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INDIAN ORGAN TRADE

FROM THE PERSPECTIVE OF WEAK CULTURAL RELATIVISM

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Abstract

The topic of this study was the Indian organ trade. It was assumed that the research literature on the Indian organ trade is dominated by a human rights discourse (HRD), which restricts analysis. The purpose was to examine whether thinking outside the HRD and taking a stance in weak cultural relativism could create a better understanding of the underlying causes of the Indian organ trade. Using discourse analysis the Indian reality was included and conceptualized as the 'inequality poverty discourse' and discussed in relation to the HRD and to organ trade. The aim was to aid in creating a diverse basis for solving the problem of organ trade. Research questions posed was: How does the HRD influence research literature on the Indian organ trade? What other causes and explanations can a stance in weak cultural relativism unveil, and which alternative solutions can be contributed to the problem of organ trade? Using empirical evidence from Bangalore it was shown that the literature was restricted by the HRD. The study concluded that organ trade cannot be stopped by legislation based in human rights, but can be countered by scientific medical studies, by providing alternatives to organ sale and by strengthening the media.

Contents

1 Introduction

Due to advances in medicine and surgery, organ and tissue transplantation has been transformed over the last 30 years from an experimental procedure performed only in highly developed countries to being a therapeutic intervention carried out in hospitals and clinics around the world[1]. The shortage of available organs has created a thriving global organ market in which kidneys are the most traded commodity. A combination of poverty, a significant level of inequality, and an all-pervading corruption makes India a fertile ground for this trade. At one end, there is an abundance of desperately poor people who see the sale of a kidney as a possibility to raise cash, and at the other end, there are rich patients in need of a kidney and some of the world's best medical facilities to perform the actual operations. The trade in organs was prohibited in 1995 by law in many of the Indian states, but the trade, having gone underground, continues to flourish[2].

This study originated in seeking an answer to the question: "Why do poor people continue to sell their kidneys when it has such negative effects on their health and economy, as shown by Goyal (2002)?" However, when confronted with the situation in the field the study took a change in direction. It became clear that the literature unanimously proposed only one solution to organ trade: namely, a ban on the basis of violations of universal human rights. The literature[3] was found to be dominated by the Human Rights Discourse (HRD), which adopts the view that human rights are universal and fundamental in nature and not grounded in any specific culture, and of which organ trade is a violation.

Whilst in the field, in Bangalore, the capital of the South Indian state Karnataka, I was confronted with a completely opposite solution, namely legalisation of the organ trade. I found that what I call the Inequality/ Poverty Discourse (IPD) is very powerful in India, and that this discourse is a counter- discourse to the HRD. It became clear that the universal human rights, referred to by the HRD, had not penetrated the Indian society to any great extent. The components which make up the IPD are a high degree of segregation, inequality, corruption and poverty. In opposition to the HRD the view on human life in the IPD is relative; humans are not equal, but exist within an hierarchical order, with hierarchal rights and duties. The problem arises when the solution *–to ban the trade*,

[1] For a thorough historical analysis of the commodification of the body, see Sharp:2000
[2] See for instance Ghosh: 2005.
[3] The Bellagio Task Force: 1997; Cohen: 1999 and in Shepher-Hughes & Wacquant ed. 2002; M.D. Goyal: 2002; Patel, Trupti 1996

proposed on the basis of human rights – is inadequate due to the conditions in the society in question. Furthermore, the research literature lacks practical guidelines for how the total ban can lead to an actual stop to the trade of kidneys. I believe that it is when solutions are tested practically, the inherent weaknesses become apparent. The fact that the organ market continues to grow is proof that legislation is not sufficient to stop the trade. We have to start thinking contextually and take into account the socio-economical and cultural features of the societies in which the trade takes place.

1.1 Assumptions and Research Question

I postulate that the literature fails to create workable solutions, as it is dominated by the HRD and that it does not take the forces of the IPD into account. I believe that in order to create workable solutions to complex phenomena, it is essential to have as full an understanding of the various factors that contribute to the problem as possible. Therefore, the purpose of this study is to examine if thinking outside the HRD, by taking a stance in weak cultural relativism, which includes cultural and socio-economic conditions under which the trade takes place, can create a fuller understanding of the root causes of the organ trade. The aim is to aid in creating a more diverse basis for generating solutions to the global problem of organ trade. The guiding research questions are:

- **How does the HRD influence research literature on the Indian organ trade?**
- **What other causes and explanations can a stance in weak cultural relativism unveil, and which alternative solutions can be contributed to the problem of organ trade?**

1.2 Delineations

The phenomenon of organ and tissue trade is global in nature. As this is a case study of the trade in kidneys in the South Indian state Karnataka, the analysis is consequently limited to this. This study does not claim to assess the distribution of the discourses in Karnataka but merely demonstrates the existence of the HRD and the IPD and gives some examples of how these discourses have influenced practices at various levels in important ways. Furthermore, it must be noted that the field work took place in an urban setting and is consequently limited to this.

1.3 Design of the Study

In order to trace the two discourses' interactions with and influences on Indian society, I have chosen to do a qualitative study using case study method. The empirical base was constructed in Bangalore, the high–tech capital of India; situated in the South Indian state Karnataka. Bangalore was chosen because I wanted to find out if a stance in weak cultural relativism could unveil

underlying reasons for the organ trade other than the ones found in the literature. I therefore followed in the foot steps of the authors of the current research literature on organ trade. Case study method is used because it is well–suited for the study of complex phenomena and processes (Alvesson & Skjöldberg 2000) such as human rights and organ trade. Moreover, case study method and the qualitative interview have the advantage of using two sources of evidence, namely direct observation and systematic interviewing (Yin 1984).

1.4 Empirical Base: Liability and Validity of Data

My primary data consist of interviews with doctors from the nephrology departments at two hospitals, a journalist from The Hindu newspaper, a law professor, a government official, 8 related donors[4] – 5 women and 3 men, and 18 women living in the slum.[5] In addition to interviews I use the following written sources; the legislation on organ and tissue transplant, two court transcripts from Madras High Court, and various newspapers and journals.[6]

The contact with the doctors, the government official and the law professor was obtained through my supervisor at ISEC (Institute of Social and Economic Change), Professor R.S. Deshpande. The hospital KANTI (Karnataka Nephrology and Transplant Institute) was chosen on the basis of both Cohen (1999 and 2002) and newspaper and journal articles covering the organ trade. The journalist was selected on the basis of having been on the team covering the "kidney scams" in the national newspaper The Hindu and the journal Frontline.

