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SAGE Publications
London · Thousand Oaks · New Delhi

Originally published as Volume 7, Numbers 2–3 of *Body & Society* 2001

This edition first published 2002


Published in association with *theory, Culture & Society*, Nottingham Trent University



SAGE Publications Ltd
6 Bonhill Street
London EC2A 4PU

SAGE Publications Inc
2455 Teller Road
Thousand Oaks, California 91320

SAGE Publications India Pvt Ltd
32, M-Block Market
Greater Kailash – I
New Delhi 110 048

**British Library Cataloguing in Publication Data**

A catalogue record for this book is available from the British Library

ISBN 0 7619 4033 2
ISBN 0 7619 4034 0 (pbk)

**Library of Congress Control Number: 2002105445**

Typeset by Typestudy, Scarborough, North Yorkshire
Printed in Great Britain by The Alden Press, Oxford

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# Body & Society
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# Bodies for Sale – Whole or in Parts

NANCY SCHEPER-HUGHES

While in the academy (as in this journal) 'the body' is generally treated as a text or a trope or as a metaphor that is 'good to think' with, in the larger society and in the global economy 'the body' is generally viewed and treated as an object, albeit a highly fetishized one, and as a 'commodity' that can be bartered, sold or stolen in divisible and alienable parts (see Berlinger, 1999; Sharp, 2000). The professions – but especially reproductive medicine, transplant surgery, bioethics and biotechnology – have been complicit in the process of commodifying bodies contributing to what Lawrence Cohen (1999) has called a new 'ethics of parts' in which the divisible body (and its owners) respond rationally (it is presumed) to the demands of the market and to what I would call a politics of the belly, both contributing to new forms of late modern cannibalism (see Awaya, 1999; Scheper-Hughes, 1998a, 1998b).

Allow me to illustrate. In a Madras slum in South India several women explained to Cohen (1999) why they had taken the drastic step to sell a kidney. Forced to the brink by crippling debts or by the incapacity of a husband and primary wage earner, the women had sold a kidney to *feed* the family, the most common explanation given by kidney sellers world-wide. In Cape Town, South Africa, Dr Johan Brink, a transplant surgeon trained by Christian Barnard, explained to me why, under the old (apartheid) regime, human tissues and organs were harvested from black and mixed race bodies in the ICU (intensive care unit) without the family's knowledge or consent and transplanted into the bodies of more affluent white patients: 'The doctors were from conservative [i.e. Dutch reform] backgrounds and they followed a Christian family ethic. To them the idea of "wasting" a good organ was sinful, like wasting a good piece of bread.' Last spring (2001), a middle-class couple from Orange County, California approached

*Body & Society* © 2001 SAGE Publications (London, Thousand Oaks and New Delhi),
Vol. 7(2–3): 1–8
[1357–034X(200106/09)7:2–3;1–8;019698]

my organization, Organs Watch, for help – they wanted to sell one of their kidneys to avoid losing their threatened family business, an outdoor flower stand. Coming from one of the most affluent counties in the United States, they tried to post the following ad on our Berkeley 'Organs Watch' web site: 'Desperately need dentures! Will sell one good kidney – left or right, your choice.' In these troubling new contexts the commodified organ becomes an object of desire for one population and a commodity of last resort for 'the other' and socially disadvantaged population (Scheper-Hughes, this issue).

So, while the body is a text it is always a great deal more than that and the articles collected for this special issue attempt to return sociological and anthropological thinking and practice to a consideration of the body as tangible, palpable and undeniably 'real' material object. We are aware, however, that the desire to locate *some* essential truth, some *basic* ontological certitude of a Wittgensteinian nature ('If we do know that here is one hand, we'll grant you all the rest') in the irreducible reality of the body is always a dangerous move. Given the constant exchange of meanings between commodities as plain, matter-of-fact things-in-themselves and commodities as spirits and fetishes of human desire, *all* commodities possess what Lucas (see Taussig, 1980) called a *phantom* objectivity. So we are compelled to consider the commodified bodies discussed in these articles as *both* objects and as semi-magical and symbolic representations. Above all, commodities are everywhere heavy with social meanings and significations (see Appadurai, 1986).

