PRIVATE PARTS: BODY ORGANS IN GLOBAL TRADE

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The question of the social, said Richard Titmuss in his 1970 study of blood-supply systems, The Gift Relationship, is the question: ‘Why give to strangers?’; and more fundamentally still, ‘Who is my stranger in the ... affluent, acquisitive and divisive societies of the twentieth century?’

Since its development in the 1960s transplant surgery has constituted, amongst other things, a problem in gift theory: should my body accept or reject the transplanted organ, and on what terms? Who is my stranger, and why should they give me a part of their body? Should their giving receive a return payment, or should it be its own reward? These are problems in national medical policy, but they are also, now, an international problem, since the growing trade in body parts crosses national boundaries and the hierarchies of interdependency that they represent. They are also, I shall suggest, a problem for postcolonial theory to the extent that it holds out the promise of being able to provide a generalised model of socio-cultural dependency.

I should stress that my access to information about this trade is mediated largely by press reports and television documentaries which have as a part of their agenda or their effect the construction of the third world as a site of disorderly otherness. They are organised around a relatively small number of figures—indeed, the same stories and even the same personnel tend to travel from report to report (the mysterious kidney broker Count Rainer Rene Adelman von Adelmannsfelden, for example), as do the simplifying metaphors (the ‘bazaar’, the ‘underground network’, the ‘organ factory’) and the ways of posing the ethical questions. What the reports construct is a domain of facticity structured around the tropes of the body resurrected and the body dispersed in pain.

The simplest way of describing the markets in organs, particularly kidneys, that have arisen in about the last decade is to distinguish between three narrative paradigms.
I THE AUTHORITARIAN STATE

The first paradigm is that of markets run or sponsored or at least tolerated by the state, and more importantly supplied by the state from its prisons. The major instance, the Chinese market, is constructed in terms of a relationship between mainland and diasporic Chinese, particularly from Singapore and Hong Kong. Specific sites in China are nominated—the Nan Fang hospital in Guangzhou, another hospital in Guangdong—and there is speculation about the source of the kidneys, hardening into a certainty in the more recent reports that they come from the cadavers of executed prisoners. Prices range from $10,000 to a somewhat implausible $200,000. A typical story from June of 1991 tells of a letter that has been sent to 'virtually all Hong Kong doctors' offering kidney transplants at the Eastern China Military Region Main Hospital in Nanjing for $12,880. The price covers the cost of a round-trip airfare and a kidney from a living donor. The report details rumours that the kidneys are taken from executed prisoners; this has repeatedly been denied by the Chinese Ministry of Health, which says that the kidneys are taken not from live donors at all but from Chinese who have died in hospital and whose relatives have consented to the donation of the kidneys. The article concludes by mentioning—as a way of casting some doubt on these denials—the 'traditional Chinese belief' that the body must be buried intact (New York Times, 3 June 1991). More recently, Amnesty has recorded a rise in the number of executions from 392 in the first half of 1993 to 696 in the first half of 1994 (although, since these are state secrets, the real figure may be many times higher), and Human Rights Watch/Asia has estimated that 2,000 to 3,000 organs, mainly kidneys and corneas, have been harvested annually from executed prisoners. Human Rights Watch warns that, although it is the increased use of capital punishment that has until now driven the organ transplant industry, that logic could be reversed as the industry becomes an increasingly lucrative source of foreign exchange earnings (The Age, 1 November 1994, reprinting from The Independent).