The contact with the related donors was obtained through the help of the directors and staff at KANTI. The basis for the selection was that they resided in or just outside Bangalore and were English-speaking. One problem with this selection is that I did not have access to the patient lists and therefore I cannot verify that my data is representative even for this hospital. However, from the

[4] A related donor under the Indian legislation is defined as spouse, son, daughter, father, brother and sister.
[5] I must here emphasise that having only used female respondents naturally has implications for the generalization of the constructed data. Please consult the Field Work Report for an explanation of why no men were included.
[6] The articles were selected on the basis of an open internet search using the words "kidney" and "trade". Articles from the Hindu and Frontline were the ones covering the trade most extensively in Karnataka and are also the ones referred to in the literature. Extensive notes were taken during all interviews, and as a rule they were written up immediately after the interview was over. Due to the very sensitive nature of organ trade all interviewees were guaranteed anonymity and I only give their gender and age. In addition some of the respondents wanted to remain anonymous; in these cases I only give the title. The interviews were semi-structured with both open-ended questions to closed questions such as age, housing, etc. The interview guide to the interviews with residents of Munivenketappa Garden was designed to give multiple entries into the subject of kidney trade and the interviews were therefore guided by the information the respondents supplied.
[6] Ranging from 1997 – 2005. Please see the bibliography for the ones included in this study.

interviews with the doctors at KANTI, I got the impression that they portrayed themselves as being highly responsible and successful. I therefore have reason to believe that they chose the most positive, reflective and informed donors for me to interview.

The slum district – Munivenketappa Garden in Ulsoor – was selected on the basis of newspaper articles and because of its proximity to KANTI, as I hoped to locate people who had sold a kidney. This was not successful. The initial contact to the respondents was obtained through the help of a local NGO called FIDES (Family Integral Development and Education Scheme), and then snowballing was used in the district.

Snowballing has inherent problems with the representability. However, since neither the press nor the government official I interviewed had been able to locate kidney sellers because hospital records were false, this was the only possible way to locate the donors. One might claim that this limits the validity and the extent to which generalisation from the empirical material is possible in the final analysis. However, as Yin points out, the concept of generalisation in the case study is not related to populations or universes but to theoretical propositions (Yin 1984). Furthermore, I argue that my empirical base is valid because my analysis is based in discourse analysis. This form of analysis increases the validity of the empirical base because it focuses on reconstructing the discourses per se and relating them to other discourses. Therefore there is no attempt to uncover any underlying "truth".

> … [B]ecause discourse is constitutive of the phenomena of interest, not merely a reflection of phenomena, it cannot serve as a route to the inner workings of mind or as a tool to reconstruct events. That is, in discourse we are dealing with a version, and it is this version that is important, not the inferences that we (cannot) make from it.
>
> (Wood & Kroger 2000)

In discourse analysis the focus of analysis is precisely what is presented as truth, why it is presented, and how it is accepted. Therefore, the empirical base of this study, which would have been problematic had I for instance attempted an analysis based in hermeneutics, becomes reliable precisely because the different interviewees and respondents eagerly portray different images according to their orientation.

1.5 Theoretical Stance

Contemporary debates on human rights focus on either one or both of two sets of dichotomies; universalism versus particularism, and individualism versus collectivism/ communalism (Schech & Haggis 2000). My focus is on the first dichotomy. On one side of the dichotomy we have the evolutionist approach of modernisation i.e. that once all societies have achieved a certain degree of development, culture will also develop and become better aligned with the liberal doctrine of human rights. The proponents of the evolutionist approach believe that human rights are grounded in human nature and are as such universal in nature and thereby applicable to all societies. On the other side there are the critics – postmodernists, cultural relativists and subaltern studies – who deny (as in other branches of the development debate) the evolutionist approach of modernisation. They claim that the major problem with human rights is the claim to universal application. According to the critics, human rights are an ethno-centric construct and as such they are particularistic in nature and have limited applicability[7].

I follow the view of the critics to some extent. I believe that human nature is relative and to some extent culture-bound and culture-defined. Therefore, the claim that human rights are universal is, in my view, the major weakness in human rights because it fails to acknowledge the need to take cultural and socio-economic aspects into account. Abdullah An-Na`im makes an excellent point:

> The proponents of universality need to understand the nature and dynamics of this process in order to develop appropriate strategies for the achievement of their objectives, instead of expecting affirmation of universality to emerge as simply "self-evident" or the inevitable outcome of national politics and/ or international relations. (An Na-`im "2003: 2)

In my point of departure for the later discussion I follow An-Na`im and Jack Donnelly (1993), who both adhere to weak cultural relativism, which states that culture is an *important* source of a moral right or rule, not the *sole* source[8]. It follows from this that dialogue is a precondition for constructing the universality of human right:

> [U]niversitality of human rights should be seen as a product of a process rather than as an established "given" concept and specific predetermined normative content to be discovered or proclaimed through international declarations and

[7] Under the impact of decolonisation, globalisation and postmodernism, the conception of culture as a homogeneous, integral, and coherent unity has gradually been abandoned or softened.
[8] See also An-Na`im: 1990

rendered legally binding through treaties. In fact, the idea of "discovery" or "proclamation" itself already implies a process, which requires certain actors, context, and other conditions that are conductive to success. If this is true, understanding the meaning and implications of the universality of human rights calls for an examination of the nature of that process, the role of the actors and context, and other relevant conditions (An-Na`im 2003: 2)

Adopting this understanding of human rights will provide for a more constructive foundation for putting an end to organ trade. It is insufficient to make solutions to organ trade based on a universalist understanding of human rights. The Indian peoples[9] are active participants in negotiating their lives, not silent bystanders. Therefore, if we are to put an end to the organ trade, we need to think more constructively and beyond the obvious answers – poverty and exploitation- and try to understand which other factors within the Indian society fuel and justify the trade[10].

1.6 Model of Analysis

With a stance in weak cultural relativism I propose to use discourse analysis in order to incorporate the Indian society into the analysis. I operate with two discourses; the Human Rights Discourse, which dominates the research literature and the Inequality/ Poverty Discourse, which dominates the Indian society. My model of analysis is inspired by Patrik Hall's (2003) "Diskursanalys av nationell identitet"[11]. Hall draws on Foucault and develops a two-phase model: Phase I *Describing the discourse* is strictly structuralist and concentrated on identifying the discourse and its parts. Phase II *The practical meaning of the discourse*, is concerned with relating the discourse to the reality in which it exists. Therefore it is important to investigate firstly, what the discourses that are active within the organised social relations that reproduce or produce a certain version of reality look like; secondly, to try to analyse how and why these organised social relations have been created, and which networks of "actors" create, sustain and change them. Hall follows Foucault quite closely by stating that a discourse is built up by relations between different discourses. Thus a discourse is an open system of representations, which is defined through its relations to something else. Hall states that discourses are both representations of reality as well as reality creating, and they are successful when they have been elevated to an ontological truth. Revealing the underlying factors of what seems to be ontological truths or primordial notions is precisely the overall objective of discourse analysis.

