NEO-CANNIBALISM: THE GLOBAL TRADE IN HUMAN ORGANS

Nancy Scheper-Hughes

Nancy Scheper-Hughes is Professor in the Department of Anthropology at U. C. Berkeley. She is preparing a book, The Ends of the Body: The Global Traffic in Human Organs, to be published by Farrar, Straus, and Giroux. Scheper-Hughes's publications include: Saints, Scholars and Schizophrenics: Mental Illness in Rural Ireland, which received the Margaret Mead Award from the American Anthropological Association; Death without Weeping: The Violence of Everyday Life in Brazil, which received several awards and prizes, including the Wellcome Medal for Anthropology Applied to Medical Problems, awarded by the Royal Anthropological Institute of Great Britain and Ireland. She is the Director of Organs Watch.

The Global Market in Human Organs

During the summer of 1998, I was sitting at a sidewalk café in downtown São Paulo with Laudiceia Cristina da Silva, a young mother and office receptionist, who had just legally requested an investigation of the large public hospital where in June 1997, during a routine operation to remove an ovarian cyst, she had “lost” a kidney. That she was missing a

1 The extensive, multi-sited field research for this article was supported by a generous grant from the Open Society Institute New York City, with matching funds from the Institute for International Studies, International and Area Studies, and the Center for Human Rights at the University of California, Berkeley.
kidney was discovered soon after the operation by the young woman's family doctor during a routine follow-up examination. When confronted with the information, the hospital representative told a highly improbable story: Laudiceia's missing kidney was embedded in the large "mass" that had accumulated around her ovarian cyst. But the hospital refused to produce either their medical records or the evidence—the diseased ovary and the kidney had been "discarded," she was told, along with some of her medical records. The regional Medical Ethics Board refused to review the case. Laudiceia believes that her valuable kidney was taken to serve the needs of another, wealthier, patient in the same hospital. To make matters worse, Laudiceia's brother had been killed in a random act of urban violence several weeks earlier, and the family arrived at the hospital too late to stop organ retrieval. Brazil's new "presumed consent" law assumes that people have agreed to donate their organs unless the proper paperwork has been filled out. "Poor people like ourselves are losing our organs to the state, one by one," Laudiceia said angrily.

In July of 2000, Avraham, a retired lawyer in Jerusalem, explained why he went through considerable expense and danger to travel to Eastern Europe to purchase a kidney from a displaced rural worker, rather than wait in line for a cadaver organ in Israel:

Why should I have to wait years for a kidney from someone who was in a car accident, pinned under the 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 is not going to be any good! Or, even worse, I could get the organ of an elderly person, or an alcoholic, or a person who died of a stroke. That kidney is all used up! It’s far better to get a kidney from a healthy man who can also benefit from the money I can afford to pay. Where I went the people were so poor they did not even have bread to eat. Do you have any idea of what one thousand, let alone five thousand dollars, means to a peasant? The money I paid was a gift equal to the gift that I received.
Amidst the neo-liberal readjustments of the new global economy, there has been a rapid depletion of traditional, modernist, and humanist values. New relations between capital and work, bodies and the state, citizenship and social and medical inclusion (and exclusion) are emerging. The rapid growth of “medical tourism” for transplant surgery and for other advanced bio-medical and surgical procedures has exacerbated older divisions between North and South, core and periphery, haves and have-nots, spawning a grotesque niche market for sold organs, tissues, and other body parts. There are race, class, and gender inequalities in the procurement and distribution of tissues and organs. In general, the flow of organs, tissues, and body parts follows the modern routes of capital: from South to North, from third to first world, from poor to rich, from black and brown to white, and from female to male. In the very worst instance, this market has resulted in theft and coercion ranging from kidney theft, as in the case of Laudiceia, and a self-serving belief in property rights over the spare parts of the poor, as in the case of Avraham.

