

Parts unknown

Undercover ethnography of the organs-trafficking underworld

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ABSTRACT ■ This article addresses some of the ethical, ethnographic and political dilemmas of an idiosyncratic multi-sited research project exploring the illegal and covert activities surrounding the traffic in humans and their body parts by outlaw surgeons, kidney hunters and transplant tourists engaged in 'back-door' transplants in the global economy. In its odd juxtapositions of ethnography, documentation, surveillance and human rights work, the project blends genres and transgresses long-standing distinctions between anthropology, political journalism, scientific reporting, political engagement, public interest anthropology and human rights work. How does one investigate covert and criminal behavior anthropologically? When, if ever (and on what grounds), is it permissible to conduct research 'under cover'? When crimes are being committed, to whom does one owe one's divided loyalties? Following a discussion of politically engaged research I pluck a few 'backstage' scenes from this Goffmanesque study of the organs trade to illustrate the very different forms, practices and emotions it encompasses. I want to recapture the 'basic strangeness' of a routine medical procedure – kidney transplant – that has become increasingly dependent on medically supported claims and rights to the healthy bodies of marginalized 'others'. I close with an argument against bioethics and its capitulations to medical markets in bodies.

KEY WORDS ■ undercover ethnography, hybrid research: documentation, surveillance and human rights work, scholarship with commitment, organs-trafficking

In a poignant scene from producer Stephen Frears' neo-Gothic film 'Dirty Pretty Things', which treats the traffic in human frailty and vulnerability in the shadowy underworld of immigrant London, Okwe, a politically framed, haunted and hunted Nigerian doctor-refugee who is hiding out as a hotel receptionist, delivers a freshly purloined human kidney in a Styrofoam cooler to a sleazy body-parts broker in the underground parking lot of the sham elegant hotel staffed almost entirely by new immigrants, many of them (like Okwe) desperate illegals and refugees on the lam.

'How come I've never seen you before?' the English broker (one of the very few Anglo-speaking white people to appear in the film) asks Okwe before gingerly accepting the strangely animate and 'priceless' parcel handed over to him. Barely concealing his rage, Okwe replies between clenched teeth in his finely accented Nigerian English: 'Because we are the people you never see. We are the invisible people, the ones who clean your homes, who drive your taxis, who suck your cocks'. And, now it goes without saying, who provide you with their 'spare' body parts.

Little did Steven Knight, the London-based scriptwriter of 'Dirty Pretty Things', realize how close to the mark his imaginative portrayal of the global transplant underworld had struck. 'Why set this drama in a hotel?'¹ I asked a Miramax film representative, noting that a three-star 'hospit-el' (as such medical and 'transplant tourist-trap' clinics are called in the Philippines) would have worked just as well and not let the world's transplant outlaws off the hook so easily. But the film is not a documentary but a social thriller which blends aspects of the global urban legends about child kidnapping for organs and prostitutes drugging unsuspecting barflies who wake up in a hotel bathtub minus a kidney (see Scheper-Hughes, 1996, 2001b, 2002; White, 1997) with the very real social dramas of human trafficking for transplantable organs and tissues (see Andrews and Nelkin, 2001; Rothman et al., 1997; Scheper-Hughes, 2000, 2001a, 2001c, 2002, 2003a, 2003b; Sharp, 2000). The back-door/backstage scenes of organs and tissues procurement combine aspects of the real, the unreal and the uncanny.

To a great many social scientists and folklorists like the tireless Véronique Campion-Vincent (1997) and the prolific Alan Dundes (1991), the organs theft story is little more than a contemporary variant of ancient body-stealing motifs that include the liver-eating Pishtaco monsters of the Andes (Oliver-Smith, 1969) and blood libel slanders that once accused European Jews of eating Christian babies or drinking their blood (Dundes, 1991). If the organ- and baby-stealing rumors provide an endless supply of good copy for journalists in global outposts (see, for example, 'Russian Woman Tries to Sell Grandson for His Organs')² and Gothic subtexts to novels and films, the organ-stealing motif is also a great source of entertainment among the more sophisticated.

During a reception at the University of California following a lecture by

the celebrated South African writer J.M. Coetzee (whom I had got to know at the University of Cape Town), the prickly author asked me what in the world I was now up to. I mumbled, 'fieldwork on the global traffic in human organs', as I quickly turned my head to avoid a topic that was hardly apropos to the festive occasion. But an acquaintance from the English department, who had joined the circle around Coetzee, broke in (thinking, no doubt, of films like 'Coma', 'Jesus of Montreal', and 'Central Station') to say: '*Fabulous topic!* I suppose you have been going to a lot of movies lately'. 'Actually', I replied, 'I have been going to quite a few morgues'.

So, take the ethnographer. She has chosen to investigate a hidden and taboo subject, as forbidden a topic as witchcraft, incest or pedophilia. Using the traditional method of 'snowballing' – one patient, one surgeon, one hospital, one mortuary, one eye bank leading to the next – she begins to uncover a string of clues that will eventually take her from Brazil to Argentina and Cuba, and from South Africa to Israel, the West Bank and Turkey, and from Moldova in Eastern Europe to the Philippines in South-east Asia. Finally, the clues lead her back to transplant units in Baltimore, Philadelphia and New York City. What she discovers is an extensive and illicit traffic in human organs and tissues procured from the bodies of vulnerable populations – some very dead, some in that 'dead/not quite dead' status known as brain death and a great many of them still very much alive.

Following new paths in the global economy, she discovers not one but *several* organs-trade circuits and triangles circulating body parts and living bodies – buyers, sellers, brokers and surgeons – often traveling in reverse directions. She finds that strange rumors and metaphors do at times harden into 'real' ethnographic facts. She learns how effectively organ-theft jokes, science fiction novels and urban legends conceal and distract attention from the 'really real' covert traffic in humans and their body parts. But once her writings begin to give credence to the material grounds underlying some of the rumors, she finds herself isolated, her research disvalued as too 'positioned', too engaged and therefore lacking in methodological rigor or theoretical discernment. Worse, she is labeled as naïve for she has begun to buy into the assumptive world of her informants, many of them poor, Third World, medically and technologically unsophisticated.

Like the French anthropologist Jeanne Favret-Saada (1977), who left her comfortable psychoanalytic practice in Paris to undertake fieldwork on sorcery and counter-sorcery among the peasants of the Bocage in western France, I found myself 'caught up' in a seemingly delusional belief system. Favret-Saada began to believe in the power of witches to harm and to heal. I began to believe in the ability of some transplant 'sorcerers' to harm one population of bodies in order to bring vitality to another (more privileged) population of patients. I was between what Favret-Saada called 'catching' (as in 'getting'/understanding) and being 'caught' in the web of the very

thing I was trying to understand analytically. Participant-observer research is often like that.

Favret-Saada alternated in the roles of witch and unbewitched. I alternated in the role of cultural broker – sometimes helping organs buyers, sellers and brokers to avoid the worst damage to themselves and others – and the role of undercover agent, as when I briefly posed as a kidney buyer at a notorious bus station and ‘Russian suitcase market’ in the immigrant section of Istanbul where everything from smuggled cigarettes to sex and to kidneys was procured by broker-toughs and other intermediaries from dazed Eastern European peasant ‘guest workers’ hungry for a job. Or, as when I traveled incognito with a private detective from Buenos Aires in order to enter a locked state facility for the profoundly mentally retarded, the infamous Colonia Montes de Oca in Torres, to investigate and ultimately to document allegations of tissue, blood, kidney and child theft from the neglected, emaciated, socially abandoned and unknown, so-called ‘no-name’ inmates. These allegations not only appeared in hundreds of newspaper articles in the Argentine press,³ but also in the annals of the *British Medical Journal* (1992).

My naïve and intrusive opening question – ‘whose organ?’ (followed by ‘where in the world did you get it?’) – took me from my usual haunts as a critical medical anthropologist – the impoverished homes and shantytowns of the Third World – to some of the more privileged and technologically sophisticated transplant units, research institutes, biotechnology firms, organs banks and public and private hospitals in the world. My basic ethnographic method – ‘follow the bodies!’ – brought me to police morgues, hospital mortuaries, medical-legal institutes, intensive care units, emergency rooms, dialysis units, surgical units, operating rooms, as well as to police stations, jails and prisons, mental institutions, orphanages and court rooms in North and South America, Europe, the Middle East, Africa and Asia. But the project also took me back into the slums, inner cities, townships, refugee camps, farmers’ markets, Turkish bazaars, shopping malls, bars, shabeens, prisons, unemployment offices and flea markets where living people are recruited and sometimes tricked into selling spare body parts, mostly kidneys.

This research, and the collaborative, interdisciplinary documentation and medical human rights project Organs Watch,⁴ into which it emerged (see Monaghan, 2000; Scheper-Hughes, 2003b), could not have taken place without the close, collaborative assistance of dozens of graduate student field assistants, young anthropologists and human rights workers in the dozen countries in which I have worked.⁵ Additionally, I was aided and at times accompanied by young and sympathetic doctors and surgeons, international human rights activists, documentary filmmakers, private detectives, political journalists and ‘fixers’,⁶ a class of paid research

'intermediaries' long used by documentary journalists. In addition to observing practices and social interactions at the many different sites and scenes of organs and tissues procurement, processing, harvesting and transplant, my primary method was open-ended key informant interviews, often followed up (with the help of local research assistants) by structured questionnaires (see Appendix A).

At times, my voyages into the darker side of organs procurement and back-door transplants felt like Orpheus' descent into Hades, a theme suggested in the film 'Pretty Dirty Things' when Okwe attempts to rescue his own Euridice, the beguilingly waifish Turkish muse. Senay (like many of my kidney-seller informants) is all too willing to make a Faustian pact with the appropriately nicknamed 'Sneaky', Señor Juan, the hotel manager/organs broker who promises illegal immigrants freshly minted counterfeit passports in exchange for a freshly extracted 'spare' kidney. At other times my underground voyages to back-door transplant clinics, where living donors are housed in wards resembling 'kidney motels', seemed reminiscent of Giorgio Agamben's terrifying vision in *Homo Sacer* (see Agamben, 1998).⁷ In Agamben's book, the postmodern condition is the final flowering of the perverse biologic of the mid-20th century death camps, where human life is redefined in terms of the audacious claims and rapacious desires of one population of super-citizens on the bodies and vitality of an(other) population of stripped down non-citizens, those whose naked or 'bare lives' can be taken, dismantled and sacrificed at will.

