

# The Ends of the Body: Commodity Fetishism and the Global Traffic in Organs

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Amidst the neoliberal readjustments of the new global economy, there has been a rapid growth of “medical tourism” for transplant surgery and other advanced biomedical and surgical procedures. A grotesque niche market for sold organs, tissues, and other body parts has exacerbated older divisions between North and South, haves and have-nots, organ donors and organ recipients. Indeed, a kind of medical apartheid has also emerged that has separated the world into two populations—organ givers and organ receivers.

Over the past 30 years, organ transplantation—especially kidney transplantation—has become a common procedure in hospitals and clinics throughout the world. The spread of transplant technologies has created a global scarcity of viable organs. At the same time the spirit of a triumphant global and “democratic” capitalism has released a voracious appetite for “fresh” bodies from which organs can be procured. The confluence in the flows of immigrant workers and itinerant kidney sellers who fall prey to sophisticated but unscrupulous transnational organ brokers is a subtext in the recent history of globalization. Today’s organ pro-

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curement transactions are a blend of altruism and commerce; of science and superstition; of gifting, barter, and theft; and of voluntarism and coercion.

### **International Organ Markets, Bioethics, and Social Justice**

The problem with markets is that they reduce everything—including human beings, their labor, and their reproductive capacity—to the status of commodities that can be bought, sold, traded, and stolen. Nowhere is this more dramatically illustrated than in the

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market for human organs and tissues. The concepts of the integrity of the body and human dignity have given way to ideas of the divisible body and detachable organs as commodities. The new field of bioethics has largely capitulated to the dominant market ethos.<sup>1</sup> Conventional medical ethics obscures the ancient perception of virtue in suffering and dying, while bioethics creates the sem-

blance of ethical choice (e.g., the right to buy a kidney) in an intrinsically unethical context. 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. This idea erases any possibility of a global social ethic.

In the rational choice language of contemporary bioethics 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. In a market context, paying for a kidney “donation” is viewed as a potential “win-win” situation that can benefit both parties.<sup>2</sup> Individual decision making has become the final arbiter of medical bioethical values. Social justice hardly figures into these discussions because bioethical standards have been finely calibrated to mesh with the needs and desires of consumer-oriented globalization.

The only dissident voices raised against the dominant transplant narrative come from far afield and are expressed in unpalatable forms that are all too easily discredited. These alternative bio-

ethical positions have been expressed, perhaps somewhat “primitively,” in the context of the discourse of organ theft that represents the underlying fears of the poor and other socially marginalized groups. To a great many of those living on the fringes of the new global disorder, the scramble for “fresh” organs and tissues increases their profound sense of ontological insecurity in a world that values their bodies as a reservoir of spare parts.<sup>3</sup> The rumors of blood and body parts theft have provoked strong popular resistance to new laws of presumed consent recently passed in such countries as Brazil and Mexico. Opponents of presumed consent laws contest the state’s right to claim dead bodies for organs and tissues harvesting. Yet their limited resistance is unable to forestall the rapid growth of the international organs market as those on both sides of the transplant equation are beginning to accept these still largely covert transactions, protected by transplant medicine’s coyly averted gaze.

### **Organs Watch: Uncovering the Hidden Dimensions of Organ Transplant Rhetoric and Practices**

Organs Watch, a medical human rights group affiliated with the University of California, Berkeley, monitors the trade in organs with a view toward advancing social justice concerns in the organs market. From this base—and with the assistance of a small group of anthropology, law, journalism, and medical student interns, volunteers, and local field assistants—the group conducts basic ethnographic research on transplantation practices worldwide and is mapping the mechanics of the organs market. Above all, Organs Watch attempts to make public and transparent all practices regarding the harvesting and distribution of human body parts. Until now, these transactions have been protected from scrutiny because the population of organ suppliers—both living and brain dead—is largely poor and socially marginalized.

Organ Watch’s first task has been to raise some basic but necessary questions: How does the organ market function? Whose needs are privileged? Whose voices are silenced? What invisible sacrifices are being demanded? What “noble lies” are concealed in the transplant rhetoric of gifting, scarcities, and needs? In answering these questions, three crucial points about the organs trade emerge. The first is about invented scarcities and artificial needs despite the widespread fetishization of organs. Supply and demand for organs has, however, increasingly evolved toward the trade in

“fresh” body parts, which has sustained the rapid growth of “medical tourism” as well as “biopiracy.” The second concerns altruism versus invisible sacrifice in the new global markets for bodies and “fresh” organs. The third point concerns surplus empathy and the relative visibility of two distinct populations—excluded and invisible organs givers and included and highly visible organs receivers.

