Organs Trafficking: the Real, the Unreal and the Uncanny

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The neo-liberal readjustments of societies worldwide to meet the demands of economic globalization have been accompanied by a depletion of traditional modernist, humanist, and pastoral ideologies, values, and practices. New relations between capital and labor, bodies and the state, inclusion and exclusion, belonging and extra-territoriality have taken shape. Some of these realignments have resulted in surprising new outcomes (for example, the emergence and applications of democratic ideas and ideals of "medical" and "sexual" citizenship[1] in countries such as Brazil and India, which have challenged international patent laws and trade restrictions to expand the production and distribution of generic, lifesaving drugs), while others have reproduced all too familiar inequalities. Nowhere are these trends more stark than in the global markets in bodies, organs, and tissues to supply the needs of transplant patients who are now willing to travel great distances to procure them. But rather than lament the decline of humanistic social values and social relations, we recognize that the material grounds on which once cherished values were based have shifted today almost beyond recognition.

On the Trail of Organ Stealing Rumors

Stephen Frear's film *Dirty Pretty Things* treats the traffic in human frailty and vulnerability in the shadowy underworld of immigrant London. In a particularly poignant scene Okwe, a politically framed, sleepless, haunted Nigerian doctor-refugee, hiding out as a hotel receptionist, delivers a freshly purloined human kidney in a Styrofoam cooler to a sleazy bodyparts broker waiting in the underground parking lot of the sham hotel. "How come I've never seen you before," the tight-lipped White English broker asks Okwe before gingerly accepting the strangely animate and "priceless" parcel. Barely concealing his rage, Okwe replies between clenched teeth in 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, he could have added, the ones who are even asked to provide you with our "spare" body parts.

Little did the London-based scriptwriter of *Dirty Pretty Things* realize how close to the mark his fictive portrayal of the global transplant underworld struck. But the film is a social thriller, not a documentary, and it toys with the theme of organ theft, blending elements of fantasy with realist scenes of human trafficking for kidneys. When Senay, a pretty Turkish waif pledges her kidney for a passport and visa to New York City, the filmmakers unwittingly captured a real life dilemma among illegal workers from the Third World jockeying for a toehold in the North. Filipina domestic workers overseas are often lured by unsavory brokers and traffickers into selling a kidney in exchange for help with their legal status.

The Organs Watch project had its origins in another sort of popular drama, in the circulation of bizarre rumors of body snatching and organ theft in urban shantytowns, squatter camps, and refugee camps the world over in the mid-1980s. The residents of Alto do Cruzeiro, Northeast Brazil, site of my long-term anthropological research in Northeast Brazil, reported yellow vans scouring poor neighborhoods looking for street kids and other social marginals whose bodies would not be missed. The drivers were described as North American or Japanese medical agents working for large hospitals abroad. The abducted bodies, they said, would appear later on the sides of country roads or in hospital dumpsters missing vital parts, especially eyes, kidneys, hearts and livers. "You may think this is nonsense," my ordinarily trustworthy field assistant Irene da Silva said, "but we have seen things with our own eyes in public hospitals and in police morgues, and we know better." Irene's neighbor, Beatrice, agreed: "In these days, when the rich look at us, they are eyeing us greedily as a reservoir of spare parts." Edite Cosmos added: "So many of the rich are having transplants and plastic surgeries today we hardly know anymore to whose body we are talking. Where do you think they are getting all those body parts? "

The rumors of organ theft often embellished with outlandish details, were all too easily discredited by the medical profession, who like the medical director of the police morgue in Rio de Janeiro, dismissed the charges as the ignorance of the poor who imagined that even their penises and uteruses might be taken to serve the needs of the rich. But altogether credible stories like the following, told to me by Irene Maria da Silva, a poor washerwoman from Recife, illustrate the material grounds for the profound sense of insecurity experienced by shantytown residents who are sure that almost anything can happen to themselves and to their bodies:

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"When I was working in Recife, I became the lover of a man who had a large, ugly ulcer on his leg. I felt sorry for him and I would go to his house and wash his clothes for him, and he would visit me from time to time. We were lovers for several years when all of a sudden he died. The city sent for his body. I decided to follow and make sure that his body wouldn't get lost in the bureaucracy. My partner didn't own a single document, so I was going to serve as his witness and as his identification papers. But, by the time I got to the morgue it was too late; they had already sent his body to the medical school for the students to practice on. So I followed him there and what I saw happening I could not allow. They had his body and were already cutting off little pieces of him. I demanded his body back, and after a lot of arguing they let me take it home with me. "

Buried within the rumors and urban legends of kidnapping and organ stealing were real social issues and research questions that needed to be pursued on the ground and empirically. I began following the rumors in slums and shantytowns of the third world and then following the bodies of the dead in police mortuaries and hospital morgues, and ultimately, I began following the bodies of the living who were being recruited as kidney sellers. The dead have always had their defenders, like the Brazilian washerwoman (above) and relatives and friends have posed real obstacles to the zeal of ICU and mortuary organs and tissues harvesters. The living have to fend for themselves in a new dog-eat-dog context in which unsavory organs brokers and kidney hunters are in hot pursuit of 'fresh' organs still encased in relatively healthy bodies.

Founding Organs Watch

The Organs Watch project evolved from meetings of the "Bellagio Task Force on the International Traffic in Organs" (see Rothman et al. 1997). The Task Force, of which I was a member, was a self appointed and free standing study group comprised of a dozen international transplant surgeons, transplant professionals, and medical human rights workers[2]. The Task Force met in Bellagio, Italy in 1995 and 1996 to discuss the medical, social, and bioethical consequences of the spread of organs markets and other troubling methods of organs procurement, including the use of organs from executed prisoners in China. As the sole anthropologist on the Task Force I was "delegated" to undertake exploratory ethnographic research on the social and economic context of transplantation and organ harvesting as practiced in parts of the world where reports of organs trafficking were rift but where little on-the-ground research had been conducted. I began my work in countries and sites where I already had considerable entrée- Northeast Brazil and South Africa. Lawrence Cohen, a medical anthropological colleague, soon joined the project to explore the social and economic dynamics of debt peonage and living donor kidney sales in India.

In November 1999, with funding from the Soros Foundation's Open Society Institute in New York City, Cohen and I launched Berkeley Organs Watch as a university based fact finding, documentation and research project designed to investigate and document the spread of commerce in tissues and body parts and of human trafficking for 'fresh' organs to supply the needs of international transplant tourism. Second, Organs Watch monitored the adequacy of national laws and international norms and regulations guiding transplantation in the global context. Transplant capabilities (especially kidney transplant) spread rapidly to parts of the world where new organ scarcities and demands interact with very different conceptions of medical and social ethics and in the absence of infrastructures capable of acquiring and distributing human organs by conventional means. Working together with raduate students, medical students and local field assistants, we began documenting the social meanings and effects of buying and selling organs and tissues, investigating rumors and allegations of organ and tissue theft, and attempting to pierce the secrecy surrounding transplant waiting lists (where these exist) in response to complaints of exclusions and exceptions based on social, racial, and financial factors.

Third, the Organs Watch project was motivated by a more broadly theoretical concern with the body and society in late modernity, especially the particular vulnerability of the body under neo-liberal globalization and the fragility of bio-sociality and communitas in the post-human era. Transplant has demonstrated its awesome power to re-conceptualize and refashion the human body, the relations of (body) parts to whole, and of people and bodies to each other. Organs trafficking within the context of transplant tourism provides a sharp lens to view economic globalization and its effects on conceptions of 'the human' and of life itself. Transplant practices, even illicit ones, give a unique view of who we are at the present time, how we imagine our selves and our bodies in relation to others, as intimates and as strangers, and a glimpse of how we are living and under what conditions we are willing to accede to the nevitability of death.

The bio-ethical dilemmas and quandaries of transplant can be subsumed under the four C's: [1]consumption: under what conditions is the compassionate consumption of the 'body of the other' permissible; [2]consent: the use of vulnerable populations – the dying, prisoners, the poor and the socially fragile – as organ donors and where fully informed consent is difficult to achieve; [3]coercion: the demand for sacrificial violence – bodily self-sacrifice to fulfill altruistic, kin-based, or economic survivalist needs; and, finally, [4]commodification: the fragmentation of the body and its parts as special objects of manipulation for sale and distribution. The exploration of these dilemmas entails a philosophical and moral quest for the elusive message in the bottle: Who are we? What have we become through the globalization of new medical scarcities, desires and needs?

