

WHERE IT HURTS: INDIAN MATERIAL FOR AN ETHICS OF ORGAN TRANSPLANTATION

by *Lawrence Cohen*

Abstract. This article focuses on ethical issues surrounding the selling and buying of human organs. The author argues that most people who sell their organs (mainly kidneys) in India do so in order to pay already existing debts. The transaction is only temporarily an exchange of “life for life,” and most “donors” are back in debt soon after the operation. The author discusses the flexible ethics that reduce reality to dyadic transactions and the purgatorial ethics that collapse real and imaginary exploitation in the service of complex interests. He also offers a sophisticated discussion of the ethics of publicity and public ethics. He emphasizes the lack of factual information, intentional manipulation of information, and the dissemination of kidney panics and kidney scandals, especially by the new developing bioauthorities and bioethical brokers.

Keywords: debt; India; kidneys; medical ethics; scars; transaction.

THE SCAR

We are sitting in a one-room municipal housing-project flat in a Chennai slum in south India, in a room filled with photographs of the man of the house posing with Tamil political leaders. His wife, one of the persons I am interviewing this June 1998 morning, all of whom had sold a kidney several years earlier for 32,500 rupees (roughly \$1,200 at the time of sale), is speaking about why poor people get into debt. Chennai used to be

Lawrence Cohen is a medical doctor and Professor of Social and Cultural Anthropology and Medical Anthropology at the University of California at Berkeley, Medical Anthropology, 319 Kroeber Hall, University of California, Berkeley, CA 94720; e-mail cohen@uclink.berkeley.edu. He is cofounder of the Organs Watch. A version of this article appeared in *Daedalus: Journal of the American Academy of Arts and Sciences*, 128:4 (Fall 1999), 136–65. Portions of this essay were presented in a paper at the Annual Lecture Series in Science and Religion at Aurora University, Aurora, Illinois, Spring 2002.

[*Zygon*, vol. 38, no. 3 (September 2003).]

© 2003 by the Joint Publication Board of *Zygon*. ISSN 0591-2385

called Madras, and it has become the place where people come in search of a “selling-their-kidneys-to-survive” story. This woman has invited us—myself, the hospital orderly Felix Coutinho, who introduced me to her, and the four other sellers we have found—to use her place for interviews. All of the sellers are women, and all but one have gone through Dr. K. C. Reddy’s clinic to have the operation. “Operation” is one of the few words I recognize in the Tamil conversation that Mr. Coutinho is translating. I am used to working in north India and the United States, but neither English nor Hindi is of particular use at this moment. As they are cut out from the flesh, organs reconstitute the spaces of bodily analysis, and to delineate these spaces I have found myself continually moving about and ever more reliant, uncomfortably, on translation.¹

Dr. Reddy has been India’s most outspoken advocate of a person’s right to sell a kidney. His practice—until 1994, while it was arguably still legal to remove someone’s kidney without a medical reason—was apparently exemplary: education for potential sellers on the implications of the operation, two years’ free follow-up health care, and procedures to avoid kidney brokers and their commission. My anthropological colleague Patricia Marshall, on her own and with the Omani transplant surgeon Abdullah Daar, studied the practice of Reddy and his colleagues (Marshall 1996; Marshall and Daar 1998). She did not find evidence of the often-reported practices of cheating, stealing from, or misinforming sellers. Marshall introduced me to Reddy and to the general practitioner who had run his follow-up clinic for local sellers.

When I first visited the follow-up clinic, an estate with an abandoned air set back from the Poonamaial High Road, I met Coutinho sitting on the verandah with several other orderlies. He had previously been the go-between hooking up sellers with the clinic and knew where to find them. We talked for a while: there were not many patients. The follow-up clinic had closed when Reddy shut down his program in the wake of India’s 1994 Transplantation of Human Organs Act, which made the selling of solid organs unambiguously illegal, authorized the harvesting of organs from the bodies of persons diagnosed as brain dead, and forbade the gift of an organ from a live donor other than a parent, child, sibling, or spouse. There were exceptions, approved by Authorization Committees set up in each state that implemented the Act to ensure that the donor was some kind of relation or close friend. *Frontline*, a Chennai-based newsweekly, had published an article the year before (“Kidneys Still for Sale” 1997) documenting how easily these committees were circumvented. As long as the paperwork was in order, the investigative team argued, it was virtually impossible for committee members to differentiate an altruistic donation from a sale masquerading as such.

Coutinho and I sat on the verandah and talked about my project. He was interested in helping out, he said, because he, too, was a social worker.

Later he told me about his project, the LOVE Foundation, a home for the destitute elderly that he and some friends from his church had set up. Would I consider visiting the LOVE home and helping it out? We agreed to meet the next morning to visit Ayanavaram and Ottery slums, and when I had had enough of kidneys for me to talk to the Secretary of LOVE.

Many investigators had taken this route before, into the Chennai slum: the abject stories, the repeated and identical image of a man or a woman turning his or her flank to the camera and tracing the line of the scar. The slum of choice was Villivakkam, nicknamed “Kidneyvakkam” because so many of its residents had undergone the operation. Raj Chengappa, senior deputy editor at the newsmagazine *India Today*, told me that after breaking the Villivakkam story with an article called “The Great Organs Bazaar” (1990) he was deluged with calls from American and European media. Villivakkam gothic became routinized, as in its wake of scandal and shock did a counternarrative in which sellers were informed agents making rational choices under unenviable but real conditions. Information brokers joined organ brokers in leading filmmakers and reporters—and, following them, anthropologists, ethicists, and medical fact-finding teams—along well-rutted paths to predictable stories. Depending upon the need, terrains of violence or of agency and reason materialized. There was material in the slum for all manner of social workers.

Few of the growing number of Villivakkam experts have commented on what is to the outsider a pronounced feature of the slum: it is saturated with pawn shops where moneylenders buy and sell gold and other precious items. Outside many shops in the slum’s central shopping area are boards noting the day’s buying and selling prices. Women in particular examine jewelry they are considering buying to consolidate their earnings or bargain over the money and credit earned by pawning their gold. There are few banks.

I worried that Villivakkam might not be the place to begin, given the neighborhood’s media glut and my sense of the emergence of information brokers offering investigators whichever version of the trade they seem to want to find. I asked Coutinho whether there were other neighborhoods, where one might learn something new. We ended up in the Ayanavaram municipal projects, in the room with the political pictures, listening to one woman after another recount her story. The stories were similar, but they differed in quality from the various public accounts, being tales of neither graphic exploitation nor heroic agency. There were obvious biases: Coutinho was identified with Reddy, and his presence might have dampened any accounts of malpractice or exploitation. I was significantly well-off, dressed like the middle class, foreign, and white, and the possibility of future patronage might have heightened accounts of poverty and disappointment. We came in the late morning, when many of the women were back from domestic service but the men were still out working or looking for day

jobs; we may have overestimated the proportion of women to men sellers. But the one man we interviewed as well as all of the women said that few men in this neighborhood had undergone the operation. In each neighborhood, the stories we heard varied in the details of a body and its particular situation but shared several common threads.²

What was common: I sold my kidney for 32,500 rupees. I had to; we had run out of credit and could not live. My friend had had the operation and told me what to do. I did not know what a kidney was; the doctors showed me a video. It passes water; it cleans the blood. You have two. You can live with one, but you may get sick or die from the operation or from something later. You have to have the family-planning operation because without a kidney childbirth is very dangerous. I had already had *that* operation. What choices did I have? Yes, I was weak afterwards, sometimes I still am. But generally I am as I was before. Yes, I would do it again if I had another to give. I would have to. That money is gone, and we are in debt. My husband needs his strength for work, and could not work if he had the operation. Yes, I also work.

Around us are several pictures of the husband meeting with the beloved late chief minister of Tamil Nadu, known by his initials: MGR. The husband organizes for the All India Anna Dravida Munnetra Kazhagam party in the housing project. The wife says he had been better connected with leaders in the days when MGR was alive. She nods toward MGR in the photo: "He needed a kidney, too," she says. "He was dying, and received one from his niece; they did the operation in America. At that time, I did not know about kidneys. If I had, I would have given him both of mine."

