

# The Global Traffic in Human Organs<sup>1</sup>

by Nancy Scheper-Hughes

Inspired by *Sweetness and Power*, in which Sidney Mintz traces the colonial and mercantilist routes of enslaving tastes and artificial needs, this paper maps a late-20th-century global trade in bodies, body parts, desires, and invented scarcities. Organ transplant takes place today in a transnational space with surgeons, patients, organ donors, recipients, brokers, and intermediaries—some with criminal connections—following new paths of capital and technology in the global economy. The stakes are high, for the technologies and practices of transplant surgery have demonstrated their power to reconceptualize the human body and the relations of body parts to the whole and to the person and of people and bodies to each other. The phenomenal spread of these technologies and the artificial needs, scarcities, and new commodities (i.e., fresh organs) that they inspire—especially within the context of a triumphant neoliberalism—raise many issues central to anthropology's concern with global dominations and local resistances, including the reordering of relations between individual bodies and the state, between gifts and commodities, between fact and rumor, and between medicine and magic in postmodernity.

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1. This essay is offered as a "transplanted" surrogate for the Sidney Mintz lecture, "Small Wars: The Cultural Politics of Childhood," which I was honored to present at Johns Hopkins University, October 28, 1996. A revised and expanded version of that lecture was published as the introduction to *Small Wars: The Cultural Politics of Childhood*, edited by Nancy Scheper-Hughes and Carolyn Sargent (Berkeley and Los Angeles: University of California Press,

The urgent need for new international ethical standards for human transplant surgery in light of reports of abuses against the bodies of some of the most socially disadvantaged members of society brought together in Bellagio, Italy, in September 1995 a small international group of transplant surgeons, organ procurement specialists, social scientists, and human rights activists, organized by the social historian David Rothman. This group, the Bellagio Task Force on Organ Transplantation, Bodily Integrity, and the International Traffic in Organs, of which I am a member, is examining the ethical, social, and medical effects of the commercialization of human organs and accusations of human rights abuses regarding the procurement and distribution of organs to supply a growing global market.

At the top of our agenda are allegations of the use of organs from executed prisoners in China and elsewhere in Asia and South America for commercial transactions in transplant surgery; the continuing traffic in organs in India despite new laws which make the practice illegal in most regions; and the truth, if any, behind the global rumors of body stealing, child kidnapping, and body mutilations to procure organs for transplant surgery. My earlier research on the social and metaphorical truths underlying child-and-organ-stealing rumors in Brazil (see Scheper-Hughes 1991; 1992: chap. 6) and elsewhere (Scheper-Hughes 1996a) had led to my being invited to serve on the task force as its anthropologist-ethnographer. At its second meeting, in 1996, I was delegated to initiate ethnographic research on the social context of transplant surgery in three sites—Brazil, South Africa, and (through collaborations with my UC Berkeley colleague Lawrence Cohen) India—chosen because transplant surgery is currently a contentious issue there.

India continues to be a primary site for a lively domestic and international trade in kidneys purchased

1998). I hope that traces of Mintz's historical and ethnographic sensibility can be recognized in my analysis of the commodification of human organs, yet another variant of the global trade in bodies, desires, and needs (see Mintz 1985). This article has emerged from a larger comparative and collaborative project entitled "Selling Life," codirected by Nancy Scheper-Hughes and Lawrence Cohen at the University of California, Berkeley, and funded by an individual fellowship from the Open Society Foundation in New York City. David and Sheila Rothman are collaborators in this larger project. A first draft was written while I was a resident scholar at the Institute on Violence, Culture, and Survival at the Virginia Foundation for the Humanities, Charlottesville, Va. João Guilherme Biehl collaborated in the compilation of field data and in discussing many of the points in this paper. In Brazil I was assisted by Mariana K. Ferreira (Department of Anthropology, University of São Paulo), Núbia Bento Rodrigues (Community Medicine, Medical School, University of Salvador), and Misha Klein (Anthropology, University of San Carlos). In South Africa I was aided immeasurably by my field assistants, Anthony Monga Melwana of the University of Cape Town and Charlotte Roman of Goodwood, Cape Town. The research assistance offered by Suzanne Calpestri of the George and Mary Foster Anthropology Library of UC Berkeley has been inestimable. Several of my colleagues in the Department of Anthropology at Berkeley and the Department of Social Anthropology, University of Cape Town, made substantial contributions to the revision of this paper. To all of the above I am extremely grateful.

from living donors. Despite medical and philosophical debates about kidney sales (see Daar 1989, 1990; 1992a, b; Reddy 1990; Evans 1989; Richards et al. 1998) and medical outcome studies showing high mortality rates among foreign recipients of purchased Indian kidneys (see Saalahudeen et al. 1990), there have been no follow-up studies documenting the long-term medical and social effects of kidney sales on the sellers, their families, or their communities. In Brazil, allegations of child kidnapping, kidney theft, and commerce in organs and other tissues and body parts continue despite the passage in 1997 of a universal-donation law intended to stamp out rumors and prevent the growth of an illegal market in human organs. In South Africa, the radical reorganization of public medicine under the new democracy and the channeling of state funds toward primary care have shifted dialysis and transplant surgery into the private sector, with predictable negative consequences in terms of social equity. Meanwhile, allegations of gross medical abuses—especially the illegal harvesting of organs at police morgues during and following the apartheid years—have come to the attention of South Africa's official Truth and Reconciliation Commission. Finally, Sheila Rothman (1998) and a small team of medical students in New York City have initiated parallel research in New York City. Their preliminary findings indicate obstacles to the successful pre-screening of African-American, Latino, and all women as candidates for organ transplantation.

The first report of the Bellagio Task Force (Rothman et al. 1997) recommended the creation of an international human-donor surveillance committee that would investigate allegations of abuses country by country and serve as a clearinghouse for information on organ donation practices. As a first step toward that goal, Lawrence Cohen, David Rothman, and I have launched a new three-year project entitled Medicine, Markets, and Bodies/Organs Watch, supported by the Open Society Institute and housed at the University of California, Berkeley, and at the Medical School of Columbia University, New York, that will investigate, document, publicize, and monitor (with the help of international human rights activists and local ethnographers and medical students) human rights violations in the procurement and distribution of human organs. In 1999–2000 we expect to add new sites in Eastern Europe, the Middle East, Southeast Asia, and Latin America to our ongoing and collective research.

### Anthropologists on Mars

This essay reports on our initial forays into alien and at times hostile and dangerous<sup>2</sup> territory to explore the practice of tissue and organ harvesting and organ trans-

plantation in the morgues, laboratories, prisons, hospitals, and discreet operating theaters where bodies, body parts, and technologies are exchanged across local, regional, and national boundaries. Virtually every site of transplant surgery is in some sense part of a global network. At the same time, the social world of transplant surgery is small and personalistic; in its upper echelons it could almost be described as a face-to-face community. Therefore, maintaining the anonymity of informants, except for those whose opinions and comments are already part of the public record, is essential.

The research by Cohen and me took place between 1996 and 1998 during a total of five field trips, each roughly six to eight weeks in duration, in Brazil (Recife, Salvador, Rio de Janeiro, and São Paulo), South Africa (Cape Town and Johannesburg), and India. At each site, aided by a small number of local research assistants and anthropologist-colleagues, we conducted observations and interviews at public and private transplant clinics and dialysis centers, medical research laboratories, eye banks, morgues, police stations, newspaper offices, legal chambers and courts, state and municipal offices, parliaments, and other sites where organ harvesting and transplant surgery were conducted, discussed, or debated. In addition to open-ended interviews with transplant surgeons, transplant coordinators, nurses, hospital administrators, research scientists, bioethicists, transplant activists, transplant patients, and living donors in each of these sites, Cohen and I spent time in rural areas and in urban slums, townships, and shantytowns in the vicinity of large public hospitals and medical centers in order to discover what poor and socially marginalized people imagined and thought about organ transplantation and about the symbolic and cultural meanings of body parts, blood, death, and the proper treatment of the dead body.

Of the many field sites in which I have found myself, none compares with the world of transplant surgery for its mythical properties, its secrecy, its impunity, and its exoticism. The organs trade is extensive, lucrative, explicitly illegal in most countries, and unethical according to every governing body of medical professional life. It is therefore covert. In some sites the organs trade links the upper strata of biomedical practice to the lowest reaches of the criminal world. The transactions can involve police, mortuary workers, pathologists, civil servants, ambulance drivers, emergency room workers, eye bank and blood bank managers, and transplant coordinators. As a description of our approach to this trade, Oliver Sacks's (1995) felicitous phrase "an anthropologist on Mars" comes immediately to mind. Playing the role of the anthropological court jester, we began by raising foolish but necessary first questions: *What is going on here?* What truths are being served up? Whose needs are being overlooked? Whose voices are being silenced? What unrecognized sacrifices are being made? What lies behind the transplant rhetoric of gifts, altruism, scarcities, and needs?

I will argue that transplant surgery as it is practiced today in many global contexts is a blend of altruism and

2. Although I have been harassed in the field with respect to other research projects, this was the first time that I was warned of being followed by a hit man representing a deeply implicated and corrupt judge.

commerce, of science and magic, of gifting, barter, and theft, of choice and coercion. Transplant surgery has reconceptualized social relations between self and other, between individual and society, and among the "three bodies"—the existential lived body-self, the social, representational body, and the body political (see Scheper-Hughes and Lock 1987). Finally, it has redefined real/unreal, seen/unseen, life/death, body/corpse/cadaver, person/nonperson, and rumor/fiction/fact. Throughout these radical transformations, the voice of anthropology has been relatively muted, and the high-stakes debates have been waged among surgeons, bioethicists, international lawyers, and economists. From time to time anthropologists have intervened to translate or correct the prevailing medical and bioethical discourses on transplant practice as these conflict with alternative understandings of the body and of death. Margaret Lock's (1995, 1996) animated discussions, debates, and difficult collaborations with the moral philosopher Janet Radcliffe Richards (see Richards et al. 1998) and Veena Das's (n.d.) responses to the latter and to Abdullah Daar (Das 1996) are exemplary in this regard.

But perhaps what is needed from anthropology is something more akin to Donna Haraway's (1985) radical manifesto for the cyborg bodies and cyborg selves that we have already become. The emergence of strange markets, excess capital, "surplus bodies," and spare body parts has generated a global body trade which promises select individuals of reasonable economic means living almost anywhere in the world—from the Amazon Basin<sup>3</sup> to the deserts of Oman—a miraculous extension of what Giorgio Agamben (1998) refers to as *bios*—brute or naked life, the elementary form of species life.<sup>4</sup> In the face of this late-modern dilemma—this particular "end of the body"—the task of anthropology is relatively straightforward: to activate our discipline's radical epistemological promise and our commitment to the primacy of the ethical (Scheper-Hughes 1994). What follows is an ethnographic and reflexive essay on the transformations of the body and the state under conditions of neoliberal economic globalization.

## The Global Economy and the Commodification of the Body

George Soros (1998a, b) has recently analyzed some of the deficiencies of the global capitalist economy, particularly the erosion of social values and social cohesion in the face of the increasing dominance of antisocial market

3. At the Hospital das Clínicas, Mariana Ferreira and I were able to follow the relatively uncomplicated transplant surgery of Dombo, a Suya religious leader with end-stage renal disease who had been flown to São Paulo from his small reserve in Amazonas. Dombo was, in fact, considerably less anxious about the operation than the local businessman who shared his semiprivate hospital room. He was certain that his spirit familiars would accompany him into and through the operation.

4. I am indebted to João Biehl for the reference to Agamben's recent work and for pointing out its relevance to this project.

values. The problem is that markets are by nature indiscriminate and inclined to reduce everything—including human beings, their labor, and their reproductive capacity—to the status of commodities. As Arjun Appadurai (1986) has noted, there is nothing fixed, stable, or sacrosanct about the "commodity candidacy" of things. Nowhere is this more dramatically illustrated than in the current markets for human organs and tissues to supply a medical business driven by supply and demand. The rapid transfer of organ transplant technologies to countries in the East (China, Taiwan, and India) and the South (especially Argentina, Chile, and Brazil) has created a global scarcity of viable organs that has initiated a movement of sick bodies in one direction and of healthy organs—transported by commercial airlines in ordinary Styrofoam picnic coolers conveniently stored in overhead luggage compartments—often in the reverse direction, creating a kind of "kula ring" of bodies and body parts.

What were once experimental procedures performed in a few advanced medical centers (most of them connected to academic institutions) have become commonplace surgeries throughout the world. Today, kidney transplantation is virtually universal. Survival rates have increased markedly over the past decade, although they still vary by country, region, quality and type of organ (living or cadaveric), and access to the antirejection drug cyclosporine. In parts of the Third World where morbidity rates from infection and hepatitis are higher, there is a preference for a living donor whose health status can be documented before the transplant operation.