Elsewhere I have described the pressures resulting from the transfer of transplant capabilities and technologies to the developing world and the new scarcities and rapacious desires that this technology brings in its wake (see Scheper-Hughes, 2000, 2001b, 2001d, 2002a, 2003a). Today, kidney transplant has spread from a small number of privileged medical centers in the First World to every continent, producing in its wake a global 'scarcity' of transplantable organs. This, in turn, has led to the identification of an abundant new source of organs in the bodies of the living, as well as of the dead, especially among the poor, the naïve, the medically illiterate, the displaced and the desperate – those whose social frailty and all too evident 'bioavailability' have proven too tempting to bypass or overlook. I have mapped the circuits of trade and illicit trafficking that bring strangers from different ethnic groups, classes, regions, religious backgrounds, political affiliations and nations into intimate contact for the procurement and transfer of tissues and organs. These transactions range from consensual contracts (formal and informal), to coerced deals, to criminal trafficking verging on transnational kidnapping by local and international brokers involved in a multi-million-dollar business that extends life to some highly privileged patient-clients at the expense of other more expendable and anonymous bodies of 'non-patients' (see especially Scheper-Hughes, 2003a).

Late modern ‘millennial’ or ‘second-coming’ capitalism (see Comaroff and Comaroff, 2001) has facilitated a rapid dissemination to virtually all corners of the world of advanced medical procedures and biotechnologies alongside strange markets and ‘occult economies’ and other forms of what Jaddish Bhagwati (2002) calls ‘rotten trade’.⁸ Together, these have incited new tastes and desires for the skin, bone, blood, organs, tissue and reproductive and genetic material of others. The spread of transplant capabilities into new areas has created a global scarcity of organs at the same time that the processes we call globalization have released an exodus of displaced persons and a voracious appetite for foreign bodies to do the shadow work of production and to provide ‘fresh’ organs for medical consumption.

These ideal conditions have put into circulation mortally sick bodies traveling in one direction and ‘healthy’ organs (often encased in their living human packages) in another direction, creating a bizarre ‘kula ring’ of international body trade. The emergence of strange markets, excess capital, renegade surgeons (see Jimenez and Scheper-Hughes, 2002), local ‘kidney hunters’ with links to an international Mafia (Lobo and Maierovitch, 2002) – and to a parallel traffic in slave workers, sold babies, drugs and small arms – has produced a small but spectacularly lucrative practice of ‘transplant tourism’, much of it illegal and clandestine. For these reasons, hard data and reliable statistics on the extent of organs and transplant traffic are hard to come by.⁹

This confluence in the flows of immigrant workers and itinerant kidney sellers who fall into the hands of ruthless brokers and unscrupulous, notorious, but simultaneously rewarded, protected and envied outlaw transplant surgeons is a troubling subtext in the story of late 20th- and early 21st-century globalization, one that combines elements of pre- and postmodernity. These new transplant transactions are a blend of altruism and commerce, consent and coercion, gifts and theft, science and sorcery, care and human sacrifice.

On the one hand, the phenomenal spread of transplant technologies, even in the murky context of black markets in medicine, has given the possibility of new, extended or improved quality of life to a select population of mobile kidney patients from the deserts of Oman to the rainforests of the Amazon Basin.¹⁰ On the other hand, new developments in transplant tourism have exacerbated older divisions between north and south, core and periphery, haves and have-nots, spawning a new form of commodity fetishism in demands by medical consumers for a quality product – ‘fresh’ and ‘healthy’ kidneys and part-livers purchased from living bodies. In these radical exchanges of body parts and somatic information, life-saving measures for the one demand a bodily sacrifice and self-mutilation by the other. And one man’s biosociality (Rabinow, 1996) is another woman’s

biopiracy, depending on whether one is speaking from a Silicon Valley biotech laboratory or from a sewage-infested *barangay* in Manila.

The circulation of purchased body parts exemplifies the classical liberal episteme, a political discourse based on juridical concepts of the autonomous individual subject, equal opportunity, radical freedom, accumulation and the expansion of medical citizenship¹¹ to include such strangely articulated demands as ‘the right to a fresh living, rather than a dead man’s kidney’. The commodified kidney is, to date, the primary currency in transplant tourism; it represents the gold standard of organ sales worldwide. In the past year, however, markets in part-livers and single corneas from living vendors are beginning to emerge in Southeast Asia.

Here I am taking up the challenge of the organizers of the ‘Ethnografeast’ panel in which it was first presented (‘The Contested Politics and Ethics of Field Work’) to address some of the ethical dilemmas involved in a hybrid and idiosyncratic research project that relied on a blend of conventional and unconventional methods (some invented on the spot and by the seat of the pants) to explore illegal and covert activities surrounding the traffic in human body parts by outlaw surgeons and transplant tourists engaged in ‘back-door’ transplants in the global economy. Following a dissection of such politically engaged – some might say ‘muckraking’ – ethnographic research, I will pluck a few backstage scenes from this Goffmanesque study of the organs trade to illustrate the very different forms, practices and emotions it encompasses. I will close with an argument against mainstream bioethics and its capitulations to medical markets in bodies – whole or in parts. In all, I want to recapture the ‘basic strangeness’ of a routine medical procedure – kidney transplant – that has become increasingly dependent on medically supported claims and rights to the healthy bodies of marginalized ‘others’.

Engaged and enraged ethnography

At a Social Science Research Council workshop in Prague in May 2002 (‘Oikos & Anthropos’) I heard some amazing things. Paul Rabinow announced that ‘ethnography was dead’, a claim that no one contested and that many participants appreciatively embraced. As Loïc Wacquant later quipped, ‘Of course it’s dead if you no longer do it’. But at that point I had already ‘checked out’ of the workshop to collaborate with a political journalist from the *London Times* investigating two transplant wards in the suburbs of Prague.

The following day Aihwa Ong said that there was no place in anthropology for frank political engagements and the paper I tried to present (a version of this one) was interrupted several times on the grounds of

derailing the conference by taking a political and a moral (rather than a theoretical position) on my subject. The conference organizers rejected what they perceived as a crude ‘no-global/anti-globalization’ view on the emergence of black markets in human tissues and in living peoples’ solid organs (that I have elsewhere called ‘neo-cannibalism’ to give it an acceptably post-modern ring). In editing my article for publication, the editors suggested that I should strive to explicate ‘the novel intersections in geographical and social spaces, the formation of new and unexpected assemblages of institutions, biomedicines, actors, and ethics’. Rather than a simple and ‘old-fashioned’, neo-Marxist, core-periphery model of global capitalism, my data suggested to them ‘an exciting new landscape where good and bad guys and goods are distributed in both expected and unexpected places’.

But with all due respect for the changing face of late modern capitalism, the human organs markets still conform to an earlier model of mercantile global capitalism, one that bears some resemblance to the Atlantic slave trade. Like the slave routes of old, the traffic in human organs requires ‘donor’, ‘recipient’ and ‘transfer’ nations.¹² The ‘global cities’ (cf. Sassen, 1991) that provide the ‘raw materials’ – human kidneys, livers, corneas, skin, tendons, heart valves and other body parts – are Bucharest, Chennai, Chisenau, Johannesburg, Lvov, Lima, Manila and Moscow, while the ‘global cities’ that are the recipients of these body parts are Berlin, London, New York City, Philadelphia, Tel Aviv, Tokyo and Vancouver.

Like other global businesses, the kidney trade is driven by a simple market calculus of supply and demand. In the Middle East, from the Gulf states to Israel, transplantable cadaver organs are extremely scarce owing to religious reservations, both Jewish and Islamic, about the ontological status of the brain-dead donor, and to the elaborate religious protocol for the proper treatment and burial of the dead. Both orthodox Judaism and Islam permit organ transplantation, however, and their religious scholars and ethicists generally treat living donation as a meritorious act, even if the donor has been paid (Steinberg, 1996). Consequently, one solution to long waiting lists of frustrated kidney patients in this region was found in transplants abroad, in some cases with the support of government-sponsored medical insurance. For the last 20 years organized programs have carried affluent patients from Israel, Saudi Arabia, Oman and Kuwait initially to India for transplant and later to Turkey, Iran and Iraq, later to Russia, Romania, Moldova and Georgia and more recently to Brazil and South Africa where kidney sellers are recruited from army barracks, jails and prisons, unemployment offices, flea markets, shopping malls and bars. Thus one can speak of organ-donor vs. organ-recipient nations.

Transplant tourism has become a vital asset to the medical economies of rapidly privatizing hospitals and clinics in poorer countries struggling to stay afloat. In general, the circulation of kidneys follows the established

routes of capital from south to north, from poorer to more affluent bodies, from black and brown bodies to white ones, and from females to males, or from poor males to more affluent males. Women are rarely the recipients of purchased or purloined organs anywhere in the world.

Breaking and entering into the secret world of transplant

As a blend of experimental, multi-sited, ethnographic research and of medical human rights documentation, this project attempts to pierce the secrecy surrounding organ transplantation and to ‘make public’ and transparent all practices regarding the harvesting, selling and distribution of human organs and tissues. These practices are protected not only by the invisibility and social exclusion of organ donors but also by the great social trust invested in transplant medicine as an unquestioned social and moral good.

From the outset I was stymied by unwritten codes of professional loyalty and secrecy and by the impunity enjoyed by a professional medical elite. Transplant surgeons vie only with the Vatican and its cardinals with respect to their assumption of privilege, irrefutability and of a kind of ‘divine election’ that seems to place them above (or outside) the mundane laws that govern ordinary mortals. Like other humans, transplant surgeons are sometimes rogues and outlaws and their behavior causes anger, exasperation and consternation among their colleagues. Yet, like child-molesting priests among Catholic clergy, these outlaw surgeons are protected by the corporate transplant professionals hierarchy.

When I began I did not know that I would face a wall of silence, preventing access to the field by outsiders to the profession. To say the least, transplantation is an opaque rather than a transparent practice. The national and international organizations governing and regulating transplant – UNOS (US), Eurotransplant (Europe), Rio Transplant (Brazil), INCUCAI (Argentina) – collect data and publish or otherwise provide ample statistical tables but no direct access to the confidential medical data or to their files to check or verify the aggregate data. I was amused when, during a visit to Eurotransplant, I was walked through the offices, laboratories and corridors and given an excellent general orientation that ended in front of a large enclosed room with full-length glass windows on all sides, the space where the real work of matching ‘anonymous’ donor organs to ‘anonymous’ recipients took place. I could not enter, much less observe, any aspects of the decision-making process that had to be taken on faith as being totally objective. ‘See, all windows here – we are totally transparent!’ I was told by the administrator in a Kafkaesque manner.