A triumphant global and “democratic” capitalism has released a voracious appetite for foreign bodies to do the shadow work/dirty work of production and for “fresh” bodies for domestic and international medical consumption. A confluence in the flows of immigrant workers and itinerant kidney sellers who fall into the hands of unscrupulous and highly sophisticated transnational organs brokers is a sub-text in the story of late twentieth century and early twenty-first century globalization, one which combines elements of pre- and post-modernity. As practiced today in many global contexts, these new organs procurement transactions are a blend of altruism and commerce; of science, magic, and sorcery; of gifting, barter, and theft; of voluntarism and coercion. Transplant surgery has re-conceptualized social relations between self and other, individual and society, and among the “three bodies”: the existential lived body-self; the social, representational body; and the body politic.2 Finally, it has redefined the meanings of real/unreal, seen/

unseen, life/death, body/corpse/cadaver, person/non-person, rumors/fiction/fact. Throughout these radical transformations, the voice of anthropology (and of medical anthropology) has been relatively muted, and the real and high-stake debates have been waged among surgeons, bio-ethicists, international lawyers, and economists.

There now exists an unregulated, international, multi-million dollar business in tissues and body parts, obtained from naive donors who believe their gifts are being used in heroic rescues to save lives and comfort burn victims. Instead, as in many parts of the U.S., the bones and skin are sold and processed by private bio-tech firms into expensive products for dentistry and plastic surgery. One of these new products is Dermalogen™, recently released by Collagenesis. The company describes this processed human skin product as an injectable human tissue implant for the treatment of facial contour defects. It is designed “to meet the needs of patients who are seeking a safe, long-lasting and natural alternative to animal and synthetic implants for soft tissue augmentation.” In fact, Dermalogen™ is a skin-based gel sold to plastic surgeons, who use it in operations to enlarge the lips and smooth wrinkles. The targeted market is the aging “baby boomer generation.”

In many third-world countries today, human tissue is exchanged with first-world countries for medical technology or expertise. In South Africa the director of an experimental research science unit of a large public medical school showed me official documents approving the transfer of human heart valves taken (without consent) from the bodies of poor blacks in the police mortuary and shipped for “handling costs” to medical centers in Germany and Austria. These fees, which were intentionally inflated to the maximum, helped support the unit’s research program in the face of austerities and the downsizing of advanced medical research facilities in the new South Africa.

Global market capitalism together with advanced medical and bio-technologies have incited new tastes and desires for the skin, bones, blood, organs, tissues, marrow, and reproductive and genetic material of the other. In these new transactions the body as we knew 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, alienated, 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, fetishized objects of desire and of consumption, a form of neo-cannibalism.

For most bio-ethicists the “slippery slope” in transplant medicine begins with the emergence of a black market in organs and tissue sales; for the anthropologist the slippery slope is other and earlier: it is the first time one ailing human looked at another living human and realized that inside that other body was something that could prolong his or her life. Desperation on both sides and a willingness of the transplant doctors to see only one side of the transplant equation allows the commodified and fetishized kidney to become an organ of opportunity for the buyer and an organ of last resort for the seller. Ads like the following one, which appeared in the Diario de Pernambuco, of Recife, Brazil, pop up almost every day in newspapers around the world:

I, Manuel da Silva, 38, unemployed sugar cane worker, father of three hungry children and a sick wife, announce my willingness to sell any organ of which I have two, and the immediate removal of which will not cause my immediate demise.

The sale of human organs and tissues requires that certain disadvantaged individuals, populations, and even nations have been reduced to the role of “suppliers.” It is a scenario in which only certain bodies are broken, dismembered, fragmented, transported, processed, and sold in the interests of a more socially advantaged population of organs and tissues receivers. I use the word “fetish” advisedly to conjure up the displaced magical energy that is invested in the purchased living, and thereby strangely animate, kidney.

The ultimate fetish—as recognized many years ago by Ivan Illich—is the idea of “life” itself as an object of manipulation, a relatively new idea in the history of modernity. The fetishization of life—a life preserved, prolonged, enhanced at almost any cost—erases any possibility of a social ethic.
Living Organ Donation

There has been a dramatic increase worldwide in unrelated living kidney donation in attempts to increase the “supply” of organs to meet growing demands for transplant. Israel, for example, is currently experimenting with a program of “altruistic,” unrelated kidney donation, a contradiction in terms according to the head of the medical committee that was set up to screen applicants, who stated that: “Of the 40-some applications we reviewed and approved, perhaps two were truly altruistic. The others were all paid. We are being made into either fools or liars.” Employers and employees are engaging in “compensated” gifting in which body parts are exchanged for emotional and material support, including secure work and other benefits, or prisoners offer kidneys in exchange for reduced sentences or to alleviate their disgraced social condition.