Meanwhile, *commodification*, the unifying theme of this issue, remains a problematic concept. What range of widely disparate body practices can be said to participate in the processes of commodification? The sympathetic magic of the primitive animist and his/her tool kit of purchased or stolen charismatic body parts (see Comaroff and Comaroff, 1999; Scheper-Hughes, 1998b)? The economically and psychologically costly open-casket funeral that demands a body, and preferably the correct one (Brandes, this issue)? Holy Communion? Eye, tissue and sperm *banks* (Tober, this issue)? The 'body counts' of the forensic specialists charged with the aftermath of a human and social-political tragedy (see Klinenberg, this issue)? We have opted here for a broad concept of commodification, encompassing all capitalized economic relations between humans in which human bodies are the token of economic exchanges that are often masked as something else – love, altruism, pleasure, kindness. All of the articles in this collection attempt to grapple with the commodity form as applied to the body under late capitalism and in the new global economy.

Why are markets in human bodies, body parts, sexual favors, reproductive material or blood sports (like boxing) so disturbing, so hard to take – as, for

example, when an Indian kidney seller says that the only thing she regrets is that she does not have a third kidney, with *two* to sell. Or when an inner-city boxer (Wacquant, this issue) puts a price on a six-round fight in which he admittedly plays the role of 'fucked over' whore to their pimp-managers? The neo-classical economists of the global economy, and a new class of bioethicists following their lead, now argue that free markets, including body markets, are liberating in their valuing of individual choice, autonomy and the impersonality of the economic exchanges. Body parts are, and should remain, private parts, free of outside meddling, let alone state or governmental regulation. Social theorists, we are told, can all too easily fall prey to an uncritical moralizing rhetoric, a knee-jerk reaction against body commodification to which still attaches fairly 'primitive' sentiments of bodily integrity and sacredness which demand that the body be treated as an exception.

There are, of course, many genealogies and continuities to explore – from the animated sale, collection and veneration of medieval relics of the bodies of Catholic saints to the grave-robbings of the 16th and 17th centuries by barbers and surgeons in search of corpses for dissection and for teaching gross anatomy (Lock, this issue; Richardson, 1996, 2001) to the sale of hair and teeth in the 19th century to the late 20th-century markets in kidneys, ova, semen, stem cells, genetic material and codes. Meanwhile, the commodification of sex spans the history of the species, with marriage contracts constituting only the most common and legalized of such transactions, if we are to take the early radical feminist critique to heart.

At one level, then, the commodification of the body is a new discourse, linked to the incredible expansion of possibilities through recent advances in biomedicine, transplant surgery, experimental genetic medicine, biotechology and the science of genomics *in tandem with* the spread of global capitalism and the consequent speed at which patients, technologies, capital, bodies and organs can now move across the globe. But on another level the commodification of bodies is continuous with earlier discourses on the desire, need and scarcity of human bodies and body parts for religious edification, healing, dissection, recreation and sports, and for medical experimentation and practice.

In this regard the social historian Ruth Richardson notes the 'fearful symmetry' between the medical production of bodies for dissection and bodies for organ harvesting for transplant. In each case 'once the need was recognized, a supply was obtained; and once a supply was obtained, it always fell short of demand' (2001: 412). This dynamic, set in place in the late medieval period, continues to this day. The expansion of new patient populations and the invented needs and artificial scarcities that result in their wake is a case in point. At their annual

meetings in Leiden, the Netherlands, in September 2000, representatives of Eurotransplant reviewed experimental programs to expand organ transplant waiting lists to include the medical margins – patients over 70 years, patients with hepatitis C and HIV serropositivity, and those immunologically prone to organ rejection. Scarcely any recognition was given to the fact that these dubious experiments would serve to inflate the demand for scarce organs and lead to other desperate measures, including commerce in organs. The experiments were defended as a democratic service to those clients and transplant consumers demanding medical inclusion.

Continuous throughout these transactions across time and space is the division of society into two populations, one socially and medically included and the other excluded, one with and one utterly lacking the ability to draw on the beauty, strength, reproductive, sexual, or anatomical power of the other. When, for example, the Hippocratics established the foundations of medical science they recognized two classes of patients – freemen and slaves. Freemen, treated by their private physicians, were given access to their diagnosis and prognosis as well as information about the choices of therapeutic intervention. Slaves were treated by slave physicians, hastily dispatched and with little communication between doctor and patient. Similarly, I argue (Scheper-Hughes, this issue ) that commercialized transplant medicine has allowed global society to be divided into two decidedly unequal populations – organ givers and organ receivers. The former are an invisible and discredited collection of anonymous suppliers of spare parts; the later are cherished patients, treated as moral subjects and as suffering individuals. *Their* names and their biographies and medical histories are known, and their proprietary rights over the bodies and body parts of the poor, living and dead, are virtually unquestioned.

