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Spring 2012
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Following the Organ Trail:
An Analysis of the Underground Trade in Human Organs and the Factors
That Sustain It

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Abstract

Innovations in the field of transplant medicine have revolutionized our perceptions of the body and our willingness to accept its limitations. Transplantation has become a beacon of light for persons suffering from organ failure. However, most national allocation systems devised to find donor matches lack the capacity to procure enough organs to meet demand. For some of the wealthy and desperate patients left waiting for an organ, purchasing one on the black market becomes a viable solution. The commercial trade in human organs and the proliferation of organ trafficking thrive off of scenarios like these; yet the simple principle of supply and demand that they demonstrate hardly explains how the organ trade has grown into one of the largest global underground economies. This paper examines the other pressing factors that affect the capacity for the trade to flourish, focusing more narrowly on ethical dilemmas, cultural issues, legal infrastructure, and the process of commodification. Utilizing interviews and analyzing literature produced results indicative of an interdependence of given factors and a need to see them in a more comprehensive manner than is currently treated by the existing literature.

Keywords: organ trafficking, transplant tourism, organ trade, commodification, underground economy

Word Count: 18,165

Table of Contents

1 An Introduction to the Commercial Trade in Human Organs	5
1.1 Examining How the Trade Functions	5
1.2 Concepts Defined	6
2 Methodology	8
2.1 Creating the Research Plan	8
2.2 Qualitative Methods	9
2.2.1 Interview Approaches	9
2.2.2 Problems With Open-Ended Method	10
2.3 Minor Case Studies	11
3 The ‘Who, What, Where’: Logistical Considerations	13
3.1 Estimating the Value of the Trade	13
3.1.1 Distribution of Funds	13
3.2 The Geographic Extent of the Trade	14
4 Cultural Considerations	17
4.1 Social Status	17
4.2 Religion	18
5 Legal Framework	20
5.1 What Does “Illegal” Really Mean?	20
5.2 International Documents	20
5.2.1 The Declaration of Istanbul on Organ Trafficking and Transplant Tourism	20
5.2.2 The World Health Organization and World Health Resolution 57.18	21
5.2.3 International Prioritization	22
5.3 National Policies	23
5.3.1 National Organ Procurement Schemes	24
5.3.2 Opting-in: the USA	24
5.3.3 Opting-out: Spain	25
5.3.4 The Legalized Market: Iran	26
6 Theoretical Considerations	28
6.1 Commodification	28
6.1.1 The Biovalue of Our Bodies	30
6.2 Ethical Dilemmas in Classical Medicine	31
6.2.1 Treating Returning Patients	31
6.2.2 Determining the Cessation of Life	33
6.3 Corruption	34
6.3.1 Defining Corruption	35

6.3.2 The Medicus Case: Kosovo	35
6.3.3 The Netcare Case: South Africa	37
6.3.4 The Rosenbaum Case: the USA	39
6.4.5 The Red Thread	40
7 Conclusion	41
7.1 Where Does This Leave Us?	41
7.2 Proposed Solutions	41
7.2.1 Compensation	41
7.2.2 Legalization	42
7.3 Final Remarks	43
8 Executive Summary	45
9 Bibliography	47
10 Appendix 1	54

1 An Introduction to the Commercial Trade in Human Organs

1.1 Examining How the Trade Functions

In as much time as it takes for someone to book a chartered vacation package to spend a summer holiday basking in the sun, a similarly “all-inclusive” medical tourism package can be brokered offering the high-paying recipient a functioning organ and the procedure required to transplant it. The illegal and unethical processes of procuring, harvesting, and transplanting human organs for profit have gained attention in recent years as the number of donors and recipients worldwide increases, resulting in major profits to the underground economy. Gruesome and exploitative in nature, the trafficking of organs, as well as the practice of trafficking in persons for the removal of organs, is a troubling practice that merits further international and domestic attention. However, with little data available on the profits and dynamics of the trade, and as a result of contrasting opinions on how to combat the illegal trade, the welfare and humanity of those on the supply end of the chain, the donors, continues to be compromised.

Rather than viewing the lack of hard data on the illegal organ trade as a roadblock, we can look at it as a proverbial detour, one that forces us to examine other pathways of obtaining information, by asking how the trade works both within states and internationally. The first questions to spring to mind typically express a desire to know what is considered organ trafficking, who is trading organs, and perhaps most puzzling of all, how and why does a trade like this exist? What void is this filling or what purpose does it serve? After asking these questions time and again to myself, I have found that the most explanatory one worth answering helps to simultaneously answer the others. *What makes the illegal trafficking in human organs such a viable and flourishing trade?*

The process of answering this question will produce research that is expansive yet focused enough to encompass all aspects of the subject. Literature written about international human organ trafficking and transplant tourism focuses on the aforementioned violation of human rights, as well as supply and demand economics, poverty, bioethics, societal and cultural attributes, corruption and the commodification of body parts. These major themes can be viewed essentially as crutches upon which the trade stands and flourishes. Yet, these themes are often treated separately in the literature, and it is therefore difficult to say which bears more influence on the viability of the trade. Further frustration regarding the literature is born from the feeling that certain subjects are given more attention, such as poverty,

human rights, and the concept of supply and demand. It is my intention, therefore, to acknowledge the role that these three ideas play in correlation with the organ trade, but to showcase the equal bearing that other given themes have by discussing them more extensively. Initially, this paper was to be written from the viewpoint that corruption was the most influential factor in fueling the trade in human organs. That position has since changed. The trade is far too complex for such simple conclusions to be made in its regard. By focusing on the role of society and culture, corruption, commodification, and ethics, in the context of the greater picture, the paper will shed further light on the multiple threads that weave this intricate picture, while at the same time offering new contributions to the subject at hand.

1.2 Concepts Defined

In order to proceed with further discussions, we need to clarify what the relevant terms are and how they are defined. According to the Declaration of Istanbul on Organ Trafficking and Transplant Tourism, organ trafficking is:

“[T]he recruitment, transport, transfer, harboring or receipt of living or deceased persons or their organs by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abused of power or of a position of vulnerability, or of the giving to , or the receiving by, a third party of payments or benefits to achieve the transfer of control over the potential donor, for the purpose of exploitation by the removal of organs for transplantation” (2008 p. 3375, 3376)

This definition encompasses two concepts that other formal bodies have treated as separate of one another: trafficking in organs and trafficking in persons for the purpose of removing their organs. The Council of Europe and the United Nations conducted a study in 2009 that declared that the former entailed a process of organ obtainment through coercion, which was followed by the transportation of the organ for the purpose of transplant. The latter observed the entire movement of the person as a coercive act (i.e. kidnapping) for the purposes of later removing his or her organs (Caplan et al. 2009 p.93). It is important to acknowledge the different treatments and definitions of “organ trafficking” by non-governmental and intergovernmental organizations; however, this paper will utilize the definition provided by the Declaration of Istanbul when using the term. The significance of the Declaration will be discussed at a later point, but in order to further clarify the terms of this study, we will make use of it once more in defining the term “transplant tourism”. Transplant tourism is the “practice in which an organ is treated as a commodity, including by being bought or sold or used for material gain” (The Declaration of Istanbul on Organ

Trafficking and Transplant Tourism¹ 2008). Organs are either purchased by living donors or, in more rare cases, extracted from dead bodies and then sold for purposes of transplantation (Panjabi 2010 pg.16). Some refer to this “second track” of the illegal organ trade as a form of “reverse trafficking” (Whitehead 2008 p.19). A person in need of an organ (most oftentimes a new kidney) pays to travel to a second country where there is a large market in human organs, receives an organ from a live donor, and has that organ transplanted into her or her own body (id.). Each aspect of the process is negotiated and paid for. Despite their differences, organ trafficking and transplant tourism are inextricably linked, and merit the same level of exposure and response. They redefine the body and its parts as material goods to be traded or sold, thereby making them commodities.