### **The Body and Commodity Fetishism**

Global market capitalism, together with advanced medical and biotechnologies, has incited new tastes and desires for the skin, bones, blood, organs, tissues, marrow, and reproductive and genetic material of others. There now exists an unregulated, international, multi-million dollar business in tissues and body parts, obtained in many parts of the world without consent from police mortuaries or hospital morgues.

In many developing countries, human tissue is exchanged with first-world countries for medical technology or expertise. In South Africa, for example, an experimental research science unit of a large public medical school ships human heart valves, taken without consent from the cadavers of poor Blacks in police mortuaries, to medical centers in Germany and Austria. The exorbitant “handling” fees they charge for supplying such valuable body parts helps support the unit’s research program in the face of the downsizing of advanced medical research facilities in the new South Africa.

As commercialization has entered almost every sphere of medicine and biotechnology, those in the North cannot claim any moral highground. Mortuary practices and tissues harvesting resemble a kind of human strip farming in some parts of the United States. Heart valves, cornea, skin grafts, bone fragments, and other body parts are used for research, teaching, and experimentation as much as for advanced surgeries. “Excess” cornea are shipped in bulk from the United States to other countries, including developing countries, enabling sellers to reap enormous profits from the handling charges reported as legitimate sales.

The sale of human organs and tissues has resulted in certain disadvantaged individuals, populations, and even nations being reduced to the role of “suppliers.” It is a scenario in which bodies are broken, transported, processed, and sold in the interests of a more socially advantaged population of organs and tissues receivers. Desperation on both sides and the willingness of both trans-

plant doctors and their patients to see only one side of the transplant equation allows the commodified and fetishized kidney to become an organ of opportunity for the buyer and an organ of last resort for the seller. The policy among kidney transplant doctors in the United States might best be described as “don’t ask, don’t tell.” This also might be called neocannibalism.

In the United States, for instance, organs brokers like “Livers-4-You” advertise freely on the Internet:

Want a living donor next week, or a morgue organ in five years?  
We are a new organization with a New York City phone number  
and unique in locating the overseas pathway for those waiting too  
long for a transplant.

This group states that it has “joined with medical professionals in the Philippines (and other as yet undesignated countries) to help ‘fill the gap’ between the supply and demand for organs.” For those nervous about traveling to a developing country for transplant surgery, the website notes that medical schools in the Philippines are “carbon copies” of U.S. schools and that Philippine transplant surgeons are trained in the United States. Those in doubt about the quality of medical care in the Philippines are told to contact the U.S. consulate in Manila, the Manila office of multinational corporations, or the Catholic Church in Manila. All will provide positive references on the practice of transplant surgery in the Philippines. The only glitch is that the cost for a live donor is “higher than for a cadaver.” Overall though, the cost is still about half the current cost of transplant in the United States. The payment mechanics—through bank wire transfers—are handled by the Livers-4-You online staff. Medical arrangements are handled by the organization’s head surgeon, who is a U.S.-trained and licensed doctor who has “done many operations in the United States.”

Transplant procedures are astronomically expensive (in the United States a heart transplant costs more than \$300,000) and are frequently hindered by unremitting shortages in organs. The media, prompted by organs procurement organizations, produce frequent references to the number of people who will die each year waiting for an organ. In the United States over 70,000 people appear on organs waiting lists. Every year the demand for organs increases as transplant organizations, transplant professionals, and patients’ rights groups demand that new categories of people become eligible for organ transplants. For example, at their annual meetings in Leiden, the Netherlands, in September 2000, members

of Eurotransplant supported new experiments that expanded transplant waiting lists to include the medical margins—those over 70 years, infants, those with hepatitis C and HIV seropositivity, and those proven to be immunologically prone to organ rejection. There was no acknowledgement that these experiments would inflate the demand for organs and promote the development of desperate means, including the black market, to obtain them. Instead, these experiments were defended as a democratic gesture and a service to those potential transplant consumers demanding the right to any and all advanced medical procedures now available.

