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The Great Organ Bazaar Revisited:  
The Appropriations of Organ Transplant Technology  
in Modern India

By  
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A thesis submitted in partial satisfaction of the  
requirements for the degree of

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in

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of the

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*Dedicated to the loving memory of  
my grandfather,*

*Chaman Lal Aggarwal*

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# Introduction



The demonstrated efficacy of the immunosuppressant cyclosporine in the late 1970's and early 1980's transformed transplant medicine almost overnight from a rare, experimental procedure to a standard, successful therapeutic possibility for patients with End Stage Renal Disease(ESRD).<sup>1,2</sup> Previously, ESRD patients' only options were hemo-dialysis or peritoneal dialysis, both of which required substantial time commitments and lifestyle changes. Transplantation, on the other hand, offered patients the possibility of relatively healthy lives free from a perpetual reliance on machines. This fact, combined with the aggressive marketing of the transplant apparatus\*, allowed organ transplantation to truly become a global phenomenon. As the procedure spread and became a normal one, the number of eligible recipients soon outstripped traditional procurement strategies (primarily voluntary, cadaveric donations). In the past twenty years, various alternative methods of addressing the expanding "supply-demand gap" have been suggested, debated, implemented, and even revoked.<sup>3</sup>

To borrow Cohen's phrase, this "ethical circuit" of transplant debates has evolved into a complex site of scholarly and intervention oriented engagement with organ transplantation.<sup>4</sup> One example, and perhaps the most contentious, is the continuing acrimonious debate surrounding the possibility of a commoditized organ trade in India. Concomitant with and juxtaposed to the rise of the "ethical circuit" has been the rise of the "uncanny circuit," the site of organ theft "rumors."<sup>5</sup> Global in pervasiveness, these stories detail the monstrous ways in which kidneys are thought to be stolen primarily from the disenfranchised poor (children, day laborers, transients) in developing countries.

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\* "Transplant apparatus," as defined in this paper includes in its scope the various social institutions, collective groups, and individuals who have a vested interest in promoting transplantation. These actors operate at the local, national, and transnational level. The transplant apparatus includes, but is not limited

Examples of these rumors include child kidnapping in Brazil, blood sucking “firemen” in Africa, and human-hyena hybrids stealing children in rural, northern India.<sup>6,7,8</sup> Even in the United States, organ theft rumors have appeared, albeit with a different cast of characters and underlying concerns. Between these two circuits exists the domain of the “public circuit,” the site where accusations of organ theft (the “rumors” of the “uncanny circuit”) come to be taken seriously by judico-legal authorities as literal “Truth,” and thus investigated.<sup>9</sup>

This thesis engages the first and last of these three circuits with respect to India. The first essay, “An Evaluation of the Practice and Dialogue of the Indian Commerce in Kidneys,” addresses the “public circuit.” The first part of the essay outlines a brief history of the trade and the current structures through which commercial organ transfers continue to occur in India. From this framework, three proposals regarding the trade are evaluated. As it was written in part as a response to the growing popularity and possibility of a legalized, regulated organ trade, the essay’s main argument refutes the idea that this will benefit sellers or recipients in India. Instead, a targeted educational campaign is advocated. The second essay, “Kidney Theft and the Indian “Public Circuit”: an Examination of the NOIDA Medicare Center Scandal of Summer 1998,” addresses the Indian “public circuit.” Like the first essay, the second attempts to contextualize the location of organ transplant technology within modern India, albeit with a different approach. Instead of a straightforward account of the current context, the second examines the responses of various parties whose participation was implicated in the NMC Scandal. As much as the “public circuit” essay, the examination of these

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to, transplant surgeons, nephrologists, Novartis representatives (the Swiss pharmaceutical company which produces cyclosporine), and middlemen who connect sellers and buyers.

positions and supporting dialogues reveals the important social, political, and economic issues that kidneys come to represent.

In Writing at the Margin, Kleinman writes, “Perhaps the chief contribution that medical anthropologists can make to these fields [international medicine and social development] is not primarily to assist them to engage different ethnic groups and function more effectively in different social contexts- the sort of thing we are most often asked to do. Instead, we need to specify how it is that the very processes that make biomedicine effective as a technical rationality and strategy of social action so often become, under particular political and economic regimes, a barrier... to improved health and good quality health care.”<sup>10</sup> Which of these interventions is more applicable to the Indian context of organ transplant technology remains a debatable question. It is hoped that the following two essays contribute to this debate, if only to help frame it.

## References

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<sup>1</sup> Joralemon, Donald. "Organ Wars: The Battle for Body Parts." *Medical Anthropology Quarterly*. 1995; 9(3):335-356.

<sup>2</sup> Starlz, Frank. A. "The Early Days of Transplantation." *Journal of the American Medical Association*. 1994; 272(21):1705.

<sup>3</sup> For an overview of these strategies, see Marshall, P. "Introduction: Organ Transplantation- Defining the Boundaries of Personhood, Equity and Community." *Theoretical Medicine*. 1996; 17: 2.

<sup>4</sup> Cohen, Lawrence. "The Man With Four Kidneys: Indian Organs and the Space of the Ethical." Paper presented at U. of Texas, Austin. March 4, 1999.

<sup>5</sup> Ibid.

<sup>6</sup> See Scheper-Hughes, Nancy. "Theft of Life." *Anthropology Today*. June 1996; 12(3): 3-11.

<sup>7</sup> Cohen, Lawrence.

<sup>8</sup> Comaroff JL, Comaroff J. "Occult Economies and the Violence of Abstraction: Notes from the South African Postcolony." Max Gluckman Memorial Lecture. ABF Working Paper #9724. 1998

<sup>9</sup> Cohen, Lawrence.

<sup>10</sup> Kleinman, Arthur. *Writing at the Margin* Berkeley. U of California Press. 1995: 16-17.

An Evaluation of the  
Practice and Dialogue of  
the Indian Commerce in Kidneys

Transplant medicine's explosive popularity has been paralleled by an equally dramatic "supply-demand gap" between donors and recipients. Of the various methods that have concomitantly arisen in the last twenty years, a commoditized organ trade was among the first. In 1983, the same year that the FDA approved the use of Cyclosporine within the USA, a Virginia based physician, Dr. H. Barry Jacobs, founded International Kidney Exchange, Inc. His stated goal was the creation of a for-profit, transnational kidney brokerage.<sup>1</sup> Though the U.S. Government quickly outlawed commercial organ sales, global biosocial structures rapidly developed to facilitate the flow of kidneys from the poor in developing nations to the bodies of the wealthy, both nationally and internationally.<sup>2</sup> Early documented cases included Europeans buying from Turkish villagers, affluent Persian Gulf nationals travelling to India, and traffic connecting patients in Korea, Japan, Taiwan, Singapore, to Chinese organ sources.<sup>3,4,5,6,7</sup> Despite the near universal ban on organ commerce by 1995, the trade continues to thrive by operating along past, albeit slightly modified, trade lines.<sup>8,9</sup> Indeed, the modern transplant era is defined as much by the global narrative of organ commerce as it is by cyclosporine.

While initial reports of organ commerce brought near universal condemnation, as early as 1990, physicians and ethicists, spurred by the inadequacy of cadaveric donations in fulfilling the organ demand, began re-examining the moral and ethical feasibility of living non-related transplants(LNRT's).<sup>10</sup> Marshall, Daar and Thomasma document the rise of these procurement and distribution proposals, which have "taken on the patina, mechanisms, and entrepreneurship of a business enterprise."<sup>11</sup> The debates continue today, though no legislative body has yet overturned a previously imposed ban.

Recently, critiques have cited the need for organ transplantation debates to be removed from the sterile realm of abstract principles and placed within the particular local, social, political and economic contexts in which the practices occur.<sup>12,13</sup> This paper attempts to heed these calls in evaluating the dialogue surrounding the Indian commerce in organs. The three current proposals that will be addressed are: a- stricter enforcement of the existing ban on organ commerce; b- a legalized, regulated organ trade; c- an educational campaign. In the following sections, I attempt to highlight the limitations of all three proposals. Nevertheless, I argue that an educational campaign will more directly and efficaciously address at least the first of the two stated primary concerns of all proposals. These are the welfare of the donors (in this case, sellers) and that of the recipients. This argument is not meant to suggest that an educational campaign necessarily precludes the other proposals. However, this paper will argue that because the educational campaign is the only proposal of the three that does not have potential to do harm, it is the only one that should be implemented.

The first part of the paper will briefly outline the history of and current structures through which commercial organ transfers occur in India. Then, the issues regarding sellers and buyers will be fleshed out, followed by an analysis of the arguments.