Travel for transplant can be legal, in certain cases, if a donor and recipient pair are related and can undoubtedly prove this relationship. If the pair comes from countries without efficient transplant procedures or if one crosses a border to donate to his or her relative, the travel may be appropriate (Budiani-Saberi & Delmonico 2008 p.926). Furthermore, organ-sharing programs between two or more countries that are officially regulated and based on reciprocity do not fall under the category of transplant tourism. Examples of this are the ScandiTransplant network observed by Denmark, Sweden, Norway, Finland, and Iceland, and the EuroTransplant network that encourages interaction between Austria, Belgium, Germany, Luxembourg, the Netherlands, and Slovenia (ScandiTransplant; EuroTransplant). These are legally established partnerships whose goal is to combat the incredibly problematic organ shortage within their member states.

The term “underground economy”, which is exchangeable with “shadow economy”, “informal economy” or simply the “black market”, is used throughout this paper to characterize the illegal nature of the trade in human organs. According to the International Monetary Fund, underground economies are illegal activities and “unreported income from the production of legal goods and services, either from monetary or barter transactions” (Enste & Schneider 2002). The most common examples given for an illegal underground economy are those involving activities like drug dealing and prostitution (id.). There is an observed link between high corruption in a state and the value of its underground economy, which will be addressed in a later chapter.

¹ Hereafter cited as “The Declaration of Istanbul”

2 Methodology

2.1 Creating the Research Plan

The inspiration for conducting this research came from a 2011 paper that I was assigned at Lund University, in which I attempted to use theory regarding new paradigms of violence and apply them to the illegal trade in human organs. The research was fascinating in an alarming, hard-to-fathom and, no pun intended, hard-to-stomach way. I became very familiar with the contemptuous yet witty tone of University of California Berkeley professor Nancy Scheper-Hughes, whose research and expertise in the field of organ trafficking and transplant tourism has spanned over a decade and has also led to the exposure and eventual arrests of criminals involved in the trade. I also familiarized myself with the work of Francis L. Delmonico, a world-renowned expert in the field of transplant medicine. Upon reading his articles dealing with ethics in medicine, I found myself in a position where I needed to step back and understand that this trade was significant for professionals in numerous fields of study. Scheper-Hughes' anthropology background and Delmonico's medical background allowed them to produce knowledge in regards to the organ trade that is met by the (sometimes) complementary work of experts from the fields of sociology, philosophy, political science, and criminal justice. I was deemed "over ambitious" in my initial attempt to link organ trafficking to new models of violence as characterized by sociologist Michel Wieviorka. This did not, however, discourage me, as I knew that within the foundation of that paper a great platform existed from which to spring into further, more profound research.

The basic understanding that I had established for how different interests and different perspectives affected the literature written on organ transplantation and the commercial trade in organs allowed me to look at documents in a more calculated, and considerate manner. I began researching by drawing from texts that I had used in my previous research, sans the literature regarding violence. After re-reading them, I felt a sense of gratification that verified my instinctual decision to pursue further research of the organ trade; however, this time the focus would be shifted. Instead of trying to view the trade as something that could fit within the constraints of a single, over-arching explanation, I would need to begin with a sort of tabula rasa, and let the literature guide me. Ultimately, that pathway led me to a point of wanting to know more in order to gather a sufficient amount of knowledge to answer a question that had been weighing heavily on my mind for over a year: how is it possible that the crimes that allow this dirty, shameful, and callous trade to exist can go unnoticed and/or unpunished? I realized that I wanted to know more about the "how" aspect of

the puzzle. In order to do so I would have to look at the most influential factors allowing the market to not only sustain but to prosper, from the perspective of theorists and researchers in all of the aforementioned fields. Just as an overly excited young artist incessantly adds to his or her breakthrough masterpiece turning it instead into an incoherent canvas, I realized that I could run the risk of taking on too much in my endeavor. Ultimately, I stand firmly in saying that this was not the end result. This chapter will provide a further overview of the methodological processes that allowed this paper to come to fruition, including the mistakes, and the lessons learned.

2.2 Qualitative Methods

One of the most difficult truths to circumnavigate when studying the organ trade is that there is a lack of concrete and reliable data. Due to the illegal and culturally stigmatizing nature of the crimes committed in order to obtain, buy, and sell these body parts, brokers, sellers, and recipients are not often willing to divulge figures or acknowledge participation in such activities. As is pointed out in a 2011 report published by Global Financial Integrity, “[...] illicit markets are, by their very nature, opaque and thus estimates are often based on insufficient data” (Haken p.11). A framework that implements quantitative methodology is therefore inadequate and would be incapable of creating valuable data to answer the research question. Rhonda S. Robinson and Wilhelmina C. Savenye define qualitative research as “research devoted to developing an understanding of human systems, be they small, such as technology [...] or large, such as a cultural system” (2004 p.1046). They state that this type of research has “several hallmarks” which include its involvement with “rich descriptions of human behaviors and opinions”. Additionally, it encourages the researcher to want to know more and to understand “what is happening”; this has an effect of changing the research question over time so that the focus is widened and less biased than it may have been in the beginning (Robinson & Savenye 2004 p.1046). Qualitative methods can include interviews, case studies, surveys, observations and document analysis (id.). Open-ended interviews, semi-structured interviews, an analysis of literature, and minor case study evaluations were employed to gather information.

2.2.1 Interview Approaches

After doing an exhaustive search of relevant and interesting literature, I came across a piece written by a professor of ethnology at Lund University, Susanne Lundin. The article entitled “The Valuable Body: Organ Trafficking in Eastern Europe” intrigued me as it discussed the development of the trade in post-Soviet countries, a geographical zone I had rarely come across in my research (2010). I realized after reading the text that its usefulness and insight could be compounded greatly by an

interview with its author. After a quick correspondence via email, Lundin agreed to host me for a short discussion one morning, during which time we could discuss my research as well as questions that I had. In preparing for this meeting, I now realize that it would have been wise to record the discussion; nonetheless, I brought a notebook with me in which I had prepared an outline of appropriate, intriguing, and open-ended points of conversation. These topics included the debate over the concept of brain death, the role of corruption in facilitating the trade, and cultural norms in regards to organ donation. This became the first of two “interviews” that we engaged in, and helped bring about the communication that I would come to have with my second interviewee, Frederike Ambagtsheer. Ms. Ambagtsheer works for the Kidney Transplant Unit at Erasmus Medical Center in Rotterdam, the Netherlands, and agreed to talk to me about her extensive research of organ trafficking as well as her role as coordinator for the Living Organ Donation Project in Europe (EULOD).

The interview with Ambagtsheer and the second with Lundin took on what Timothy John Rapley would characterize as a “(semi)-open ended interview” that makes use of “topic-initiating questions [that] introduce topics of talk on which the interviewer would like the interviewee to focus” (2001 p. 315). Rapley continues with a simple explanation of how the follow-up questions “provide the possibility to gain very detailed and comprehensive talk” that seek “to unpack” the earlier issues or what he calls “mentionables”. These mentionables become the resources for research and it is therefore the responsibility of the interviewer to maintain control in order to learn as much as possible about them. It was my goal to use these interviews from the position of “interviews as part of the answer”, as described by Andrew P. Carlin in his breakdown of interviews into three separate orientations. In the second orientation, quoted previously, interviews “cannot stand alone as a means to access the problem”, and an interviewer who takes this position will regard his or her interviews as “conduits to meanings and interpretations, as furnishing information or ‘data’ for study” (2009 p. 336). Carlin’s first orientation emphasizes that the interviews are part “of a larger project”; however, they differ from the second strategy in that the eventual data comes entirely from the interviews. The third views the interview as a process employing “collaborative language practices produced by the interviewer and interviewee” and uses the data obtained as “interactional products” (id.). Despite my frequent reference to them in the text as “discussions” or “conversations” the interviews are to be considered “information-gathering techniques” and not “collaborative interactions” between the interviewees and myself.