### **Biopolitics: Race, Class, and Ethnicity in Organs Procurement**

There is little consciousness of the vulnerability of some social classes and ethnic groups who can be described as the “designated donor” populations. In the United States, this group is disproportionately poor—including whites, Latinos, and African Americans. The poor are over-represented in the intensive care centers (ICUs) of large urban hospitals, due to their disproportionate exposure to urban violence, the higher rates of suicide and vehicular death in their communities, and the cumulative effects of societal and

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medical neglect. The great irony is that those lacking public insurance (44 million citizens) also comprise the greatest number of those whose family members

are asked to be altruistic and voluntarily donate the organs and tissues of loved ones. That a great many of these families refuse to donate should come as no surprise. They are being asked to give organs to support a social and medical system that excludes them and within which they would have a lower probability of receiving an organ, should that need arise. One needs to be relatively affluent and otherwise healthy and well looked after to be recommended for organ transplant. Widespread refusal to donate among poor Latino and African Americans is a political act of considered resistance.

Meanwhile, across the globe, medical human rights workers in the West Bank complained of gross violations of Palestinian

bodies by Israeli pathologists at the National Legal Medical Institute in Tel Aviv. An official investigation committee appointed by the Minister of Health confirmed the suspicions of Palestinian health workers. The harvested organs and tissues were sold by the Institute to hospitals and medical centers for surgical procedures, research, and medical teaching. A special “squad” of surgeons on military reserve duty performs the harvesting. This practice was established by the head of the national skin bank, who was formerly also Chief Medical Officer of the Israeli Defense Forces. Relying on “presumed consent” the staff of the Forensic Institute and the surgeons who illegally harvested skin and organs said that they believed they were helping to save lives, and that this was more important than trying to procure the consent of ill-informed and grieving family members. As elsewhere, tissues and organs were regarded as mere detachable objects that could be transformed into something valuable. Some bodies were, however, exempt from this practice, namely the bodies of Israeli soldiers, which are returned intact to their families for burial.

### **Invented Scarcities—The Slide to Living Organ Donation and Medical Tourism**

Sadly, however, the discourse on scarcity conceals the actual existence of excess and wasted organs that end up in hospital dumpsters on a daily basis throughout those parts of the world where the necessary infrastructure to use them is lacking. Indeed, the ill will and competitiveness of some hospital workers and medical professionals also contributes to the production of organ “wastage.” For example, transplant coordinators in public hospitals in many developing countries are often told to dispose of usable organs rather than allow the competition to “get their hands on them.”

The very idea of organ “scarcity” is what Ivan Illich would call an artificially created need, invented by transplant technicians and dangled before the eyes of an ever-expanding sick, aging, and dying population. The resulting artificially created organs scarcity is “misrecognized” as a natural medical phenomenon.<sup>4</sup> In this environment of “survivalist” utilitarian pragmatics, the ethics of transplantation is modeled after classical “lifeboat” ethics.<sup>5</sup> With ethical presumptions of scarcity, there appears to be clear choices to be made, namely who gets into the lifeboat (“getting on the waiting list”); who will be shoved off the boat when it gets overcrowded (getting triaged while on the waiting list); and who will, in the end,

be “eaten” so that others may live (race and class disparities in organs procurement and distribution practices).

A new kind of organ trade has emerged out of the global economy: transplant tourism. Along with it, a group of self-defined transplant outlaws—doctors, patients, brokers, and kidney sellers—has emerged. They short-circuit national waiting lists and make a mockery of national and international codes of ethics prohibiting the sale of organs, from either living or dead donors. The key actors are a new class of entrepreneurial organs brokers, who take advantage of questionable organs scarcity panics and the desperation of both the organs buyers and the organs sellers. The sellers are recruited from populations that are suffering from economic transitions. These include displaced rural populations, guest workers, refugees, and young soldiers.

### **Supplying the Market Through Biopiracy: Tissues Procurement Practices**

Drawing on widely cited ethnographic field research, Organs Watch has investigated international organs buying, selling, and transplantation in an effort to document the impact of the organs market on the bodies of some of the most vulnerable citizens of the new world order. Organs Watch researchers have followed transplant patients from dialysis clinics to meetings with brokers in suburban shopping malls, and into illicit surgeries. They have also visited the township *shabeens*, squatter camps, and city jails where people are most likely to sell their organs, sometimes in “organs motels” inside private hospitals. They have seen dead bodies flow from hospital morgues and police mortuaries to the issue banks and biotech companies where their parts are harvested and processed—often for sale. All of this field research confirms the existence of a new form of “apartheid medicine” that privileges one class of patients, organ recipients, over another class of unrecognized “patients,” organ donors, about whom almost nothing is known.