Getting access to available statistics on the circulation of organs and

tissues was a Herculean task in some places and easy enough in others. Cuba had a paper shortage and only with great difficulty could I get two pieces of paper from a medical director at MINISAP (the Cuban Ministry of Public Health) with the numbers of transplants performed over the past five years. South Africa did not produce national statistics on transplant and organs sharing (each hospital kept their own data); São Paulo's Transplant Central (the regional board that monitored organs procurement and distribution) gave me access to aggregate data on waiting lists, but these lists turned out to include large numbers of dead patients as well as patients who had already been transplanted. Argentina's national system, INCUCAI, produced more statistics than I knew what to do with, but some of which did not 'jibe' with the data that came from the smaller regional centers of organs procurement and distribution.

In one instance I was angrily confronted by the director of kidney transplants in a large public hospital in Johannesburg about a public statement I had made to the effect that South Africa did not really have official and public waiting lists: 'How dare you say that!' Dr B. fumed. 'Of course we have waiting lists'. To prove it he took a small agenda book out of his jacket and showed me his own personal penciled-in list of transplant candidates. While this private waiting list was not exactly what I had in mind, the best and most reliable data did come from individual surgeons, hospitals, clinics, private doctors' offices and tissue banks where some individuals took the time to review their own clinical data with me.

The social world of transplant surgery is small and personal. At the upper echelons transplant medicine could even be described as a face-to-face society. Like other professionals, transplant surgeons meet frequently at international meetings where they share jokes, anecdotes and personal concerns as well as strategic information. Not infrequently, a transplant surgeon would be 'prepped' in advance of my visit by a colleague in another country who would suggest how to 'manage' the 'Organs Watch Lady'. I soon lost the kind of anonymity that makes traditional fieldwork possible, although, to be sure, this project was decidedly *un*traditional.

Despite this, I did gain considerable entrée into some corners of the secretive world of transplant medicine. I am grateful to the many transplant professionals around the world who took me in from the cold, as it were, and allowed me not only to observe them at work, but who patiently answered an endless number of impertinent questions (many of which they obviously ducked and deflected), and who in some cases gave me access to their personal data and files, an extraordinary trust that I will honor here by caution and discretion, but which provides the background to my discussion.

Perhaps one source of entrée derived from the markedly different status of anthropologists and surgeons. While surgeons occupy the highest and

most prestigious ranks in modern medicine, anthropologists occupy the lower ranks in the social sciences, especially at a time when quantitative approaches and rational choice-based models of human behavior predominate. (Anthropologists concern themselves with the ineffable and the irrational aspects of human life that are not so easily quantified.) The benefit of our exclusion from the world of 'real' power and influence is that anthropologists are generally perceived as benign, even amusing characters. We enter our research sites open-handedly and often without complicated research protocols or standardized interview questions. We visit, observe as unobtrusively as possible and try to make ourselves at home in the world, wherever that may be.

And so, I sometimes brought the tea cakes for the mid-morning tea break at the kidney transplant unit of Groote-Schuur Hospital in Cape Town, while in nearby Chris Hani shantytown, I often accompanied anxious patients to and from local hospitals via crowded combi-taxis. In the Salt River Mortuary in Cape Town I was drafted by mortuary police to accompany the bereaved relatives and friends into the viewing room to identify the dead, following a horrendous political massacre (Scheper-Hughes, 1994). On one occasion, when a young woman used my shoulder to cry on after having had to identify a dear friend who had been murdered in the above mentioned Heidleberg Pub massacre which took place during the last days of the apartheid state in South Africa, she suddenly looked up at me and asked: 'Who are you, anyway? What are you doing here?' – a question I often had to ask myself during the course of this project.

But anthropologists make ourselves 'useful' in other ways. Most of us can 'read' bodies and translate emotions across class, gender, language and culture. We know when a quiet patient is not so much calm and resigned as worried to death and we can translate those anxieties in terms of cultural views of the body, sickness, death and dying. As hunters and gatherers of human values, we are acutely conscious of, and sensitive to, ethical and moral quandaries that we interpret from a relativist rather than a universalistic perspective. Indeed, every operating room, like every Navajo family, ought to have its own anthropologist cloaked in native attire – surgical scrubs in this instance rather than fancy Navajo shawls.

Strange bedfellows: anthropology, journalism and human rights

In its odd juxtapositions of ethnography, documentation, surveillance and human rights work, this project not only blends genres but transgresses long-standing distinctions between anthropology, political journalism, scientific reporting, moral philosophy and human rights advocacy. My forays into the backstage scenes of organs procurement and transplantation



Figure 1 Scheper-Hughes in surgical ‘drag’ in the kidney transplant unit of Groote-Schur Hospital, Cape Town, South Africa. Photo credit: ©Viviane Moos

required a different set of research skills and operating procedures, best made explicit at the outset.

How does one investigate covert and criminal behavior as an anthropologist? To whom does one owe one's divided loyalties? Under normal conditions anthropologists proceed with a kind of 'hermeneutic generosity' toward the people they study. We tend to accept at face value and not to second guess much of what we are told, out of respect for the people who are our hosts. We tend to see our anthropological subjects as friends rather than as 'informants', and as collaborators and co-conspirators in our work. We expect resistance at first, but expect to win people over to what we believe can be a mutually rewarding experience. But in this study all the normal rules of fieldwork practice and ethics seemed inadequate. My task required a neutral and demedicalized language unencumbered by the transplant rhetoric of scarcities, gifts, altruism and lifesaving so that I could think in fresh and uninhibited ways about the bodies of those *presumed* to be dead, or *presumed* to be 'unidentified' and abandoned public cadavers, or *presumed* to be willing donors engaged in *presumed* acts of altruism. In other words, the research required a dose of long overdue and healthy skepticism, the best that a critical medical anthropology could offer. These ethnographic engagements required me to enter spaces and into conversations where nothing can be taken for granted and where a hermeneutics of suspicion sometimes replaced earlier fieldwork modes of bracketing, cultural and moral relativism and suspension of disbelief.

That these transgressive uses of anthropology make some of my colleagues uneasy is understandable. Neither am I entirely comfortable with what I have taken on. But I 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.

From the outset I collaborated with local anthropologists, journalists and human rights workers. For several weeks in 1999 I travelled with Dr Hernan Reyes, medical director of the International Committee of the Red Cross (Geneva), to investigate allegations of organs trafficking in Argentina and to learn something about organs procurement in Cuba, a country fairly isolated from global market forces, but with an emerging form of medical (including transplant) tourism. Dr Reyes was an informed and insightful collaborator though he did not seem to grasp the urgency of the project, given his life's work investigating allegations on torture of political prisoners – that is, (in his mind), 'real' medical abuses. But after we visited the grounds of the Montes de Oca asylum in Buenos Aires, with its vulnerable, mentally retarded blood and cornea donors, the 'trouble with transplant' began, I think, to become apparent to him.

The greatest departure from normal anthropological practice was the

several fieldtrips I took in the company of investigative reporters and documentary journalists, a class of professionals most anthropologists avoid and not without reason. Journalism is, in anthropological parlance, ‘quick and dirty’ research, similar to historians referring to journalism as providing a ‘rough draft’ of history. Anthropology follows a much slower tempo and the anthropologist is more intimate, and more personally engaged with, and responsible to, the people and the communities studied.

The disadvantage of anthropological research, however, is the normal reluctance of fieldworkers to take a critical, let alone an activist or a political stance vis-à-vis the communities and events observed, even when these concern, as they sometimes do, criminality, mass violence and genocide (Starn, 1992). Over the years, I have proposed an approach that could be called, following the late Pierre Bourdieu (2002), scholarship *with* commitment, an engaged (sometimes enraged) and militant anthropology (Scheper-Hughes, 1995). It was quite clear to me that some findings had to be made known to a broadly concerned public as quickly as possible so that measures could be taken to correct abuses that were threatening to undermine transplant medicine as a humane practice.

Thus, in March 2001, after contacting the *New York Times Sunday Magazine* section editor about my doing a story on the growing traffic in organs, I was presented some weeks later with a different option – that of collaborating with a young and at that time a ‘star reporter’, Mike Finkel. After meeting at the Organs Watch office in Berkeley we arranged to travel together to research a cover story he would write on the organs traffic in the Middle East (Finkel, 2001), relying primarily on my key sources in Israel and drawing on my published and unpublished articles and research files. While ‘ownership’ of anthropological data is of preeminent concern in conventional anthropological research, it seems to me that once we enter the sphere of human rights abuses, we need to ‘loosen up’ and to rely on all the useful collaborations we can muster.

In general, the collaborations with Finkel were collegial, though I chafed at being written out of the story and more so at his insistence that the story include portraits of satisfied as well as dissatisfied kidney sellers so as to provide a necessary balance and the appearance of neutrality. ‘But Mike’, I protested, ‘what if, in the real world, we cannot find any happy kidney sellers?’ (which pretty much turned out to be the case). He replied, ‘The story just won’t go down that way – it will look biased without at least one happy ending’ (fabricated or not; in his story, fabricated). So much, I thought, for objectivity in reporting in one of the world’s premier newspapers.

Following my Israeli leads, in December 2001, I traveled to Moldova, meeting up with Catherine Berthillier, an independent documentary filmmaker affiliated with Galaxie Presse in Paris.¹³ Together and with the

assistance of two local journalists (Alina and Oleg Radu) and a Romanian graduate student in sociology from UCLA (Calin Goiana), we approached several kidney sellers in the village of Mingir and in the capital city of Chisenu. Catherine filmed while I conducted the interviews with translations supplied by Calin. Despite differences in language, professional culture and work style, Catherine and I were both enriched by the collaboration, and Calin continued to work for Organs Watch, returning to Moldova in the summer of 2002 for follow-up fieldwork in several other villages.

