Transplantation and Body Politics: Toward Assessing and Addressing Inequalities

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Introduction

Numerous works that have been written about organ transplantation, from multiple disciplines and perspectives, note that the practice has become increasingly common in the past decades (cf., Fox 1996:259–260). With the development of cyclosporine and related improvements in immnosuppressant therapies, the threat of transplant rejection has dramatically declined, and demands for transplantable organs now consistently outweigh any increases in their availability (U.S. Department of Health and Human Services 2005). A rich body of medical anthropological and sociological literature has developed around the issues of exchanging these limited supplies of tissues and organs—conceptualized as gifts, commodities, or both—between donors and recipients. Indeed, internet, billboard, television, radio, and other advertisements that promote organ and tissue donation and that market the transplant services of regional health care centers in many ways confirm a commodification of human bodies and body parts in the context of transplantation. Such advertisements also point to the increasing
presence of transplantation in daily life. This growing ubiquity calls for further examination of “what’s at stake” (Cohen 1999:141) with regard to organ and tissue transplantation.

The general thrust of this paper is that anthropological and sociological theory about the body offers critical tools for understanding organ and tissue transplantation from a sociocultural perspective. I will draw upon relevant literature to argue that approaching transplantation in terms of body objectification and commodification can reveal an important facet of transplantation that is worthy of critique. However, I also will argue that Nancy Scherer-Hughes and Margaret Lock’s 1987 notion of “the body politic” may enable additional insights into transplantation that can be of use in efforts to address the injustices and inequalities that are associated with the practice. More specifically, this paper argues that organ and tissue transplantation is a complex collection of socially situated biomedical knowledge and practices through which particular types of bodies are created, employed, and managed. If transplantation and its sociocultural context are so interwoven in this way, then it could follow that efforts to ameliorate structural inequalities in one would have an analogous effect in the other.

“The transplant community” as ethnographic setting

As Lesley Sharp notes, “transplant ideology unites a diverse array of parties into a self-defined transplant community” (1995:366). Following this notion, it is useful to think of organ and tissue transplantation not only as a practice, but as a social community whose residents include multiple agents across space, time, and social positions. Veena Das (2000) discusses this in terms of the different and multiple genealogies of transplantation. Some of the most public members of this community include donors, both brain–dead and
living; donors’ families and friends; patients with life-threatening chronic illness; patients’ families and friends; and doctors, nurses, social workers, and other members of medical teams on various hospital units. But it also extends beyond those situated in more visible central neighborhoods to those that are more hidden, whether by privilege or by oppression. These include pharmaceutical companies and their investors, as well as the impoverished kidney-sellers, unscrupulous creditors, and organ ‘brokers’ of places like Chennai, as documented by Lawrence Cohen (1999), along with all the other players who together sustain an underground global market in organs (see Schep-Hughes 2002a,b). Conceptualizing the transplant enterprise as a community opens it up to ethnographic inquiry into the relations among its members, as well as into the types of ‘ideologies’ that sustain a level of coherence in the processes that (re)produce its infrastructures, flows, ordinances, and particular types of community members. Importantly, it also makes visible the stratifications and inequalities that persist between and among those residing in its various ‘neighborhoods.’ Further, the community metaphor is fruitful because it provides a space for including the notion of the political as a central tenet in an understanding of transplantation.

Just as communities engage in struggles with issues that persist even as times change, so it is also the case within the realm of organ and tissue transplantation. Many of the dilemmas raised in early writings about transplantation continue to evade resolution:

But one must, indeed, cut through a thicket of agonizing moral and legal questions spawned by recent medical advances in the organ transplant field. The proliferation of problems is a vast and continuing process. As dynamic forces on the
medical frontiers expand and explode, the lag in moral, ethical and legal concepts to match those advances has created an ever-widening chasm. In fact, progress in resolving the peripheral issues—those perplexing spin-offs from the transplant era—remains, in some instances, almost static. [Porzio 1969:17–18]

To a significant degree, Ralph Porzio’s words from 1969 are as contemporary-sounding as ever. But it is important to add sociocultural issues to the list of questions spawned by organ transplant. Further, these issues are not peripheral, but integral to the matter. A focus on the sociocultural aspects of transplantation also challenges Porzio’s implicit assumption that an expanding frontier of biotechnology exists independently from a society that must struggle to “keep up” with its advancements. Examining transplantation from a sociocultural perspective instead allows us to better understand how the practice is rooted in already existing cultural norms.