### Emerging Markets: shades of gray

Between 1983 and 1994, the annual number of kidney sales in India increased dramatically from less than 50 at the outset to over 4,000, earning India the moniker of “the great organ bazaar of the world.”<sup>14,15</sup> In addition to kidneys, the sale of skin and eyes (due to the need for corneas) became commonplace. As Cohen states, this growth

cannot be framed simply as a function of Indian poverty in the context of “extensive technocratic enterprise.”<sup>16</sup> Rather, several intersecting processes facilitated the emergence of the Indian market in the wake of heavy global marketing of transplant medicine. These include:

- a- a pre-established flow of Indians to and from the Persian Gulf states as labor, sex workers, and blood donors/sellers;
- b- a pre-existing informal social apparatus overseeing the commercial market in blood;
- c- the global circulation of Indian medical and paramedical personnel to create the transnational links between wealthy patients, sellers and Indian clinics;
- d- changes in the Indian economy and society by which moneylenders and middlemen in the commercial blood market occupied similar spaces in the lives of the indebted;
- e- the development of public-private hybrid hospitals, shifting the national focus from primary health care to tertiary, ultramodern procedures;
- f- within India and the Gulf States, a lack of resources devoted to developing cadaveric kidney donations that, in effect, promoted poor Indian bodies as the predominant source of kidneys.

By contextualizing this phenomenon, Cohen demonstrates how the major Indian trade routes came to connect the kidneys of poor Indians to the bodies of wealthy nationals in the Persian Gulf states.<sup>17</sup>

In 1995, the Indian central government ratified the Transplantation of Human Organs Act (THOA) prohibiting the sale of organs. While the stated goal of THOA was the protection of donors in light of national and global condemnation of organ commerce, it remains unclear why the Indian government chose to act at that particular juncture when such criticism appeared much earlier. One possibility is that only in the early 1990's did the increased trade flow create the intersection of increased publicity with reports of decreased efficacy of LNRT's and with accompanying accusations of unscrupulous practices designed to maximize profit at the expense of recipients'



welfare.<sup>18</sup> Dr. R.R.Kishore, one of the law's drafters, states that it was intended to protect donors while simultaneously ensuring an adequate supply of donors through the promotion of cadaveric donation.<sup>19</sup> This was accomplished by including in THOA a legal recognition of "brain-death," thereby facilitating the procurement of organs. The law intended to provide the capital necessary for the implementation of adequate structural and social policies. Most of this has yet to materialize.

There has been some evidence of THOA's success, especially as seen through the decrease in the number of transnational transactions.<sup>20,21</sup> Further, some hospitals such as the prestigious All India Institute of Medical Sciences(AIIMS) and the private, ultramodern Apollo Hospital in New Delhi refuse to perform LNRT's. Nevertheless, as of 1999 THOA's success in curtailing kidney commerce has been limited for four reasons.

First is the fact that in India, laws pertaining to health fall under the purview of state legislation. Any centrally passed law, such as THOA, does not affect individual state law until adopted by that state. Thus, while THOA appeared to ban organ sales throughout India, in effect only a small fraction of India, the Union Territories, was initially effected. Since 1995, only two states have ratified the law, Goa and Maharashtra. Several others(Tamil Nadu, Karnataka, Kerala, Andhra Pradesh, West Bengal and most recently Uttar Pradesh) have passed temporary emergency ordinances similar to THOA.<sup>22,\*</sup> Because of this gradual implementation, organ commerce has continued in states without the law, taking advantage of the permeability of state borders

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\* This distinction is important because an Act requires the approval of the state legislative body while ordinances are made(and potentially revoked) at the behest of the State Minister alone. While no state has revoked a past ordinance, THOA in most of India remains, at least in theory, easily revocable.

to shift practices to unregulated states. This trend is likely to continue until all states have adopted THOA.

Second, THOA's provision of allowing LNRT's if sufficient emotional attachment can be demonstrated to appointed Authorization Committees governing each transplant center has been exploited. Originally intended to allow for altruistic donations in the context of organ shortage, this provision requires each transplant facility to establish an Authorization Committee whose function is to oversee and approve all LNRT's. Authorization Committees do so by establishing the validity of emotional connection between donor and recipient. Since 1995, the provision has become an easily bypassed loophole through which organ commerce, in effect, becomes legally sanctioned.<sup>23</sup> This is partly because Authorization Committee members have been bribed.<sup>24</sup> Another reason is the inability of the Committee to accurately determine whether sufficient emotional attachment exists. Middlemen have adapted to the law, coaching donor and recipients about the Authorization Committee interviews and even staging photos of donor and recipient together on vacation as a method of proving emotional attachment.<sup>25</sup> The Committee's impotence is further compounded by the desire of health officials not to serve as policing agents that actively prevent such sales from occurring.<sup>26</sup> More about this will be said below when considering arguments concerning the curtailment of sellers' agency.

Third, the privatization of health care has driven organ commerce into an invisible, unregulated sphere where enforceability of THOA is near impossible. The rash of scandals accusing nursing homes of kidney theft in the past three years serves to

highlight the increasing ubiquity of this practice and the need for further investigation.<sup>27,28</sup>

Finally, in response to THOA, since 1995 the market has been forced to shift focus from the Gulf to the regional markets of the Indian subcontinent where recipients look more similar to Indians than do Persian Gulf nationals. Certain Indian transplant centers, such as KANTI in Bangalore, have even begun marketing to potential recipients in Bangladesh and Sri Lanka.<sup>29</sup>

By some accounts, through the processes detailed above, the number of commercial transactions has risen to pre-THOA levels.<sup>30</sup> It is evident that organ sales continue in India in varying shades of gray by occupying the space between the black market and legally sanctioned transactions. It is within this context that the issues and proposals regarding sellers and buyers will be subsequently evaluated.

### The Concerns

#### *Sellers*

Before the issues are discussed, a few words must be said as to why people sell their kidneys. As noted above, explanations alluding simply to poverty ignore the larger biosocial structures that facilitated the growth of India's trade. Despite the importance of these structures in allowing the trade to expand, poverty remains the single underlying reality facing all sellers. In 1998, sellers received between 20,000RS- 40,000RS (\$500-\$1000) for a kidney, a substantial amount with respect to the daily average income(\$2) of day laborers. Yet, this comparatively large sum cannot be considered income in light of the fact that most of it flows directly into the pockets of local money lenders to whom the

sellers are indebted. The ways in which kidneys are increasingly being seen as collateral by local money lenders requires further research and will reveal much about why kidney sales are occurring in select populations, rather than becoming a ubiquitous practice among India's poor.

Regardless of why sellers participate in the organ trade, the two issues surrounding their wellbeing that various proposals attempt to address are those of informed consent and those of agency.

True informed consent on behalf of the sellers is important to ascertain because accurate information may alter their decision making process. Current sources of information include the media, the experience of others, rumors, and the transplant structure of middlemen and health professionals. All of these sources present skewed pictures to potential sellers and do not present sellers with an adequate knowledge base to make informed decisions.

Popular Indian press involves itself with organ transplant issues primarily by covering the kidney theft scandals that occur fairly regularly. These scandals have the shared narrative structure of a poor, ignorant, uneducated, male being befriended by a stranger and eventually being offered a promising job in the Gulf or Far East. This is followed by the "required health check" in a hospital to confirm the potential employee's health. It is during this time that a kidney is removed. In the case of the most recent kidney scandal in New Okhla Industrial Development Association(NOIDA), one of the "donors" stated that he was convinced to receive a glucose drip, despite being healthy. He awoke sometime later with an abdominal scar. Accusations of theft usually occur once the nephrectomy is "discovered" by the "donor," followed by counter accusations

by doctors implicating the accusers as greedy sellers wanting more money. Often doctors further invoke the notion that larger political interests have aligned against them. In these publicity blitzes, the victims are represented as pawns in a larger social, political and legal game. I suggest that these reports serve to reinforce the disenfranchised feeling of potential sellers whose own situation is reflected in the repeated narrative of the accusers. This feeling, in turn, prevents sellers from seeking more information regarding the procedure.

The second source of information is from the experiences of others. In the early 1990's, Villivakkam, an urban slum of Madras, Tamil Nadu, gained notoriety for its high incidence of organ sale. It is estimated that over 5,000 kidneys have been sold, suggesting the participation of approximately 10% of the slum's population.<sup>31</sup> More recently, other slums in Tamil Nadu as well as in the neighboring state of Karnataka have witnessed equally high rates of organ sale.<sup>32</sup> Sellers from these slums could receive information from their neighbors regarding the procedure, and thus knew what to expect. In the rest of India, organ donation has not clustered in such communities. Instead, middlemen scour urban parks and mass transit stations, seeking out rural villagers coming to the city in search of jobs. These middlemen additionally approach the urban poor.<sup>33</sup> These two populations lack the human information resources of organ sellers in select southern slums, and likely have a more limited understanding of the risks and benefits of the organ transfer before agreeing to an operation.