In general, the flow of organs 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. Religious prohibitions in one country or region can stimulate an organs market in more secular or pluralistic neighboring areas. Residents of the Gulf States travel to India and Eastern Europe to obtain kidneys made scarce locally by fundamentalist Islamic teachings that will in some areas allow organ transplantation (to save a life) but draw the line at organ donation. Japanese patients travel to North America for transplant surgery with organs retrieved from brain-dead donors, a definition of death only recently and very reluctantly accepted in Japan. To this day heart transplantation is rarely performed in Japan, and most kidney transplants rely on living, related donors (see Lock 1996, 1997, n.d.; Ohnuki-Tierney 1994). For many years Japanese nationals have resorted to various intermediaries, sometimes with criminal connections, to locate donor hearts in other countries, including China (Tsuyoshi Awaya, testimony before the International Relations Committee, U.S. House of Representatives, June 4, 1998) and the United States.

Until the practice was condemned by the World Medical Association in 1994, patients from several Asian countries traveled to Taiwan to purchase organs harvested from executed prisoners. The ban on the use of organs from executed prisoners in capitalist Taiwan merely opened up a similar practice in socialist China;

the demand of governments for hard currency has no fixed ideological or political boundaries. Meanwhile, patients from Israel, which has its own well-developed but underused transplantation centers (see Fishman 1998, Kalifon 1995), travel elsewhere—to Eastern Europe, where living kidney donors can be found, and to South Africa, where the amenities in private transplantation clinics can resemble those of four-star hotels. Meanwhile, Turkey is emerging as a new and active site of illegal traffic in transplant organs, with both living donors and recipients arriving from other countries for operations. In all these transactions, organs brokers are the essential actors. Because of these unsavory events, the sociologist-ethnographers Renée Fox and Judith Swazey (1992) have abandoned the field of organ transplantation after some 40 years, expressing their dismay at the "profanation" of organ transplantation over the past decade and pointing to the "excessive ardor" to prolong life indefinitely and the move toward financial incentives and purchased organs. More recently, Fox (1996:253) has expressed the hope that her decision will serve as moral testimony against the perversion of a technology in which she had been a strong believer.

Cultural notions about the dignity of the body and of sovereign states pose some barriers to the global market in body parts, but these ideas have proven fragile. In the West, theological and philosophical reservations gave way rather readily to the demands of advanced medicine and biotechnology. Donald Joralemon (1995:335) has noted wryly that organ transplantation seems to be protected by a massive dose of cultural denial, an ideological equivalent of the cyclosporine which prevents the individual body's rejection of a strange organ. This dose of denial is needed to overcome the social body's resistance to the alien idea of transplantation and the new kinds of bodies and publics that it requires. No modern pope (beginning with Pius XII) has raised any moral objection to the requirements of transplant surgery. The Catholic Church decided over 30 years ago that the definition of death—unlike the definition of life—should be left up to the doctors, paving the way for the acceptance of brain-stem death.

While transplant surgery has become more or less routine in the industrialized West, one can recapture some of the technology's basic strangeness by observing the effects of its expansion into new social, cultural, and economic settings. Wherever transplant surgery moves it challenges customary laws and traditional local practices bearing on the body, death, and social relations. Commonsense notions of embodiment, relations of body parts to the whole, and the treatment and disposal of the dying are consequently being reinvented throughout the world. Not only stock markets have crashed on the periphery in recent years—so have long-standing religious and cultural prohibitions.

Lawrence Cohen, who has worked in rural towns in various regions of India over the past decade, notes that in a very brief period the idea of trading a kidney for a dowry has caught on and become one strategy for poor parents desperate to arrange a comfortable marriage for

an "extra" daughter. A decade ago, when townspeople first heard through newspaper reports of kidney sales occurring in the cities of Bombay and Madras, they responded with understandable alarm. Today, Cohen says, some of these same people now speak matter-of-factly about when it might be necessary to sell a "spare" organ. Cohen argues that it is not that every townsperson actually knows someone who has been tempted to sell a vital part of the self but that the idea of the "commodified" kidney has permeated the social imaginary: "The kidney [stands] . . . as the marker of one's economic horizon, one's ultimate collateral" (n.d.). Some parents say that they can no longer complain about the fate of a dowry-less daughter; in 1998 Cohen encountered friends in Benares who were considering selling a kidney to raise money for a younger sister's dowry. In this instance, he notes, "women flow in one direction and kidneys in the other." And the appearance of a new biomedical technology has reinforced a traditional practice, the dowry, that had been waning. With the emergence of new sources of capital, the dowry system is expanding, along with kidney sales, into areas where it had not traditionally been practiced.

In the interior of Northeast Brazil, in response to a kidney market that emerged in the late 1970s, ordinary people began to view their matched organs as redundancies. Brazilian newspapers carried ads like this one published in the *Diario de Pernambuco* in 1981: "I am willing to sell any organ of my body that is not vital to my survival and that could help save another person's life in exchange for an amount of money that will allow me to feed my family." Ivo Patarra, a São Paulo journalist with whom I have been collaborating on this project, traced the man who placed this ad to a peripheral suburb of Recife. Miguel Correia de Oliveira, age 30, married and the father of two small children, was unemployed and worried about his family's miserable condition. His rent was unpaid, food bills were accumulating, and he did not even have the money to purchase the newspaper every day to see if there had been a response to his ad. He told Patarra (1982:136)

I would do exactly as I said, and I have not regretted my offer. I know that I would have to undergo an operation that is difficult and risky. But I would sell any organ that would not immediately cause my death. It could be a kidney or an eye because I have two of them. . . . I am living through all sorts of crises and I cannot make ends meet. If I could sell a kidney or an eye for that much money I would never have to work again. But I am not stupid. I would make the doctor examine me first and then pay me the money up front before the operation. And after my bills were paid, I would invest what remains in the stock market.

In 1996 I interviewed a schoolteacher in the interior of Pernambuco who had been persuaded to donate a kidney to a distant male relation in exchange for a small compensation. Despite the payment Rosalva insisted

that she had donated "from the heart" and out of pity for her cousin. "Besides," she added, "wouldn't you feel obligated to give an organ of which you had two and the other had none?" But it had not been so long before this that I had accompanied a small procession to the municipal graveyard in this same community for the ceremonial burial of an amputated foot. Religious and cultural sentiments about the sacredness and integrity of the body were still strong. Rosalva's view, less than two decades later, of her body as a reservoir of duplicate parts was troubling.

### India: Organs Bazaar

A great many people—not all of them wealthy—have shown their willingness to travel great distances to secure transplants through legal or illegal channels, even though survival rates in some of the more commercialized contexts are quite low. For example, between 1983 and 1988, 131 patients from just three renal units in the United Arab Emirates and Oman traveled to India to purchase, through local brokers, kidneys from living donors. The donors, mostly from urban shantytowns, were paid between \$2,000 and \$3,000. News of incipient "organs bazaars" in the slums of Bombay, Calcutta, and Madras appeared in Indian weeklies (Chengappa 1990) and in special reports on U.S. and British television. It was not clear at the time how much of this reporting was to be trusted, but in the early 1990s scientific articles began to appear in *The Lancet* and *Transplantation Proceedings* reporting poor medical outcomes with kidneys purchased from individuals infected with hepatitis and HIV (see Saalahudeen et al. 1990).

The first inklings of a commercial market in organs appeared in 1983, when a U.S. physician, H. Barry Jacobs, established the International Kidney Exchange in an attempt to broker kidneys from living donors in the Third World, especially India. By the early 1990s some 2,000 kidney transplants with living donors were being performed each year in India, leading Prakash Chandra (1991) to refer to India as the "organs bazaar of the world." But the proponents of paid living donors, such as K. C. Reddy (1990), a urologist with a thriving practice of kidney transplantation in Madras, argued that legalizing the business would eliminate the middlemen who profit by exploiting such donors. Reddy described the kidney market as a marriage bureau of sorts, bringing together desperately ill buyers and desperately poor sellers in a temporary alliance against the wolves at their doors.

The overt market in kidneys that catered largely to wealthy patients from the Middle East was forced underground following passage of a law in 1994 that criminalized organ sales. But recent reports by human rights activists, journalists, and medical anthropologists, including Cohen and Das, indicate that the new law has produced an even larger *domestic* black market in kidneys, controlled by organized crime expanding out from the heroin trade (in some cases with the backing of local

political leaders). In other areas of India the kidney business is controlled by the owners of for-profit hospitals that cater to foreign and domestic patients who can pay to occupy luxuriously equipped medical suites while awaiting the appearance of a living donor. Investigative reporters (see *Frontline*, December 26, 1997) found that a doctor-broker nexus in Bangalore and Madras continues to profit from kidney sales because a loophole in the new law permits unrelated kidney "donation" following approval by local medical authorization committees. Cohen and others report that these committees have been readily corrupted in areas where kidney sales have become an important source of local income, with the result that sales are now conducted with official seals of approval by local authorization committees.

Today, says Cohen (n.d.), only the very rich can acquire an unrelated kidney, for in addition to paying the donor, the middlemen, and the hospital they must bribe the authorization committee members. As for the kidney sellers, recruited by brokers who often get half the proceeds, almost all are trapped in crippling cycles of debt. The kidney trade is another link, Cohen suggests, in a system of debt peonage reinforced by neoliberal structural adjustment. Kidney sales display some of the bizarre effects of a global capitalism that seeks to turn everything into a commodity. And though fathers and brothers talk about selling kidneys to rescue dowry-less daughters or sisters, in fact most kidney sellers are women trying to rescue a husband, whether a bad one who has prejudiced the family by his drinking and unemployment or a good one who has gotten trapped in the debt cycle. Underlying it is the logic of gender reciprocity: the husband "gives" his body in often servile and/or back-breaking labor, and the wife "gives" her body in a mutually life-saving medical procedure.

But the climate of rampant commercialism has produced rumors and allegations of organ theft in hospitals similar to those frequently encountered in Brazil. During an international conference I organized in April 1996 at the University of California, Berkeley, on the commerce in human organs, Veena Das told a National Public Radio reporter for the program *Marketplace* the story of a young woman in Delhi whose stomach pains were diagnosed as a bladder stone requiring surgery. Later, the woman charged that the attending surgeon had used the "bladder stone" as a pretext to operate and remove one of her kidneys for sale to a third party. True or false—and allegations like these are slippery because hospitals refuse to open their records to journalists or anthropologists—such stories are believed by many poor people worldwide, who therefore avoid public hospitals even for the most necessary and routine operations.

### China: The State's Body

China stands accused today of taking organs from executed prisoners for sale in transplant surgeries involving mostly foreign patients. Human Rights Watch/Asia (1995) and the independent Laogai Research Foundation

have documented through available statistics and the reports of Chinese informants, some of them doctors or prison guards, that the Chinese state systematically takes kidneys, corneas, liver tissue, and heart valves from its executed prisoners. While some of these organs are used to reward politically well-connected Chinese, others are sold to transplant patients from Hong Kong, Taiwan, Singapore, and other mostly Asian nations, who will pay as much as \$30,000 for an organ. Officials have denied the allegations, but they refuse to allow independent observers to be present at executions or to review transplant medical records. As early as October 1984, the government published a directive stating that "the use of corpses or organs of executed criminals must be kept strictly secret . . . to avoid negative repercussions" (cited in Human Rights Watch/Asia 1995:7).

Robin Monroe, the author of the Human Rights Watch/Asia report (1995), told the Bellagio Task Force that organs were taken from some 2,000 executed prisoners each year and, worse, that number was growing, as the list of capital crimes in China had been expanded to accommodate the growing demand for organs. These allegations are supported by an Amnesty International report claiming that a new "strike hard" anticrime campaign in China has sharply increased the number of people executed, among them thieves and tax cheaters. In 1996 at least 6,100 death sentences were handed down and at least 4,367 confirmed executions took place. Following these reports, David Rothman (1997) visited several major hospitals in Beijing and Shanghai, where he interviewed transplant surgeons and other medical officers about the technical and the social dimensions of transplant surgery as practiced in their units. While they readily answered technical questions, they refused to respond to questions regarding the sources of transplant organs, the costs for organs and surgery, or the numbers of foreign patients who received transplants. Rothman returned from China convinced that what lies behind its anticrime campaign is a "thriving medical business that relies on prisoners' organs for raw materials."