2.2.2 Problems With the Open-ended Method

These interviews were the second and third of four interviews total that answered my questions and also answered questions that I didn’t actually realize I was harboring. Using a more open-ended approach, I could follow the direction of the interviewee and proceed with follow-up questions in order to learn more. The fourth interview

was born out of a curious attempt to find out more about organ trafficking in North Sinai, Egypt. In the beginning stages of my research, my supervisor directed me towards two insightful, yet deeply disturbing documentaries. One of the documentaries follows an investigative journalist whose goal is to uncover human smuggling, torture, and the trafficking of human organs in Sinai. In an effort to expose these crimes, he meets with Egyptian human rights activist Hamdy Al-Azazy. Mr. Hamdy, as he has inferred I should call him, responded quickly to an email I sent to him inquiring about his organization and their efforts in North Sinai, as well as the abuse of human rights that has and continues to unfold in the region. He requested that I call him at my convenience. It was my initial emotional response to the documentary that inspired me to write Mr. Hamdy, and as a researcher I found myself entering a grey area in which my subjective thoughts and feelings would undoubtedly reveal themselves during the interview. I formulated a series of questions that were aimed at gaining qualitative data that could be used later in my writing, but the manner in which they were to be asked was open-ended, allowing for further insight from my interviewee. Mr. Hamdy's tone was engaging and passionate and as he began to answer my first question I could tell that this interview would take a direction of conversation in which he shared the history of his work in the desert and I was sympathetically drawn in (Al-Azazy 27 April 2012). Despite researcher Elizabeth Hoffman's suggestion that qualitative researchers should "abandon some of their power" and control in order to obtain the best data, I realized that my interjections and responses of emotional sympathy could have an influence on the overall tone and direction of the conversation (2007 p.322). Eventually, I found the human side of me incapable of listening to the sadness that he spoke of and decided to use this interview to reflect upon as I wrote. Reflections on the victims of trafficking and the corruption that allows it to happen in very lawless regions like the deserts of Sinai inspired me to work as hard as I could to portray to my readers the impact of the human trade in organs.

2.3 Minor Case Studies

The decision to study corruption through a qualitative case study approach came after initial plans to try to quantify it were criticized heavily in a research seminar. As was stated towards the beginning of this chapter, the overall lack of concrete data on the finances, locations, and scale of the organ trade make it difficult to study in a quantitative manner. I felt that one aspect that could however be measured was the extent to which corruption in a state made it vulnerable to the activities of trafficking in human organs. By using figures given by the 2011 Corruption Perceptions Index ranking countries from 0-10 (highest to lowest levels of corruption), in conjunction with the World Bank's customizable scorecard figures, my plan was to create a chart showcasing five measurements of corruption. The measurements were to be used for the following eight countries: Moldova, the Philippines, Egypt, Pakistan, the United

States, Israel, Saudi Arabia, and South Korea. The first four represented countries where organs are exported, whereas the last four represented countries to which organs are often imported. The integrity of this study was questioned based on concerns that the Transparency International index has been criticized for numerous reasons, including the lack of uniformity in its methodology from one country to another (the Economist 2010). I attempted to remedy the situation by examining other sources for measuring good governance and corruption, but ultimately came to the conclusion that the study would be more productive and effective if it focused on actual cases. The original chart that was created to show the measurements in relation to the eight countries is shown in the appendix of this report. In spite of my acknowledgement that it was not a comprehensive or reliable enough means of validating my point, it was a part of my research process and I find it therefore suitable to include it for reference.

The selection process for choosing three solid cases was brief yet efficient. During my interview with Frederike Ambagtsheer, I asked her about the role of corruption in the organ trade. The brief discussion that followed included a suggestion on her part that I look at three cases: the Medicus case in Kosovo, the Netcare case in South Africa, and the prosecution of Rabbi Levy Rosenbaum in Brooklyn, New York, USA (Ambagtsheer 13 April 2012). Having already read extensively, I was familiar with all three cases and heeded her advice in taking a closer look at the corruption involved in each. What I was not, however, so aware of was their likeness to one another nor their relationship to the other, as acknowledged in the “Corruption” chapter of this paper. Her recommendation was a verification of earlier considerations I had weighed regarding the importance of cases like these in my research. These cases would be used to support the idea that corruption played a role in the proliferation of illegal organ selling; however, they would not be the main focus of the research and would be balanced among the interviewing methods and an analysis of documents and articles pertaining to or written on the subject. It was important to approach the research question in a manner that did not unfairly attribute one factor more heavily than the other in terms of encouraging the trade. Ethics, cultural and social norms, insufficient legislation, and commodification had proven incredibly significant in the literature from which they were to be analyzed, so a case study would need to remain rather small in size yet large enough to serve its purpose.

3 The ‘Who, What, Where’: Logistical Considerations

3.1 Estimating the Value of the Organ Trade

The international trade in human organs is enormous, and traces of it can be found in every corner of the world. In a 2011 Global Financial Integrity Report entitled “Transnational Crime in the Developing World”, reporter Jeremy Haken reports that of the roughly 68,500 kidney transplants that take place around the globe annually, approximately 3,400 to 6,800 are the result of illegal trafficking (Haken 2011 p.21). Summarizing data obtained from a joint Council of Europe and United Nations study, Haken points out that those illegal transplants account for anywhere from five to ten percent of the total. Furthermore, after valuing each illicit kidney transplant at roughly \$150,000, he values the illicit global trade in this commodified part to be anywhere from \$514 million to \$1 billion annually (id.). It is important to remember that these figures are mere estimates. Due to the nature of the crime and the lack of concrete data, it is impossible to project exactly how many millions of dollars are made off of the trade in human organs. The joint efforts by the UN and Council of Europe expressed that the large number of unreported or undocumented cases could be attributed in part to the “shame, fear and guilt” experienced by the donors and recipients (Panjabi 2010 p.6).

Haken’s estimates in the GFI report allow for a great margin of error; however, even if we assume that the market value is closer to the lower end of his projected range, this still places human organs as the tenth largest underground economy, surpassing even small arms and light weapons (Global Financial Integrity 2011).

3.1.1 Distribution of Funds

It is difficult to say exactly how the money received from an illegal kidney sale is distributed among the involved parties. However, most experts agree that the person receiving the smallest portion of the transaction is the organ donor, or seller. In an interview with the New York Times in 2001, a self-proclaimed “international transplant coordinator” discussed the break down of money among parties. He explained that his asking price for a viable kidney was \$125,000. For \$500, a potential buyer would be sent an application, then asked to pay the broker a sum of

\$10,000 dollars, and eventually, he or she would pay the remaining sum before leaving the country where the transplant was to occur (Finkel 2001). In a very business-conscience tone, he informs the reporter that these host countries would vary based on what was currently “going on in the world and what [was] available” (id.). Like trading in timber, oil, or other natural resources, his words express how the market is accommodated by where the supply is made available. Once the transaction is complete, the broker admits that only a “small portion”, anywhere from \$800-\$10,000 goes to the organ seller; he obtains what he refers to as a “modest cut” of ten percent, and the rest is largely reserved to pay medical personnel like surgeons and nurses, as well as agencies and local police (id.)

Despite his objection to the term “broker”, the man in the above-given example embodies the very characteristics of these so-called “middlemen” in the organ-buying scheme. These brokers are responsible for recruiting organ donors locally and internationally from the most “vulnerable and marginalized populations” (Aronowitz 2009 p.114). These active participants stand in the company of hospital staff, directors of transplant units, nephrologists, laboratory technicians, surgeons, travel agents, religious organizations, and insurance agents who all defy the ethical responsibility and professional trust expected of them by the public, in order to profit from the business of organ selling (id.).