In February 2002 I traveled with the Canadian journalist Marina Jimenez to Istanbul where we interviewed Eastern European kidney sellers as they stepped out of their minivans and into a flea market where these mostly illegal workers tried to find work, from house-painting to gardening and selling bootleg red wine, smuggled Russian cigarettes . . . and their own 'spare' body parts. Together, we tracked down the elusive Dr Jusef Somnez, a notorious kidney hunter and transplant surgeon, and found him operating at a small private hospital in the outskirts of Istanbul. I then made two trips to the Philippines, once in 2002 accompanied by a medical reporter (Kathy Fowler) for ABC News, Washington, DC, and once with Canadian filmmaker David Paperny in May 2003 to interview and to film kidney sellers in a huge shantytown of unemployed stevedores called Banong Lupa, and the hospitals and doctors who promote or tolerate transplant tourism in the Philippines. (*Transplant Tourism* aired on the CBC in November, 2003.) Finally, in October 2003 I met up with Brian Kates and his BBC team in Israel to film a segment of a BBC documentary on the broker networks that arranged illegal transplants for more than 50 Israelis in South African hospitals with paid donors trafficked from Eastern Europe and northwest Brazil.

Another departure from normal anthropological practice was a decision to report some of these findings to responsible officials – from the prime minister of Moldova, to the secretaries and ministers of health of the Philippines, Turkey and South Africa, and to members of Congress (US), the Israeli and Moldovan Parliaments and to a CPI (parliamentary commission of investigation) in Recife, Brazil. In giving testimony in the US Congress, to the Council of Europe, to the ethics committee of UNOS, to Eurotransplant, and serving as a temporary advisor to a World Health Organization panel on transplant ethics (October 2003), I tried to give a general picture without reference to particular individuals, hospitals or transplant specialists.

But as I became privy to information on criminal practices regarding the trafficking of desperate people as well as of purloined organs and tissues into the US, I shared some of this data, selectively, with criminal investigators from the US Food and Drug Administration, the US Attorneys Office

in New York, FBI special agents and with the State Department's Visa Fraud Division. Finally, in February 2004 I went to Durban, Johannesburg and Cape Town to work with the South African Police (SAP) in its round-up of organs traffickers. The information I gave concerned only the traffickers and surgeons and not the people who had been trafficked. The decision to do so was not easy. Anthropologists are not detectives and we are trained to hold anthropologist–informant relations as a kind of sacred trust. But in discovering that bodies of the poor were being strip-mined in an academic hospital mortuary in South Africa and shipped to Korea for 'processing' and then to the US where they were resold to biotech companies I felt I had no other option except to collaborate with investigators. Similarly, when I found that some Russian and Eastern European workers were being trafficked into the US as involuntary kidney sellers by violent, gun-wielding brokers, I shared this information with police and FBI agents. But I had no precedents to follow and had to rely on my conscience and on the values of social justice, equity and human dignity that I hold as the bedrock of anthropological humanism, as quaint and as antiquated these may seem in the posthuman age.

Behind the scenes of the organ trade

Equally problematic were the covert methods I sometimes had to use to access information on covert and illegal (as well as often highly stigmatized) activities. In some sites I posed as a patient (or the relative of a patient) looking to purchase or otherwise broker a kidney. I sometimes visited transplant units and hospital wards unannounced, posing (if anyone bothered to ask) as a confused friend or family member looking for another part of the hospital. At times I introduced myself, honestly enough, to transplant staff and nurses as 'Dr Scheper-Hughes conducting an international study of transplant', while leaving it vague just what kind of 'doctor' I was.¹⁴

In travelling incognito, as I did when investigating allegations of illegal organs and tissues harvesting at Montes de Oca, the Argentine asylum for the profoundly mentally retarded, I had only Laud Humphreys (1975) and his award-winning but ethically questionable observational study of impersonal sex in public bathrooms as a shaky reference point. Erving Goffman had once posed as a mental patient for his study of St Elizabeth's Psychiatric Hospital in Washington, DC, but such deceptions are no longer permissible for researchers operating under the strict guidelines of human subjects protection committees.

But there are times when one must ask just whom the codes are protecting. As I could see no way of having my research pass through the University of California's Human Subjects Protection Committee, I applied for an

exceptional dispensation from the university's human subjects committee, requesting that, for the purpose of this study, I be viewed as a human rights investigative reporter with the same rights as my colleagues in the Berkeley School of Journalism. Permission was eventually granted. How else, except in disguise, could I learn of the hidden suffering of an invisible, silenced and institutionalized population like the patients of Montes de Oca mental asylum (see Chaudhary, 1992)? What alternative methods of investigation exist in tortured circumstances like these? These new engagements required not only a certain militancy but also a constant self-reflexive and self-critical rethinking of professional ethics, the production of truth and the protection of one's research subjects.

I ran up against other problems, some of them more mundane but equally important. Research on covert behavior results, quite naturally, in a skewing of data. My writings on the organs traffic, to date, have emphasized illicit activities in the Middle East and in Southeast Asia where for complex reasons they are conducted more openly. I have written far less on the commerce in human organs in the US, parts of Latin America and in Europe where public denial, moral condemnation and official prohibition force the activities underground and make the work of documenting the activities far more daunting. In contrast, Iran sponsors an official government program, the only one of its kind that regulates the sale of kidneys from poor to rich. It is guardedly praised by some (see Al-Khader, 2002; Ghods, 2002) but criticized by others (see Zargooshi, 2001). Similar programs are being considered in the Philippines and Israel. In the US, more than half of all kidney transplants are using living donors, some 20 percent of whom are unrelated, 'altruistic' donors, a claim (or pretense) that many transplant centers in the US are reluctant to question (see Delmonico and Scheper-Hughes, 2002).

Meanwhile, multi-sited research (even when based on many return and follow-up trips) still runs the risk of being too thinly spread, and demanding a sacrifice of the normally leisurely pace of traditional ethnographic work. I have had to travel, observe, respond, reflect and write more quickly than I am accustomed to. One of the many ironies associated with this project was its funding via George Soros' fortune accumulated through his own global 'trafficking' in money-markets that had destabilized so many of the economies where the traffic in humans and in organs is now common, especially Eastern Europe and Southeast Asia. Another irony is that the knowledge garnered from this difficult research is being transformed – from flesh into words as it were – into a book that is every bit as much a commodity as the pink, healthy kidneys snatched from the poor. In a word, as my Brazilian favela friends often reminded me, 'Nancí, here no one is innocent'. Least of all the anthropologist herself.

Avraham R., a retired lawyer of 70, stepped gingerly out of his sedan at

the curb of the Beit Belgia Faculty Club at the University of Jerusalem in July 2000. The dapper gent, a grandfather of five, had been playing a game of 'chicken' with me over the past two weeks, ducking my persistent phone calls. But whenever I'd catch him in the flesh, rather than getting his recorded message, Avraham was a wonderful conversationalist, speaking uninhibitedly, full of zest and at length. Israeli style, most of these conversations were exchanged on cell phones while each of us was driving somewhere else in an increasingly booby-trapped terrain. In Israel today cell phones are a lifeline to an anxious people constantly checking in with each other throughout the day. Indeed, during return fieldwork in Israel in March 2001, when I accompanied the controversial former *New York Times Magazine* writer, Mike Finkel, to the Middle East for 'his' (i.e. my) story on transplant tourism (Finkel, 2001), we were twice within earshot of exploding bombs. Finkel and I wondered, given the political situation, who in the world would care about a news report dealing with Mr Tati's 'poisoned kidney' that he purchased from a peasant in Turkey and that all but cost him his life, or with Mr Sibony's furlough from a jail in Tel Aviv gotten in exchange for a kidney for his lawyer.

Each time I asked the genial Avraham for a face-to-face interview he demurred: 'It's not to protect me', he said, 'but my family'. Then, one afternoon, worn down perhaps by my repeated requests, Avraham surprised me, not only agreeing to meet me but insisting that he come over to my comfortable quarters where he settled in over a few bottles of mineral water to explain why and how he had come to the decision to risk traveling to an undisclosed location in Eastern Europe to purchase a kidney from an anonymous displaced rural worker and to face transplant in a spartan operating room ('I have more medicines in my own medicine chest than they had in that hospital', he said) rather than remain on dialysis at Hadassah Hospital as his nephrologist had suggested.

Avraham was still active and proud of his distinguished military record that had left him with more than a few scars. His noticeable limp, he said, had nothing to do with the effects of his diabetes or his kidney disease diagnosed several years earlier. As a veteran of active military service Avraham was still eligible for a transplant, but at his age, his doctors warned, such a long operation was risky. Dialysis, they said, was really his best option. But Avraham protested that he was not yet ready for the 'medical trash-heap', which is the way he and many other Israeli kidney patients now view hemodialysis. Also, like a growing number of Israeli kidney patients, he rejected the idea of a cadaver organ (the 'dead man's organ') as 'disgusting' and unacceptable:

Why should I have to wait years for a kidney from somebody who was in a traffic accident, pinned under a car for many hours, then in miserable

condition in the I.C.U. [intensive care unit] for days and only then, after all that trauma, have that same organ put inside me? That organ isn't going to be any good! Or worse, I could get the organ of an old person, or an alcoholic, or someone who died of a stroke. That kidney has already done its work! No, obviously, it's much better to get a kidney from a healthy person who can also benefit from the money I can afford to pay. Believe me, where I went the people were so poor they didn't even have bread to eat. Do you have any idea of what one, let alone 5000 dollars, means to a peasant? The money I paid him was 'a gift of life' equal to what I received.

Then, in December 2001, following one of several paths indicated by the Israeli kidney buyers I had met in Jerusalem and Tel Aviv, I found myself in a dank, freezing dug-out wine cave in Mingir, central Moldova, where a boyish young man with a rakish stud in his lower lip and a tattoo on his arm, drew each of us a glass of smoky red wine from a homemade barrel while debating just how much of his story he should tell.¹⁵ I knew only that, at the age of 19, Vladimir was one of 17 young men lured away from the village by a local kidney hunter, a former prostitute who began styling herself as an overseas employment broker during the difficult years in the late 1990s when 40 percent of the rural Moldovan labor force was working overseas. Nina arranged Vladimir's traveling papers and his bus fare to Istanbul, a 17-hour, bumpy, overnight ride from the capital city of Chisinau.