Tsuyoshi Awaya, another Bellagio Task Force member, has made five research trips to China since 1995 to investigate organs harvesting in Chinese prisons. On his most recent trip, in 1997, he was accompanied by a Japanese organs broker and several of his patients, all of whom returned to Japan with new kidneys that they knew had come from executed prisoners. Awaya told the U.S. House International Relations Committee in 1998 that a great many Japanese patients go overseas for organ transplants. Those who cannot afford to go to the West go to one of several developing countries in Asia, including China, where purchased organs from executed prisoners are part of the package of hospital services for a transplant operation. Since prisoners are not paid for their "donation," organs sales per se do not exist in China. However, taking prisoners' organs without consent could be seen as a form of body theft.

Finally, Dr. Chun Jean Lee, chief transplant surgeon at the National Taiwan University Medical Center and also a member of the Bellagio Task Force, is convinced

that the allegations about China are true because the practice of using organs from executed prisoners is fairly widespread in Asia. He says that until international human rights organizations put pressure on his institution, it too had used prisons to supply the organs it needed. China has held out, Lee suggests, because of the desperate need for foreign dollars and because there is less concern in Asia for issues of informed consent. In some Asian nations the use of prisoners' organs is seen as a social good, a form of public service, and an opportunity for them to redeem their families' honor.

Of course, not all Chinese citizens embrace this collectivist ethos, and human rights activists such as Harry Wu, the director of the Laogai Foundation in California, see the practice as a gross violation of human rights. At the 1996 Berkeley conference on traffic in human organs, Wu said,

In 1992 I interviewed a doctor who routinely participated in removing kidneys from condemned prisoners. In one case, she said, breaking down in the telling, that she had even participated in a surgery in which two kidneys were removed from a living, anesthetized prisoner late at night. The following morning the prisoner was executed by a bullet to the head.

In this chilling scenario brain death followed rather than preceded the harvesting of the prisoner's vital organs. Later, Wu introduced Mr. Lin, a recent Chinese immigrant to California, who told the National Public Radio reporters for *Marketplace* that shortly before leaving China he had visited a friend at a medical center in Shanghai. In the bed next to his friend was a politically well-situated professional who told Lin that he was waiting for a kidney transplant later that day. The kidney, he explained, would arrive as soon as a prisoner was executed that morning. The prisoner would be intubated and prepared for the subsequent surgery by doctors present for the execution. Minutes later the man would be shot in the head and the doctors would extract his kidneys and rush them to the hospital, where two transplant surgery teams would be assembled and waiting.

Wu's allegations were bolstered by the result of a sting operation in New York City that led to the arrest of two Chinese citizens offering to sell corneas, kidneys, livers, and other human organs to U.S. doctors for transplant surgery (*Mail and Guardian*, February 27, 1998; *San Jose Mercury News*, March 19, 1998; *New York Times*, February 24, 1998). Posing as a prospective customer, Wu produced a videotape of the two men in a Manhattan hotel room offering to sell "quality organs" from a dependable source: some 200 prisoners executed on Hainan Island each year. A pair of corneas would cost \$5,000. One of the men guaranteed this commitment by producing documents indicating that he had been deputy chief of criminal prosecutions in that prison. Following their arrest by FBI agents, the men were charged with conspiring to sell human organs, but the trial has been delayed because of concerns over the extent to which

the defendants were entrapped in the case (*New York Times*, March 2, 1999). As a result of this story, Fresenius Medical Care, based outside Frankfurt, announced that it was ending its half-interest in a kidney dialysis unit (next to a transplant clinic) in Guangzhou, noting its suspicion that foreign patients there were receiving "kidneys harvested from executed Chinese criminals" (*New York Times*, March 7, 1998).

## Bioethical Dilemmas

While members of the Bellagio Task Force agreed on the human rights violations implicit in the use of executed prisoners' organs, they found the issue of organ sales more complex. Those opposing the idea of sales expressed concerns about social justice and equity. Would those forced by circumstance to sell a kidney be in a roughly equivalent position to obtain dialysis or transplant surgery should their remaining kidney fail at a later date? Others noted the negative effects of organ sales on family and marital relations, gender relations, and community life. Others worried about the coarsening of medical sensibilities in the casual disregard by doctors of the primary ethical mandate to do no harm to the bodies in their care, including their donor patients.

Those favoring regulated sales argued against social science paternalism and on behalf of individual rights, bodily autonomy, and the right to sell one's organs, tissues, blood, or other body products, an argument that has gained currency in some scholarly circles (see Daar 1989, 1992a, b, n.d.; Kervorkian 1992; Marshall, Thomas, and Daar 1996; Richards et al. 1998). Daar argues from a pragmatic position that *regulation* rather than *prohibition* or moral condemnation is the more appropriate response to a practice that is already widely established in many parts of the world. What is needed, he argues, is rigorous oversight and the adoption of a "donor's bill of rights" to inform and protect potential organ sellers.

Some transplant surgeons on the task force asked why kidneys were treated differently from other body parts that are sold commercially, including skin, corneas, bones, bone marrow, cardiac valves, blood vessels, and blood. The exception was based (they suggest) on the layman's natural aversion to the idea of tampering with *internal* organs. Influenced by Daar's "rational-choice" position, the Bellagio Task Force report (Rothman et al. 1997:2741) concluded that the "sale of body parts is already so widespread that it is not self-evident why solid organs should be excluded [from commercialization]. In many countries, blood, sperm and ova are sold. . . . On what grounds may blood or bone be traded on the open market, but not cadaveric kidneys?"

But the social scientists and human rights activists serving on the task force remain profoundly critical of bioethical arguments based on Euro-American notions of contract and individual choice. They are mindful of the social and economic contexts that 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 metaphorically at the door—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, as Veena Das (n.d.) so aptly puts it. And the argument for regulation is out of touch with social and medical realities in many parts of the world, 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.

Responding to Daar during the Berkeley conference on the question of regulating organ sales, Das countered the neoliberal defense of individual rights to sell by noting that in *all* contracts there are certain exclusions. In family, labor, and antitrust law, for example, anything that would damage social or community relations is generally excluded. Asking the law to negotiate a fair price for a live human kidney, Das argued, goes against everything that contract theory represents. When concepts such as individual agency and autonomy are invoked in defending the right to sell a spare organ, anthropologists might suggest that certain living things are not legitimate candidates for commodification. The removal of nonrenewable organs leads to irreparable personal injury, and it is an act in which, given their ethical standards, medical practitioners should not be asked to participate.

While to many surgeons an organ is a thing, an expensive "object" of health, a critical anthropologist like Das must ask, "Just what is an organ?" Is the transplant surgeon's kidney seen as a redundancy, a "spare part," equivalent to the Indian textile worker's kidney, seen as an "organ of last resort"? These two "objects" are not comparable, and neither is equivalent to the kidney seen as that precious "gift of life" anxiously sought by the desperate transplant patient. And, while bioethicists begin their inquiries with the unexamined premise of the body (and its organs) as the unique property of the individual, anthropologists must intrude with our cautionary cultural relativism. Are those living under conditions of social insecurity and economic abandonment on the periphery of the new world order really the "owners" of their bodies? This seemingly self-evident first premise of Western bioethics would not be shared by peasants and shantytown dwellers in many parts of the Third World. The chronically hungry sugar plantation workers in Northeast Brazil, for example, frequently state with conviction, "We are not even the owners of our own bodies" (see Scheper-Hughes 1992: chap. 6).

Nonetheless, arguments for the commercialization of organs are gaining ground in the United States and elsewhere (Anders 1995, Schwindt and Vining 1986). Lloyd R. Cohen (1989, 1993) has proposed a "futures market" in cadaveric organs that would operate through advance contracts offered to the general public. For organs successfully transplanted at death such contracts would provide a substantial sum—\$5,000 per organ used has been suggested—to the deceased person's designee. While gifting can always be expected among family members, fi-

nancial inducements might be necessary, Cohen argues, to provide organs for strangers. The American Medical Association is considering various proposals that would enable people to bequeath organs to their own heirs or to charity for a price. In a telephone interview in 1996, Dr. Charles Plows, chair of the AMA's Committee on Ethical and Judicial Affairs, said that he agreed in principle with Cohen's proposal. Everyone, he said, except the organ donor benefits from the transplant transaction. So, at present the AMA is exploring several options. One is to set a fixed price per organ. Another is to allow market forces—supply and demand—to establish the price. The current amalgam of positions points to the construction of new desires and needs, new social ties and social contracts, and new conceptions of justice and ethics around the medical and mercantile uses of the body.

## Artificial Needs and Invented Scarcities

The demand for human organs—and for wealthy transplant patients to purchase them—is driven by the medical discourse on scarcity. Similar to the parties in the international market in child adoption (see Schepers-Hughes 1991, Raymond 1989), those looking for transplant organs—both surgeons and their patients—are often willing to set aside questions about how the “purchased commodity” was obtained. In both instances the language of “gifts,” “donations,” “heroic rescues,” and “saving lives” masks the extent to which ethically questionable and even illegal means are used to obtain the desired object. The specter of long transplant waiting lists—often only virtual lists with little material basis in reality—has motivated physicians, hospital administrators, government officials, and various intermediaries to employ questionable tactics for procuring organs. The results are blatant commercialism 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 gross human rights violations in intensive care units and morgues. But the idea of organ scarcity is what Ivan Illich would call an artificially created need, invented by transplant technicians for an ever-expanding sick, aging, and dying population.

Several key words in organ transplantation require radical deconstruction, among them “scarcity,” “need,” “donation,” “gift,” “bond,” “life,” “death,” “supply,” and “demand.” Organ scarcity, for example, is invoked like a mantra in reference to the long waiting lists of candidates for various transplant surgeries (see Randall 1991). In the United States alone, despite a well-organized national distribution system and a law that requires hospitals to request donated organs from next of kin, there are close to 50,000 people currently on various active organ waiting lists (see Hogle 1995). But this scarcity, created by the technicians of transplant surgery, represents an artificial need, one that can never be satisfied, for underlying it is the unprecedented possibility

of extending life indefinitely with the organs of others. I refer, with no disrespect intended to those now patiently waiting for organ transplants, to the age-old denial and refusal of death that contributes to what Ivan Illich (1976) identified as the hubris of medicine and medical technology in the face of mortality.

Meanwhile, the so-called gift of life that is extended to terminal heart, lung, and liver patients is sometimes something other than the commonsense notion of a life. The survival rates of a great many transplant patients often conceal the real living-in-death—the weeks and months of extended suffering—that precedes actual death.<sup>5</sup> Transplant patients today are increasingly warned that they are not exchanging a death sentence for a new life but rather exchanging one mortal, chronic disease for another. “I tell all my heart transplant patients,” said a South African transplant coordinator, “that after transplant they will have a condition similar to AIDS and that in all probability they will die of an opportunistic infection resulting from the artificial suppression of their immune system.” While this statement is an exaggeration, most transplant surgeons I interviewed accepted its basic premise. Dr. N of South Africa told of major depressions among his large sample of post-operative heart transplant patients, some leading to suicides following otherwise successful transplants. For this and other reasons he had decided to give up heart transplant surgery for less radical surgical interventions.

The medical discourse on scarcity has produced what Lock (1996, 1997) has called “rapacious demands.” Awaya (1994) goes even farther, referring to transplant surgery a form of “neo-cannibalism.” “We are now eyeing each other’s bodies greedily,” he says, “as a source of detachable spare parts with which to extend our lives.” While unwilling to condemn this “human revolution,” which he sees as continuous with, indeed the final flowering of, our evolutionary history, he wants organ donors and recipients to recognize the kind of social exchange in which they are engaged. Through modern transplant technology the “biosociality” (see Rabinow 1996) of a few is made possible through the literal incorporation of the body parts of those who often have no social destiny other than premature death (Schepers-Hughes 1992; Castel 1991; Biehl 1998, 1999).

The discourse on scarcity conceals the overproduction of excess and wasted organs that daily end up in hospital dumpsters in parts of the world where the necessary transplant infrastructure is limited. The ill will and competitiveness of hospital workers and medical professionals also contributes to waste of organs. Transplant specialists whom Cohen and I interviewed in South Africa, India, and Brazil often scoffed at the notion of organ scarcity, given the appallingly high rates of youth mortality,

5. The suffering of transplant patients caused by the blend of clinical and “experimental” liver transplant procedures has led one noted bioethicist (M. Rorty, personal communication) to stipulate an exception in her own living will: All “usable” organs—minus her liver—are to be donated to medical science. Likewise, Das (n.d.) refers to “the tension between the therapeutic and the experimental” in liver transplant surgeries performed in parts of India.

accidental death, homicide, and transport death that produce a superabundance of young, healthy cadavers. These precious commodities are routinely wasted, however, in the absence of trained organ-capture teams in hospital emergency rooms and intensive care units, rapid transportation, and basic equipment to preserve "heart-beating" cadavers and their organs. And organ scarcity is reproduced in the increasing competition between public and private hospitals and their transplant surgeons, who, in the words of one South African transplant coordinator, "order their assistants to dispose of perfectly good organs rather than allow the competition to get their hands on them." The real scarcity is not of organs but of transplant patients of sufficient means to pay for them. In India, Brazil, and even South Africa there is a superabundance of poor people willing to sell kidneys for a pittance.

