Exotic No More

Anthropology on the Front Lines

EDITED BY JEREMY MacCLANCY

2.

Min(d)ing the Body: On the Trail of Organ-Stealing Rumors

NANCY SCHEPER-HUGHES

For many years I have been documenting the violence of everyday life—the many small wars and invisible genocides—resulting from the structural violence of poverty and the increasing public hostility to the bodies, minds, children, and reproductive capacities of the urban poor. Here I will be addressing an uncanny dimension of the usual story of race and class hatred to which we have become so accustomed. This is the covert violence occurring in the context of a new and thriving global trade in human organs and other body parts for transplant surgery. It is a business that is justified by many—including doctors and bio-ethicists—as serving "altruistic" ends. But for the poorest and most marginalized populations living on the fringes of the new global dis-order, the scramble for fresh organs for transplant surgery increases the already profound sense of ontological insecurity in a world that values their bodies more dead—as a reservoir of spare parts—than alive.

Descend with me for a few moments into that murky realm of the surreal and the magical, into the maelstrom of bizarre stories, fantastic allegations, and a hideous class of rumors that circulate in the world's shantytowns and squatter camps, where this collaborative research project had its origins. The rumors were of kidnapping, mutilation, and dismemberment—the removal of blood and organs—for commercial sale. I want to convey to you the terror and panic that these rumors induce in the nervous and hungry residents of urban shantytowns, tent cities, squatter camps, and other "informal settlements" in the Third World.

I first heard the rumor in the shantytowns of Northeast Brazil in the mid-1980s, when I was completing research for my book, *Death without Weeping*, on maternal thinking and practice in the context of extremely high infant and child

mortality. The rumors told of the abduction and mutilation of poor children who were eyed greedily as fodder for an international traffic in organs for wealthy transplant patients in the first world. Residents of the ramshackle hillside *favela* of Alto do Cruzeiro, the primary site of my research, reported multiple sightings of large blue and yellow combi-vans [the so-called "gypsy taxis" used by the poor the world over] driven by Americans or Japanese "agents" said to be scouring poor neighborhoods in search of stray youngsters, loose kids and street children, kids that presumably no one would miss. The children would be grabbed and shoved into the van. Later their discarded and eviscerated bodies—minus certain organs—heart, lungs, liver, kidneys, and eyes—would turn up on roadsides, between rows of sugarcane, or in hospital dumpsters. "They are looking for donor organs. You may think this is just nonsense," said my friend and research assistant, "Little Irene" in 1987. "*But we have seen things with our own eyes in the hospitals and the morgues, and we know better.*"

"Nonsense! These are stories of the poor and illiterate," countered another of my friends, Casorte, the skeptical manager of the municipal cemetery of Bom Jesus da Mata. "I have been working here for over a year and never have I seen anything. Where are these bodies?" Yet even as we spoke on the following day, a municipal truck arrived at the gates of the cemetery with the body of a "desconicido," the remains of an unknown, unclaimed man found murdered in an abandoned field not far from town. The eyes and genitals had been removed. "Death squads," whispered Casorte, by way of explanation, and he made the gesture of a throat being slit.

The body-snatching rumors were picked up by newspapers in Recife and reported on the radio. Most news reports mocked the credulity of illiterate people. But the media coverage, meant to dispel the rumors, actually exacerbated them. "Yes, it is true," wept Dona Aparecida, wringing her hands on the doorstep of her shack on the garbage strewn street called the Vultures' Path. "I even heard them talk about it on the radio." Consequently, a great many toddlers and small children were kept securely locked in at home while their parents were out working. I found one terrified little girl tethered like a goat to a wobbly table leg. Street children believed themselves to be at particular risk of kidnapping for their organs (see figure 1).

Soon after I began writing articles that interpreted the Brazilian organ-stealing rumors in terms of the normal, accepted, everyday violence practiced against the bodies of the poor and the marginal in public medical clinics, in hospitals, and in police mortuaries, where their ills and afflictions were often treated with scorn, neglect, and general disrespect, I began to hear other variants of the organ-theft stories from anthropologists working in Argentina, Colombia, Peru, Guatemala,

FIGURE 1 The Real Central Station, Rio de Janeiro, Brazil. In the wake of street child executions, a terrified street child grabs at passers-by for support. (Photo by Viviane Moos)

Honduras, Mexico, India, and Korea. Though most of the stories came from Central and South America, organ-theft rumors were also surfacing in Poland and Russia, where it was reported that poor children's organs were being sold to rich Arabs for transplant surgery. Luise White recorded blood-sucking/blood-stealing vampire stories from East and Central Africa, and South African anthropologist Isak Niehaus recorded blood- and organ-stealing rumors in the Transvaal collected during fieldwork in 1990–1993. The African variants told of "firemen" or paramedics driving *red* combi-vans looking to capture unsuspecting people to drug and to kill in order to drain their blood or remove their organs and other body parts—genitals and eyes in particular—for magical medicine *(muti)* or for more traditional medical purposes. The Italian variants identified a *black* ambulance as the kidnap vehicle.

The rumors had powerful effects, resulting in a precipitous decline in voluntary organ donation in some countries, including Brazil and Argentina. What does it mean when a lot of people around the world begin to tell variants of the same bizarre and unlikely story? How does an anthropologist go about interpreting the uncanny and the social imaginary of poor, third-world peoples? To folklorists like Alan Dundes and Veronique Campion-Vincent, and to oral historians like Luise White, the rumors are seen as constituting a genre, an oral literary form, the "ur-

ban legend." The stories are circulated and repeated because they are "good to tell," they entertain by fright just like good old-fashioned ghost stories. The French folklorist Campion-Vincent interprets the organ-theft stories as the literary inventions of semiliterate people who lack the skills to sort out the credible and realistic from the incredible and the fantastic. To members of the global transplant community of surgeons and patient activists, the rumors are groundless, pernicious lies that need to be exposed, refuted, and killed.

To the anthropologist, however, working closely with the urban poor, the rumors spoke to the ontological insecurity of people "to whom almost anything could be done." They reflected everyday threats to bodily security, urban violence, police terror, social anarchy, theft, loss, and fragmentation. Many of the poor imagined, with some reason as it turns out, that autopsies were performed to harvest usable tissues and body parts from those whose bodies had reverted to the state: "Little people like ourselves are worth more dead than alive." At the very least the rumors were (like the scriptures) metaphorically true, operating by means of symbolic substitution. The rumors express the existential and ontological insecurities of poor people living on the margins of the postcolonial global economies where their labor, their bodies, and their reproductive capacities are treated as spare parts to be bought, bartered, or stolen. Underlying the rumors was a real concern with a growing commodification of the body and of body parts in these global economic exchanges.

The organ-stealing stories were told, remembered, and circulated because they were true at that indeterminate level between the real, the surreal and the uncanny. They expressed an intuitive sense that something was amiss, signaling the chronic "state of emergency" of the world's subcitizens living in a negative zone of existence where lives and bodies are experienced as a constant crisis of presence (hunger, sickness, injury) on the one hand, and as a crisis of absence and disappearance on the other.