New forms of “debt peonage” have emerged in which the commodified and fetishized kidney occupies a critical role as collateral. Here the work of my colleague Lawrence Cohen on the emergence of “kidney belts” in southern India is pivotal. Cohen interviewed half a dozen women in a municipal housing-project in a Chennai (Madras) slum in South India, each of whom had sold a kidney for about $1,000. Each woman had undergone her “operation” at the clinic of Dr. K. C. Reddy, India’s most outspoken advocate of the individual’s “right to sell” a kidney. Reddy prides himself on running an exemplary clinic: the kidney sellers are fully informed about the implications and potential dangers of the operation; they are carefully followed for two years after the organ removal and receive free health care at his clinic during that period; and he avoids contact with intermediaries and organs brokers.

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

---

and could not get by. Friends had passed on the word that there was quick money to be had through Dr. Reddy’s clinic. Cohen asked whether the sale made a difference in their lives and was told that it did for a time, but the money was soon swallowed by the usurious interest charged by the local money lenders, and the families were in debt again. Would they do it again? Yes, the women answered. What other choice did they have, with the money gone and the new debts piling up? If only there were three kidneys, with two to spare, then things might be better for them. 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 matter of factly about when it might be necessary to sell a “spare” organ. The idea of the “commodified” kidney has permeated the social imaginary, and so today the kidney represents “everyman’s” last, economic resort, one’s ultimate collateral.

Now occurring is the “coerced” gifting of organs within families in which vulnerable members are “fingered” by means of medical tests for cross matching and demands are made that are difficult to resist. In an op-ed piece in *The New York Times Magazine*, entitled, “Silent Bond,”4 David Biro argues that his potentially fatal illness gave him the right to expect any one of his three younger sisters to respond unquestionably to his need for a bone marrow transfer and transplant. For “that is what families are supposed to do,” even families like this one where brother and sister remain—even after the transplant—relative strangers to each other. Thanks, Biro says, should be unnecessary. And he feels justified in putting his younger sister’s life—the one whose genetic number was, he writes, his “jackpot”—as well as her freedom (travel and mobility were central to her life) on hold, perhaps indefinitely. The bone marrow transfer made Biro feel that his sister had actually “become part of me.” And his continuing, chronic illness constitutes a future claim over his sister’s body. He wants to keep her nearby and at hand, for he very well

---

might need her again. Is this an example of “family bonds” or of family bondage? Was this a gift or a coerced and unrecognized sacrifice?

Transplant Tourism

A new kind of tourism has emerged out of the global economy—transplant tourism—and along with it, a culture of self-defined transplant outlaws—doctors, patients, brokers, and kidney sellers—who short-circuit national waiting lists, on the one hand, and make a mockery of national and international codes of ethics prohibiting the sale of organs, from either living or dead donors, on the other hand. The key actors are a new class of entrepreneurial organs brokers, who capitalize on medically incited organs scarcity panics and prey on the desperation of both the kidney buyers and the organs sellers. The sellers are recruited from vulnerable populations produced in the wake of transitional economies: displaced rural populations, guest workers, refugees, and young soldiers.

For example, in Israel there is an amazing tolerance at official levels toward outlawed “transplant tourism,” which is organized through a local business corporation in conjunction with a leading transplant surgeon, operating out of a major medical center not far from Tel Aviv. Mr. D., the head of “the company” (as transplant patients call it), has developed links with transplant surgeons in Turkey, Russia, Moldavia, Estonia, Georgia, Romania, and (most recently) New York City. The cost of the “package” increased from $120,000 in 1998 to $200,000 in 2001 and, with the pressure from transplant candidates to develop links in more developed countries, the cost is still rising. The transplant “package” covers: the rental of a private plane (to accommodate a group of six patients, each accompanied by a family member, the Israeli doctors, and the business coordinator); the “double operation” (kidney “extraction” and kidney transplant); the kidney and the “donor” fee (the donor is usually paid no more than $5,000); the “fees” paid to bribe airport and customs officials; the rental of private operating and recovery rooms and operating room staff; and hotel accommodations for accompanying family members. The covert operation (in both senses of the term) is accomplished in five days. Day 1: on-site, pre-operative
rests and dialysis; days 2 and 3: the operations (two or three patients per night, depending on the size of the group); days 4 and 5: on-site recovery and the flight home.