And, while "high-quality" organs and tissues are scarce, there are plenty of what Dr. S, the director of an eye bank in São Paulo, referred to as usable "leftovers." Brazil, he said, has long been a favored dumping ground for surplus inventories from the First World, including old, poor-quality, or damaged tissues and organs. In extensive interviews in 1997 and 1998, he complained of a U.S.-based program which routinely sent surplus corneas to his center. "Obviously," he said, "these are not the best corneas. The Americans will only send us what they have already rejected for themselves."

In Cape Town, Mrs. R, the director of her country's largest eye bank (an independent foundation), normally keeps a dozen or more "post-dated" cadaver eyes in her organization's refrigerator. These poor-quality "corneas" would not be used, she said, for transplantation anywhere in South Africa, but they might be sent to less fortunate neighboring countries that requested them. Nearby, in his office at an academic hospital center, Dr. B, a young heart transplant surgeon, told me about a human organs broker in southern California who promises his clients delivery of "fresh organs" anywhere in the world within 30 days of placing an electronic mail order.

Because commercial exchanges have also contributed to the transfer of transplantation capabilities to previously underserved areas of the world, transplant specialists I interviewed in Brazil and South Africa are deeply ambivalent about them. Surgeons in São Paulo told me about a controversial proposal some years ago by Dr. Thomas Starzl of the University of Pittsburgh Medical School to exchange his institution's transplant expertise for a regular supply of "surplus" Brazilian livers. The public outcry in Brazil against this exchange, fueled in large part by the Brazilian media (see *Isto É Senhor*, December 11, 1991; *Folha de São Paulo*, December 1, 1991), interrupted the agreement.

Although no Brazilian livers were delivered to Pittsburgh, many other Third World organs and tissues have found their way to the United States in recent decades. In the files of an elected official in São Paulo I found results of a police investigation of the local morgue indicating that several thousand pituitary glands had been

taken (without consent) from poor people's cadavers and sold to private medical firms in the United States, where they were to be used in the production of growth hormones. Similarly, during the late military dictatorship years, an anatomy professor at the Federal University of Pernambuco in Recife was prosecuted for having sold thousands of inner-ear parts taken from pauper cadavers to the U.S. National Aeronautics and Space Administration for its space training and research programs.

Even today such practices continue. Abbokinase, a widely used clot-dissolving drug, uses materials derived from kidneys taken from deceased newborns in a hospital in Cali, Colombia, without any evidence of parental consent, informed or otherwise (Wolfe 1999). In South Africa, the director of an experimental research unit in a large public medical school showed me official documents approving the transfer of human heart valves taken (without consent) from the bodies of the poor in the morgue and shipped "for handling costs" to medical centers in Germany and Austria. These permissible fees, I was told, helped defray the costs of the unit's research program in the face of the downsizing of advanced medical research facilities in the new South Africa.

But a great many ordinary citizens in India, South Africa, and Brazil protest such commercial exchanges as a form of global (South-to-North) "bio-piracy" (see Shiva 1997). Increasingly, one hears demands for "nationalizing" dead bodies, tissues, and body parts to protect them from global exploitation. The mere idea of Brazilian livers' going to U.S. transplant patients gives Dr. O, a Brazilian surgeon, "an attack of spleen." A white South African transplant coordinator attached to a large private hospital criticized the policy that allowed many wealthy foreigners—especially "ex-colonials" from Botswana and Namibia—to come to South Africa for organs and transplant surgery. "I can't stop them from coming to this hospital," she said, "but I tell them that South African organs belong to South African citizens and that before I see a white person from Namibia getting their hands on a heart or a kidney that belongs to a little black South African child, I myself will see to it that the organ gets tossed into a bucket." The coordinator defended her harsh remarks as following the directives of Dr. N. C. Dlamini Zuma, then minister of health, to give preferential treatment, as it were, to South Africa's long-excluded black majority. Such nationalist medical sentiments are not shared by hospital administrators, for whom other considerations—especially the ability of foreign patients to pay twice or more what the state or private insurance companies will allow for the surgery—are often uppermost. In one academic and public hospital in Cape Town a steady stream of paying foreigners from Mauritius was largely responsible for keeping its beleaguered transplant unit solvent following the budget cuts and the redirection of state funds toward primary care.

## The Death That Precedes Death

Death is, of course, another key word in transplantation. The possibility of extending life through transplantation was facilitated by medical definitions of irreversible coma (at the end of the 1950s) and brain-stem death<sup>6</sup> (at the end of the 1960s), when death became an epiphenomenon of transplantation. Here one sees the awesome power of the life sciences and medical technology over modern states. In the age of transplant surgery, life and death are replaced with surrogates, proxies, and facsimiles, and ordinary people have relinquished the power to determine the moment of death, which now requires technical and legal expertise beyond their ability (see Agamben 1998:165).<sup>7</sup>

Additionally, the new biotechnologies have thrown conventional Western thinking about ownership of the dead body in relation to the state into doubt. Is the Enlightenment notion of the body as the unique property of the individual still viable in light of the many competing claims on human tissues and genetic material by the state and by commercial pharmaceutical and biotechnology research companies (see Rabinow 1996, Curran 1991, Neves 1993)? Can it exist in the presence of the claims of modern states, including Spain, Belgium, and, now, Brazil to complete authority over the disposal of bodies, organs, and tissues at death? What kind of state assumes rights to the bodies of both those presumed to be dead and those presumed to have given consent to organ harvesting (see Shiva 1997, Berlinger and Garrafa 1996)? Since the passage of the new compulsory donation law in Brazil, one hears angry references to the dead person as "the state's body." Certainly, both the family and the church have lost control over it.

While most doctors have worked through their own doubts about the new criteria for brain death, a great many ordinary people still resist it. Brain-stem death is not an intuitive or commonsense perception; it is far from obvious to family members, nursing staff, and even some medical specialists. The language of brain death is replete with indeterminacy and contradiction. Does brain death *anticipate* somatic death? Should we call it, as Agamben does, "the death that precedes death" (1998: 163)? What is the relation between the time of techni-

cally declared brain death and the deadline for harvesting usable organs? In a 1996 interview, a forensic pathologist attached to the Groote Schuur Hospital in Cape Town, where Christiaan Barnard experimented with the first heart transplants, vehemently rejected the medical concept of brain death:

There are only two organic states: living and dead. "Dead" is when the heart stops beating and organs decompose. "Brain-dead" is not dead. It is still alive. Doctors know better, and they should speak the truth to family members and to themselves. They could, for example, approach family members saying, "Your loved one is beyond any hope of recovery. Would you allow us to turn off the machines that are keeping him or her in a liminal state somewhere between life and death so that we can harvest the organs to save another person's life?" Then it would be ethical. Then it would be an honest transaction.

Dr. Cicero Galli Coimbra of the Department of Neurology and Neurosurgery at the Federal University of São Paulo, where he also directs the Laboratorio de Neurologia Experimental, has written several scientific papers questioning the validity of the criteria established in 1968 by the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death. During interviews with me in 1998, Coimbra reiterated his claims, backed by his own research and his clinical work, that brain-stem death, as currently defined, is applied to a number of patients whose lives could be saved. Moreover, he claims that "apnea testing" as widely used to determine brain-stem death actually *induces* irreversible brain damage. All the so-called confirmatory tests, he said, "reflect nothing more than the detrimental effects of doctor-induced intercranial circulatory arrest." Coimbra, who refused anonymity, is a major critic of Brazil's new compulsory donation law, which he sees as an assault on his clinical population of brain-traumatized patients.

The body may be defined as brain-dead for one purpose—organ retrieval—while still perceived as alive for other purposes including family ties, affections, religious beliefs, or notions of individual dignity.<sup>8</sup> Even when somatic death is obvious to family members and loved ones, the perceptual shift from the dead body—the "recently departed," the "beloved deceased," "our dearly departed brother"—to the anonymous and depersonalized cadaver (as usable object and reservoir of spare parts) may take more than the pressured "technical time" al-

6. Brain-stem death implies that there are no homeostatic functions remaining; the patient cannot breathe spontaneously, and support of cardiovascular function is usually necessary. However, the criteria used in defining brain death vary across states, regions, and nations. In Japan only 25% of the population accepts the idea of brain death, while in Cuba the fact of irreversible damage to the brain stem is sufficient to declare the person dead. Some doctors accept brain-stem death alone, while for others the upper brain, responsible for thought, memory, emotions, and voluntary muscle movements, must also have ceased to function.

7. I recall how recently it was in rural Ireland that it was customary to call the priest, not the doctor, when a parishioner began to approach death—a situation that every villager recognized. Dr. Healy would berate a villager for calling him to attend to a dying person. "Call the priest," he would say. "There's nothing that I can do here." Thus the passage to death was mediated by spiritual, not medical, rituals.

8. A young farmer from the Dingle Peninsula shared with me in the 1970s the wisdom that informed the country people's practice of long wakes: "It just wouldn't be right or seemly to put 'em into the hole when they are still fresh-like. You see, you never know, exactly, when the soul leaves the body." One thing was certain: the soul, the spirit force and persona of the individual, could hover in and near the body for hours or even days after the somatic signs of death were visible. One can scarcely imagine what he would have to say today about brain-stem death after his 60-odd years of sitting up with the dying and keeping company with the dead and their resistant, hanger-on spirits.

lowed to harvest organs usable for transplantation. But as the retrieval time is extended with new conservation methods, the confusion and doubt of family members may increase.

The "gift of life" demands a parallel gift—the "gift of death," the giving over of life before its normally recognized time. In the language of anthropology, brain-stem death is social, not biological, death, and every "gift" demands a return (Mauss 1966). To Coimbra and some of his colleagues, brain-stem death has created a population of living dead people. It has yet to be embraced as common sense even in a great many industrialized societies, including Japan, Brazil, and the United States (see Kolata 1995), let alone in countries where transplant surgery is still rare. And yet the public unrest in Brazil following passage of the country's new "presumed-consent" law in 1997 is an exception to the general rule of public apathy toward the state's assumption of control over the dead body. Transplant surgeons often explain popular resistance in terms of a cultural time lag that prevents ordinary people from accepting the changes brought about by new medical technologies.

While the postmodern state has certainly expanded its control over death (see Agamben 1998:119–25) through recent advances in biotechnology, genetics, and biomedicine, there are many antecedents to consider. The Comaroffs (1992), for example, showed the extent to which British colonial regimes in Africa relied on medical practices to discipline and civilize newly colonized peoples. The African colonies became laboratories for experiments with medical sciences and public health practices. And the medical experiments under National Socialism produced, through applied eugenics and death sentencing, a concentration-camp population of walking cadavers, living dead people (Agamben 1998:136) whose lives could be taken without explanation or justification. Agamben dares to compare these slave bodies to the "living dead" candidates for organ donation held hostage to the machine in today's intensive care units.

The idea of organ scarcity also has historical antecedents in the long-standing "shortage" of human bodies and human body parts for autopsy, medical training, and medical experimentation (see Foucault 1975; Richardson 1989, 1996). Who and what gets defined as "waste" in any given society often has bearing on the lives of the poorest in countries with a ready surplus of unidentified, unclaimed pauper bodies, as in Brazil (see Scheper-Hughes 1992, 1996a, b; Biehl 1998), South Africa (Lerer and Matzopoulos 1996), and India. In Europe during the 16th, 17th, and 18th centuries, the corpses of gallows prisoners were offered to barbers and surgeons to dispose of as they wished. "Criminal" bodies were required then, just as they are now, for "scientific" and medical reasons. In Brazil as in France (Laqueur 1983) during the early phases of modernity, paupers had no autonomy at death, and their bodies could be confiscated from poorhouses and workhouses and sold to medical students and to hospitals. Because the body was considered part of the estate of the dead man and could be used to cover outstanding debts, the bodies of paupers were often left unclaimed

by relatives to be used for medical research and education. Indeed, medical claims to "surplus" bodies have a long history. To this day many rural people in Northeast Brazil fear medicine and the state, imagining that almost anything can be done to them either before or at the hour of their deaths. Those fears—once specific to the rural and shantytown poor—have spread today to working-class Brazilians, who are united in their opposition to Brazil's universal donation law, fearing that it will be used against them to serve the needs of more affluent citizens. Such fears, we have learned, are not entirely groundless.