If one paid attention to the timing and geopolitical distribution of the organ-stealing rumors, certain patterns began to emerge. While rumors of blood and body snatching appear and disappear periodically, the current spate of organ- and child-stealing rumors arose and spread in the late 1980s. In Brazil, Argentina, Guatemala, El Salvador, and South Africa the organ-stealing rumors arose within a specific political context, following a history of military regimes, police states, civil wars, and "dirty wars" in which abductions, "disappearances," mutilations, and deaths were commonplace. Mayan Indian villages in Guatemala sustained military attacks that were nothing less than genocidal over the past decade. The counterinsurgency war, which reached its height between 1978 and 1984, left more than one hundred thousand people dead, thousands mutilated, another one

million internally displaced, and caused thousands to flee across the Mexican border. More than 440 rural Indian villages in the highlands were destroyed. Women were widowed, and children were displaced, lost, and orphaned by the tens of thousands. These displaced children became the focus of international adoption efforts, contributing to villagers' mounting sense of panic, terror, and disaster, which they expressed, in part, through child and organ-stealing rumors. The spate of physical attacks on American tourists—especially those seeking to adopt Indian babies—had to be understood in light of that terrifying recent history.

Similarly, in Northeast Brazil—where my research focused for many years on the causes of infant and childhood death, and, later, on the deaths and "disappearances" of older street children—the child- and organ-stealing rumors had to be understood within the context of a transitional postmilitary state in which privatized death squads had taken the place of the military police in launching attacks on "superfluous" and marginalized populations. According to a report issued by the Brazilian Federal Police, more than five thousand children and youths were murdered in Brazil between 1988 and 1990. Few of these deaths have ever been investigated, hardly surprising when off-duty police officers are often the prime suspects. Most of the victims were black males between the ages of fifteen and nineteen. The Medical-Legal Institute (the public morgue) in Recife, the capital of Pernambuco, received an average of fifteen bodies of unidentified children a month in the early 1990s. Eighty percent of the bodies arrived at the morgue already damaged or mutilated. These acts of brutality against the bodies of the poor and socially abandoned provided the missing social and political context within which strange events occurred and even stranger rumors circulated to account for them.

During the Argentine "Dirty War" (1976–1982), university students, journalists, and other suspected subversives were captured, interrogated, tortured, and killed. The babies of imprisoned dissidents were kidnapped and given to reward loyal, childless military families. This reproductive theft was justified in terms of "saving" Argentina's innocent children from the "germ" of Communism. Older children were abducted by security officers, brutalized in detention, and then returned, "transformed," to relatives. Others were tortured in the presence of their captive parents. Much later scientific reports appeared in the *British Medical Journal* of blood, corneas, and organs taken from "executed" political prisoners and from abandoned mental patients during the late military and postmilitary periods (Chaudhary 1994).

Despite the work of official truth commissions, established in the mid-1980s, in documenting the atrocities that had terrorized large segments of the Argentine population, Dr. Felix Cantarovitch, representing the Ministry of Health in

Buenos Aires in 1990, felt compelled to deny any truth behind the "child kidnapping" rumors. In an article published in the international medical journal *Transplantation Proceedings* (1990), Dr. Cantarovitch wrote: "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 totally spurious." But here we have the fox reporting on the safety of the hen house. In fact, children *were* kidnapped, and my research in 2000 documented that blood and organs were taken from mental patients in public asylums without consent.

Similar allegations of body- and organ-stealing by doctors working in hospitals and in police mortuaries in South Africa began to circulate during the late apartheid years when the country was plunged into a civil war and apartheid's medical bureaucrats sometimes were complicit in the physical and medical abuse of suspected political "terrorists." In each context the body- and organ-stealing rumors arose at a time when members of the military believed that they could do as they pleased to the bodies of subcitizens, people perceived as social and political "waste."

In Latin America 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 Mas* in Argentina and *Brazil Nunca Mas.* 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. Insofar as the poor of urban shantytowns are rarely called upon to speak before official truth commissions, the body-theft rumors could be seen as a surrogate form of political witnessing. The rumors participated in the spirit of human rights testifying to human suffering on the margins of "the official story." Still, in our "rational," secular world, rumors are one thing, while scientific reports in medical journals are quite another. But in the late 1980s the two distinct narratives began to converge as articles published in *The Lancet*, *Transplantation Proceedings*, and the *British Medical Journal* began to cite evidence of an illegal global commerce and black market in human organs and other body parts. Indeed, wild rumors, like metaphors, do sometimes harden into ethnographic "facts."

Recognizing the need to define new international standards for human transplant surgery, an international task force from ten countries, comprising fourteen transplant surgeons and transplant specialists, medical human rights profession-

als, and three social scientists was formed. The "Bellagio Task Force on Securing Bodily Integrity for the Socially Disadvantaged in Transplant Surgery" met in 1995 and 1996 at the Rockefeller Conference Center in Bellagio and several times in smaller groups at medical, public health, and bio-ethics meetings and conferences in Japan; Washington, DC; Berkeley, California; and New York City. We came together to share experiences and data, to discuss, analyze, and recommend new ways of dealing with the vulnerability of certain social groups—the urban poor, cultural minorities, refugees, prisoners, and women—called upon and coerced into serving as organ donors, living and dead. At the top of our agenda were allegations of the use of organs from executed prisoners in China for commercial sale in transplant surgery; the traffic in organs in India; and the truth, if any, behind the rumors and urban legends of body and organ theft and other gross violations in the procurement and distribution of organs.

Finally, in 1996, encouraged by my medical colleagues on the task force, I decided to track down independently the rumors to their most obvious, and yet least studied, source: the routine practices of organ procurement and distribution for transplant surgery. But as soon as I abandoned the more distanced and symbolic analyses of the organ-stealing rumors for anthropological "detective work" to determine whether or not a market in human organs actually existed, my research was both suspect and discredited. "Is this some kind of anthropological detective work?" one anthropological colleague asked. Others charged that I had fallen into the "assumptive world" of my uneducated and gullible informants. Indeed, a great deal is invested in maintaining a social and clinical reality which denies any factual basis for poor people's fears of medical technologies. The transplant community's insistence on the patent absurdity of the organ-stealing rumors offers a remarkably resilient defense and protection against having to respond seriously to allegations of medical abuses in organ procurement, harvesting, and distribution.

For example, a transplantation website *(TransWeb)* posts the "Top Ten Myths about Donation and Transplantation" next to 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 simply denied: "The organ allocation system is blind to wealth or social status." But our exploratory research in several countries indicates that this and other transplant "myths" have some basis in contemporary transplant practices. And so for example, the director of his region's Transplant Central in São Paulo, Brazil, explained exactly how wealthy clients (especially foreigners) and those with political clout or other social connections managed to bypass established waiting lists, while patients without private insurance were often dropped, *without their knowledge*, from "active status" on the official waiting lists for organs. Even the most far-fetched of

the organ rumors ("I heard about a guy who woke up the next morning in a bathtub full of ice. His kidneys were stolen for sale on the black market"), which the *TransWeb* site states has never been documented anywhere, finds some basis in the uncanny stories told by some of our informants in India (Cohen 1999), South Africa, and Brazil, stories backed up by lawsuits and criminal investigations concerning organ theft at public hospitals. The following section introduces a few scenes from our ongoing and collaborative research.