A Note on Method

What began as a conventional exploratory research project rather quickly led the need for new fieldwork

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methods and approaches that transgressed the normally discrete boundaries among anthropology, human rights work, political journalism, and detective work. My and my associates forays into the backstage scenes of organs procurement and transplantation required a different set of research skills and operating procedures, perhaps 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. By training we tend to accept at face value, and not to second guess, much of what we are told. We try to see our anthropological subjects as friends rather than as 'informants', and as collaborators in our work. The ethnographic method is qualitative and requires building trust and penetrating the 'back stage' and 'behind the scenes' activities and practices of everyday life. Anthropological ethnography, based on participant observation of the social settings in which we immerse ourselves – be these villages, urban slums, or hospitals and medical centers – is good at making what is generally invisible seen and heard and at revealing the secret underside of things. Anthropologists expect to win people over to what we believe can be a mutually rewarding experience. But in these ethnographic encounters in the organs trafficking underworld all the normal rules of fieldwork practice and ethics were inadequate. These new engagements required me to enter spaces and into conversations where nothing could be taken for granted or on face value and where a 'hermeneutics of suspicion' replaced earlier fieldwork modes of bracketing, cultural and moral relativism, and suspension of disbelief. In other words, this research project required a dose of healthy skepticism, the best that a critical medical anthropology could provide.

The research sometimes required the use of semi-covert methods to access information on illegal or unethical activities. In some sites I posed as a patient (or as the relative of a patient) looking to purchase or otherwise broker a kidney. I sometimes visited transplant units and hospital wards unannounced and (if anyone bothered to ask) presented myself as a confused family member of a patient looking for another part of the hospital. At other times I introduced myself to a nursing sister or orderly as Dr. Nancy Scheper-Hughes, visiting the war or clinic, without qualifying just what kind of 'doctor' I was. Posing as a kidney buyer in a flea market in Istanbul in order to understand the misery that prompts a poor person to bargain over a cup of mint tea the price and value of his kidney, I was complicit in the behavior I was studying, even though I always 'debriefed' the person I had initially wronged and offered to help them insofar as I could to find another solution to their desperate need. 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. In the end, the ethics of the 'craft' of anthropology took precedence over the professional ethics of informed consent and full transparency with ones research subjects.

Another departure from the usual "lone stranger" model of anthropological research was the several brief and strategic fieldtrips I made accompanied by investigative reporters and documentary filmmakers. Anthropological fieldwork generally follows a much slower tempo, and the anthropologist is more personally intimate with, and responsible to, the people and the communities they study. But our pace is often so leisurely that, the timely moment has passed and the world has moved on to other concerns. In this instance, I felt that my findings had to be made known and communicated broadly so that a public discussion of the pressing issues could begin.

The most difficult decision concerned selectively sharing with medical and other authorities – the Council of Europe, WHO, parliamentary investigations and federal police among them – some of the information on the networks of illicit human trafficking I had discovered in the course of the research. But as I came to perceive human trafficking for organs as a medical human rights abuse, I decided that being an anthropologist (and thereby committed to protecting the confidentiality of my informants) did not mean that I had to be a "bystander" to crimes committed against the bodies of vulnerable populations. Thus, I found myself in the strange situation of interviewing transplant brokers in jail who knew that my field research had contributed to their undoing. Given these research quandaries, I do not expect the Organs Watch project to become a model for engaged anthropology[3] and I expect my refashioning of the ethnographer's craft to be greeted with lively debate and criticism.

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, onehospital, 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 Southeast 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 the liminal status known as brain dead – and others, very much alive. Following new paths in the global economy, she discovers not one but several organstrade 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.

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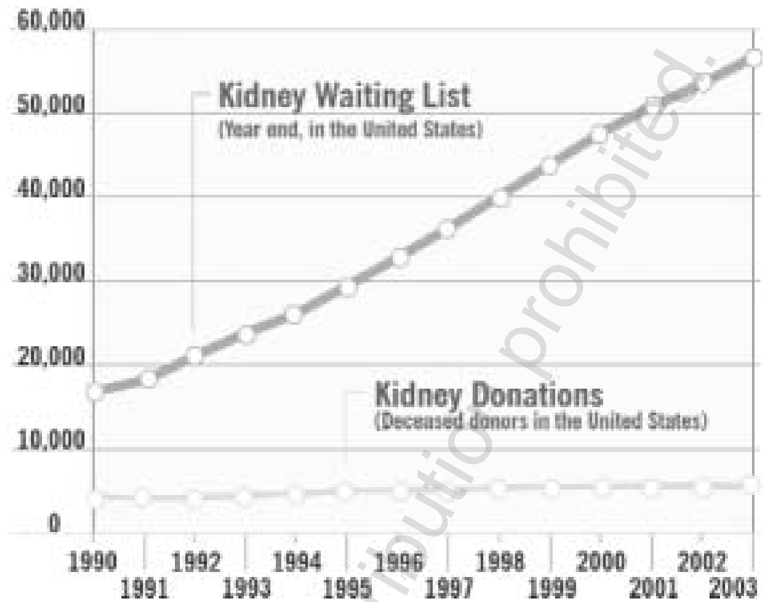
Growing Demand, Longer Lines

The number of kidney transplants performed in the United States increased by 46 percent between 1990 and 2000. During the same period, the number of kidney transplant patients on the waiting list grew by 167 percent. Trends are similar in other rich countries, where longer life spans create growing demand.

Kidney Waiting List (U.S.)

Kidney Donations (Deceased donors) (U.S.)

Source: *United Network for Organ Sharing*



The Donor Deficit

Millennial capitalism[4] has facilitated the spread of advanced medical procedures and biotechnologies to all corners of the world, producing strange markets and "occult economies. " Together, these have incited new tastes and desires for the skin, bone, blood, organs, tissue, and reproductive and genetic material of others. Nowhere are these processes more transparent than in the field of organ transplants that now takes place in a transnational space, with both donors and recipients following new paths of capital and technology in the global economy.

The above figure shows that the demand for organ transplants in rich countries is rising exponentially producing a global 'donor deficit of epic proportions, a fact all too well known to the transplant world. Less well known, perhaps, is the effects of the spread of transplant technologies on creating a global scarcity of organs. This has occurred at roughly the same time that economic globalization released an exodus of displaced and "surplus" persons to do the shadow work of production and to provide bodies for sexual and medical consumption. The global market economy provided the ideal conditions for an unprecedented movement of people, including mortally sick bodies traveling in one direction and "healthy" organs (encased in their human packages) in another direction, creating a bizarre new networks of international body trade.

Like any other business, the organs trade is driven by a simple market calculus of supply and demand. Its brokers organize transplant junkets that bring together

Rich Man, Poor Man

The trade in kidneys from live donors generally flows from poor, underdeveloped countries to rich, developed ones.

Common Countries of Origin for Those Selling Kidneys:

Common Countries of Origin for Those Buying Kidneys:

Source: *Organs Watch*

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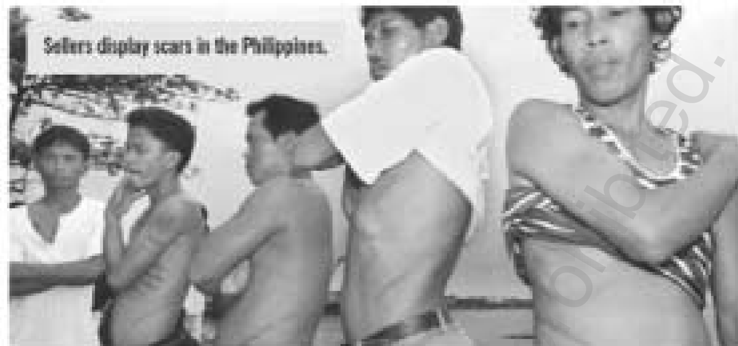
Transplant Tourism

Durban, South Africa, has become a common meeting point for buyers and sellers. In many cases, kidney sellers—"transplant tourists"—are accommodated in hotels and given sightseeing tours before and after the surgery. In 2003, South African authorities broke up an organ trafficking ring that involved South Africans, Israelis, and Brazilians.

Source: *Organs Watch*


Sellers display scars in the Philippines.

An unemployed musician holds a sign advertising his kidney for sale in Sao Paulo, Brazil, 2003.

Typical Seller Profile (Philippines)

- Age: 28.9
- Sex: Male
- Annual Family Income: $480
- Education: 7 years

Typical Buyer Profile (Israel)

- Age: 48.1
- Sex: Male
- Annual Family Income: $53,000
- Education: University degree

affluent kidney patients from Japan, Italy, Israel, Canada and the United States and Saudi Arabia with the stranded Moldovan and Romanian peasants, Turkish junk dealers, Palestinian refugees, AWOL soldiers from Iraq and Afghanistan, unemployed stevedores of Manila's watery slums and Afro-Brazilians from the favelas and slums of Northeast Brazil whom they will buy a lifesaving 'spare'part.