Vlad was told there was a job waiting for him at a dry cleaner's store. He was put up in a room with two other Moldovan villagers in a rundown hotel facing a notorious Russian 'suitcase market' in Askaray, Istanbul, a place where dozens of newly arrived guest workers from the former Soviet countries peddled smuggled goods and their labor for a variety of service jobs. After a week of anxious waiting Nina arrived to tell a young girl that her 'waitress' job was in a bar where lap dancing was expected. And Vlad was told that he was wanted for a lot more than pressing pants and shirts. He could start by selling some blood and after a 'match' was made, he would sell his 'best' and 'strongest' kidney for \$2700 minus his rent and food. The patient was an Israeli waiting downtown in Istanbul's most famous five-star hotel. 'I had no choice', Vlad told me the next day. 'I was scared and this was my only chance to get home again'.

Just before ducking into the wine cellar to hide from the view of his elderly father who had warned his son against talking to outsiders, Vlad had stood his ground firmly at the rickety gate to his small home, refusing to let us in. Nervously chewing sunflower seeds and spitting them out rapid-fire in our direction, Vladimir boldly demanded a 'fair price' – '200, OK, 100 dollars' – for an interview. When I slipped him a crisp \$20.00 bill Vlad nodded his head and indicated that we should follow him down into the



Figure 2 Vladimir was only 18 when he was lured from the village of Mingir to the city of Chisenau by an organs broker and from there to Istanbul where he thought he would be working in a dry cleaning store. He soon learned that he was wanted for a lot more than pressing men's pants. Like Viorel, he was forced to go through with a procedure that terrified and revolted him. 'I am a disgrace to myself and my country', the devastated young man told me. Vladimir's father was barely speaking to him at the time and Vladimir spent most of his time drinking with one or two friends in their dug out, half-frozen wine cellars. My assistant Calin and I were able to reconcile Vladimir to his father by pointing out that his son was a victim of a particularly vicious international organs mafia. Photo credit © Nancy Scheper-Hughes.

outdoor wine cellar. It was so cold that our cameras froze and all I could think about was my feet turning into bloodless blocks of ice while trying to shake out the fresh snow that had gotten inside my leather boots. We begged for another interview to take place somewhere, *anywhere*, that was indoors and warm. Vlad shook his head. That was impossible. He could not think of any place in the village where we would not be seen and he and his elderly father – the remains of what was once a strong rural family – subjected to ridicule, and opening a wound that was still fresh.

‘People in this village despise us for what we have done’, Vlad said, referring to the other young men of the village who had been either tricked into or had willingly sold a kidney abroad in the past three years. Mingir now has the distinction of being disparaged throughout the region as ‘the little village of half-men’. ‘They say we are no better than whores’, he said bitterly. Since his return home, Vlad has barely spoken to his elderly father, a recent widower in his 70s. I asked if I might not talk to his father in an attempt to convince him that his son – rather than an incorrigible juvenile delinquent – was the victim of an increasingly widespread international medical human rights abuse. Vlad was doubtful but arranged a return visit the following day. Then, recovering his cool and his youthful braggadocio, Vlad warned us, with a cocky twist of his head, that it would cost us ‘big time’ if we wanted to photograph his scar. I assured Vlad that I didn’t, having accumulated more than enough photos of those deforming saber-length scars running the length of the torsos of young, healthy peasants and urban laborers in various parts of the world.

According to Moldovan police and local human rights activists, more than 300 Moldovans have sold their kidneys abroad since 1998. At least 17 sellers are from Minjir, a rustic and hardscrabble village of 5000, while others come from surrounding villages and from the capital city of Chisenu. In an interview with Vasile Tarlev, Moldova’s prime minister, he acknowledged that the trade is linked to organized crime, but that it was difficult to ‘fight an enemy that doesn’t show its face’. The country’s intelligence service said that almost every day a Moldovan sells a kidney, despite the social stigma the trade engenders, especially in small villages. Because they have sold a priceless body part that can never be replaced, kidney sellers are held in even lower esteem than the young village women who have entered the active sex trade in order to survive the collapse of the local economy.

In Mingir, as in five other rural villages where men have been lured into the kidney trade, sellers are ostracized and excluded from the agricultural and construction labor that is the only work available to them. I was told by one agricultural team leader: ‘No one wants a “one-kidney” on their team’. The kidney sellers try to hide their scars and sometimes only their closest friends know and will compensate for their lack of strength on the



Figure 3 Ray Arceles, Banong Lupa's notorious local kidney hunter who (following his own kidney sale) was recruited by his surgeon to locate other willing paid donors. In the past few years Ray has 'helped' more than 50 of his neighbors and extended family members to sell their 'spare' kidneys, as he did, to foreigners who come to Manila's best medical centers from the Gulf States, Japan, and Canada for transplants with scarce and healthy 'fresh' [i.e., living] kidneys they cannot get at home. 'Without us', Ray says, 'the rich would die. They should be grateful to us, the poor'. Photo credit © Nancy Scheper-Hughes.



Figure 4 Niculae Bardan, age 26, was trafficked to Istanbul in 2000 from his native village of Mingir in rural Moldova, the poorest country in Europe, by a local kidney hunter. Niculae was paid \$3,000 for his kidney minus his travel expenses and a cut for the broker. Today Niculae is unable to work, is in constant pain, and has been told by the local doctor that he is showing signs of kidney failure. ‘I am not the man I was’, he told me in December 2002. Photo credit © Nancy Scheper-Hughes.

teams that are organized to prune and harvest grapes from the extensive vineyards in Mingir. Months and even years later the young men suffer from deep shame and regret. 'All I have to show for my stupidity', a young married kidney seller said, wiping a stray tear from his eye, 'is a stamp in my passport and an ugly scar on my body'. His little toddler crawled across the wedding bed that served as living room 'sofa' in their one-room home to pat her daddy on the face.

Not one of the kidney sellers I interviewed in Moldova had seen a doctor or been treated at a medical clinic following their illicit operations abroad. The young men had to be coaxed to submit to a basic medical exam at the expense of Organs Watch. The men were ashamed to appear in a public clinic as they were trying to keep the kidney sale a secret. Others were fearful of negative medical results as none would be able to pay for necessary medical treatments. One of the village men, Niculae Bardan (see Figure 1), was found to have extremely high blood pressure and signs of early kidney failure. The local doctor of Mingir asked Niculae to leave the room while he told me that the young man was eligible for total disability: 'If he does not get immediate treatment, he will lose his only kidney and he won't live to see his children leave primary school'.

On 6 December 2001, on the feast day of St Nicolas, Father Antonie, Minjir's Orthodox priest, delivered a sermon to his congregation of careworn parishioners: 'Certain of our brothers sell their body and commit a very serious sin'. He urged the local kidney sellers to confess their sins and be 'forgiven'. He called the kidney trade an 'unholy business'. 'By selling their body, they are also selling their souls', he said. 'They wanted to get rich, but they only became poorer by selling their good health. This business is an attack on all Christendom', he continued, referring to the Turkish Moslem doctors and the Israelis who make up the bulk of transplant patients. Metaphors of warfare, genocide, *jihad* and terrorism abound. The director of Chisenau's large public hospital referred to the kidney trade as 'bioterrorism' against Eastern European peasants.

In Chisenau, the urban capital of Moldova, a streetwise smuggler of 27, Viorel Vadyam, was taken in by a broker's offer of a \$300-a-month job in Istanbul. After he arrived in Istanbul he was moved from a fleabag hotel to a factory basement, while awaiting the promised job that never materialized. Finally, he was taken to the house of a Turkish 'strong man'. 'At this time they told us the truth', Viorel said. 'They wanted my kidney! I was astounded and flatly refused', recalled Mr Vadyam. 'But when I resisted, they pulled out knives and there was even a gun. I had no choice. I couldn't escape because they had my identity papers'. A few days later, Viorel was flown to the Republic of Georgia, where the infamous Dr Shapira of Bellinson Medical Center near Tel Aviv was waiting with two of his private transplant patients. In the operating room next door, the thin man with

glasses in the surgical gown waiting to take Viorel's kidney was Dr Yusef Sonmez, Shapira's transplant partner from Istanbul. Before being wheeled into the operating room, Mr Vadyam was forced to sign a document in Turkish (which he could not read) stating that he was donating his organ without coercion. 'If I hadn't gone along with it, my body could have been sent floating somewhere in the Bosphorus Strait'. Today Viorel is still angry: 'How can that man call himself a doctor? That sonofabitch left me an invalid. If I had Yusef Sonmez in front of me now, I would crush him with my own hands'. Above all, Viorel suffers from feelings of self-hate and emasculation. What Viorel's neighbors say about the slim young man is that he will never find a wife. 'No one wants a half-man to marry one of their daughters'.

Who would imagine that, in the midst of the long-standing religious and ethnic hostilities and an almost genocidal war in the Middle East, one of the first 'sources' of living donors for Israeli kidney transplant patients would be Palestinian guest workers, or that, as recently as March 2002, Israeli patients would be willing to travel to Istanbul to be transplanted in a private clinic by a Moslem surgeon who decorates his waiting room with photos of Atatürk and a plastic glass eye to ward off evil (see Jimenez and Scheper-Hughes, 2002)? Or that the transplanted kidneys would be taken from impoverished Eastern Orthodox peasants from Moldova and Romania who came to Turkey to sell smuggled cigarettes until they ran into the famous kidney brokers of Istanbul's Askaray flea market?

In some parts of the world, especially in rural Eastern Europe (Romania and Moldova in particular), naïve villagers looking for work and to make their fortunes in seemingly wealthy cities like Istanbul are tricked and coerced into parting with a kidney by knife- and gun-wielding Russian and Turkish small-time Mafia. Afterwards the kidney sellers return home to face ridicule and ostracism. While young men in Moldova are targeted by brokers as fair game for the kidney business in Istanbul, village women in the same economic straits are recruited to work abroad in more conventional forms of body selling. But both itinerant kidney sellers and female sex workers of Moldova are held in contempt at home as shameless prostitutes. 'No', said Viorel. 'We [kidney sellers] are worse than prostitutes because what we have sold we can never get back. We have given away our health, our strength and our lives'. Months and even years later the young men suffer from deep shame and regret. Vladimir broke down during a meeting in his small home in December 2000, calling himself 'a disgrace to my family and to my country'.