STRANGER THAN FICTION

During the summer of 1998 I was sitting at a sidewalk cafe in downtown São Paulo with Laudiceia da Silva, an attractive, young mother and office receptionist who had agreed to share her bizarre medical story with me. She had just filed a legal complaint with the city government requesting an investigation of the large public hospital where in June 1997, during a routine operation to remove an ovarian cyst, she had "lost" a kidney. The missing kidney was discovered soon after the operation by the young woman's family doctor during a routine follow-up examination. When confronted with the information, the hospital representative told a highly improbable story: that Laudiceia's missing kidney was embedded in the large "mass" that had accumulated around her ovarian cyst. But the hospital refused to produce either their medical records or the evidence—the diseased ovary and the kidney had been "discarded," she was told. When I called on representatives of the São Paulo Medical Council, which investigates allegations of malpractice, they refused to grant an interview. A representative of the council said that there was no reason to distrust the hospital's version of the story, and they had no intention of launching an independent investigation. Laudiceia insists that she will pursue her case legally until the hospital is forced to account for just what happened, whether it was a gross medical error or a criminal case of kidney theft. To make matters worse, Laudiceia's brother had been killed in a random act of urban violence several weeks earlier and the family arrived at the hospital too late to stop organ retrieval based on Brazil's new "presumed consent" law. "Poor people like ourselves are losing our organs to the state, one by one," Laudiceia said angrily.

Across the globe at roughly the same time (summer 1998), Lawrence Cohen sat in a one-room flat in a municipal housing-project in a Chennai (Madras) slum in South India talking with five local women, each of whom had sold a kidney for 32,500 rupees (about 1,200 dollars at the time of the sale). Each had undergone their "operation" at the clinic of Dr. K. C. Reddy, India's most outspoken advocate of the individual "right to sell" a kidney. Unlike those who ran the more seedy "organs bazaars" that sprang up a decade ago in Bombay, Dr. Reddy prides himself on running an exemplary clinic: the kidney sellers are fully informed about the impli-

cations and potential dangers of the operation. They are carefully followed for two years after the organ removal and receive free health care at his clinic during that period, and he carefully avoids contact with intermediaries and organs brokers. The women Cohen interviewed were primarily low-paid domestic workers with husbands in trouble or in debt. Most said that the kidney sale was preceded by a financial crisis: the family had run out of credit and could not get by. Friends had passed on the word that there was quick money to be had through Dr. Reddy's clinic. Cohen asked if the sale had made a difference in their lives, and was told that it had, for a time, but the money was soon swallowed by the usurious interest charged by the local moneylenders, and the families were all in debt again. Would they do it again? Yes, the women answered; what other choice did they have, with the money gone and the new debts piling up? If only they had three kidneys, with two to spare, then things might be better.

Cohen, who has worked in rural towns in various regions of India over the past decade, reports 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. In other words, a spare kidney for a spare 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 predictable 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. Today the kidney represents "everyman's" last economic resort; the kidney stands as the marker of one's ultimate collateral." Some parents say they can no longer complain about the fate of a dowryless daughter. "Haven't you got a spare kidney?" one or another neighbor is likely to respond. With the appearance of new sources of capital, the dowry system is expanding, along with kidney sales, into areas where it had not been a traditional practice.

Several months later, I sat next to Mrs. Rosemary Sitshetshe on a torn black plastic couch in her small but neat concrete slab house in Guguletu township outside Cape Town, South Africa. On her other side sat Rosemary's mother, a powerful woman, who sustained her daughter as she retold the painful story of how the body of her only son, seventeen-year-old Andrew, had been manhandled and mutilated at the police mortuary in Cape Town, his eyes and possibly other body parts removed without consent and given to doctors to transplant into other people's bodies.

Andrew was caught in the crossfire of township gang warfare during the dangerous period just before the end of apartheid. Badly wounded, he was taken to the

local police station where Rosemary found him lying on the floor with a bleeding chest wound. By the time the ambulance attendants arrived, late as usual, Andrew was dead (or very nearly so) and the police advised Rosemary to go home until the morning when she could claim her son's body for burial. But the following morning, the officials at the police mortuary turned Rosemary away saying that the body was not yet ready for identification and viewing. Two days later, when the family was finally allowed to view Andrew's body they were shocked at what they saw (figure 2): the blanket covering the body was bloody and Andrew's head had two deep holes on either side of his forehead "so you could easily see the bone." His face was swollen and there seemed to something was wrong with his eyes. "So, I did the unthinkable, I lifted up his eyelids."

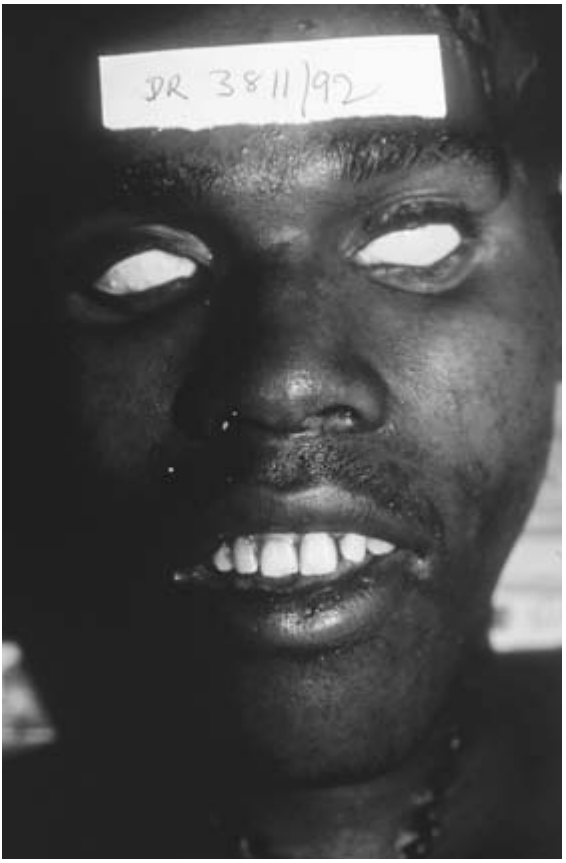

FIGURE 2 The mutilated body of Andrew Sitshetshe, as his mother found it at Salt River Mortuary in Cape Town, South Africa. (Courtesy of Mrs. Rosemary Sitshetshe)

But when Rosemary questioned the people in charge, they denied that anything was wrong and treated Rosemary and her estranged husband abusively. Later, accompanied by her own private pathologist paid for by the African National Congress, Mrs. Sitshetshe learned at the morgue that her son's eyes had been removed and that inside his abdominal cavity the organs found there had all been severed and carefully replaced for viewing. "But were those parts his own?" Mrs. Sitshetshe asked me. "I know my son's eyes by color but not his heart or kidneys."