In its odd juxtapositions of ethnography, documentation, surveillance, and human rights work, the Organs Watch project blends genres and transgresses old distinctions between anthropology, political journalism, scientific report, moral philosophy, and human rights advocacy. More than any other discipline, however, anthropology is best suited to investigate values and practices from a position of epistemological openness and to offer alternatives to the limited pragmatic utilitarianism that dominates medical bioethical thinking today.

### Brazil: Organ Theft

The spread of biopiracy has affected many in the developing world, whose plight is often the result of the medical establishment's complicity in the illegal organ trafficking. For example, during the summer of 1998 Laudiceia Cristina da Silva, a young mother and office receptionist in Sao Paulo, filed a formal *denuncia*—a complaint—requesting a criminal investigation of the large teaching hospital where, a year earlier, during a routine operation to remove an ovarian cyst she had “lost” a kidney as well.

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The “missing kidney” was discovered soon after the operation by the woman's family doctor during a follow-up examination. Laudiceia was continuing to experience excruciating pain and changes in her urination. Her doctor was suspicious of the large surgical scar and ordered a sonogram.

When confronted with the information, the hospital representative told a highly improbable story—that Laudiceia's missing kidney was embedded in the large “mass” that had accumulated around her ovarian cyst, and was removed with it. But the hospital refused to produce their medical records or the evidence. The diseased ovary and the kidney had been “discarded,” she was told, and her medical records had been temporarily misplaced. Laudiceia and her family doctor are convinced that her kidney was taken to serve the needs of another, wealthier patient in the same hospital. To make matters worse, the young woman's only brother had been killed in a random act of urban violence several weeks earlier, and the family arrived at the hospital too late to stop organ retrieval. Brazil's new “presumed consent” law, which has since been revoked, allowed doctors to remove organs unless the individual had gone to a civil registry office and had a declaration stating “I am Not A Tissues or Organs Donor” stamped on his official identification papers. “Poor people like ourselves are losing our organs to the state, one by one,” Laudiceia complained angrily.<sup>6</sup> Laudiceia's legal case is now “in process” and will most likely be resolved, as many of these cases are, out of court. If so, the young woman will not be allowed to discuss her case any further.

Neither is there a lack of desperate people willing to sell a kidney for a pittance—as little as \$1,000. Many of them wait out-

side transplant units or in special wards of surgical units reserved for them, in places like India, Iraq, Moldova, the Philippines, and Turkey, begging to be considered and hoping for a good match with a prospective buyer. In general, the circulation of organs flows from South to North, from poorer to more affluent bodies, from black and brown bodies to white ones, and from females to males. Entire regions are known in the transplant world as “kidney belts” because so many who live there are willing to sell their “extra” kidney.

### **India: The Right to Sell?**

Across the globe during the summer of 1999, Lawrence Cohen sat in a one-room flat in a municipal housing project in a Chennai slum in South India talking with several local women, each of whom had sold a kidney for about \$1,000. Each had undergone her kidney removal at the clinic of Dr. K. C. Reddy, India’s most outspoken advocate of the individual’s “right to sell” a kidney. The

women Cohen interviewed were primarily low-paid domestic workers with husbands in debt. The kidney sale was usually preceded by a financial crisis: the family had run out of

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credit and the bill collectors were at the door. The women said that the money from selling their kidneys had offered temporary relief but that it was soon swallowed up by the usurious interest charged by local moneylenders. The families were all in debt again. They also stated emphatically that they would do it again. If only they had three kidneys, with two to spare, then things might be better.<sup>7</sup>

A decade ago, when townspeople first heard through newspaper reports of kidney sales occurring in the cities of Bombay and Madras, they responded with predictable alarm. Now, Cohen says, some of these same people speak as matter of fact about when it might be necessary to sell a “spare” organ. Globalization has encouraged the development of new forms of “debt peonage” in which the commodified and fetishized kidney occupies a critical role as collateral. Today the spare kidney represents everyman’s last economic resort, one’s ultimate collateral.

