitalism and advanced biotechnology have released new medically incited ‘tastes’ (a New Age gourmet cannibalism, perhaps) for human bodies, living and dead, for the skin and bones, flesh and blood, tissue, marrow and genetic material of ‘the other’. What is different today is that the sacrifice is disguised as a ‘gift’, a donation, and is unrecognized for what it really is. The sacrifice is rendered invisible by its anonymity, and hidden within the rhetoric of ‘life saving’ and ‘gift giving’, two of several transplant ‘key words’ we are trying to open to a long overdue public discussion.
Inserting ourselves into transplant surgery theaters that were sometimes more like theaters of the absurd, and following transplant patients from dialysis clinics to surgery, and donor bodies from township *shabeens* to police stations and public mortuaries and from there to the various eye banks, medical clinics and research laboratories where their parts were harvested and redistributed, we encountered a kind of *apartheid medicine* that privileged some patients—organ recipients—over other patients, organ donors, about whom almost nothing is known. Organ donors represent a social and semiotic zero, an ideal place for a critical medical anthropologist dedicated to ‘following the bodies’ to begin. We made the conscious decision to position ourselves on the ‘other side’ of the transplant equation, representing the voice of the silent or silenced organ donor, living and dead, here seen as rights bearing individuals and as vulnerable patients rather than as fodder for advanced medical technologies.

Here, perhaps two anecdotes convey the origins of this decision for me. After I had begun to write about the fears of the Brazilian shantytown poor following rumors of child kidnapping for organ removal (Scheper-Hughes, 1992), my husband, then a medical social worker at a large children’s hospital, returned home one day deeply moved by a transplant operation that had just saved the life of a 12-year-old child. Quite unthinkingly I asked, ‘Whose organ?’ Michael’s anger at my ‘inappropriate’ question led me to realize that here was a question that *had* to be asked. Then, later, in 1996 when I was already deeply involved in this research, a transplant surgeon in Recife, Brazil who relied on live kidney donors, answered my questions about patient follow-up procedures quite defensively. ‘Follow up!’, he fairly boomed, ‘With transplant patients it’s like a marriage—you are never free of them!’ ‘Yes’, I replied, ‘But what about your other patients, your kidney donors. Do you follow them?’ To which the surgeon replied. ‘Of course not. They are not patients. They are healthy people just like a woman who gives birth.’ When I spoke of the many kidney donors I met who later encountered medical and psychological difficulties, he replied: ‘These are neurotic people who want to be heroized for what they have done.’ But when I countered: ‘Why shouldn’t they be?’, the doctor had no reply.

Then, during a field trip to Brazil in 1998, I encountered in Salvador, Bahia, a ‘worst-case scenario’ showing just how badly a live kidney donation could turn out in a Third World context. ‘Josefa’, the only girl among eight siblings from a poor, rural family in the interior of the state, developed end-stage kidney disease in her twenties. With the help of people from her local Catholic church, Josefa moved to Salvador for dialysis treatments, but there her condition continued to deteriorate. Her only solution, she was told, would be a transplant, but as a ‘public’ patient her chances of getting to the top of local ‘waiting lists’ was next
to nil. At her doctor’s suggestion, Josefa sought a kidney donor among her siblings. An older brother, ‘Tomas’, the father of three young children, readily offered to help his ‘baby’ sister. But what at first seemed like a miraculous transfer of life rather quickly turned problematic. Soon after the ‘successful’ transplant, Josefa suffered a crisis of rejection and lost her new kidney.

Meanwhile, Tomas himself fell ill and was diagnosed with kidney disease resulting from a poorly treated childhood infection. What the doctors referred to as a ‘freak accident’ and a stroke of ‘bad luck’ struck Josefa (and her brother) as evidence of a larger social disease: ‘We were poor and ignorant; the doctors didn’t really care whether we were properly matched or whether I could afford the drugs I needed to stay alive after the transplant.’ Josefa’s enormous guilt toward her mortally ill brother brought tears to her eyes throughout our interviews. She was committed to doing everything possible to help out his family to which she felt so miserably indebted. Tomas, a slender, nervous man, looking far older than his years, said ruefully during a separate interview: ‘I love my sister and I don’t hold her responsible for what has happened. The doctors never asked about my own medical history before the operation. And afterwards it was too late.’

Perhaps this last ethnographic anecdote may serve as a partial response to the following, often raised, challenge: if a living donor can do without the organ, why can’t the donor profit and medical science benefit? Transplant surgeons have disseminated an untested hypothesis of ‘risk-free’ live kidney donation in the absence of any published, longitudinal studies of the effects of nephrectomy (kidney removal) among the urban poor living anywhere in the world. Live donors from shantytowns, inner cities or prisons face extraordinary threats to their health and personal security through violence, injury, accidents and infectious disease that can all too readily compromise the kidney of last resort. As the use of live kidney donors has moved from the industrialized West, where it takes place among kin and under highly privileged circumstances, to areas of high risk in the Third World, transplant surgeons are complicit in the needless suffering of a hidden population.