Why Chennai? Deeper poverty and debt are found elsewhere, but the urban south was the first fertile ground for organ harvesting. Part of the answer is not surprising. Both primary health care and tertiary medical innovation are more developed in south India, leading not only to some of the earliest transplantations in India but also to greater access to medical institutions for persons across class lines.³ For the question of contemporary kidney sales in Chennai, additionally relevant is the fact that the relation of medicine to what we might term the constitution of the citizen's body is gendered.

What might such a link between gender, citizenship, and the possibility of transplantation entail? Cecilia Van Hollen (1998a, b) has studied the high usage of reproductive medicine and family planning by poor women in Chennai and other cities in the state of Tamil Nadu. The situation differs significantly from much of north India, where women have been less likely to use state biomedical interventions like tubal ligations (Jeffery, Jeffery, and Lyon 1989; Van Hollen 1998a). Many poor women in Chennai incorporate surgery and other obstetric and family-planning procedures into their lives, frequently electing extensive medical intervention. Van Hollen's findings suggest the ubiquity and intensive character of this

medicalization as central to any account of agency in women's encounters with the state. *What they said* in Ayanavaram: I already had that operation. They told me I needed to have it before I could have the kidney operation, but I already had it.

Thus, most women have chosen to undergo tubal ligation before the decision to sell a kidney is imagined. The emergence of Chennai's various "Kidneyvakkams" must be located in the prior operability of these bodies. The operation here is a central modality of citizenship, by which I mean the performance of agency in relation to the state. It is not just an example of agency; it is agency's critical ground. In other words, having an operation for these women has become a dominant and pervasive means of attempting to secure a certain kind of future, to the extent that means and ends collapse: to be someone with choices is to be operated upon, to be operated upon is to be someone with choices. "Operation" is not just a procedure with certain risks, benefits, and cultural values; it confers the sort of agency I am calling citizenship.⁴

Intriguingly, in these interviews the operation was said to weaken men more than it did women. A prior moment of contest over operability was, of course, the nationwide "emergency" more than two decades earlier with its legacy of coercive family-planning operations, particularly vasectomies (Van Hollen 1998a). Current accounts of the operation's greater danger to men draw upon memories of that earlier time, as well as upon a more generalizable phenomenology of male anxiety in the face of imagined female regeneration (Herdt 1981; Theweleit 1989). In these women's accounts of their husbands' concerns, an operable citizenship came at far higher risk to men: it literally "unmanned" them. Regions such as the "kidney belts" of rural Tamil Nadu feeding the Bangalore industry, where more sellers were men than in Chennai, often comprised settlements of mostly male migrant workers paying off large debts in the wake of the collapse of the booming power-loom industry. Women were back in the village and were less likely than urban women to have been hospitalized in childbirth or to have had procedures like tubal ligations (Van Hollen 1998a).

"I would have given him both of mine." If the gendered terms of citizenship in Chennai are set in part by one's operability, and if women here are the primary sites of the operation, then this woman's proposed gift of both of her kidneys to MGR can be rethought. Her gesture momentarily seems to redeem the operative losses of citizenship by framing them as a critical gift that might have saved the famous leader. Our hostess transforms her second operation from an abject transaction to an act that reconstitutes Tamil Nadu's beloved late chief minister. A young man, the son of another woman who sold her kidney, complained to us later that day that other boys call him names: "Your mother is a kidney seller!" The current order of the commoditization of everything, in which the operation transforms this mother into a prostitute, is countered here by resuscitating MGR as the politician-father and the idealized order he has come to

represent. In invoking MGR's need for a kidney, this seller rescripts her sale into a gift to the Tamil leader that revives the idealized social relations of that time and renders all such sales unnecessary.

Within the terms of such an imaginable gift, what language would pain take? One of the women in the room offers the beginning of an answer. Her operation, she says, caused her body to hurt. "It still hurts." She points to her flank, to the scar. "It hurts there." I ask her, through Coutinho, to describe the pain. There are no data in India on the effects of nephrectomy for these very poor sellers, most of whom lack long-term primary care. I begin to ask her more and more specific questions, sensing a symptom.

She looks at me, then at Coutinho. She had been talking, before my asking her about this pain, about her husband: a story of sporadic work, frustration, and drinking. Were we listening? She looks toward her scar again, and she says: "*That's* where he hits me. There. When I don't have any more money."

Arthur Kleinman (1995, 98–99) has written of ethnography as the study of what is at stake, an elegant and deceptively transparent formulation. The stakes in the postoperative scar differ for the women in the room, for the doctors in Bangalore, for the husband who hits, and for me. For the women, the scar has two moments: a recent past when it marked their successful efforts to get out of extreme debt and support their households, and an indebted present when it has come to mark the limits of that success. A sign of the embodiment of the loans one seeks to supplement wages and give life to one's family, the scar reveals both the inevitability of one's own body serving as collateral and the limits to this collateralization. One has only one kidney to give, but the conditions of indebtedness remain. At some point the money runs out and one needs credit again, and then the scar covers over the wound not of a gift but of a debt.

For the doctors, the scar is the sign that nephrectomy can and does heal, given their knowledge of the operation, skills, and commitment to what they are doing. Life for life, another physician had said: the real wound is poverty, and the operation provided the money to heal it. And yet there is the persistent fear, the counterknowledge that things can and do go wrong, not only in the healing of the flesh but in the healing of the impoverishment. Doctors know that sellers have little to no access to hospital care, that they often have to work at strenuous labor, that they are undernourished, and that they live in neighborhoods where infectious disease and alcohol are endemic. They know that much of the money passes quickly through the hands of sellers and goes to moneylenders and that many sellers lack bank accounts. Doctors also know that the public is concerned about rumors of organ-thieving gangs, and rival hospitals might foment an accusation against one or another of them: both public anxiety and the strategies of rivals can bring the police in at any moment. No matter how good the surgery, the scar could still betray them, and sellers have to be

kept out of sight.⁵ Like de Sade's libertines, the doctors try to erase all evidence of the cut.

For me, there was the search for traces of a more accountable medical narrative. Also, and less credibly, there were the thrill of the chase, the elite pleasures of building theory, and perhaps the premature anxiety over new biosocial arrangements that Paul Rabinow (1999) has called "purgatorial" driving my attack on medical practice from a putatively higher ground.

And for the husband? I never met him, and for all my easy if persistent repugnance I do not know how to imagine the pain of the wound he felt on another's body and the absence behind the arc of his blows (Das 1998).⁶ One is left with an inadequate sense of the deformation of the operation's promise, and with it the scar's slow slide from a mark of positive exchange to one of persistent debt.

LIFE FOR LIFE

Contemporary debate on the ethics of the sale of organs surgically removed from the bodies of the poor is shifting. Increasingly, philosophers, physicians, and social scientists are willing to suspend concern and to consider the case for a market in human organs. In India, the most well known of what is now a large number of countries supporting an emerging market in kidneys, several prominent opponents of sales have reversed their position. One of the most vocal of these is R. R. Kishore, formerly a high-ranking medical bureaucrat and currently an active player in the multilateral conferences and task forces constituting the global expansion of the field of bioethics. An architect in the development of the 1994 Transplantation of Human Organs Act, Kishore, in a 1998 interview in Delhi with my colleague Malkeet Gupta and me, concluded that he had made a terrible mistake.

Kishore went through his reasoning carefully. Cadaveric donation will not work in our country, he said, repeating a frequently heard claim. The infrastructure is not adequate; the mentality will not support it. And even though in a few years "we will be able to grow fetuses like popcorn"—a tantalizing phrase—the use of clone technology may have its ethical limits. For the needs of our population, Kishore suggested, we have to reconsider our stance. He turned to a bit of role playing: "Look, I'm a man dying of hunger. I ask this one for help, he does nothing. That one, nothing. Now I ask you. You say: I'm also dying. I need an organ. I'll help you if you help me." Allowing for an exchange of one man's surplus money for another man's surplus kidney is not really traffic, Kishore concluded, but "life for life." Everybody wins.