The other instance of this paradigm that I know of is the Philippines, where a major source of transplants is said to be the maximum-security penitentiaries. Donations are 'voluntary', but one television documentary cites Cardinal Sin as saying that a prisoner who donated a kidney to a priest was given a remission of sentence from twenty-five to five years.
II First-world Free Enterprise

The second major paradigm is that of ‘first-world’ free enterprise. The leading case here is the United Kingdom, the most important European centre for transplants for people from many other countries lacking transplant facilities; these operations are conducted in private clinics in London. Press coverage of England is focused, however, on a single notorious case in which the trade in kidneys came to prominence. The scandal concerns the sale of his kidney by a Turkish printing worker, Ferhat Usta, aged 33, for transplantation to an Israeli citizen, Colin Benton, in a London clinic in 1988. Usta earned about £10 a week and needed money to pay for an operation for his eight-year-old daughter who was suffering from tuberculosis. After advertising in Turkish newspapers for several months, he was approached by a Turkish go-between for the London hospital and paid £2,500 for his kidney.1

Much of the reporting of this case is concerned with the scandal of persons rather than the scandal of structures. The figure to whom major responsibility was attributed was the nephrologist, Dr Raymond Crockett, whose name had appeared in advertisements in international editions of al-Ahram, Egypt’s leading newspaper, offering payments to kidney donors. The owner of a home overlooking the Thames at Henley worth £750,000, a villa in Sardinia, and a ski chalet in Switzerland, Crockett was struck off the register of the General Medical Council in 1989. The two renal surgeons involved, Mr Michael Bewick and Mr Michael Joyce, were found guilty of serious professional misconduct. The British Government subsequently established a register of all transplant operations, and then introduced legislation outlawing sales of human organs (The Times, 5 April 1989, summarising a number of earlier reports).

III The Oriental Bazaar

The metaphor of the oriental bazaar organises this third paradigm, of which India and Egypt are the major exemplars. India is described in a 1993 report as being the leading international centre for the organ trade:

Arabs from oil-rich countries in the Gulf who have terminal renal failure and cannot obtain a kidney transplant fly to Bombay or Calcutta, where there is a lively kidney bazaar with an estimated turnover of £10 million a year. Every day, dozens of kidney brokers descend on slum villages looking for prospective donors—not difficult in places
where the daily subsistence wage is 30p and the brokers can offer donors £750 in cash (The Times, 3 August 1993).

The central issue in the reports from India is the role of this ‘bazaar’ in matching a limitless supply to an equally vast demand. There are some 80,000 cases of renal failure a year in India, and for most of these people dialysis is not a realistic option—because of the cost, because of the lack of facilities, and because of the high risk of infection. Citing a Madras transplant surgeon, Mr K. C. Reddy, the Times article summarises a prevalent argument that

modern medicine has created a valuable asset in the form of a spare kidney tradeable for a capital sum which, wisely used, can transform the lives of the very poor and their families. Banning the commercial trade in transplants would, as Mr Reddy argues, "only drive the business underground to the ultimate detriment of donor and patient". It concludes that "rewarded giving" seems a much better option. (The Times, 3 August 1993).

The complication to this rather simplified argument, however, is that it ignores the disparity of chances that structure this market; as the New York Times report of 17 August 1992 says,

in India as in other countries, the donors are often poor, sometimes sick and invariably in need of money. The patients are predominantly affluent, with many coming from the Middle East and some from Europe.

The Egyptian market is the other major journalistic instance of the oriental bazaar. A long report in the New York Times (23 September 1991) details the social and economic conditions that allow a major trade in kidneys to thrive here. Kidneys sell for between $10,000 and $15,000 (or for the equivalent in electronic goods or apartments). Six major centres in Cairo, performing direct transplants from live donors to recipients, service both wealthy Egyptians and other Arabs, especially from the oil-producing nations; these clients can buy replacement kidneys either here or in India. Doctors are prohibited by the physicians' union from transplanting from an Egyptian citizen to a foreigner, but this restriction doesn't apply to non-Egyptians wishing to sell their kidneys. Many of the donors are Sudanese and Somalis, but others seem to be Egyptians; the report says that
the decision to sell organs is often a desperate act by young men who once dreamed of an education or work in Europe, but instead found themselves unable to rise above the crushing weight of third-world poverty.

In 1992 the Egyptian government enacted legislation forbidding kidney transplants from living donors to recipients who are not relatives (New York Times, 23 January 1992)—although whether this would have any effect in stopping the trade, and indeed the active recruitment of donors from the slums of Cairo, seemed to be doubtful.