At the local eye bank Rosemary was told that her son's corneas had been "shaved" (figure 3) and given to two "lucky" patients at the nearby academic hospital. The remains of Andrew's eyes were being kept in the refrigerator and the di-

FIGURE 3 Shaving the cornea from two eyes taken from the police mortuary in Cape Town, South Africa. (Photo by Viviane Moos)

rector refused to return them to Andrew's mother for burial. And so, unwilling to argue any further, Andrew Sitshetshe was buried without his eyes. But Rosemary found she could not bury her anger. "Although my son is dead and buried," Mrs. Sitshetshe said, with tears coursing down her cheeks, "Is it good that his flesh is here, there, and everywhere, and that parts of his body are still floating around? Must we be stripped of every comfort ? How could the medical doctor know what was most important for us?" Mrs. Sitshetshe has since taken her complaint against the mortuary and eye bank staff to South Africa's Truth and Reconciliation Commission. She wants her case to be treated as but one example of a practice that was widespread in police mortuaries under apartheid and which may have continued out of habit, even in the "new" South Africa.

Because of the casual disregard of the bodies of those who are brought to police mortuaries, the residents of black townships in Nanga, Langa, and Guguletu townships, just a stone's throw from the famous Groote Schurr teaching hospital where Christian Barnard first pioneered heart transplants, 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 magically increase the wealth, influence, health or fertility of a paying client. An older Xhosa woman and recent rural migrant a squatter camp on Guguletu commented in disbelief when my assistant, Monga Melwana, 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."

Younger and more sophisticated township residents are more knowledgeable about organ transplant but are equally critical of a practice which they see as a 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, and hazardous transportation, in addition to the overt political violence of the apartheid state and the black struggle for freedom—and transplanted to older, debilitated, affluent, white bodies.

Despite the insistence of Cape Town's current generation of heart transplant patients that Dr. Chris Barnard was no racist, race was always at issue in South Africa's organ transplant program, and it continues to haunt the practices of transplant surgery to this day. During the heyday of apartheid, transplant surgeons were not obligated by law to solicit family consent before harvesting organs (and tissues) from cadaveric donors. "Up until 1983 or 1984 the conditions for transplantation were easier," said Dr. Johan Brink, the head cardiac and transplant surgeon from the University of Cape Town. "We didn't worry too much in those early days. We just took the hearts we needed, but it was never really a racial issue." But what Dr. Brink meant was that there was no hesitancy on the part of doctors in transplanting black and colored (mixed race) hearts—sometimes taken without the consent or knowledge of family members—into the ailing bodies of their mostly white, male patients. (Until the early 1990s, 85 percent of South Africa's heart transplant recipients were white males). Surgeons refused to reveal the race of donor hearts to concerned and sometimes racist organ recipients, saying that hearts have no race. "We always used whatever hearts we could get," Dr. Brink said, whether or not the patient feared he might be getting an "inferior" organ. In 1994, the year of the elections, for the first time a significant percentage (36 percent) of all heart transplant patients at the university hospital in Cape Town were assigned to mixed-race, Indian, or black patients. However, by that time, most heart transplant surgery had moved to the private-sector hospitals where patients of means, many of them arriving from foreign countries, were housed in relative luxury while awaiting a scarce organ. Dr. Brink directed my attention to the real "culprit" in the commodification of human organs—the independent organs brokers who solicited patients, doctors, and transplant coordinators, one of whom, Brink said, "comes from your neck of the woods."

Consequently, in September 1999, I sat nursing a cherry Coke in a dilapidated Denny's Restaurant on Sunset Blvd. in Hollywood. Across from me sat a tall, extremely thin, middle-aged man with intensely blue eyes and a nervous, tentative manner. He gulped frequently and seemed ready to flee from our booth at the slightest provocation and put an end to this strange ethnographic interview. Jim Cohan is a notorious "organs broker" who solicits international buyers and sellers from his home office using the telephone, Internet, and fax. No, I could not tape record our conversation, Jim said, though he was willing to be interviewed about his activities on behalf of "matching up people in need."

"There's no reason for anyone to die in this country while waiting for a heart or a kidney to materialize. There are plenty of spare organs to be had in other parts of the world. One can't be choosy. One has to play by my rules and go where I say. And one has to move quickly." Though Jim operates in a gray, nether world, he in-

sists that what he does is not illegal. He deals with doctors, hospitals, and a "soft" commerce in "excess" cadaveric organs. Although he was arrested and jailed in Italy in 1998 for illegally "brokering" organs, the charges were dropped eventually, and Jim maintains his innocence. In fact, he is proud of his newly invented profession. "Don't think of me as an outlaw," he said. "Think of me as a new version of the old-fashioned marriage broker. I locate and match up people in need; people whose suffering can be alleviated on either side."

FOLLOWING THE BODIES: THE TRAFFIC IN HUMAN ORGANS

As these few scenarios plucked out of hundreds of transcribed interviews with transplant specialists, transplant patients, organs brokers, organ buyers, and sellers suggest, transplant surgery today is a blend of altruism and commerce; of science and magic; of gifting, barter, and theft; of choice and coercion. We have found that the "organs trade" is real, spectacularly lucrative, and widespread, even though it is illegal in most countries and unethical according to every governing body of medical, professional life. It is therefore covert. In some of the sites we have explored—India, Brazil, South Africa, and the United States—the trade in organs and other body parts links surgeons and technicians from the upper strata of biomedical practice to "body mafia" from the lowest reaches of the criminal world. The transactions involve police, mortuary workers, pathologists, civil servants, ambulance drivers, emergency room workers, eye bank and blood bank managers, biotechnicians, funeral directors, and transplant coordinators.

Together, we are documenting hard and soft forms of organ sales, investigating rumors of body theft, allegations of human rights violations of the nearly dead, and mutilations of pauper cadavers in police mortuaries. We are trying to pierce the secrecy surrounding organ transplantation and to "make public" all practices regarding the harvesting, selling, and distribution of human organs and tissues. These transactions have been protected, even concealed, by a deadly indifference to the population of organ donors, living and dead, most of them poor, and by an unquestioned acceptance in most industrialized nations of transplant surgery as a social and moral good.

But the entry of "free markets" into the business of organ procurement poses a challenge to the social ethics of organ transplant. By their nature, markets are indiscriminate and inclined to reduce everything—including human beings, their labor, and their reproductive capacity—to the status of commodities—things that can be bought, sold, traded, and stolen. And the global economy has stimulated the movement of mortally sick bodies in one direction and detached "healthy" organs—transported for shorter distances by commercial airlines in ordinary Styrofoam beer coolers conveniently stored in the overhead luggage com-

partment of the economy section—in another direction, creating a "kula ring" of international trade in surgeries, bodies, and body parts. 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 bodies.