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

The passivity of the Ministry of Health in refusing to intervene and crack down on this multi-million dollar business, which is making Israel something of a pariah in the international transplant world, requires some explanation. First, in the absence of a strong culture of organ donation and under the pressure of angry transplant candidates, each person transplanted abroad is one less client with which to contend. A more troubling phenomenon is the support and direct involvement of the Israeli Ministry of Defense in the illicit national “program” of transplant tourism. Some patients who traveled with the outlaw Israeli transplant surgeon to Turkey and Eastern Europe noted that in each of the organized groups of patients were members of the Ministry of Defense or those (such as family members) directly linked with them.

We in the U.S. cannot claim any high moral ground given the new transplant centers in Texas and elsewhere that court and cater to paying foreigners, thereby subverting the notion of donated organs as a national treasure. Dr. F., a nephrologist at Hadassah hospital in Jerusalem, counts among his recovering international transplant patients, several Israelis who have recently returned from Europe and the U.S. with purchased kidneys from living donors. Meanwhile, active organs brokers, working through the Internet and private web sites, have tried to cash in on a new and lucrative field that includes gaining access to experimental genetic surgeries, as well as to purchased organs.
Tissue and Organs Harvesting

The emergence of death camps, torture camps, and tissue and organs harvesting camps came together at certain junctures in the late twentieth century. Our research has uncovered what can only be called fascist, military, and “dirty war” tactics used on the bodies and the organs of the enemy. A footnote to the story of military terrorism during (and following) the “dirty war” in Argentina and the dictatorship years in Brazil is that doctors provided, in the case of Argentina, not only children for military families but also blood, bones, heart valves, organs, and tissues for transplant taken from the bodies of the politically “disappeared” and from the socially disappeared, including captive populations like the mentally retarded in state institutions, such as Montes de Oca and Open Door in Lujan, Buenos Aires province.

In Brazil, transplant doctors told of being given “quotas” of organs to be delivered to military hospitals, organs got by any means possible, including (I was told by one guilt-ridden practitioner) chemically inducing the signs of brain death. The execution of street children in Brazil (seen as enemies of decent people) that reached a peak in the 1990s (well after democratization) involved not only death squad killings but mutilations in the public morgues, a secret dimension of what was essentially class warfare.

In South Africa toward the end of apartheid when a super-abundance of black bodies produced in the violence and chaos of the anti-apartheid struggle piled up in police mortuaries, the harvesting (and sometimes the selling) of desired body parts both for muti (magical medicine) and for transplant was a hidden feature of that struggle. In these sad contexts, traditional sangomas and surgeons could both be described as witch doctors. Meanwhile, human rights groups in the West Bank complained of medical violations of “enemy” cadavers by Israeli pathologists at the legal medical institute.

Mrs. Thandiwe-Sitsheshe Mfundese has taken her complaint—the desecration of her son Andrew’s body at the Salt River Mortuary in Cape Town, after he was killed in township violence in 1992—to the highest arbiter of human suffering in South Africa today, the Truth and
Reconciliation Commission. She sees organs and tissue harvesting without consent as a continuing residue of the practice of an apartheid medicine in which black bodies were and continue to be disrespected in preference for servicing the needs of mostly white and affluent transplant patients in South Africa.

*Gifts and Invisible Sacrifice*

The idea of heroic sacrifice is as old as humanity and central to many religious and secular traditions and ideologies. Individuals have sacrificed themselves consciously and willingly throughout history, giving their bodies and lives for what they believe is a greater cause. But there is a darker side of human sacrifice—when individuals or certain groups are taken in unwilling sacrifice for others: Christians thrown to lions in the Roman Coliseum, Aztec hearts ripped from living bodies, vestal virgins, castrati in papal courts, or slave concubines. We can easily multiply the examples of involuntary and forced bodily sacrifice. The sacrifice is justified as giving life or pleasure to the other, inevitably a more powerful and socially worthy other: “your death will appease the gods,” “your suffering and death will give honor and pleasure to the emperor,” and so on.

A more modern form of human sacrifice is the hidden or invisible sacrifice—a sacrifice that is unrecognized because it is buried and hidden from view. This is the kind of sacrifice that occurs in many fields of organs and tissue procurement. Here the sacrifice that is demanded is prettily wrapped up in the language of gift giving and life saving. Sometimes the gift has been taken without any or at least without any fully informed consent.