Like the media narratives, rumors focus primarily on stories of organ theft. As Scheper-Hughes writes of the child stealing rumors for organs, these scandals likely exist "at that indeterminate level between fact and metaphor."<sup>34</sup> The rumors do reflect the

structural violences suffered daily by the middle and lower classes.<sup>35</sup> However, because they exist in a more metaphorical realm, the rumors tell donors little of the actual procedure.

Fourth, sellers receive information during the organ transfer process. As this information comes from sources with vested interests (likely but not limited to the informal sector of middlemen) it is likely biased and inaccurate. The situation is exacerbated by the class differences between sellers and health professionals that make it difficult for sellers to ask questions within health care settings.<sup>36,37</sup> The one documented exception to this phenomenon has been Dr. Reddy in Bangalore who, prior to THOA's passage, provided free, full pre- and post-operative health care checkups for up to three years for all sellers.<sup>38</sup>

Through these current sources of information, sellers do not appear to receive accurate information regarding a procedure that at best is inessential and at worst is extremely harmful. Given this scenario, it is possible that additional, accurate information regarding the procedure's risks and benefits could affect the decisions of potential sellers. This issue is further addressed in the discussion of the proposals.

The second issue regarding sellers is one of agency. Supporters of the ban on organ commerce have argued that the crushing poverty, burdens of ill health, lack of resources and institutional support that sellers face erase any semblance of voluntariness that agency entails. To borrow Usha Ramanathan's phrase, "the involuntary-voluntariness" by which these structural violences impose the choice of organ commerce onto sellers precludes any discussion of agency.<sup>39</sup> In their essay, Marshall, Thomasma, and Daar detail the contrary position, embraced by proponents of a legalized trade, that

critiques the ban on organ commerce as arrogant and paternalistic.<sup>40</sup> Brody echoes a similar position with respect to all cross cultural ethical evaluations of biomedical and biosocial proposals.<sup>41</sup> He cautions against the desire to reject any proposal that does not fulfill all the criteria deemed necessary to be ethically appropriate from a Western bioethical standpoint. Limiting choices that fall short of an unrealistic ethical yardstick may actually be detrimental to the populations in question because they lose an opportunity to improve their situation. While these opportunities may involve some difficult decisions and tradeoffs, they remain realistic options and avoid curtailing all possibilities that may provide some net benefit to the populations in questions. With respect to the Indian organ trade debates, this position has been espoused most recently by Janet Radcliffe-Richards *et al.*<sup>42,43</sup> Rather than using the “involuntary-voluntariness” argument to restrict sellers’ options, this position embraces it as a reason to allow sellers to continue selling.

### *Buyers*

In the 21 years since cyclosporine was first used for organ transplants and increased survival times dramatically, the language of a “supply-demand gap” has been taken as a matter of common sense. As the criteria for becoming an organ recipient have loosened, the number of eligible ESRD patients has grown dramatically. In the United States, for example, the number of patients on the United Network for Organ Sharing(UNOS) list waiting for kidneys increased from 16,026 in 1988 to 64,423 in 1998.<sup>44</sup> During this same time the number of kidney donations and subsequent transplants has leveled off at close to 5,000.<sup>45</sup> Using these numbers as well as analogous

numbers from other nations, the global transplant apparatus normalized the notion of a supply gap.

The debate surrounding a legalized, regulated trade in India grounds itself in this presumption. While ethicists argue the effect of such a proposal on the sellers' wellbeing, the unstated, underlying belief remains that ESRD patients will necessarily benefit from the increased supply of kidneys. The following section critiques this assumption as inapplicable to the current Indian context. It is specifically addressed while evaluating the possibility of a legalized trade.

## The Proposals

### *Enforcement*

This position argues that stricter enforcement of the existing ban (THOA) will decrease the organ trade. Thereby, it increases the wellbeing of participants by decreasing their ability to participate in illegal, dangerous kidney transfers. This position suffers from a few major flaws.

First, as described above, the nature of THOA has pushed organ sales into the interstice where prevention is difficult. The desire to allow for LNRT's between individuals with genuine emotional attachment and subsequent creation of Authorization Committees has become an easily bypassed loophole. The difficulty of enforcement is compounded by the increasing sophistication of middlemen in bypassing the Committee, a practice which includes bribery, coaching, and false documents.

More importantly, health officials do not wish to serve as policing agents of THOA, a desire partially honored by the law itself. According to THOA, Authorization



Committee members must evaluate the genuineness of the claims based on supplied evidence. They are prohibited from actively seeking information regarding the claims. Thus, even when the vast class differences between donor and recipient point to a likely sale, Committee members often condone the transfer if the proper paperwork is in order. Clearly, vested interests make such facile rubber stamp approvals easier. Yet, underlying this position is a belief that the role of health professionals is to care for patients, not to act as active enforcers of the law. Interviewed doctors expressing this opinion relied on arguments that invoked the agency of the seller, à la Radcliffe-Richards *et al.*, as well as a desire to help *their* patients get better, i.e. the recipients.<sup>46</sup> Donors, on the other hand, are rarely seen as patients by health professionals, despite their obvious need for pre-, peri- and post-operative care.

In light of the nature of THOA and the sentiments of health professionals, stricter enforcement seems difficult. This proposal is further weakened by the fact that its underlying assumption that further bureaucratization and state intervention will decrease the ritual abuses of organ commerce is made with little empiric data.<sup>47</sup> Rather, it is more likely that in an environment consisting of increased middlemen/bureaucrats with vested interests, structures to bypass these constraints will rapidly arise.

### *Legalized Trade*

This position, resurrected most recently by Radcliffe-Richards *et al.*, argues that both sellers and buyers will benefit from such a policy. In response to the issues of informed consent and agency facing sellers, proponents argue that a legalized, regulated trade will create options for those in poverty rather than curtail them. Given full

information, the sellers decide for themselves whether to participate in the organ commerce. Further, through regulation, unscrupulous middlemen can be eliminated. This position, though it never directly states it, assumes that the benefit to Indian ESRD patients will be through an increased supply of kidneys. The argument's flaws regarding seller and buyer is presented in turn.

With respect to the seller, three points make it difficult to espouse the position of a legalized trade.

First, as with the enforcement argument, this position's rhetoric of increased bureaucratization and state intervention as eliminating abuses is made with little empiric data. It is doubtful that the state can succeed in eliminating middlemen through increased legislation. This is especially true in light of THOA's current inability to prevent organ commerce as well as the recent failed legislative attempts to prevent commercial blood sales.<sup>48,49</sup> In both practices, middlemen have continued past practices, highlighting the inadequacies of legislation alone. The argument against further legislation becomes more significant when one considers the apathy with which the Indian central government has responded to numerous calls and legislation(THOA) to promote cadaveric donation. It remains highly uncertain whether legislation sanctioning the creation of organ commerce oversight structures will be met with a different response.

Second, as the Bellagio Task Force argues, current abuses of sellers are substantial enough to restrict the agency of potential sellers in the hopes of protecting this group's most vulnerable members of potential, more egregious abuses.<sup>50</sup> In light of the absolute paucity of information regarding long term risks of nephrectomy in populations subject to undue health burdens in a setting of already inadequate health care, this

restriction carries greater authority. The common health burdens facing this population includes sexually transmitted diseases, urinary tract infections, hypertension, and diabetes, all of which can compromise renal function.

Third, the organ commerce has not demonstrated any longitudinal benefit to sellers. Recent reports suggest that the often publicized success stories whereby sellers are able to permanently break the cycle of debt<sup>51</sup> rarely occur. In these stories, a man or woman, by selling a kidney, is able to purchase a modest shop, which eventually leads their family to increased financial stability and freedom. Though uplifting, such stories remain an exception. While sales may allow sellers to pay off specific debts (such as dowry), sellers soon find themselves in debt once again.<sup>52</sup> Because moneylenders often act as middlemen in the trade and because the larger societal structures causing indebtedness continue to exist, such ephemeral gains are not unexpected. Thus, the logic of allowing sellers to realize their agency in order to escape the poverty grind becomes less tenable as a justification for a legalized trade. In the words of one seller, Ganapathy, "Everything is still the same... We're rich for a few weeks and then go back to our normal lives."<sup>53</sup>

It is true that the *rhetoric* of Radcliffe-Richards et al addresses the issues of informed consent and agency. However, the above arguments bring into question the likelihood that a legalized trade, *when implemented* at the local context where the practices would occur, can truly protect the wellbeing of sellers

In addressing the welfare of recipients, questions regarding the function of legalized trade once again arise. As stated above, the legalized trade position assumes the equation that trade = more kidneys = more transplants for ESRD patients = better health.