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, the United States, and Eastern Europe to obtain kidneys and other organs made scarce locally due to 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 and to China for transplant surgery with organs retrieved from brain-dead donors, a definition of death only recently and very reluctantly accepted in Japan. Until the practice was cited and condemned by the World Medical Association in 1994, patients from several Asian countries traveled to Taiwan to purchase organs harvested from executed prisoners. But the ban on using organs from executed prisoners in capitalist Taiwan merely opened up a similar practice in socialist China. The demand for hard currency by strapped governments has no fixed ideological or political boundaries. Turkey comes and goes as an active site of illegal traffic in transplant organs, with both living donors and recipients arriving from other countries for operations organized by illegal organs brokers.

Meanwhile, patients from Israel, which has its own, well-developed, but underused, transplantation centers travel to the West Bank, Turkey, Russia, Moldava, Georgia, and Romania, where kidneys are purchased from living donors, and to the United States, Europe, and South Africa, where transplantation clinics in private hospitals can resemble four star hotels.

In all these transactions, a new profession of organs brokers—ranging from entrepreneurial doctors to criminal "body mafia" and new businesspeople like the elusive Jim Cohan in the United States and Coby Dyan in Israel—are the essential actors. Together, they have generated a "body trade" which promises to certain, select individuals of reasonable economic means living almost *anywhere* in the world—from the Amazon Basin (and I have met a Suya Indian who was flown to São Paulo from Mato Grosso to receive a new kidney) to the deserts of Oman—a "miraculous" extension of what Giorgio Agamben calls "brute" or "naked" life—the life of the species rather than a *consciously* lived human and ethical life.

ANTHROPOLOGISTS ON MARS

Our initial forays have taken us into alien and, at times, hostile and dangerous territory, where we are exploring some of the backstage scenes of organ transplanta-

tion. Of the many fieldsites in which I have found myself, none compares to the world of transplant surgery for its mythical properties, its codes of secrecy, its impunity, and its exoticism. Dr. Christian Bernard, the world's first heart transplant surgeon, now comfortably retired and enjoying his later years in the peace and tranquility of the rural western Cape wine lands, spends his time writing science fiction thrillers with a strong autobiographical flavor—for example, *The Donor*; (1996)—which deals with the passions and insatiable "appetites" surrounding the quest for organs for transplant. But Dr. Bernard refused to be interviewed about the real-life struggles that were taking place in the Supreme Court of Cape Town in 1998 among some of his own protégés, heart transplant surgeons operating in competing public and the private sectors, each suing the other for concealing negative data on unacceptably high transplant mortalities, destroying slides and other data, and destroying usable hearts to keep them from "the competition" (see *Vosloo vs. Von Oppel*, Supreme Court of Cape Town, February 1998), a case that was tossed out of court by the judge, who issued a stinging reprimand to both parties to "clean up" their "houses."

Operating in these back ward to back-alley contexts, Cohen and I sometimes feel that Oliver Sack's felicitous phrase, "an anthropologist on Mars" is most apropos. Playing the role of the anthropological court jesters, we have begun our work 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 secrets lie behind the transplant rhetoric of gifts, altruism, scarcities, and needs?

To date, our initial findings reveal the following: (1) race, class, and gender inequalities and injustices in the acquisition, harvesting, and distribution of organs; (2) widespread violation of national laws and international regulations against the sale of organs; (3) the collapse of cultural and religious sanctions against body dismemberment and commercial use in the face of the enormous market pressures in the transplant industry; (4) the appearance of new forms of debt peonage in which the commodified kidney occupies a critical role; (5) the emergence of soft sales in the form of "compensated gifting" of kidneys within extended families along with "coerced" gifts, as vulnerable workers "donate" organs to their employers in exchange for secure work and other entitlements, and prisoners donate them in exchange for reduction in prison sentences; (6) popular resistance to new laws of presumed consent for organ donation; (7) widespread violations of cadavers in public morgues, organs and tissues being removed without any consent for international sale; (8) the disposal and wasting of viable organs in the context of intense competition of public and private hospitals; (9) the critical importance of transplant surgery and commodified organs to the new economics of privatized

health care throughout the world; (10) the circulation of narratives of terror concerning the theft and disappearance of bodies and body parts globally, some of which have a basis in reality; (11) the spread of a lucrative transplant tourism in which patients, doctors, and sellers are serviced by rings of organ brokers. Perhaps what is needed from anthropology is something akin to Donna Haraway's (1985) radical "manifesto" for the cyborg bodies and selves we have already become through the appearance of strange markets, excess capital, advanced biotechnologies, "surplus bodies," and spare body parts.

KEYWORDS: ARTIFICIAL SCARCITIES AND INVENTED NEEDS

Several keywords in organ transplantation require a radical deconstruction: for example: *scarcity*, *need*, *donation*, *gift*, *bond*, *life*, *death*, *supply*, and *demand*. The "gift" of life, for example, hides the real demand for a "gift of death," insofar as, for a great many people, brain death is still understood as a relinquishing of life before it is time, a false death, as it were, that *precedes real* death.

The "demand" for human organs—and for wealthy transplant patients to purchase them—is driven by the medical discourse on scarcity. The specter of long transplant "waiting lists"—often, we have found, only virtual lists with little material basis in reality—has motivated and driven questionable practices of organ harvesting with blatant sales alongside "compensated gifting"; doctors acting as brokers; and fierce competition between public and private hospitals for patients of means. At its worst, the scramble for organs and tissues has lead to human rights abuses and violations in intensive-care units and in public morgues. But the very idea of organ "scarcity" is what Ivan Illich would call an artificially created need, invented by transplant technicians and dangled before the eyes of an ever-expanding sick, aging, and dying population.

The medical discourse on scarcity has produced what Margaret Lock has called "rapacious demands." Japanese sociologist, Tsuyoshi Awaya (1994) goes even further, referring to transplant surgery as 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," Awaya wants organ donors and recipients to recognize the kind of social exchange in which they are engaged.

The discourse on scarcity conceals the actual existence of "excess" and "wasted" organs that daily end up in hospital dumpsters throughout those parts of the world where the necessary infrastructure is lacking to use them. But the ill will and competitiveness of hospital workers and medical professionals also contributes to the production of organ wastage. The transplant specialists whom Cohen and I interviewed in our respective field sites scoffed at the notion of organ

scarcity given the appallingly high rates of youth mortality, accidental deaths, homicides, and transport deaths that produce a superabundance of young, healthy cadavers. But these precious commodities are routinely wasted in the absence or indifference of trained "organ capture" teams in hospital emergency rooms and intensive care units.

And organ scarcity is reproduced in the increasing competition between public and private hospitals and their competing teams of 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, we have found, is not of organs but of transplant patients of sufficient means to pay for the expensive surgery. In India, Brazil, and even in South Africa there is a superabundance of poor people willing to sell a kidney or even a cornea for a pittance.