Transplant tourism depends on four populations: desperate patients willing to travel great distances and face considerable insecurity to obtain the transplants they need; equally desperate and mobile organ sellers; outlaw surgeons willing to break the law or ignore regulations and longstanding medical norms; organs brokers and other intermediaries with established connections to the key players in the shadowy underworld of transplant tourism.

In some developing countries – China, Pakistan, the Philippines – transplant tourism is vital to the medical economies of rapidly privatizing clinical and hospital services in poorer countries that are struggling to stay afloat. The "global cities"[5] in this nether economy are not London, New York, Tokyo, and Frankfurt, but Istanbul, Lima, Lvov, Tel Aviv, Chisenau, Bombay, Johannesburg, and Manila. However, the United States has not been isolated from this global market that pits desperate transplant patients against equally desperate poor people, each trying to find a solution to basic problems of human survival.

Transplant tourism packages, arranged in the Middle East, have also brought hundreds of affluent kidney patients to U.S. transplant centers for surgeries conducted with paid donors or with cadaver organs that are otherwise described as painfully scarce.[6] Until recently, the University of Maryland Medical Center, advertised its kidney transplant program in Arabic, Chinese, Hebrew, and Japanese on its website.[7] Mt. Sinai Hospital in New York City published promotional advertisements on its transplant capabilities in the *Wall Street Journal* and in the *International Herald Tribune*. The United States is very democratic in at least one sense – anyone with enough cash, regardless of where they come from, can become a "medical citizen" of the U.S. and be transplanted, even with a scarce "made in the U.S.A. " transplant organ.

On the one hand, the spread of transplant technologies, even in the murky context of illicit surgeries, has given the possibility of new, extended, or greatly improved life to a select population of mobile kidney patients from the deserts of Oman to the rain forests of Central Brazil.[8] On the other hand, the spread of "transplant tourism" has 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 purchased from living bodies.

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. We can even speak of organ donor versus organ recipient nations.

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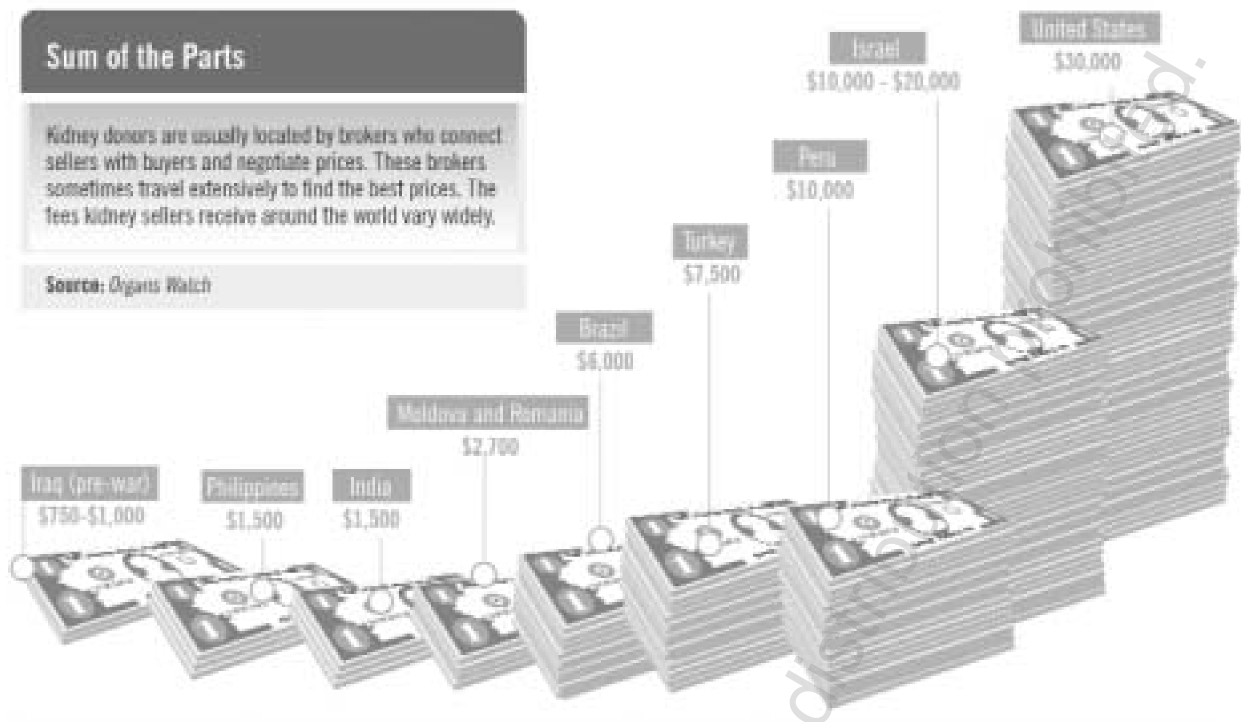

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The commodified kidney is, to date, the primary currency, in transplant tourism; it represents the gold standard of organ sales worldwide. But markets in part-livers from living vendors are beginning to emerge in Southeast Asia, a phenomenon I have referred to elsewhere as the "end of the body" to signal a radical historical conjuncture, a rupture in the 'exceptional status' once granted by moral philosophers to the human body as exempt from commodity candidacy, not to be reduced to an object, a mere 'thing', like any other – pork butts or mechanical 'weegies' – that can be bought, bartered and sold.

In all, the strange markets, excess capital, occult medical economies, renegade surgeons,[9] and local rings of "kidney hunters" with links to an international Mafia[10] exist side by side with a parallel traffic in slave workers, adoptive babies, drugs, and small arms. This confluence in the flows of immigrant workers and itinerant kidney sellers is a troubling subtext in the story of late 20th and early 21st century economic globalization.

The entry of markets (black and gray) and market incentives[11] into organs procurement has thrown into question the tired transplant rhetoric on "organs scarcity. " There is obviously no shortage of desperate individuals willing to sell a kidney, a portion of their liver, a lung, an eye, or even a testicle for a pittance. But while erasing one vexing scarcity, the organs trade has produced a new one – a scarcity of transplant patients of sufficient means and independence and who are willing to break, bend, or bypass laws and longstanding codes of medical ethical conduct.

Post-Human Transplant Ethics

From its inception, transplant medicine put severe demands on modernist conceptions of the body, the person, and the meanings of life and death. For one, transplantation demanded a radical redefinition of death, to allow the immediate harvesting of organs from bodies neither completely dead nor yet still living, which to this day still troubles many of the world's religious leaders and a surprising number of medical specialists[12] – not to mention the relatives of the nearly dead, who so often refuse to allow the term to be applied to their loved ones and prevent harvesting from taking place.

Diametrically opposed to the "softer" medical ethic of the clinic and the emergency room, based on a commitment to save the sickest, transplant ethics originally operated on the less 'civil' ethic of the lifeboat and of the battlefield, based on a commitment to save the salvageable and to allow the sickest to die. But as transplant capabilities developed and the desires for transplant have "democratized", medical consumers have begun to challenge the old battlefield triage and are demanding an end to "wartime" rationing based on scarcities that could be addressed by applying neo-liberal market principles to organs harvesting and thereby legally tapping into the bodies of the living.

This move to organs markets has required a radical breach with, or a highly selective use of, classical medical ethics, based worldwide on a blend of Aristotelian theories of virtue (wisdom, courage, temperance, and justice), and the Hippocratic ethic of purity, loyalty, compassion, and respect for the dignity

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of the individual. In the Hippocratic tradition of medical ethics, with its markedly individualist conception of physician responsibility and virtue, the physician may be seen as owing his loyalties to the patient alone, as if society – let alone the rest of the world – did not exist. In recent years, and in response to the privatization and commercialization of medicine (transplant in particular), many surgeons now espouse a frankly post-humanist utilitarian ethic based on the moral philosophy of John Stuart Mill[13] and Jeremy Bentham,[14] but stripped of their original social content and concerns.

In an essay published in *The Lancet*[15] a few years before his untimely death, Michael Friedlaender, transplant nephrologists at Hadassah Hospital in Jerusalem, explained his about-face with respect to accepting the "greater good" that can result from adopting a utilitarian ethic with respect to the individual's right to buy (or sell) a kidney: "Recently I was told [by Nancy Scheper-Hughes] that I am a utilitarian. I had always considered myself a humanitarian, but I have since developed some doubts about my beliefs. " He could not deny the growing number of kidney patients in his unit, both Jews and Arabs, who had traveled abroad for a transplant, Jews to Eastern Europe and Arabs to Iraq, returning with a purchased kidney from a living 'donor'. Although a few patients became seriously ill and more than one died as a result of the illicit transplant, most fared as good and often better than those transplanted safely at home with a cadaver kidney. "If I were ill with kidney disease I would do the same", Friedlaender said on many occasions, although he did not counsel his own patients to break the law to save themselves.