As stated, the small portion of the overall transaction that is received by the organ seller can vary within a range of approximately \$800-10,000. This price is heavily dependent on where the organ is sold and the nationality of the seller. In a 2010 report on the underground organ economy in the Philippines, economist Roger Lee Mendoza attributes “asymmetric information” to the acceptance of low prices by sellers for their organs. This term describes a situation in which one party has a “greater quantity and/or quality of information [...] in a market transaction” (Mendoza 2010 p.103). When questioned by Mendoza, most Filipinos who had sold an organ stated that they accepted the price offered by brokers because they were desperate for the money and didn’t know what was considered a fair price. Their compensation is among the lowest globally, with most respondents stating that they made less than \$3,000 upon selling a kidney. This stands in contrast to what Mendoza cites as minimum asking prices of \$30,000 per kidney in the US, \$10,000-\$20,000 in Israel, \$7,500-\$8,000 in Turkey, and approximately \$6,000 in Brazil. He does note, however, that it is slightly higher than the average payment of \$2,700 that is accepted in Moldova and Romania (id.).

3.2 The Geographical Extent of the Trade

There is a general trend for the flow of organs to go from poorer, less developed nations, to wealthier, developed nations. The world can be divided into what some have called “organ-exporting” and “organ-importing” countries (Shimazono 2007). Although there is some overlap within these categories, it is still possible based on

raw data, to create a general picture of who is who in this trade. Israel, the United States, Saudi Arabia, Canada and Japan are among the major players importing organs from patients abroad, typically through transplant tourism. Those selling organs to citizens of these countries are from exporting countries like the Philippines, Pakistan, Moldova, Colombia, Egypt, and Brazil. Although there are documented cases of citizens obtaining organs domestically from the poor in their own country (Mendoza 2010 p.104), a typical transplant tourist will travel from country *a* to country *b*; he or she will then receive the transplant from a resident of country *b*, or from a seller who comes from a third country, but has been transported to country *b* for the transplant.

In her 2004 report, “The Last Commodity: Post-human Ethics, Global (In)Justice, and the Traffic in Organs”, University of California Berkeley Professor, and founder of Organs Watch, Nancy Scheper-Hughes, provides several real-life scenarios depicting how the organ trade works. One such example showcases what she refers to as “the new Atlantic trade triangle”:

In a third scenario, kidney sellers were recruited from the slums and favelas of Recife, Northeast Brazil (by brokers including a military police officer), and sent by plane to Durban and Johannesburg in South Africa where they were met by South African brokers who ‘matched’ these unfortunates up with Israeli patients arriving from Tel Aviv. (2004 p.36)

Scheper-Hughes refers to this process of the wealthy purchasing body parts from the poor as “neo-cannabilism”, and attributes it to the creation of what she calls “apartheid medicine” (Scalise 1999). Medical tourism divides the world into buyers and sellers, suppliers and consumers of what the market has created into goods. After years of researching the trade and standing side by side with its victims and its perpetrators, Scheper-Hughes expresses outright that she cannot take a stance of neutrality on the issue, having witnessed the trauma that it brings to the most marginalized citizens of so-called organ exporting countries. The list of organ-importing countries given above reflects findings by Organs Watch as highlighted in a 2007 article by the World Health Organization (Shimazono 2007). The article by Yosuke Shimazono, featured in the WHO Bulletin, echoes earlier sentiments expressed in this report, that the trade is prevalent in all regions of the world. In certain regions, however, data is more readily available and establishes a greater base for analysis. Shimazono interprets this data to show a higher dependency on foreign organs obtained through transplant tourism in the Middle East and in Asia (id.). Shimazono’s analysis is echoed by other researchers who link the shortage and long transplant waiting times to both religious beliefs and a fear held by many that doctors purposely allow patients to die in order to harvest their organs (Panjabi 2011 p.19). Discussing cultural reservations and ideological reasoning can help shed further light why demands are higher in certain states, and how some come to justify their decision to purchase an organ.

4 Cultural Considerations

4.1 Social Status

In two separate studies conducted in Sweden and in the Netherlands, it was found that patients who reported having gone abroad for transplantation were oftentimes first-generation immigrants born outside of Europe (Berglund & Lundin 2012 p.322; Ambagtsheer et al. 2012 p.5). From 1992 to 2012, approximately 30 Swedes have gone abroad for a kidney transplant, unable or unwilling to wait the expected two years for a kidney through the national registry (Berglund & Lundin 2012 p.322). In almost every one of those cases, the patient holds Swedish citizenship but was born outside of the Europe, making them a first-generation Swede. In the Dutch case, interviewers spoke with physicians and coordinators who expressed that patients who had gone abroad for transplant had traveled to the Middle East and Asia, as well as the United States and Colombia. The patients either originated from their destination country or its region, or had some sort of connection to it, having lived or worked there (Ambagtsheer et al. 2012 p.5).

Understanding the cultural and societal significance of this phenomenon is a difficult process, one quite vulnerable to debate. In Sweden, purchasing or selling organs is forbidden, but it is not illegal to acquire one abroad (Berglund & Lundin 2012 p.327). Essentially, doctors are required to care for citizens who return from abroad after a transplant, out of ethical and legal obligations. These doctors have, however, expressed a general disapproval of the practice and discourage their patients from undergoing a transplant abroad. In a report published in 2012 in the anthology “The Body as Gift, Resource, and Commodity”, Susanne Lundin and Sara Berglund share the stories of several interviewees who went abroad, namely to Pakistan and Iran, for an organ transplant. They describe the patients’ feelings and motivations for going abroad, and state that the patients expressed “frustration” as well as “alienation from the Swedish medical system” prior to their travels (ibid. p.332). The respondents acknowledged the cultural norms present and the social stigma around medical tourism; yet for reasons that cannot be fully explained, but only theoretically analyzed, they decided to forego the national waiting list and act on their own.

The political and social atmosphere present in their countries of origin has also been acknowledged as a source for further insight. Many first-generation immigrants come from countries ridden with corruption and where authority figures are not seen as legitimate. This creates feelings of mistrust and dissatisfaction with the state, which are then carried with them into their next country of residence. If they have survived without major assistance or intervention by the state in the past, they may feel that it

is only natural to improve their situation individually again in their new country. (Lundin 2012.)²

4.2 Religion

The role of religion is another major point of discussion present in certain literary works on the organ trade. For many, religious beliefs and values dictate how one views death and the body. For example, the definition of death as a loss of total brain function is rejected by some Christians who protest that it interferes with the “pro-life” movement (Keller 2003 p.874). Other religious objections come from Orthodox rabbis who state that breathing is a sign of life, and Buddhists who see life as something that envelops the whole body, not just the brain (id.). These differing viewpoints can have an effect on donation levels in states where brain death is the main way of determining cessation of life. Families incapable of accepting the declaration of death can feel and observe the heartbeat of their loved one and therefore find it impossible to give consent for organ donation. Views on death as expressed by spokespersons of certain major religions may, however stand in contrast to official positions on donation and transplantation, as shown by the following table. The second and third columns represent the standpoint of the given faith on the practices of both donation (D) and transplantation (T) by indicating approval with a “Y” and disapproval with a “N”. Data was taken from the Australian government’s official informational website on organ donation.

Table 4.1

Religion	D	T	Remarks
Baha'i Faith	Y	Y	Guardian of the faith says it is "noble".
Buddhism	Y	Y	Matter of individual conscience; valued as compassionate.
Catholicism	Y	Y	Donation is a testament of charity.
Mormon Church	Y	Y	Individual decision made with family, doctors, and church
Greek Orthodox	Y	Y	No objections; donation is an act of solidarity
Hinduism	Y	Y	No indications that donation is not acceptable.
Romani	N	N	Dead body to remain intact in order for the soul to return to it.
Islam	Y	Y	Transplant permitted for purpose of saving lives.
Jehovah's Witness	Y	Y	Organs must be drained of blood before transplantation.
Judaism	Y	Y	Reform and Conservative movements support donation.
Lutheran Church	Y	Y	Decision is left to the individual.