The two opening articles by Cohen and Scheper-Hughes explore one of the more graphic instances of late modern, runway commodification, the market in kidneys. Cohen analyses the commodification of immunopolitics. He notes that the most salient feature of the new tissue-typing procedures necessary in advance of organ transplant is an understanding/recognition of what needs to be *suppressed* – the codes regulating organ rejection. This led to the development of powerful antirejection drugs that greatly expanded the population of potential organ donors and of quiet and 'invisible' sales that corrupt cadaver-based waiting lists, even in the United States, and the more blatant auto-cannibalism and kidney sales by subaltern and generally stigmatized populations who are rendered chemically 'safe' enough and 'same enough' through the expensive miracle drug, cyclosporine. In the second half of his provocative article, Cohen examines popular and film media images and representations of the perceived social impact

of transgressive blood transfusions and organ transplants that entail transfers from the wrong kinds of bodies according to 'traditional' Indian conceptions of class, caste and racial difference. 'Where, under the microscope, does caste reveal itself *in the blood*?' asks a progressive Indian in the film *Sujata*. Cohen's article brings to mind a school children's anti-racist exercise devised years ago by UNICEF. English-speaking children the world over were challenged to spin the globe while singing:

> Close your eyes and put your finger
> on the map and let it linger
> Any place you point your finger to
> There's someone with the same blood type as you!

But in the present context, the jingle takes on ominous undertones.

At the heart of Scheper-Hughes's mutli-sited project on the global traffic in organs, tissues and body parts is an anthropological analysis of postmodern forms of human sacrifice. Global capitalism, advanced medical and biotechnologies, have incited new tastes and desires for the skin, bone, blood, organs, tissue and reproductive and genetic material of the other. Her article discusses the darker side of organs harvesting and transplant, focusing on the emergence of the fetishized kidney for both organs sellers and organs buyers for whom this commodity has become an organ of opportunity and an organ of last resort. What is different today is that the sacrifice is disguised as a 'donation', rendered invisible by its anonymity and hidden under the medical rhetoric of life saving and gifting. In all, the ultimate fetish is the idea of life itself as an object of endless manipulation. Her examples are drawn from ethnographic research in several countries, but especially Israel, which has emerged as both a powerful player in and critic of the unregulated black market in human organs.

Lock presents a historical survey of the alienation of body parts along with an astute anthropological critique of gift relations as applied to organs and body parts. This is followed by an overview of the dilemmas and controversies surrounding the Human Genome Diversity Project, which was originally designed to map genetic diversity among the world's populations, focusing on the 'rights of indigenous people'. One of the objectives of the World Trade Organization was to ensure that intellectual property rights and access to resources are handled uniformly. However, in practice, biotechnology companies freely help themselves to genetic material from the South and less developed countries, isolate useful genes, patent the genes, and then sell the products based on these gene lines *back to the people and countries* from which the genes were extracted. The lack of informed consent is an egregious problem posed by these new global transactions and negotiations. In these scenarios, indigenous people are reduced

to biotechnology resources and commodities by hyper-aggressive pharmaceutical firms. Not surprisingly, as Lock recounts here, cultural resistance has proven to be a formidable obstacle. One exception to this rule, however, and not treated by Lock is the exceptional case of the Icelandic genome uniformity project (see Palsson and Rabinow, 2001).

The Icelandic people are in many ways analogous to many indigenous groups because of the historical isolation of their gene pool, but differ with respect to their centralized and democratic political institutions. Iceland was the first country to authorize (following a vote in the Icelandic Parliament) the sale of the rights to its entire population's genetic code to a local company, deCODE Genetics, allowing the biotech firm to hold a 12-year monopoly on data marketing rights. A pharmaceutical firm, Roche, jumped in soon after signing a $200 million, five-year deal to develop new drugs and tests from the data. At first glance it seems that these agreements have been negotiated between two equal partners (the view that Palsson and Rabinow espouse) where one benefits from *harvesting itself as its own resource*, putting a new spin on the concept of auto-cannibalism.

Tober's article on donor insemination explores the linkages between the sperm banking industry, semen donors and women who purchase donor sperm, in an effort to illustrate how perceptions of genetic heritability affect the market value of semen. However, despite the express *commodity* value of semen, it is typically redefined at the point of collection and sale (i.e. sperm banks) as a gift of those who sell it and to the women who purchase it. Paradoxically, perhaps, the cherished idea of donor 'altruism' is maintained in the face of a complex system of banks, and finely calibrated prices affixed to specific 'varieties' of sperm. Tober's article further extends the understanding of body commodification by exploring parallels between reproductive work and sex work as two forms of labor in which the sexual body and its products are both fetishized and commodified.