A more sophisticated version of this case for the sale of organs has been made by British philosopher Janet Radcliffe-Richards (1996) and endorsed by her fellow members of the WHO-supported International Forum for Transplant Ethics in an article in *The Lancet* (Radcliffe-Richards et al. 1998).

In brief, the group has made four points:

1. The standard arguments against the sale of kidneys rely less on logic than on emotion and require more to justify paternalist refusals to allow people to do as they wish with their bodies.
2. Such arguments make an exceptionalist case for the exploitation, coercion, and risk of selling organs while ignoring the myriad other exploitative, coercive, and risky things poor people do to survive and will have to do more of if organ sales are disallowed.
3. The particular forms of exploitation involved in the organ trade result in large measure from its informality and illegality, and the best response to them may be to centralize, formalize, and legalize the trade.
4. The fact that few people with chronic renal failure are able to avail themselves of this expensive option is no indictment of the kidney trade in itself but of the nature of private medicine and, more generally, of the political economy, and responses should focus there.

The authors go on to challenge many of the communitarian, slippery-slope, and denial-of-agency arguments made by opponents of a regulated market. In a nutshell, the traffic in kidneys, if properly regulated by the state, is a win-win situation. You get a kidney, I get money, and we both therefore survive against all hope.

I wish to provide suggestions from field materials for why neither Kishore's nor the International Forum's theoretical formulations may be adequate on the ground. These formulations are not necessarily the dominant ones, either in India or in the global world of bioethical debate, but they are important because they challenge an easy paternalism. I take seriously Radcliffe-Richards's call to go beyond any a priori malfeasance of organ sales, reading her concern in line with Rabinow's criticism of an ethics of suspicion in his work on genomic debate (Radcliffe-Richards 1996; Rabinow 1999). She asks us at the least to consider the case for organ sales rather than to jump into the sort of purgatorial ethics of alarm and remorse depicted by Rabinow. Fair enough. But just as the paternalist ethicist depicted by Radcliffe-Richards presumes "nefarious goings on" prematurely, before the fact, so she (along with her colleagues in the *Lancet* piece) appears to make several premature counterpresumptions of recognizable terrains of agency, risk, exchange, and bureaucratic rationality.

Thus, our purgatorial paternalist is content to read the wretchedness of selling an organ in formalist terms without asking about relative risks and benefits for persons whose wretchedness will not disappear with the banning of such transactions. But in parallel fashion, Radcliffe-Richards's thoughtful rationalist is content to presume from scattered news clippings and equally wretched stories (for example, of a Turkish man whose daugh-

ter dies because he cannot sell his kidney to save her) that we can speak with some authority about risks and benefits in the emerging Kidney-vakkams of the world without sustained inquiry.

The question of authority is critical. Both the straw-man paternalist and the rationalist operate through a particular logic of deferral, what I have framed as a persistent writing before the fact. This persistence is not incidental, I would suggest, but constitutive of our writing to the extent we occupy what I will term the space of *ethical publicity*. To get at what I mean by this, my argument has three parts, which address ethics as a practice more or less central to all social and human scientists of medicine under the exigencies of globalization. As such, ethics is an ideal type. If my argument (which in its understanding of ethics as a central feature of globalization comes out of conversation with the recent work of Rabinow) is reduced only to a disciplinary attack, then I will have failed (see Palsson and Rabinow 1999, 14–18).

First, I suggest that practices of deferral allow for the reduction of ethical analysis to a transactional frame in which all considerations outside of dyads like buyer-seller, donor-recipient, or doctor-patient are reduced to secondary processes. Alan Wertheimer's thoughtful book *Exploitation* (1996) offers an example of the value and limits of such a reduction more generally. For the International Forum, as for Kishore, the goal seems to be to get to a win-win scenario, achievable as a matter of life for life. Policy is to be built on an understanding of social analysis as an aggregation of individual transactions.

Second, the transactional frame—describable once questions of particular institutional forms and processes are reduced to secondary phenomena—are flexible and exportable. There is a global audience for *The Lancet*, but even before the report was published almost every Indian transplant surgeon I interviewed in Bangalore and Chennai was conversant with the particulars of Radcliffe-Richards's writing. Ethics must be able to travel light. Neither the purgatorial visions of religiously based ethics, nor social-scientific specificity, nor modes of critical or poststructural analysis serve the contemporary moment well: they are not ecumenical or economical, and they fail to valorize the emergent subject of globalization. Radcliffe-Richards's ethics are sensibly concerned with the small minority of Indians who can afford the cost of dialysis or transplantation. For the rest, there is no point in worrying too much about organ sales, as nothing short of massive social change would have an impact on health care anyway. As medical care and expensive biotechnology become increasingly synonymous, fewer eschatological options for the health care of the poor become unimaginable. Several Bangalore surgeons whose procedures, unlike those of Reddy, provided inadequate to no follow-up care to poor sellers were among the most vocal popularizers of Radcliffe-Richards's writings and of the subsequent *Lancet* report. Arguments will always be

productively misread, but the point is that certain ethics travel well precisely because of the flexibility of their reductive transactional frame.⁷

Third, not only flexible but also purgatorial ethics can be mobilized to serve the exigencies of the moment. Kidney scandals have erupted in Bangalore, Delhi, and many other Indian cities on a regular basis, with doctors arrested on the grounds of tricking the poor and gullible into an unnecessary operation during which a kidney was removed. Though such events may have occurred on occasion, the scandals I have studied appear to be based on trumped-up charges. Accusations are used by hospital owners and politicians in league with the police to challenge rival combines of medicine and politics: given widespread public concern across class about organ theft, kidney scandals are devastating for politics and business and therefore are an increasingly useful regulative mechanism.

What is the relation between the flexible ethics of life for life and the purgatorial ethics of nefarious goings-on? My sense is that, despite their substantive opposition, these modes of engagement share at least some things, things I group under the heading of publicity. Ethics has become the dominant mode of public conversation about emergent biosocial situations.⁸ I mean “public” conversations in the double sense that has emerged via Kant and Habermas, and their critics from Horkheimer and Adorno to Michael Warner: a conversation that not only is located *in* the public sphere but more fundamentally is constitutive *of* it.⁹ I will term as *ethical publicity* the rationalization of emergent biosociality through flexible logics of win-win, logics that posit an identity (“life for life”) between the life of the comparatively wealthy person in organ failure and that of the debtor pressed to sell one of her organs. As Nancy Scheper-Hughes (1996) has noted, this public is divided into bodies that can be designated patients and bodies that can be designated sellers: one is either a client of the new biosociality or a vendor to it. Unlike ethical publicity and its realism, scandalous publicity—in which I include the mobilization of purgatorial ethics into public scandal—demands a single public united in opposition to a piracy that yokes together imaginary and real tissue flows.

The position of philosophical consideration—the abstract perusal of the case for organ sales—is a poor defense against one’s misapplication to the extent one occupies such a position of ethical publicity. The challenges that medical anthropologists have offered to ethical publicity, though partaking (as does this essay) of the same purgatorial muck that blurs reasoned apperception, remain critical maneuvers as long as the fiction of distanced ethical consideration substitutes flexible transactions for institutional and local specificity. In particular, Kleinman’s critical engagement with bioethics (1995) and Scheper-Hughes’s refusal to allow us any remove from the bodies and lives of poor donors and sellers (1996) map out localized responses by ethnographers that must complement critical distance.

The first problem is the dyad. Take, for example, the very real claims of sellers to be able to do as they wish with this unexpected resource. Sellers are presented within flexible ethics as having a need (for money) and a desire (to sell an organ for that money). “Yes, I would do it again.” But listen further in Chennai: “. . . if I had another to give.” And further: “I would have to.” Radcliffe-Richards would question paternalist denials to the poor of their agency, an understandable move against a vanguard logic that invokes false consciousness whenever “the poor” do not tell ethnographers what they want to hear. But the question is not whether the statement “I would do it again” is coerced or alienated but rather what happens if one keeps listening: “I would have to.” Does the opposition of agency and coercion sufficiently account for this “would have to”?