(Donate Life: Religion and Donation, 2012)

² Information obtained in 2012 interview based on material in the yet unpublished text “Global Bodies”. See appendix 3 for further citation.

As the table demonstrates, with the exception of Romani and Shinto (although not listed), most religious bodies advocate the donation of organs and also permit worshippers to receive transplants. Judaism encourages organ donation by expressing that it is an act that has the power to save human lives. Many Israelis have, however, tried to attribute the overwhelming shortage of organs in their state to orthodox religious beliefs, which oppose donation citing that the body should be intact upon burial (Scheper-Hughes 2004b p.37; Francis & Francis 2010 p.286). Others in Israel claim that this idea is misconstrued and overplayed in order to legitimize the practice of transplant tourism by so many citizens in need of a new organ. Debates over the permission or encouragement of Jews to donate have been a major point of controversy for years.

Nancy Scheper-Hughes claims that the modern transplant tourism scheme was essentially created to accommodate the demand for healthy organs by Jewish patients. In her words, “there is no other way to put [it]” (Scheper-Hughes 2011 p.66). Criticism can easily arise from showcasing the part that one group played in the history of a troubling practice, but the purpose of this chapter is to regurgitate the facts, not to interpret them. She states that transplant tourism began in the 1970’s in the Middle East, with patients in the Gulf States going abroad to receive organ transplants (ibid. p.64). Before the first Gulf War, citizens of countries in the region surrounding Iraq could pay upwards of \$10,000 for an all-inclusive transplantation package, offering them transportation, accommodation, an organ, and surgery in a Baghdad military hospital. Those supplying the organs included ethnic minorities in Iraq and refugees living in neighboring states. Bearing witness to the process by which their neighbors were obtaining foreign organs, Israelis became intrigued and entered the scene shortly after, seeking a similar route to transplantation. Seeing a market for transporting Israelis to a second location to get a healthy organ, transplant brokers began to emerge, and established relationships with partners in Turkey, Moldova, and within Israel. (Scheper-Hughes 2011 p.64-66)

Out of the over 10,000 transplants that Israelis underwent from 1980 to 2008, only 84 were from cadavers (Whitehead 2008 p.24). The government and some members of society use the argument of an intact body upon burial as a means of drawing understanding from a cultural relativist point of view. They label themselves as a “non-donating” people, and it is inferred that they have no options outside of seeking organs abroad. Furthermore, the government banned transplant tourism as recently as 2008; before this time citizens could have the cost of their commercial transplant paid for by insurance companies. (Lundin 2012). In an effort to clarify the religion’s stance on organ donation and transplantation, the Israeli National Transplant Center has published the official justifications for both in accordance with halachic law. They acknowledge the Chief Rabbinate Council’s approval of death as total brain death, and state that with the exceptions of incest, idolatry, and blood shedding, any commandment may be “transgressed” in order to save a life (Israeli Transplant Center). Informing worshippers of the position on organ donation should be considered a matter of high priority for all leaders of the world’s religions.

5 Legal Framework

5.1 What Does “Illegal” Really Mean?

An investigation into the existence of legal documents condemning transplant tourism and organ trafficking on an international level produces limited results.

Currently, the only two documents aimed at defining both practices while also condemning them, are the Declaration of Istanbul (DOI) and Resolution 57.18 from the World Health Assembly (WHA) (Ambagtsheer et al. 2012 p.3). There are indeed other conventions or protocols legislated by intergovernmental organizations, like the United Nations (UN), and the Council of Europe (COE); however, within these documents, organ trafficking and transplant tourism are often addressed among other issues, such as human trafficking. Using the DOI and Resolution 57.18, in addition to two pieces of national legislation condemning organ trafficking, this chapter will focus on defining what “illegal” or “legal” actually mean in regards to the organ trade. Lastly, it will briefly discuss Iran’s policy towards paid organ transplantation, as it is the only country in the world that has legalized a trade in human organs.

5. 2 International Documents

5.2.1 The Declaration of Istanbul on Organ Trafficking and Transplant Tourism

The Declaration of Istanbul on Organ Trafficking and Transplant Tourism was adopted during an international symposium conducted by the Transplantation Society and International Society of Nephrology in Istanbul, Turkey in May of 2008. Over the course of three days, over 150 specialists in the fields of ethics and medicine, as well as governmental representatives convened to address the growing concern of organs being trafficked. (The Declaration of Istanbul 2008 p.3378). Before concluding the summit, each participant had the opportunity to give his or her input on a document drafted by the Steering Committee on the participants’ behalf. After a period of deliberation, the participants reached a consensus and soon after, the declaration was published. The publication officially put down into words their concerns and recommendations for how to curb the practices of both transplant tourism and organ trafficking. (id.)

The preamble of the Declaration of Istanbul acknowledges the ideas mentioned previously in this paper, that the commercial trade in human organs is a practice that depends on poor people supplying an essential good to the wealthy. In mentioning the relationship that the trade has to divisions in wealth before providing their proposals, it would appear that the participants felt that the well being of the most vulnerable citizens that should be at the forefront of the discussion. A later conversation with one of the invited participants revealed, however, that the interests of each group represented (e.g. transplant surgeons, ethicists, and legal scholars) created an environment riddled with personal agendas. Only several of those “agendas” sought to place the protection of vulnerable persons towards the top of the priority list. In any case, the proposals to follow the preamble and set-forth principles were categorized into two major themes: (1) to respond to the need of organ shortage and (2) to ensure the safety of living donors and recognize the heroic nature of their act, whilst still combating transplant tourism, organ trafficking, and what the Declaration refers to as “transplant commercialism” (The Declaration of Istanbul 2008 p.3377).

The first theme was supplemented by four distinct proposals that urged governments to take action to increase domestic supply by: working closely with healthcare institutions and officials to increase deceased donor donation; creating transplantation infrastructure if no national policy was currently present, thereby establishing a deceased donor scheme; maximizing the therapeutic potential of deceased donation and transplantation; offering information and technology to other countries for the purpose of improving their donation efforts (id.). The second theme consists of seven proposals that center around the persons involved in organ transplants. They recommend that altruistic donors be honored by the state for their act, that the donor’s psychological health be evaluated prior to donation, and that organ donors, whether they be unlawfully forced donors or voluntary donors, be cared for and seen as a responsibility for the state. Furthermore, the donor’s physical and mental health should be protected in both the short and long term following donation. The sixth and seventh recommendation by the DOI under the second category of its given proposals distinguishes between paying for an organ and treating the organ recipient, when encouraging reimbursement for the costs of donation. They clarify that personal expenses should be reimbursed not by the donor, but from the facility or organization overseeing the transplant. Such personal expenses include travel and accommodation for pre- and post-operative evaluations, as well as income lost during the donation process (id.). Reimbursement is not treated as a reward.

This document is the first to be drawn by transplant professionals and in spite of it not being legally binding, it has influenced individual states and over 100 transplant organizations that endorse its principals (Ambagtsheer et al. 2012 p.3). It draws upon principles laid out in WHA 57.18, which stands similarly in its condemnation of transplant tourism (ibid).