The ‘preferential option’ for the organ donors expressed here does not imply a lack of empathy for transplant recipients or for the expanding queues of waiting-list patients who have been promised a kind of immortality by transplant professionals. Poised somewhere between life and death, their hopes waxing and waning as they are stranded at the middle or at the bottom of official waiting lists, which are subject in a great many places to corruption by those with access to private medicine and to powerful surgeons who know how to circumvent or bend the rules, these all-but-abandoned transplant ‘candidates’ have their own painful stories to contribute to the larger project.

In Israel, for example, I encountered transplant patients who, denied access to
the transplant waiting list at home for sound medical reasons, were enrolled in the illicit programs to purchase organs abroad, and who encountered medical traumas as a result of their foolhardy actions.

I think, for example, of Mr Tati, a municipal public health food inspector in Jerusalem, who travelled to Turkey with Dr S two years ago for transplant with a purchased kidney and who came home very ill, close to death, and very poor indeed. Mr Tati was, to begin with, a very poor candidate for transplant. He had suffered a coronary event in his mid-forties and was removed from the official kidney transplant waiting list by his doctors at Hadassah Hospital and told that dialysis was his best solution. Angered, Mr T took his medical records to B Hospital in Tel Aviv where Dr S agreed to include him on his list of transplant tourists. Immediately following the outlaw transplant, and while he was still in the recovery room, Mr T suffered a massive heart attack. This was followed by a crisis of rejection. The outlaw surgeons packed him back into the private jet with an RX to his regular doctors at Hadassah Hospital to treat the medical mess they had created. The doctors at Hadassah were furious, but treated Mr T at the government’s expense. Seven months later, Mr T was still a hospital patient. ‘He was a real basket case’, Dr G told me ruefully, ‘but he did manage to recover.’

Avirham, at age 71, was also, like Mr T, a poor candidate for a kidney transplant. He was too old to be listed on an official transplant waiting list, and he had multiple, pre-existing medical conditions that would have put him in a very low category of priority for transplant even if he were a much younger man. A year after the surgery, Avirham was unsteady, and needed help in negotiating a curbstone, but he was still on his feet. Yet his recovery was, he said, distressingly slow. He attributed this to the miserable conditions he had had to face in the ‘Third World’ hospital where his transplant took place. ‘It was a real shock’, he said. ‘I wanted to get out of there as quickly as possible.’

Finally, I think of ‘Pettia’, the earlier mentioned guest worker from Bulgaria, who offered her kidney several times over to desperate transplant candidates in Jerusalem, soliciting from each several hundred dollars for pre-tests and cross-matches which always proved disappointing. Meanwhile, Pettia kept the money... and her kidney. The desperately sick easily fall prey to kidney scams like these.

**Whose Values are These?**

Amidst the contestations between organ givers and organ receivers, between doctors and patients, between North and South, between individuals and the state, between the illegal and the ‘merely’ unethical, anthropologists need to be especially clear about their values in these complex transactions. Indeed, as
professional hunters and gatherers of human values, anthropologists are characteristically shy when it comes to discussing their own individual or cultural notions of the good and its opposites. Why would anthropologists regard such ‘Western’ and modernist notions of bodily autonomy and bodily integrity as basic human rights? This would seem particularly ironic given the deconstructionist and relativist impetus that lay behind Margaret Lock’s and my earlier ‘mindful body’ essay (1987).

However, we have since found that notions of bodily autonomy and integrity are almost universally shared today. They lie behind ‘First Peoples’ demands for the repatriation and reburial of human remains warehoused in museum archives. They lie behind patients’ rights movements, demanding access to medicine and medical technology – rights to ‘medical citizenship’ as it were. They lie behind the demands of the wretchedly poor for dignified death and burial. And they certainly lie behind organ stealing rumors and popular resistance to ‘presumed consent’ laws. But admittedly for some of those living on the margins of the global economy, however, who are daily assaulted by disease, hunger and premature death, and by degrading living and work conditions, and for whom the experience of bodily alienation is already a defining feature of their lives, the possibility of selling an organ seems like an act of empowerment. ‘I prefer to sell it [my body] myself rather than to let the state get it’, was a sentiment expressed by some shantytown residents in urban Brazil.

In fact, it is in the West where the modernist values of bodily autonomy and integrity are most under assault. As commodification and commercialization have entered almost every sphere of life – from markets in ‘beauty queen’ ova and ‘genius sperm’ to a corrupted ‘willed body’ program at the University of California Irvine Medical School – those in the North cannot claim any high moral ground. Meanwhile, the new constitutions and bills of rights adopted by democratic Brazil and post-apartheid South Africa are highly developed with respect to recognizing human rights to bodily autonomy and integrity.

We are particularly concerned about social and race-based inequities in the selection of candidates for transplant surgery in the USA. While it is true that African-Americans are, at best, reluctant organ donors, we would question the biomedical rationale for race-based ‘matching’, a procedure that is not followed in either Brazil or, historically, in South Africa where black donors provided a great many organs for white recipients. Trust in medicine and in transplant procedures – especially medical definitions of brain death – are low in black ‘inner-city’ neighborhoods in the USA and contributes to the low incidence of organ donation. Hence, a vicious cycle is created and maintained. Medical exclusions based on poor tissue matches, previous medical and reproductive
histories, and exposure to infectious disease disqualify a great many black candidates for transplant surgery (see Koch, 2001).