### **Argentina: Targeting the mentally ill**

One place where Organs Watch found social justice lacking in the organs harvesting process was Argentina. In January 2000, the group conducted an undercover visit to the Montes de Oca state mental asylum to investigate reports of blood, tissue, and organ stealing from the bodies of mentally retarded, but otherwise physically healthy, inmates. Reports of illicit organs trafficking surfaced during the early 1990s in respected medical journals, as well as in the popular press. A court-ordered investigation of the grounds of the asylum by members of Argentina's celebrated anthropological forensic team recovered the bodies of several "unidentified" patients from a swamp and a water tower on the grounds of the asylum. The causes of death were never determined and the bodies were too decomposed to verify whether they had been tampered with. "The fact is," said Alejandro Inchaurregui, a member of the forensic team, during a visit to his Missing Persons Bureau in the Police Station of La Plata, "nobody really cares about the bodies of those who are abandoned [at the mental asylum] and left to the care of the state."<sup>8</sup>

Montes de Oca remains a frightening place. The asylum is grossly understaffed, and the inmates, many naked and almost all emaciated, wander the asylum grounds unsupervised. A night nurse and ward supervisor interviewed later at her home explained that hospital staff members commonly take blood from living inmates and remove cornea from the deceased, almost always without consent. She described these practices as a "payback" for the inmates' care at the state's expense. "Isn't that the way it is done everywhere?"<sup>9</sup>

These horrific stories, which are far from unique, highlight the need to bring social justice concerns to bear on global practices of organ harvesting and distribution. Transplant surgery is the most social practice of medicine and as such is particularly dependent on trust within the medical community.

### **Growing Demand for Live Organ Donation and the Rise of Medical Tourism**

The real scarcity in organs transplant is of patients of sufficient economic means to pay for these expensive operations. Hence the paradox of U.S. transplant centers actively recruiting wealthy foreign patients, so-called "medical tourists," to receive organs that

are otherwise described as painfully scarce.<sup>10</sup> The University of Maryland Medical Center, for example, advertises its kidney transplant program in Arabic, Chinese, Hebrew, and Japanese on its website.<sup>11</sup> The United States is extremely democratic in at least one sense—anyone, regardless where they come from, with enough cash can become a “medical citizen” of the United States and receive a bonafide “Made in the USA” organ.

The idea of the organ as fetish conjures up the magical energy that is invested in the “fresh” organ purchased from a living donor. Averham, a 71 year old kidney buyer who flew from Jerusalem to Georgia in Eastern Europe where he purchased a kidney from a young peasant, explained to me why he would never tolerate a cadaveric kidney: “That kidney is practically dead. It was probably pinned down under the wheels of a car for several hours and then it was put on ice for another several hours. Then you expect it to go right back to work for me? It’s really disgusting to think about putting that dead man’s organ inside you. So I chose a better way. I was able to see my donor [in a small town in Eastern Europe]. He was young, strong, healthy. Just what I was hoping for.”

As Averham’s preferences show, cadaver organs are no longer the primary organs of desire. In the last decade, there has been a dramatic shift worldwide toward the procurement and use of organs from living donors who can give one kidney, half a liver, or the lobe of one lung. The move to living organ donation is seen as the only solution to the chronic scarcity of organs for transplant and a means to increase the viability and longevity of transplanted organs. In the United States live donor kidney transplants account for 50 percent of all transplants, and live donor liver transplants for 10 percent.<sup>12</sup> Similarly, in Israel, an experimental program of live, unrelated kidney donation was established to screen and select purely “altruistic” donors. But the head of the screening committee stated that: “Of the 40-some applications we reviewed and approved, it is possible that two were truly altruistic. All the others were paid.”

Israel, for example, is a major player in the global market for organs; its citizens purchase, proportionally, the largest number of organs in the global market. Caught between a highly educated and medically conscious public and a very low rate of organ donation, only 7 percent of the population was registered in 1996 as “card-carrying” donors in contrast with 20 to 30 percent in the United States and most of Western Europe. As a result, the Israeli Ministry of Health has permitted the expansion of transplant tour-

ism. But the Israeli market operates in one direction only and no organs are sold from Israel to the global market.

The business of transplant tourism in Israel is fairly transparent and organized through a local business corporation in conjunction with a leading transplant surgeon, Dr. Zaki Shapira from Bellinson Medical Center near Tel Aviv. The “company” has developed links with transplant surgeons in Turkey, Russia, Moldavia, Estonia, Georgia, Romania, and (most recently) the United States. The cost of the transplant “package” increased from \$120,000 in 1998 to \$200,000 in 2001. With pressure from transplant candidates to develop links in more developed countries, the cost is still rising. The covert operation (in both senses of the term) is accomplished in five days. On the first day, the patients rest and undergo a dialysis. The operations take place on the second and third days. Depending on the size of the group, doctors will perform two to three operations per night. On days four and five, the patients recover on site and then fly home. The transplant “package” covers the rental of a private plane, which accommodates six patients, each of whom can be accompanied by a family member, the Israeli doctors, and the business coordinator. The cost also includes the “double operation” (kidney extraction and kidney transplant), the “fees” paid to bribe airport and customs officials, the rental of private operating and recovery rooms, and hotel accommodations for accompanying family members. The donor fee is also included but the donor is paid no more than \$5,000, and most of the donors from rural Eastern Europe are paid less than \$3,000.