[9] Here I use the plural term to indicate that India comprises a multitude of different cultures and people.
[10] For an explanation of An-Na`im's constructive method of implementing human rights in a society please see An´Nain: 2003.
[11] Discourse Analysis of National Identity

Hall understands discourses as connected representations of reality which regulate what can and cannot be said about this reality. He follows one of the proponents of Critical Discourse Analysis, Norman Fairclough (in Wodak & Meyer eds. 2001), by adhering to a broad understanding of discourse. This understanding encompasses language and semiotics in the definition of discourse. Consequently the basis for analysis is widened and not only restricted to speech and text. This study follows the above definition of discourse.

The weighting of the two phases in Hall's model is not quite clear, but he states that only going through phase I is possible but not advisable because the actual analysis takes place in the second phase and would consequently be missed.[12] My focus is on phase II, but in order to have a basis for doing this, I will begin by briefly going through phase I and describing the discourses. Phase II is where I use my empirical material to trace how the discourses manifest themselves in Indian society. Hence my model of analysis is as follows:

Phase I: Describing the discourses in relation to the organ trade and to each other
Phase II: Tracing the discourses in the empirical evidence

1.7 Disposition

In chapter 2 I go through phase I of the analysis in respect to both HRD and IPD and show how the influence of the discourses form the conceptualisation of organ trade. In chapter 3 I begin phase II of the analysis using empirical evidence from the public sphere in Indian society. I analyse the legislation regarding organ and tissue donation, and show how IPD has had the power to transform the human rights intentions of the law to effectively making the poor more vulnerable. I analyse how organ trade is portrayed in the written media and show how sensationalism affects the media's role as the public's guard dog. My interviews with the doctors show how IPD influences the medical conduct and opinion of organ trade and give examples of causes of organ trade not found in the research literature. Finally, I discuss how the Indian gender inequality is mirrored in Indian society. Chapter 4 applies phase II to the empirical material from the private sphere represented by a group of related middle class donors and a group of residents of a Bangalore slum. Through data from these interviews I broaden the understanding of both why buying a kidney can be attractive and why selling a kidney may be an appealing choice. Additionally, I expand the understanding of

[12] For a more thorough description of Hall's analysis model see Hall: 2003.

why there is gender inequality within related organ donations. Chapter 5 presents the final discussion and conclusion.

2 Analysis: Phase I

This chapter contains phase I of the analysis: *Describing the discourses in relation to the organ trade and to each other*.

2.1 Human Rights Discourse

The main academic research centre into organ trade is situated at Berkeley University. In 1997 a working group, The Bellagio Task Force, wrote *Report on Transplantation, Bodily Integrity, and the International Traffic in Organs*, which addressed the commercialisation of organs from paid donors and the use of organs taken from living or dead prisoners.[13] The report resulted in an institutionalisation in the form of "Organs Watch", a human rights-oriented documentation centre which monitors and investigates organ trade issues. By creating this institution, members of the founding group – Professors Nancy Scheper-Hughes and Lawrence Cohen – have become the major recognised articulators of the HRD within academic research on human organ trade. The WHO is also a recognized articulator of the HRD as it recommends "…that any commercialization of organs should continue to be declared illegal and unethical"[14]. The WHO acknowledges that organ trade is permitted or not punished in many countries and that some philosophers, patients and clinicians would allow payment for organs, and therefore calls for further work are needed in order to understand the ramifications of programmes that permit payment for organs[15].

The academic research done on organ trade in India is limited to the above report and studies conducted by Lawrence Cohen: 1999 and 2002; M.D. Goyal: 2002; Patel, Trupti 1996. Additionally, the findings of this academic research have generated a multitude of discussions in various medical journals[16]. Cohen's and Goyal's research in India includes socio-economic aspects in the analysis, but only in terms of the negative effects of organ sale. Socio-economic aspects are not a part of the final analysis or proposed solution. The solution, proposed by the researchers in unison and based on human rights values is a ban of the trade. This common solution is, I believe, a strong indicator that the research is dominated by the HRD, which is so powerful that it prevents the

[13] 'The Bellagio Task Force: 1997
[14] WHO (2003): *Human Organ and Tissue Transplantation Report by the Secretariat.* EB113/14
[15] The WHO thereby fails to acknowledge that a proportion of the kidney sellers should also be included in this category.
[16] See especially British Medical Journal: 2001

researchers from thinking outside it. The research done by Organs Watch has a clear subaltern perspective explicitly posing the question "Whose voices are being silenced? (Scheper-Hughes 2002: 35)". However, by being dominated by the HRD, I believe, the researchers themselves silence some of the voices of the participants in the debate.

One example of what is left out of the HRD is provided by Cohen (1999), who narrates a story about interviewing a group of women who have sold a kidney in the clinic of Dr. K.C. Reddy. The story of these women is of a positive experience of selling with adequate follow up care and no reports of post–operative pain or negative impact on family income. As such their experience is in stark opposition to the conclusions of both Cohen and Goyal, but in accordance with reports from related donors in the West. Cohen could have taken up the positive experiences of the women in an open discussion, addressing the reality of the women and the very limited possibilities they have for raising cash and thereby providing a fuller understanding of why this choice appeals to them. However, Cohen keeps within the HRD using the example to enter into an academic discussion of the ethics of the trade, and of the agency of the sellers and rejects that this story can be used to advocate kidney trade. Cohen claims that because poverty motivates the women to sell the transaction cannot be deemed ethical. The problem here is that Cohen takes human rights for granted and applies general western ethics to a specific Indian example. Ethics, like human rights, are not universal, and thus Cohen discusses from a western academic standpoint. He fails to acknowledge that these women's circumstances are as per the IPD, and that their possibilities for raising money are very limited. Selling an organ and getting the required aftercare may be an attractive option for them in their current circumstances. Reducing these women's positive experience to an academic discussion, as Cohen does, is to exclude the Indian reality from the discussion. Firstly, we need to acknowledge that organ sale can be an appealing choice within Indian reality and secondly, we need to include Indian reality into the discussion in order to understand *why* it is appealing. I will do this below by elaborating on the characteristics of the IPD.

2.2 Inequality Poverty Discourse

Indian society is characterized by a high degree of inequality, poverty, corruption, and a highly segregating caste system. According to Stig Toft Madsen (1996) this segregation "means that some segments may maintain a high degree of self-determination or autonomy. This has implications for any project to promote citizenship rights and human rights in the sub-continent" (Madsen: 39). Furthermore, the caste system, which traditionally categorizes people into 4 overall hierarchically

organised groups with distinct duties and rights, has served to make Indian concepts of duties and rights particularistic.[17] In short, this means that Hinduism, by far the largest religion in India, is fundamentally unequal. Madsen describes the Indian society as being "[c]haracterized simultaneously by segmental autonomy and moral relativism" (ibid: 57).