Linda F. Hogle (1996:680) has asserted that we must “[move] beyond studies that persist in maintaining the domains of ‘human body’ and ‘medical technology’ as distinct and medical practices as deterministic.” Building upon the idea that the present-day human body and medical technology are intricately connected, I suggest in the following section that much of the classic theoretical medical anthropological literature on the body can capably guide our efforts to document and better understand transplantation. Later, I will argue that medical anthropological perspectives on organ transplantation can help us to better understand (and address) the human suffering, inequalities, and other social justice concerns that the practice reveals, and potentially ameliorates or exacerbates.
Transplantation and the body

Much of the unease expressed by medical anthropologists regarding organ transplantation centers around the idea that it can entail rather extreme forms of body objectification and commodification (e.g., Cohen 1999, 2002; Hoge 1996; Joralemon 1995; Schep-er-Hughes 2002a,b). Efforts to increase the supply of transplantable organs often follow one of two modes of promotion: that of altruism or gift-giving, and that of individual rights or property rights (Joralemon 1995). Both of these can be considered forms of objectification of the body and its parts. As Sharp notes, “a key aspect of the ideological focus on altruism is that it is deliberately designed to teach recipients to objectify their new organs as gifts. Transplant professionals work aggressively to desensitize recipients to the idea that these gifts bear any emotional or other qualities that they might associate with their donor” (1995:369). Sharp goes on to argue that these actions reveal ideological contradictions as the language and euphemisms used in the transplant process (such as “procure” and “gift of life”) are designed to simultaneously depersonalize the transplant process and avoid hinting at the commodification of body parts. Yet, as Schep-er-Hughes (2002a,b) and Cohen (1999, 2002) point out, the objectification of the body through the commodification of its parts could not be more literal in many cases. Both authors cite case examples in which organs are bought, sold, and at times, even stolen.

Hoge (1996) has studied the ways in which materials from the body are prepared and transformed into therapeutic tools that are then employed to extend life. This notion of bodies—as tools sits alongside the writings of Donna J. Haraway (1991) and others (e.g., Dumit and Davis-Floyd 1998) regarding the idea that the present-day human body is a “cyborg,” that is, a human-machine
The use of biotechnologies to transform human tissues and organs into bio-tech tools for the purposes of transplantation provides further illustration of body objectification. However, Hogle’s comparison between the United States and Germany demonstrates that procurement practices and transplantation do not inevitably involve outright objectification of the human body. Instead, context and circumstances surrounding transplantation play a significant role. Thus it may be more accurate to say that transplantation and its accompanying practices entail the *embodiment* (see Csordas 1990) of a world in which body alienation and objectification are sociocultural norms in some contexts but not in others. Organ and tissue transplantation may signal not so much a retreat of the human shape of things (see Schepers-Hughes and Lock 1987:23), but rather a re-working of the human shape of things.

Similarly, Donald Joralemon (1995) argues that both the ideology of altruism and that of individual rights in organ transplantation are *suppressing*, not replacing, traditional concepts of the embodied self. He compares this to the way in which immunosuppression drugs suppress the rejection of the transplanted organ, but can never completely eliminate the potential for rejection. This supports the idea that analyses of transplantation can offer profound commentary on the lived world of experience (or what Csordas 1990:36 has called “perceptual phenomena”). As donors and recipients “embody” a world in which transplantation is relatively common, I suggest that the importance of finding instances of body objectification and commodification is not so much that body objectification and commodification in themselves take place, but that they can be indicators of larger structural inequalities and forms of human suffering.

A 2003 study among adults with cystic fibrosis who were transplant recipients illustrates some of these points. Karen Lowton
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(2003:1363,1364) found that some interviewees openly spoke of organs as “spare parts,” “recyclable,” and “replaceable.” Lowton proposes that this active objectification and commodification of organs can be explained as a “practical way of dealing with the transplant process” (2003:1363). She also suggests that adults with cystic fibrosis might be more comfortable with “objectification” of the body due to having lifelong extensive experiences with biomedicine. Yet Lowton also presents evidence that her interviewees do not fully consider their bodies as objects, nor do they completely separate their notion of ‘self’ from their notion of ‘body.’ For example, a number of transplant recipients in her study attributed their own bodily survival pre– and post–transplant to sheer will and a positive attitude (Lowton 2003:1361–1362). The important lessons to learn from these patients who simultaneously hold up and tear down mind–body dualisms, and who report experiences representative of both body objectification and embodiment, might have less to do with whether or not bodily commodification or objectification is happening, and more to do with the roles played by different forms of human suffering (and resilience).