5.2.2 The World Health Organization and World Health Assembly

Resolution 57.18

As the decision-making body of the World Health Organization, the World Health Assembly (WHA) acts to uphold the organization's objectives to serve as a catalyst for change, to set and promote global health standards, and to assess and monitor trends in global health (World Health Organization 2012). In May 2004, the 57th WHA met to address the need to incorporate "new provisions in response to current trends in transplantation, particularly organ transplants from living donors and the increasing use of human cells and tissues" to previously adopted resolutions WHA40.13, WHA42.5 and WHA 44.25 (World Health Organization 2008 p.1). Citing recent technological advancements in medicine that have led to an increased demand for organs, the assembly declared the need to establish a new set of guiding principles that would promote an ethical framework for the "acquisition and transplantation of human cells, tissues, and organs for therapeutic purposes" (id.). Eleven principles were decided upon, each addressing a specific aspect of organ transplantation and donation, including coerced donation and exploitation of donors. Many principles are echoed in the later-drafted DOI. Due to length limitations, and in an effort to avoid repetition, the WHA principles will not be addressed individually. Resolution 57.18 has been used as a guideline and resource for national legislation and for establishing professional codes of conduct and ethics in transplant organizations and facilities (Jafar 2009 p.1147). Nonetheless, codes inspired by the document have failed to create a major impact in condemning the use of financial incentives to increase organ supply or decreasing commercialized tissue operations globally (ibid.). Like many international treaties or declarations, resolutions like WHA 57.18 are difficult to implement due to their non-binding nature. Furthermore, criminal networks and the parties involved in the commercial organ trade, brokers, sellers, buyers, and medical personnel, are "extremely difficult to map out" and therefore pursue to bring forth an investigation or eventual prosecution (Lundin 2010 p.8).

5.2.3 International Prioritization

The prioritization of organ trafficking on the international level is much lower than the trade in weapons and drugs or that placed on counter-terrorism. During a discussion with Frederike Ambagtsheer, coordinator for the European Union Living Organ Donation in Europe project and researcher of organ trafficking and transplant tourism, the issue of prioritization was raised. When asked if the discussions on organ transplantation and the illegal organ trade had evolved significantly or if they had been raised more frequently within the last few years, Ambagtsheer explained that although both are deemed important by organizations like the WHO and the European Union, their level of priority has neither increased nor decreased recently. Organ trafficking discussed in the context of combating organized crime has been brought up by further organizations like the United Nations Office on Drugs and Crime

(UNODC) and the Home Affairs department of the European Commission (Ambagtsheer et al. 2012 p.13). Nonetheless, the response by both groups has been minimal. The UNODC first began discussing organized crime in conjunction with organ trafficking in June of 2010; the European Commission expressed their first major sign of interest in fall of 2011. Ambagtsheer attributed the low prioritization level to a general “lack of exchange of information between, for instance, researchers on the one hand, and public international organizations on the other hand” (13 april 2012). She expressed that if awareness was higher and if these organizations knew what the researchers knew, then they would undoubtedly be alarmed and feel compelled to do something to address the problem further.

5.3 National Policies

National laws condemning exploitative transplant practices are varied, but similar in the regard that, like international documents, they are difficult to implement. Limitations on national laws primarily derive from the fact that they can only be applied within a territorial jurisdiction. The practices of both transplant tourism and organ trafficking often extend beyond the borders of one state, yet it is the judicial responsibility of individual states to prosecute crimes committed within their jurisdiction. According to a 2012 report published by Dutch transplant professionals including Ambagtsheer, if it is suspected that a medical patient may have obtained his or her new organ from a commercial transaction (i.e. transplant tourism), the state should respond by applying provisions set forth in national legislation prohibiting organ purchase or trafficking. Additionally, they should apply applicable provisions concerning extraterritorial jurisdiction, which, if existent, give the state the power to prosecute nationals for committing a crime abroad. In order for extraterritorial jurisdiction to be met, specific conditions must be present; additionally, it must be proven that the perpetrator purchased his or her organ. Establishing this proof is nearly impossible, and even if it were, it is not the transaction from recipient to a second or third party that constitutes proof, but rather the profit made from the organ purchase that declares the act illegal and the patient criminally liable.

Furthermore, in countries where governments are weak in implementing the law in general, or where corruption is widespread, the introduction of laws whose purpose is to prosecute persons involved in commercial organ trading is ineffective. In 1994, India, a long-time hub of transplant tourism, enacted “The Transplantation of Human Organs Act”, a detailed law to end organ trafficking. (Budiani-Saberi & Karim 2009 p.50). Nonetheless, the trade persists in various forms and according to the Condeferation of Indian Industry, the country could see annual profits of roughly \$2.3 billion from medical tourism by 2012 (Panjabi 2010 p.67). The 1994 act includes a loophole that has been exploited by organ brokers, allowing non-relatives to donate organs when the motivations are “altruistic”, meaning the donor has an emotional or

affectionate connection to the recipient of his or her organ and donates out of good will (ibid. p.71). Once a designated Authorization Committee has approved transplantation between non-related, consenting adults, then the procedure can take place. The obvious pitfall to this rule is that documents can be forged, authorities can be paid off, and other actions can be taken to falsify a relationship and/or consent.

This problem is not unique to India and occurs in other countries. The Philippines prohibits transplants between unrelated recipients and donors in a similar fashion; the pair should either be related or friends. When a group of Filipino organ donors were surveyed in 2010, however, 85.2-93.2% reported being unrelated (neither a family member or friend) to their kidney recipient (Mendoza 2010 p.103). Only 3.5-11.5% claimed that their recipient was a relative or friend. Furthermore, the survey revealed that 56.3-64.3% had sold their kidneys to a foreign recipient (ibid). When commercial transplantation is not the result of exploiting loopholes in legislation, the trade persists in countries at “clandestine transplant centers” (Panjabi 2010 p.71). The law in India, though penetrable, also had the effect of shifting the destination for some transplant tourists away from the country into neighboring Pakistan. We see here, that similar to other black market trades, those involved in the buying and selling of organs find ways to manipulate or evade the law. “The passage of prohibitory legislation only pushes the donors and recipients farther afield to areas where law and implementation are less precise and where bribery and corruption more prevalent” (ibid p.59).

5.3.1 National Organ Procurement Schemes

When looking at legislation responding to organ trafficking and medical tourism at the national level, it is imperative to not only look at national laws condemning the trade and their effectiveness, but also to investigate government-enacted policies that work to suppress the trade by increasing the supply of organs available for transplant. Whereas the laws aimed at prosecuting perpetrators often fail to make an impact, laws allocating deceased organs and advocating living organ donation have seen more promising results. To examine this type of legislation further, we will look at the two most common donor registration systems used globally, by briefly discussing each in the context of two countries: Spain and the United States.

5.3.2 Opting-in: the USA

In 1994, the United States congress enacted the National Organ Transplant Act (NOTA) in order to increase the number of organ donors and to address legal aspects of organ donation and transplantation (Keller 2003 p.879). The NOTA declared the purchasing of organs to be illegal, set up a task force to monitor such practices, and now states that persons charged with buying or selling organs could be fined up to

\$50,000 and/or a five-year prison sentence (id.). The NOTA also established an Organ Procurement and Transplantation Network, which then commissioned a private-sector entity, the United Network for Organ Sharing (UNOS), to “regulate the procurement and distribution of organs for transplant purposes” (ibid p.881). NOTA can be seen as an advancement of the 1968 legislation entitled “the Uniform Anatomical Gift Act” (UAGA) which was revised in 2006 to maximize organ supplies. Together, the UNOS and UAGA serve to monitor a nationwide patient list and a donor list, as well as define the terms by which donors are recruited. The UAGA “details the rights of individuals to designate their organs for donation after their death” (Jafar 2009 p.1147).