Friedlaender saw the current situation as having all the elements of a classic Shakespearean tragedy in which identifiable Ophelias, Desdemonas, King Lears and Shylocks paraded in and out and around today's operating 'theatres'. "The pound of flesh which I demand of him/Is dearly bought as mine, and I will have it" (4.1.94) Friedlaender would often quote during his elegantly argued but morally tortured presentations to fellow surgeons, moral philosophers, and medical anthropologists in which he defended 'the right to buy a kidney'. The good doctor was all too keenly aware of the paradoxes inherent in his position. He was bold and courageous in arguing for an end to the current donor deficit impasse that had paved the way for independent brokers and black markets which have engendered antagonisms toward Israel as an unsuspecting global leader in transplant tourism. Indeed, the kidney trade evokes a timeless moral and ethical "gray zone"[16] – the lengths to which it is permissible to go in the interests of saving or prolonging one's own life at the expense of diminishing another person's life or sacrificing cherished cultural and political values (such as social solidarity, justice, or equity).

In the following discussion I will draw on several ethnographic sites and scenes of organ buying and selling in order to contrast the highly variable meanings and medical and social consequences of selling (or buying) a body part (in Israel, Moldova, the Philippines, and Brazil) with a growing consensus in the international transplant community that supports a patient-centered ethic that includes the right to purchase advanced, expensive, and experimental biomedical/surgical procedures, as well as to buy and sell body parts from the living and the dead. Both are compatible with neo-liberal economics. Indeed, commercialized transplant exemplifies better than any other biomedical technology the reach of economic liberalism. Transplant technology trades comfortably in the domain of postmodern biopolitics, with its values of disposability and free and transparent circulation. The uninhibited circulation of bought and sold kidneys exemplifies a neoliberal political discourse based on juridical concepts of the autonomous individual subject, equality (at least, equality of opportunity), radical freedom, accumulation, and universalism, expressed in the expansion of medical rights and medical citizenship.

In fact, however, what makes transplant tourism possible are networks of organized crime that are responsible for putting into circulation and bringing together ambulatory organs buyers, outlaw surgeons, illicit and sometimes makeshift transplant units, and clandestine laboratories in an example of what economist Jagdish Bhagwati[17] refers to as "rotten trade. " Rotten trade refers to any trade in "bads" – arms, drugs, stolen goods, and hazardous and toxic products, as well as traffic in humans, babies, bodies, and slave labor. The organs trade is fueled by a dual "waiting list, " one formed by sickness, the other by misery. We have found almost everywhere a new form of globalized "apartheid medicine" that privileges one class of patients, organ recipients, over another class of invisible and unrecognized "nonpatients", about whom almost nothing is known.

Scenes from the Field

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. Each time I asked the genial grandfather for a face-to-face interview, he demurred: "It's not to protect me, " he said, "but my family. " Then, one afternoon, Avraham surprised me, not only agreeing to meet me but insisting that he come over to my comfortable quarters where, over a few bottles of mineral water, he explained 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 "peasant, " 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 eligible for a transplant, but at his at his age, his doctors warned, such a long operation was risky. Dialysis, they told him, was really his best

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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. And, like a growing number of 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 five thousand dollars, means to a peasant? The money I paid him was ‘a gift of life’ equal to what I received.

Then, in December 2001, during an early snowstorm, I ducked into a small, dark, subterranean wine cave in the rustic little village of Mingir, Moldova. There, once out of earshot of his elderly father and beyond the prying eyes of disapproving neighbors, 22-year-old Vladimir, a skinny lad with a rakish metal stud in his lip, explained how he had been approached a few years earlier by Nina, a local kidney hunter, who arranged his passport, visa, and bus ticket to Istanbul, a bumpy 18-hour overnight ride. With the demise of the Soviet Union, the agricultural economy of rural Moldova collapsed in the mid-1990s. Here, in the heart of central Europe, economic globalization has meant one thing only for agricultural villagers – that 40 percent of the adult population has had to leave home to find work abroad. Today, Moldova is the poorest country in Europe: an indigenous “third world” within European borders.

Once in Istanbul, Vladimir was housed in the basement of a run-down hotel facing a notorious Russian “suitcase market” in the tough immigrant neighborhood of Askary. He shared the space with several other Moldovan villagers, including a few frightened village girls barely out of high school. First, Nina arrived to break the news to one of the girls that her “waitressing” job would be in a bar where “exotic” dancing was required. Then Vladimir was told that he was wanted for more than pressing pants. He would start by selling a few pints of his blood and once a “match” was found, he would be taken to a private hospital where he would give up his “best” kidney for $3,000, less the cost of his travel, room, and board and the fees for his “handlers. ” And a few days later Vlad was told that an elderly transplant patient from Israel, who had traveled to Istanbul with his private surgeon, was matched and ready to go. When Vlad demurred, Nina arrived with her pockmarked, pistol-carrying Turkish boyfriend, who told Vladimir that he was quickly losing patience. “Actually, ” Vlad says ruefully, “If I had refused to go along with them, my body minus both kidneys, and who knows what else, could be floating somewhere in the Bosporous Strait. ”

Safely home again – or so they think – hapless kidney sellers such as Vladimir face ridicule and ostracism. Both kidney sellers and female sex workers are held in contempt in rural Moldova as shameless prostitutes. Months and even years later, these young men suffer from feelings of shame and regret – like Nicolae, a 26-year-old former welder from Mingir, who broke down during an interview in December 2000, calling himself “a disgrace to my family, my Church, and my country.”

While kidney selling is deeply stigmatized in Moldova, where it is symbolically linked to prostitution, it is a routine event in the slums and shantytowns of Manila in the Philippines even though the operation has put a great many young men out of work there. “No one wants a kidney seller on his work team,” an unemployed kidney seller and father of three told us, while his wife fumed at him from across the room.

Across the globe in the Philippines kidney selling is routine and ordinary in some urban slum communities. Bangon Lupa is a garbage-strewn slum built on stilt shacks over a polluted and feces-infested stretch of the Pasig River that runs through the shantytown on its way to Manila Bay. In Bangon Lupa, “coming of age” now means that one is legally old enough to sell a kidney. But, as with other coming of age rituals, many young men lie about their age and boast of having sold a kidney when they were as young as 16 years old: “No one at the hospital asks us for any documents” they assured me. The kidney donors lied about other things as well – their names, addresses, and medical histories, including their daily exposure to the general plagues of the third world – TB, AIDS, dengue, and hepatitis, not to mention chronic skin infections and malnutrition.

In this barangay of largely unemployed stevedores, I encountered an unanticipated “waiting list,” comprised of 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. When word spread that I was looking to speak to kidney sellers, several scowling and angry young men approached me to complain: “We are strong and virile men, and yet none of us has been called up to sell. ” 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. But 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 an American kidney hunter. “I registered six months ago, and no one from St. Luke’s has called me... But I am healthy. I can lift heavy weights. And my urine is clean. ” Moreover, he was willing, he said, to sell below the going rate of $1,300 for a fresh kidney.

When one donor is rejected, another, younger and more healthy looking, family member is often

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substituted. And kidney selling becomes an economic niche in some families that specialize in it. Indeed, one large extended family Bangong Lupa supplied St. Luke's Hospital with a reliable source of kidneys, borrowing strength from across the generations as first father, then son, and then daughter-in-law each stepped forward to contribute to the family income.

The Consumers – The Expansion of Medical Citizenship

Finding an available supply of organ vendors was only a partial solution to the new scarcities produced by transplant technologies. The tempting 'bio-availability' of poor bodies has been a primary stimulus to the 'fresh organs' trade. Today, 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 hospital beds 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. Entire neighborhoods, cities, and regions are known in transplant circles as "kidney belts" because so many people there have entered the kidney trade.

More difficult is locating patients of sufficient economic means to pay for these expensive operations, as well as sufficiently courageous to travel to the largely third world locations where people are willing to selfmutilate in the interests of short-term survival. Here is a classic problem in microeconomics – one of supply and demand side sources separated by vast geographies, different cultures, and even by fierce religious and political hostilities.

Who, for example, would imagine that, in the midst of the longstanding 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 Ataturk and a plastic glass eye to ward off evil? 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 Askary flea market?

New forms of social kinship and "bio-sociality" must be invented to link strangers, even at times political "enemies" from distant locations who are described by the operating surgeons as "a perfect match – like brothers, " while they are prevented from seeing, let alone speaking to, each other. If and when these "kidney kin" meet at all, it will be by accident and like ships passing in the night, as they are wheeled, heavily sedated, on hospital gurneys into their respective operating rooms, where one surgeon removes the seller's kidney of last resort and the other inserts the buyer's kidney of opportunity.