First and foremost, most ESRD patients in India cannot afford the cost of organ transplant. Much like the surrounding nations of Bangladesh and Pakistan, only 2.5% of ESRD patients are able to afford therapy.<sup>54,55,56</sup> In India, 90,000 patients suffer from ESRD annually.<sup>57</sup> By combining the two statistics, one arrives at a rough estimate of 2500 ESRD annual patients able to afford renal transplant. Even if previous reports that the volume of renal transplants has attained pre-THOA levels(4000/yr) are exaggerated, there does not appear to be an organ shortage *for those who can afford the procedure*. The claims that more kidneys are needed for Indian ESRD patients fail to account for the inability of the majority of this population to pay for the therapy. Thus, by imposing the narrative of organ shortage on India, these claims inaccurately presume that increased organ supplies will alleviate the suffering of Indian ESRD patients. Ethnographic research of the four main New Delhi transplant hospitals(AIIMS, Batra Hospital, Apollo Hospital, Sir Ganga Ram Hospital) during June-July 1998 supports this argument by finding no evidence that ESRD patients who could afford a kidney were unable to undergo renal replacement therapy. As Shrivastava et al state, "In India, more than the organs, financial affordability is a major constraint to providing...therapy to patients with ESRD."<sup>58</sup>

The argument against a legalized trade fits into a larger critique of the transplant apparatus as aggressively marketing and attempting to normalize transplant medicine while suppressing the hesitations, questions and ambivalence that have been expressed by the public.<sup>59</sup> Most of these critiques have focussed on the United States. Most notable are Renée Fox and Judith Swazey, who after forty years of intensive sociological research on transplantation, removed themselves from the field. In defending her decision, Fox

points to the increasing “professionally rationalized... hubris,” and the “profanation” and subsequent commodification of organ transplant.<sup>60</sup> She argues that the transplant apparatus increasingly espouses an irrational belief in the unequivocal goodness of transplantation as a method of sustaining life, in the feeling of death as the enemy, and in the unwillingness to accept the mortal nature of human existence. These beliefs have led to proposals oriented towards a “profit-oriented, desacralized look on the human body.”

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The extent to which such critiques are applicable in other nations remains a subject for further research. Yet, ethnographic research by Cohen and Scheper-Hughes hints at the possibility that the global transplant apparatus’s hubris has led to a local shortage of *recipients* rather than donors.<sup>62,63</sup> In India, as trade routes to the Persian Gulf have contracted, marketing has increasingly been directed towards the regional middle class. Cohen’s ethnographic research demonstrates that this hard sell has led to the financial ruin of many families. Initially resources are pooled, sold and mortgaged. But, as these financial streams dry up and recipients are unable to afford the necessary immunosuppressants, graft rejection ensues. The ESRD patients end back where they started, but their families suffer the additional burden of debt. Thus, the supply-demand gap mantra is turned upside down, where the gap remains in finding recipients rather than donors. When this is taken into account, a legalized trade is again difficult to justify as benefiting Indian ESRD patients.

The final argument against a legalized trade is that it will hinder efforts to promote cadaveric and living related donations, an argument analogous to Titmuss’s regarding blood donation.<sup>64,65,66</sup> As stated above, the Indian government has yet to

promote cadaveric donations. Some speculate that this unwillingness stems from a belief that commercial sales serve as adequate supply of kidneys.<sup>67</sup> One nephrologist who works in a hospital that refuses to perform LNRT's stated that 80% of his ESRD patients initially plead with him to find them a "donor," claiming that no one in their family is willing to donate.<sup>68</sup> Eventually after repeated attempts to acquire a donor through the nephrologist, the family brings forth a newly arrived long lost cousin who just happens to be willing to donate a kidney.\* This phenomenon, what I refer to as the cousin syndrome, exemplifies to two things. First, the willingness of ESRD patients to approach their physicians demonstrates the pervasive feeling/reality that health professionals directly participate in organ commerce. Second, and more importantly, it highlights the unwillingness of some Indians to part with their own kidney when that of another can readily be bought. Only when this option is unavailable does the possibility of related donation become a reality. This trend has been documented outside of India as well. Saudi Arabian nephrologists speak of the inability to promote national related transplants when many of their patients knew that Indian kidneys could readily be obtained.<sup>69</sup> Presuming the preferability of cadaveric and related transplants to LNRT's, a legalized trade once again becomes difficult to defend.

Considering growing concerns of an iatrogenically created need for transplants and the inability of a legalized trade to address the concerns of sellers, this position become a difficult one to maintain. While any proposal attempting to address the moral, ethical, and practical complexities of India's organ trade is likely to have gaps, the above is resoundingly rejected because of its potential *to do harm*. One of the first tenets of the

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\* The discussed nephrologist is able to ascertain relatedness through HLA cross-matching, precluding the possibility that the long lost cousin is actually a seller procured by the family.

Hippocratic Oath remains, *primum non nocere*, first do no harm. While originally intended to only apply to a physician's actions and not social policy, the Hippocratic Oath serves as a solid vantage point from which to judge the organ trade. A legalized trade fails to pass this test with confidence.

### *Education*

This position stems from a recognition of the need for more accurate information and transparency in the organ transfer process for both sellers and buyers. The education proposal arises to the forefront when one considers the inadequacies of both previous proposals. In theory, they both appear reasonable. Yet, when removed from the abstract and applied to the particular, flaws invalidating their practicality emerge.

Clearly, the same critiques can be applied to the position of education- a facile, simplistic and ultimately vague one for any complex situation involving multiple players and sites of contest. From the outset, let me acknowledge the inadequacies of the "health belief" model of education. Such a model based on rational choice arguments, states that with increased knowledge, people will make "better" decisions, i.e. decisions that will better ensure their wellbeing. With respect to sellers, increased knowledge of nephrectomy risks likely will not change patterns of behavior in and of itself. The structures creating a state of "involuntary-voluntariness" continue to exist and will likely supercede risk based arguments against kidney sales. As one nephrologist colorfully explained, "You see all the people lying on the street for want of water. And if you tell them that you can live without one kidney and that you will give them 40,000RS, then no wonder they sell their kidney."<sup>70</sup> To his portrayal, I only add the figure of a moneylender

hovering over the head of our thirsty protagonist. The situation remains equally dire with respect to ESRD patients. ESRD patients have three options: a- acquire access to dialysis through some combination of luck and wealth; b- procure a transplant; c- die as a result of renal failure. Because so few patients have access to dialysis machines and because of the general dislike for the third option, transplant remains the only option. Thus, the possibility remains that financially insecure families, even when given complete information regarding the long term risks and prohibitive costs of renal replacement therapy, may elect to undergo the procedure for short term gains.

Despite these critiques, I believe there exists a place for targeted educational campaigns in addressing the wellbeing of at least sellers. Though other potential proposals exist, I detail only one below in the hopes that it can serve as a model for future proposals. I specifically propose the creation of a video targeting the slums around the “kidney vakkams” of Tamil Nadu and Karnataka.

I select this population, for two reasons. First, because of their proximity to past organ commerce centers, they represent a group at high risk for future participation in the organ trade. Second, they are an easily reachable population. Unlike in the north, organ commerce in south India has clustered around communities. Targeting potential future “kidney vakkams” maximizes limited resources by focussing on specific high risk populations that are also easily reachable.

The video itself will contain three messages:

- a- information regarding risks of nephrectomy as well as the risks of living with one kidney considering the health problems that population faces;
- b- information of the past experiences of sellers presented through interviews;
- c- information regarding other resources that can combat the intersection of moneylenders and the transplant apparatus. This includes, but is not limited to, local micro-credit programs.



The hope is that this video, through ensuing dialogues, will foster feelings of community and self-empowerment which will thereby lead to actions appropriate to each community's specific local environment. I propose distribution and education to occur through local non-governmental organizations(NGO's) currently working with the target populations. Because of their pre-established bonds, these NGO's should allow for more trust and open lines of communication with the target populations.

The inspiration for this proposal comes from evidence suggesting that educational campaigns of sex workers in Bombay regarding condom usage has decreased rates of HIV transmission.<sup>71</sup> Like kidney sellers, sex workers face numerous seemingly insurmountable structural obstacles. That outreach to this population has demonstrated positive results provides hope that the same can be done for kidney sellers.

Clearly, this proposal is limited in scope. Nevertheless, it remains important because of its potential to better ensure the wellbeing of future sellers from these high risk communities. More importantly, unlike a regulated trade, there exists little potential for causing harm to these populations.

### *Final proposals*

Though not mentioned in the discussion above, there exist three additional proposals for addressing the issues facing potential sellers and buyers. Because all require substantial capital and longitudinal effort, they are unlikely to be implemented in the near future. Nevertheless, they remain important policy suggestions(dreams?) for the future.