Individuals in the United States designate their organs through what is often referred to as an “opt-in” system, or an “expressed” system. In an expressed system, the person gives his or her consent to donate after death. If his or her consent is not obtained before death, consent can be obtained from his or her spouse, children, parents, siblings, or guardian so that his or her organs may be harvested and transplanted (Caplan et al. 2009 p. 24). Critics of expressed systems say that supplies could be higher if persons were registered automatically, as is done in an alternative “opt-out” or “presumed” system. Proposed cultural, societal, or religious reasons for why one refrains from “opting-in” have been previously mentioned. In spite of efforts by the UNOS to encourage Americans to register as organ donors, the number of persons waiting for an organ on the national transplant list dramatically outweighs the supply available. From 1993 to 2002, transplants rose by 41%, yet the number of patients waiting for a transplant rose 150% (Panjabi 2010 p.14). As the simple laws of supply and demand dictate, needs are not being met in the United States. It is not, therefore, surprising that we see the United States mentioned predominantly as an “organ-importing” country. Americans with the financial means to purchase an organ abroad have participated and will continue to participate in transplant tourism for the purpose of surviving at any cost, should no better scheme be implemented to legally increase the domestic organ supply.

5.3.3 Opting-out: Spain

In comparison to the “opt-in” system present in countries like the United States, presumed consent or an “opt-out” system automatically registers citizens as organ donors upon death. The presumed consent system “mandates that every adult who dies is a potential donor unless during his or her life he or she specifically declines to participate” (Jafar 2009 p.1153) Oftentimes, families are contacted upon the death of a loved one in order to receive further consent, even if the will of the dead or dying patient was to see his or her organs donated. Family refusal to consent to donation is responsible for limiting donation rates and therefore supply (ibid). According to researcher Tazeen H. Jafar of Aga Khan University in Pakistan, in countries where presumed consent is present, roughly 20-60% of relatives interviewed by a transplant

coordinator refuse to give consent. Spain, however, has seen a favorable response to this system and family refusals remain around 20-23% annually, with some regions reporting refusal rates of only 10% (2009 p.1153). Furthermore, since effective coordination was gradually put into place during the 1990's, presumed consent has seen donation rates increase from 14 donors per million persons (PMP) in 1989 to 34 donors PMP in 2001 (Miranda et al. 2003 p.1191).

What are countries like Spain doing so differently to both increase supply and potentially reduce dependency on foreign organs? In addition to observing presumed consent laws, they are coordinating effectively. In Spain, the National Transplant Organization (ONT) was set up in 1989 with the purpose of increasing organ supplies and transplantation rates (Miranda et al. 2003 p.1189). They work in coordination with physicians (namely intensive care unit specialists), hospital staff, and transplant coordinators and allocate authority to 143 hospitals that oversee donor programs (ibid p.1190). The physicians involved are advised to declare death when cardio-respiratory functions fail or when brain activity has come to a state of "total and irreversible" cessation. Evaluation and legal procedures are taken before organs can be retrieved from the former, "non-heart-beating" donors or the latter, "brain-stem death" donors (id.). Discrepancy over how to define death is a problem, but in many countries like Spain, it is often up to the doctor to determine. The ethical discussions concerning determination of death will be addressed at a later point in this paper, but it is appropriate to note at this point that the system is not without its critics. In any case, there is little debate over the efficiency of the Spanish model. The uniformity by which the system has played out in real life has improved the supply levels in Spain considerably. Other states that have implemented successful presumed consent and coordination systems are Italy, Austria, Belgium, Sweden, and Singapore (Jafar 2010 p.13; Livsviktigt.se).

5.3.4 The Legalized Market: Iran

Before we begin looking at ethical implications of legal structures or lack thereof, it is important to take a look at the policies regarding organ donation in one more country: Iran. In 1988 Iran implemented a legal paid-donor program that finds potential donors for patients facing organ failure. The program is state-sponsored but run by a non-profit organization called the Dialysis and Transplant Patients Association, or Datpa. If a deceased donor or a living relative cannot be matched to a person in need of an organ, Datpa conducts a search within their database for donors (Tabarrok 2010). The kidney is more often than not the organ sought by patients. The program offers a fixed amount of approximately \$1,200 per kidney to donors and assures pre- and post-transplant care, including one year of unlimited health-insurance coverage and the administration of immunosuppressive drugs like cyclosporine, at subsidized costs. The recipient arranges the payment; however, if a recipient cannot afford the operation, Datpa uses donated charity funding to cover the expenses (id.). In 1999,

after eleven years of implementation, Iran met equilibrium with supply and demand and the shortage of transplantable kidneys was eliminated (id.). It is also important to note that recipients cannot be foreign nationals, ruling out a legalized scheme for transplant tourism to Iran (Jafar 2009 p.1150). This does not mean, however, that the letter of the law is carried out and there exist many reports claiming travel to Iran for the purposes of commercial transplantation (Scheper-Hughes 2004a p.16).

Some have pointed to the Iranian case as an exemplary one that should be mimicked in countries where shortages are high. However, many experts in the field of transplantation and organ trafficking point out that the system is not without its failures and that it can be seen as one plagued with ethical problems. One of the greatest concerns is that the poorest citizens are the most likely donors; there are few reasons imaginable for why someone would give up a healthy kidney to a non-relative or acquaintance if he or she did not need the money it would provide. These citizens live a post-operative life oftentimes ridden by “chronic pain, unemployment, social isolation and stigma, and severe psychological problems” (Scheper-Hughes 2004a p.41,42). Furthermore, the value placed on a kidney is questionable by some, considering black market organs can be sold for considerably more money. They argue that the non-negotiable price of \$1, 200 per kidney is unjust (Jafar 2009 p.1150). Is any price truly just? How does one put a price on a human body part? How is its worth determined? In the same ways that the illegal practice of transplant tourism treats human organs as goods to be bought and sold, a legal system of commodifying parts holds a tremendous amount of significance in how we view the body and the ethical implications that our views and treatment of it present.

6 Theoretical Considerations

While this century and the one recently passed have brought the world unprecedented wonders in terms of technology, these eras may later be remembered more for the exacerbation of human misery, the egregious violations of human rights, and economic inequity that brought so much wealth to a few and bare subsistence to so many.

Panjabi 2010 p.3

As it has been previously noted several times in this report, there are numerous ethical implications that a commercial trade in organs has on medicine, law, and arguably the most important subjects, the human body and the human being. The role of ethics in the organ trade is multifaceted. Whether we are questioning the role of religion in one man's refusal to donate after death, or one theorist's insistence that selling an organ is an individual choice, we frame the question in an ethical context. Ethics will be treated not only as the application of values to specific situations, but also as the response when questioning how a subject, society or the individual, should live (Collier & Lakoff 2004 p. 421).

In their analysis of the ethics of organ transplantation, researchers at the University of Singapore's Centre for Biomedical Ethics, adequately summarize the concerns and dilemmas involved with the procedure as: the responsibility to care for the sick and dying and the limits of that care; informed consent used as a means to safeguard patients' interests and its role in the context of autonomy; notions of death; the "value of bodily life and integrity"; the effect that technology has in maintaining value and professionalism in medicine; and "social equity in the allocation of basic health goods" (Voo et al. 2009 p.363,364). A simple reflection upon each of these individual concerns merits far more attention and time than this report allows. However, their concerns serve as a means of supporting the earlier sentiment expressed that ethical concerns are present in almost every aspect of transplantation, legal or otherwise. This chapter will address the ethical implications of the commodification of organs, the role of technology in changing our bodies as well as our attitudes about the body, and the moral responsibilities of healthcare professionals. The chapter will also include an analysis of the extent to which corruption encourages organ trafficking and transplant tourism. Although this discussion will take on less of a theoretical perspective, it is important to associate it with the preceding discussions as it showcases the general disregard for ethics present in law enforcement, government, and again, the healthcare system.

6.1 Commodification

Since the 1980's, with the development of cyclosporine, a drug that aids in the tolerance of transplant recipients to their acquired foreign organ, the business in organs has risen dramatically (Panjabi 2011 p.11). According to Dr. Raneer Khooshie Lal Panjabi, History and Human Rights professor at the Memorial University of Newfoundland, Canada, the distribution and obtainment of this drug enabled "greater proliferation of transplant procedures" (id.). It did not take long for the spread of this technology to create a scarcity of organs available for transplant worldwide. That void was filled by what Nancy Scheper-Hughes calls "healthy organs, encased in their human packages" traveling to meet "mortally sick bodies" traveling in the other direction, forming a new means of accommodating the organ shortage and creating the phenomenon of transplant tourism. She explains that this process was made possible by the openness of the global market economy that, like today, allows for people, goods, and services to move easily from one point to another (2004a p.18).