Transplant patient advocacy groups have sprung up in many parts of the world, from Brazil to Israel to Iran to the United States, demanding unobstructed access to transplant and to the lifesaving "spare" organs of "the other," for which they are willing to pay a negotiable, marketdetermined price. They justify the means by recourse to the mantra that it will "save a life". However, many kidney patients have, but reject the option of hemodialysis, weakening the "lifesaving" argument. The problem is that dialysis, even as a bridge while waiting for transplant, is increasingly viewed by sophisticated kidney activists today as unacceptable suffering. In September 2000, 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. The cost of the surgery ($200,000) was paid for by his Israeli "sick funds" (medical insurance that is guaranteed to all Israeli citizens). Noteworthy in his narrative is an almost seamless "naturalization" of living donation accompanied by a 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. There are still a lot of poisons in the body and when you can't remove them, you feel tired. Look, it isn't a normal life. And also you are limited to certain foods. You are not allowed to eat a lot of meat, salt, fruits, vegetables. Every month you do tests to see that the calcium level is OK, and even so your skin becomes yellow. Esthetically, it isn't very nice. So, a kidney transplant from a living donor is the best, and the most natural solution".

Similarly, many kidney activists reject conventional "waiting lists" for organs as archaic vestiges of wartime triage and rationing, or reminiscent of hated socialist bread lines and petrol "queues." In the present climate of biotechnological optimism and biomedical triumphalism, any shortage, even of body parts, is viewed as a basic management, marketing, or policy failure. The ideology of the global economy is one of unlimited and freely circulating goods. And these new commodities are evaluated, like any other, in terms of their quality, durability, and market value. In today's organs market, a kidney purchased from a Filipino costs as little as $1,200, one from a Moldovan peasant $2,700, and one from a Turkish worker up to $8,000, while a kidney purchased from a housewife in Lima, Peru, can command up to $15,000 in a private clinic.

Bioethics – Handmaiden of Free Market Medicine?

What goes by the wayside in these new medical transactions are the modernist conceptions of bodily holism, integrity, and human dignity, not to mention traditional Islamic and Judeo-Christian beliefs in the "sacredness" of the body. Free market medicine requires a divisible body with detachable and demystified organs seen as ordinary and "plain things,"

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simple material for medical consumption. But these same "plain" objects have a way of reappearing and returning like the repressed, when least expected, almost like medieval messengers and gargoyles from the past, in the form of highly spiritualized and fetishized objects of desire. As Veena Das once wryly observed, "An organ is never just an organ."

Indeed, the highly fetishized kidney is invested with all the magical energy and potency that the transplant patient is looking for in the name of "new" life. As Avraham, the Israeli kidney buyer put it: "I was able to see my donor [from a village of Eastern Europe]. He was young, strong, healthy, and virile – everything I was hoping for."

It might be fair to ask if the life that is teased out of the body of the living donor bears any resemblance to the ethical life of the free citizen (bios) or whether it is closer to what Giorgio Agamben, 18 drawing on Aristotle's Politics, referred to as zoe – brute, bestial, or bare life, the unconscious, unreflective mere life of the species? Thomas Aquinas would later translate these ancient Greek concepts into medieval Christian terms that distinguished the natural life from the good life.[19]

But neither Aristotle nor Aquinas is with us. Instead, medical practitioners consult and take counsel from the new specialists in bioethics, a field finely calibrated to meet the needs of advanced biomedical biotechnologies. Even as conservative a scholar as Francis Fukuyama refers to the "community of bio-ethicists" as having "grown up in tandem with the biotech industry... and is [at times] nothing more than a "sophisticated (and sophistic) justifiers of whatever it is the scientific community wants to do."[20]

The field of bioethics has to date offered little resistance to the growth of markets in humans and body parts, and many now argue that the real problem lies with outdated laws, increasingly irrelevant national regulatory agencies (such as UNOS), and archaic medical norms that are out of touch with economic 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.[21] Some argue for a free trade in human organs; others, like the philosopher Janet Radcliffe-Richards, argue for a regulated market.

In the meantime, the rupture between practice and the law can be summarized as follows: while commerce in human organs is illegal according to the official legal codes of virtually all nations where transplant is practiced, nowhere are the renegade surgeons (who are well known to their professional colleagues), organs brokers, and kidney buyers (or sellers) pursued by the law, let alone prosecuted. It is easy to understand why kidney buyers and sellers would not be the focus of prosecution under the law. Compassion rather than outrage is the more appropriate response to their acts. But the failure on the part of governments, ministries of health, and law enforcement agencies to interrupt the activities of international transplant outlaws, their holding companies, money laundering operations, and Mafia connections, can only be explained as an intentional oversight.

Indeed, some of the most notorious outlaw transplant surgeons are the medical directors of major transplant units, who serve on prestigious international medical committees and on ethics panels. None have been censured by their own profession, though a few have been investigated, and some live in self-imposed social isolation. But all practice their illicit surgeries freely, though some move their bases of international operations frequently so as to avoid medical or police surveillance. One of transplant medicine's most notorious outlaws, Dr. Zaki Shapira, recently retired from Bellinson Medical Center near Tel Aviv, served on the prestigious international "Bellagio Task Force" investigating the global traffic in organs, of which I was also a member.[22] In one of his subsequent trips to Italy, he was the recipient of a prestigious human service award. Meanwhile, one of Dr. Shapira's transplant tour patients from Jerusalem provided me with copies of his medical and financial records that led to a fraudulent medical society in Bergamo, Italy, to whom the patient had sent the $180,000 that his illicit transplant (in Turkey) had cost.

The impunity of these transplant outlaws concerns more than government lassitude and obvious professional corruption. Outlaw surgeons are also protected by the charisma that accompanies their seemingly miraculous powers over life, death, and adverse circumstances. As much as his younger colleagues worry about Dr. Shapira's questionable ethics, they praise his surgical technique and his "golden hands." The head of the Turkish medical ethics committee lamented that Dr. Yusef Somnez, the "Doctor Vulture" of Istanbul fame, was one of Turkey's most celebrated transplant surgeons. "Somnez is the man who put transplant on the map in Turkey," he said.

Some transplant surgeons themselves see themselves as "above the law", a tradition they inherited from the early days of transplant, when the "founding fathers, " such as Christian Bernard in South Africa and Thomas Starzel in the United States, battled against prevailing social norms and those who resisted transplant's redefinition of death to allow the removal of "fresh" organs to transplant from neo-morts or quasi-morts. That same sense of embattlement continues today among transplant surgeons who may publicly support international regulations against buying and selling organs, but who privately say that this is the only solution to organs scarcities. In the face of illicit transplants with paid donors, many surgeons simply look the other away. Others actively facilitate sales, while others counsel kidney patients for transplant trips overseas and care for them on their return from a trip to South America, South Africa, or China, where organs are purchased from the living or (as in the case of China) taken from an executed prisoner.

In the rational choice language of contemporary medical ethics, the conflict between non-malfeasance ("do no harm") and beneficence (the moral duty to perform good acts) is resolved in favor of the market

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and consumer-oriented principle that those able to broker or buy a human organ should be allowed to do so. Paying for a kidney "donation" is viewed as a potential "win–win" situation that can benefit both parties.[23] 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 their discussions. In the post-humanist context, the idea of virtue in suffering and grace in dying can only appear as 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. A belief in the absolute value of a single human life saved or prolonged at any cost ends all ethical inquiry and erases any possibility of a global social ethic. And the traffic in kidneys reduces the human content of all the lives it touches.

Strange Bedfellows: Transplant Medicine and the Organs Mafia

Illicit transplant transactions are obviously complex and require expert teamwork among technicians in blood and tissue laboratories, dual surgical teams working in tandem, nephrologists, and post-operative nurses. Travel, passports, and visas must be arranged. These awesome organizational requirements are arranged in many parts of the world by a new class of organs brokers, ranging from sophisticated businessmen, medical insurance agents, and travel agents to criminal networks of armed and dangerous Mafia to the local "kidney hunters" of Istanbul, Bangong Lupa, and Mingir. In Israel and the United States religious organizations, charitable trusts, and patient advocacy organizations sometimes harbor organs brokers. I have identified a large network operating between Israel and several cities in the United States on both coasts. Some have recruited organ donors locally, while others have recruited Russian and Moldovan immigrants, ex-prisoners, and other marginalized people who have been smuggled into the U.S.A. as tourists.

The outlaw surgeons who practice their illicit operations in rented, makeshift clinics or, just as often, in operating rooms of some of the best public or private medical centers in the city, do so under the frank gaze of local and national governments, ministries of health, regulatory agencies, and professional medical associations. In short, the illegal practice of transplant tourism, which relies on an extensive network of body brokers and human traffickers, is a public secret, one that involves some of the world's most prestigious hospitals and medical centers. Transplant crimes – even when they explode into gunfire and leave a trail of blood – (as they had in Manila several years ago) – normally go undetected and unpunished. And some of the more active and competitive surgeons can find themselves trapped and more deeply involved in "the business" than they had ever anticipated.