The problem with an ethical argument of this sort is the unrelenting presumption that ethics can be reduced to a primary transaction.¹⁰ This reduction frames most relevant considerations as second-order phenomena and generates a utopian formula: if second-order phenomena can be controlled for, then an ethics is possible. But in fact the primary transaction is constituted out of the very second-order phenomena that the analyst would defer: everyday indebtedness and extraordinary debt bondage in which money passes from the patient through the donor and to the moneylender and other creditors. If one keeps listening, beyond the desire that sets the market in motion, one regains the temporal specificity lost in these transactional analyses: “I would have to. That money is gone and we are in debt.” In the Tamil countryside with its kidney belts, debt is primary. But it is not only debt that constitutes the frame of the primary transaction and troubles its claim of life for life. In Chennai city, debt intersects with operability and the contingent logic of biopolitical regulation. Operable women are vehicles for debt collateral—and bear the scar. “My husband needs his strength for work and could not work if he had the operation.” “Yes, I work too.”

Against what is heard, the two kinds of publicity constitute alternate public terrains. For ethical publicity, gender and debt become second-order phenomena, and ethics is restored to rational actors *pace* Adam Smith. What happens several months down the line is elided. Rational consideration appears not only removed from the purgatorial but also removed from outcomes distant *in time* from the primary transaction.

In scandalous publicity, as manifest in Indian and international media, images of male victims showing the scar from an involuntary nephrectomy are ubiquitous. These are not the bodies of rumor: an operation has occurred, perhaps involving some measure of coercion. But the point here is that the public scar is almost always male: men offer the paradigmatic surfaces bearing scars that in urban areas cover operations on female bodies. Scandalous publicity reconstitutes the “emergency.”

PRELIMINARY CONCLUSIONS

How do we steer between a flexible ethics that reduces reality to dyadic transactions and a purgatorial ethics that collapses real and imaginary exploitation in the service of complex interests? I am in the midst of a four-year study in Chennai, Bangalore, Delhi, and Mumbai (Bombay), and in lieu of a full answer I offer six points as part of a work in progress.

1. No data exist on the long-term effects of nephrectomy to sellers or families. Many surgeons in these four cities reported an absence of long-term effects and then went on to insist that follow-up research was impossible because they have no way of knowing where the itinerant or illiterate sellers have gone. Yet the ability of activist physicians, factfinding teams of ethicists, and journalists to locate sellers suggests that epidemiological research on such long-term effects is eminently possible and would seem to predicate any future calculations of risk-benefit ratios.

After Reddy, two of the most internationally prominent physicians who are advocates for organ sales are doctors S. Sundar and A. K. Huilgol of the Karnataka Nephrology and Transplantation Institute (KANTI), housed in Bangalore's Lakeside Hospital. All physicians in Bangalore and Chennai acknowledged the high standard of care KANTI offers: medically, it is an exemplary site. Like Reddy, Sundar and Huilgol make no secret of their commitment to organ sales as a win-win scenario in the context of local conditions. Like Reddy, they are carefully acquainted with Radcliffe-Richards's work and cite it to challenge opposing positions as both intellectually unsustainable and naive. Unlike Reddy, however, Sundar, in several 1998 interviews, deflected my question each time I asked about meeting his former sellers. When pressed, he pleaded the impossibility of finding these people or learning much from them.

Many of the Bangalore sellers have come from the Salem-Erode kidney belt. According to social workers and small-town reporters working in that region, these sellers are primarily men who left unirrigated "dry" farming districts for the promise of steady work as the power-loom industry dispersed from cities like Chennai to cheaper production sites. Unlike the Ayanavaram and Villivakkam sellers, these men are more likely to be recent migrants who are indeed harder to follow. This difficulty has been used to forestall attempts to generate data.

Part of Sundar's cautiousness may arise from the possibility of KANTI's knowing or unknowing involvement in the trade. Sundar denies awareness of any illegalities: if his patients say the donor is a relative or family friend, and if the state authorization committee has concurred when necessary, it would be wrong, he argues, not to go ahead. Sundar is open about patients who seek out the committee. KANTI in fact makes a public display of its transparency. The waiting room is lined with large wall charts listing the numbers of every procedure carried out by KANTI and

its sister clinics in the state. News clippings attesting to KANTI's popularity in Bangladesh are hung along with a computer-generated sign from Bangladeshi patients thanking the clinic.

Despite this transparent design, three members of the Karnataka State authorization committee who were interviewed acknowledged that few of the donors they were asked to consider were relations or friends, from KANTI or most other Bangalore clinics. Why do committee members approve these donors, then? The state secretary who runs the committee said in an interview with me that patients and physicians have political allies who pressure the committee to grant approvals. Reddy is but the most prominent of several transplant doctors who specifically accused Sundar and Huilgol of "going too far" in turning transplants into big business. Reddy claimed that KANTI has advertised in Sri Lanka and Bangladesh for patients and that Sundar and Huilgol had come to the Kidneyvakkams of Chennai in search of sellers. Part of Reddy's concern might have been territorial: the urban Kidneyvakkams had for several years supplied Chennai clinics, while the rural kidney belts to the west had supplied Bangalore. "They have become greedy," he said—suggesting that, far from being unable to determine the provenance of kidneys, Sundar and Huilgol themselves served as procurers.

Sundar and Huilgol may well be the victims of false accusations by competitors. But their resistance to follow-up research is striking. The only things missing from the prodigious display of data shown by KANTI on its walls, in its publications, on its Web site, and through its dealings with the press are the bodies and statistics of donors. The second time I tried to get Dr. Sundar to talk about a possible follow-up study of donors, he took out a copy of a Radcliffe-Richards article from his desk and asked me if I had read her. He read choice phrases of the article to me, dismissing my concerns over sellers as paternalist. But where were the donors? If the market structure of transplantation deflects attention from the actual bodies of sellers onto ideologically constituted proxies, how complicit are flexible ethics in maintaining postoperative inattention to sellers?

2. Decisions to sell a kidney appear to have less to do with raising cash toward some current or future goal than with paying off a high-interest debt to local moneylenders. Sellers are frequently back in debt within several years.

The Ayanavaram slum dwellers who sold their kidneys described their reasons for selling and their desire to sell again if biologically possible in terms of a transaction not with the present or future—an operation to pay for, a house to buy, a shop to set up, a wedding to finance—but with the past. They were in debt and could no longer manage their indebtedness and still feed and shelter a household. This finding is tentative, for, as most of these borrowing and lending transactions are through private moneylenders and small shopkeepers as opposed to state or private banks or

credit associations, data to confirm sellers' and nonsellers' patterns of indebtedness are difficult to generate. But the testaments of sellers do correlate with the work of investigative journalists in Chennai.¹¹ Furthermore, they make sense within the topography of credit in poor Chennai neighborhoods, in which moneylenders and pawnbrokers are ubiquitous.

None of the Chennai sellers interviewed claimed to have a bank account, and they offered the usual reasons: they were illiterate or poorly literate and of low status, and therefore could not negotiate the language and status practices of the bank bureaucracy with any certainty. Stories of money lost to bankers were common. Jewelry offered a seemingly more practical locus for saving, though stories of gold stolen or appropriated were not uncommon. Most of the kidney money went to pay off debt, and the expenses of husbands and children—education, marriage, medical costs, legal fees—took the rest. Several of the women interviewed mentioned men who drank up the savings.

Persons sell a kidney to get out of debt, but the conditions of indebtedness do not disappear. All of the thirty Chennai sellers with whom Coutinho and I spoke were back in debt again. Organs and blood, from the perspective of the debt broker, are but two of the multiple sites of the collateralization of the poor, ranging from patterns of debt peonage with lengthy pedigrees to expanding new markets in children for adoption, labor, and sex work. Technological transformation like that mediated by the emergence of cyclosporine offers new biosocial strategies for debt markets seeking under the logic of capital to expand.