First, a cadaveric program must be promoted by the Indian government. As mentioned above, most ESRD patients will still be unable to afford renal replacement therapy. However, there exists the possibility that cadaveric sources will obviate the need for an organ trade. In addition to governmental apathy, many other hurdles remain before this becomes a reality, the most important of which is the creation of the necessary local, regional and eventually national infrastructures.

Second, increased government subsidies of hemodialysis for the majority of ESRD patients who cannot afford the annual \$3000 cost are required.<sup>72</sup> Recent efforts of Giants Group of Garden City in Bangalore demonstrate the beginnings of such public, rather than government, initiatives.<sup>73</sup> Together with B. Braun Medical Industries of Germany, this group will soon provide a limited number of dialysis units to be used strictly on a charitable basis. Such efforts, while laudable, will require the participation of the Indian government to make a large scale impact. Until then, the vast majority of ESRD patients in India will continue to suffer regardless of the status of the organ trade.

More importantly, the numerous structural violences that the majority of Indians suffer need to be addressed. The number one priority is reforming the social and state structures that place people in the position of “involuntary-voluntariness.” Until the Indian Government actively participates in doing so, a population of willing sellers will always exist in India. Additionally, access to primary health care must be increased. In doing so, the hope is that the causes of renal failure can be addressed before patients progress to ESRD.

## Conclusion

In the post THOA era, organ commerce continues in India. Because it operates in the private sector and through pseudo-legal channels, totally eradicating the trade will be difficult. Projects addressing the welfare of the participants are equally difficult. Nevertheless, I remain committed to the belief that targeted educational campaigns can positively address the growing concerns surrounding the organ trade in ways that the other two proposals cannot.

## *Postscript*

This paper grounds its arguments without considering the possibility of a legalized, transnational organ commerce. Much of the debate within India occurs in the context of alleviating the Indian problem of ESRD patients and the issues that this particular population faces such as inadequate financial resources. A transnational trade, because of the number of fairly affluent ESRD patients worldwide, would obviate many of the concerns with respect to recipients. The arguments of Radcliffe-Richards *et al.* do not specify whether they consider the possibility of a transnational trade, but there is little reason to think that they do not. In responding to this, this paper takes the position of the Bellagio Task Force stated above: considering the lack of information regarding post-nephrectomy risks in vulnerable populations and the potential for abuses, a transnational trade cannot be ethically sanctioned at this time.

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**Kidney Theft and the Indian “Public Circuit:”  
An Examination of  
the NOIDA Medicare Center Scandal  
of Summer 1998**

This paper attempts to address the particular dearth in scholarship related to the “public circuit” of organ transplantation by analyzing how it has taken shape in the Indian context as kidney scandals.<sup>1</sup> These scandals pit the accusations of poor men that transplant surgeons stole their kidneys against the counter accusations of those accused. They occur regularly in India and are widely reported in popular media.

In the introduction to Social Suffering, Kleinman, Das and Lock write, “Cultural representations of suffering- images, prototypical tales, metaphors, models- can be (and frequently are) appropriated in the popular culture or by particular social institutions for political and moral purposes. For this reason, suffering has social use.”<sup>2</sup> In India, kidney scandals become one such cultural representation of suffering that has social use. This paper focuses on one particular scandal, the New Okhla Industrial Development Association(NOIDA) Medicare Center(NMC) Scandal which occurred in May 1998. By examining how the various social actors involved with the scandal attempt to appropriate and thereby utilize the scandal for personal means, this paper attempts to construct the social matrix in which kidneys come to matter in India. The argument of this paper borrows from White’s *Tsetse Visions*.<sup>3</sup> In her article, White argues that rumor and scientific truth, with equal validity, can be used to reconstruct the history of a particular event. This essay is similar in that the “Truth” regarding the NMC Scandal does not matter so much as does the possibilities offered by the various actors. It is these possibilities and the justifications/arguments made to buttress them that allow one to understand the stakes highlighted by this “public circuit.”



First, a brief overview of the current context of organ transplantation in India will be given and will be followed by an outline of the NMC Scandal as it appeared in the popular press. Then, a detailed analysis of each actor's position will be discussed.

### The Current Context

Until February 1995 when it was outlawed, commercial organ sales were a legal, increasingly common practice in India. Between 1983 and 1994, the annual number of kidney sales in India increased dramatically from less than 50 at the outset to over 4,000, earning India the moniker of "the great organ bazaar of the world"<sup>4,5</sup> The majority of this trade involved wealthy Persian Gulf nationals buying from India's urban poor. The Transplantation of Human Organs Act (THOA) was passed to curb this growing trend with the intended goal of protecting donors while simultaneously ensuring an adequate supply of donors through the promotion of cadaveric donation.<sup>6</sup> This was accomplished by including in THOA a legal recognition of "brain-death." Provided concomitant implementation of adequate structural and social policies occurred, such legislation attempted to facilitate the procurement of organs.

There has been some evidence of THOA's success, especially in contracting trade routes to the Persian Gulf. However, its success has been limited for a number of reasons.<sup>7,8</sup> With respect to kidney scandals, two deserve particular mention.

The first is the fact that in India, laws pertaining to health fall under the purview of state legislation. Thus, while THOA appeared to ban organ sales throughout India, in effect only a small fraction of India, the Union Territories, was initially effected. Since 1995, only two states have ratified the law, Goa and Maharashtra. Several others (Tamil

Nadu, Karnataka, Kerala, Andhra Pradesh, West Bengal) have passed temporary emergency ordinances similar to THOA.<sup>9</sup> Because of this gradual implementation, organ commerce has continued in states without the law, taking advantage of the permeability of state borders to shift practices to unregulated states. NOIDA, though a growing suburb of New Delhi, technically lies in the state of Uttar Pradesh which at the time of the NMC Scandal, May 1998, was one such unregulated state. However, New Delhi, because it was a Union Territory at the time, remained subject to THOA.

Second, the central government continues to ignore pleas and legislation(THOA) to invest capital to create the infrastructure necessary for the promotion of cadaveric donations as an adequate supply of kidneys. Some doctors I spoke with in India speculated the government's apathy was informed in no small part by the government's belief that the bodies of the poor via commercial sales obviated the need for another source of kidneys.<sup>10</sup>

Thus, despite the THOA's *apparent* ban, commercial organ transfers continue to occur, and the poor continue to serve as the primary source of kidneys in India. By some accounts, the number of commercial transactions has now risen to pre-THOA levels.<sup>11</sup> It is in this context that the NMC Scandal must be placed and subsequently analyzed.

### The Incident, as Reported

In the following section, the NMC Scandal is presented as reported in the popular Indian press. This is done to demonstrate to the reader the level of detail to which the national and international public usually critically engages with these scandals.

On May 11, 1998, the following short article appeared in the New York Times:

*“Three surgeons and several other people have been arrested and charged with luring poor people with promises of cash or jobs and robbing and selling their kidneys, authorities said today. The doctors reportedly paid agents to cruise shantytown for patients. The police arrested the suspects, including the owner of the prestigious NOIDA Medicare Center, Sunday [May 10].*

*A mechanic, Shaukat Ali, had filed a complaint that he had been robbed of a kidney after having been taken to the NOIDA Medicare Center, one of the few in the country that performs kidney transplants, for a medical examination. Solicitors had promised him a lucrative job in Singapore and told him that he needed the exam to obtain a visa, Mr. Ali said. Two similar accusations had also been made against the hospital. A spokesman for the center... denied wrongdoing by the hospital’s doctors.”<sup>12</sup>*

This succinct article represents the sole publicity given to the incident by the popular American press. It additionally summarizes the initial reports by the Indian media.

On Friday, May 8, Shaukat Ali filed a “First Information Report” (FIR) with the police which is a complaint officially brought to the police by a civilian. According to the official police report, an investigation was subsequently launched into the case. The ten people arrested included the following: the head transplant surgeon(Dr. Harsh Jauhri), two nephrologists(Dr. Sanjay Wandavan, Dr. Navin Chaudhary), NMC’s head administrator(Ms. Sadhna Sood), a police constable(Sanjay Singh, alleged ring leader), and five other individuals who were suspected as various accomplices in the ring(Sushil Kumar, Mukesh Kumar, Yeshpal Singh, Suraj Prakash Roy, Akhilesh). On May 10, one day following the arrest of the accused, three more individuals(Brijesh Kapoor, Harish Chander, Rajesh Kumar) came forward with similar stories and subsequently confirmed identification of the previously accused.