Brandes's little gem of anthropological inquiry narrates in a precise, economical and poignant fashion how the accidental cremation of the body of a Guatemalan foreign worker in San Francisco creates a crisis of meaning for the Central American Indian village and family members. Nonetheless, they accept legal assistance – and the skills of a practicing cultural anthropologist – to get financial compensation for the spiritual and personal damage they have suffered.

Eric Klinenberg's article is drawn from his brilliant, long-term fieldwork on the great Chicago Inferno, the heat wave of the summer of 1995 during which some 600 people perished in a few days. His detailed study of the various scenes and behind-the-scenes settings, actors, and vested political and professional interests that gathered around the official response to the tragedy reveals an absurdist public drama in which the cause of the deaths – the everyday structured and

political violence of the urban inner-city as a zone of abandonment and untimely death – is obscured and obfuscated by an aggressive and unseemly forensic and media attention focused on the 'dead bodies' themselves as if they were the uncontested objective evidence of a horrific 'natural' disaster. The dead bodies assume a commercial value as the headline subjects for tabloid journalism and for tabloid-quality local politics. His argument shows that bodies are not self-evident entities that carry or speak social truths.

Meira Weiss's contribution represents the work of a tough-minded public intellectual working in the extremely fraught context of nation-building and the difficult assimilation of minority bodies in modern-day Israel. Her article deals with a national scandal that erupted many years after the fact known as the 'Yemenite Children Affair'. Weiss assiduously followed strange rumors of infant kidnapping and medical experimentation circulated by elderly Yemenite immigrants to Israel who arrived *en masse* in 1949–50 at the dawning of the new Israeli state. The new immigrants were held hostage for many months in huge, overcrowded, under-staffed and unhygienic transit camps while their citizenship was processed. Dozens of women gave birth in the camps and infant and child mortality was high. Many women believed, however, that their infants and sick children did not die in the medical clinics of the transit camps, as they had been told, but that they were kidnapped and sent to infertile Jewish couples in the USA. In addition to gathering the narratives of the original immigrants and their adult children, Weiss conducted observations at government hearings and at the National Forensic Institute in Tel Aviv where exhumed skeletal remains of the immigrants' infants and young children were brought for DNA purification and testing. In this scenario commodification takes many forms from the aggrieved women's demands for an expensive and ill-advised program of exhumation and testing to the medicalization of national identities.

María Epele examines the dual moral economies of sexual slavery and female liberation in San Francisco's Mission District, where sex workers struggle to defend and maintain a sense of ownership of their body despite a tension between conflicting desires and needs, their own and those of their clients. Epele analyses the particularities of a hyper-modern social context, in which women's addiction to drugs intersects with sex work, which in turn draws its value and power from a male addiction to paid-for sex. But in the end, 'the johns' emerge as the winners in a system that manages to preserve and reproduce the androcentric moral economy of gendered street culture.

Finally, Loïc Wacquant's short but exquisite article on the body praxis of inner-city boxers in Chicago returns social science to the painful subject of vulnerable people's collaborations in their own exploitation. Why do people – the poor and

racially excluded in particular – so often turn themselves into their own executioners, consenting, as it were, to their reduction to the status of 'a most miserable commodity'? Wacquant enumerates the many sources of misrecognition which are occasionally breached by all too clear self-revelations of the real condition of their lives. Nonetheless, boxers struggle to maintain – as do Turkish kidney sellers, drug addicted sex workers, and sperm bank users – a sense of their own moral and physical worth, along with a sense of dignity, courage, beauty and/or strength. Perhaps, they think, they will manage to beat the system in the end. Stranger things have happened. But, in fact, the only *real* sense of power and control in their lives derives from a certain kind of command and ownership of their bodies – the very grounds of their own existence – which they express, paradoxically, by selling it off in parts or in its entirety, a modern-day tragedy of decidedly heroic proportions.

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# The Other Kidney: Biopolitics beyond Recognition

LAWRENCE COHEN

This article examines the Indian variant of the global enframing and recruitment of the bodily tissues of the poor and vulnerable. It locates this recruitment as a relation between two moments of technique: *recognition* and *suppression*. Work by Nancy Scheper-Hughes has extensively tracked new and ongoing organ commodification, and theorized its sacrificial economy; my argument here presumes this intervention and links it to questions of both technical and imaginary form. I combine elements of an ethnography of renal transplantation – including extensive clinic visits and talks with nephrologists, urologists, state regulators, kidney buyers, kidney sellers and brokers of organs, information and ethics – with an extended discussion of tissue transfer in Indian popular film. Narratives of both transfusion and transplantation are staples of film narrative in India, constituting forms of ethical publicity that posit the limits to human connectedness as a surgical problem.