The caste system is instrumental in creating a high level of inequality. In 1999/2000 according to the Human Development Index[18] India scored 32, 5 on the gini index indicating a high level of inequality. In my analysis, IPD is premised on segregation, corruption and widespread poverty. As such, IPD stands in direct opposition to HRD and thus serves to articulate resistance to HRD in the case of Indian society. The Indian State is characterised by corruption and rent seeking, and there is an overlap between of the civil society and the State[19]. As I will show in the following chapter, elite groups are able to pressure the State into making legislation that is favourable to them.

Gender inequality is another aspect of the IPD. This has many manifestations; the reverse sex ratio, dowry deaths, significantly lower female adult literacy to name a few.[20] This inequality is reflected in both organ trade and in organ donation. More than 80 % of the organs are donated by women whereas 65 % of the recipients are men[21]. One of the reasons is that one of the components of the IPD is a patriarchal social system, under which the husband is *perceived* as the main bread winner of the family, and therefore the wife's income considered supplementary. Moreover, women's work is *perceived* as being easier, less skilled and less important. By perceiving the work of women as secondary to men's, the patriarchal family structure is maintained. Additionally, the impact of organ trade and organ donation on the female body, in terms of the risks of surgery and subsequent loss of capability to work, are perceived to be minor compared that on the male. In phase II of the analysis I will discuss how gender inequality is reflected in organ trade and organ donation.[22].

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[17] Post-modernists have shown that prior to the arrival of the British the caste system was more fluent than today. The divide and rule policies of the British and the academic discipline Orientalism cemented a relatively fluent social system into a fixed law. Especially the surveys of the colonial government and the interpretation of indigenous laws were instrumental in this. For more on this subject see for instance Said, Edward W.: 1978*;* Breckenridge, Carol A. and van der Veer, Peter eds. 1993

[18] The HDI – human development index – is a summary composite index that measures a country's average achievements in three basic aspects of human development: longevity, knowledge, and a decent standard of living. http://hdr.undp.org/statistics/data/cty/cty_f_IND.html

[19] See for instance Evans: 1995.

[20] See for instance Olsen: 1996.

[21] The Hitwada *Organ Transplant: Women are Major Donors* New Delhi, October 14th 2004

[22] Unfortunately it is beyond the scope of this study to go further into a discussion of gender inequalities in India. See for instance Sridharan, Indirani: 2000

2.3 Discussion and Summary

Figure 1: Position and Themes within the Discourses below shows the recurring themes in the inter-discursive dialogue, and illustrates how the orientation and conceptualisation serve to create not only opposing solutions to organ trade but also gives examples of how facts are reformulated differently depending on the discourse under which they are used.[23] I use the model as a point of departure to illustrate features of the two discourses.

Figure 1: Position and Themes within the Discourses

Nr.	Themes	Human Rights Discourse	Inequality Poverty Discourse
1	Orientation	Sellers	Recipients
2	Politically correct	Yes	No
3	Attitude towards health hazards of donation	Serious health hazards for poor people	None, the donors claim that just to get more money
4	Effect on sellers	Negative	Positive or none
5	Attitude towards cadaver based transplant system	Possible, especially due to the high rate of accidents in India, but requires education of the public and medical personnel.	Not possible due to culture-bound concepts of brain stem death and poor infrastructure
6	Success rate of live vs. cadaver transplant	Almost the same	Significantly lower
7	Dialysis as a solution	Yes, one can live a good life on dialysis	No, only transplant is a cure
8	Attitude towards The Act, 1995	Negative, it exploits the poor as it enables them to sell, but gives them no protection or anywhere to complain.	Negative, it prevents people in need of a kidney gaining access to one
9	Attitude towards the exploitation element	They are forced to sell due to the socio-economic reality and inequality	No one forces them to sell
10	Attitude towards middlemen	Negative, they exploit the poor. Kidney sale is always exploitation	Negative, they should be eliminated and the role taken over by the Authorization Committee
11	Major argument	The sale of any body part is unethical and should always be rejected	No one should die of kidney failure if someone else can benefit from selling a kidney
12	Human Rights issue	To buy an organ from a person is a violation of that person's human rights.	The ban is a violation of the individual's right to do with his body what he wants.
13	Solution	To stop the trade and develop a cadaver based transplant system and give the poor alternatives	To legalise and control the trade

Fig. 1: Haagen 2005

I find it especially interesting that facts are bent in different ways within the two discourses. If we consider no. 4, 'Effects of the sellers', we have the postulate from the HRD that the effects are negative and from the IPD that it is positive (due to monetary gain) or neutral. I believe that this is an expression not only of the discourses' orientation but also of the fact that currently there are no scientific studies on the effects of removing an organ from a poor body.[24] I believe that scientific studies will facilitate a more informed discussion within and between the two discourses.

[23] I must emphasize that by setting up this dichotomy I exclude the standpoints that are between the discourses. Therefore, the figure should not be perceived as being exhaustive, but rather illustrative of the extremes within the two discourses.

[24] "Where appropriate medical care is available, the risks associated with live nephrectomy are low but not negligible – in addition to operative complications; they include long-term risks of failure of the remaining kidney. No reliable data are available on the risks to living donors in low-quality facilities with poor clinical services" WHO: 2003

Another example is no. 6, 'Success rate of live vs. cadaver transplant', which within the HRD is claimed to be almost the same, whereas within the IPD it is significantly lower. According to the WHO live kidney transplants do produce better results, but cadaver transplants are preferred because inherent risks for the donor are avoided.[25] Here we see a manifestation of the orientation of the two discourses: within the HRD concern for the donor is included and consequently a positive phrasing is used; within the IPD this concern is excluded and hence the phrasing is negative. This in turn has an impact on no. 13, 'The solution', where the cadaver based transplant system is proposed within the HRD but a legalisation of the trade within the IPD. No. 8, 'The attitude towards The Act, 1995' is negative within both discourses but again the orientation within the discourses determines the reasons why.

The human rights orientation gives the literature an orientation towards organ sellers, whereas the IPD's relativist perception of humans gives an orientation towards the recipients. This orientation has wide-reaching effects on how the problem of organ trade is conceptualised. Within the HRD the problem of organ trade is conceptualised as an exploitation and violation of the human rights of the poor. This demands a complete rejection of the trade. Within the IPD the conceptualisation revolves around the problem of organ shortage and therefore serves to justify the trade. I t is important to recognise this fundamental difference between the orientation of the two discourses, because it is one of the main reasons why legislating against organ trade is inadequate. The orientation towards the recipients and an exclusion of the poverty-afflicted sellers is an expression of the relativist notion of human rights within the IPD. Therefore the desire to perform kidney transplants with purchased kidneys is not solely founded on a desire for monetary gain, as it is claimed within the HRD.