But in Turkey one actually finds a diverse population of kidney sellers, some of whom gather at weekends on the sidelines of a minibus station and flea market in Askaray, a dilapidated immigrant section of Istanbul. Among them are indigent Turks, small-time criminals and recently arrived



Figure 5 Viorel, a 27-year-old kidney seller in Chisenau, Moldova is still angry at Nina, the local broker, who tricked him into leaving home with the promise of a good job in Turkey. Held like a hostage in the basement of a rundown hotel in Istanbul before he was trafficked into Georgia (Russia) where Viorel gave up his kidney under threats of physical violence. 'If I hadn't gone through with it', he told me, 'My body could be floating somewhere in the Bosphorous Strait'. But he is most angry at the surgeon, Dr. Jusef Somnez, who operated on him: 'How can that son-of-a-bitch call himself a doctor? He has left me an invalid.' Photo credit © Nancy Scheper-Hughes.

immigrants from Eastern Europe. Negotiations are conducted over a cup of Turkish tea in a café across the street from the ‘suitcase market’ and away from the disapproving stares of the more conventional vendors of smuggled cigarettes, Russian vodka, Pokemon chocolates and imitation French perfumes. Like the carpet sellers and gold merchants at the famous covered bazaar of Istanbul, they haggle furiously over the price of their wares but are always willing to agree to less.

In March 2002 I sat across from Saltimis K., a 40-year-old former baker with dirt-stained fingers, a deeply lined forehead and a defeated air. ‘I never thought it would come to this’, he said of his desperate decision to enter the kidney market. Originally from a small village on Turkey’s Black Sea coast, Mr K. lost his job and now shares a one-room flat with a friend. He now lives on the \$2 a day he earns as a junkman, wheeling his wooden cart past the cheap hotels and discount leather shops in Askaray, collecting scrap metal and empty pop cans. It was in the flea market that he first heard about the brokers in suits who arrive at the weekend looking for sellers. He felt lucky, he said, to have run into our ‘broker’ (actually a Turkish journalist traveling with me in disguise, i.e. wearing a flashy suit and lots of gold jewelry) and was anxious to begin the negotiation. Mr K.’s opening price for one of his kidneys (‘left or right, your choice’) was \$50,000. In the space of a few minutes he reduced his price to \$20,000.

Mr K. believed he was a ‘perfect match’ for a kidney transplant patient with AB blood type. When questioned about it, he dismissed the two badly infected sores on his hand as superficial wounds. ‘I have had a tetanus shot’, he assured us, though he could not afford the antibiotic he was prescribed. ‘But I am clean’, he insisted, while unraveling the tattered blood and pus-stained cloth bandage on his right hand. ‘And I am healthy. I’ve only ever had the flu’. Mr K. was unafraid of the surgery because his own brother had lost a kidney as a result of untreated kidney disease and manages to make do without it. Mr K.’s only requirement was that the operation take place in a ‘good hospital’. Saltimis realized that the sale of his kidney was a radical and risky act, one for which he believed he should be well compensated (‘My final offer’, he said definitively, as we rose to leave, ‘is \$10,000’). To the guest workers from Romania and Moldova, however, the sale of a kidney seemed an unholy and unnatural act, comparable to rape, and ‘theft’ was the term most commonly employed by them, even in cases where initial consent had been given to the operation.

But for those living in parts of the world that have been subjected to centuries of colonization, forced labor and peonage, as in the Philippines, the idea of selling a spare body part seems as natural and ordinary as any other form of indentured labor. In the extensive shantytown of Bangong Lupa, Manila, for example, the majority of young men are willing, even anxious, to sell a kidney, and they express few regrets afterwards, except



Figure 6 ‘Willie’, an unemployed carpenter in Banong Lupa slum in Manila, willingly agreed to sell his kidney at St. Luke’s Episcopal Hospital to a foreign transplant tourist for \$1200 in order to get needed medical care for two of his babies who were deathly sick. The ‘kidney windfall’ came too late to help and he spent half of his hard-earned kidney money on his babies’ funerals. With the money that was left Willie purchased some consumer items, including a large radio/boom box and a fan. Willie’s wife says her husband was a fool. Photo credit © Nancy Scheper-Hughes.



Figure 7 Panoramic scene of garbage dump of Banong Lupa. Photo credit: © Nancy Scheper-Hughes.

for the natural limits imposed on other saleable body parts. ('Can I sell a testicle?' a former kidney seller from the shantytown asked me. 'Filipino men', he boasted, 'are very potent, very fertile'.)

In the same *barangay* of unemployed stevedores I encountered an unanticipated 'waiting list', which comprised angry and 'disrespected' kidney sellers who had been 'neglected' and 'overlooked' by the medical doctors at Manila's most prestigious private hospital, St Luke's Episcopal Medical Center. Perhaps they had been rejected, the men surmised, because of their age (too young or too old), their blood (difficult to match) or their general medical condition. Whatever the reason, they had been judged as less valuable kidney vendors than some of their lucky neighbors who now owned new VCRs, karaoke machines and expensive tricycles. 'What's wrong with me?' a 42-year-old man asked, thinking I must be a North American kidney hunter. 'I registered on "the list" over six months ago, and no one from St Luke's has ever called me', Mr S. complained. 'But I am healthy. I can still lift heavy weights. And my urine is clear'. Moreover, he was willing, he said, to sell below the going rate of \$1300 for a 'fresh' kidney.

Indeed, a great many eager and willing kidney sellers wait outside transplant units; others check themselves into special wards of surgical units that resemble 'kidney motels' where they lie on mats or in a hospital bed for

days, even weeks, watching color television, eating chips and waiting for the 'lucky number' that will turn them into the day's winner of the kidney transplant lottery. Such macabre scenes can be found in hospitals and clinics in India, Iraq, Iran, South Africa, the Philippines and Turkey. Entire neighborhoods, cities and regions are known in transplant circles as 'kidney belts' because so many people there have found a temporary niche in the kidney trade. One large extended family in a Philippine slum can and often does supply a steady stream of sold kidneys, borrowing strength from across the generations as first father, then son and then daughter-in-law each step forward to contribute to the family income.

The eager kidney sellers of Bangong Lupa shantytown are helped by the many new 'donors for dollars' transplant programs that are sponsored by enterprising hospital administrators. Dr B. Clemente, medical director of Capitol Medical Center in Manila, saw no conflict in advertising to foreigners (especially to patients from the US and Canada) the availability of modern transplant services at her modest hospital and of fresh kidneys procured from local donors for whom (she said) 'a few hundred dollars or even a large sack of rice is payment enough'. When asked why cadaver kidneys were not generally used, Dr Clemente replied that the Philippines was a very Catholic country in which a great many people still had strong feelings about 'the proper disposal of the dead'. As for the living? They were free to dispose of themselves as they saw fit, the good doctor replied. Donating an organ for a small compensation – 'Remember, we are not talking about sales' – was consistent, she said, with Catholic beliefs: 'They would be acting like the Good Samaritan, saving the life of a stranger'.

A militant anthropology beyond bioethics

In the *Anthropology of Reason* (1996), Rabinow characterized one dominant mode of social science practice, the vigilant virtuoso, which he exemplified in the work of Pierre Bourdieu, whose guardian spirit hovered over the Ethnografeast. The defining moment for Bourdieu's reflexive sociology was the unveiling of the lie – the illusion – of those forms of collective and individual self-deception necessary to maintain any social group: a marriage; a family; a profession; a community; or a society. The power of the sociological-anthropological imagination derives from the social scientist's claim to occupy a privileged position outside the social field and the powerful interests at play within it. Achieving such extraordinary clarity of vision demands a sacrifice – the refusal of all social action and the rejection of all personal interest in the meaning and stakes of social life. Rabinow characterized this stance as based on a set of ascetic techniques, central to which is a renunciation of the 'real' world – the world of power, action and high stakes.

But Bourdieu had long embraced what he himself called the life of an ‘engaged and militant intellectual’. In one of his last public lectures delivered in Athens in May 2001, Bourdieu discussed his active, sometimes combative, engagement with social movements, labor unions, the homeless, displaced rural workers, against the worldwide embrace of economic and cultural globalization that he insisted was a dangerous *theory* of social reality rather than a *description* of it. In his public lecture ‘Unite and Rule’, Bourdieu referred to the ‘global market’ as a political creation, and to globalization as a pseudo-concept masking a kind of neo-evolutionary model of the world in which a city or a nation’s insertions into the global market (where cities are classified as ‘global’, for example) are diagnostic of a new kind of developmental trajectory. Given the gravity of the world situation, Bourdieu called for the practice of ‘a scholarship with commitment’ toward building collective structures capable of giving birth to new social movements and new sites for international action.

It is in that same spirit that I am arguing here for a dual vision of anthropology as a disciplinary field, a traditional field of study, and as a force field, a site of political struggle and resistance. Another aspect of the struggle is epistemological. As Laura Nader has often pointed out, the truly radical promise of our discipline lies in its ability to question taken-for-granted assumptions and to problematize the received and conventional wisdoms of the day by virtue of our insistence upon reading the world from a topsy-turvy and outsider view of institutions and power relations.

Transplant surgeons often see themselves as embattled by overly cautious social norms that stand in the way of their ability to save or to prolong the lives of their patients. Most would rather not have to consider where the organs they need come from or just how they were obtained. The procurement of organs (both legal and illicit) is generally managed by third (and supposedly neutral and less self-interested) parties. Meanwhile, surgeons tend to be pragmatic thinkers who individualize ethical dilemmas and are often oblivious to the ‘larger picture’, such as the effects and consequences of certain biomedical practices and procedures on the well-being of society (the social body) or on the health of the political body, the body politic.

Transplant stories are generally told from the patient-recipient’s point of view and in a deeply affecting, emotional, rhetorical, even ideological language of gift-giving, altruism, reciprocity, lifesaving and heroism. To this day, transplant surgeries still evoke biblical sentiments and images of resurrection and of doctor-healers ‘raising the dead’.¹⁶ Thus, like visionary shamans, transplant surgeons wear a mantle of charisma that protects (sometimes even exempts) their work from critical scrutiny, especially from outside the ranks of the profession.¹⁷ Nor are bioethicists, who are so closely identified with medicine and its projects, able to break ranks with powerful biomedical and biotechnological interests. They are too embedded

within the medical culture on which they are attempting to comment. 'Morality', writes the philosopher of selfless love, Emmanuel Levinas, 'does not belong to culture; it enables one to judge it' (1988: 100).

Anthropologists, archetypal 'professional strangers' and traveling people, are better positioned to examine social and medical values from an unaligned, inside-outsider perspective and to bring into the equation the 'view from afar' as well as people, places and things that are often hidden from view.