The technique: at mid-century, a new biology of increased scale became able to recognize a specificity of human tissue of far greater complexity than blood-typing and with as profound clinical application. With the resulting tissue-typing procedures organ transplantation escaped its bleak infancy and became the heroic technology sociologists Renee Fox and Judith Swazey could celebrate in *The Courage to Fail* (1974).[1] Monozygotic twins were no longer necessary for a good transplant prognosis: with tissue-typing materializing new sites of sameness and difference, one could screen a large number of potential donors to discover bodies suddenly compatible, far from the family tree.

It has become a commonplace that the new recognition and its molecular

*Body & Society* © 2001 SAGE Publications (London, Thousand Oaks and New Delhi),
Vol. 7(2–3): 9–29
[1357–034X(200106/09)7:2–3;9–29;019699]

specificity contributed to shifting the ground of self–other discrimination away from the individual body, dissolving the apparent solidity of both the citizen-patient of bourgeois revolution and his or her corporeal extension, the family. Dispersed inward to cell membranes and outward to the population to be screened, the site of recognition no longer privileged bodily boundaries – skin or kin – as envelopes or guarantors of life. This move helped constitute late 20th-century immunology, in Donna Haraway's framing, as one of the signal post-humanist sciences of the body (1991).

The language, practice and materiality of recognition, long of interest to philosophers, theologians, psychoanalysts and critics, took on new importance for human and social scientists engaged in conversations with biomedicine. Such attention was ratcheted up to a state of emergency in the wake of early AIDS; prominent among many examinations of immune recognition and the forms and politics of life it engendered were Haraway's 1991 essay and Emily Martin's 1994 book *Flexible Bodies*. The arguments of both scholars tracked a movement of disease control from protection (keeping the other out through good defenses) to recognition (identifying the other permeating oneself by anticipating its difference) and speculated on its relevance for biopolitical engagement.

Professional assemblies of transplant clinicians and researchers understandably have taken the emergent understanding of immune recognition as a charter moment in the growth of their practice. Yet transplantation raised different articulations of recognition, self and other than did AIDS, and was not central to the new immuno-theorization. Its biopolitics seemed to lie elsewhere, in explosive narratives of organ stealing and media exposés of organ selling, in debate (or the lack of debate)[2] about brain death and harvesting, and in new tasks for professional bioethicists as both transplant medicine and its mediated public came to speak of a 'shortage' in human organs. These politics, as Scheper-Hughes has noted, raised both old and new concerns about the body as a commodity, as a whole and in parts, about indebtedness and the suddenly mobile pound of flesh, and about organized violence, the persistence of rumor and the ontological insecurity of the poor (2000). Jean and John Comaroff cite transplants as a metonymic feature of the everyday and occult economies of 'millennial capitalism' (1999, 2000). Most critical attention to the transplant has utilized its emergent ethnography to think about such futures of value (Sharp, 2000). Considerable new scholarship has also attended closely to technologies of harvesting and brain death, and to what kinds of subject-death and object-life are being reconstituted (Agamben, 1998; Hogle, 1999; Lock, 1996a). And considerable critical work has questioned the trajectories of organs, desires and prohibitions in troubling assumptions about the ground of the gift, of the commodity,

and of their juridical and ethical separation (Daar and Marshall, 1998; Das, 2000; Marshall et al., 1996; Radcliffe-Richards et al., 1998; Scheper-Hughes, 2000).

In this article, I want to return to the problem of immunopolitics. Despite some notable subsequent conversation, like many fronts of critical AIDS activism, the concept has drifted and atrophied somewhat since Haraway's and Martin's aforementioned work.[3] I return by way of an observation. Despite the promise of immune recognition and tissue-typing for the rise of an effective transplant medicine, it was not the recognition of molecular sameness and difference but the *suppression* of the entire system of code that ultimately materialized the population – rather, specific populations – as viable donors. Suppression, not recognition, turned transplantation into a major industry.