The argument here is that the decision to sell may be set for debtors by their lenders, who advance money through an embodied calculus of collateral value. In other words, the aggressiveness with which moneylenders call in debts may correlate with whether a debtor lives in an area that has become a kidney zone. If so, the decision whether or not to sell is a response not simply to some naturalized state of poverty but to a debt crisis that might not have happened if the option to sell were not present. Based upon these interviews and discussions with historians, social workers, and journalists in Chennai, my hypothesis is that kidney zones—the vakkams and belts of Tamil Nadu—emerge through interactions between surgical entrepreneurs, persons facing extraordinary debt, and medical brokers. As a region becomes known to brokers as a kidney zone, their search for new sellers intensifies. Persons in debt are approached. In urban areas, more women than men respond. Creditors, who must advance and call in loans with an eye to interest, collateral, and reproduction—that is, to how much of the debtors' resources to take while keeping them alive and healthy enough to be able to make future payments and take out more debt—also respond to these shifting circumstances.

Debtors' recounting of the process of debt supports such a process, as does my informal observation of moneylenders and discussions with

Chennai and rural Tamil Nadu journalists and social workers who cover questions of credit and debt. More analysis of local credit practices is needed.

3. Few persons in India can afford the cost of transplantation or dialysis, so, whether or not organ sales are legalized, the majority of persons with end-stage renal disease will die. Programs to prevent end-stage renal disease are few, and prevention is not part of the dominant European or American conversations on organ sales, whether pro or con.

The first part of this finding is a commonplace. Radcliffe-Richards and her colleagues accept it but argue that the question of the poor's access to medical care is irreducible to their access to transplant surgery. Purgatorial anxiety over organs is a self-serving substitute for concern over universal health care.

Again, at an imagined distance this logical maneuver makes sense. Reformulated in terms of ethical publicity, however, it deforms in a predictable fashion. At KANTI, when I asked Sundar how he could support a market in kidneys given no data on the risks to Indian sellers, he, like Reddy and most other transplant physicians interviewed, responded that when a person dying from poverty comes to your door and asks why you will not help him, the situation requires action. The scenario of a request from a dying person is disconcerting and problematic, for the vast majority of persons living with and dying from renal disease could not and would not be attended to, as they lack the funds for dialysis or transplantation. Yet the sellers fulfill the terms of the ethical scenario as set by these doctors: A dying person asks you for help—what do you do? Somehow, such a scenario does not trouble these physicians in the way the suffering of the more well-to-do appears to.

When I asked the KANTI team about this apparent inconsistency, they smiled indulgently. We are a poor country, Sundar reminded me, and as much as it would improve my business to have the government pay for transplantation for the majority of Indians, I do not think it can be a priority for us. Government money needs to go to primary care.

The move is impressive, and dizzying. Sundar and the majority of transplant doctors who concur with him are masters of ethical publicity. There is no need to worry about health risks to the poor seller, because a physician must always worry about the individual patient: his or her ethical compact is with the individual sufferer. Yet there is no need to worry about the majority of individual sufferers, because an Indian physician must always think on the societal level, where the money would be better spent on inoculations. What is alarming is the sleight of hand by which individualist and communitarian rationales for a medical ethics replace each other in turn to justify business as usual.

In this context, the inattention to questions of prevention, to renal medicine that in the long term might be both affordable and effective for “a

poor country,” is particularly significant. Communitarian logic serves only to justify inattention and to slough off poor patients to public hospitals. Transplant physicians, despite their immersion in bioethics and communitarian appeals, are with notable exceptions not involved in campaigns of public education or the development of low-cost alternatives to current dialysis. Their persistent resistance to cadaveric donation, which would provide an alternative to the use of the organs of the poor, is troubling. Most surgeons interviewed cited India’s “infrastructure” or “mentality” as problems, but several pioneering cadaveric programs in the country are emerging, and their founders argue that the single most significant impediment to success is the unwillingness of most private transplant clinics to participate. Reliance on cadavers cuts down on a ready supply of organs and diminishes profits. In Bangalore, John and Rebecca Thomas—trained in Pittsburgh, the Mecca of transplant surgery—launched an effort to build an equivalent to the United Network for Organ Sharing (UNOS), a distribution and information network linking brain-dead cadavers to persons on a waiting list. Their efforts, though publicly applauded, have been met with significant resistance. No hospital wants to give away its own cadavers to a pooled list. Both brain-death transplantation and lists are far from perfect alternatives to sales, as the work of Margaret Lock on the former and Schepers-Hughes on the latter have shown (Lock 2002; Schepers-Hughes 1998). But debate on cadavers has not focused on the medical and ethical limits of brain death as a viable concept. Rather, lip service under a rhetoric of development is paid to ever-deferred infrastructural and institutional possibilities.

4. Buyers of kidneys often underestimate the risks and long-term costs of immunosuppressive therapy, leading to dose tapering and organ rejection after catastrophic expenditure.

Buyers no less than sellers are at risk. Schepers-Hughes has documented the predicament of poor organ recipients in Brazil who cannot afford to maintain cyclosporine immunosuppressant therapy and so taper or pool doses. Members of the Bangalore Kidney Patients’ Welfare Association, which meets once a month in a city park to distribute low-cost immunosuppressant therapy (but not the most expensive and most necessary drug, cyclosporine), offer similar stories of middle- and working-class persons who utilize networks—relatives, job benefits, insurance, and statewide “governor’s funds” set up for medical emergencies—to raise the cash for the operation, for the organ in the case of sales, and for the medication. These organ recipients anticipated one to three years of diminishing immunosuppressant therapy and thus either were not anticipating the long-term costs adequately or simply did not realize that therapy might last for many more years. A monthly dose of cyclosporine costs more money than many of these families bring in each month as income. Further ethno-

graphic work is needed to study the preoperative interactions between patients and doctors to understand what message about long-term costs patients are receiving and how they interpret it over time.

Part of the problem is that younger nephrologists are less aggressive in how many tissue factor “matches” there need to be between donor and recipient kidneys in order to go ahead with the operation. Cyclosporine, in combination with other drugs, makes a transplantation with fewer matches medically viable in certain patients. With the predominance of transplants of kidneys from nonrelatives (now disguised under the terms of the 1994 act), requiring fewer matches means one is more likely to find available sellers and conduct more procedures. I have witnessed debates between older and younger physicians over the appropriate number of matches. As the number of matches comes to be seen as less important, the length of time patients will remain on cyclosporine increases. Patients and physicians reported one to three years as a ballpark figure to me, but the figure may be based on data from a different climate of tissue typing and matching.

Novartis, the maker of cyclosporine, is ubiquitous in the global transplant world and in India. It funds many conferences, not only on organs but on medical ethics more generally, and its representatives attend public gatherings like those of the Welfare Association. At one such meeting, one recipient’s father literally begged the drug representative for a free month’s supply of the drug as he had no credit left. The drug was provided, and apparently this exchange was a repeated scene. Novartis becomes the great benefactor for this organization of recipients, and no actions to lower the price are proposed.

5. In major urban centers, the growing number of transplant programs led to intensified competition in the mid-1990s for recipients who could afford the cost: the ethics of transplantation in India are driven less by a shortage of donors than by market demands given a shortage of recipients.

KANTI is one of eight transplant centers that was established in Bangalore within a decade, in a state where dialysis is almost nonexistent. This rapid expansion was in part a function of demand, though the supply of persons who could afford the triple cost of operation, organ, and drugs was quickly exhausted. Beyond demand, a transplantation ward advertises a new or competitive private hospital as modern and well equipped: this reputation may be profitable beyond the income generated by the ward itself. Transplantation signifies (marketable) modernity.

As the supply of persons who could afford the operation diminished, competition between these many programs intensified, and directors began looking for new markets. With the passage of the 1994 act, the number of foreign recipients—typically from the Persian Gulf region, Europe, and Asia—went down sharply. Hospitals were worried about scandals,

and it was harder to pass off a local donor as a friend or relation of a foreigner. Clinics like KANTI looked to both Sri Lanka and Bangladesh, where recipients without relatives could bring their own donors or sellers. With the number of applicants for kidneys in decline, it is possible that middle- and working-class households who could afford the operation but not the immunosuppression were more aggressively approached. This impression is the one offered by Welfare Association members, but further study is needed.