I will now turn to phase II of the analysis *tracing the discourses in the empirical evidence* and elaborate on how a foundation in Weak Cultural Relativism can create a broader understanding of the causes of the continued trade in organs.

[25] According to WHO "In case of kidney transplantation, the use of organs from live donors produces better results medically than material from deceased donors"(Ibid.). However, WHO recommends the use of deceased donors because "…a broader range of human material can be obtained and because the risks and burdens inherent on a living donor are avoided" (ibid).

3 Analysis: Phase II –The Public Sphere

In this chapter I will focus on the public sphere of Indian society, as represented by the legal framework, the media and the medical society, respectively.

3.1 The Legal Framework

In 1995 Karnataka State passed The Transplantation of Human Organs Act, 1994 (The Act)[26] and The Authorisation Committee (AC) was set up to administer the law. The law was drafted because India did not have a comprehensive legislation to regulate organ removal. The main objective of the law is "to enact a comprehensive law for regulating the removal and transplantation of human organs by providing punishment for such dealings"[27]. The objective is consistent with the HRD, but the many loopholes in the law, makes it open to implementations which are consistent with the IPD.

Section 9.3 of The Act permits unrelated organ donation "… by reason of affection or attachment towards the recipient or for any other special reasons" and is often referred to as the major problem of the law. According to Dr. Sudarshan, member of the AC, The National Human Rights Commission and of Karnataka Lokayukta[28], and also according to various articles in Frontline[29] section 9.3 has been widely abused to facilitate organ trade. The recipient and the seller get the approval of the AC by fabricating a story of close relationship when it is actually a trade.[30] Dr. Sudarshan recognises that there has been a problem with corruption and a bias towards the recipients in the AC, but even when The Act is administered properly, and dubious transplant applications are dismissed, pressure from the political system can also be a problem:

> We get so much pressure. The patients and the doctors go to the Chief Minister to complain. Therefore Karnataka Lokayukta has educated the Chief Ministers so that they know that no one dies from renal failure; dialysis is a perfectly safe option. There is also a lot of pressure from the ministers and it is a question of educating them – People with a lot of influence also need to be educated[31].

The Act which has a clear human rights orientation is being transformed within the IPD because of corruption and the connections of elites groups. This is supported by Professor Nagaraj from The

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[26] The Transplantation of Human Organs Act, 1994
[27] The Act, 1994: p. 3
[28] An ombudsman institution.
[29] See for example: Frontline Vol 19: no. 7, March 30 – April 12, 2002 *Features in the 1994 Act*
[30] See the example of how this Section is misused in the quotation from the Madras High Court below on page 18
[31] Interview with Dr. Sudarshan October 11th 2004

National Law School of India, who states that "The holes in the law have been built in on purpose in order to serve the interests of elites"[32].

A further problem is that The Act is non-cognisable (The Act: Section 22). This means that the police can not launch an independent investigation into a claim of organ trade, but have to wait for action to be taken by The Appropriate Committee[33]. According to Professor Nagaraj[34], a law is made non-cognisable when either a) there is no urgency or b) when the legislators want the juridical magistrate to control the investigation. Normally, when a law is non-cognisable a private person and the police can go directly to the Juridicial Magistrate, who can then launch an investigation. But under this law, the Juridical Magistrate has to wait 60 days for the Appropriate Committee to do its own investigation.[35] This impedes swift investigations of complaints of organ trade, thereby weakening enforcement of the law.

The Act is also problematic from the gender inequality point of view. Due to the very weak position of women in Indian society, including spouses in the category "related donors[36]" (who do not require the permission from the Authorisation Committee), is very problematic. It must be remembered that organ transplants in India are performed by the private health care sector, and therefore it is only available to the middle- and upper classes. Hence this discussion only pertains to this group of women. According to a recent PhD thesis conducted by lecturer Anju Vali Tikoo at Delhi University[37], there is a gender misbalance in the statistics of Delhi hospitals. More than 80 % of the organs are donated by women whereas 65 % of the recipients are men. The proposed solution is to exclude spouses from the 'related donors' category, but this solution is in my opinion inadequate. The Act states that any decision to donate an organ must be taken without any pressure or coercion. This pressure referred to come from family, friends and medical personnel, but fails to take the reality of the Indian society into consideration, the reality I refer to as the IPD. Middle class women in India generally live in dependency relationship with their husband.[38]. Consequently it is

[32] Inteview with Prof. Nagaraj October 25th 2004
[33] This is another regulative institution set up by the state Government under this law to ensure that that transplant hospitals are up to standards and to investigate any complaint of breach of the law (Section 13)
[34] From the National Law School of India
[35] Interview October 25th 2004
[36] Besides spouse the category includes son, daughter, father, brother and sister.
[37] The Hitwada *Organ Transplant: Women are Major Donors* New Delhi, October 14th 2004
[38] For a discussion on how in the lower middle class the wife's income is continued to be perceived as supplementary under the patriarchal dominance please see Kibria, Nazli: 1995 For a discussion on the emancipation of poor women through work in Tamil Nadu India please see Sivakami M.: 2002

in the wife's best interest to donate, thereby ensuring future family income. She may not be coerced by her surroundings as such, but by her general weak position within the Indian society, and so she does not have much choice. Therefore, even if spousal donations were to be approved by the AC, I do not believe it would change the statistics significantly.[39]

The final major problem with the law is that since the organ trade is banned (The Act: Section 19) the poor are not able to complain anywhere if they are cheated by doctors and middlemen, because selling a kidney is a violation of the law and is punishable with 2 - 7 years imprisonment and a fine from Rs. 10.000 to Rs. 20.000. The High Court of Madras[40] has examples of this. In a case from 2003 where a kidney seller approached the State Human Rights Commission to obtain the remainder of the money he was promised for his kidney:

> The State Human Rights Commission has no jurisdiction to entertain the complaint of M.R. Balasubramani (donor). Since Section 19 of the Act makes it clear that no Donor of his kidney can claim payment of money. Further, in his affidavit dated 13-12-2001 sworn in the presence of the XXI Metropolitan Magistrate, Egmore, Chennai-8, the donor has specifically stated that "there was no monetary consideration". (…) He also points out that since the complainant – M.R. Balasubramani (donor) has prayed for payment of the balance amount of Rs. 1,05,000/- (Rs. 1,50,000 – Rs. 45,000 = Rs. 1,05,000/-), which is prohibited under section 19 of the Act, the same cannot be taken note of and enforced by the State Human Rights Commission.[41]