A source of seemingly miraculous cures, of new understandings, imaginaries and ideologies, and of high profits for a changing assemblage of health care, transplantation rapidly went global with the development, production and marketing of the immunosuppressant drug cyclosporine by the Swiss pharmaceutical corporation Sandoz (which merged with Ciba-Geigy in 1997 to become the global giant Novartis AG). Unlike tissue-typing, cyclosporine and the combination therapies that emerged with it made possible transplants from a far larger group of potential organ donors than before. One no longer had to screen large populations: since many more persons could serve as donors; in place of extensive screening one could recruit flexible and specific donor subpopulations. Industrial, state and patients' association responses to the defined shortage could shift from an unwieldy biopolitics of recognition, mobilizing large populations and searching for identifiable tissue matches within it, to a more pragmatic biopolitics of suppression, disabling the recognition apparatus so that operability and not sameness/difference becomes the criterion of the match.[4]

There is, more precisely, a shift to *multiple* biopolitics of suppression. As transplant technology and cyclosporine and other drugs migrate, the 'organ shortages' they materialize emerge in national and regional markets with particular sources and structures of tissue recruitment.[5] There have been the quiet sales of cadaveric organs built into the American system and wrapped in layers of prestational and Christian rhetoric that both Scheper-Hughes and I are studying.[6] There is the Indian state's involvement at various levels in simultaneously outlawing and brokering the sale of organs with the effect of limiting foreign consumption of the poor's organs while increasing wealthy domestic and diasporic consumption. There is the emergence of China's new post-socialist military as transplant entrepreneur, its growth abetted by India's withdrawal from the South-East Asian kidney market, scheduling operations on festivals around public executions under the sign of socialist communitarianism and efficiency.[7] Cyclosporine *globalizes*,

creating myriad biopolitical fields where donor populations are differentially and flexibly materialized. Difference is selectively suppressed, allowing specific subpopulations to become 'same enough' for their members to be surgically disaggregated and their parts reincorporated.

Though the transplant shifts from the heroic age of immune recognition to the assembly-line surgeries of the immunosuppression era, its formally enacted history seldom registers a break. At the international transplantation conference in Montreal in 1998, Nobel Laureate Sir Peter Medawar was remembered with a keynote address by his widow, celebrating the *Ur*-moment of recognition. Medawar was one of the fathers of the first moment of the transplant era through developing the conceptual and technical assemblage of recognition to make tissue-typing possible. Again, tissue-typing extended the logic of blood-typing: graft survival improved the more closely matched were the 'HLA antigens' of donor and recipient. But young nephrologists I interviewed throughout India and elsewhere were abandoning rigorous HLA-matching as better combination immunosuppressant therapy was making it unnecessary. Basic cross-matching (making sure the would-be recipient lacks circulating antibodies directed against the donor's HLA antigens) and blood-typing remained the standard of care: the cyclosporine era has not done away with recognition altogether. But with the abandonment of HLA-matching, clinics no longer were dependent upon general population-based recruitment and screening: one no longer, in most cases, needed to test large numbers of potential donors to find a match.

Early in the cyclosporine era the implications of these changes for the economic organization of clinics were becoming clear, and by 1988 standard textbooks could note that:

> Many centers appear to have adopted the position that the greater degree of immunosuppression associated with cyclosporine overrides the effect of matching for HLA antigens. This position allows a center to transplant cadaver kidneys with very short ischemia times and to curtail expensive organ-sharing programs required to increase the recipient pool size so that well-matched transplants are possible. *This position also reduces the ability of centers that do not harvest their own kidneys to perform transplants.* (Toledo-Pereyra, 1988, my emphasis)

With the necessity of large donor registries diminished, local harvesting became critical to the productivity of clinics: differently positioned centers developed different strategies of procurement. Transplantation programs rapidly spread globally: each required a procurement plan. In many if not most cases globally, as Scheper-Hughes and I are continually learning, these plans involved procurement beyond the supply generated by mobilizing local practices and rhetorics of the gift. In India, with long-standing commercial blood donation and the ubiquity of brokerage as a social and economic form, physicians and other clinic management

turned to the recruitment and brokerage structures that sustained the blood supply. Brokers quickly became adept at meeting the new requirements for recognition and procurement, and understanding their limits, and cultivated neighborhoods, caste communities, local industries and entire villages: specific populations. A broker in a proverbial back alley in Chennai (the former Madras), himself a former seller as well as the domestic servant of a vascular surgeon involved in renal transplantation, outlined for me with impressive precision the different kinds of matching, to explain why only cross-matching matters. Aggressive immunosuppression opened up a large population of indigent sellers as living organ 'donors'. For most, the money went to pay off debts and was quickly exhausted; several, like this man, turned to recruitment of others. A number of Chennai slum-dwellers could discuss the basics of immune recognition and suppression (Cohen, 1999).[8]

Obviously, the moment of suppression is linked, causally and formally, to the moment of recognition that precedes it. But working the distinction between the two may be useful. My effort engages some of the politics of the kidney transplant in the cosmopolitan medical centers of Chennai, Mumbai (formerly Bombay), Delhi and Bangalore and in the dispersed regions of debt – urban slums and rural hinterlands – that have become organ supply centers for a powerful local industry with enormous social and symbolic significance.