The trade in kidneys in these centres has arisen because of their relatively long survival time outside the body and because one of the body’s two kidneys is deemed to be ‘spare’ (although the operation to remove it is a major one, which leaves the body vulnerable to any failure of the remaining kidney). Storage technologies now make it increasingly possible to build up stockpiles of other organs, transportable and transplantable parts taken from cadavers; but reports on trade in these other organs are relatively infrequent. The one other body tissue in which there does seem to be a major trade is the cornea.

A Times report on a 1993 BBC documentary, ‘The Body Parts Business’ (Times, 18 November 1993), documents a number of cases not just of sale of body parts but of forcible removal as a prelude to sale. One of these cases is that of Pedro Reggi, a patient in the Montes de Oca psychiatric clinic outside Buenos Aires, whose corneas were dug out with coffee spoons and who was then thrown into a sewer and left to die. He was rescued by friends and identified his mutilator, but is unable to do anything to bring him to trial as the testimony of psychiatric patients is not admissible in Argentine courts. After the families of other patients had complained,

an official investigation revealed a gruesome underground network which specialised in removing corneas from corpses in the institute’s morgue for distribution to hospitals around the country where they fetched as much as $7,000.

The documentary identifies a number of other cases of organised theft of organs from living people. Eight hundred children are said to have been kidnapped in 1992 in Tegucigalpa (Honduras), many of them for sale of their body parts. Similarly, evidence is presented of the organised kidnapping of people in Moscow for their organs, which are sold to the West at vast profit; and in Cordoba in Argentina,
organs were for a period systematically removed from children who were not completely brain-dead.

Moscow seems to be one of the centres for the international trade in organs of all kinds, because of the almost complete lack of regulation of commercial activity:

Although the sale of human tissue is illegal in Russia, the investigators found a company which in one year extracted 700 organs, including kidneys, hearts and lungs, over 1,400 liver sections, 18,000 thymus organs, 2,000 eyes and more than 3,000 pairs of testicles. Another company offered to sell 600 kidneys at $20,000 each; and doctors offered to export bio-materials anywhere in the world for use in pharmaceuticals, cosmetics, or surgery (The Times, 18 November 1993).

With reports like this, however, we reach the verge of mythology. Two independent accounts of widespread stories about the kidnapping and murder of Latin American children for the sake of their body parts do much to illuminate the ease with which factual evidence (or rather the journalistic construction of factual evidence) passes into and is itself perhaps partly organised by the great archaic structures of legend. In the first, an American anthropologist, Nancy Scheper-Hughes, writes of a 'terrifying rumour' which swept the shantytowns of Recife in Northeast Brazil in 1987, and which continues to be prevalent. The rumour tells of vans driven through slum streets by North American or Japanese agents seeking to abduct stray children; some of their victims

were murdered and mutilated for their organs (especially eyes, lungs, hearts, and livers) and their discarded bodies would be found by the side of the road, or tossed outside the walls of municipal cemeteries. Others were taken and sold directly to hospitals and major medical centres, and the remains of their eviscerated bodies were said to turn up in hospital dumpsters.5

While discounting the reality of the stories, Scheper-Hughes relates them to the realities of Brazilian slum life: the police round-ups of street children; the 'disappearance' of children into prisons and reform schools; the killings of street children by death squads; and 'an active domestic and international black market in babies' (58). The urban legend of bodysnatching, she argues, has its roots in a general understanding that the bodies of the poor are worth more as sources
of spare parts than as incarnate persons. In a world where symbolic and economic exchange is set up to allow the wealthy and the powerful to prey upon the bodies of the poor, the 'ring of organ exchange' is logically perceived to proceed

to the bodies of the young, the poor, and the beautiful to the bodies of the old, the rich, and the ugly, and from the bodies of Brazilians in the south to the bodies of North Americans, Germans, and Japanese to the north (59).