In addition to organized crime, the organs business is often protected by military and state interests, particularly during periods of political conflict and war.

Israel became embroiled in the international kidney trade when a small market in living donors that that began in the West Bank moved to Turkey when the government of Israel chastised the surgeons who were involved in the recruitment of Palestinian donors.

Israeli citizens purchase, proportionally, the largest number of organs per capita in the world. Caught between a highly educated and medically conscious public and a very low rate of organ donation, the Israeli Ministry of Health has expedited the expansion of transplant tourism by allowing Israeli patients to use their national insurance to pay for transplants conducted elsewhere, even if illegally. The cost of the transplant "package" increased from $120,000 in 1998 to $200,000 in 2001. The cost includes the air travel, bribes to airport and customs officials, "double operation" (kidney extraction and kidney transplant), the rental of operating and recovery rooms, and hotel accommodation for accompanying family members. The donor fee of between $3,000 and $15,000 (depending on the status of the donor) is also included.

Corrupt business men and their associates have formed "corporations" with ties to established medical centers and to rogue transplant units (public and private) in Turkey, Russia, Moldova, Estonia, Georgia, Romania, Brazil, South Africa and the United States. The specific sites of the illicit surgeries are normally kept secret from transplant patients until the day of travel. And the locations are continually rotated to maintain a low profile. The surgeries are performed at night in rented operating rooms. In one plan that originated in Israel in the late 1990s, Israeli patients and doctors (a surgeon and a transplant nephrologist) were flown by a small commercial airline to a hospital in a town on the Turkish-Iraqi border for illegal transplants with kidneys procured from Iraqi soldiers and guest workers. Israeli and Turkish doctors and their patients also flew to Estonia and to Russia for commercialized transplants using unemployed workers from elsewhere in Eastern Europe. In a third and more recent scenario, kidney sellers were recruited from the slums and favelas of Recife, Northeast Brazil, (by brokers including a military police officer) and sent by plane to Durban and Johannesburg in South Africa where they were met by South African brokers who 'matched' these unfortunates up with Israeli patients arriving from Tel Aviv. In this instance South African surgeons operated independently, without Israeli surgeon accomplices.

The participation of South Africa's largest HMO, Netcare, and Israel's national insurance programs in the illegal multi-million dollar transplant tourism business, which has made Israel into something of a pariah in the international transplant world, and also sullied South Africa's 'grand' tradition of transplant medicine, requires some explanation. In Israel, the absence of a strong culture of organ donation, an inadequate national system of cadaver organs 'capture' and the pressure exerted by angry transplant candidates, has contributed to a belief (in Ministry of Health circles) that each patient transplanted abroad is one less angry and demanding client at home. The

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corruption of South Africa's private hospitals, surgeons and health maintenance organizations (HMOs) was in part the result of the withdrawal of public support for transplant surgery, previously provided under the apartheid regime for white South Africans. The channeling of public funds for primary health care resulted in the privatization and commercialization of tertiary medical care, including transplant surgery. Indeed, if transplants are to happen at all in South Africa today they must be paid for by private insurance. This state of affairs paved the way for illicit transplant tourism. One hardly needs to explain why Northeast Brazil became the target of active recruitment of desperate and hungry kidney sellers? Despite President Lula's "Zero Hunger" program, hunger and other raw needs are still commonplace in the slums and rural villas near Recife's international airport. Young mostly Afro-Brazilian men were ideal candidates for kidney forfeit.

Operation Scalpel – Policing the Trans-Atlantic Kidney Scam

A kidney purchased from a slum dweller in Recife, from 2003 to 2004, began at $10,000 and rapidly decreased to $6,000 and then $3,000 when police interrupted an aggressive trafficking scheme that recruited more than a hundred kidney patients from Israel, Europe and the United States, and kidney sellers from the slums of Brazil for illicit transplant transactions that took place in a private Netcare clinic of Durban's premier private medical center, St. Augustine Hospital. Among the Brazilian kidney sellers coaxed to South Africa in 2003 were dozens of undernourished and unemployed men who dreamed of finding a way out of their economic difficulties. When Gaddy Tauber, a lean and mean-looking ex-Israeli Defense Force broker, and his Brazilian side-kick, Captain Ivan, a retired military policeman, set loose rumors of $10,000 to be made in South Africa by parting with a "spare" kidney, a stampede of willing "donors" lined up to sell an "inert" part of themselves they had never thought very much about. The Brazilian sellers hoped they would be able "to see the world, " even if it was no more than a "safe house" in Durban where they were kept as virtual prisoners and a shared hospital room at St. Augustine's Hospital where they tossed and turned with the agony of post operative pain. Later the hapless kidney sellers, who were actually paid between $6,000 and $3,000, grieved the loss of the "little thing" (the missing kidney) that constantly announced its absence with a tingling or itching at the site of their ugly wound. "What have I done to myself", Paulo, a house painter in a slum of Recife, asked himself aloud. Today, depressed and disgruntled, the disillusioned kidney sellers of Areas slum in Recife meet among themselves to share their anxieties about their loss of work, of reputation, their strength and their health.

But at least the trans-Atlantic trafficking scheme was interrupted by the Brazilian Federal Police sting called "Operation Scalpel", which put the key brokers, Gaddy Tauber and Captain Ivan, away in military brigs in Recife where they are serving long sentences (10 + years) for their crimes: fraud, organ selling and organized crime. Taking a drag on his cigarette during Sunday visiting hours in July 2005, Gaddy was resigned and philosophical. "I broke the law", he told me in his thickly accented Israeli-English. "I deserve to be here. But in my defense I saved many Israeli lives with the kidneys the guys sold of their own free will. Did I torture them? Did I beat them up? No! Did I force them to get up on the operating table? No! They did it to themselves. So I ask: who was the victim of this victimless crime?"

Captain Ivan, housed in a small cell in another military battalion headquarters, denies his involvement in the trafficking scheme. He angrily claims that he was a fall-guy and a minor figure, duped by Gaddy Tauber and betrayed by some of the kidney sellers who, he said, became active brokers and kidney bounty hunters themselves that later turned on him to protect their own skin. As for the South African surgeons and transplant coordinators in Durban who, as Geremias, a Brazilian kidney seller puts it, "took what they wanted from us and then threw us away like garbage", are free on bail. They are, and I hope nervously, awaiting the medical trial of the century to be held in a South African court before the end of 2006. The surgeons and their associates have been charged with three crimes: fraud, contravening the 1983 South African Organs and Tissues Act, which prohibits the buying and selling of human body parts, and "assault to do grievous bodily harm" on the bodies of the vulnerable kidney sellers. The latter charge took them and the transplant world by surprise.

The trans-Atlantic organ trade triangle that brought together an unlikely bunch of Israeli and U.S. buyers, Brazilian and Moldovan kidney sellers, South African doctors and transnational brokers from Israel, the United States, Brazil and South Africa may prove to be the ultimate Achilles heel that can determine the fate of commerce in living peoples' organs and whether it will be judged as something the neoliberal world can live with or as the ultimate form of human exploitation. But one fact is indisputable: it took two countries to the south-Brazil and South Africa-to challenge the power of transplant outlaws and their kidney bounty hunters. And they did so in the name of protecting and defending the vulnerable bodies of the world's socially disadvantaged.

The Social and Medical Consequences of Selling a Kidney

Transplant surgeons have disseminated the idea of "risk-free" live donation in the absence of published, longitudinal studies of the effects of nephrectomy among the urban poor living anywhere in the world. The few available studies of the effects of neprectomy on kidney sellers in India[24] and Iran[25] are unambiguous. Even under attempts (as in Iran) to regulate and control systems of "compensated gifting" by the Ministry of Health, the outcomes are devastating. Kidney sellers suffer from chronic pain, unemployment, social isolation and stigma, and severe psychological problems.

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The evidence of strongly negative sentiments – disappointment, anger, resentment, and even seething hatreds for the doctors and the recipients of their organs – reported by 100 paid kidney donors in Iran strongly suggests that kidney selling there represents a serious social pathology.