A particular analytical tool that is useful for better understanding these issues is Schepers-Hughes and Lock’s (1987) notion of “the body politic.” In developing this theoretical construct, Schepers-Hughes and Lock assert that societies tend to “reproduce and socialize the kind of bodies that they need” (1987:25). There are numerous examples of the production of particular types of bodies at all stages of the transplant process. The next section of this essay will build upon the notion of ‘the body politic’ as it articulates with evidence about transplantation that has been gleaned from a variety of sources and disciplines. The reader will notice that the body politic is conceptualized as a mechanism that is part

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of the larger social order, through which social processes can act with and upon its constituents to (re)produce itself. Thus, by better understanding the body politics of transplantation, we might be better equipped to address the forms of human suffering that accompany it.

The reader also will note below that transplantation is depicted as a chronological process through which organs are passed from donors to recipients. Framing transplantation in this way is not intended to focus excessively on the organs themselves, portraying them as if they were the actors moving through the chronology, instead of on the lives of the numerous persons involved in each transplant. Rather, following Arjun Appadurai (1986) and others (e.g., Hutchinson 2000; Marcus 1995), it can be worthwhile to analyze the social trajectories of material things as a tool for understanding human relationships. Appadurai has noted that “even though from a theoretical point of view human actors encode things with significance, from a methodological point of view it is the things in motion that illuminate their human and social context” (1986:5, emphasis in original). Further, by analyzing transplantation from donation to post–transplant life, I hope to reveal common themes regarding the body politic as areas where related social justice concerns might be most salient.

**Donation**

Transplantable organs currently come from both living and ‘brain–dead’ persons, and anthropologists have documented ways in which the bodies of both donor groups are shaped by the practice of transplantation. Lock (2002), for example, has theorized the creation of the category of brain death as being inextricable from its relationship with organ transplantation. Through the general
acceptance of the idea of brain death in North America, there is the literal production of bodies who fill a ‘need for’ or ‘shortage of’ useable organs for transplantation. Along these same lines, Jonalemon has asked, “are we prepared to think about the cadaver in more material terms because of its increasing medical utility for others? What significance does this have for our understanding of death?” (2000:225) The production of brain–dead, cadaveric organ–donor bodies takes place within an already-existing system of knowledge, values, technologies, and techniques, that exists within a socio–historical context that is unique to areas of the world that are often referred to as “the West.” Lock (2002) illustrates the distinctiveness of this Western phenomenon through the comparative case of Japan, where brain death and organ transplantation are highly contested and viewed with suspicion.

The production of brain–dead donor bodies takes place through the performance of multiple actions, primarily by medical teams, employing not only specialized tools and technologies, but also knowledge, experience, and clinical skills. For example, tremendous medical efforts are focused on the production and maintenance of appropriate physical bodily states in brain–dead donors’ bodies in order to keep the organs healthy and usable. As Hoge found in her research: “Donors were clinically managed in the intensive care unit (ICU) in much the same way as were ‘live’ patients who had sustained major head injuries, the primary goal being to maintain oxygenation and fluid balance” (1995:484).

But first, the critically ill or injured patient’s status must be transformed into that of a cadaver through the use of confirmatory tests that signal the absence of brain function. Indeed, “technology reveals death in a more decisive way than does the body itself” (Lock 2002:242). Lock also notes that, “complete unanimity about criteria and tests for brain death does not yet exist, although there is
much more uniformity than there was in the 1970s and 1980s” (2002:237). Yet, as Hogle (1995) argues, ‘standard’ protocols must always be carried out at the level of local practice. Because the work object of medical practice is the human patient, organ transplantation is a site of tension as the medical community strives to create and follow standard guidelines for non-standard situations (Hogle 1995:483). There is evidence of resistance, then, at local levels of practice, against efforts to mould bodies into exact, standardized tools to fulfill the needs of organ transplantation.