In the second account Véronique Campion-Vincent explores the earlier of two cycles of a very similar rumour about children being kidnapped in Latin America and taken to the United States to be murdered for their organs.6 Her essay is in two parts. In the first, she traces the construction of this story in the media. It first surfaces on 2 January 1987, in the Honduran daily La Tribuna in the course of an interview with the secretary-general of a non-governmental human rights organisation; he retracts the story the next day, saying that he had only reported beliefs held by certain social workers. The story, without the retraction, is then taken up in the Latin American press. On 5 February the same story reappears in Guatemala with a different cast (this time the key figure is a middle-ranking police officer), and is likewise immediately retracted; it is now taken up by newspapers in Holland and Yugoslavia, again without the retraction. On 5 April Pravda reports that 'thousands' of Honduran children are being used as sources for organ transplants in the United States; this story is retransmitted by TASS and taken up around the world. Two further versions of the story, with the same content and narrative structure, appear during 1988, one more in Guatemala and one in Paraguay, and—despite vigorous denials by the USIA and the US State Department—the story becomes the subject of investigation by several UN committees and of a resolution of the European Parliament, on 1 September, condemning the cannibalisation of children in Latin America.

In the second part of her essay, Campion-Vincent analyses the story as a legend, part of a lively oral tradition recently developed in Latin America around the theme of the traffic in children and human organs. Like Schepers-Hughes, she sees it in part as a response to the killing of street children by death squads and by militias recruited by shopkeepers; to the increasingly widespread adoption of Latin American children by foreigners; and to the traffic in human organs. At the same time, noting the structural isomorphism between both the content and the narrative process of this group of stories with four distinct points of origin, she stresses its folkloric lineage. Echoing many
of the themes of Western mass culture (the theme of a perverted science preying on its victims—Frankenstein, Coma; the theme of the poor having to sell their bodies to survive—Swift’s Modest Proposal, Hugo’s Les Misérables), it belongs more generally to the story of the Western Ogre: the evil white man with supernatural qualities and a need to devour the blood or the organs of the coloured people he dominates (a story reported from many parts of Africa and from the Andean regions of South America). A contemporary Peruvian version, apparently fostered by the Maoist guerrilla organisation Sendero Luminoso and given widespread credence in the suburbs of Lima, is the story of the Sacajoos: armed strangers in large black cars who gouge the eyes out of children captured in the slums (in some versions, the eyes are sold abroad to help pay the Peruvian foreign debt).

The legend of cannibalised children, says Campion-Vincent, is part of an ancient and probably universal fable about young children kidnapped and murdered by evil strangers. Its variants include mediaeval European stories about children killed by Jews, contemporary North American stories about satanic sects, and innumerable stories, such as that of Gilles de Rais, about powerful and monstrous figures feeding on poor children. Its uptake by contemporary intellectuals owes much to its exemplary value as a fable of the insatiable imperialist Ogre devouring the resources and even the children of the impoverished third world. But to emphasise its mythical charge is not to deny the reality of the traffic in human organs; and, as Campion-Vincent concludes, legends may always serve as a model for a future reality.

An important aspect of the present reality is the drastic shortage in all countries of replacement organs for people desperately in need of them (although this ‘need’ is of course relative to a particular state of technological possibility and social expectation). It is in the fact of this demand that some of the more difficult ethical issues around transplantation arise.

The Transplant Bill enacted in the United Kingdom in 1989 seems to be typical of many other such pieces of legislation in banning all transplants from living donors unless they are genetically related: that is, in privileging ties of blood over contractual ties. This is a move, however, that is at odds with almost all of the rest of the Thatcher Government’s market-oriented policies: its unremitting favouring of commodity relations over gift relations. At the same time—and not unsurprisingly, given the drastic shortage of transplantable and potentially life-saving kidneys, on the one hand, and the biological fact...
of a 'spare' kidney, on the other—there has been a persistent current of argument in favour of a market solution to the problem of supply.

The New York Times of 1 August 1989 quotes one Joel L. Swerdlow, an analyst with the Annenberg Washington Program, as saying that

The altruistic "gift relationship" may be inadequate as a motivator and an anachronism in medicine today ... If paying seems wrong, it may nevertheless be preferable to accepting the suffering and death of patients who cannot otherwise obtain transplants.