Sometimes donation is a coerced or manipulated gift. And sometimes the donation or the gift is really a commodity that is traded, bartered, and sold on the open market. This kind of “invisible sacrifice” is grounded in the bad faith of medical institutions and eye and tissue banks. And, unfortunately, it is where tissue and organ harvesting—not only in the so-called Third World but also in the U.S.—is moving today. The sacrifice is hidden when living relations are made to feel that
they are obligated to donate the organs or tissues of a loved one in order to “save lives.” Advantage is taken of exemplary people who are asked to perform acts of mercy and altruism at a time of profound grief, like Linda Johnson-Schuringa, from Orange, California, who put her late husband’s body into the care of the Orange County Eye and Tissue Bank, believing that his tissues and bones would alleviate the suffering of another person, only to discover later that the gift of her husband’s bones had been shipped to Germany and “processed” into a dental product and sold internationally. The sacrifice is hidden when living relations are made to feel that those they love—or at least those to whom they are biologically and genetically related—have a right to their “spare” organs. The silent and often invisible organ donors, living and dead, are often treated not as persons in their own right but as sources of medical material needed for advanced medical technologies.

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

During a field trip to Brazil in 1998, I encountered in Salvador, Bahia, a “worst-case scenario,” showing just how badly a live kidney donation could turn in a third-world context. “Josefa,” the only girl among eight
siblings from a poor, rural family in the interior of the state, developed end-stage kidney disease in her twenties. With the help of people from her local Catholic Church, Josefa moved to Salvador for dialysis treatments, but there her condition continued to deteriorate. Her only solution, she was told, would be a transplant, but as a “public” patient her chances of getting to the top of local “waiting lists” was next to nil. At her doctor's suggestion, Josefa sought a kidney donor among her siblings. An older brother, “Tomas,” the father of three young children, readily offered to help his “baby” sister. But what first seemed like a miraculous transfer of life, rather quickly turned problematic. Soon after the “successful” transplant, Josefa suffered a crisis of rejection and lost her new kidney. Meanwhile, Tomas himself fell ill and was himself diagnosed with kidney disease resulting from a poorly treated childhood infection. What the doctors referred to as a “freak accident” and a stroke of “bad luck” struck Josefa (and her brother) as evidence of a larger social disease: “We were poor and ignorant; the doctors didn’t really care whether we were properly matched or whether I could afford the drugs I needed to stay alive after the transplant.” Josefa’s enormous guilt toward her dying brother brought tears to her eyes throughout our interviews. She was committed to doing everything possible to help out his family to which she felt so miserably indebted. Tomas, a slender, nervous man, looking far older than his years, said ruefully during a separate interview: “I love my sister, and I don’t hold her responsible for what has happened. The doctors never asked about my own medical history before the operation. And afterwards it was too late.”

This anecdote offers one response to the hypothetical challenge: “If a living donor can do without an organ, why shouldn’t the donor profit and medical science benefit?” In the third 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 nephrectomy (kidney removal) among the urban poor living anywhere in the world. Living donors from shantytowns, inner cities, or prisons face extraordinary threats to their health and personal security through violence, injury, accidents, and infectious disease that can all too readily compromise the kidney of last resort. As the use of live kidney donors has moved from the industrialized West, where it takes place among kin
and under highly privileged circumstances, to areas of high risk in the third world, transplant surgeons are complicit in the needless suffering of a hidden population.

**Surplus Empathy**

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

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

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

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

For example, Mr. Tati, a municipal public health food inspector from Jerusalem, went to Turkey for an illegal transplant of a kidney purchased from an Iraqi soldier and returned home close to death and very poor indeed. To begin with, Mr. Tati was a very poor candidate for a transplant. He had suffered a coronary event in his early 40s. He was removed from the official kidney transplant waiting list by his doctors at Hadassah Hospital and was told that dialysis was his best solution. Approached by brokers, Mr. Tati took his medical records to another, competing hospital in Tel Aviv where Dr. Zaki Shapira, a renowned medical outlaw, agreed to include him on his list of transplant tourists. Immediately following his risky transplant, and while he was still in the recovery room, Mr. Tati suffered a second and this time, massive heart attack. This was followed by a crisis of kidney rejection. The outlaw surgeons packed the frail man back into the private jet with an RX to his regular doctors at Hadassah Hospital to treat the medical mess they had created. The doctors at Hadassah were furious, but treated Mr. Tati at the government’s expense. Seven months later, when I first interviewed him, Mr. Tati was still a hospital patient. “He is a real basket case,” his attending physician told me ruefully, “but he did manage to survive the ordeal.” The next time I visited Mr. Tati, in March 2001, he was living at home in a modest working class housing project, but he
was unemployed and disabled. But even worse, he said, was the huge debt he had accumulated. In getting together the $145,000 in cash ("green," i.e., American dollars) to pay for his transnational transplant, Mr. Tati had borrowed from banks and from family, friends, and co-workers. His Israeli medical insurance plan paid $80,000 for the transplant procedure, but he still owed the rest.