### The Organ-Stealing Rumor

The poor and disadvantaged populations of the world have not remained silent in the face of threats and assaults to their bodily integrity, security, and dignity. For those living in urban shantytowns and hillside *favelas*, possessing little or no symbolic capital, the circulation of body-stealing and organ-theft rumors allowed people to express their fears. These rumors warned of the existence and dangerous proximity of markets in bodies and body parts (Pinero 1992). As Das (1998:185) has noted, there is a substantial literature in radical social science on the role of rumor in mobilizing crowds. Some scholars in this tradition have seen in rumors a special form of communication among the socially dispossessed. Guha (1983:256, 201, cited by Das 1998:186) identified various features of rumor, including "its capacity to build solidarity, and the overwhelming urge it prompts in listeners to pass it on to others. . . . the performative power of [rumor] circulation results in its continuous spreading, an almost uncontrollable impulse to pass it on to another person."

The latest version of the organ-stealing rumor seems to have begun in Brazil or Guatemala in the 1980s and spread from there like wildfire to other, similar political contexts (see Scheper-Hughes 1996a). The South African variants are so different, however, that they should be considered independent creations. I first heard the rumor when it was circulating in the shantytowns of Northeast Brazil in the 1980s. It warned of child kidnapping and body stealing by "medical agents" from the United States and Japan, who were said to be seeking a fresh supply of human organs for transplant surgeries in the First World. Shantytown residents reported multiple sightings of large blue-and-yellow combi-vans scouring poor neighborhoods in search of stray youngsters. The children would be nabbed and shoved into the trunk of the van, and their discarded and eviscerated bodies—minus heart, lungs, liver, kidneys, and eyes—would turn up later by the roadside, between rows of sugarcane, or in hospital dumpsters.

At first I interpreted this rumor as expressing the chronic state of emergency (see Taussig 1992, citing Benjamin) experienced by desperately poor people living on the margins of the newly emerging global economy. I noted that it coincided with a covert war against mostly

black and semiabandoned street children in urban Brazil (see Scheper-Hughes and Hoffman 1998) and with a booming market in international adoptions (see Scheper-Hughes 1991). The rumor confused the market in "spare babies" for international adoption with the market in "spare parts" for transplant surgery. Poor and semiliterate parents, tricked or intimidated into surrendering their babies for domestic and/or international adoption, imagined that their babies were wanted as fodder for transplant surgery. The rumor condensed the black markets for organs and babies into a single frightening story.

It is the task of anthropologists working in these murky realms to disentangle rumors from the realities of everyday life, which are often horrific enough. In the following analysis I am not suggesting that all rumors and urban legends about body stealing and organ theft can be reduced to specific historical facts. These rumors are part of a universal class of popular culture dating back to at least medieval Europe (see Dundes 1991), and they serve multiple ends. But the current spate of organ-stealing rumors seem to constitute what James Scott (1985) has called a classic "weapon of the weak." The rumors have shown their ability to challenge and interrupt the designs of medicine and the state. They have, for example, contributed to a climate of civil resistance toward compulsory organ donation in Brazil and caused voluntary organ donations to drop precipitously in Argentina (Cantarovich 1990). The organ-theft rumors, combined with media reports of rampant commercialism in the procurement of organs, have contributed to a growing backlash against transplant ethics and to demoralization among some transplant surgeons themselves.

Dr. B, a heart transplant surgeon in Cape Town, said during an interview in February 1998 that he was disheartened about his profession's decline in prestige and popular confidence:

Organ transplantation has moved from an era back in 1967 when the public attitude was very different. . . . People then spoke about organ donation as that fantastic gift. Our first organ donor, Denise Ann Darvall, and her family were very much hallowed here; they were honored for what they did. Today, organ donation has lost its luster. The rumors of organ stealing are just a part of it. The families of potential donors throughout the world have been put under a lot more pressure. And there have been some unfortunate incidents. So we've begun to experience a sea of backlash. In Europe there is a new resistance toward the state's demand to donate. Suddenly, new objections are being raised. The Lutheran Church in Germany has started to question the idea of brain death, long after it was generally accepted there. And so we are seeing a drop of about 20% in organ donations in Europe, most acutely in Germany. And what happens in Europe has repercussions for South Africa.

## Bio-Piracy: The State and its Subcitizens

It is important to note the timing and the geopolitical mapping of these organ-theft rumors. While blood-stealing (see Dundes 1991) and body-snatching rumors have appeared in various historical periods, the current generation of rumors arose and spread in the 1980s within specific political contexts. They followed the recent history of military regimes, police states, civil wars, and "dirty wars" in which abductions, disappearances, mutilations, and deaths in detention and under strange circumstances were commonplace. During the military regimes of the 1970s and 1980s in Brazil, Argentina, and Chile, the state launched a series of violent attacks on certain classes of "subcitizens"—subversives, Jewish intellectuals, journalists, university students, labor leaders, and writers and other social critics—whose bodies, in addition to being subjected to the usual tortures, were mined for their reproductive capacities and sometimes even for their organs to serve the needs of "supercitizens," especially elite military families.

During the Argentine "dirty war" (1976 to 1982) infants and small children of imprisoned dissidents were kidnapped and given as rewards to loyal childless military families (see Suarez-Orozco 1987). Older children were abducted by security officers, brutalized in detention, and then returned, politically "transformed," to their relatives. Other children of suspected subversives were tortured in front of their parents, and some died in prison. These forms of state-level "body snatching" were justified in terms of saving Argentina's innocent children from communism. Later, revelations of an illegal market in blood, corneas, and organs taken from executed political prisoners and mental patients in Argentina appeared in the *British Medical Journal* (Chaudhary 1992, 1994). Between 1976 and 1991 some 1,321 patients died under mysterious circumstances, and another 1,400 patients disappeared at the state mental asylum of Montes de Oca, where many "insane" political dissidents were sent. Years later, when some of the bodies were exhumed, it was found that their eyes and other body parts had been removed.

Despite these grotesque political realities, Felix Cantarovich (1990:147), reporting from the Ministry of Health in Buenos Aires, complained in a special issue of *Transplantation Proceedings*:

In Argentina between 1984 and 1987 a persistent rumor circulated about child kidnapping. The rumor was extremely troublesome because of its persistence sustained by the exaggerated press that has always been a powerful tool to attract attention of people about the matter. In November 1987 the Secretary of Health gathered the most important authorities of justice, police, medical associations and also members of Parliament with the purpose of determining the truth. As a result it was stated that all the rumors and comments made by the press were completely spurious.

Similarly, in Brazil during the military years, adults and children were kidnapped, and now it appears that their organs were sometimes appropriated as well. Organ transplant surgeries and organ sales reached a peak in São Paulo in the late 1970s during the presidency of General Figueiredo. According to my well-placed sources, during the late military dictatorship period a covert traffic in bodies, organs, and tissues taken from the despised social and political classes was supported by the military state. A senior physician attached to a large academic hospital in Brazil said that the commerce in organs there in the late 1970s was rampant and "quasi-legal." Surgeons like himself, he charged, were ordered to produce quotas of "quality" organs and were protected from any legal actions by police cover-ups: "The transplant teams in [X and Y] hospitals were real bandits after money. They were totally organ-crazy. The transplant team of hospital [Y] would transport freshly procured organs by ambulance from one region to the next via Super Highway Dutra. The ambulance was accompanied by a full military police escort so that the organs would arrive quickly and safely."

Sometimes, Dr. F continued, organs were acquired by criminal means. He told of surreal medical scenarios in which doctors and transplant teams met their quotas by "inducing" symptoms of brain death in seriously ill patients. The donors, he said, were the usual ones—people from the lowest classes and from families unable to defend them. The doctors would apply injections of strong barbiturates and then call on two other unsuspecting doctors to testify, according to the established protocols, that the criteria for brain death had been met and the organs could be harvested. Because of this history of abuses, Dr. F adamantly opposes Brazil's law of presumed consent, calling it a law against the poor. "It is not the organs of the supercitizen that will disappear but those of people without any resources."

Similar allegations of body tampering and organ theft against doctors working in hospitals and morgues in South Africa during the late apartheid years surfaced during the hearings of the South African Truth and Reconciliation Commission. In these accounts we can begin to see some material basis for the epidemics of organ-stealing rumors. They surfaced at a time when the military in each country believed that it could do as it pleased with the bodies, organs, and progeny of its sub-citizens, people perceived as social and political "waste."

In Argentina, Brazil, and Guatemala the organ-stealing rumors surfaced during or soon after the democratization process was initiated and in the wake of human rights reports such as *Nunca Más* in Argentina and *Brazil Nunca Más*. They appeared during a time when ordinary people became aware of the magnitude of the atrocities practiced by the state and its military and medical officials. Given that the poor of urban shantytowns are rarely called upon to speak before truth commissions, the body-theft rumors may be seen as a surrogate form of political witnessing. The rumors participated in the spirit of human rights activism, testifying to human suffering on the margins of "the official story."

The body- and organ-stealing rumors of the 1980s and 1990s were at the very least metaphorically true, operating by means of symbolic substitutions. They spoke to the ontological insecurity of poor people to whom almost anything could be done, reflecting everyday threats to bodily security, urban violence, police terror, social anarchy, theft, loss and fragmentation. Recently, new variants of the organ-stealing rumor, originating in the impoverished periphery of the global economic order, have migrated to the industrialized North, where they circulate among affluent people through e-mail chain letters despite the efforts of an organized U.S. government disinformation campaign to kill them (see USIA 1994). Indeed, a great many people in the world today are uneasy about the nature of the beast that medical technology has released in the name of transplant surgery (see White 1996). But in our "rational," secular world, rumors are one thing, while scientific reports in medical journals are quite another. In the late 1980s the two narratives began to converge as dozens of articles published in *The Lancet*, *Transplantation Proceedings*, and the *Journal of Health, Politics, Policy and Law* cited evidence of an illegal commerce and black market in human organs. Indeed, urban legends and rumors, like metaphors, do sometimes harden into ethnographic facts.

Finally, in 1996, I decided to track down the strange rumors to their most obvious but least studied source: routine practices of organ procurement for transplant surgery. But as soon as I abandoned more symbolic analyses for practical and material explanations, my research was discredited by social scientists and medical professionals, who suggested that I had fallen into the assumptive world of my uneducated informants. Indeed, a great deal is invested in maintaining a social and clinical reality denying any factual basis for poor people's fear of medical technologies. The transplant community's narrative concerning the absurdity of the organ-stealing rumors offers a remarkably resilient defense against having to respond seriously to allegations of medical abuses in organ harvesting.

For example, a transplantation website (TransWeb) posts the "Top Ten Myths About Donation and Transplantation" with authoritative refutations of each. The "myth" that "rich and famous people get moved to the top of the waiting list while regular people have to wait a long time for a transplant" is refuted with the following blanket statement: "The organ allocation system is blind to wealth or social status." But our preliminary research indicates that this, like some other transplant myths, has some basis in contemporary transplant practices. The director of his region's transplant center in southern Brazil explained exactly how wealthy clients (including foreigners) and those with political and social connections managed to bypass established waiting lists and how patients without resources were often dropped, without their knowledge, from "active status" on such lists.

Even the most preposterous of the organ-stealing rumors, which the TransWeb authors say has never been documented anywhere—"I heard about this guy who

woke up the next morning in a bathtub full of ice. His kidneys were stolen for sale on the black market"—finds some basis in lawsuits and criminal proceedings, some still unresolved or pending. In Brazil, for example, the case of the theft of the eyes of Olivio Oliveira, a 56-year-old mentally ill man living in a small town near Porto Alegre, has never been solved. The story first surfaced in local newspapers in November 1995 and soon became an international cause célèbre. The case was investigated by doctors, surgeons, hospital administrators, police, and journalists. While some experts claimed that the man's eyes were pecked out by *urubus* (vultures) or gnawed away by rats, others noted that they seemed to have been carefully, even surgically removed. More recently, Laudiceia Cristina da Silva, a young receptionist in São Paulo, filed a complaint with the city government requesting a police investigation of the public hospital where in June 1997 one of her kidneys was removed without her knowledge or consent during a minor surgery to remove an ovarian cyst. Her loss of the kidney was discovered soon after the operation by her family doctor during a routine follow-up examination. When confronted with the information, the hospital surgeon explained that the missing kidney had been embedded in the large ovarian cyst, a highly improbably medical narrative. The hospital refused to produce its medical records and said that the ovary and kidney had been "discarded." Representatives of the São Paulo Medical Council, which investigates allegations of malpractice, refused to grant us an interview; the director told us in a telephone call that there was no reason to distrust the hospital's version of the story. Laudiceia insists that she will pursue her case legally until the hospital is forced to account for what happened, whether it was a gross medical error or a case of kidney theft.