Recognition and the shift from organism to code, in the AIDS-informed work of Haraway and Martin, mark the biopolitics of late capital and the network society. But the slippage from recognition to suppression I identify in the globalization of the transplant implies a prior moment of recognition and code, one in the case of India tied to the high systems-era of Nehruvian polity and planned development. Haraway recognizes this earlier figuration of code in the Cold War deployment of cybernetics, but, in noting the closed and self-referential 'techno-organicism' of the moment, distinguishes it from the open coding systems of immunology and optimization that follow. The postwar deployment of closed systems, however, coding nature and society within the postcolonial project of development, generated hybrid and ambivalent forms (Gupta, 1998; Prakash, 1999). Recognition and the problem of code were mobilized as critical and anxious features of scientific nation-building at an earlier moment than that offered by Haraway or Martin's Euro-American historicization. The subsequent globalization of the 'postmodern' biopolitics these authors describe suggests less the intensification of an already emergent biopolitics of code than its encompassment by a flexible biopolitics of suppression.

To locate the moment of immunosuppression in relation to the postcolonial workings of recognition I begin with transfusion medicine and blood-typing, a

widely disseminated and public practice ubiquitous in popular media like film from the early years of Indian independence. The biopolitical effects of transplantation can then be located in their radical dissimilarity to this earlier figuring of transfusion and the recognition of a national body. I focus on popular film both as it offers an archive of a widely disseminated public imaginary and as my earlier work on transplantation has centered on the ethical as a function of publicity (Cohen, 1999). I start with a classic 1959 Hindi film.

## From Transfusion to Transplantation

The film is *Sujata*.[9] A high-caste couple take in the title character, an 'untouchable' orphan girl, and raise her in fosterage along with their own daughter. Their relatives object to Sujata's presence on the grounds of blood, a marked substance indelibly coding her and the family as different. The couple itself is divided about the implications of what they have done. The wife, who must bear the gendered burden of defending caste norms, is anxious about the girl's presence and her persistent inability to recognize her own difference. Her progressive husband challenges their family critics by demanding that they show him *under a microscope* what caste is and where in the blood it is to be found. Blood, he presumes as a modern, carries no code.

When the girls grow older, a suitable marriage is arranged for the couple's biological daughter. An untouchable groom, portrayed as a bumpkin, is found for Sujata. Love intervenes as the daughter falls for another man and Sujata and the high-caste groom discover each other. When the mother finds that her careful arrangements are coming apart, she collapses and falls down a flight of stairs. Hospitalized and in a coma, she needs a blood transfusion to survive. Neither the blood of her husband and daughter nor of any other appropriate donor matches with hers. Then Sujata volunteers. The foster daughter's is the only blood that matches.

As in anthropologist McKim Marriott's now classic discussion of the construction of body and person in India – in which people are 'dividual' assemblages of flows that circulate as both substance and code – here blood, despite the progressive challenge of microscopy, *persists* as indelibly coded substance (Marriott, 1976). But as transfusion replaces alliance as the critical modality of exchange, the logic of coding shifts from caste to blood group. Sujata and the mother are united through the physician's needle, and the demonstrable ability of the transfusion relation to sustain life extends its power to the legitimization of intercaste marriage and descent. Under the 'microscope' of immunological tissue-typing, everyone is not the same. Modernity is less a matter of decoding than *recoding*.

In *Sujata*'s Nehruvian vision, modern medicine recodes what Marriott termed the biomoral logic of local transactions across caste, gender and generation into a national logic of distinction amenable to scientific planning and demonstrably supportive of life.