Lloyd Cohen, a Chicago professor of law, has proposed the creation of a futures market in organs, allowing payment during life for posthumous donation—a kind of successorial contract—as a way of allowing the market to reallocate resources from less to more useful ends. And the Times Higher Education Supplement of 8 November 1991, reporting a conference organised by the Manchester University Centre for Social Ethics and Policy, asks:

What is it that makes profiting from the body and its parts criminal when tens of thousands die each year as a result of chronic donor shortage? Is a society which allows people to die each year from want of donated organs morally preferable to one which offers incentives to others to run risks?

Professor John Harris, a member of the Centre, put the market argument in an interestingly trenchant way: "Nobody should be driven by poverty to do things they don't want to do", he said. "But preventing the poor from selling their body products creates a cartel from which the poor are excluded".

Similar defences of an ostensibly free trade in body parts were made by an emeritus professor of social history at Warwick University, who asked:

What possible objection can there be if one person, of their own free will and without duress, should sell their kidney to someone else? The seller is able to indulge in a few of the good things in life. The buyer may well be paying to survive.

He was echoed by a Conservative member of the British Parliament, Sir Michael McNair Wilson, who is himself on a waiting list for a new kidney and who argued that selling a kidney is 'like women in the nineteenth century selling their hair' (both reported in the New York Times, 1 August 1989).
More considered and more qualified cases for private property in the body and its organs have been made by other commentators. Marie-Hélène Parizeau contrasts an anglo-saxon ‘utilitarian’ tradition of ethical analysis structured around concerns for personal autonomy, for equity in the context of a disparity between demand and supply, and for balancing ‘gift’ relations against ‘commodity’ relations, with a continental neo-Kantian tradition built on the principles of the integrity of the human body as an incarnation of the person; of consent, which modifies the first principle so as to allow a contract or gift based in gratuitousness; of the gift as guarantee of the priceless nature of the person and of human solidarity; and of the rights of the human person to the dignity indissociable from respect for the body. Within the neo-Kantian tradition ‘all forms of gift of organs or tissue are a priori acceptable in so far as these gifts are the expression of social solidarity and have no commercial basis’. At the same time, this tradition closes the door on any commercialisation of organs because of its fear that the act of giving will be instrumentalised, transformed into an ‘order of cannibalism’ (349). The strength of the utilitarian tradition, by contrast, is its ability, within the cost constraints of existing health systems, to develop pragmatic solutions to the question of allocation of scarce resources of organs and tissue—solutions which respect both individual freedom and technological development, while leaving open the status of the human body and its parts.

Lori Andrews structures her argument negatively: without property rights there is no protection against certain kinds of exploitation of or harm to the body. Thus John Moore, sections from whose spleen were used without his consent to found a commercial cell line, has had no redress against his surgeons and the Sandoz corporation because the courts have ruled that he has no property rights either in the genetic information encoded in his cells or, indeed, in the cells themselves; the patent in the cell line is vested in the corporation, which could, in theory, prosecute him were he to sell his own cells to another company. Similarly, ‘without characterising the body as some form of property, theft or other harm to dead bodies or extracorporeal body parts is difficult to prosecute’ (29), as is harm to sperm or embryos entrusted to a hospital.

The property rights Andrews envisages would be similar to the rights that allow me to gain compensation in the courts for harm to myself or to a close relative; in the law of torts, parts of the body and mental states routinely have a value put upon them (that is, they are routinely commodified) for the purposes of assessing compensation. Likewise, Andrews argues—picking up an argument also made by Brecher—creating property rights in one’s own body is not
dissimilar to the sale of labour power for a wage, or to the commodification of the products of my intellect in intellectual property law (32).