The specific sites of the illicit surgeries are normally kept secret from transplant patients until the day of travel. Meanwhile, the locations are continually rotated to maintain a low profile. The surgeries are performed between midnight and the early morning hours. In a common scenario, Israeli patients and doctors (a surgeon and a nephrologist) fly to a small town in Turkey on the Iraqi border, where the kidney sellers are often young Iraqi soldiers or guest workers. In another scenario, the Israeli and Turkish doctors travel to a third site in Eastern Europe, where the organ sellers are unemployed locals or guest workers from elsewhere.

The refusal of the Ministry of Health to crack down on this multi-million dollar business, which is making Israel something of a pariah in the international transplant world, requires some explanation. In the absence of a strong culture of organ donation and under the pressure of angry transplant candidates, each person transplanted abroad is one less demanding and angry client

with which to contend. More troubling is the support and involvement of the Ministry of Defense in the illicit transplant tourism. Patients who traveled on the outlaw Israeli transplant junkets to Turkey and Eastern Europe noted the presence of members of the military among the organized groups of patients.

Transplant surgery has reconceptualized social relations between self and other, individual and society, and among the “three bodies”—the existential live body-self; the social, representational body; and the body politic.<sup>13</sup> Throughout these radical transformations, the voice of anthropology has been muted while the high-stake debates have been waged among surgeons, bioethicists, international lawyers, and economists.

The spread of new medical technologies and the artificial needs, scarcities, and the new commodities (i.e., fresh organs and tissues) that they demand raises urgent public issues concerning the emergence of new forms of barter and social exchange that breach the conventional dichotomy between gifts and commodities and between kin and strangers.

### **The Lie Behind the Demand for Donor Altruism**

The language of organ donation, which stresses altruism and benevolence, both obscures and contributes to the social inequalities of the larger medical system. Organ transplantation is, as Renee Fox so famously put it, both life-saving and death-ridden. Under traditional cadaver donation, the “gift” of life simultaneously demands a “gift of death.” It demands that grieving family members readily accept “brain death” as the end of the life of a loved one. To this day, brain death is not recognized by a great many people, including many intensive care workers who express profound misgivings about the “real” ontological status of their brain dead patients.<sup>14</sup>

The director of a private eye bank in Pretoria, South Africa, complained that the American company that sold his private institution corneas charged exorbitant prices—up to \$1,000 per cornea. “Where do all these ‘excess cornea’ come from in the United States?” The answer is that they are procured from naive donors who believe their “gifts” are being used to heal and comfort burn victims.

One unethical aspect of the organs market is that organs solicitors commonly deceive people in times of grief, asking them to perform acts of mercy and altruism by donating the organs of a deceased loved one. This is what happened to Linda Johnson-Schuringa, a middle class woman from Orange, California. She put

her late husband's body into the care of the Orange County Eye and Tissue Bank, believing that his tissues and bone would alleviate the suffering of another person. Several months later she learned through an investigative reporter that the "gift" of her husband's bones had been shipped to Germany where they were "processed" into a dental product and sold internationally. Ms. Johnson-Schurninga still believes in organs and tissues donation but she wants the consent forms to explain that some or all parts of the donated body parts may be sold to biotech firms and processed into commercial products.<sup>15</sup>

Organs and tissue donors—both living and dead—are treated not as people, but as suppliers of the organic medical material needed for research, experimentation, and advanced medical technologies. Prof. Johan Brink, of Goorte-Schuur hospital at the University of Cape Town, South Africa, and currently head of the South African Transplantation Society, explained that during the apartheid years, transplant professionals simply took the organs they needed from the bodies of black, brain dead patients in the Intensive Care Unit without seeking the consent of their family members. These organs were destined for transplant into the bodies of privileged white patients: "The surgeons were from conservative backgrounds and they followed a rural Christian family ethic. The idea of 'wasting' a good organ was sinful to them, like wasting a good piece of bread."<sup>16</sup>

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### Surplus empathy

Dialysis and transplant patients are highly visible and their stories are frequently reported by the media. We can see and hear their pain and suffering. But while there is empathy—even a kind of surplus empathy for transplant patients, there is an absence of empathy for both living and dead organ and tissue donors. Their suffering, for the most part, is hidden from the general public.