One has to be relatively ‘healthy’, affluent and white in the USA to be a candidate for a cadaveric organ. Under these exclusionary conditions, resistance to organ donation makes sense in the African-American community. One result is, however, that African-Americans are more frequently counseled by their doctors than white Americans to pursue live (kidney) donation. And, there is evidence that African-Americans express more resistance to making such demands on their loved ones.

In conclusion, the goal of our project is to bring broader social and social justice concerns to bear on global practices of organ harvesting and distribution. While our research has taken place largely in the Third World, we are quickly learning the extent to which these exchanges involve and implicate the USA and Western Europe. The demand for organs in one area stimulates the market for brokers and organ sellers in other nations.

Organ transplantation depends on a social contract and a social trust, without which it simply cannot exist. Transplant surgery represents the most social of all aspects of medicine. Consequently, we are seeking assurances that the practices around organ transplantation include attention to the needs and wishes of organ donors, both living and dead. We want transplant surgeons to pay attention to where organs have come from and the manner in which they were procured and harvested. We want assurances that organ donation everywhere is voluntary. And we want the bodies of potential donors – living and dead – to be protected and not exploited by those charged with their care. We want the ‘risks’ and ‘benefits’ of organ transplant surgery to be more equally distributed among and within nations, and among ethnic groups, genders and social classes. Finally, we want assurances that the so-called ‘gift of life’ never deteriorates into a ‘theft of life’. We hope that this new project will be seen as an attempt to establish a new ethical blueprint for anthropology and for medicine into the 21st century.

Notes

The field research for this collaborative study has been supported by the Open Society Institute in New York City. Lawrence Cohen is a co-principal investigator and has been an invaluable intellectual companheiro and friend throughout all phases of this project. A shorter version of this paper was presented at the 3rd International Symposium on Coma and Death, Havana, Cuba, 21–26 February 2000. I am grateful to Calixto Machado for the invitation to share my research with a large gathering of international neurologists and intensivists who daily temper the extraordinary death-defying skills of advanced biomedicine with the sensibilities of closet metaphysicians.

1. The members of the Bellagio Task Force are: Tsuyoshi Awaya, Professor of Medical Sociology and Law at the School of Law, Tokuyama University, Japan; Bernard Cohen, Director, Eurotransplant Foundation, Leiden, the Netherlands; Abdallah Daar, MD, Chairman, Department of Surgery, Sultan Qaboos University, Muscat, Oman;
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2. In South Africa, the director of an experimental research science unit of a large public medical school showed me documents approving the transfer of human heart valves taken (without consent) from the bodies of the poor in the police mortuary and shipped ‘for handling costs’ to medical centers in Germany and Austria. These permissible fees, I was told, helped defray the unit’s research program in the face of the austerities and downsizing of advanced medical research facilities in the new South Africa. But to a great many ‘ordinary’ citizens in Brazil, India and South Africa, such commercial exchanges are seen as a form of global ‘bio-piracy’.

During the heyday of apartheid, transplant surgeons in South Africa were not obligated by law to solicit family consent before harvesting organs (and tissues) from cadaveric donors. ‘Up until 1983 or 1984 the conditions for transplantation were easier’, said Dr Brink, head cardiac surgeon from the Medical School of the University of Cape Town. ‘We didn’t worry too much in those early days. We just took the hearts we needed, but it was never really a racial issue.’ But what Dr Brink meant was that there was no hesitancy in transplanting black and colored (mixed race) hearts – sometimes taken without the consent or knowledge of family members – into the bodies of white, male patients. (Until the early 1990s 85 percent of South Africa’s heart transplant recipients were white males.) Surgeons refused to reveal the race of donor hearts to organ recipients, saying that hearts have no race. ‘We always used whatever hearts we could get’, Dr Brink said. In 1994, the year of the elections, for the first time a significant percentage, 36 percent, of all heart transplant patients at the university hospital in Cape Town were assigned to mixed-race, Indian or black patients. However, by that time, most transplant surgery had moved to private sector hospitals, where patients of means, many of them arriving from foreign countries, were housed in relative luxury while awaiting an organ.

3. I was introduced to the guards at the gate and to the administrative staff of Montes de Oca as an American visitor who was searching for a missing aunt.

4. The Equipo Argentino de Antropologia Forense, the Argentine Forensic Anthropology Team, was formed from a young group of university students who volunteered to help the celebrated American forensic anthropologist Claude Snow and his collaborator, Mary Clare King, in using the technology of DNA to identify the remains of the politically disappeared exhumed from mass graves, and to locate and identify the adult children and grandchildren of some of the ‘disappeared’ who were adopted into military families during the Argentine ‘dirty war’.

References


Body and Society


Newspaper Articles

[Review of BBC’s ‘The Great Organ Bazaar’]

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