MEDICAL BIO-PIRACY

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" floating around the world. 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 with Dr. S. in 1997 and 1998, he complained of a U.S.-based program which routinely sent surplus cornea to his center. "Obviously," he said, "these are not the best cornea. The Americans will only send us what they have already rejected for themselves." "Excess" cornea are shipped in bulk from the United States to other (including Third World) countries. And permissible handling charges constitute sales.

The director of a private eye bank in Pretoria, South Africa, complained that the American company that provided his institution with human cornea charged exorbitant prices, up to $1,000 per cornea. "And where do all these 'excess' cornea come from in the U.S.?" the eye bank director asked pointedly, a question we at Organs Watch are just now beginning to pursue. Meanwhile, in Cape Town, the director of South Africa'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 cornea" (actually *eyes*) would not be used, she said, for transplantation anywhere in South Africa. They could, however, be sent for "handling fees" to less fortunate, neighboring countries in Africa that requested them.

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, Brazil told of a controversial plan proposed some

years ago by Dr. Thomas Starzl of the University of Pittsburgh Medical School, in which Starzl proposed an exchange of North American "state-of-the-art" transplant expertise for a regular supply of surplus Brazilian human livers. Since Brazil had not yet at that time developed a liver transplant program, it had a surplus of livers that could help meet the needs of American transplant patients. In exchange for those excess livers, Starzl and his colleagues would help surgeons at the major public medical center in São Paulo develop their own liver transplant program. The public outcry in Brazil against this ghoulish exchange fueled in large part by the Brazilian media interrupted the agreement.

Although Brazilian livers were not delivered to Pittsburgh, many other Third World organs and tissues have found their way to the United States. In the files of a town council member in São Paulo, I found results of a police investigation of the local Medical-Legal Institute (police 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 used in the production of growth hormones. Similarly, an anatomy professor at the Federal University of Pernambuco in Recife was prosecuted some years ago for having sold thousands of inner ear parts taken from pauper cadavers to NASA for their space training and research programs.

Transplant surgeries reached a peak in Brazil in the late 1970s during the presidency of General Figueiredo, when relations between academic and military hospitals involving criminal organs transactions were flagrant. A retired transplant physician who was attached to a major academic medical center in Brazil told us that doctors and surgeons were under military orders to produce quotas of organs sometimes gotten "on demand" by chemically inducing the appearance of "brain death" in seriously ill patients from the lowest classes who had been abandoned as charity patients and, therefore, seen in every sense as wards of the state. Because of the history of past abuses by some of his own colleagues, this surgeon vehemently opposes Brazil's new law of presumed consent, calling it a law against the poor. "It is not the organs of the super-citizen," he said, "which will disappear, but those of nameless people without resources."

In South Africa, the director of an experimental research science unit of a large public medical school showed me official documents approving the transfer of human heart valves taken (without consent) from the bodies of the poor in the police mortuary and shipped "for handling costs" to medical centers in Germany and Austria. These permissible fees, I was told, helped defray the unit's research program in the face of the austerities and downsizing of advanced medical research facilities in the new South Africa. But to a great many ordinary citizens in India, South Africa, and Brazil, such commercial exchanges are seen as a form of global

bio-piracy, and increasingly today one hears demands to "nationalize" dead bodies, tissues, and body parts to protect them from global exploitation. The mere idea of "Brazilian livers" going to American transplant patients gives Dr. O., a Brazilian surgeon, "an attack of spleen." But whatever their destination, the removal of organs, tissues, and other body parts without consent is terrifying for those populations, mostly poor and socially marginalized, who see their bodies at risk of medical bio-piracy—whether in Cape Town, Rio de Janeiro, *or* New York City.

TRANSPLANT ETHICS AND HUMAN SACRIFICE IN THE POSTMODERN ERA

At the heart of this project is an anthropological analysis of postmodern forms of human sacrifice. Though it bears little resemblance to the burnt offerings of the desert Hebrews or to the agony of Christian martyrs thrown to lions at the dawn of the second millennium, human sacrifice is still with us. Organ harvesting carries some trace elements and vestigial images of Aztec hearts ripped—still beating—from the chests of state-appointed, ritual scapegoats. Global capitalism and advanced biotechnology have released new, medically incited "tastes" (a New Age gourmet cannibalism, perhaps) for human bodies, living and dead, for the skin and bones, flesh and blood, tissue, marrow, and genetic material of "the other." Like other forms of human sacrifice, transplant surgery partakes in the really real, the surreal, the magical, and the uncanny. What is different today is that the sacrifice is disguised as a "gift," a donation, and is unrecognized for what it really is. The sacrifice is rendered invisible by its anonymity and hidden within the rhetoric of "life saving" and "gift giving," two of several transplant "key words" we are trying to open to a long overdue public discussion.

Inserting ourselves into transplant surgery theaters that were sometimes more like theaters of the absurd and following transplant patients from dialysis clinics to surgery, and donor bodies from township shabeens to police stations and public mortuaries and from there to the various eye banks, medical clinics, and research laboratories where their parts were harvested and redistributed, we encountered everywhere a kind of *apartheid medicine* that privileged some patients—organ *recipients*—over other patients, organ *donors,* about whom almost nothing is known. Organ donors represent a social and semiotic zero, an ideal place for a critical medical anthropologist dedicated to "following the bodies" to begin. We made the conscious decision to position ourselves on the "other side" of the transplant equation, representing the voice of the silent or silenced organ donors, living and dead, here seen as rights-bearing individuals and as vulnerable patients rather than as fodder for advanced medical technologies.

Two anecdotes convey the origins of this decision for me. After I had begun to

write about the fears of the Brazilian shantytown poor following rumors of child kidnapping for organ removal (Scheper-Hughes 1992), my husband, then a medical social worker at a large children's hospital, returned home one day deeply moved by a transplant operation that had just saved the life of a twelve-year-old child. Quite unthinkingly I asked, "Whose organ?" Michael's anger at my "inappropriate" question lead me to realize that here was a question that *had* to be asked. Then, later, in 1996 when I was already deeply involved in this research, a transplant surgeon in Recife, Brazil, who relied heavily on live kidney donors, answered my questions about patient follow-up procedures quite defensively. "Follow up!" he fairly boomed. "With transplant patients it's like a marriage—you are never free of them!" "Yes," I replied. "But what about your *other* patients, your kidney donors. Do you follow *them?*" To which the surgeon replied. "Of course not. They are *not* patients. They are healthy people just like a woman who gives birth." When I spoke of the many kidney donors I met who later encountered medical and psychological difficulties, he replied, "These are neurotic people who want to be heroized for what they have done." But when I countered, "Why *shouldn't* they be?" the doctor had no reply.