Thus the body politic here is a contested domain where struggles that are particular to transplantation mirror those of the larger socio-cultural, political context. Not only is there a creation of a new category overall, the brain–dead body, but there also is a fine-tuning in the delineation and creation of the particular types of brain–dead bodies that are appropriate types of persons to produce useable organs. In this case, the production of ideal donors is carried out through the selection of donors based increasingly on behavioral attributes and moral status, as opposed to objective ‘scientific’ criteria. Hogle (1995) noticed the use of social history in her own observations:

A rather remarkable example was a call about a potential donor reported to have been a lesbian. This caused an intensified concern with obtaining results of an HIV test and tests for other sexually transmitted diseases before continuing the placement effort. When I asked the reason for the extra concern, I was told it was because she engaged in homosexual activity and was therefore ‘riskier’ as a donor. I put this question to others in the organization and was told the same thing:
‘homosexuals are higher risk in general’ and ‘we just need to be more cautious of people who engaged in that behavior.’ This is one case where practice flies in the face of scientific facts, as lesbians have a lower incidence of sexually transmitted diseases and are among the lower risk groups for HIV/AIDS. [1995:488]

Conversely, Hogle (1995) also found that dire life circumstances or situations are sometimes cited as reasons not to deny donor eligibility but rather to promote it, even when standard criteria would define the donor as a rather poor candidate. In this way, lives that might otherwise be considered worthless can be transformed into something of use or value (Hogle 1995:494); that is, into the gift of life itself.

This notion of salvaging otherwise worthless lives runs throughout the processes surrounding the procurement of organs from living donors as well. Cohen (1999, 2002) and Scheper-Hughes (2002a,b) have documented the commodification and sale of organs by poor people around the world. Here, organ transplantation and globalization converge to produce bodies that can serve as a steady supply of organs as desperate persons agree to vend their body parts, sometimes lamenting that they have but one kidney to sell (Cohen 1999:138). Those who advocate the organ market do so under the assertion that a win–win situation is created in an exchange of one person’s surplus money for another person’s surplus kidney (Cohen 1999:143).

This reasoning bears resemblance to the transformation–of–worthless–lives logic. As the argument goes, the world’s poor should be allowed to cash-in on what resources they do have even if those resources are their own organs. In this globalized, neoliberal
moment, perhaps organ transplantation exemplifies the body politic in that a global society creates the kinds of bodies it needs: independent entrepreneurs who are enabled to capitalize on the resources they possess (in this case, body parts). But it might also be viewed in this case rather as the *maintenance* of the bodies of international ‘others’ in oppressed, exploited, and impoverished positions. These positions already existed but have been exacerbated by the politics of global economic restructuring. This is not to say that the only persons who offer their body parts for sale are those living in the slums of India, South Africa, or other parts of the world. As Schepfer-Hughes (2002) reports, a couple living in one of the wealthiest counties in the United States approached the Organs Watch\(^5\) organization for help because they wanted to sell one of their kidneys in an effort to save their family business.

It also is not the case that all living donors are in the position for economic reasons. Of the more than 25,000 organs that were transplanted in the United States in 2003, 6,806 of them came from living donors, which marked an increase of 2.9% in the number of living donors over the previous year, larger than the 1.9% increase in the number of deceased donors (U.S. Department of Health and Human Services 2004:I-1). In 2004, another 6,990 of the transplanted organs came from living persons (U.S. Department of Health and Human Services 2005:I-2). Both years, most of the living-donor organs were kidneys (U.S. Department of Health and Human Services 2004:I-1, 2005:I-2). These cases of ‘above-ground’ living donation do not routinely involve outright monetary compensation, but as in organ donation from deceased persons, there also is evidence of body politics in ‘altruistic’ living donation. Sharp notes that, “the phrase ‘gift of life’ is…designed to evoke in potential donors the American values of humanitarianism, generosity, and altruism” (1995:370). In theory, the existence and widespread use
of transplantation as a way to stave off death makes just about everyone a potential source of life-saving body parts. This is especially so among the family members of the person in need of a transplant.

A case presented in the CBS documentary film, The Gift of Life, provides an illustrative (even if not so recent) example (Fine and Fine 1985). In it, the family members of a 16-year-old girl in need of a kidney transplant have themselves tested to see if one of them might be a suitable donor candidate. They find that the best candidate is the patient’s 15-year-old sister. The documentary goes on to follow the sisters through the operation and a short way into their post-transplant lives. Here, organ transplantation has transformed the healthy sister from a supportive sibling into a vessel which carries a lifesaving tool. In light of the magnitude of these contexts, the extent to which she actually has a choice in whether or not to give up one of her kidneys is in question. But the documentary explores neither this issue, nor that concerning the “inherently unreciprocal” relationship between the donor and the recipient, which Renée C. Fox and Judith P. Swazey have termed “the tyranny of the gift” (1992:40). Lock also notes the tremendous burden of responsibility felt by Japanese transplant recipients toward their living related donors: “If the donor falls ill, or if the transplant is rejected, even years later, then recipients experience overwhelming remorse and a sense of failure. Their bodies become tangible evidence of outright rejection of someone they love, who has made an unrepayable sacrifice on their behalf” (2002:334).