On the same day, May 10, the Indian Medical Association(IMA)joined the fray by calling for a strike of all nursing homes\* in NOIDA “in protest of the ‘high handedness and unwarranted’ arrest of the three doctors.” In addition, IMA president V.S. Chauhan termed the action as a “conspiracy to defame the institution and strongly condemn[ed] the police action.”<sup>13</sup> Over the next two weeks, the major newspapers of New Delhi (NOIDA has no paper of its own) continued to follow the scandal’s progression. No new information concerning the case surfaced at this time. The only developments concerned the actions of various doctors’ organizations (the IMA, the Delhi Medical Association, and the Delhi Nephrology Society) and the question of whether the doctors would be released from jail. The involvement of two professional New Delhi-based organizations becomes understandable for two reasons. First, NOIDA is a suburb of New Delhi, and thus has not developed its own politically active professional organizations. Second, and more importantly, Dr. Jauhri, the head transplant surgeon, worked in a New Delhi hospital in addition to working in the NMC.

The doctors’ organizations remained vocal during this time by implementing their own investigation into the case(May 12), by resolving to halt all transplants in Delhi until the doctors were cleared(May 18), and by eventually calling for a one day dialysis *bandh*(strike) in a show of solidarity with the accused doctors(June 3).<sup>14,15,16</sup>

Despite these efforts, the repeated requests of the accused for bail were denied on the premise that the police needed time to collect evidence in order to formally charge the accused. Because Uttar Pradesh had not passed THOA, the doctors were being investigated for possible charges under the Indian Penal Code that applies to all Indian

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\* Nursing homes in India are small, private hospitals that cater to all ages. Unlike the United States, these are not live-in facilities for the elderly.

states. Among other charges, the police were attempting to utilize the following infractions: 420(cheating), 120-B(conspiring to cheat), 320(causing grievous injury), 467-8(fabricating, manufacturing false documents), and 471(using false documents as genuine documents). The false document charges pertain to “irregularities” found in about half of the 230 transplant records seized by the police. In the initial police report, these irregularities concerned repeated inconsistencies in the relationship between “donor” and recipient pairs. In the medical files, some forms stated that the kidney was being donated “for humanitarian reasons,” while others stated that the kidney was being given to a blood relation. In addition, certain legally required pretests such as donor psychiatric profiles and tissue compatibility tests were missing from the medical records.<sup>17</sup>

All of the above occurred between May 8 and June 1, 1998. The popular Indian press abruptly stopped monitoring the progress of the scandal, and no further information was made available to the public over the following two months. By August 1998, when my own research ended, the accused remained in jail, and police had yet to file an official charge sheet against anyone.

### Representations, Uses

Clearly, the above story begs additional questions. Yet, the national media never further engaged the NMC Scandal. In the following section, the above is supplemented by ethnographic research done over June and July 1998. Each of the social actors involved in the scandal were sought out, and where possible, interviewed. Their particular representations and subsequent uses of the NMC Scandal are detailed. By

interpreting, intertwining, and juxtaposing these dialogues, one begins to get a sense of the current stakes involved with organ transplant technology in modern India.

### *The Accusers*

Since 1995, at least five kidney theft scandals been widely reported in the Indian national media.<sup>18,19,20</sup> In all, media representations of the accused share a similar narrative structure to Shaukat Ali- a poor, uneducated male seeking a job abroad whose kidney is unknowingly removed during the course of a required “health check.” During a personal interview with Shaukat Ali, I was given the same narrative that was promulgated in the media, albeit with more explicit detail regarding his entire experience.

Shaukat Ali had met someone in Subhash Park and was promised a job in Singapore. Over the next few days, he met many of the accused including Mukesh Kumar, Sadhna Sood, Sanjay Singh, and Dr. Sanjay Wandavan. They repeatedly gave him cash “advances” for his job and also told him not to “discuss silly things with family members.” Shaukat Ali states that his joy over finding a job abroad and the presence of a police officer clouded his judgement and made him feel safe when he should have been more wary. During this time, Shaukat Ali recalled undergoing xrays, urine tests, blood tests, and finally a glucose drip. After the drip, Shaukat Ali awoke with a bandage on his abdomen. When he asked what it was, it was told not to worry about it, and that if he started asking too many questions, he might spoil everything. Though flummoxed, Shaukat Ali recalled feeling little pain. During each of the five nights he remained in the hospital, he received an injection. Finally, when he was released, he was given 500RS(\$12.50) and told that everything was almost set and that he was to return in a few

days. In the next few days, Shaukat Ali stated that he developed some severe abdominal pain and went to see a local doctor. Only after the doctor asked him when he had donated his kidney did Shaukat Ali realize what had happened to him. Shaukat Ali soon returned to NMC. He stated that “all hell broke loose, “ and that no one would speak with him. Over the next few months, Shaukat Ali stated that he remained extremely ill and that his weight reduced by half. When we spoke, Shaukat Ali appeared ill and in acute physical distress.

The other three accusers proved difficult to access. Rajesh Kumar refused to answer his door despite numerous attempts. Neither Harish Chander nor Brijesh Kapoor had permanent addresses in New Delhi. Reporters and police who had previously interviewed them stated that they were unable (unwilling?) to locate them as per my requests. Thus, for the purpose of analysis one is left only with the common narrative connecting all these scandals as well as the detailed story of Shaukat Ali.

*A priori*, their stories may be “True.” Thrust into a complex medical arena with little previous exposure and driven by a desire not to upset potential employers, Shaukat Ali was unlikely to ask many questions. This already restrictive environment was likely exacerbated by class differences that make it hard for patients to ask doctors questions in most hospital settings. These factors could easily have mediated the theft of a kidney. If so, the NMC Scandal indicates the extent to which the poor are disenfranchised in contemporary India. The local transplant apparatus is able to take advantage of asymmetries in knowledge and power for atrocious personal gain, banking on the likelihood that accusations of theft by the marginalized against powerful doctors and health technocrats will not be made. This support gains credence from Brijesh Kapoor’s

claim that he knew of 70-80 more individuals who had suffered the same fate as he did at the NMC.<sup>21,\*</sup> If indeed true, that none of these individuals came forth only lends further credibility to the hubris with which the transplant apparatus is acting. In this scenario, more disturbing is the likelihood that organ theft is a ubiquitous, and undocumented, practice throughout India.

Another possibility is that the sellers are at least partially complicit to the organ transaction. Here, Shaukat Ali may not have been given what he was initially promised—a specified amount of cash, employment overseas, or both. Because THOA was not passed in Uttar Pradesh and because accusations of broken promises against powerful doctors were not likely to be acted on by police, Shaukat Ali embraced a position of passive victim, claiming kidney theft as retribution. Interpreted in this manner, the NMC Scandal once again points to a certain hubris and medical vampirism embraced by the transplant apparatus.

Regardless, the claims of Shaukat Ali and others reflect the daily sufferings, the literal and metaphorical thefts, which scar their lives. Thus the suffering of the poor caused by the structural violences become embodied in the common culturally resonant idiom of kidney theft.<sup>22</sup> By representing themselves as victims with no agency in the NMC Scandal, Shaukat Ali and others utilize the image of literal body theft to draw attention to and lament the other various literal and metaphorical ways that their bodies are stolen from them. Here the ultra modern hospital, such as the NMC, exemplifies the modern state, where the poor are sacrificed for the capital accumulation and the health of the wealthy.

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\* Such accusations are not uncommon. In the Bangalore Scandal, Bangalore Police alleged that over 1,000 people were robbed of their kidneys by the accused doctors. Reported in Mendonca, Sandhya. "Watch



Lyotard writes, “It is in the nature of a victim not to be able to prove that one has been done a wrong. A plaintiff is someone who has incurred damages and who disposes of the means to prove it. One becomes a victim if one loses these means.”<sup>23</sup> The accusers, victims in their inability to address the structural violences of their daily lives, attempt to transform themselves into plaintiffs through the NMC Scandal. Ironically, this transformation from victim to plaintiff becomes possible only when the accusers embrace and participate in the media representations of themselves as victim.

### *Third Party Beneficiaries*

Third party beneficiaries can be defined as actual and potential social actors who were not directly involved with the disputed organ transfer process at the NMC. Rather, their benefit from the NMC Scandal could have and did come indirectly, by way of the national attention given the Scandal. Two examples are given below.

One such third party beneficiary materialized during my visit to Shaukat Ali’s *basti*(shantytown). Upon arrival, a translator and I were directed to a small corner-shop and told to wait. From the small crowd that quickly gathered, a man emerged and announced himself as Shaukat Ali’s protector. He argued that he wanted to shield his neighbor from any further political harm and unnecessary attention. In the course of his diatribe, he stated that Shaukat Ali would only speak if a local political party could also be guaranteed press coverage. During this speech, another man attempted to interject numerous times but was abruptly cut off by the speaker, apparently the head of this local party. Finally, the second man stated that he was Shaukat Ali and offered to give us his

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Your Kidney!” *Sunday*. 1995, February 12-18: 11-13.

story. Miffed, the local politician continued to interject throughout the ensuing conversation.