Then, during a field trip to Brazil in 1998, I encountered in Salvador, Bahia, a "worst-case scenario" showing just how badly a live kidney donation could turn out in a Third World context. "Josefa," the only girl among eight siblings from a poor, rural family in the interior of the state, developed end-stage kidney disease in her twenties (figure 4). With the help of people from her local Catholic church, Josefa moved to Salvador for dialysis treatments, but there her condition continued to deteriorate. Her only solution, she was told, would be a transplant, but as a "public" patient, her chances of getting to the top of local "waiting lists" was next to nil. At her doctor's suggestion, Josefa sought a kidney donor among her siblings. An older brother, "Tomas," the father of three young children, readily offered to help his "baby" sister (figure 5). But what first seemed like a miraculous transfer of life rather quickly turned problematic. Soon after the "successful" transplant, Josefa suffered a crisis of rejection and lost her new kidney. Meanwhile, Tomas himself fell ill and was himself diagnosed with kidney disease resulting from a poorly treated childhood infection. What the doctors referred to as a "freak accident" and a stroke of "bad luck" struck Josefa (and her brother) as evidence of a larger social disease: "We were poor and ignorant; the doctors didn't really care whether we were properly matched or whether I could afford the drugs I needed to stay alive after the transplant." Josefa's enormous guilt toward her dying brother brought tears to her eyes throughout our interviews. She was committed to doing everything possible to help out his family, to which she felt so miserably indebted. Tomas, a slender, nervous man, looking far older than his years, said ruefully dur-

FIGURE 4 "Josefa da Silva," Salvador, Brazil. (Photo by author)

ing a separate interview: "I love my sister and I don't hold her responsible for what has happened. The doctors never asked about my own medical history before the operation. And afterwards it was too late."

Perhaps this last anecdote may serve as a partial response to the following, often-raised challenge: If a living donor can do without the organ, why can't the donor profit and medical science benefit? Transplant surgeons have disseminated an untested hypothesis of "risk-free" live kidney donation in the absence of *any* published, longitudinal studies of the effects of nephrectomy (kidney removal) among the urban poor living anywhere in the world. Live donors from shantytowns, inner cities, or prisons face extraordinary threats to their health and personal security through violence, injury, accidents, and infectious disease that can all too readily compromise the kidney of last resort. As the use of live kidney

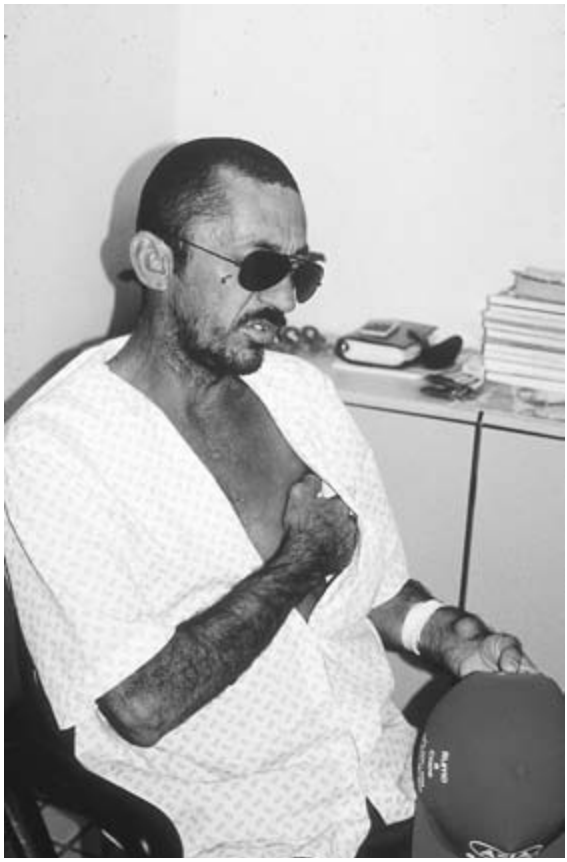

FIGURE 5 "Tomas da Silva," Bahia, Brazil. (Photo by author)

donors has moved from the industrialized West, where it takes place among kin and under highly privileged circumstances, to areas of high risk in the Third World, transplant surgeons are complicit in the needless suffering of a hidden population.

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

Few organ recipients know anything about the kinds of demands being made on the bodies of "the other," living or dead. They recognize, of course, that their good fortune comes out of the tragedy of another and they pass along the transplant folklore of the permissible guilt and glee they experience on rainy nights when traffic accidents rise. But cadaveric donor anonymity prevents scruples in the recipient population, although organ recipients often do try to learn something about their donors. But they are never privy to the secret negotiations and sometimes the psychological manipulations of the donor's family members while they are in shock and deep grief.

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

WHOSE VALUES ARE THESE?

Amid the contestations between organ givers and organ receivers, between doctors and patients, between North and South, between individuals and the state, between the illegal and the "merely" unethical, anthropologists need to be especially clear about their values in these complex transactions. Indeed, as professional hunters and gatherers of human values, anthropologists are characteristically shy when it comes to discussing their own individual or cultural notions of the good and its opposites. Why would anthropologists regard such "Western" and modernist notions of bodily autonomy and bodily integrity as basic human rights? This would seem particularly ironic given the deconstructionist and relativist impetus that lay behind Margaret Lock's and my earlier "mindful body" essay (1987).

However, we have since found that notions of bodily autonomy and integrity are almost universally shared today. They lie behind "First Peoples" demands for the repatriation and reburial of human remains warehoused in museum archives (as witnessed in the tremendous flack around the recovery of Ishi's brain). They lie behind patients' rights movements demanding access to medicine and medical technology—rights to "medical citizenship" as it were. They lie behind the demands of the wretchedly poor for dignified death and burial. And they certainly lie behind organ-stealing rumors and popular resistance to "presumed consent" laws.

For some of those, however, who live on the margins of the global economy, who are daily assaulted by disease, hunger, and premature death, whose living and working conditions are degrading, and for whom the experience of bodily alienation is already a defining feature of their lives, the possibility of selling an organ can sometimes appear as an act of empowerment. "I prefer to sell it [my body] myself rather than to let the state get it," was a sentiment frequently expressed by shantytown residents in urban Brazil.

In fact, it is in the West where the modernist values of bodily autonomy and integrity are most under assault. As commodification and commercialization have entered almost every sphere of life—from markets in "beauty queen" ova and "genius sperm" to a corrupted "willed body" program at the University of California, Irvine, Medical School—those in the North cannot claim any high moral ground. Meanwhile, the new constitutions and bills of rights adopted by democratic Brazil and post-apartheid South Africa are far more developed than ours with respect to recognizing human rights to bodily integrity.

We are particularly concerned about social and race-based inequities in the selection of candidates for transplant surgery in the United States. While it is true that African-Americans are, at best, reluctant organ donors, we question the biomedical rationale for race-based "matching," a procedure that is not followed in either Brazil or, historically, in South Africa, where black donors provided a great many organs for white recipients. Trust in medicine and in transplant procedures—especially medical definitions of brain death—is low in black, inner-city neighborhoods in the United States, and this contributes to the low incidence of organ donation. Hence, a vicious cycle is created and maintained. Medical exclusions based on poor blood and tissue matches, previous medical and reproductive histories, and exposure to infectious disease disqualify a great many black candidates for transplant surgery. One has to be relatively "healthy," affluent, and *white* in the United States to be a candidate for a cadaveric organ. Under these exclusionary conditions, resistance to organ donation makes perfect sense. One result is that African-Americans are counseled by their doctors more frequently than white Americans to pursue live (kidney) donation. And there is some evidence that African-Americans express more resistance to *making* such demands on their loved ones.