Interestingly, the percentage of living donors who fall under the “unrelated to recipient” category who are not the spouse of the recipient has increased steadily, occupying the second-largest percentage among living donors, at 21.3% (the largest was “full sibling,” at 27.3%) (U.S. Department of Health and Human Services
The 2004 OPTN/ SRTR Annual Report also notes that this increase in unrelated living donation reflects the fact that it has become possible to relax the criteria for tissue matching in recent years (U.S. Department of Health and Human Services 2004). This is due to improvements in immunosuppressant therapy for recipients, which has decreased rejection of organs transplanted between non-relatives. But greater ethnographic exploration is necessary regarding what the numbers concerning unrelated (and presumably sometimes unknown) non-spousal living donors actually mean, in order to answer questions about who such unrelated donors are and what their relationship to the recipients might look like.

**Supply and demand**

The 2004 OPTN/ SRTR Annual Report also notes that the organ transplant waiting list increased in size in the year before it was published: “As a consequence of the steeply increasing demand for transplants and slowly increasing supply of organs, the waiting list is getting longer and the waiting times for transplant candidates, which are already long, are getting longer” (U.S. Department of Health and Human Services 2004:1-2). According to the report, the number of patient waiting list registrations grew from 82,152 in 2002 to 86,355 in 2003, which marks a 5.1% increase (U.S. Department of Health and Human Services 2004:1-2). This increase signifies a number of phenomena. For one, it represents the idea that advancements in biotechnologies and pharmacology have made transplantation at least a theoretical possibility for many seriously ill persons for whom no further treatment could otherwise have been offered. But this possibility also signals a ‘need’ that previously did not exist. The ‘shortage’ of organs is a recently created phenomenon, based not on a decline in the supply of organs (to the
contrary, the supply has been increasing, as the 2004 OPTN/ SRTR Annual Report indicates), but on an increase in the demand for organs. Megan Crowley-Matoka (2005) has documented some of the ways in which the ‘desire’ for organ transplants (in this case, for kidney transplants) has had to be actively cultivated among persons in Guadalajara, Mexico who are initially hesitant to offer themselves up for the transplant procedure. Crowley-Matoka (2005:825) cites this as a contrast to the situation in North America, where the demand for kidney transplantation exists in absence of cajoling.

Yet, I would argue that U.S.–based marketing strategies (like the advertisements mentioned in the introduction to this essay) work to fuel the demand for organs and to normalize organ transplantation, depicting it as the best answer to the problems of serious chronic illnesses. This is congruent with ‘common sense’ notions that we in the West live in an individual consumer–oriented and ‘disposable’ society. The risk becomes, then, that extreme attitudes could gain footing, in which the expectation of the availability of transplantation might trump any emphasis on macro–oriented, preventative efforts to improve public health through better nutrition, a less toxic environment, and healthier activity levels. This is not at all to suggest that those in need of a transplant are to blame for their condition. Further, as will be discussed below, many chronic illnesses are not the result of behavior. But the marketing strategies used in organ transplantation in the U.S. do provoke critical questions about how transplantation might work with the body politic to foster conspicuous consumption, as opposed to preservation and conservation, even at the biological level of the body.

Schepers-Hughes writes about the expanding globalized disparity between supply and demand in organ transplantation:
I argue…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 latter 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. [2002:4]

Under this line of argument, the body politic is at work, creating and partitioning off more and more patients in need, while harnessing the power of oppression over anonymous poor organ ‘givers.’