The above interaction highlighted the very real way that media attention magnified and potentially altered the local power dynamics of Shaukat Ali's community. The local politician's attempts to appropriate Shaukat Ali's suffering for political gain were apparently being met with resistance by Shaukat Ali himself. This suggests that the political gains desired did not necessarily directly benefit Shaukat Ali. Rather, the local politician's primary purpose appeared to be personal promotion. Because the underlying power dynamics and interpersonal dynamics of this *basti* could not be explored, one is left only with the *possibility* that Shaukat Ali's suffering transformed into a political bargaining chip. Yet, even this possibility hints at the ways in which the NMC Scandal came to matter.

The second third party beneficiary concerns much larger interests, and larger stakes. Doctors, often furthering this argument as vindication of their own innocence, argued that larger political forces aligned against them to *create* the scandal. Indeed, IMA President V.S. Chauhan's claim that the Scandal was a "conspiracy to defame the institution" hints at such a possibility.<sup>24</sup> In a personal interview, Dr. Jauhri's wife was much more explicit. She alleged that the NMC Scandal stemmed from the professional jealousy of Dr. Sharma, who headed a large, rival hospital in NOIDA called the Kailash Medicare Center(KMC). Apparently, the NMC's success had overshadowed the KMC. As an explanation, Mrs. Jauhri stated, "Dr. Jauhri is the jewel of the NMC. He is the reason that the NMC is doing so well. Without him, the NMC would not be what it is." Thus, Dr. Sharma sought to impugn Dr. Jauhri as a method of indirectly bolstering his

own faltering institution. Mrs. Jauhri stated that through his connections to Members of Parliament(MP's), Dr. Sharma maneuvered the transfer of Inspector D.S. Chauhan to NOIDA three days prior to the Scandal. With his professional influence, Inspector Chauhan, who was heading the police investigation of the Scandal, fabricated a case against Dr. Jauhri and the NMC. Mrs. Jauhri ended by bitterly claiming that Dr. Sharma's ploy had been effective. From her deck, Mrs. Jauhri motioned towards the KMC, and stated, "Now, the NMC is empty. No one comes there. And at night, there are many more lights at Kailash. Before this[the Scandal] there were only a few."

Such accusations of vested interests creating a kidney scandal are not unique to the NMC Scandal and have been proffered by doctors in the Bangalore Scandal as well.<sup>25</sup> In the eyes of the accused doctors, a professional rival knowingly created and capitalized on the negative publicity of the NMC Scandal. Here, the suffering of Shuakat Ali (or perhaps the representation of his suffering) matters only in its ability to further personal agendas. Such appropriations of the NMC Scandal indicate the way in which the idiom of kidney scandal serves to express the politics of medicine in India. In addition, they suggest the at least partial complicity of the accusers. Once again, Lyotard's quote becomes relevant in analyzing this possibility.

### *The Voice of the Accused Doctors*

Unlike the above two groups, the accused doctors and the professional medical organizations(IMA, DNA, DNS) which advocated on their behalf did not use the representations of suffering as much as they negotiated the NMC Scandal's representation of themselves. Hence, rather than furthering the image of Shuakat Ali as

victim of the doctors' greed, they reverse the roles so that doctors became a victim of Shaukat Ali's greed. Simultaneously, the doctors offered a variety of other reasons for their innocence. These are presented below.

The DMA, DNS, and IMA all countered initial reports regarding the NMC scandal with outright denial that the accused doctors could have been involved in a deception ring. They supported their position with the position that, "*It's impossible to steal a kidney.*" IMA General Secretary, Dr. Prem Aggarwal, stated, "A donor has to go through various invasive tests, his kidney has to match with the kidney of the receiver and the two operations take place (the donor's as well as the receiver's) simultaneously... The entire process means hospitalization of about six days. So how come these innocent victims never questioned why they were in the hospital for so long?"<sup>26</sup> This argument, which was also often offered as a vindication of Dr. Jauhri by health professionals uninvolved with the Scandal, grounded itself in the commonsense notion that in any complicated procedure such as organ transfer, both parties must have been complicit. Clearly, it ignored the possibility that Shaukat Ali, through the processes detailed in the Accusers section, could have been subject to organ theft.

Dr. Aggarwal additionally stated that the NMC Scandal appears more to be a case of the "seller not receiving adequate compensation and fil[es] a complaint on second thought. And so, he pretends his kidney has been stolen when actually he has donated his kidney for monetary gain."<sup>27</sup> Dr. Rajesh Chawla, head of DMA, offered a similar explanation during a personal interview. They further buttressed their explanation of the NMC scandal by pitting the credibility of the accusers against that of the accused doctors. IMA unit president V.S. Chauhan opined, "It is a sad day when the words of a drug

addict hold more weight than the words of those individuals who have spent half of their life serving the ailing millions in this country.”<sup>28</sup> Shaukat Ali and his fellow accusers were additionally called, “not-so-innocent donors,” and “of dubious antecedent,” while the accused doctors were hailed as “concerned doctors... who have saved a number of precious lives of people suffering from chronic renal failure.”<sup>29,30,31</sup> Here, the image of a concerned, socially conscious doctor is invoked as indicative of the doctors’ innocence. On the other hand, the plaintiffs are portrayed as drug addicts and therefore untrustworthy. Given this choice, whose story is more credible, these organizations asked?

It becomes clear that in responding to the NMC Scandal and the representations of their colleagues as avaricious and heartless, these professional organizations attempted to reverse the role of victim and aggressor.

In addition to echoing similar beliefs, Mrs. Jauhri articulated two additional arguments.\* The first, presented above, implicated the KMC. In the second argument, which contradicted the it’s-impossible-to steal-a kidney argument, Mrs. Jauhri claimed that an organ theft racket could have existed at the NMC. However, *Dr. Jauhri could not have been involved*. She supported this statement with two reasons. First, Mrs. Jauhri asserted Dr. Jauhri was too busy performing transplants in the NMC and in Sir Ganga Ram Hospital in New Delhi to involve himself in the intricacies of an organ theft racket. Second, she argued that Dr. Jauhri wouldn’t have participated even if he could have. Mrs. Jauhri states that had they been interested in money, they would have stayed abroad. Instead, after Dr. Jauhri completing his training, they returned to India. She states, “We

could have stayed abroad. Dr. Jauhri had many offers. But we said to ourselves, 'No. Let's go home and do a good work.' So we came back to India six years ago." Finally, Mrs. Jauhri stated that Dr. Jauhri had been lobbying the Uttar Pradesh government to ratify THOA for four years. Mrs. Jauhri argued that when these circumstances were considered, it was unlikely that he was involved with a racket, if indeed one did exist. When Mrs. Jauhri's arguments were presented to a colleague of Dr. Jauhri's in Sir Ganga Ram Hospital, he simply replied, "Well, you know the saying- 'Money, by hook or by crook.'"<sup>32</sup>

The arguments of the professional organizations and of Mrs. Jauhri suggest three concerns that the NMC Scandal highlights.

First, the arguments underline their attempts to divorce themselves from situating their own practices within the larger debates concerning the appropriation of organ transplant technology in modern India. As previously mentioned, these debates have traditionally revolved around various methods of increasing the supply of kidneys. The balance between this benefit and increased abuses(both actual and potential) to vulnerable populations of potential "donors" has remained the predominant issue.<sup>†</sup> As kidney scandals continue to surface, doctors are increasingly represented as a locus of the abuses. That the accused doctors would deny any wrongdoing seems commonsensical. Yet, the refusal of professional organizations to acknowledge the possibility that doctors could be involved with the Scandal suggests their desire to absolve themselves of

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\* Because of the ongoing investigation into the NMC Scandal during June and July 1998 and Dr. Jauhri's prolonged jail time without bail, he was inaccessible. The responses of his wife who served as his public advocate are substituted for his own.

<sup>†</sup> Recently, critiques have also begun to question the notion of a supply gap at all. Instead, they argue that the transplant apparatus's financially driven hubris has led to a shortage of *recipients* rather than donors. See Gupta Malkeet. "An Evaluation of the Practice and Dialogue of the Indian Commerce in Kidneys." Unpublished.

responsibility to the larger debates. Rather than acknowledgement of the possibility, they attempt to shift blame to sellers and to larger forces. They represent themselves as being caught at the intersection of greedy sellers and politicians who both hinder their principal aim of assisting ESRD patients. The physicians' portrayal is buttressed by the fact that most doctors I spoke with only characterized the recipient as patient and omitted donor from the equation. Perhaps, this is partly because as nephrologists, they were accustomed to only seeing people with renal problems as patients. More central, however, is the likelihood that "donors," for a variety of social and financial reasons, are simply devalued when compared to recipients. Regardless, there is no engagement of the difficult problems facing physicians entailed in negotiating the role of an expensive technology with high abuse potential within a population with few other options.