### South Africa: Bodies of Apartheid

A stone's throw from the Groote Schuur Hospital, residents of black townships express fearful, suspicious, and negative attitudes toward organ transplantation. Among older people and recent arrivals from the rural homelands the very idea of organ harvesting bears an uncanny resemblance to traditional witchcraft practices, especially *muti* (magical) murders, in which body parts—especially skulls, hearts, eyes, and genitals—are removed and used or sold by deviant traditional practitioners to increase the wealth, influence, health, or fertility of a paying client. An older Xhosa woman and recent rural migrant to the outskirts of Cape Town commented in disbelief when my assistant and I confronted her with the facts of transplant surgery: "If what you are saying is true, that the white doctors can take the beating heart from one person who is dead, but not truly dead, and put it inside another person to give him strength and life, then these doctors are witches just like our own."

Under apartheid and in South Africa's new, democratic, and neoliberal context, organ transplant practices reveal the marked social and economic cleavages that

separate donors and recipients into two opposed and antagonistic populations. Paradoxically, both witchcraft and witchhunting (see Niehaus 1993, 1997; Ashforth 1996) have been experiencing a renaissance in parts of South Africa since the democratic transition. These seeming "gargoyles" of the past testify, instead, to the "modernity of witchcraft" (Geschier 1997, Taussig 1997) and to the hypermodern longings and magical expectations of poor South Africans for improved life chances since the fall of apartheid and the election of Nelson Mandela. Long-frustrated desires for land, employment, housing, and a fair share in the material wealth have fostered a resurgence of magic.

In 1995 an angry crowd of residents of Nyanga township in Cape Town tore down the shack of a suspected *muti*-murderer after police, tipped off by a local informer, discovered the dismembered body of a missing five-year-old boy smoldering in the fireplace and stored in medicine jars and boxes in the suspect's shack. On June 8, 1995, Moses Mokgethi was sentenced in the Rand Supreme Court, Gauteng, to life imprisonment for the murder of six children between the ages of four and nine whose bodies were mutilated for hearts, livers, and penises, which Mokgethi claims he sold to a local township businessman for between 2,000 and 3,000 rands to strengthen his business (see Ashforth 1996:1228). Such widely publicized incidents are often followed by anxious rumors of luxury cars prowling squatter camps in search of children to steal for their heads and soft skulls or rumors of body parts stolen or purchased by "witch doctors" from corrupt doctors and police officials for use in rituals of magical increase. These rumors are conflated with fears of autopsy and organ harvesting for transplantation.

Younger and more sophisticated township residents are critical of organ transplantation as a living legacy of apartheid medicine. "Why is it," I was asked, "that in our township we have never met or even heard of such a person who received a new heart, or eyes, or a kidney? And yet we know a great many people who say that the bodies of their dead have been tampered with in the police morgues?" Township residents are quick to note the inequality of the exchanges in which organs and tissues have been taken from young, productive black bodies—the victims of excess mortality caused by apartheid's policies of substandard housing, poor street lighting, bad sanitation, hazardous transportation, and the overt political violence of the apartheid state and the black struggle for freedom—and transplanted into older, debilitated, affluent white bodies. In their view, organ transplantation reproduces the notorious body of apartheid. Even in the new South Africa, transplant surgery and other high-tech medical procedures are still largely the prerogative of whites.

During the apartheid years, transplant surgeons were not obligated to solicit family consent before harvesting organs (and tissues) from cadaver donors. "Up until 1984 the conditions for transplantation were easier," said Dr. B, a heart transplant surgeon at Groote Schuur Hospital. "We didn't worry too much in those days. We just took

the hearts we needed. But it was never a racial issue. Christiaan Barnard was very firm about this. He was one of those people who just ignored the government. Even when our hospital wards were still segregated by law, there was no race apartheid in transplant surgery." But what he meant was that there was no hesitation in transplanting black and colored (mixed-race) "donors" hearts—taken without consent or knowledge of family members—into the ailing bodies of their mostly white male patients.

Up through the early 1990s about 85% of all heart transplant recipients at Groote Schuur Hospital were white males. Transplant doctors refused to reveal the "race" of the donors of hearts to concerned and sometimes racist organ recipients, saying that "hearts have no race." "We always used whatever hearts we could get," the doctor concluded, whether or not the patient feared he might be getting an "inferior organ." When asked why there were so few black and mixed-race heart transplant patients, Dr. B cited vague scientific findings indicating that "black South Africans coming from rural areas did not suffer the modern urban and stress-related scourges of ischemic heart disease, which primarily affects more affluent white males in urban settings." But this medical myth was difficult to reconcile with the reality of the forced migrations of South African blacks to mines and other industries in the periurban area and the history of forced removals to urban squatter camps, worker hostels, and other highly stressful urban institutions. And by 1994, the year of the first democratic elections, for the very first time a significant percentage (36%) of heart transplants at Groote Schuur Hospital were assigned to mixed-race, Indian, or black patients. With the passage of the Human Tissue Act of 1983, requiring individual or family members' consent at the time of death, organ harvesting became more complicated. South African blacks are reluctant organ, blood, and tissue donors (see Palmer 1984, Pike, Odell, and Kahan 1993), and few voluntary donations come from the large Cape Malay Muslim community because of perceived religious prohibitions.

In 1996 and again in 1998 I began to investigate allegations of body-part theft at the state-run police mortuary in Cape Town. During the antiapartheid struggle years many physicians, district surgeons, and state pathologists working with police at the mortuaries collaborated in covering up police actions that had resulted in deaths and body mutilations of hundreds of "suspected terrorists" and political prisoners. Meanwhile, rumors of criminal body tampering were fueled by several cases that came to the attention of journalists. On July 23, 1995, the Afrikaans-language newspaper *Rapport* (July 23, 1995) ran a story about a private detective who testified in the Johannesburg Regional Court that a policeman had shown him the mutilated body of Chris Hani in a Johannesburg mortuary the day after the black activist and political hero was murdered in 1993. A human heart alleged to be Hani's was sold for 2,000 rand by a mortuary worker to disguised investigative reporters. The heart was subsequently handed over to police, and

Sergeant Andre Schutte was charged with defiling and corrupting the body of the slain leader. Because of stories such as these, the morgue remains a place of horror for township residents.

In the course of my investigations I learned that corneas, heart valves, and other human tissues were harvested by state pathologists and other mortuary staff and distributed to surgical and medical units, usually without soliciting family members' consent. The "donor" bodies, most of them township blacks and coloreds and victims of violence and other traumas, were handled by state pathologists attached to morgues still controlled by the police (see also NIM 1996). Some pathologists held that these practices were legal, if contested, but others considered them unethical.

A state pathologist attached to a prestigious academic teaching hospital spoke of his uneasiness over the informal practice of "presumed consent." A loophole in the 1983 Organ and Tissue Act allows the "appropriate" officials to remove needed organs and tissues without consent when "reasonable attempts" to locate the potential donor's next of kin have failed. Since eyes and heart valves need to be removed within hours of death and given the difficulty of locating families living in distant townships and informal communities (squatter settlements) without adequate transportation and communication systems, some doctors and coroners use their authority to harvest the prized organs without giving too much thought to the feelings of the relations. They justify their actions as motivated by the altruistic desire to save lives. In return these organ providers gain, minimally, the gratitude, professional friendship, and respect of the prestigious transplant teams, who owe them certain professional favors in return. Since harvested corneas and heart valves are sometimes sold to other hospitals and clinics—domestically and, in the case of heart valves, internationally—that request them, the possibility of secret gratuities and honoraria paid on the side to cooperating mortuary staff cannot be discounted. Small gratuities were paid, for example, by a local independent eye bank to transplant coordinators for the favor of carrying donor eyes designated for air transport to the local airport.

Currently, the South African Truth and Reconciliation Commission (TRC) is considering allegations of gross human rights violations at the Salt River Mortuary by the parents and survivors of 17-year-old Andrew Sitshetshe of Guguletu township, who failed to get a response to their complaint from the ethics committee and administrators at Groote Schuur Hospital. The case was taken up by the TRC in its health-sector hearings in June 1997 (see Health and Human Rights Project: Professional Accountability in South Africa, Submission to the TRC for Consideration at the Hearings on the Health Sector, June 17 and 18, 1997, Cape Town). Andrew Sitshetshe had been caught in the fire of township gang warfare in August 1992. Badly wounded, he had been taken to the Guguletu police station, where his mother, Rosemary, found him lying on the floor with a bleeding chest wound. By the time the ambulance attendants arrived

he was dead, and the police had him taken to the Salt River Mortuary. They advised Mrs. Sitsheshe to go home until the morning, when she could claim her son's body for burial. When Andrew's parents arrived at the mortuary the following morning, the officials turned them away, saying that the body was not yet ready for viewing. When later in the day they were finally allowed to view the body, they were shocked.

As Mrs. Sitsheshe testified, "The blanket covering the body was full of blood, and he had two deep holes on the sides of his forehead so you could easily see the bone. His face was in bad condition. And I could see that something was wrong with his eyes. . . . I started to question the people in charge and they said that nothing had happened." In fact, Andrew's eyes had been removed at the morgue, and when members of the Sitsheshe family returned to confront the staff they were treated abusively. A few days later, Mrs. Sitsheshe, unable to rest, went to the eye bank to confront the director and request what was left of her son's eyes. The director informed her that her son's corneas had been "shaved" and given to two recipients and his eyes were being kept in the refrigerator. She refused to surrender them to Andrew's mother for burial. Consequently, Andrew Sitsheshe was buried without his eyes. Mrs. Sitsheshe asked, "Although my son is buried, is it good that his flesh is here, there, and everywhere, that part and parcel of his body are still floating around? . . . Must we be stripped of every comfort as well as our dignity? . . . How could the medical doctor decide or know what was a priority for us?" Leslie London, a professor of health at the University of Cape Town, testified on behalf of the Sitsheshe: "These were not events involving a few band apples. . . . These abuses arose in a context in which the entire fabric of the health sector was permeated by apartheid, and in which basic human rights were profoundly disvalued."

In response to this case, the TRC raised two questions of central concern: How, under the new Bill of Rights, might the new government ensure equal access to organ transplantation for all of South Africa's people in need, especially those not covered by medical aid schemes? And how might the state institute equitable harvesting and transplantation? The relevant section in the Bill of Rights dealing with bodily integrity specifies "the right of all citizens to make decisions about reproduction and their bodies free from coercion, discrimination and violence." The inclusion of the words "and their bodies" was intended to refer directly to organ harvesting.

Popular sentiments against organ harvesting and transplantation practices in the African community may have contributed to the health minister's transfer of public support away from tertiary medicine to primary care—a move not without its own contradictions. At present, organ transplantation is moving rapidly from state hospitals and the academic research centers where organ transplantation was first developed in South Africa to new, relatively autonomous private, for-profit hospitals. Soon only the wealthy and those with excellent private medical insurance will have access to any transplantation.

In November 1997 the Constitutional Court of South Africa decided against a universal right to dialysis and kidney transplant (see *Soobramoney v. Minister of Health, Kwa Zulu-Natal*), a decision that Judge Albie Sachs described to me as necessary given the country's limited economic resources but "wrenchingly painful." The court was responding to the case of a 41-year-old unemployed man from Durban who was a diabetic with kidney failure. The man had used up his medical insurance and was denied dialysis at public expense at his provincial hospital following a stroke. The high court upheld the South African Ministry of Health's policy that restricts public support of dialysis to that small population approved for kidney transplant and awaiting the surgery. Candidates must be free of all other significant physical or mental disease, including vascular disease, chronic liver disease, or lung disease, alcoholism, malignancies, or HIV-positivity. Therefore Soobramoney was sent home to die.

As organ transplantation has moved into the private sector, commercialism has taken hold. In the absence of a national policy regulating transplant surgery and of any regional, let alone national, official waiting lists, the distribution of transplantable organs is informal and subject to corruption. Although all hospitals and medical centers have ethics boards to review decisions concerning the distribution of organs for transplant, in fact transplant teams are allowed a great deal of autonomy. Public and private hospitals hire their own transplant coordinators, who say that they are sometimes under pressure from their surgeons to dispose of usable hearts or kidneys rather than give them to a competing institution following the rather informal rules set up between and among hospitals and transplant centers.