**Waiting**

The widening organ deficit also creates a new type of time, a sort of suspended chronicity of illness, that of waiting for a lung (Lock 1995:391), a heart, a liver, a kidney, etc. When we look more closely at this notion of waiting, and who is waiting, we see that a significant qualification of Scheper-Hughes’s (2002) critiques of organ transplantation is in order. In the United States, unless one has the resources and is of the persuasion to arrange for a transplant via the underground market in organs, one usually must follow a lengthy and difficult path to transplant and post–transplant life. Not all persons waiting for an organ to become available for transplantation enjoy the privileges outlined in the above excerpt. Many of those on transplant waiting lists are persons with illnesses that have no
behavioral component to them. Further, scholars have convincingly argued that behavioral components to illness are better conceptualized in terms of structural inequalities (e.g., Farmer 2005; Marmot and Wilkinson 1999). In addition, the waiting time for an organ such as a liver can be lengthened by social circumstances. For example, relapses in substance abuse are often grounds for removal from organ waiting lists, as the majority of transplant centers have policies that require abstinence from substance use of any kind in order to remain under “active” status on the waiting list. But other factors, over which a patient may have no control, can also affect the wait time:

Changes in a patient’s medical or social status may result in the patient’s status on the list being changed to “inactive” for liver transplantation. During a period of time being “inactive,” patients will temporarily not be eligible to receive a liver until the issues have been resolved. Common reasons for an “inactive” status include development of infections such as pneumonia requiring antibiotics or new medical problems such as a heart condition that may increase the risk of transplantation. In addition, changes in insurance, relocation, travel, or family support may lead to temporary “inactive” status. [University of Michigan Transplant Center 2007, emphasis added]

Thus, the waiting process itself can present opportunities for sociocultural groups to “reproduce and socialize the kind of bodies that they need” (Schepet-Hughes and Lock 1987:25).
The process of getting *listed* as a transplant candidate (i.e., just being admitted to the waiting list) is in itself an example of body politics at work. One issue that is less frequently explored in the medical anthropological literature on organ transplantation is that of the criteria used for the selection of transplant candidates. This may be due to the emphasis that has been placed on ethical problems and social injustices in organ donation. On the one hand, opening up the possibility for ever–expanding echelons of people to be placed on transplant waiting lists creates the pressures and dangers of increased demands for organs, as outlined above. But on the other hand, restrictions to the listing of transplant candidates—depending upon the criteria used for determining transplant eligibility—can be another powerful form of maintaining and building upon already existing inequalities, of which health inequalities are just one variety.

**Organ distribution**

Patricia A. Marshall has noted that, “in anthropology the definition of a medical dilemma and its ethical resolution are seen as inextricably bound to broad cultural circumstances that influence health and illness behavior” (1992:54). Thus, our discipline is well–positioned to gain better insight into the selection process for transplant recipients, and organ distribution is a matter worth examining and critiquing in medical anthropology. I would argue that the value of this area of inquiry is not overshadowed by the injustices that have been documented in organ donation, but rather is an under–examined yet vital piece of an ethnographic view of the transplant community (described earlier) as a whole.

A number of studies have examined the public’s priorities and values in organ transplant distribution decisions (good examples
include Browning and Thomas [2001] in Australia, and Ubel and Loewenstein [1996] in the United States. But little of this has been ethnographic work, which is needed to explore how organ allocation actually happens ‘on the ground’ in real-life situations. In practice, decisions about the allocation of organs happen in two phases: (1) selection of transplant patients through their admission to the waiting list, and (2) distribution of organs to members of the waiting list as organs become available. I argue here that both stages are deeply infused with body politics.

Marshall (1992) attended weekly meetings of a Heart Transplant Team, where decisions were made about placement of patients on the transplant waiting list. She found that these decisions often were based on constructions of a patient’s character, which determined the patient’s worthiness to be listed or not. As narrative acts, these constructions were based on “inconclusive medical evidence—that is, data that could be interpreted either to support or to reject transplant approval—and an investment in the patient’s story (and character) on the part of a powerful member of the heart transplant team” (Marshall 1992:62). In this way, Marshall points to the idea that allocation decisions are thoroughly and fundamentally sociocultural endeavors: “cultural assumptions about the life-giving potential of organ transplantation and the deservingness of prospective recipients also influence significantly the resolution of ethical dilemmas that arise in the selection of transplant patients” (1992:61). This emphasis on the patient’s story also echoes Vinh-Kim Nguyen’s (2004) notions of biological citizenship and therapeutic citizenship. Volker H. Schmidt and Chee Han Lim (2004) found the case in Singapore to be quite similar. There, too, ‘personality traits’ such as propensity to lead a healthy lifestyle, to take care of oneself, and to contribute to society, while not having a criminal record or other indication that one might lack
self-discipline are among the unwritten biases that affect the allocation of organs (Schmidt and Han Lim 2004:2179). Although protocols differ globally by organ and medical setting, medical need—its a subjective notion—often is not the only aspect that comes into play.