And then there is "Pettia," the Bulgarian guest worker who offered her kidney several times over to desperate transplant candidates in Jerusalem, soliciting from each several hundred dollars for pre-tests and cross-matches that always proved disappointing. Meanwhile, Pettia kept the money... and her kidney. Similarly, the FBI and several international transplant surgeons who have had dealings with him, consider Jim Cohan, the indefatigable broker from West Hollywood, Los Angeles, a "scammer" and a "fraud," a man who widely advertises the ability to broker organs when, in fact, there is no evidence that he has ever arranged a transplant. But he has collected substantial "deposits" up to $10,000 from the sick and desperate people he has solicited over the years with his "Dear Prospective Organs Recipient" letter, in which he claims to have arranged hundreds of transplants in the Philippines, Africa, and Europe. The desperately sick are easy prey to kidney scams like these.

**Artificial Scarcities and Invented Needs**

The “demand” for human organs, tissues, and body parts—and the search for wealthy transplant patients to purchase them—is driven by the medical discourse on *scarcity*. The specter of long transplant “waiting lists”—often we have found only virtual lists with little material basis in reality—has motivated and driven questionable practices of organ harvesting with blatant sales alongside “compensated gifting,” doctors acting as brokers, and fierce competition between public and private hospitals for patients of means. At its worst the scramble for organs and tissues has led to human rights abuses and violations in intensive care units and in public morgues. But 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. Conventional medi-
cal ethics obscure the practice of virtue in suffering and dying. Bioethics creates the semblance of ethical choice (e.g., the right to buy a kidney based on a principle of individual autonomy) in an intrinsically unethical context. The magical transformation of a person into a “life” that must be prolonged, saved, at any cost, has made life into the ultimate fetish. Illich once described this transmogrification of a human into a life as “a lethal operation,” as dangerous as Adam and Eve reaching out for the tree of life in the Biblical Garden of Eden.5

Meanwhile, the discourse on “scarcity” conceals the actual existence of “excess” and “wasted” organs that daily end up in hospital dumpsters throughout those parts of the world where the necessary infrastructure is lacking to use them. But the ill will and competitiveness of some hospital workers and medical professionals also contributes to the production of organ “wastage” to the extent that transplant co-ordinators in one public hospital in the third world were told to dispose of usable organs rather than allow the competition to “get their hands on them.” Meanwhile, there is no lack of desperate people willing to sell a kidney for a pittance, as little as $1,000. Many of them wait outside transplant units or in special waiting rooms and wards of surgical units reserved for them in India, Iraq, and Turkey, begging to be considered and hoping for a good match with a prospective buyer.

Can the language of gifting, of life saving, of altruism, or of scarcity and need be maintained in the face of this kind of 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 somehow co-exist. The American Medical Association’s proposals for a “futures market” in

cadaveric organs are just one example. Serious proposals to expand programs allowing unrelated living kidney donors (obviously with compensation) are on the table. Bioethicists, religious leaders, social scientists, and transplant specialists are now leaning towards the individual’s “right to sell.”

*Whose Values Are These?*

Bioethical arguments about the right to sell are based on Euro-American notions of contract and individual “choice.” The social and economic contexts make the “choice” to sell a kidney in an urban slum of Calcutta or in a Brazilian *favela* 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. 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 removal of non-renewable organs is an act in which medical practitioners, given their ethical standards, should not be asked to participate. Finally, the argument for “regulation” is 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.

Amidst the contestations between organ-givers and organ-getters, between doctors and patients, between North and South, between individuals and the state, between the illegal and the “merely” unethical, we need to be clear about whose values and whose notions of the body and embodiment are being represented. Are modernist notions of bodily autonomy and bodily integrity essentially Western conceptions of
human rights? In fact, these values are almost universally shared today. They lie behind “First Peoples” demands for the repatriation and reburial of human remains warehoused in museum archives. They lie behind patients’ rights movements demanding access to medicine and medical technology—rights to “medical citizenship” as it were. And they lie behind the demands of the wretchedly poor for dignified death and burial. And they certainly lie behind organ stealing rumors and popular resistance to “presumed consent” laws.