Among the possible negative consequences of such rights would be the possibility of state coercion (the welfare system, for example, could view a person with two whole kidneys as possessing potential capital and thus disqualify them for welfare benefits, and the taxation system could similarly revalue that person’s assets) and of financial coercion: ‘The strongest argument against paying donors is that people in dire straits will consent to debilitating surgeries out of a desperate need for money’ (32). But disallowing such sales would equally exercise coercion upon these people, and in any case the inequities between rich and poor that a free market in organs would exacerbate are already present in other forms as long as the provision of medical care is based on ability to pay (34). Many of these problems can be avoided, however, if the commodification of the body is limited: body parts would not be subject to ownership or lien by others, but would generate an entitlement to compensation. Under such an arrangement, human beings would ‘have the right to treat certain physical parts of their bodies as objects for possession, gift, and trade, but they do not become objects so long as others cannot treat them as property’ (36).

It is through such arguments as these that the historical process of drawing boundaries between what may properly be alienated as a commodity and what should remain outside commodity transactions is continually mediated. There are several direct historical analogues to these liminal struggles.

The first is that of the life insurance industry, where the whole issue of the commodification of the body and of body parts was fought out in very similar terms in the nineteenth century. Viviana Zelizer has traced the transition from a value system that considered such things as ‘death, life, human organs and other generally ritualised items or behaviour ... sacred and therefore beyond the pale of monetary definition’, to a market system of exchange which established monetary equivalents for those aspects of human life.14

In the United States, and in all countries of Europe apart from Britain, the early growth of the industry was hindered by a massive resistance to what was seen as a speculation on death. This resistance was built into the heart of Western law. The Roman legal system had always had as one of its basic principles that there could be no monetary equivalent for the life of a freeman and had proscribed
successorional contracts; the French civil code ruled that ‘only things belonging to commerce can be the subject of a contract’ and that a man’s life ‘cannot be the subject of commercial speculation’—thereby outlawing life insurance, trusts, and successorial contracts. Zelizer adds, however, that even countries that forbade life insurance in principle allowed the insurance of slaves. Their presumed lack of human value justified economic equivalences without presenting serious moral difficulties (44).

We know from other sources that slaves in the Middle Passage were at times cast overboard if it was estimated that the insurance payout on their lives would exceed their landed price.

A number of factors eventually enabled the transition to market valuation of the human body to come about. It was bound up with a series of formalisations of the management of death: the professionalisation of funerals; the formal drafting of wills and a highly structured system of estate management; and the growth of financial institutions specialising in the economic management of death (trust companies, in addition to life insurance). These changes represented a process of rationalisation of the management of risk, such that ‘strictly individualistic conceptions of self-help dwindled, replaced by more efficient cooperative risk-bearing techniques’; at the same time ‘the indispensability of efficient risk management legitimised and upgraded certain speculative ventures as risk-bearing enterprises, clearly differentiated from purposeless gambling’ (88).

Once established, the system of life insurance gave rise to new modes of actuarial calculation defining the capital values of working males as a function of their age, defining disease in terms of a depreciation of capital values, and allotting precise monetary sums to different forms of disablement and disability; it set in train both a commodification and a parcellisation of the body, and each of these aspects anticipates the trade in human tissue.

The second historical analogue to the struggle over the demarcations at stake in the trade in organs is the existence of two different systems for the public supply of blood with directly opposed philosophical underpinnings: one based in donation, the other in sale.

Richard Titmuss’s classic study of the two systems is directed against the sort of utilitarian calculus that has since become more familiar as the doctrines of neoliberal economic rationalism. The underlying ethical issue that he identifies is this: if blood is morally sanctioned as something to be bought and sold, then all social values would in principle and eventually in fact be subordinated to monetary values and
pursued within the framework of a utilitarian calculus: 'Each individual would act egoistically for the good of all by selling his blood for what the market would pay' (12). It is in this sense that blood constitutes a test case as to where the dividing line between the social and the economic should be drawn:

If blood is considered in theory, in law, and is treated in practice as a trading commodity, then ultimately human hearts, kidneys, eyes and other organs of the body may also come to be treated as commodities to be bought and sold in the marketplace (158).