Clearly, the above argument does not apply to all, nor even to a majority, of Indian physicians. Numerous physicians have instigated and participate in national and international efforts of addressing the role of organ transplant technology in India. Yet, there appears to remain a contingent of physicians, perhaps those with vested interests, that attempts to divorce itself from the larger context and operate in a vacuum.

Second, the doctors' responses might be interpreted as reflecting the pains of their own crumbling theodicy in light of ongoing kidney scandal accusations. Previously, physicians in the field of transplant medicine served as a source of national pride and were held in high esteem by the general public since they made life-saving technological advances available in the subcontinent. Even today, advances in transplant medicine are widely reported and the involved physicians are valorized.<sup>33</sup> Yet, these positive reports are increasingly counteracted by the negative publicity of kidney scandals. The impact of

the changing public opinion on transplant physicians is evident in IMA unit President V.S. Chauhan's comment quoted above whereby he laments the fact that a "drug addict" garners the same credibility as an accomplished, conscientious doctor. Chauhan's defense mechanism whereby Shaukat Ali is caricatured as a drug addict suggests an underlying fear that the theodicy transplant physicians once enjoyed is splintering. Dr. Rana, head of the DNS, was much more explicit during a personal conversation. He stated that he was increasingly hesitant and embarrassed to identify himself as a nephrologist in public because of the assumptions by association that he too participated in illicit, unscrupulous activities. Because of his prominent position as head of the major nephrology association of Delhi, Dr. Rana's opinion becomes all the more telling.

Finally, the responses of the doctors may to some extent reflect a desire not to serve as the prime focus of expression by the poor of their daily sufferings. As the idiom of kidney theft comes to subsume and express the myriad of other violences that the marginalized face, doctors are necessarily implicated as the agents of these violences. Understandably, doctors would want to shun such a representation, especially considering the underlying difficulties in delivering adequate health care to large populations without the necessary resources.

### *The Police*

I spoke with two members of the unit investigating the NMC Scandal, SSP D.S. Chauhan and DSP Ajay Joshi. As mentioned above, Chauhan was heading the entire investigation. Joshi, another ranking police officer, reported to Chauhan. More than any other social actor, the police remain an enigma as it is difficult to ascertain whose



representation of the Scandal they are buttressing. Why did the police investigate the NMC Scandal at that particular time? First, reports of theft at NMC were circling much before any action was taken. For example, Rajesh Kumar's father stated that he had been approaching the Delhi police for months.<sup>34</sup> Yet, they did not act until May 1998. Second, the police are rarely championed as the protector of the marginalized in India. Many people I spoke with whose own lives paralleled Shaukat Ali's stated that they tended to avoid the police whenever possible and seemed wary of their intentions. Thus, that the police became involved with the NMC Scandal and arrested high profile doctors provokes questions of motive. Perhaps, the police were simply responding to the complaints of the four accusers without any ulterior motives. Or maybe outside political forces, such as those alluded to by Mrs. Jauhri, may have instigated an investigation. (Here, it remains uncertain whether the claims were also fabricated or simply responded to because of their utility as a political tool.) Undoubtedly, the interactions of the media and the public sensitization to the issue of kidney theft mediated the responses of the police to some extent. Yet, the questions remain: why this case? why now?

The uncertainty surrounding the police's actions is not unique to the NMC Scandal. Rather, it ironically embodies the general enigmatic, questionable nature of the police's interactions with high profile public affairs in India which concern influential people and large stakes. This uncertainty has prompted numerous calls for an "ethnography of the state."<sup>35</sup>

### *The Media*

As mediator and distributor of the NMC Scandal story, the media's role in forming/buttreasing a particular version of the Scandal warrants examination. While a thorough analysis would historicize the role and effect of the media in popular Indian culture, this paper because of limited space does not do so. Rather, it only makes suggestions for future research. The Indian and American media will be examined in turn.

At best, the local media's reporting can be interpreted as dispersing information and tracking an issue that resonated with the public at that particular time. The scandal's particular resonance can be understood in light of the national and international attention focused on Indian kidney transfers since reports of kidney sales first began to surface in the mid 1980's. The kidney scandals in recent years have only increased this attention. At worst, the local media's attention to the NMC Scandal may be influenced by a connection to larger political forces whose vested interests are somehow served by the Scandal. Thus, once the local papers cover the story, it spreads to the national and then international media.

The American media's attention to the scandal was by in large limited to the short New York Times article reproduced above. Nevertheless, I believe that this article, combined with the shocked reactions of most people I spoke with regarding the article highlight two points.

First, it can be interpreted as fitting into a larger critique of the transplant apparatus as aggressively marketing and attempting to normalize transplant medicine while suppressing the hesitations, questions and ambivalence that has been expressed by

the public.<sup>36,37</sup> Even though the kidney scandals happened in India, I would argue that their reporting in the United States coincide with the American public's ambivalence regarding transplantation. Hence, the increasing scope of the "uncanny circuit," the lens through which these kidney scandals may be being understood by the American public.

The second point applies equally to Indian and American media. This is that kidney scandals such as the NMC Scandal are being interpreted on some level simply as entertainment, or "infotainment." Kleinman and Kleinman write, "Images of suffering are appropriated to appeal emotionally and morally both to global audiences and local populations. Indeed, those images have become an important part of the media. As "infotainment" on the nightly news, images of victims are commercialized; they are taken up into processes of global marketing and business competition."<sup>38</sup> Here, the complexities of the NMC Scandal become thinned and the underlying issues are dropped from the representation. What is left is the social use of Shaukat Ali's suffering as a perverse form of entertainment.

### Conclusions

As with the other kidney scandals, the NMC Scandal involves the intersection of multiple conflicting interests. For this reason, the question, "What really happened?" remains unanswerable. Nevertheless, by triangulating the responses and appropriations of the involved parties without evaluating their "Truth" content, a rough sketch of the context whereby kidneys take meaning in India materializes.

For the accusers, kidneys appear to have become a powerful idiom for addressing the various social ills that they are plagued by. To quote Comaroff and Comaroff, such

events as the NMC Scandal, ‘Because (they) distill complex material and social forces into palpable human motives, they tend to... map translocal scenes onto local landscapes...’<sup>39</sup> Doctors, because they are increasingly represented as the agents of these social ills and because they feel an erosion of public trust, understandably have attempted to deflect some attention away from themselves and buttress their positions. Kidney scandals additionally make it evident that doctors are struggling with their role in negotiating the use of transplant medicine in India. Mediating the exchange between these parties are police and media, both of whose motivations are questionable at best. Finally, there exist third party beneficiaries who attempt to capitalize on the attention and concern given to kidney theft scandals.

It is important to note that of the ten people accused, only the voices of the doctors were expressed in the media. No space, voice or access was given to the various middlemen and accessories, some of whom were implicated as being the heads of the kidney stealing gang.<sup>40,41</sup> Likely, this marginalization stems from this group’s lack of social and financial resources as well as their low “infotainment” value. Yet, because they served as buffers between the doctors and accusers, the responses of these individuals would likely have proved valuable in evaluating the extent of interactions between the two. This remains a site for future research.

Increasingly, critiques from within the “ethical circuit” cite the need for organ transplantation debates to be removed from the sterile realm of abstract principles and placed within the particular local, social, political and economic contexts in which the practices occur.<sup>42,43</sup> While further research into these local contexts will certainly provide much needed information to ground the debates, a significant amount of material

can also be gathered from the examination of the “public circuit” as well as the “uncanny circuit” of organ transplantation. By engaging the former as manifest through kidney scandals, this paper attempts to provide texture and depth to the context in which organ transplant technology exists in modern India.

In Writing at the Margin, Kleinman writes, “Perhaps the chief contribution that medical anthropologists can make to these fields [international medicine and social development] is not primarily to assist them to engage different ethnic groups and function more effectively in different social contexts- the sort of thing we are most often asked to do. Instead, we need to specify how it is that the very processes that make biomedicine effective as a technical rationality and strategy of social action so often become, under particular political and economic regimes, a barrier... to improved health and good quality health care.”<sup>44</sup> The “public circuit” occupies this space and highlights the contradictions inherent in biomedicine in ways that the other two circuits cannot. It is precisely this margin, to borrow Kleinman’s phrase, which deserves most attention in India’s struggles with transplant technology.

### *Postscript*

As of August 1998, two of the four FIR’s filed against the accused had been dropped.<sup>45</sup> Uttar Pradesh passed an emergency ordinance implementing THOA in June 1998. Subsequently, the first permission granted by the Uttar Pradesh government to a hospital allowing it to perform transplants occurred in early 1999. The hospital- the NOIDA Medicare Center.<sup>46</sup>

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