Based on the findings of M. D. Goyal (2002) which shows that kidney sellers on an average are given 1/3 less of the price that was agreed upon, this is likely to be a true complaint. However, as the transaction is illegal the court can only dismiss the claim. In this way the HRD has indirectly served to weaken the position of the poor. One might object that the law is for all to follow – also the poor, but as Professor Nagaraj points out "[a]s the situation is now, the poor are forced out of poverty to sell their one kidney, so as long as the conditions of the poor are not alleviated, there is no need to talk about values, such as it is wrong to sell a kidney"[42]. This is an expression of the debate of conflicting systems of value within the human rights debate, which in relation to organ trade is expressed by the fact that the right to economic security conflicts with the right to bodily

[39] For a discussion of the concern for spousal donations see also Bhowmik, Dipankar et.al.: 1999
[40] Tamil Nadu has also passed The Transplantation of Human Organs Act, 1994
[41] Writ petition Nos. 40101 and 41806 of 2002, W.P.M.P. NOs. 59587 and 61806/2002 and WvMP No. 393/2003, section 4 and 11
[42] Interview October 25th 2004.

integrity.[43] Professor Nagaraj proposes a legalisation and regulation of the trade, but this solution is rejected by Dr. Sudarshan: "It is a human rights violation and it is against our constitution, which forbids suicide. For a poor person to sell a kidney it is suicide. The solution is to guide these people to employment. The government has so many poverty alleviation programmes. Selling a kidney is not a solution"[44]. Dr. Sudarshan here points to a central feature of the IPD namely that the poor do not have adequate alternatives to selling a kidney. As I will show below, to sell a kidney is a last resort, and therefore giving the poor alternative options would most likely serve to bring down the number of kidneys for sale.

3.2 Media

The media has been instrumental in creating awareness of kidney trade and theft in Bangalore. In 2002 reporters from The Hindu, Karnataka launched an investigation into the kidney trade because there were reports about organ trade continuing despite being banned in 1995 and about widespread corruption in the Authorisation Committee[45]. Dr. Sudarshan gave reporters from the Hindu and the affiliated journal Frontline access to records of the AC that are normally inaccessible to the public. He was thereby instrumental in bringing out the problem of the Act and of corruption in the public.

The series of articles from Frontline and The Hindu[46] can be divided into two overall groups both of which have a clear human rights orientation. The first is focused on analysing problems with the law, corruption in the AC and the underlying reasons for the very weak cadaver programme. The articles *Features of the Act 1994*, *Popularising the Programme*, and *Options before Kidney Patients* are illustrative of this group. The second group consists of exposure stories covering the element of scandals. Examples are *Murder and Kidney Commerce*, *A Case of Organ 'Theft'* and, *A Racket in Karnataka*. According to N. V Anandraman (in C. J. Nirmal ed. 2000), who has made a case study of Tamil newspapers, most newspapers are interested in sensationalism[47]. The impact of these two groups on public debate differs. Whereas the first group of articles has served to create awareness of

[43] See Schech & Haggis: 2000 for a discussion of conflicting systems of value within human rights.
[44] Interview on October 11th 2004
[45] The Authorisation Committee is a regulative body set up under the 1995 Act to ensure that all unrelated kidney donations are in accordance with the law.
[46] See the bibliography for a list of the articles I have used in this study.
[47] Even though I am not using vernacular language newspapers, I believe that especially the element of scandal evident in the Hindu are similarly found in the newspapers read by the poor segment of the population.

the problem, the second group has created fear and mistrust among the poor towards the medical society.[48] This will be exemplified in the following chapter.

The attitude towards The Act is clearly negative in the articles. The solution to the problems with the legislation is to pressure the government to making the law cognisable and to make data from the AC publicly accessible. This would function as a counter-weight to the political pressure on the AC to approve dubious applications.[49] This solution is supported by N. V Anandraman (ibid.), but he points out that since the media is primarily interested in sensationalism, there is a lack of follow-up enquiries: Therefore the media does not live up to its role as the public's guard dog public and does not utilise its power to pressure the government.

3.3 Medical Society

Karnataka Nephrology and Transplant Institute (KANTI) is one of 8 centres that provide nephrectomy (kidney transplants) in Bangalore[50]. According to evidence from Frontline there are strong indications that KANTI has performed transplants on patients who gave the AC false information regarding the relationship with donors.[51] Like Dr. K.C. Reddy (see page 12), the directors[52] openly advocate organ trade as a win-win scenario in the context of local conditions, and claim that if a donation is approved of by the Authorization Committee then they have no right to refuse the donation.

KANTI is a medically well-reputed centre and have very clear information on kidney transplant both on the internet[53] and in the form of an information brochure: *What you Should Know about Kidneys and Kidney Diseases*, which is given to all recipients. The brochure consists of 39 questions/answers. Out of these only 5 concerns the donor and 2 are official disclaimers that it is possible to buy a kidney. The brochure gives a good description of the procedure for the recipient, but the procedure for the donor is completely absent. This is puzzling because the operation on the donor is comparatively much larger than the one on the recipient. According to the directors "It is a

[48] The poor do not read English language newspapers but it is clear from my interviews with the poor that the stories printed in vernacular language newspapers are similar to the ones published in The Hindu.
[49] Interview with Parvathi Menon on the 5th of October 2004.
[50] I also talked to doctors at Chinmaya Hospital, and they were much more cautious talking about organ trade, but there was a similar orientation towards the recipients.
[51] See for instance Vidya Ram *Data Sources and Insights*, Frontline, Vol. 19, issue 7, 2002
[52] In the following I refer to the directors in unison as opposed to naming every one specifically because they all participated in the discussions, and voiced the same opinions and attitudes as well as substantiated and supplemented each others' stories.
[53] www.kanti.com

major surgery; we have to remove one rib, which will not be reinserted, and to cut open a muscle. The donor is in this way made into a patient"[54]. As I will discuss below, the acknowledgement that the donor is transformed from a healthy person to a patient is interesting because this conflicts with the directors' non-commitment to the checking up on donors.

Regarding the effects donor's health the brochure states that "Several scientific studies conducted world-wide have proved that kidney donation is safe, if performed at a reputable centre" (page 13). One problem with this statement is of course that the scientific studies are not specified and that it is only a true statement if adequate post-donation care is provided for. The brochure states that donors should be followed up annually for the rest of their lives. In addition to the brochure the recipients are given an additional paper, which emphasises that they have a responsibility for the donor's follow-ups. It is stated that KANTI can reject recipients if they do not observe follow up of their donors**.** It is quite unlikely that any recipients have been or will be rejected on this basis because KANTI's directors deny having any responsibilities for these follow-ups. When asked if donors are contacted when they are due for check ups I got the answer: "No we only contact the recipients. They are the ones who brought the donors, so they know where they live"[55]. There is a striking difference in between the care provided for the recipients and donors.