The converse of this utilitarian calculus is the system of voluntary donation of blood, and the values of social giving that it expresses. It is the 'creative altruism' of the social gift that makes possible the binding together of strangers in large-scale social orders. Structures like the National Health Service—'the most unsordid act of British social policy in the twentieth century' (225)—are both dependent upon and in turn foster the moral expression of altruism, reciprocity and social duty. In this context, social policy has the role of putting into practice a reasoned choice between the freedoms given by this system (the freedom to give to unnamed strangers) and the more private freedoms (the freedom to sell blood and to decide who should receive it) which are given by the market and which ultimately diminish collective freedoms. It is the responsibility of the state, in other words,

to reduce or eliminate or control the forces of market coercions which place men in situations in which they have less freedom or little freedom to make moral choices and to behave altruistically if they so will (242).

Tittmuss's conclusions about the workings of the market system are scathing, and can be applied point for point to the workings of the trade in body organs:

From our study of the private market in blood in the United States we have concluded that the commercialisation of blood and donor relationships represses the expression of altruism, erodes the sense of community, lowers scientific standards, limits both personal and professional freedoms, sanctions the making of profits in hospitals and clinical laboratories, legalises hostility between doctor and patient, subjects critical areas of medicine to the laws of the marketplace, places immense social costs on those least able to bear them—the poor, the sick and the inept—increases the danger of unethical behaviour in
various sectors of medical science and practice, and results in situations in which proportionately more and more blood is supplied by the poor, the unskilled, the unemployed, Negroes and other low-income groups and categories of exploited human populations of high blood yielders. Redistribution in terms of blood and blood products from the poor to the rich appears to be one of the dominant effects of the American blood banking systems. (245-6)

Such a redistribution from the poor to the rich clearly holds true for the traffic in body organs. Indeed, it holds true at both ends of the transaction: it is not just that the poor give more, but that the socially privileged receive more. Three studies done in 1988 found that white men in the United States 'are twice as likely to get a new kidney as blacks of either sex and a third more likely than white women'—even when the socioeconomic groups involved were comparable, and despite the fact that blacks in the United States have three times the rate of renal failure of whites and that the Government has since 1972 paid most of the costs of a transplant operation (New York Times, 24 January 1989).

This is to say that even where market forces are quite strongly controlled, the practice of organ transplantation still constructs a market in which the cannibalised bodies of the poor, of women, and of blacks are used to feed the bodies of the rich, of men, and of whites. At the same time, transplantation constructs a culturally very powerful myth of the social body—that is, of the limits and the powers of all our bodies. This is a myth of the restoration of wholeness and of the integrity of the body: a myth of resurrection. Yet this wholeness can be achieved only by the incorporation of the other. The restored body is prostheticised: no longer an organic unity but constructed out of a supplement, an alien part which is the condition of that originary wholeness.

This paradox of an originary state which comes into being only retrospectively, and by virtue of a prosthetic addition is foregrounded in some of the key ethical issues that have been raised by transplantation: by, for example, the ban in South Africa under apartheid on the transplantation of black organs into a white body; and by the furor raised by religious groups, and many others, at the prospect of the transplantation of pigs' or baboons' hearts into human bodies. These issues of course are 'problems' only within the framework of that myth of organic integrity and self-presence. This is, however, the major framework that has been available as a source of critique of market forces.
A *Times* leader of 5 April 1990, commenting on the 1989 Transplant Act in the United Kingdom, rehearse some of the arguments raised by the advocates of market forces (and it must be said again that the arguments for regulation of supply and demand by the market do address real issues of market imbalance, and hence of the sufferings undergone by those who are in need of replacement parts to keep them alive). Giving the example of a father who would willingly donate a kidney to save the life of his daughter (the example closely resembles the Turk Ferhat Usta who was at the centre of the scandal that led to this legislation), the *Times* leader then makes the supposition that the daughter has some other medical condition, to which a kidney transplant is not relevant. What is morally wrong in his selling to a third party the kidney he would willingly have donated to her, in order to raise money to pay for her medical treatment for this other condition?