Our research and fieldwork among kidney sellers in Moldova, Brazil, and the Philippines, which included diagnostic exams and sonograms, determined that kidney sellers face many post-operative complications and medical problems, including hypertension and kidney insufficiency, without their having access to adequate medical care or medications. Kidney sellers find themselves weakened, sick, and unemployable because they are unable to sustain the demands of heavy agricultural or construction work, the only labor available to men of their skills. Kidney sellers are often alienated from their families and coworkers, excommunicated from their churches, and excluded from marriage. The children of kidney sellers are ridiculed as "one-kidneys. "

Kidney sellers in Moldova had no access to post-operative medical care following their illicit 'nephrectomies' (kidney removal) in Turkey, the U.S, and Russia. We had to coax young kidney sellers to accept a sonogram at the expense of Organs Watch. Some said they were ashamed to appear in a public clinic, as they had tried to keep the sale a secret. Others said they were afraid of learning negative results from the tests. If medical problems were discovered they would be unable to pay for necessary treatments or medications. Above all, they feared being labeled as "weak" or "disabled" by their employers and coworkers, or as "inadequate" males by girlfriends and wives. "No young woman in the village will marry a man with the tell-tale scar of a kidney seller", a village elder in Mingir told us. Sergei said that his mother was the only person who knew the reason for the large, saber-like scar on his abdomen. His young wife believed that he had been injured in a construction accident while he was away in Turkey.

Is a Regulated Market the Solution?

"If a living donor can do without an organ, why shouldn't the donor profit and medical science benefit? "
Janet Ratcliffe-Richards[26]

From the exclusively market-oriented "supply and demand" perspective that is gaining ground among transplant specialists and bioethicists today, the buying and selling of kidneys is viewed as a potential solution to the global scarcity in organs and as a "win–win" situation that benefits both parties. In so doing, however, the human and ethical dilemmas are reduced to a simple problem in management. The problems with this rational solution are many. The arguments for "regulation" are out of touch with the social and medical realities operating in many parts of the world, but especially in second and third world nations. The medical institutions created to "monitor" organs harvesting and distribution are often dysfunctional, corrupt, or compromised by the power of organs markets and the impunity of the organs brokers, and of outlaw surgeons willing to violate the first premise of classical medical bioethics: above all, do no harm.

Philippine Secretary of Health, Manuel Dayrit, had two proposals on his desk at the time of my interview with him in February 2002. The first would create a government-regulated kidney bank (to be called KIDNET) that would allow poor people to sell and deposit a kidney into a virtual "organs bank" that would presumably make these available to all Philippine citizens who needed them. Dr. Dayrit was, however, reluctant to discuss just how the Ministry of Health might set a "fair price" for a poor person's kidney, preferring to leave this task to the free market. Dr. C., the director of a large private hospital in Manila, agreed: "Some of our 'donors' are so poor that a sack of rice is sufficient. Others want medical care for their children, and we are quite prepared to provide that for them." The second proposal is a government-sponsored program to grant death row prisoners (most of them killers) a reprieve in exchange for donating a kidney. Their death sentence would then be replaced by life imprisonment. Supporters of this program believe that the donor incentives program could end up convincing society that the death penalty is a terrible waste of a healthy body. "Organ donation is a medical equivalent of Catholic Lenten rites of self-flagellation", Professor Leonardo Castro, of the University of the Philippines said in defense of the prisoner organ donation incentives program.

For most bioethicists, the "slippery slope" in transplant medicine begins with the emergence of an unregulated market in organs and tissue sales. But for the critical medical anthropologist, the ethical slippery slope occurs the first time one ailing human looks at another living human and realizes that inside that other body is something capable of prolonging or enhancing his or her life. Dialysis and transplant patients are highly visible and their stories are frequently reported by the media. Their pain and suffering are palpable. But while there is empathy – even a kind of surplus empathy – for transplant patients, there is little empathy for the donors, living and brain dead. Their suffering is hidden from the general public. Few organ recipients know anything about the impact of the transplant procedure on the donor's body. 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.

In the absence of any national or international registries of living donors or mandatory reporting laws concerning complications following living donation for the donor/seller, there is really no reliable data on the medical/psychological risks and complications suffered by living organ donors anywhere in the world. In the U.S.A., two kidney donors have died during the past 18 months and another is in a persistent vegetative state as a result of donation.[27] The fact that any living donors have died immediately following the surgical procedure, or are themselves in dire need of a kidney transplant at a later date, sounds a cautionary note

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about living donation and serves as a reminder that nephrectomy (kidney removal) is not a risk-free procedure.[28]

Bioethical arguments supporting the right to sell an organ are based on Euro-American notions of contract and individual "choice". But the social and economic contexts make the "choice" to sell a kidney in an urban slum of Calcutta, or in a Brazilian favela or Philippine shantytown, anything but a "free" and "autonomous" one. Consent is problematic with "the executioner" – whether on death row or at the door of the slum resident – looking over one's shoulder. Putting a market price on body parts – even a fair one – exploits the desperation of the poor, turning suffering into an opportunity. Asking the law to negotiate a fair price for a live human kidney goes against everything that contract theory stands for. When concepts such as individual agency and autonomy are invoked in defending the "right" to sell an organ, anthropologists might suggest that certain "living" things are not alienable or proper candidates for commodification. And the surgical removal of nonrenewable organs is an act in which medical practitioners, given their ethical standards, should not be asked to participate.

The problems multiply when the buyers and sellers are unrelated, because the sellers are likely to be extremely poor and trapped in lifethreatening environments where the everyday risks to their survival are legion, including exposure to urban violence, transportation- and workrelated accidents, and infectious disease that can compromise their kidney of last resort. And when that spare part fails, kidney sellers often have no access to dialysis, let alone to organ transplant. While poor people in particular cannot "do without" their "extra" organs, even affluent people need that "extra" organ as they age, and when one healthier kidney can compensate for a failing or weaker kidney.

How can a national government set a price on a healthy human being's body part without compromising essential democratic and ethical principles that guarantee the equal value of all human lives? Any national regulatory system would have to compete with global black markets that establish the value of human organs based on consumer-oriented prejudices, such that in today's kidney market Asian kidneys are worth less than Middle Eastern kidneys and American kidneys worth more than European ones. The circulation of kidneys transcends national borders, and international markets will coexist and compete aggressively with any national, regulated systems. Putting a market price on body parts – even a fair one – exploits the desperation of the poor, turning suffering into an opportunity. And the surgical removal of nonrenewable organs is an act in which medical practitioners, given their ethical standards, should not be asked to participate. Surgeons whose primary responsibility is to provide care should not be advocates of paid self-mutilation, even in the interest of saving lives.

Market-oriented medical ethics creates the semblance of ethical choice (for example, the right to buy a kidney) in an intrinsically unethical context. Bioethical arguments about the right to sell an organ or other body part are based on cherished notions of contract and individual "choice". But consent is problematic when a desperate seller has no other option left but to sell an organ.

The demand side of the organs scarcity problem also needs to be confronted, especially the expansions of waiting lists to include patients who would previously have been rejected. Liver and kidney failure often originate in public health problems that could be treated more aggressively preventively. Ethical solutions to the chronic scarcity of human organs are not always palatable to the public, but also need to be considered. Foremost among these are systems of educated, informed "presumed consent", in which all citizens are assumed to be organs donors at brain death unless they have officially stipulated their refusal beforehand. This practice, which is widespread in parts of Europe, preserves the value of organ transplant as a social good in which no one is included or excluded on the basis of their ability to pay.

Conclusion – A Return to the Gift

"The material needs of my neighbor are my spiritual needs."

Emmanuel Levinas, Nine Talmudic Readings

We conclude this ethnographic essay with a reminder of the radical premise entailed in organs sharing which envisioned the body as a gift, meaning also a gift to oneself. In the most simple Kantian or Wittgensteinian formulatiom the body and its parts are not proper candidates for commodification and sale because they are inalienable from the bodyself. The body provides the grounds of certainty for saying that one has a 'self' and an existence at all. Humans both are and have a body. For those who view the body in more collectivist terms as a gift (whether following Judeo-Christian, Buddhist, or animistic religious traditions or following a socialist ethic) the body cannot be sold, while it may be re-gifted and recirculated in humanist acts of generosity and caritas.

From its origins, transplant surgery presented itself as a complicated problem in gift relations and gift theory, a domain to which sociologists and anthropologists from Marcel Mauss to Levi-Strauss to Pierre Bourdieu have contributed mightily. The spread of new medical technologies and the artificial needs, scarcities, and the new commodities that they demand have produced new forms of social exchange that breach the conventional dichotomy between gifts and commodities and between kin and strangers. While many individuals have benefited enormously from the ability to get the organs they need, the violence associated with many of these new transactions gives reason to pause. Are we witnessing the development of bio-sociality or the growth of a widespread bio-sociopathy?

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.