It is clear that KANTI is oriented solely towards the recipients. When I asked about the stories that donors have become ill after donating, the directors became very agitated and it was obvious that they had been through this question before: "Do you know this guy Lawrence Cohen? He came here and had already made up his mind. When the donors complain afterwards it is only because they want more money – that is why they say there are complications. It is exploitation by the poor. You actually forget the recipients in all this"[56]. This quote brings up several issues for discussion.

First of all there is the anger/frustration towards the scholar Cohen, which can be seen as a clash between the IPD represented by the directors and the HRD represented by Cohen. According to Cohen (1999) he conducted a series of interviews with the directors in 1998 wherein they constantly deflected his questions regarding donors. In discussing the directors' non-commitment to donors Cohen refers to information obtained from Dr. K.C. Reddy who accuses the directors of having

[54] Interview October 4th 2004. In comparison the operation on the recipient only involves a small incision through which the new kidney is inserted. The failed kidneys are left in the abdomen.
[55] Ibid.
[56] Ibid.

served as procurers of organs in Chennai. Cohen thus constructs the directors as being motivated solely by economic gain. By doing this Cohen shows how HRD limits his understanding. If we return to the last sentence in the above quote "You forget the recipients in all this", and in another statement by the directors' "When you deal with patients every day, it makes you change your mind [about organ trade]"[57], we see another part of the explanation of organ trade namely the directors' bias and sympathy towards the recipients. This motivation should not be overlooked as it forms part of the directors' positive attitude towards organ trade and thereby also constitutes a part of the solution. On a similar note a suggestion to stop the practice of personal interviews at the AC was put forward at a workshop in National Law School of India. It was suggested that decisions should instead be based solely on written documentation, because seeing the ill recipients put "enormous pressure on them to clear the applications"[58]. The problem is that at present there are no scientific studies into the effects of organ donation on the bodies of the poor[59] I believe that scientific studies will generate less bendable facts and thereby provide the opponents and proponents a common ground for the discussion of organ trade. M.D. Goyal's study is the largest study on organ sellers in India, and does not include any medical tests on the kidney sellers. The study can as such only be perceived as strongly suggesting there is a problem, but does not prove it scientifically.

The final element of the quote that I want to discuss is "When the donors complain afterwards it is only because they want more money – that is why they say there are complications. It is exploitation by the poor." It is interesting how the directors here take the main argument from the HRD "organ trade is exploitation of the poor" and reverses it by claiming that it is the poor who are the exploiters. This again shows the directors' sole concern for the recipients, and is also a denigration of the poor. It is an extreme example of the IPD, as it is a complete rejection of even the possibility that there might be some truth to the concerns about organ trade. The directors believe that "unrelated donations are the solution for India"[60].

But let me here return to the gender element which I touched upon above in section 3.1 *The Legal Framework.* The directors acknowledged that there is a problem with coercion: "Whenever I am talking to a family and say they should go for transplant, I do not look at the mother because everyone in the family immediately look at her. If that is not pressure, I do not know what is. How

[57] Ibid.
[58] Parvathi Menon *Against the Organ Trade* in Frontline Vol. 19, issue 10: 2002
[59] See for instance WHO: 2003
[60] Interview October 15th 2004 See also Reddy, K.C.: 1993

can she possibly withstand that if she for some reason does not want to donate – what if she is scared of the operation?"[61] I would like to add that it is not only in relation to the category of "spousal" that there is a problem, but also in relation to the category "mother". That mothers are more likely to donate to their children than fathers is not a unique Indian phenomenon, but a common feature of donations worldwide.[62]

3.4 Discussion and Summary

In this chapter I have shown that in having a basis in weak cultural relativism, I have been able to identify causes and explanations for the organ trade other than the ones found in the human rights-influenced literature. I have shown that the IPD has been so strongly manifested in the drafting of the law that it has actually served to weaken the position of the poor while at the same time facilitating organ trade for the elites. I have found that the general gender inequality within IPD is mirrored in the legislation, but I have also shown that this feature is not unique to India, thereby opening up the discussion on why there is gender inequality within organ transplantation[63].Within the media I have identified two groups of articles and found that there is a clear human rights orientation, but that sensationalism has caused the media to neglect its role as the public's watchdog.

I have shown that the research literature on organ trade, by being dominated by the HRD, constructs a perception of the doctors who advocate kidney trade, as being solely motivated by monetary gain. Accordingly, one of the components of the positive attitude towards organ trade, namely the concern for the recipient, is excluded and the basis for constructing workable solutions to organ trade is weakened. I have also shown that the doctors, under the IPD, demonstrate a fundamental disregard for not only potential poor sellers but also of related donors.

4 Analysis Phase II – The Private Sphere

I will now move on to the private sphere beginning with interviews with the related donors and finishing with the interviews with residents of the slum Munivenketappa Garden. These two groups come from the middle and the bottom of Indian society respectively. In relation to organ trade the first group comprises the potential buyers and the second group the potential sellers.

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[61] Interview October 4th 2004
[62] See for instance Scheper-Hughes & Wacquant eds.: 2002
[63] Unfortunately it is beyond the scope of this paper to undertake this task.

4.1 Related Donors

The group of respondents consist of eight related donors; four wives, two mothers and two husbands with family income of Rs. 18.000/ month on average.

As I discussed above in sections 3.1 '*The Legal Framework'* and 3.3 '*The Medical Society*', related organ donation is characterised by gender inequality. In both of the cases where husbands donated to their wives there were objections from their families and friends, and this added to the stress felt by their wives: "I am so happy that my husband is fine. If something had happened to him, I would have to answer to his family"[64]. This concern was not expressed by any of the recipient husbands. In all the instances where a woman donated, she was the first choice: "The first choice was obviously the mother, the brother, and then the father"[65]. It was considered the "natural" choice for the woman to donate, based on her being the mother or wife and therefore obliged.[66] Love for the recipient was also a reason, and this factor has to be taken into the analysis as it forms a part of the motivation for organ donation. Nevertheless, this love does not account for gender inequality in donations. This "natural choice" can be seen as an expression of the IPD having become an ontological truth, and therefore not even questioned by the women themselves. In one case where a wife donated to her husband, the family objected because due to her husband's illness, she had become the sole bread winner of the family. This indicates that she, through work, had achieved the same status as the one of the male donors.

Three of the eight families admitted having tried to buy a kidney, and their motivation was to protect their immediate family from the risks of surgery. To translate this concern into a disregard for the bodies of the poor will only give us part of the explanation. My first nuance is the element of love, which I again must stress, must be included, as it constitutes the major reason for wanting to buy a kidney. Secondly, I believe that the issue of buying a kidney is complicated by the fact that it is possible to donate a kidney safely and that doctor repeatedly assure families of this. In this understanding, the potential risks associated with a kidney sale can be compensated for with money and thus a win-win situation is created.