There is a growing consensus today among the international transplant community and among the world's leading bioethicists that paid organs procured from living donors will soon supplant cadaveric donation for those organs. The sale of organs from living humans is, at least for the time being, limited to one kidney, half of a liver, or one lung – in other words those organs that are divisible or that exist 'in duplicate'. Thus, surgical practices that, not so long ago, were viewed as almost unthinkable violations of medical ethics have over a short period of time and in some parts of the world become almost routine despite the fact they still constitute violations of national laws and international regulations that prohibit and/or condemn the buying and selling of human body parts.

Today, ethical debates in transplant medicine no longer concern the redefinition of life, death and brain death (see Lock, 2000, 2002) but rather the conditions – altruistic, compensated, or some blend of gift, sale, theft and barter – under which organs may be procured from *living* donors. Today the lines are drawn between those who support some form of regulated sales (Friedlander, 2002; Radcliffe-Richards et al., 1998) and those who argue for continued 'prohibition' (see Delmonico and Scheper-Hughes, 2002) and for a renewed commitment to increase the availability of cadaver organs by various means including financial 'incentives' (see Delmonico et al., 2002), or by imposing national systems of 'presumed consent' (in its most radical form, redefining the dead body as communal or state property), through xenotransplant (the use of animal, mainly pig, organs which is becoming a realistic possibility), and through human stem cell research and experimentation with genetically altered organs.

What is going by the wayside in these new illicit medical transactions are not only laws and long-standing medical regulations but the very bedrock supporting traditional medical ethics – modernist and humanist conceptions of bodily holism, integrity and human dignity. It might be fair to ask if 'the life' that is teased out of the body of the one and transferred into the body of the other bears any resemblance to the ethical life of the free citizen (*bios*) or whether it more closely resembles the bare or naked life of the slave. Here, I am referring to the distinction made by Giorgio Agamben (1998), drawing on Aristotle's *Politics*, between *bios*, the proper life of the citizen, and *zoe* – the mere, brute life of the species. Thomas Aquinas would later

translate these ancient Greek concepts into medieval Christian terms distinguishing the natural life from the good life.¹⁸

But neither Aristotle nor Aquinas are with us. Instead, we are asked to take counsel from the new discipline of bioethics which has been finely calibrated to meet the needs of advanced biomedical procedures/biotechnologies and the desires of postmodern medical consumers.¹⁹ Even as conservative a scholar as Francis Fukuyama refers to the 'community of bioethicists' as having 'grown up in tandem with the biotech industry . . . and [at times] nothing more than sophisticated (and sophistic) justifiers of whatever it is the scientific community wants to do' (2002: 204).

Not surprisingly, bioethics has offered little resistance to the growing markets in humans and body parts. Today the 'right' to buy or sell human organs is increasingly defended in the world's premier medical journals, including *The Lancet* and *JAMA*, among others. Recently, a highly respected transplant professional defended the patient's 'right to buy' an organ as a 'mellowing' and 'maturing' of medical ethics (Friedlaender, 2002). This maturation process to which he refers is the attempt to thoroughly rationalize transplant medicine, stripping it of its early religious trappings (see below) and of its humanist biases so as to bring it into alignment with neoliberal conceptions of the human, the body, labor, value, rights and economics.

In effect, the corrective field of bioethics and the profession of transplant medicine have both capitulated to the dominant market ethos. Growing numbers of transplant doctors now argue that the real problem lies with outdated laws, increasingly irrelevant national regulatory agencies (like UNOS) and archaic medical professional norms that are out of touch with transplant realities today and with the 'quiet revolution' of those who have refused to face a premature death with equanimity and 'dignity' while waiting patiently on an official waiting list for a cadaver organ. Some argue for a free trade in human organs; others argue for a regulated market.

Transplant surgeons sometimes see themselves as 'above the law'. The younger generation of transplant doctors sees themselves as societal mavericks breaking down 'old taboos' standing in the way of advancing technological capabilities. In the face of illicit transplants with paid donors, a great many kidney transplant surgeons simply look the other way. Some actively facilitate an informal sale that will save or improve the life of one of their patients. Others prepare and counsel kidney patients for transplant trips overseas and admire the initiative of those who have returned having purchased a kidney from a hapless woman in a Lima slum or from an executed Chinese prisoner, as the case may be. Patient autonomy, individual freedom, the right to choose and the commitment to a utilitarian ethos of 'the greatest good for the greatest number' guide the sense of 'the ethical' in these illicit transplant practices.

In the rational choice language of contemporary medical ethics the conflict between non-maleficence ('do no harm') and beneficence (the moral duty to perform good acts) is increasingly resolved in favor of the libertarian and consumer-oriented principle that those able to broker or buy a human organ should not be prevented from doing so. Paying for a kidney 'donation' is viewed as a potential 'win-win' situation that can benefit both parties (see Radcliffe-Richards et al., 1998). Individual decision making and patient autonomy have become the final arbiters of medical and bioethical values. Social justice and notions of the 'good society' hardly figure at all in their discussions.

Continuing to articulate the current dilemma of transplant, under these new social conditions, in terms of scarcity, supply and demand – when the precious 'commodities' in question are increasingly attached to living bodies – creates serious ethical dilemmas for the patients and for their doctors who find themselves in the position of passively and inadvertently, or actively, creating a medically protected space for the kidney commerce. 'Who am I to second guess, let alone to judge, my patients?', Michael Friedlaender, a kidney transplant specialist at Hadassah Hospital, asked me with reference to the growing numbers of patients in his hospital-based practice who have returned from overseas having purchased a kidney.

Later, he was to write:

Here began my conversion from fierce objection to kidney marketing to passive acquiescence in this trade. We could not prevent our patients travelling to Iraq [later to Turkey, Romania, and the US]. We gave patients who asked our advice all the information I have presented here, and warned them that we could not help them outside our national boundaries, but assured them that we would immediately assist them on their return. (Friedlaender, 2002: 971–2)

'If my own kidneys failed I would opt for a transplant from a living donor', Dr Friedlaender has said on more than one public occasion. The data on different survival rates are circulated widely among kidney transplant surgeons around the world, and are frequently cited by their patients and directly contribute to the decision to abandon conventional cadaver organ waiting lists in pursuit of 'fresh' kidneys from living people.

Another consumer-based stimulus behind the occult economy in living donor kidneys and part-livers (see Liver4you@yahoo.com) is the growing rejection of hemodialysis by increasingly sophisticated kidney patients. Dialysis treatment for any period of time, even as a bridge while waiting for transplant, is increasingly viewed by kidney activists as unacceptable suffering, as time on the cross. In September 2000 a young man I will call Amatai, a 23-year-old university student from Jerusalem, flew to New York City for a kidney transplant with an organ purchased from a local 'donor'

arranged through a broker in Brooklyn. Most of the cost of the surgery (US\$200,000) was paid for by his Israeli 'sick funds' (medical insurance that is guaranteed to all Israeli citizens). Particularly noteworthy in his narrative was the almost seamless naturalization of living donation and the rejection of the artificiality of the dialysis machine:

Kidney transplant from a living person is the most *natural* solution because you are free of the [dialysis] machine. With transplant you don't have to go to the hospital three times a week to waste your time for three or four hours. And after each dialysis you don't feel very well, and you sleep a lot, and on weekends you feel too tired to go out with your friends . . . Look, dialysis isn't a normal life. You are limited to certain foods. You are not allowed to eat a lot of meat, salt, fruits, vegetables. Even if you are careful, sometimes your skin becomes yellow. Aesthetically, dialysis isn't very nice. A kidney transplant from a living donor is the very best solution.

At the same time, many kidney patients resist the idea of conventional 'waiting lists' for cadaver organs as archaic vestiges or residues of wartime triage and rationing, or worse, as reminiscent of socialist bread lines and petrol 'queues'. In the present climate of biotechnological optimism and biomedical triumphalism, the very idea of a shortage, even an organs shortage, suggests a basic management, market or policy failure. The ideology of the global economy is one of unlimited and freely circulating goods. And those new commodities are evaluated, like any other, in terms of their quality, durability and market value.

In the late modern consumer-oriented context, the ancient prescriptions for virtue in suffering and grace in dying can only appear patently absurd. But the transformation of a person into a 'life' that must be prolonged or saved at any cost has made life into the ultimate commodity fetish. And an insistence on the absolute value of a single human life saved, enhanced or prolonged ends all ethical or moral inquiry and erases any possibility of a global social ethic. Meanwhile, the traffic in kidneys reduces the human content of all the lives it touches.

For bioethicists the 'slippery slope' in transplant medicine begins with the emergence of an unregulated market in organs and tissue sales. But perhaps the dilemma actually begins earlier, with the first time that one ailing human being looks at another living person and recognizes that inside that other living body is something that could prolong, improve or extend his or her own life. But few organ recipients know anything about the impact of transplant procedures on the donor's body and the donor's social life and world. If the medical and psychological risks, pressures and constraints on organ donors and their families were more generally known, transplant patients might want to consider opting out of procedures that demand so much of the other. The division of the world into organ buyers

and organ sellers is a medical, social and moral tragedy of immense and not yet fully recognized proportions.

In addressing the darker side of transplant tourism I am breaking a long-standing taboo against 'knowing' the organ donor or acknowledging the invisible sacrifice of those whose gifted, bartered or sold organs gave new life or increased vitality to others. Organ donors, living and dead, represent a social, political and semiotic zero, an ideal place for a critical medical anthropologist to begin. In positioning myself on the 'other side' of the transplant equation in order to represent the silent or silenced organ donors, I am attempting to reconstitute living donors as rights-bearing individuals and persons rather than as faceless organs 'suppliers', 'vendors' or living cadavers and medical material for transplant procedures. In exercising a 'preferential option'²⁰ for the organ donors and sellers of the world I am not denying the dilemmas of expanding queues of waiting and expectant transplant patients who have been promised a kind of immortality by medical professionals. Poised somewhere between life and death, their hopes waxing and waning as they are left stranded on official waiting lists, these all-but-abandoned transplant 'candidates' have had their own painful stories to contribute to this project. I trust that both organ donors and organ recipients will see in this project an attempt to recapture transplant medicine from the pressures of the global market and to restore it to its senses and to its original premise of social solidarity based on a shared humanity.