The *Times* answers this hypothetical case by saying that its logical conclusion would be that the practice of self-mutilation would become widespread, and by insisting—although this 'may seem a sentimental distinction in this no-nonsense age'—on the need to draw a line between illegitimate and legitimate motives for self-mutilation: 'Mutilation for profit falls into the former category, for charity into the latter'.

The concept of self-mutilation is I think misleading to the extent that it sets the body organic, the whole and uncut body, as the standard against which to judge the action of market forces. What it can't satisfactorily explain (and this is why it stresses the arbitrariness of the drawing of moral and legislative lines) is why there should be a difference in kind between charitable and profitable mutilation. If we recognise that it may be right to mutilate one's body for the good of another, there is no a priori reason to exclude profit as a factor if it achieves equally desirable ends, as indeed it may. It is not mutilation as such that is the problem (and my earlier figure of a cannibalised social body must thus be seen to be too simple); rather, the problem is that of the effects on bodies of market forces in a world where market power is unequally distributed.

This is a systemic question and can only be addressed as such; but which account of the world market-system has explanatory adequacy? The inequalities of power that I have been examining do not fit neatly into a pattern of exploitation of the third world by the first, or of the periphery by the centre. Much of the exploitation that takes place in the trade in organs is of the third-world poor by the third-world rich.
(of Indians or Somalis by Gulf-State Arabs, for example; or of mainland by diasporic Chinese); it seems to be flourishing in the newly capitalist, or capitalising, countries of the former second world; and almost all of it involves local, semi-legal risk capital rather than international capital and transnational corporations—although this would certainly change were the trade to be legalised.

I do want to argue, however—as a sort of methodological coda to this paper—that the concept of the postcolonial has little purchase on phenomena of this order. The focus of postcolonial theory (to the extent that its concern is the "postcolonial") is on the aftermath of empire, and it works with the assumption that it is this aftermath that is of crucial significance to the construction of cultural and national identities, and of a body that it calls postcolonial.

I argue instead that, at the macro level, ties of dependence in the contemporary world are not primarily ties between nations. Postcolonial theory owes its present vitality to the fact that it is coded as that place within the humanities disciplines where it is possible to talk about the third world. At the same time, however—and with the major exception of such writers as Spivak and Bhabha—its restrictively literary concerns and its focus on culture-to-culture relations, conceived as relations between an emergent nation-state and the former imperial nation-state, mean that it has largely failed to come to terms with the major explanatory accounts of these multi-layered ties of dependence—I have in mind in particular contemporary theories of globalisation, current work in social geography, and world-systems theory. Increasingly, cultural dependencies follow the routes of capital flow through global capital markets and through sub-systems of economic dependence, some of which are internal to the third world. The plundered and commodified body of those who must sell pieces of themselves is not a postcolonial body but a body torn and scattered along these routes of capital dependence.

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3 James LeFanu, 'In the Kidney Bazaars, Life Comes Cheap', *The Times*, 3 August 1993.
4 A similar scandal about payment for organs had occurred in 1985;
payment was not illegal in England before 1989, but following the earlier case the British Transplantation Society adopted a code of conduct forbidding it (Times, 28 January 1989).

Nancy Schepers-Hughes, 'Theft of Life', Society, (September-October 1990), 57.


Reynolds and Barney give precise figures for transplants of visceral organs in the United States from 1981-86 and for the sharp increase in waiting lists in those years. R. Larry Reynolds and L. Dwayne Barney, 'Economics of Organ Procurement and Allocation', Journal of Economic Issues, 21, 2 (June 1988), 572.

Cf. Bob Brecher, 'The Kidney Trade: Or, The Customer is Always Wrong', Journal of Medical Ethics, 16 (1990), 120: 'There is clearly something peculiarly ironic about free marketeers, passionate advocates of "enterprise culture", objecting to people making the best use of their assets in such an enterprising way'.


Brecher, p. 121.

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