[64] 46 year old wife who received a kidney from her husband
[65] 65 year old mother
[66] However, these women may have had an interest in preserving a positive self image by claiming that they themselves decided to donate, and therefore would not volunteer information about coercion to me.

4.2 Residents at Munivenketappa Garden

The group of respondents consist of 18 women and three men. Average family income amongst the respondents was Rs. 2800/ month.

In the interviews two concepts regarding the kidney surfaced; a holistic energy-centred body concept; "If you give your kidney, you will not have energy to work. It is like half your life has been taken away –half of your energy gone away" [67], and an ownership concept: "It is your kidney. Why should you give it? It is different with blood – that you can give when it is needed urgently. The kidney we should not sell."[68] That the two concepts co-exist in Indian society can be seen as an expression of a society in the phase of modernisation. The ownership concept was also an expression of a "reversed" human right, namely the right to decide over ones own body. For the Indian poor the body constitutes the main means of raising money. Selling an organ is therefore an extension of a normal way of utilising the body for survival.

Only two of the respondents claimed that they would sell a kidney: "If there is a situation and it is the last resort, then you can sell it"[69]. Thus, selling a kidney is not a first option, but within the IPD selling a kidney is a possibility for raising money in an emergency. It is a reflection of the limited possibilities these people have. It may not be a first choice, but it is an option when there are no others. This we have to include in the analysis because it constitutes the reason for why poor people sell their organs. Providing other options such as micro-finance loans, better salaries and more employment opportunities comprise a segment of a constructive way of eliminating organ trade.

The high awareness regarding the negative health effects of selling an organ came primarily from television and newspapers. This information was not neutral, but was closely connected to scandals. This kind of media coverage spread fear among the respondents: "You know, when I was in the hospital, I was put to sleep, and when I was falling asleep, the doctors showed my mother the kidney tray – that is what they call this tray, because of the shape – but I thought they will take my kidney. I got so scared. When I woke up in the morning, I was crying and crying and crying and shouting: "You have taken my kidney, you have taken my kidney'"[70]. The predicament of needing hospitalisation and the fear of having an organ stolen are further expression of the insecurity that

[67] 30 years old woman
[68] 32 year old woman
[69] 42 year old woman
[70] 27 year old woman

characterises the lives of these people. Theft of organs is the most recent expression of the exploitation of the deprived section of Indian society, and is also in their own "reversed" human rights understanding a grave violation, because they are robbed of an essential part of their most valuable asset - the body.

4.3 Discussion and Summary

In this chapter I have shown that love is an aspect of organ trade and organ donation that must be included in the analysis. With regard to the gender aspect of related donations, I have shown that love is the major motivation for donation, but I have also shown that gender inequality can be seen as a manifestation of the IPD, which is so strong that the women themselves do not question being the "natural first choice". I have given one example of a woman who was no longer the first choice because of her status as sole bread winner of the family. Therefore, in order to correct the gender inequality within organ donations, the general gender inequality within Indian society needs to be addressed. Furthermore, I have shown that the wish to buy a kidney is motivated by love and justified by the belief that it is a win-win situation, which is based on the fact that organ donation can be safe. Therefore translating the wish of buying a kidney into disregard of poor bodies will only give a partial explanation.

I have shown that the kidney is understood under two concepts; a holistic energy-centred body concept and an ownership concept. I have interpreted the ownership concept as having a reversed human rights understanding i.e. the right to decide over ones own body, and I have shown that this body is the main asset of the poor. Further, I have explained that under the IPD, selling a kidney may be the sole option for raising money, and can be understood as an extension of a normal way of utilising the body for survival. I have shown that the fact that poor people are deprived of options for raising money under the IPD must be given consideration as it is the major motivation for wanting to sell a kidney. Further, this understanding opens up for a more constructive approach to solving the problem of kidney trade as alternatives to selling a kidney can be implemented.

I have shown that the sensational orientation of the media has added to the insecurity under which the poor people live, thereby worsening their existence under the IPD and failed in utilizing its power to pressure the government.

5 Conclusion

In this study I have taken a stance in weak cultural relativism, and used discourse analysis and case study method to examine how the HRD influences research literature on the Indian organ trade. I examined whether this approach could unveil other causes and explanations for the organ trade and thereby provide alternative solutions. I included cultural and socio-economic factors by conceptualising them as the IPD and I compared the attitudes towards organ trade under this discourse to those under the HRD. My study revealed that the opposing orientation of the discourses determines how organ trade is conceptualised and determines the solutions proposed.

I found that the influence of the HRD on the research literature has restricted the understanding of the causes of organ trade, because cultural and socio-economic factors have been excluded. These constitute part of the explanation as to why selling an organ can be an appealing choice in the Indian context. The study has shown that selling an organ is a last, and not a preferred option for raising money, but that the sale of an organ constitutes a much needed option for raising money. Thus it is an extension of the normal way of utilizing the body for survival by the poor, and legislating against organ trade can be perceived as a violation of the "reversed" human right; to decide over ones own body. Therefore, providing the poor with alternatives to organ sale constitutes part of the long-term solution to organ trade.

I have shown that the doctors, under the HRD, are perceived as being solely motivated by monetary gain. Using empirical evidence, I have broadened the understanding of doctors' motivations for advocating organ trade. I showed that in addition to a non-commitment to donors, and a rejection of claims concerning negative effects of selling a kidney, doctors have a great concern for the recipients that serves to justify the trade. Similarly, this study has shown that the wish to buy a kidney cannot only be translated into a disregard for the bodies of the poor, but must also be understood in the context of love for one's own family, and that the fact that organ donation *can* be safe serves to create a win-win scenario, wherein the potential hazards of organ selling can be compensated for by money. I have proposed that scientific medical studies into the effects of selling an organ in the Indian context, would firstly, create the basis for a common ground between the discourses, and thereby facilitate a more constructive debate than the current one, and, secondly, challenge perceptions of organ trade as a win-win scenario. Furthermore, the study has shown that the media need to take its role as the public's guard dog more seriously. Doing this the IPD can be countered and the government pressured into dealing with organ trade more thoroughly.

It has been found that the gender inequality within related donations is a reflection of the general gender inequality in Indian society. Therefore, dealing with the root causes of the Indian gender inequality is the solution to the gender inequality within organ donations.

This study has only dealt with domestic Indian organ trade. However, the organ market is not restricted to India, but forms part of an international network of organ and tissue trade. Therefore, I would like to encourage the reader to consider how his/ her own country participates in the organ trade. In my country, Denmark, organ trade is prohibited by law. Nevertheless, when a patient travels to another country and buys a kidney, the Danish state provides the necessary after care free of cost. Is it not a problem, that Denmark, and many of the other countries, which pride themselves of complying with the Universal Declaration of Human Rights, in this way facilitate organ trade? Do we not have a responsibility?

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