If clinics face less a shortage of organs than a shortage of persons wealthy enough to take them, they need to organize their practice around a manageable and relatively low-cost source of human material. Recipients can go elsewhere, and one must have potential kidneys ready. The business of these clinics depends on the market and would be made far more risky with a turn to cadaveric donation.

The point here runs against the continual language of shortage that some ethicists take for granted. Putting aside the vexed issue of whether one can even speak of a shortage of people's organs—an issue drawing on a philosophical analysis of property extending from Locke to Marx and seldom engaged within the ethical literature under consideration here—one must ask whether the critical shortage is not of donors but of recipients. The practices and the ethics we need to consider are rooted in the economics of this latter shortage.

6. The rapid growth of transplant medicine in the 1990s was part of a larger period of medical institution-building in India in which high-end, privatized medical care became a major site of investment and foreign monetary exchange, and new public-private assemblages emerged linking medical institutions and political influence to various sources of capital—liquor, armaments, pharmaceuticals, and “black money.”

Transplant medicine, as a continual goad to public and foreign anxiety, became a strategic site for intervention within and between competing assemblages. The frequent manufacture of scandals in which doctors are accused and jailed as kidney thieves appears to be one such intervention.

One must differentiate kidney panics from kidney scandals. In panics, stories of missing or murdered children circulate and become tied to fears over kidney thieves and to the legitimation of state and international involvement. The stories are often based on real disappearances and child loss in the contexts of malnutrition and hunger, debt bondage and child labor. State agencies are challenged or attacked, and state responses focus on denying the stories and providing the materials for renarrativization.¹²

Scandals are not threats to state order but forms of publicity collaboratively produced by a mix of state and nongovernmental agencies. The police arrest a group of doctors, and the media are notified. Emerging accounts are framed not as positings of hidden gangs and state conspiracies

but as stories of greed and corruption. Brokers and doctors collude in tricking people into having medical tests with the promise of a job; people wake up with a scar. Such scandals took place in Bombay (not yet Mumbai) in 1993, Bangalore in 1994, Jaipur in 1996, and the Delhi suburb of Noida in 1998. Most of the trials are still pending.

It is, of course, possible that the physicians accused are guilty of all charges. Scheper-Hughes has carefully documented organ theft worldwide, even though she began her research to show the opposite—that these stories were symptoms of histories of poverty and state violence but not necessarily real thefts. Certainly worse examples of medical malfeasance occur daily. Yet one must exercise caution. With a large and growing number of persons in debt crises there would seem to be no immediate shortage of sellers, and it is not clear why clinics would take the high risk of cheating someone. Then again, police can be easily bought off, and the victims in most of the scandals (but not all) were socially marginal and unlikely to be heard. At present, one must defer final judgment.

Why, though, in each of these cases do the police act with such speed on the claims of poor and socially marginal accusers? In Noida, a senior superintendent of the police with a medical background was specifically transferred in to monitor the case. The accused physicians have mobilized their political connections in an effort to be released, but, according to several state medical officials who spoke with me on the grounds of anonymity, the word has come down from the chief minister's office that the case is not to be touched.

The earlier Bangalore scandal was similarly surrounded by hearsay. The Yellamma Dasappa Hospital, where the scandal was centered, is owned by an industrial group that was competing with another industrial group for a lucrative state contract to supply cheap liquor. (Most of the city's hospitals are owned by large industrial concerns, several by liquor companies.) Several hospital administrators, social workers, and journalists suggested that the contract negotiations lay behind the manufactured scandal. The police denied this.

"Manufactured" is deceptive here. If most transplant clinics have violated the letter and spirit of the Indian Penal Code and the later 1994 act in using sellers or passing them off as family or friends, and if sellers are provided minimal care and shunted back to the villages or slums, most clinics are therefore vulnerable to accusation—thus KANTI's strategy of performative transparency. But why police involvement? Most new clinics and hospitals have had to rely upon extensive political patronage to wade through regulations designed to promote a public health sector and limit private growth. Available urban land often has squatter colonies, and significant political capital is needed to move a potential "vote bank." Conversely, the new hospitals offer a variety of services to politicians and industrialists, ranging from a source of political patronage to a literal tax

shelter where industrialists and others under trial for foreign exchange and tax violations can be admitted to defer a court date in perpetuity. Journalists and other cosmopolitans in each of the aforementioned cities where kidney scandals continue offered dozens of accounts of the nexus between the new medicine, politics, and industry—some substantiated, many not.

Transplantation, both because it is a critical site of publicity around which periodic panics emerge and because it often involves a nested series of illegalities and produces a class of potentially exploited persons, seems to have become a key node around which competition for control of medical, industrial, and political resources is negotiated. The paradox is therefore created of a politics that tries to quell kidney panics while abetting the periodic negotiation of scandals.

What is the relevance of these scandals to the sociology and ethics of the market in organs? First, they push us to take seriously the need for an ethnography of the state. Radcliffe-Richards and her colleagues make a classic transparency argument, parallel to those used to defeat prohibition or decriminalize prostitution and drugs: If there is exploitation, then legalizing and regulating the market cleans it up while allowing sellers their autonomy. But this argument presumes a state structure, one in which increased regulation has a specified effect and the organization of the state can address the organization of the market. But what if the organization of the trade mirrors the organization of the Indian state in its need for brokers? The presumption of the ethicists seems to be that once India is developed into a certain assemblage of rational bureaucratic forms, the current abuses will disappear. This presumption imposes a narrative of the development of the state with little empirical grounding. In consideration of the recent work of Akhil Gupta on the ethnography of the Indian state as well as the writing of Veena Das, Ravi Rajan, and others on the bureaucratic management of treatment for the Bhopal gas disaster victims, what seems more likely is that any new central bioauthority will generate a new class of agents demanding payments from sellers (Gupta 1995; Das 1995; Rajan, personal communication). Such “bioethical brokers” may supplement, rather than eradicate, currently existing tissue brokers and debt brokers in the lives of the poor. At any rate, these are empirical questions that require ongoing ethnography before distanced consideration can be achieved.

OTHER ETHICS

Neither Kishore, Reddy, and Sundar nor the agents of public scandal currently hold the field in India, although things change fast. Medical activist organizations like the Voluntary Health Association of India (VHAI) still attract multilateral fiscal support and steer a course between acknowledging some nefarious goings-on and passing over transplantation to arrive at more urgent questions of infections, environmental degradation, and ac-

cess to primary health and hospital care. The dominant formation in Indian bioethics is purgatorial, but with a somewhat different lineage from the ethics challenged by Rabinow. Missionary discourse and aesthetics predominate, and the message of a new science stressing care against commerce and love against paternalist medicine offers the reclamation of society against a sense of loss experienced and inscribed as colonial. Such missionary ethics form another public space, one that travels well along certain routes. At the Fourth World Congress of Bioethics in Tokyo, Japan, in 1998, one of the dominant presences was Darryl R. J. Macer, the author of *Bioethics is Love of Life: An Alternative Textbook* (1998). Macer challenged most professional ethical stances, but in his repeated “All you need is love” theme, what really fell out of the equation was politics. Against flexible ethics, Macer and his followers downplayed any VHAI-type response and set up a global mission, a secretariat of love.

But if the only alternatives to a world split between clients and vendors are reconstitutions of Christian love, the result seems to be that vendors are authorized to define themselves through the gift, with clients remaining the beneficiaries. In Bangalore and Delhi I was told stories of persons possessed by a kind of donation madness: a man desperate to give away any organ he could; a couple who insisted all their wedding guests sign up to donate something. But in conversations with recipients, I continue to hear love in a different sense: *Why should I put a family member I care about at risk by asking him or her to donate an organ when I can just buy one?*

The production of scandal, through sociologically complex linkages of state and market agencies and old and new media, maintains the image of a distinctive state apparatus that can intervene to regulate medical abuses against the poor. This image is central to ethical publicity, justifying its presumption of a universal and liberal state structure allowing the invisible hands of utility and reason to guide an individualist ethics of radical autonomy. The public productions of such an ethics are consumed and elaborated by transplant professionals and more generally by the corporate/political hybrid of contemporary health care.