Few organ recipients know anything about the impact of transplant procedures on the donor's body. They recognize, of course, that their good fortune comes out of the tragedy of another, and they pass along the transplant folklore of the permissible guilt

and glee they experience on rainy nights when traffic accidents arise. Donor anonymity prevents contact between donors and recipients, though transplant patients often do try to learn something about their donors, whether they were living or dead. They are never privy, however, to the secret negotiations involving occasional psychological manipulation of the donor's family members while they are grieving deeply.

Yet there is hardly any mention of the medical, social, and psychological complications donors often suffer from. For instance, at least two kidney donors have died during the past 18 months and another is in a persistent vegetative state as a result of donation.<sup>17</sup> The fact that many living donors have either died immediately following the surgical procedure, or are themselves in dire need of a kidney transplant at a later date sounds a cautionary note about living donation and serves as a reminder that nephrectomy is not a risk free procedure.<sup>18</sup>

Most recently, Organs Watch research in Moldova in December 2001 was able to document the ill health, social disability, and subsequent unemployment faced by young male kidney sellers who return to their natal villages to find that they can no longer sustain the demands of heavy agricultural or construction work, the only paid labor that is available to men of their backgrounds. Not one of the kidney sellers had seen a doctor or been treated at a medical clinic following their illicit operations in Istanbul. More telling Organs Watch had to coax the young men to agree to a basic clinical exam and sonogram at the expense of the organization. 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 too fearful of learning negative results from the tests. All said that if serious medical problems were discovered they were unable to pay for follow-up treatments or necessary medications. Above all, they said they feared being labeled as "weak" or "disabled" by employers and co-workers, as well as (for single men) by potential girlfriends and brides. "No young woman in the village will marry a man with the tell-tale scar of a kidney seller," the father of a village kidney seller said sadly. "They believe that he will be unable to support a family.

Meanwhile, organs brokers, like any other brokers, try to keep organs buyers and sellers apart. But even when live donation is transacted within families, recipients can be protected from knowing the human cost of donation. If the medical and psychological risks, pressures, and constraints on organ donors and their families were more generally known, potential transplant recipients

might want to consider opting out of procedures that demand so much of the donor.

Can the language of gifting, of life saving, of altruism, or of scarcity and need be maintained in the face of the new economic climate? Not so long ago any mention of payment for organs and tissues was rejected. Today bioethicists and transplant specialists in many parts of the world, including the United States, are actively exploring ways to promote a blended system in which altruism and commercialism, science and sentiment, love and profit, gift and commodity can coexist. The American Medical Association's proposals for a "futures market" in cadaveric organs are just one example. Serious proposals to expand paid-for organs donation are on the table. At present, Congress is reviewing several new proposals to reform organ donation, including one that would allow transplant coordinators to offer a "gratuity" to relatives at the bedside of a dying or brain dead patient. Another proposal seeks tax credits for organs donation. A great many bioethicists, religious leaders, social scientists, and transplant specialists are now leaning toward the individual's "right to sell."

### **So, What's Wrong with Selling an Organ?**

*If a living donor can do without an organ, why shouldn't the donor profit and medical science benefit?<sup>19</sup>*

In the developing world, poor people cannot really "do without" their "extra" organs. Transplant surgeons have disseminated an untested hypothesis of "risk-free" live donation in the absence of any published, longitudinal studies of the effects of organ removal on the poor. Organs

Watch has found that living kidney donors from shantytowns, inner cities, or prisons face extraordinary threats to their health and personal security through violence, accidents, and infectious disease that can all too readily compromise their remaining kidney. As the use of live kidney donors has moved from the industrialized West, where it takes place among kin and under highly privileged circumstances, to areas of high risk in the developing world, transplant surgeons have become complicit in the needless suffering of a hidden population.

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**In the developing world, poor people cannot really "do without" their "extra" organs.**

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In all these transactions, the body, as we know it, is radically transformed. The integration of the body and its parts as naturally given is exchanged for a divisible body in which individual organs and tissues can be detached, isolated, and sold. This juncture points to the demise of classical humanism and holism and to the rise of what Lawrence Cohen refers to as “an ethics of parts”—part histories, part truths, and now, it seems, divisible bodies in which detached organs emerge as market commodities, as fetishized objects of desire and consumption.