The temptation "to accommodate" patients who are able to pay is beginning to affect both public and private hospitals. At one large public hospital's kidney transplant unit, there is a steady trickle of kidney patients and their live donors arriving from Mauritius and Namibia. Although claiming to be "relatives," many are, according to the nurses, paid donors, and since they arrive from "across the border" the doctors tend to look the other way. While I was in Cape Town in 1998, a very ill older businessman from Cameroon arrived at the kidney transplant unit of a public hospital accompanied by a paid donor he had located in Johannesburg. The donor was a young college student who had agreed to part with one of his kidneys for less than \$2,000. When the two failed to cross-match in blood tests and were turned away, they returned to the hospital the next day, begging to be transplanted in any case; the patient was willing to face almost certain organ rejection. They were turned away, but would private hospitals be as conscientious in refusing such hopeless cases among those willing to pay regardless of the outcome?

Meanwhile, those acutely ill patients who live at a distance, for example, in the sprawling townships of Soweto outside Johannesburg or Khayelitsha outside Cape Town, have little chance of receiving a transplant. The rule of thumb among heart and kidney transplant sur-

geons in Johannesburg is "No fixed home, no phone, no organ." The ironies are striking. At the famous Chris Hani Bara Hospital on the outskirts of Soweto, I met a sprightly and playful middle-aged man, flirting with nurses during his dialysis treatment, who had been on the hospital's waiting list for a kidney for more than 20 years. Not a single patient at the huge Bara Hospital's kidney unit had received a transplant in the past year. But the week before I had met with Wynand Breytenbach, once deputy minister of defense under President P. W. Botha, who was recuperating at home outside Cape Town from the heart transplant he had received on his government pension and health plan after less than a month's wait. Meanwhile, at Groote Schuur Hospital a virtual if unofficial moratorium had brought "public" heart transplantation to a standstill in February 1998.

### Brazil: From Theft and Sale to Compensated Gifting and Universal Donation

There are several distinct narratives concerning abusive and deviant practices of organ procurement for transplant surgery in Brazil. The first narrative, already discussed, concerns the gross human rights violations of the bodies of poor subcitizens, living and dead, during the later years of the Brazilian military dictatorship. With the transition to democracy in the mid-1980s these violations were replaced by softer forms of organ sales and compensated gifting between family members and strangers.

Democratization and valiant attempts to centralize organ harvesting and distribution regionally in the cities of Rio de Janeiro, São Paulo, and Recife, among others, have eroded but not eliminated the many opportunities available to the wealthy to obtain organs months and years ahead of ordinary citizens who depend on the national health service or on inadequate medical insurance programs. From the industrialized south to the rural interior of Northeast Brazil, transplant surgeons, patients, organ recipients, and transplant activists told us how laws and hospital regulations were bent, "negotiated," "facilitated," or circumvented by means of personal contacts and *jeitos* (a popular expression for ways of getting through obstacles by means of wit, cunning, trickery, bribery, or influence). A young informant reported to my assistant, Mariana Ferreira, in São Paulo in December 1997 that after being told he would need a cornea transplant he was reassured by the doctor: "I can refer you to some friends of mine at X Hospital. You will still need to register with the cornea waiting list, but if you have \$3,000 cash you can cut through the list and be placed up front." A kidney transplant activist in São Paulo showed us her files on the hundreds of ordinary citizens and candidates for kidney transplant who, despite medical exams and multiple referrals, have never been called to the top of any transplant list, herself included. She was cynical about the wealthy people who arrive in São Paulo from elsewhere in the country and return home

with the organ sought, often within weeks. "The waiting list makes donkeys out of us," she said. "Sometimes I think we are just there to 'decorate' the list." Her criticisms were supported by transplant surgeons in public and private medical centers, who complained that affluent patients were hard to come by, since most traveled to Europe or the United States to get "quality organs" at up-scale medical centers. And, of course, they said, money "paved the way" for them, whether in Houston, New York, or São Paulo. Transplant surgeons at the large public hospitals in Recife, Rio de Janeiro, and São Paulo that I visited in 1997 and 1998 seemed to be engaged in a slowdown as they waited for the real scarce commodity—paying patients—to arrive. In the meantime, few transplants were done under the system of national health insurance.

The complicated workings of Brazil's two-tiered health care system—a free national health care system, universally available and universally disdained, and a booming private medical sector, available to the minority and coveted by all—generates ideal conditions for a commerce in organs and for bribes and facilitations to speed up access to transplant procedures. In the absence of a unified organ-sharing network comparable to UNOS in the United States and Eurotransplant in western Europe, private transplantation clinics compete with public-sector hospitals for available organs. Since financial incentives are so much greater in the private sector (where surgeons can be paid many times the standard fee for transplant surgery allowed by the health service), private hospitals are more aggressive in locating and obtaining organs (see Pereira Coelho 1996). The national system pays the hospital \$7,000 for a kidney transplant, of which the medical team receives \$2,000, while in a private hospital the same surgery can reap between \$25,000 and \$50,000. In the case of liver transplants, the system pays the hospital \$24,000 dollars, while in a private clinic this surgery ranges from \$50,000 to \$300,000, depending on the complications. The chief nurse responsible for the transplant unit of a private hospital in São Paulo said that the above-quoted average costs per transplant surgery pertained only to the hospital expenses. "Medical honoraria," she said, "are negotiated between the patient and the surgeons. We do not interfere in those details."

So, though the Brazilian constitution guarantees dialysis and organ transplants to Brazilian citizens who need them, waiting lists are filled with people who have been "on hold" for decades, since the fee payment schedule hardly makes the surgery worth doing. Dr. J, a young transplant surgeon in Rio de Janeiro, took me for a tour of the empty transplant unit of a huge public hospital. "It is a shame," he said, "but there is simply no motivation to operate under the state system [of payment]. Most [surgeons] just bide their time here during their weekly shifts. Their real work is with paying patients in private clinics."

But even at smaller, private hospitals, most kidney transplant patients were local and of modest means. "Why would a wealthy person come here?" asked the irritated director of the kidney transplant unit at one

such hospital in Recife in answer to my questions about commercialization in his unit. Although trained abroad at the best academic hospitals, Dr. P claimed that his kidney transplant unit was slighted by the "bourgeoisie," who went south to São Paulo or north to the United States for their operations. His unit survived largely through living kidney donations, mostly kin-related but also from compensated friends and strangers.

While the global business in organs has received extensive media attention, most organs trade is domestic, following the usual social and economic cleavages and obeying local rules of class, race, gender, and geography. According to an elderly Brazilian surgeon interviewed by my assistant in São Paulo in 1997, a "shadow" commerce in organs has long been a reality among Brazilians. "Those who suffer most," he said, "are the usual ones, mostly poor and uneducated, who are tricked or pressured into donation through private transactions that rarely come to the attention of the doctors." During the 1970s and 1980s there was evidence of the kind of rampant commercialism found in India today. I interviewed Dr. L, a nephrologist in private practice in Rio, who denounced the medical climate in his city in those days: "The [organs] traffic was practically legalized here. It was a safe thing, taking place in both large and small hospitals, with no concern over its illegality." The commerce reached a "scary peak," he said, in the 1980s, when newspapers were publishing an alarming number of ads of organs for sale: "There were just too many people offering to sell kidneys and corneas at competitive prices, not to mention the 'bad' [i.e., HIV-contaminated] blood that was also being sold to private blood banks." Beginning in the 1990s, in an improved economic climate, such blatant ads disappeared, but, according to Dr. L, "The commerce has not stopped. It is simply less visible today." According to Dr. M of São Paulo, organ donors still show up, unannounced, at transplant centers. The wording of the exchanges is more discreet: from "selling" and "buying" organs to "offers" of help. "The price of kidneys varies. If it is an economist in need of money, naturally the price is higher. If it is a simple person, it will be cheaper." For example, he said, from time to time a patient arrives dressed in the latest fashion with expensive jewelry and brings with her a "donor" wearing rubber sandals. "She describes him as her cousin from the interior of the state. We refuse to operate, and when they insist I send them to a judge to decide and leave it to him to authorize the transaction or not."

In addition to these wholly private transactions between live donors and recipients, which most doctors tolerate as "having nothing to do with them," there are organized crime rings that deal in human body parts from hospitals and morgues. Brazil's leading newspaper, the *Folha de São Paulo*, carried several stories in 1997 of police investigations of a "body Mafia" with connections to hospital and emergency room staff, ambulance drivers, and local and state morgues that traded in blood, organs, and human tissues from cadavers. In one case, falsified death certificates were provided to conceal the identities of mutilated corpses in the Rio de Janeiro morgue. In-

vestigations resulted in criminal proceedings against a ring of criminal mortuary workers.

Even where there is no explicit commerce in organs, the social inequity inherent in the public medical care system interferes with the harvesting of organs and produces an unjust distribution. Transplant specialists such as Dr. F from São Paulo note a common occurrence:

Sometimes a young patient dies in the periphery and is identified as a potential donor. A mobile intensive care unit arrives and takes him to the hospital so he can be placed in better [clinical] conditions to become a donor body. The family is confused and does not understand what is going on. Before this, there was no room for him in the public hospital. Suddenly, he is put into a super-modern intensive care unit in a private hospital or an academic research hospital. This is why the poor so often say—and with some reason—that they are worth more dead than alive.

Although the earlier law regulating living organ donors (Law No. 8489, issued in 1992) required special judicial authorization for nonrelated living donation, loopholes were common, especially in small, private hospitals where living kidney donors remain the rule. In July 1997 and August 1998 I spent time in a private hospital in Recife where 70% of all kidney transplants relied on living donors. Hospital statistics for the past decade listed 37 "unrelated" living donors in addition to a larger number of highly suspect "cousins," "godchildren," "in-laws," "nieces," and "nephews." Hospital administrators, social workers, and the psychologist were not defensive about their practice, which was legal as long as a local judge was willing to authorize an exception. Brazil has 117 medically certified centers for kidney transplant, 22 for heart transplant, 19 for liver transplant, and a large number of cornea transplant centers, of which only 17 are certified (Censo 1997). Keeping these clinics operating cost-effectively has meant greater tolerance for various informal incentives to encourage organ donation by relatives and friends. The lines between "bought" and "gifted" organs are fuzzy. Rewarded gifting is accepted by some transplant surgeons as an ethically "neutral" practice. Although most transplant surgeons avoid patients they suspect of having arranged for a paid donor, others turn a blind eye to such exchanges. A transplant surgeon in Rio de Janeiro said, "I am a doctor, not a policeman."

The compensation offered to living donors varies from small lump sums of \$1,000 to privileges over inheritance. A São Paulo surgeon explained: "Yes, of course, sometimes people get things. A brother who donates his kidney will receive a private financial bonus. Later we learn that he got a car. Or a son who donates a kidney to the father—a situation we don't usually encourage—gets extra privileges within the family." A nephrologist in Rio de Janeiro told of a young woman who agreed to donate a kidney to her uncle in exchange for a house. The surgeons resisted because the patient was a poor candidate

for transplant and noncompliant, but he eventually found a private clinic that would accept him. The outcome? "The man suffered various crises of kidney rejection, wound up back in dialysis, and was dead within the year. And there was the niece, minus a kidney but enjoying her new home."

In addition to rewarded gifting within families, there may be considerable pressure, especially on lower-status, poor, or female relatives, to volunteer as kidney donors (see De Vasconcelos 1995). Dr. N, a transplant surgeon in Salvador, Bahia, interviewed in June 1998 told of the case of a young woman whose brother had threatened to kill her if she refused to give him a kidney. He said, "The whole issue of organ capture occurring within the family involves an intensely private dynamic that often escapes the control of the most careful medical professionals."

The pressure exerted on lower-status, poor, or female relatives to volunteer as donors is especially problematic in that these vulnerable social groups have a much smaller chance of being organ recipients themselves.<sup>9</sup> A transplant surgeon in São Paulo explained that "the tendency, often unconscious, is to choose the least productive member of the family as a kidney donor. One might choose, for example, the single aunt." And by and large living related kidney donors tend to be female. A surgeon in São Paulo with a large pediatric kidney transplant practice defended his clinic's statistics: "Of course, it is only natural that the mother is the primary donor. But I usually try to enlist the father first. I tell him that the mother has already given life to the child, and now it is his turn. But the men tend to feel that organ donation is a womanly thing to do."