A short appendix on methods

Structured and open-ended interviews (almost all of them taped and transcribed) were conducted with more than 200 transplant surgeons; transplant co-ordinators; nephrologists; nurses; ER (emergency room) and ICU (Intensive Care Unit) attendants; organs procurement specialists (from official organs of transplant surveillance at UNOS; Eurotransplant; Transplant Central in Brazil; INCUCAI in Argentina; World Health Organization); pathologists and forensic workers; police; government and political leaders; ministers of health; administrators of official and/or government organs procurement agencies and institutes, etc. Open-ended, often repeated and follow-up interviews were conducted with 87 kidney sellers in Moldova, Brazil, the Philippines, Iran (via Diane Tober), Turkey, the US and Israel. Some of this work is ongoing in Romania, the Philippines and Israel. Fourteen local kidney hunters and wealthy international organs brokers were interviewed by me either in person, directly and up front, or with me posing as a prospective buyer. In several instances my interviews with organs brokers and other intermediaries were conducted via cell phone and telephone conversations with both me and the brokers using code or pseudonyms.

By far the most difficult population to reach and to interview have been the kidney buyers. To date, I have interviewed (often repeatedly) 22 'transplant tourists' (as they prefer to be identified), the majority of them from the Middle East where there is today (as in the Philippines) an active public discussion and open debate over the practice of paid living donation and where, consequently, individuals are more willing to disclose the details of their decision to buy what they need to save or improve the quality of their lives. A final and less reliable source of information was through email exchanges and Internet websites where many hopeful buyers and sellers post their messages or have contacted me via my Organs Watch contact numbers. It was through the Internet, however, that I was able to track a notorious organs-selling fraud between the US–Nigeria–South Africa.

Questionnaires were used (with the assistance of my local research assistants) to access specific data in three different contexts: a) in several shack communities and squatter camps of South Africa to gather popular opinions on organs harvesting, transplant, the cultural meanings of the body (whole and in parts) and the relationship between transplant harvesting and the use and abuse of body parts for magical medicine (*muti*); b) in five villages of Moldova (with the help of Calin Goiana) where large numbers of villagers had been trafficked to Istanbul and Russia to sell their kidneys; and c) a large slum (Bangong Lupa) of the Philippines (with the help of Jeffrey Guissen) where close to 300 residents had sold their kidneys locally to mostly foreign tourists at local public and private hospitals. These questionnaires included such questions as: why did you sell your kidney? Was there a broker or other intermediary involved? Do you know what a kidney is for? Was the decision made freely or were there pressures or coercion? Did you discuss your decision with anyone? How much money was promised? How much money did you actually receive? What kind of pre-testing and medical screening took place (and where)? What was the surgical experience like? Were there any immediate or later complications of the nephrectomy (kidney removal)? How did you spend the money you received? What was your family income before and in the year after your sale? What was your employment before and in the year after the sale? What was your health status before and after the sale? What advice would you extend to those considering selling an organ? How did your family, friends, coworkers, community react to what you did?

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collective responsibility and might erode the dignity of human beings. It fills me with sadness to consider that such words articulated today might easily be dismissed as irrelevant and out of touch with the power and promise of the new biotechnologies and the life sciences.

Notes

- 1 Miramax sent me an advance copy of the film for review.
- 2 28 November 2000. It was alleged that a five-year-old boy, Andrei, was sold for US\$90,000 in an operation that stunned police in Ryazan, an hour's drive south of Moscow (see <http://www.cnn.com/2000/WORLD/europe/11/28/russia.children/index.html>).
- 3 Dr Hernan Reyes, chief medical director of the International Committee for the Red Cross (ICRC), and I spent two days in the archives of the newspapers *El Chronista* and *Clarín*, in Buenos Aires, following the report, 'Argentina Uncovers Patients Killed for Organs', published in the *British Medical Journal* issue 304 (25 April 1992).
- 4 In November 1999 Lawrence Cohen (1999, 2002) and I co-founded Organs Watch as a stop-gap measure in the absence of any other organization of its kind. We set as our initial task some basic, but necessary, first questions: how does the human organs market function? Who are the key players? How are the relations between organized crime, medicine, business and (in many cases) military interests structured? What 'noble lies' are concealed in the tired transplant rhetoric of gifting, scarcities, saving lives and human needs?
- 5 In the field I am often accompanied by local anthropological graduate student assistants or post-doctoral fellows, or human rights professionals, including in Argentina (Dr Maria Epele, Dr Hernan Reyes), in Brazil (Dr Mariana Ferreira, Dr João G. Biehl, Nubia Rodrigues), in Cuba (Dr Hernan Reyes), in Israel/West Bank (Limor Samimia Zuika Orr), in Moldova/Romania (Calin Goiana, Alina Radu), in Turkey (Marina Jimenez), in the Philippines (Raymond Jeffrey Guison), in South Africa (Anthony Monga Melwana) and in the US (Sheldon Davis). Lawrence Cohen, my primary collaborator in the larger project, has conducted related research in India and parts of Southeast Asia (see Cohen 1999, 2002). Several trained doctoral interns and post-doctoral research associates for Organs Watch have conducted additional research in Argentina (Juan Obarrio), Ecuador (Elizabeth Roberts), Russia (José Alaniz) and Iran (Diane Tober).
- 6 In my on-site collaborations with reporters from the *New York Times*, the *National Post* (Canada), the BBC, ABC, NBC, CBS, the CBC (Canada) and with *Envoyé Spécial* (French TV), among others, I was introduced to the

marvelous and secret (at least to ethnographers) world of ‘fixers’. Fixers are paid intermediaries, often underemployed local journalists, who set up and pave the way for initial interviews, meetings and short ethnographic forays (from arranging meetings with prime ministers and ministers of health to introductions to slum lords, thugs, brokers and criminals) in advance of one’s arrival. From there, one can readily shed the ‘fixer’ and work as a longer-term ethnographer, using or building on the initial contacts to work along more normative research channels, such as moving into a slum, or attaching oneself to a dialysis unit or a surgical unit or to a forensic institute or a hospital morgue, all of which I have done over the course of the past decade. Fixers allow the global, multi-sited ethnographer to get a toehold into a new site quickly if imperfectly. However, I could not have accomplished what I did without their invaluable help. In other words, like my kidney sellers, I, too, worked through and with the assistance of paid brokers.

- 7 See especially Chapter 7, ‘The Camp as “Nomos” of the Modern’ (pp. 166–80).
- 8 By occult economies in the organs trade I am referring to the illicit harvesting, procurement, preservation, processing and repackaging of human tissues that are circulated via free trade zones in airports so that, by the time these human products are ‘received’, their origins are unknown. At a recent WHO conference on ‘Ethics, Access and Safety in Tissue and Organ Transplant Issues of Global Concern’ (6–9 October 2003, Madrid, Spain), these tissues of uncertain origins were referred to as ‘tissues without passports’. These new and largely unregulated ‘medical products’ pose a tremendous health and safety risk.
- 9 There are no international statistics on the buying and selling of human *organs* (mostly kidneys, a smaller number of half-livers) while the international commerce in human *tissues* (corneas, bone, heart valves, tendons, pituitary glands, etc.) is very poorly regulated. In India, where official authorization committees must approve all unrelated living donor transplants, roughly 50 percent of all kidney transplants, about 1000 per annum, are performed with living, paid donors, Dr K. Ghosh reported to a special WHO advisory panel in Madrid in 2003 (see WHO, 2004).
- 10 See Ferreira and Schepher-Hughes, in press. Ferreira and I interviewed Domba, a Suya Indian recovering from a kidney transplant at the famous Hospital das Clinicas in São Paulo. Domba, a middle-aged, traditional shaman, faced his surgery with enormous equanimity in comparison to the anxious São Paulo businessman in the hospital bed next to him. The relative ease with which Brazil’s indigenous people face elective surgery is captured in the recently reported story of Sapaim, shaman and spiritual leader of the Camaiura tribe in the southern Amazon, who underwent plastic surgery after a spirit directed him in a dream to ‘change his face’.

- Sapaim reported afterwards that the operation made his face feel ‘like new’, as if he were a young boy again. See ‘Shaman Gets Facelift after Dream’, 29 April 2002, Brasilia, Brazil (Reuters).
- 11 By medical citizenship I mean the growing awareness and claims made by patients and by organized patient advocacy groups of their rights as citizens and as medical consumers to free access to medical information, including the latest cutting-edge research, to participation (or not) in experimental drug-testing procedures, to control over the conditions of one’s treatment regime and ultimately over the management of one’s sickness and death. It is a variation in the theme of ‘biological citizenship’ developed by Adriana Petryana (2002).
 - 12 One trafficking circuit that I have been monitoring on site has procured dozens of desperate denizens of the *favelas* and poor slums around Recife who are taken by commercial airline to Durban, South Africa where their kidneys are transplanted into the bodies of transplant tourists from Israel, Europe and the US (see Scheper-Hughes, 2004).
 - 13 ‘Organs Traffic’ (international version without French commentary), *c/o* Galaxie Presse, 48 rue de Paradis, 75010 Paris, France.
 - 14 Following the punch-line of a bad joke passed around among medical anthropologists, we are ‘the kind of doctor that don’t do no good for nobody, no time, no how’.
 - 15 Catherine Berthillier was filming a segment for the French ‘60 Minutes’, *Envoyé Spécial*, on organs traffic, focusing in this instance on the work of Organs Watch.
 - 16 Hence the title of Ronald Munson’s new book, *Raising the Dead: Organ Transplants, Ethics, and Society* (2002).
 - 17 This is not to suggest that active debates within transplant medicine do not take place. They do, but they are circumscribed and hidden within obscure, highly specialized medical journals and in closed conferences. As the following pages will illustrate, there is a strong tendency to close ranks within the profession and to protect the notorious transplant outlaws who are well known within the profession but who are treated with a blend of mild ostracism, envy and begrudging respect.
 - 18 Agamben (1998: 2–3) and Arendt (1958: 12–49) treat the translation from ancient Greek to Church Latin in slightly different ways.
 - 19 As bioethicists become more of a force in public policy, they are coming under scrutiny with respect to the bargains they strike with medical scientists and with biotech companies and their independence is being questioned. See, for example, ‘Bioethicists Find Themselves the Ones Being Scrutinized’, *New York Times*, 1 August 2001, A1, A14.
 - 20 This is a reference to liberation theology’s preferential option for the sick-poor. See especially Gutierrez (1987).

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