Financial circumstances, too, can have a tremendous impact on whether or not a patient is deemed a suitable candidate for a transplanted organ. In order to achieve and maintain ‘active’ status on a transplant waiting list, a person must already have enough resources at hand to attend multiple medical appointments. The following list of financial considerations is provided on the University of Michigan Transplant Center webpage for Adult Liver transplant, but it undoubtedly would apply to other types of organ transplant:

While patients may have adequate health insurance coverage, there may be services their insurance will not cover, such as:

- Transportation to and from the transplant center for frequent follow up visits
- Temporary lodging and meals for family members during and after the transplant
- Parking fees for visits to the transplant center
- Insurance premiums, co-pays, and deductible amounts
- Possible loss of income while out of work for the transplant
- Child care.

[University of Michigan Transplant Center 2007]
This, of course, does not address the financial considerations of a person without some form of private or public health insurance, for whom transplantation is an unlikely possibility in the United States.

Current substance use or a history of past substance abuse can pose a formidable barrier to achieving active status on waiting lists; this is especially so in the case of liver transplantation. Policies regarding this differ from center to center, but it is common practice to require patients with current or past alcohol abuse to attend a rehabilitation program and abstain from alcohol for a certain period of time before they can be considered for transplant candidacy. On one level, this may be justified when we consider that alcoholism, for example, is a major cause of cirrhosis of the liver and therefore a need for transplant. As Schmidt and Han Lim (2004) note, in Singapore alcoholism is considered a contraindication for liver transplant for at least three reasons. First, alcoholics are seen as unable to be trusted and more likely to be non-compliant with post-transplant treatment. Second, it is thought that alcoholics will return to drinking after their transplant and quickly destroy their new liver. Finally, alcoholics’ chronic illness is considered to be self-inflicted and thus they should receive less priority than someone who has fallen ill through no fault of their own (Schmidt and Han Lim 2004:2178). Although Schmidt and Han Lim are writing for the case of Singapore, comparisons can be made to the United States.

Studies such as one by Paul McMaster (2000) indicate that patients with alcoholic liver disease who have had liver transplants actually fare equally well in the first ten years following a transplant when compared to patients who did not have alcoholic liver disease, which would run counter to the arguments posed above. In light of this evidence, all three reasons for considering alcoholism a
contraindication for transplant may be related more to moral reasoning in the context of the widely accepted notion of an organ shortage than to clinical criteria. Indeed, Schmidt and Han Lim (2004:2179) found that their respondents felt a responsibility to be stewards of the “precious” and scarce organs. This harkens back to the efforts at the donor stage to take care of the organs of donors, rather than to care for the person, once he or she has been declared brain-dead, as mentioned above. The search for worthy transplant recipients, then, is as much a search for fellow organ stewards as it is for persons in need of a transplant.

The second phase of organ allocation, that of ‘waiting,’ has been touched upon already in this essay, but I will say a bit more about it here. Waiting list policies and procedures differ from organ to organ and, to some extent, from transplant center to transplant center. The case of liver transplantation is an interesting and illustrative example because its allocation procedures have undergone recent changes. A new system, adopted by all transplant centers across the United States in 2002, ranks each patient on the liver transplant waiting list from 6 to 40 (UNOS 2003). A score of 40 signifies that the patient is at great risk of dying from liver disease within the next three months (UNOS 2003). The new system is called the Model for End-Stage Liver Disease (MELD), and it relies heavily on lab test results that indicate the biological severity of the need for a liver. Unlike previous systems, the MELD system does not give significant weight to the amount of time a patient has been on the waiting list, nor does it consider non–life threatening (even if uncomfortable) effects of liver disease in its calculation. Thus, while the decision about whether or not to admit a patient to the waiting list is a highly subjective enterprise in which individual personalities and the values of decision-makers can weigh heavily in the process, the final decisions about how livers are allocated
have been made more ‘objective’ through the use of numbers and lab tests. And yet, as Theodore M. Porter (1995) has argued, the pursuit of objectivity through reliance upon numbers (here, in the making of life–and–death decisions), is itself rooted in sociocultural processes and values.