In fact, it is really in the West where the values of bodily integrity—as well as social justice—are most under assault. The socio-economic-based, race-based inequities in the selection of the best candidates for transplant surgery in the U.S. are particularly disturbing. While African-Americans are reluctant organ donors, the biomedical rationale for a genetic, race-based “matching”—a procedure that is not followed in either Brazil or, historically, in South Africa where black and mixed race donors provided most of the organs for white recipients—is questionable. One wholly unanticipated finding, in the wake of paid kidney transactions, is the generally positive outcomes resulting from an almost “hit and miss” process of tissue cross-matching. Hence, the disproportionate exclusion of African-Americans on this basis is no longer, if it ever was, justified. Trust in medicine and in transplant procedures—especially medical definitions of brain death—is low in African-American “inner city” neighborhoods in the United States and contributes to the low incidence of organ donation. Hence, a vicious cycle is created and maintained. Medical exclusions based on poor tissue matches, previous medical and reproductive histories, and exposure to infectious disease disqualify a great many African-American candidates for transplant surgery. One has to be relatively “healthy,” affluent, and, one could add, white in the U.S. to be a candidate for a cadaveric organ. Under these exclusionary conditions, resistance to organ donation is predictable. African-Americans are counseled by their doctors to

---

pursue live (kidney) donation, more frequently than white Americans are. Meanwhile, African-Americans express greater resistance (than Euro-Americans) to making such demands on their loved ones.

Mortuary practices and tissues harvesting resemble a kind of human strip farming in some parts of the United States. The heart valves, cornea, skin grafts, bone fragments, and other body parts removed 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 (including third-world) countries. And permissible handling charges constitute sales. The director of a private eye bank in Pretoria, South Africa, complained that the American company that provided his institution with corneas charged exorbitant prices, up to $1,000 per cornea. “Where do all these excess cornea come from in the U.S.,” the eye bank director asked pointedly.

In short, as commercialization has entered almost every sphere of life—from markets in “beauty queen” ova and “genius sperm” to the corrupt “willed body” program at UC Irvine, California Medical School, those in the North cannot claim any high moral ground.

Concluding Observations

From its origins transplant surgery has presented itself as a 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 a great deal. Bourdieu reminds us that all gift giving is a deception in that every gift demands a counter gift sooner or later. The same logic may obtain in organ gifting, which helps to explain why there is so little cadaveric transplantation surgery in Japan, certainly one of the most elaborately gift-oriented societies. The gift of a human organ would incur a personal or familial debt that could never be adequately or honorably repaid. Bourdieu might reply that a gift of blood or a life-saving organ can be repaid, in part, through an exchange of symbolic capital: honor, gratitude, or spiritual grace.

In his 1971 classic *The Gift Relationship*, Richard Titmuss anticipates
many of the dilemmas now raised by the global human organs market. His assessment of the negative social effects of commercialized blood markets in the U.S. could also be applied to the global markets in human organs and tissues:

…the commercialism of blood and donor relationships represses the expression of altruism, erodes the sense of community, lowers scientific standards, limits both personal and professional freedoms, sanctions the making of profits in hospitals and clinical laboratories, legalizes hostility between doctor and patient, subjects critical areas of medicine to the laws of the marketplace, places immense social costs on those least able to bear them—the poor, the sick and the inept—increases the danger of unethical behaviour in various sectors of medical science and practice, and results in situations in which proportionately more and more blood is supplied by the poor, the unskilled, and the unemployed, Negroes and other low income groups and categories of exploited human populations of high blood yielders.7

The practices around organs harvesting should respect the wishes and needs of organ donors, living and dead. Surgeons need to pay attention to where organs come from and the manner in which they are harvested so that the “gift of life” never deteriorates into a “theft of life.” Organ donation everywhere must be voluntary. The bodies of donors—living and dead—need to be protected, not exploited, by those charged with their care. The “risks” and “benefits” of organ transplant surgery need to be more equally distributed among and within nations, and among ethnic groups, genders, and social classes. A new ethical blueprint for medicine—and for anthropology—is necessary to stop the growing abuses related to the global organs market.

---