The nationalist recoding through the transfusion persists as a routinized element of film narrative for some decades. In the 1977 *Amar Akbar Anthony*, three brothers separated at birth and brought up as Hindu, Muslim and Christian respectively reconnect when the blood of each is found to be the same as that of a dying Hindu woman who turns out to be their mother. In the transfusion scene, three intravenous lines connect the men to the woman, Bharati, whose name ['Indian'] and body figure the nation. The camera pans showing the three young transfusers in turn with a temple, mosque or church respectively as backdrop. As in *Sujata*, blood-typing incorporates the outcast body (here, Muslim and Christian) into the dominant body (here, Hindu) through their medically recoded identity.[10]

This vision of recoding, in cinema as elsewhere, now seems passé. Popular film in the 1990s resuscitated and relocated what Madhav Prasad (1997) termed the 'feudal family romance' of the classic 1950s cinema. The differences that matter in the new variant are those of bourgeois and diasporic dislocation: girl (or boy) is acculturated abroad but meets hometown boy (or girl). Hi-jinks ensue. The overt technological mediation of exchange is hyperspatial: cell phones and airplanes. The hospital itself no longer signifies the imagined nation but serves to specify a translocal elite. In the world of contemporary Bombay film, there are two moments to this translocation.

First: not too long ago it was *foreign* hospitals that were the sites of the miraculous, re-animating bodies and thus rescripting the lives of their heroes and heroines.[11] In 1989's *Chandni*, actor Rishi Kapoor played the love-mad hero Rohit who becomes an invalid after a crazy helicopter stunt to impress Chandni, his beloved. Confined to a wheelchair, Rohit grows to resent Chandni and eventually bows to pressure from his rich parents to dump her. She slowly builds a new life and meets a new man. Rohit, meanwhile, goes off to Switzerland, which in the 1980s was replacing Kashmir as the backdrop for the fantasy sequences in Bombay love songs. Here the best international care gives him his legs back. He returns to India and Chandni, and, despite the other guy, romance rekindles.

Second: in the 1990s and beyond, the foreign is increasingly repatriated in the person of the diasporic 'non-resident Indian', or NRI, who becomes ubiquitous within popular cinema. Medical miracles once again occur stateside, with 'foreign-returned' biotechnology, but the problem now is the cost of the operation. Re-animation is encompassed by the greater miracle of repayment.

Transplantation comes to serve the paradox of the moment well. An example of the new cosmopolitan medicine at its most miraculous, the transplant, given the triple cost of operation, organ and cyclosporine, is virtually unaffordable, necessitating a chain of self-commodification which in film may ironically culminate in the counter-transplant, the sale of a kidney to pay for the first operation. In the 1998 Hindi film *Kareeb*, a hero works feverishly to earn enough money for an operation for his beloved's mother, while the beloved herself eventually agrees to marry the doctor in exchange for the operation. And in the 1999 Tamil film *Thullatha Manamum Thullum*, a hero's dying mother wills her eyes to his blind beloved, but to honor his mother's sacrifice and pay for the miraculous transplant her dying gift has made possible the hero must sell his own kidney: a transplant for a transplant. There is always a supplement to the operation: a second body, a second operation, the other kidney.

The translocality of the elite clinic is literally inscribed on to the millennial landscape. Signs from Delhi's Indira Gandhi international airport point the way to the luxurious 'five-star' Indraprastha Apollo hospital, a private franchise built by clearing slums with the (arguably unkept) promise of free quality care for the displaced. These signs were designed to look like government ones, further blurring the boundaries between Apollo and the urban administration. The Apollo group has built, franchised, financed or consulted on the design of hospitals in Hyderabad, Chennai, Mumbai, Calcutta, Bangalore, Lucknow, Ludhiana, Vizag, Nagpur, Pune, Erode and Ahmedabad in India and abroad in Bangladesh, Dubai and Oman, with planning at the time of writing occurring for possible projects or collaborations in Tanzania, Malaysia, Vietnam and Burma ('Apollo Hospitals' New Venture', 1999; 'Apollo Hospitals Ties', 1999; 'India's Apollo', 1999; 'Nursing', 1999; Pillai and Kavlekar, 1999). Many of these Apollo hospitals are designed with an adjoining luxury hotel, and the boundary between hospital and hotel is all but disappearing as Apollo experiments with the profitability of working the distinction between patient and guest.[12]

Apollo is not only a hospital that looks like a five-star hotel, it is a five-star hotel that looks like a hospital. 'It's cheaper than some five-stars', someone I didn't know laughed at a Delhi party. 'My friends stay there when they come to town.'[13] It is not just a joke. Money-laundering politicians and industrialists under investigation for violation of India's still extensive foreign exchange regulations, survivals of the pre-liberalization planned economy, appear to protect themselves from arrest, interrogation and the considerable health risks of local prisons when they are implicated in a 'scam' by checking themselves into Apollo and like institutions for months on end. These maneuvers are well known and discussed. The police are reduced to seeking court orders to transfer such accused