Zulaide, a working-class physical education teacher from a small town in Pernambuco, was approached by her older brother to be a kidney donor in the mid-1990s. He had been in dialysis for years awaiting a cadaveric organ. Because of his distance from the medical center and the national health system's low fees and refusal to pay for blood-matching tests, Roberto's chances of receiving an "official" organ were slim. Along with the other 15,000 Brazilians waiting for cadaveric kidneys, Roberto would have to remain wedded to an antiquated dialysis machine. Ever since the much publicized medical disaster of 1995, in which 38 dialysis patients from the interior town of Caruaru, Pernambuco, died of a bacterial infection transmitted through just such poorly maintained public machines, kidney patients have been willing to do almost anything to avoid dialysis and obtain a transplant.

9. A survey of the distribution of renal transplants in Europe and North America (Kjellstrand 1990) shows that women and nonwhite patients had only two-thirds the chance of men and white patients of receiving a transplant. A study by the Southeastern Organ Procurement Foundation in 1978 (cited in Callender et al. 1995) noted a disparity in the United States between the large numbers of African-American patients on dialysis and the small numbers of African-American transplant patients. The preliminary research of Sheila Rothman (1998) reveals a pattern of unintended discrimination in the screening of African-American and Latino transplant candidates in New York City.

Balking at the suggestion that he find a paid donor, Roberto agreed to allow his sister, a healthy young married woman with three children, to help him out. Although Zulaide freely donated her kidney—"I gave it from the heart," she said, "and not for gain"—the operation was not a success, and Roberto died within the year. Complications arose in her own recovery, and she had to give up her physically demanding job. But when she went to the private transplant clinic in Recife looking for follow-up medical attention she was rebuffed by the doctors. She was selected as a donor, the surgeons insisted, because she was healthy. Her complaints, they said, were probably psychological, a syndrome one doctor called "donor regret"—a kind of "compensatory neurosis." Zulaide scoffed at this interpretation: "I miss my brother, not my kidney," she maintains.

On the other side of town, when Wellington Barbosa, an affluent pharmacist in his late 60s, was told that he needed a heart transplant, his private doctor was able to facilitate his move to the top of the waiting list at a prestigious medical center in São Paulo. Consequently, Wellington's new heart was beating inside his chest within a matter of weeks.

Meanwhile, in the crowded hillside shantytown which practically looks down into Wellington's property, Carminha dos Santos was engaged in a fruitless pursuit of transplant surgery for her son Tomas, who had lost his sight at the age of seven following the medical maltreatment of an eye infection. Carminha was certain that her son's condition could be reversed by a cornea transplant. The obstacle, as she saw it, was that the "eye banks, like everything else in the world, were reserved for those with money." She first took the boy to Recife, and when that failed she traveled with him by bus to Rio de Janeiro, where the two of them went from hospital to hospital and doctor to doctor. Throughout she persisted in the belief that somewhere she would find "a sainted doctor," a doctor of conscience who would be willing to help. "Don't they give new eyes to the rich?" And wasn't her own son "equal in the eyes of God"? In the end she returned home angry and defeated. Her only hope was to get a trained seeing-eye dog for her son through a Catholic charity.

According to legislators interviewed, Brazil's new law<sup>10</sup> of presumed consent, issued on February 4, 1997, was designed to produce a surplus of organs for transplant

10. The problem of presumed consent for organ retrieval from cadavers is not limited to countries in the South, where vast segments of the population are illiterate or semiliterate. In the United States today there is considerable resistance to cadaveric organ donation (Kolata 1995), and James Childress (1996:11) notes that the laws regarding organ harvesting from cadavers are "marked by inconsistencies regarding rights holders, whether these are the individual while alive or the family after the individual's death." In practice, the state assumes rights over any cadavers presumed to have been "abandoned" by kin. In addition, in many states there is "presumed consent" for the removal of corneas, skin, pituitary glands, and other tissues and parts even under ordinary circumstances and without informing the next of kin, but this presumption of consent is called into question whenever people become aware of routine organ and tissue harvesting practices.

surgery, guarantee an equilibrium between supply and demand, establish equity in the distribution of organs, and end any commerce in organs. But almost immediately, the law was contested from above and below, by surgeons and by the popular classes (see also Gabel 1996). Most transplant specialists attributed the real problems of organ transplantation to the lack of medical and technological infrastructure for organ capture, distribution, and transplant surgery. The head nurse of the largest private transplant center in São Paulo explained:

The government wanted the population to believe that the real problem was the family's refusal to donate. The truth is that the national health care system does not have the technical capacity to maintain the donor's body, and so we lose most donors. When we think we have found a perfect donor, a 25-year-old man who suffered a car accident, who is brain-dead but otherwise perfect, it is a weekend and there is no public surgeon available, and the perfect heart goes into the garbage.

The new organ law, similar to compulsory donation laws in Belgium and Spain, makes all Brazilian adults into universal organ donors at death unless they officially declared themselves "nondonors of organs and tissues." The state has assumed the function of monitoring the harvesting and distribution of cadaveric organs. But still there is nothing to prevent a continuing commerce in organs, because the new law eliminated the key requirement of court authorization for nonkin-related transplants. The pertinent section of the law reads: "Any able person according to the terms of civil law can dispose of tissues, organs and body parts to be removed in life for transplant and therapeutic ends" (Federal Law No. 9,434, Chapter 3, Section 2, Article 15). As Dr. B explained, "If you want to sell a kidney to somebody, it is no longer my duty as a doctor to investigate. According to the new law, all responsibility resides in the state alone."

And, despite the new law, those who are better off economically will continue to refuse cadaveric organs. A strong preference for a known, living donor will keep the market for kidneys alive. According to a nephrologist in private practice in Rio de Janeiro, only poorer clients will "accept" a cadaveric kidney for transplant: "In my experience the rich always want a kidney from a living person about whom something is known. . . . Deep down, there is a visceral disbelief in our national health system. The fear of contracting AIDS or hepatitis from public corpses is extreme." And, in fact, he concluded, these fears are not entirely groundless.

The director of Rio de Janeiro's notorious state morgue welcomed the new law of presumed consent as a thoroughly modern institution which offered an opportunity to educate the "ignorant masses" in the new democracy. But to the proverbial man and woman on the street in São Paulo, Rio, Recife, and Salvador, the new law is just another bureaucratic assault on their bodies. The only way to exempt oneself was to request new identity cards or driver's licenses officially stamped "I am not a donor

of organs or tissues." People formed long lines in civil registry offices all over the country to "opt out" of the pool of compulsory organ donors. At registry offices in Rio de Janeiro, São Paulo, Salvador, and San Carlos, they expressed anger and resentment over an imperious act of the state against "little people" like themselves. Here and there individuals expressed some support for the "good intention" of the law, but they doubted the moral and organizational capacity of the state to implement it fairly.

"Doctors have never treated us with respect before this law," said Magdelena, a domestic worker, referring to the scandal of sterilizations performed on poor women without their consent. "Why would they suddenly protect our rights and our bodies after this law?" Carlos Almeida, a 52-year-old construction worker, saw the law as driven by profit: "Who can guarantee that doctors will not speed up death, give a little *jeitinho* for some guy to die quicker in order to profit from it? I don't put any faith in this business of brain death. As long as the heart is beating, there is still life for me." Almeida advised his adult sons not to become donors: "I told them that there are people around like vultures after the organs of young and healthy persons." A retired accountant, Inácio Fagundes, asked, "Does this law mean that when I die they can take my body, cut it up, take what they wish, even if my family does not agree?" On being told that this was more or less the case, he told the civil registrar: "Stamp it very large on my identity card: 'Fagundes will not donate anything!'"

## Conclusion

Under what social conditions can organ harvesting and distribution for transplant surgery be fair, equitable, just, and ethical? Organ transplantation depends on a social contract and social trust, the grounds for which must be explicit. Minimally, this requires national laws and international guidelines outlining and protecting the rights of organ donors, living and dead, as well as organ recipients. Additionally, organ transplantation requires a reasonably fair and equitable health care system.

It also requires a reasonably democratic state in which basic human rights are guaranteed. Organ transplantation, even in elite medical centers by the most conscientious of physicians, that occurs in the context of an authoritarian or police state can lead to gross abuses. Similarly, where vestiges of debt peonage persist and where class, race, and caste ideologies cause certain kinds of bodies—whether women, common criminals, paupers, or street children—to be treated as "waste," these sentiments will corrupt medical practices concerning brain death, organ harvesting, and distribution.

Under conditions such as these the most vulnerable citizens will fight back with the only resources they have—gossip, rumors, urban legends, and resistance to modern laws. In this way, they act and react to the state of emergency that exists for them in this time of economic and democratic readjustments. They express their

consciousness of social exclusions and articulate their own ethical and political categories in the face of the "consuming" demands which value their bodies most when they can be claimed by the state as repositories of spare parts. While for transplant specialists an organ is just a "thing," a commodity better used than wasted, to a great many people an organ is something else—a lively, animate, and spiritualized part of the self which most would still like to take with them when they die.

## Comments

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While reading this article I also happened to be reading Michael Taussig's (1991a [1987]) *Shamanism, Colonialism, and the Wildman* and thought it only a coincidence, therefore, when these two seemingly unrelated works intersected. They intersected in the image—created by an early-20th-century missionary recording his encounter with savagery in the upper Amazon—of Indians playing a ball game with what they called the heart of Jesus. It was a ball made of rubber, the same commodity that was extracted through the atrocities of debt peonage, a commodity at the base of profound terror—an organ transplant of a different sort. But is it so different?

As one would expect from a scholar who has defined some of the primary themes in medical anthropology today, this is a critical assessment of the politico-moral economy of organ transplantation touching at once, and with extremely good effect, on the global flow of body parts and first-person narratives of desire and loss, triumph and tragedy. Scheper-Hughes deploys "the primacy of the ethical" in anthropology to question the way in which neoliberal economic globalism has transformed the relationship of people to their own and other people's body parts. Given, as she says, the radical way in which transplant surgery has redefined self and other by reconceptualizing the body as a symbolic, social, and political entity, "it has redefined real/unreal, seen/unseen, life/death, body/corpse/cadaver, person/nonperson, and rumor/fiction/fact." Transplant surgery has defined the terms of an embodied—rather than simply textual—magical realism.

Scheper-Hughes clearly shows how body parts become commodities on the world market, and there is no question about the inequities of the trade. However, I would like to push further the question of fetishism when the thing in question is both a commodity and a heart, liver, kidney, or cornea.

To explain why it was that rubber companies in the upper Amazon slaughtered, through savage torture, the same Indians upon whose debt peonage they depended

and then claimed that there were not enough workers, Taussig points out how debt itself, rather than rubber or European trade goods, became a fetishized commodity (1991a:128). And as debt—a magical conjuncture of gift and capitalist economic principles—was fetishized, the body itself became a reified object saturated with meaning. Grotesque cannibalism and savage capitalism were, in some sense, each other's otherness (p. 105):

Everything hinged on a drawn-out, ritualized death in which every body part took its place embellished in a memory-theater of vengeances paid and repaid, honors upheld and denigrated, territories distinguished in a feast of difference. In eating the transgressor of those differences, the consumption of otherness was not so much an event as a process, from the void erupting at the moment of death to the reconstituting of oneself, the consumer, with still-warm otherness.

In the case of organ transplants there is something similar going on, but the body takes on meaning and value not as a whole but only, or at least primarily, in terms of its various parts, producing a cannibalism that selectively nibbles—a gourmet cannibalism in which the "void erupting at the moment of a ritualized death" is also the "gift of life." In other words, I think transplant surgery fetishizes life to such an extent that it makes it possible to see the world, in a magically real sort of way, as populated by "immortal" body parts under the management of mortal souls. Cannibalism and capitalism are mutually constitutive by means of death and consumption, but transplant surgery and global neoliberal capitalism produce a moral space where life and death consume one another in a feast of difference that never ends.

While transplant surgery literally fragments and consumes body parts in order to give life—and Scheper-Hughes shows how consumers are almost always witting and wealthy and the producers of organs often poor or unwitting—there is an important sense in which organ transplantation is the radical instantiation of biomedicine's underlying ontological assumption about the body's natural state of health. On the assumption that an absence of sickness denotes natural good health, recovery is imperative and always possible. Biomedicine cannot accommodate death, hence the search for ever more radical modes of recovery, more technologically sophisticated means of extending life indefinitely, and also, I think, the search for more radical ways to "harvest" body parts, some of them from the same bodies whose life is extended. Although transplant surgery literally fragments the body, it is a process of fragmentation that is epistemologically linked not just to all surgery but to the fact that biomedicine reifies body parts—organs, blood, cells, chromosomes, and genes, for example—in its fetishization of life.

The problem with transplant surgery, as Scheper-Hughes argues, is that it takes fragmented bodies and commodifies vital parts. It also fuses and confuses life and death. "I am the resurrection and the life; whosoever

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