Bioethical arguments about the right to sell an organ or other body part are based on Western notions of contract and individual “choice.” But the social and economic contexts that make the “choice” to sell a kidney in an urban slum of Calcutta, a Brazilian *favela*, or a Philippine shantytown is anything but a “free” and “autonomous” one. The idea of consent is problematic when one has no other option but to sell an organ.

Putting a market price on body parts—even a fair one—exploits the desperation of the poor, turning their 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 like 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 non-renewable organs is an act in which medical practitioners, given their ethical standards, should not be asked to participate. The argument for regulation is out of touch with the social and medical realities operating in many parts of the world but especially in developing 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.

Amidst the tension between organ-givers and organ-recipients, between doctors and patients, between North and South, between individuals and the state, between the illegal and the “merely” unethical, clarity is needed about whose values and whose notions of the body and embodiment are being represented. In fact, the values of bodily integrity and dignity are more widespread in the poorer parts of the world than they are in the more affluent and more secular parts. The values of bodily integrity and dig-

nity lie behind “First Peoples” demands for the repatriation and reburial of human remains warehoused in museum archives. They lie behind the demands of the wretchedly poor for dignified death and burial.<sup>20</sup> And they certainly lie behind rumors of organ theft and popular resistance to presumed consent laws.

Organs Watch wants to make sure that that trust is not broken by aggressive doctors who are acting as organs brokers, and by a ruthless pursuit of purchased organs that exploits the poverty and the desperation of newly displaced populations searching for a niche in the global economy via the grotesque market in fresh organs. Transplant surgeons must pay more attention to where organs come from and the manner in which they are procured. There must be firm assurances that organ donation everywhere is voluntary and uncoerced. Finally, the risks and benefits of organ transplantation need to be more equally distributed among and within nations, ethnic groups, genders, and social classes. 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.

### Notes

<sup>1</sup> “Offering Money for Organ Donation Ethical, HHS Committee Says,” *AP/Nando Times*, 3 December 2001.

<sup>2</sup> Radcliffe-Richards J., Daar A., Guttman R., et al., “The case for allowing kidney sales,” *Lancet* 351 no. 9120 (1998):1950–2.

<sup>3</sup> Nancy Scheper-Hughes, “Theft of Life: Globalization of Organ Stealing Rumors,” *Anthropology Today* 12, no. 3 (1996): 3–11.

<sup>4</sup> Pierre Bourdieu, *Outline of a Theory of Practice* (Cambridge University Press, 1977).

<sup>5</sup> Tom Koch, *Scarce Goods: Justice, Fairness and Organ Transplantation* (Westport, CT: Praeger, 2001, in press).

<sup>6</sup> Interview by author.

<sup>7</sup> Arthur Max, “Stolen Kidneys Supplying India’s Transplant Industry,” *San Francisco Chronicle*, April 1995; “Researchers to Monitor Trade in Human Organs,” *New York Times*, 5 November 1999, A23.

<sup>8</sup> Interview by author.

<sup>9</sup> Interview by author.

<sup>10</sup> 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.

<sup>11</sup> See, for example, the arabic (as well as Hebrew and Japanese) version of the university’s advertisement, <<http://www.umm.edu/transplant/arabic.html>>

<sup>12</sup> Frank Demonico, Robert Arnof, Nancy Scheper-Hughes, et al., "Organ Donation by Ethical Incentives—Not by Sales," *New England Journal of Medicine* (2001) in press.

<sup>13</sup> See Nancy Scheper-Hughes and Margaret Lock, "The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology," *Medical Anthropology Quarterly* 1, no. 1 (1984): 6–41.

<sup>14</sup> see Margaret Lock, *Twice Dead: Organ transplant and the Reinvention of Death* (Berkeley, California: University of California Press, 2001).

<sup>15</sup> Interview by author.

<sup>16</sup> Interview by author.

<sup>17</sup> "Man keeps vigil for comatose wife who gave him kidney, life," *The Holland Sentinel*, 15 February 2001.

<sup>18</sup> "The live donor consensus conference," *JAMA* no. 284 (2000): 2919–2926.

<sup>19</sup> Janet Radcliffe-Richards, et al., footnote no. 2.

<sup>20</sup> Nancy Scheper-Hughes, *Death Without Weeping: The Violence of Everyday Life in Brazil* (Berkeley: University of California Press, 1992), 249–264.