**Receiving transplanted organs**

Patients who finally do receive transplants have often overcome formidable barriers to reach the point of post–transplant life. Usually the patient and his or her family and friends have extremely high expectations for life after transplant—or at least the expectation of the return to ‘normal life’—only to find that this time comes with its own significant challenges. Sharp argues that “transplants create new—or complicate existing—social relationships that affect how organ recipients assess their own social worth” (1995:360). She asserts that recipients must undergo the task of redefining themselves and their post–transplant identities as they negotiate what it means to have new organs inside of their bodies. In conjunction with the transformative experience of organ transplantation is the now very real and ever–present threat that the recipient’s own body will reject the grafted organ. To avoid this, recipients typically must take immunosuppressant drugs for the rest of their lives. The side effects of these drugs, combined with the often long recovery process following surgery, as well as the possibility that the grafted organ will fail to ever become fully functional, are such that transplantation can be thought of as trading one kind of chronic illness for another. Transplant, argues Crowley-Matoka (2005), creates a continuous liminal state for recipients and forces them to constantly hover between the statuses and roles of “healthy/productive” and “ill/dependent.”
J. B. Jones and M. Egan (2000) found that, of all concerns, economic issues were among the most salient for liver transplant patients over the long term. Immunosuppressant drugs currently can cost between US$2,000 and US$4,000 each month, and often are not covered by insurance (University of Michigan Transplant Center 2007). The drugs’ side effects, coupled with transplant complications, lapses in work history due to pre--transplant chronic illness, and stigma associated with illness and transplantation can make it difficult or impossible to hold paid employment (Crowley-Matoka 2005; Jones and Egan 2000). Consequently, rather than putting recipients back on equal footing, transplantation may in some cases actually work not only to maintain but to widen social and economic disparities. Thus, post--transplant life is also an area in need of greater and more intensive ethnographic investigation (Joralemon and Fujinaga 1997; Koenig and Hogle 1995).

Conclusion

As I have tried to show here, the concepts of body commodification and objectification offer important, but only partial, insights regarding organ and tissue transplantation. Scheper-Hughes’s and Lock’s (1987) notion of “the body politic” may offer a more comprehensive perspective on the practice that reveals social justice concerns in multiple sectors of the transplant community. An analysis of transplantation that uses the lens of body politics can widen our view to include donors, recipients, their family and friends, medical teams, pharmaceutical companies, and, significantly, their sociocultural and political contexts. It also can expose where poverty, oppression, inequality, and injustice exist at every stage of the transplant process. Thus, an examination of transplantation in terms of body politics also highlights the importance of integrating Paul
Farmer's (2005:17) ideas about structural violence, which have at their heart the argument that human rights abuses must be understood from the point of view of the poor. Farmer also asserts that “suffering is ‘structured’ by historically given (and often economically driven) processes and forces that conspire—whether through routine, ritual, or, as is more commonly the case, the hard surfaces of life—to constrain agency” (2005:40). Following these principles, the social justice concerns that are found in the context of transplantation are not separate from the injustices of the larger milieu in which it is situated. Farmer (2005) calls upon anthropologists to go beyond documenting injustices to actively working against them. As the interconnections between transplantation and its sociocultural and political contexts are better understood, our efforts toward social justice in one area can be better informed, and thus more effective in bringing about positive social change in the other.

Endnotes

1 Different authors use different terms to refer to “organ transplantation,” as I tend to call it throughout this essay. Lock (2002) uses the term “transplant enterprise,” and it seemed applicable here. Alternatively, Sharp (2000:303) uses the term “organ transfer” to refer to what she considers to be the three distinct realms of organ donation, procurement, and transplantation; and Fox and Swazey (1992) use the term “organ replacement.”

2 Many thanks to the anonymous reviewer of this paper who pointed this out to me.

3 Although the use of stem cells and xenotransplantation to supply transplantable organs remains only at very experimental stages today, it is very possible that these or similar technologies could someday supplant current techniques and sources of organ donation.

4 This is actually a rather complicated matter, as there are distinctions to be made between “whole-brain death” and “brain-stem death,” upon
which I will not elaborate here. For an in-depth analysis of this, see Lock (2002).

5 Organs Watch is a Berkeley–based organization of anthropologists, human rights activists, physicians, and social medicine specialists that investigates and documents the global context of organ transplantation (http://sunsite3.berkeley.edu/biotech/organswatch/index.html).

6 For an example of one such substance abuse policy, see the University of Michigan Transplant Center website (http://www.med.umich.edu/trans/public/), regarding the Adult Liver Transplant Process.

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