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References

1 On biological citizenship, see Adriana Petryna, Life Exposed: Biological Citizens after Chernobyl (Princeton University Press, 2002); on sexual citizenship, see Nancy Scheper-Hughes, "AIDS and the Social Body", Social Science & Medicine 39 (7), 1994, pp. 991–1003.
2 The members of the Bellagio Task Force are: Tsuyoshi Awaya, professor of medical sociology and law at the School of Law, Tokuyama University, Japan; Bernard Cohen, Director-Eurotransplant Foundation, Leiden, the Netherlands; Abdallah Daar, M.D., Chairman, Department of Surgery, Sultan Qaboos University, Muscat, Oman; Sergei Dzemeshkevich, M.D., Chief, Department of Cardiosurgery, Russian Academy of Medical Sciences, Moscow; Chun Jean Lee, M.D., Professor of Surgery, National Taiwan University Medical Center, Taipei, Taiwan; Robin Monroe, Human Rights Watch/Asia, Wan Chai, Hong Kong; Hernan Reyes, M.D; Medical Director, International Committee of the Red Cross, Geneva, Switzerland; Eric Rose, M.D. Chairman, Department of Surgery, Columbia College of Physicians &Surgeons, New York City; David Rothman, Professor and Director, Center for the Study of Society and Medicine, Columbia College of Physicians and Surgeon, New York City; Sheila Rothman, Professor, School of Public Health, Columbia University, New York; Nancy Scheper-Hughes, Professor, Anthropology, University of California, Berkeley; Zaki Shapira, M.D., Organ Transplant Department, Beilinson Medical Center, Petach Tikva, Israel; Heiner Smit, Deutsche Stiftung Organtransplantation, Neu-Isenberg, Germany; Marina Staiff, M.D., Medical Co-ordinator, Prison Detention Activities, International Committee of the Red Cross, Geneva, Switzerland.
3 Nancy Scheper-Hughes. 1995. "The Primacy of the Ethical: Towards a Militant Anthropology", "Current Anthropology 36 (3): 409-420; Bourdieu, Pierre. 2002. Pour un Savoir Engage", Le Monde Diplomatique (Feb), p. 3.
4 On biological citizenship, see Adriana Petryna, Life Exposed: Biological Citizens after Chernobyl (Princeton University Press, 2002); on sexual citizenship, see Nancy Scheper-Hughes, "AIDS and the Social Body", Social Science & Medicine 39 (7), 1994, pp. 991–1003.
5 See Elizabeth Roberts, "Examining Surrogacy Discourses; Between Feminine Power and Exploitation", in Nancy Scheper-Hughes and Caroline Sargent, eds., Small Wars: The Cultural Politics of Childhood (Berkeley: University of California Press, 1998), pp. 93–110.
6 Jean Comaroff and John Comaroff, eds., Millennial Capitalism and the Culture of Neoliberalism (Durham, NC: Duke University Press, 2001).
7 See Saskia Sassen, The Global City: New York, London, Tokyo (Princeton: Princeton University Press, 1991).
8 The United Network for Organ Sharing (UNOS) allows 5 percent of organ transplants in U.S. transplant centers to be allotted to foreign patients. However, only those centers reporting more than 15 percent foreign transplant surgery patients are audited.
9 See, for example, the Arabic (as well as Hebrew and Japanese) version of the university's advertisement; http://www.umm.edu/transplant/arabic.html.
10 In São Paulo Hospital, Mariana Ferreira and I encountered Dombe, a Suyá Indian from the forest of Mato Grosso who, to our amazement, faced kidney transplant (including two rejection crises) with remarkable equanimity and calm. See Nancy Scheper-Hughes and Mariana Leal Ferreira, "Domba's Spirit Kidney – Transplant Medicine and Suyá Indian Cosmology", in Disability in Local and Global Worlds, eds. B. Ingstad and S. Reynolds (Berkeley: University of California Press, in press).
11 See Marina Jimenez and Nancy Scheper-Hughes, "Doctor Vulture – The Unholy Business of Kidney Commerce", part one of a three-part series in The National Post (Toronto), March 30, 2002, B1, B4–B5.
12 See Flavio Lobo and Walter Fangaaniello Maierovitch, "O Mercado dos Desperados", CartaCapital, January 16, 2002, 30–34.
13 See Francis Delmonico, Robert Arnold, Nancy Scheper-Hughes, et al., "Ethical Incentives – Not Payment – For Organ Donation", New England Journal of Medicine, 2002, 346 (25), pp. 2002–2005.
14 James Stacey Taylor, 2005. Stakes and Kidneys: Why Markets in Human Body Parts are Morally Imperative. Burlington, Vermont: Ashgate, 2005. Mark J. Cherry. 2005. Kidney for Sale by Owner. Washington, D.C.: Georgetown University Press.
15 For example, Alan Shewmon, a respected pediatric nephrologist at UCLA, has argued persuasively that on neurological grounds alone, while the brain dead are incontestably and probably irreversibly dying, they are quite simply not yet dead. Margaret Lock, who has exhaustively explored the topic of brain death, refers to the brain dead as "as good as dead." Alternatively, I call them the "good enough" dead. But the point is that the brain dead are not dead in the more usual "deader than a door nail" sense of the term.
16 See John Stuart Mill, "Utilitarianism", in Ethical Theories: A Book of Readings, A.I. Melden, ed. (Englewood Cliffs, NJ: Prentice-Hall, 1967), pp. 391–434.
17 Jeremy Bentham, "An Introduction to the Principles of Morals and Legislation", in Ethical Theories: A Book of Readings, A.I. Melden, ed. (Englewood Cliffs, NJ: Prentice-Hall, 1967), pp. 367–390.
18 Michael Friedlaender, "The Right to Sell or Buy a Kidney: Are we Failing our Patients?" The Lancet 359, March 16, 2002.
19 This is a reference to Primo Levi's description, in his book *The Drowned and the Saved*, of the extent to which inmates of the concentration camps would collaborate with the enemy in order to survive.
20 Jagdish Bhagwati, "Deconstructing Rotten Trade", SAIS Review 22 (1), 2002, pp. 39–44.
21 Jean Comaroff and John Comaroff, eds., Millennial Capitalism and the Culture of Neoliberalism (Durham, NC: Duke University Press, 2001).
22 See Saskia Sassen, The Global City: New York, London, Tokyo (Princeton: Princeton University Press, 1991).
23 The United Network for Organ Sharing (UNOS) allows 5 percent of organ transplants in U.S. transplant centers to be allotted to foreign patients. However, only those centers reporting more than 15 percent foreign transplant surgery patients are audited.
24 See, for example, the Arabic (as well as Hebrew and Japanese) version of the university's advertisement; http://www.umm.edu/transplant/arabic.html.
25 In São Paulo Hospital, Mariana Ferreira and I encountered Dombe, a Suyá Indian from the forest of Mato Grosso who, to our amazement, faced kidney transplant (including two rejection crises) with remarkable equanimity and calm.
26 See Nancy Scheper-Hughes and Mariana Leal Ferreira, "Domba's Spirit Kidney – Transplant Medicine and Suyá Indian Cosmology", in Disability in Local and Global Worlds, eds. B. Ingstad and S. Reynolds (Berkeley: University of California Press, in press).
27 See Marina Jimenez and Nancy Scheper-Hughes, "Doctor Vulture – The Unholy Business of Kidney Commerce", part one of a three-part series in The National Post (Toronto), March 30, 2002, B1, B4–B5.
28 See Flavio Lobo and Walter Fangaaniello Maierovitch, "O Mercado dos Desperados", CartaCapital, January 16, 2002, 30–34.
29 See footnote 10.
30 Both Agamben, Homo Sacer, pp. 2–3, and Hannah Arendt, The Human Condition (Chicago: University of Chicago, 1958), pp. 12–49, treat the translation from ancient Greek to Church Latin in slightly different ways.
31 Francis Fukuyama, Our Postmodern Future New York: Farrar, Straus and Giroux, 2002), p. 204.
32 "Offering Money for Organ Donation Ethical, HHS Committee Says", December 3, 2001.
33 See David Rothman et al. "The Bellagio Task Force Report on Global Traffic in Human Organs". Transplantation Proceedings, 1997: 29: 2739-45.
34 See Janet Radcliffe-Richards et al., "The Case for Allowing Kidney Sales", The Lancet 352, 1998, p. 1951.
35 See Madhav Goyal, R. Mehta, L. Schneiderman, and A. Sehgal, "The Economic Consequences of Selling a Kidney in India", JAMA, October 2, 2002 – 288 (13): 1589–93.
36 Javaad Zargooshi, "Iranian Kidney Donors: Motivations and Relations with Recipients", Journal of Urology 165, 2001, pp. 386–392; Javaad Zargooshi, "Qulaity of Life of Iranian Kidney 'Donors", The Journal of Urology, 166 (5), November 2001: 1790-1799.
37 Ibid.
38 "Man Keeps Vigil for Comatose Wife who Gave him Kidney, Life", The Holland Sentinel, February 15, 2001.
39 "The Live Donor Consensus Conference", JAMA 284, 2001, pp. 2919–2926.

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