To what world do such ethics speak? Midway through this research, we are left with scattered signs: a woman offering both of her kidneys to MGR; a man in a park pleading with a Novartis representative; a postoperative complication of a painful scar that began to hurt when the money ran out.

AFTERWORD

This essay, written in 1999, was an initial effort to think through two deceptively simple questions: (1) Is the sale of an organ the win-win situation its proponents claim it to be? and (2) Given the forms of potentially exploitative commoditization making claims on peoples’ bodies and futures in the world today, why is the market in transplant organs so central to both media and ethical conversation?

The process of answering the first question remains an open one, as markets and the various techniques of physicians, brokers, and regulators shift and adapt to new medical and social knowledges. The work of Scheper-Hughes has revealed serious criminality and bad faith at all levels of contemporary transplant surgery and for-profit organ and tissue banking. This work is important because it is international and cannot be accused of relegating criminality to poorer nations alone. We continue to call for large-scale studies of the long-term effects of unilateral nephrectomy (giving up a kidney) on populations of persons with little to no access to primary health care and no treatment and unknown risks for diabetes, hypertension, and other sources of future renal failure. Many of the nephrologists I worked with in south India continue to railroad the possibility of such studies from happening, finding newer ways to keep their sellers hidden and isolated. Other nephrologists and surgeons in India—and this is a story I did not tell in this essay—have been heroic in trying to create precisely these data.

We continue to call for more data on the long-term employment prospects and occupational hazards of persons whose livelihoods depend on significant physical exertion and who give or sell a kidney. The frequent claims of sellers we witness and record of being unable to return to work are routinely discounted by many of the physicians we work with, despite their lack of any follow-up data or interest in producing the same.

At the same time, we recognize that the media glare focusing on sellers becomes one of the most acute forms of social suffering they may face. Since the Chennai work reported in this article, I have worked in two rural districts in South India where men more than women are the primary sellers. In one of these, Guntur in Andhra Pradesh, an extraordinary concentration of what here I have termed ethical brokers have shown up in wave after wave to study and comment on the wretchedness of the situation. I have stood in line with the rest. Guntur sellers uniformly regret their decision to sell and mourn their collapsed hopes and weak bodies. They point to the exacerbation of the shame of their redoubled economic and physical weakness by the unanticipated ethical publicity—both flexible and purgatorial—that has worked to shape their experience to one or another theory of bodies, markets, and futures.

Such a situation points to the ongoing relevance of my second question. I have proposed a concept of “ethical publicity” as a provisional response, arguing that transplant debates become a key site for the staking out of positions on community and the gift in the face of uncertain bodily and communal futures. Our ethical talk, in other words, becomes central to the processes of identification and disidentification by which we define self and other. My current work involves tracking our current ethical conversations and their relation to other processes of planning and regulation and the formation of a “public” space of biopolitics.

Since writing the article, I have tried to supplement this line of thinking with a third question: Is there anything new in the traffic, gift, and sale of organs? Is this the usual mix of generosity and exploitation that humans have wrestled with for millennia, in new clothes? Rather than answer yes or no, I have tried to trace what might be worth noticing in the current situation as particularly germane to our times. I have argued that at stake in transplantation in India are two forms of what philosopher Judith Butler has termed materialization. Butler was trying to find a way to show how the body is never simply a given by adapting the concept of interpellation developed by Louis Althusser to include the body. To be interpellated for Althusser is to be hailed as a certain kind of subject by the various institutions and apparatuses that constitute social and political life. To be materialized is to be hailed as a certain kind of embodied subject. What are the stakes in being materialized as a giver, or seller, of a kidney?

For me there are at least two ways to frame these stakes. I call them *bioavailability* and *operability*. By bioavailability, a term I borrow from pharmacology but take in a different way, I mean an index of the extent to which a person's body is available to be reincorporated into something or someone else given the relation between techniques (here, surgical and pharmacological techniques) and market structures. By operability I mean an index of the extent to which persons define their belonging to an ethical community in terms of their willingness to be operated upon.

We can thus offer a potted history of bioavailability in the case of transplantation, in four moments. In the early twentieth century, surgical pioneer Alexis Carrel and others developed techniques (of arterial suture and of vascular surgery) enabling them to solve the mechanical challenges of transplanting a kidney. But one dog's kidney transplanted to a different dog still led to what was soon understood as the rejection of the organ by the new host body. Only identical twins, for humans, were readily bioavailable. The second moment developed out of the immense wartime effort mid-century to create effective transfusion medicine, and the emergent techniques and knowledges that resulted in Sir Peter Medawar and colleagues' work on tissue typing. Now kidneys could be analyzed to predict the likelihood of rejection. In theory many more persons became bioavailable, but in practice a given donor or clinic seldom had enough potential donors to test in order to secure a good enough match. But, in our third moment, in a story well told by Margaret Lock (2002), the development of the respirator for the maintenance of persons with polio was deployed in other, post-traumatic situations to produce a new class of barely alive persons. With their reclassification through the conception of brain death as technically dead, these persons could be deployed as a large bioavailable reservoir. What was necessary was to create a new prestatinal ethic redefining the turning over of a barely alive body of a loved one as an act of goodness and saving a life. The United States and Western Europe

emerged as the major producers of bioavailable kidneys and of other organs and tissues, given large enough catchments of almost-dead bodies to ensure the likelihood of a match.

The fourth moment allowed transplantation to globalize. With the development of cyclosporine and of other powerful immune system suppression drugs, clinicians no longer had to search for a close match but could suppress the recognition apparatus of the recipient. Suddenly, the most profitable operations were those who could mobilize tissues and organs flexibly, on far smaller and more local scales than before. Throughout the world, myriad different regimes of bioavailability emerged to recruit bodies and tissues, increasingly of persons unambiguously alive at the time of recruitment: poor relations, servants, and more generally debtors in India, charitable strangers in the United States, prisoners in China. All of these regimes have continually adapted and readapted to changing regulations, forensics, and publicity over the past two decades in their strategies of recruitment; the accent is on flexibility.

Operability raises somewhat different questions. In this article I wrote of women sellers who had already had the “family-planning operation,” usually a tubal ligation, and speculated on the intimacy of the operation *tout court* in their lives. My current research tries to follow this link further, engaging histories of sterilization in India over the twentieth century, trying to understand the logic of planned development that framed the majority of Indian citizens as passionate creatures devoid of the necessary will to become ascetic moderns and future capitalists. The surgical operation becomes a dominant form of the modernization project, I argue, as it creates a kind of “as if” modern, a class of bodies that act as if they were ascetic moderns by virtue of having been persuaded to get sterilized. To be sterilized is not only to have no more children, it is to accede to an ethical limit. The question remains as to why the developmentalist project saw the site of this limit as being a matter of the body and not of the will.

In other words, transplantation looks beyond articulations of medical technique and market structures to critical questions of states and other disciplinary agencies fashioning particular classes of persons, and in some cases all persons, *as being as a matter of ethics* committed to being operated upon. To imagine a good life, one comes to imagine operable life.

NOTES

This research is funded in part by grants from the Open Society Institute, through its support of the Bellagio Task Force on Organ Transplantation and Organs Watch. I am indebted to my colleague Nancy Scheper-Hughes for organizing these projects as well as to project colleagues David Rothman and Sheila Rothman. Many conversations with these colleagues ground this research. In particular, many of the ideas I discuss here have emerged in the course of ongoing discussions with Scheper-Hughes. Work in India has depended upon the extensive research, analysis, and engaged criticism of Patricia Marshall, Veena Das, Malkeet Gupta, and Cecilia Van Hollen, though I alone bear responsibility for its current form. Van Hollen and Kaushalya Hart

took time out from their own research and teaching to transcribe and translate the Tamil transcripts. The advice of Bina Agarwal, Joao Biehl, Philippe Bourgois, Roma Cahatterji, Mariane Ferme, Eric Glassgold, Byron Good, Arthur Kleinman, Eric Klinenberg, Margaret Lock, Don Moore, Stefania Pandolfo, Paul Rabinow, Martha Shelby, Mira Shiva, Molly Sutphen, and Kamala Vishwaswan each in turn enabled critical shifts in my approach here. Talks at Harvard University, the University of Wisconsin at Madison, the University of Texas at Austin, and Southern Methodist University allowed for helpful seminar discussions. The research is based on extensive interviews with several hundred physicians, administrators, bureaucrats, police officers, journalists, lawyers, patients, donors, and sellers; all have been generous with their time, and many have been generous with ideas and questions critical to this essay. The names of persons in vulnerable positions have been changed; transplant physicians' names have not been changed, to keep me accountable. Part of this research was undertaken while I was a fellow at the Center for Twentieth-Century Studies at the University of Wisconsin in Milwaukee. I am grateful to its director, Kathleen Woodward, for her support.