FOUNDING THE BERKELEY ORGANS WATCH

The emergence of death camps, torture camps, and organ-harvesting camps—which came together at certain decisive junctures in the late twentieth century—points to the demise of classical humanism and holism and the rise of "an ethics of parts"—part histories, part truths, and now, it seems, divisible bodies in which detached and free-standing organs function as market commodities. Human organ

sales have emerged as a niche market in which certain disadvantaged populations and nations have been demoted and fragmented in the interests of global capitalism. This ghoulish market in bodies and body parts erodes the enormous trust invested in biomedicine by nation states and by transnational corporations. In all, it conjures up the darker side, the anarchy and chaos of the global economy.

In its odd juxtapositions of ethnography, fact-finding, documentation/ surveillance, and human rights advocacy, this project blends genres and transgresses cherished distinctions among anthropology, political journalism, scientific report, moral philosophy, and human rights advocacy. These newer ethnographic engagements with everyday violence and human suffering require the anthropologist to penetrate spaces—that is, the "back alleys and police morgues" of this research—where nothing can be taken for granted and where a hermeneutics of suspicion replaces the earlier fieldwork modes of phenomenological bracketing and suspension of disbelief. That these transgressive uses of anthropology make some of my colleagues uneasy or angry is understandable. Neither are my collaborators and I entirely comfortable with what we have taken on. Yet, is any *other* discipline better situated than anthropology to interrogate human values and practices from a position of epistemological "openness" and to offer alternatives to the limited pragmatic utilitarianism and rational-choice models that dominate medical and bio-ethical thinking today?

Rather than views from the armchair, this research reports on views from over, under, and beyond the operating table and mortuary slab. If peering into surgical slop buckets to document the number of "wasted" organs is not ethno-*graphic* research, then I am afraid to consider what *else* it might be. In bridging the normally discrete boundaries between fieldwork in elite medical centers and in shantytowns and back alleys, our orientation holds to the simple dictum—"Follow the bodies!" Problems remain, however, with respect to the incompleteness of the evidence based on innuendo and fragments of conversation, as well as on hundreds of transcribed formal interviews and structured observations in dialysis clinics and operating rooms in each of our multiple research sites. Multisited research runs the risk of being too thinly spread, but the alternatives to this are unclear, given our mandate to investigate rumors, allegations, and scandals of kidnap, body-part sales, and organ theft, many of which prove are difficult to verify because of the almost impenetrable secrecy surrounding global practices of organ harvesting and transplant surgery. Our research also demands a sacrifice of the normally leisurely pace of traditional ethnographic work. We have to respond, move, and write quickly. We are learning, and rather quickly, as we go along.

In addition to the normal production of scholarly articles, papers, and monographs, we established in Berkeley in 1999 an Organs Watch Project (Monaghan

2000) modeled after human rights surveillance programs such as Amnesty International. From this base, we are coordinating original fieldwork and archival data collection on normative and deviant practices of organ harvesting and distribution worldwide, and we are making our findings available through the Internet [see http://sunsite.berkeley.edu/biotech/organswatch] and through a bi-annual newsletter (Berkeley Organs Watch 2000). The evolving archive is mapping the routes by which organs, doctors, medical capital, and donors circulate; documenting changes in international and national regulations on organ and tissue transfer; and recording and participating in crucial debates, public forums, and governmental hearings regarding the manner in which tissues and organs are harvested and distributed (Scheper-Hughes 2001a). Finally, we are collaborating with investigative reporters from major newspapers and public radio and television—granting interviews, traveling with reporters, and introducing them to our fieldsites, a practice that is, as far as I know, extremely rare (for obvious reasons) among anthropologists. In March 2001 I traveled with Mike Finkel of the *New York Times*, who produced a cover story (Finkel 2001) on organs traffic in the Middle East that had been uncovered by me (in Israel) and by two Organs Watch interns, Jennifer Khan and Aslihan Senal (in Turkey).

In sum, our goal is to bring broader social and social justice concerns to bear on global practices of organ harvesting and distribution as an alternative to the myopic, case-by-case view of transplant surgeons. While most of our field research to date has taken place in the Third World, we are learning the extent to which these global exchanges involve and implicate the United States and Western Europe. The rapacious demand for organs in one area stimulates the market for brokers and organ sellers or body mafia in other nations. For example, during the fall and winter of 2000–2001, several Israeli kidney patients arranged, through brokers, to have transplant surgeries at major hospitals on the East Coast of the United States with kidneys purchased from living donors. Organs Watch contacted the surgical unit directors, who expressed surprise and indignation that these illicit practices were happening "behind their backs." But the rule operating in many U.S. kidney transplant centers at the present time with respect to living kidney donation can be described as an implicit policy of "Don't ask, don't tell," or "Ask, but please don't tell us anything we don't want to hear" (see Scheper-Hughes 2001a). At the very least, the loose and highly localized surveillance (or, more commonly, the lack thereof) of living kidney donation, worldwide, requires serious attention in light of the rapidly growing phenomenon of living unrelated organ donation (Live Organ Donor Consensus Group 2000).

Organ transplantation depends on a social contract and a social trust; it cannot exist without protest and refusal unless the grounds for social trust are explicit. At

a very rudimentary level, the ethical practice of organ transplantation requires a reasonably fair and equitable health care system within a reasonably democratic state in which basic human rights are protected and guaranteed. Organ transplantation occurring within the milieu of a police state where political "disappearances" or "dirty wars" are practiced, or where routine police torture and injury and deaths in detention are common, can only generate fears and panics. And organ transplantation occurring within a competitive market economy in which sellers are reduced to "suppliers" of valuable spare parts corrupts the profession of medicine. Under such circumstances, the most vulnerable people will fight back with one of the only resources they have—gossip and rumors which convey, albeit obliquely, the reality of the "situation of emergency" that exists for them.

We in Organs Watch are seeking assurances that the social and medical practices around organ transplantation *include attention to* the needs and wishes of organ donors, both living and dead. We are asking transplant surgeons to pay attention to where organs come from and the manner in which they are harvested. We want assurances that organ donation everywhere is voluntary and based on altruistic motives. And we want the bodies of potential donors—living and dead—to be protected and not exploited by those who are charged with their care. We want the risks and benefits of organ transplant surgery to be more equally distributed among and within nations, and among ethnic groups, genders, and social classes. Finally, we want assurances that the so-called "gift of life" never deteriorates into a "theft of life." We hope that this new project will be seen as an attempt to establish a new ethical blueprint for anthropology and for medicine into the twenty-first century.

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