1. George Marcus has written several well-known essays on the risks and benefits of anthropology spreading itself thin, collected in Marcus 1998.

2. Interviews were recorded and are being transcribed. This summary comes from my written notes taken at the time of the interviews and checked against the tapes; it represents what was common to most interviews and is not verbatim.

3. The history of the medicalization of the south in the *longue durée* has not been attempted, with the partial exception of a longstanding debate over the exemplary status of the neighboring state of Kerala. In what is now Tamil Nadu, such a history may extend from Chola-dynasty urbanization to the nineteenth-century emergence of large networks of medical missions and to their influence on the norms and forms through which Tamil and Telegu elites constituted the public space of Madras. I thank Eugene Irschick and Shiv Visvanathan for conversations helping me to sketch out the contours of an imaginable history.

4. The link of operative loss to citizenship has multiple referents in India. Perhaps the most illustrative is the case of castrated *bijras* (eunuchs), who claim to lift their saris and show the absence produced by an operation in order to travel on trains and buses and even to cross borders into Bangladesh: the absence is the *bijras* "all-India pass" or "passport."

5. The aforementioned Dr. Reddy, here as elsewhere, is the exception. Unlike transplant physicians interviewed in Mumbai, Bangalore, and Delhi, Reddy made it very easy to locate his sellers.

6. Veena Das (1998) offers Wittgenstein's figure of feeling pain in another's body to frame the possibilities and consequences of an anthropology of suffering. Here this figure is extended and inverted.

7. I use "flexibility" mindful of Emily Martin's adaptation of the social and economic uses of the term to the study of bodily experience, politics, and research first done by David Harvey. See Martin 1994; Harvey 1989.

8. The concept of the "biosocial" was developed by Rabinow through the Foucauldian concept of biopolitics as a way to address critical linkages between biology and society other than the adaptationist reduction of sociobiology. See Rabinow 1996.

9. On Kant, see Schmidt 1996. On the Frankfurt School, see Calhoun 1992.

10. Scheper-Hughes has been making a similar point in her current work on organ transactions in Brazil and South Africa.

11. "Kidneys Still for Sale," 1997. This *Frontline* piece includes interviews with rural male sellers: Subhash ran up a debt of Rs.35,000 after the tea shop he owned caught fire; Govindan, a powerloom worker, borrowed Rs.45,000 when his daughter was married. With their creditors pressing them to pay up and nowhere to go, each decided—not without reluctance and a feeling that it would all come to no good—to sell an asset he did still possess, a kidney. Govindan received the promised amount of Rs.35,000 while Subhash received Rs.30,000, one-third less than he was promised. They paid back a part of their debt but began to borrow heavily once again. They were weak and unable to work as earlier. Neither has visited a doctor since the surgery. Subhash is already in debt to the tune of Rs.25,000, Govindan of Rs.10,000.

12. I have written about one such panic, in the city of Varanasi and its hinterland in 1996 (Cohen 1998).

REFERENCES

- Calhoun, Craig, ed. 1992. *Habermas and the Public Sphere*. Cambridge: MIT Press.
- Chengappa, Raj. 1990. "The Great Organs Bazaar." *India Today* (31 July), 60–67.
- Cohen, Lawrence. 1998. *No Aging in India: Alzheimer's, The Bad Family and Other Modern Things*. Berkeley: Univ. of California Press.
- Das, Veena. 1995. *Critical Events: An Anthropological Perspective on Contemporary India*. Delhi: Oxford Univ. Press.
- . 1998. "Wittgenstein and Anthropology." *Annual Review of Anthropology* 27: 171–95.
- "For a Cadaveric Transplant Programme." 1997. *Frontline* 14 (23–26 December).
- Gupta, Akhil. 1995. "Blurred Boundaries: The Discourse of Corruption, the Culture of Politics, and the Imagined State." *American Ethnologist* 22 (2): 375–402;
- Harvey, David. 1989. *The Condition of Post-modernity: An Enquiry into the Origins of Cultural Change*. Oxford: Blackwell.
- Herd, Gilbert H. 1981. *Guardians of the Flutes: Idioms of Masculinity*. New York: McGraw-Hill.
- Jeffery, Patricia, Roger Jeffery, and Andrew Lyon. 1989. *Labour Pains and Labour Power: Women and Childbearing in India*. London: Zed Books.
- "Kidneys Still for Sale." 1997. *Frontline* 14 (23–26 December).
- Kleinman, Arthur. 1995. *Writing at the Margin: Discourse between Anthropology and Medicine*. Berkeley: Univ. of California Press.
- Lock, Margaret. 2002. *Twice Dead: Organ Transplants and the Reinvention of Death*. Berkeley: Univ. of California Press.
- Macer, Darryl R. J. 1998. *Bioethics is Love of Life: An Alternative Textbook*. Christchurch, New Zealand: Eubios Ethics Institute.
- Marcus, George. 1998. *Ethnography through Thick and Thin*. Princeton: Princeton Univ. Press.
- Marshall, Patricia A. 1996. "Organ Transplantation: Defining the Boundaries of Personhood, Equity and Community." *Theoretical Medicine* 17 (1): R5–R8.
- Marshall, Patricia A., and Abdullah S. Daar. 1998. "Cultural and Psychological Dimensions of Human Organ Transplantation." *Annals of Transplantation* 3 (2): 7–11.
- Martin, Emily. 1994. *Flexible Bodies: Tracking Immunity in American Culture from the Days of Polio to the Age of AIDS*. Boston: Beacon.
- "Options before Kidney Patients." 1997. *Frontline* 14 (23–26 December).
- Palsson, Gisli, and Paul Rabinow. 1999. "Iceland: The Case of a National Human Genome Project." *Anthropology Today* 15 (October): 14–18.
- Rabinow, Paul. 1996. *Essays on the Anthropology of Reason*. Princeton: Princeton Univ. Press.
- . 1999. *French DNA: Trouble in Purgatory*. Chicago: Univ. of Chicago Press.
- Radcliffe-Richards, Janet. 1996. "Nefarious Goings On: Kidney Sales and Moral Arguments." *Journal of Medicine and Philosophy* 21 (August): 375–416.
- Radcliffe-Richards, Janet, et al. 1998. "The Case for Allowing Kidney Sales." *Lancet* 351 (27 June): 1950–52.
- Raian, S. Ravi. 1998. Personal communication.
- Scheper-Hughes, Nancy. 1996. "Theft of Life: The Globalization of Organ Stealing Rumours." *Anthropology Today* 12 (3): 3–11.
- . 1998. Personal communication.
- Schmidt, James, ed. 1996. *What is Enlightenment?: Eighteenth-Century Answers and Twentieth-Century Questions*. Berkeley: Univ. of California Press.
- Theweleit, Klaus. 1987–1989. *Male Fantasies*. Minneapolis: Univ. of Minnesota Press.
- Van Hollen, Cecilia Coale. 1998a. Birthing on the threshold: Childbirth and modernity among lower class women in Tamil Nadu, South India. Ph.D. Diss., Department of Anthropology, University of California at Berkeley.
- . 1998b. "Moving Targets: Routine IUD Insertion in Maternity Wards in Tamil Nadu, India." *Reproductive Health Matters* 6 (11): 98–106.
- Wertheimer, Alan. 1996. *Exploitation*. Princeton: Princeton Univ. Press.