In citing socioeconomic reflections given by businessman and human rights activist George Soros, Scheper-Hughes sets forth the theory that as the global market has evolved, it has been at the expense of social cohesion and the capacity for society to regulate "functions to preserve human dignity and basic human rights" (2001 p.43). Globalization has facilitated the rapid trade of goods and left us at a point where we expect our demands to be met, even if it is at the expense of others. This is not, arguably, a new idea; people have long been exploiting others in order to obtain something or achieve a goal. What has changed is the speed by which we meet gratification and the distance from which we can obtain it. Scheper-Hughes argues that these factors, in conjunction with a global climate of "bio-technological optimism" and "biomedical triumphalism" allow us to see the shortage of a good simply as a "management, marketing, or policy failure" (2008 p.29). Somewhere, somehow if we can find the means to pay for it, the good can be ours. But when we speak of goods, we often think of cars, computers, clothing, and other concrete items that have become an essential part of our everyday lives. How is it that we can think of these items in the same way that others can think of a human organ?

The reduction of a human organ to a commodity requires a detachment of a human connection and the capacity to disregard the trauma or the danger that the process of obtaining one may have caused the body that it once belonged to. We will here define commodification as the "production of a good or service for a profit" (Panjabi 2010 p.15). For those in the field of bioethics, it is the emergence of an unregulated market in commodified organs that raises a red flag; for anthropologists, this flag is raised earlier, at the point when one human being can look at another and realize that within lies "something capable of prolonging his or her life" (Scheper-Hughes 2011 p.40). Whether it is the aforementioned notion of a no-longer-existent social cohesion that allows this to occur, or simply the sheer desperation of a dying patient, organs have been transformed into goods evaluated for their "quality, durability, and market value". This commercial objectification of something that should be seen as a gift can be viewed as a breach of moral guidelines that run

through not only societal and cultural contexts, but that are also present in medicine and technology.

6.1.1 The Biovalue of Our Bodies

We can turn to advancements in biotechnology in our attempt to understand the redefinition of life or of an object that helps to sustain life. Through improvements in healthcare and the capacity to lengthen quantity and quality of life through medicine, the concept of natural living beings is rapidly replaced by a new concept of an artificial “plurality of beings” whose biology has been altered. Dr. Thomas Lemke theorizes that this replacement alters our perception of once-natural entities, which now resemble “technical artifacts” (Lemke p.5). In a brilliant attempt to demonstrate the validity of this argument, Lemke turns to Hans-Jorg Rheinberger, director of the Max Planck Institute for the History of Science in Berlin, to explain how molecular engineering has evolved into a knowledge that transforms human beings. Rheinberger states:

it is on the level of *instruction* that metabolic processes are becoming susceptible to manipulation. Until that point was reached, medical intervention, even in its most intrusive physical, chemical and pharmacological forms, was restricted to the level of metabolic *performance*” (cited in Lemke p.6).

Technological processes are molding new bodies, not just modifying them but also manipulating their functions. Lemke treats this change as a leap from science for the sake of discovering to science for the sake of transforming (p.5). The body is no longer seen as an organic substance in this context, but like software that “may be read and rewritten”. The transformation of the body and the life within generates what Lemke refers to as “biovalue”, new knowledge and products that can be marketed (ibid.).

It is only natural to assume that the advancement of technological processes to modify and “improve” bodily functions came out of a desire to further knowledge and because there was a market for it. In recent years, television programs have subliminally advertised these modifications through beauty makeover shows and documentaries that follow the featured character as he or she undergoes various plastic surgeries in order to obtain his or her idea of physical perfection. It has become a normalized process that we can look at others and ourselves and imagine the ways in which we can be changed.

During one of the two conversations I had with Susanne Lundin, I brought up the idea of improving one’s body through technology and medicine. When asked if this idea of manipulation played a role in an organ purchaser’s justification for buying his or her organ, Susanne said that there was definitely a link. “You have learned in our culture nowadays, in biomedicine, that your body has organs that are

interchangeable...you have the technology and you should use it to get a healthy body and to improve your body” (Lundin 2012). She continued along these lines by discussing the individual nature of an argument or justification of this sort. She expressed that at the same time that we understand that technology can help us to move organs from one person to another, “we also have the idea that we are unique individuals...we should *never* do that” (id.). To place one’s self in the highest regard can undoubtedly lead to several ways of justifying actions that may weaken the status or livelihood of another. Scheper-Hughes calls this the “ultimate commodity fetish” and asserts that believing in the “absolute value of a single human life” extended or saved at any price “ends all ethical inquiry and erases any possibility of a global social ethic” (2004a p.33). Here, we follow the circle back to its beginning, and briefly see the intricate nature of a changing social and biomedical ethic in the context of the organ trade.

6.2 Ethical Dilemmas in Classical Medicine

The commercial trade in human organs also holds major ethical implications for healthcare professionals in the field of classical medicine. The Hippocratic oath that each physician vows to uphold centers on the principle “Do no harm” (Caplan et al. 2009 p.32). Modern science has taken the question that doctors asked in the beginning stages of transplantation, “Can we do it?” and replaced it with the question “When should we do it?” (Keller p.858) Is it morally right to transplant the kidney of a healthy, young man into the ailing body of his grandfather? Is it morally wrong to suggest that a family refrain from bringing their loved one home to die, instead of keeping him or her in intensive care so that organ donation is more feasible? There are no black and white answers to these questions; in modern medicine, a grey area has emerged and the potential implications this has on the well being of patients are huge. Due to length restraints, this paper will only address two major issues concerning the responsibility of healthcare professionals in the context of organ transplantation and the commercial organ trade. The first is the treatment of patients who have gone or intend to go abroad for a transplant; the second is the determination or declaration of death.

6.2.1 Treating Returning Patients

The ethical commitment for doctors to “do no harm” is complicated in the context of transplant tourism. When patients approach a doctor and tell him or her that they intend to go abroad for the purposes of obtaining a foreign organ, refusal to provide medical records or support could in many cases constitute medical negligence (Ambagtsheer et al. 2012 p.6). Furthermore, this refusal could be in violation of

certain codes of conduct set forth in domestic law or international conventions. Medical care has been declared by the European Court of Human Rights as the foremost interest for medical practitioners (id.). Additionally, the Universal Declaration on Bioethics and Human Rights recognizes the importance of caring for a patient, but emphasizes that decisions regarding ethics in medicine can have an impact on not only the individual, but also entire communities “and humankind as a whole” (Universal Declaration on Bioethics and Human Rights 2005).

Paid transplantations are generally looked down upon in the professional medical community. When interviewed, doctors have expressed concerns that oftentimes the organ seller’s post-operative care can be insufficient, leading to potential health complications. Further concerns are for the buyer’s health, which can also be jeopardized. There is no guarantee that his or her body will accept the transplanted organ (Berglund & Lundin 2012 p.328, 329). Additionally, the transplanted organ could be diseased and in rare cases even transmit HIV or viral Hepatitis (Brennan & Khoury 2005 p. 455; Berglund & Lundin 2012 p.329). For patients not properly treated with an immunosuppressant like cyclosporine, wound infections, urinary tract infections, pneumonia, and other bacterial and viral infections can develop as early as the first month of recovery (Brennan & Khoury 2005 p.455). Additional post-operative complications can occur if the organ is contaminated during the procurement process, causing fungal and bacterial infections. In a study done by the Department of Internal Medicine at the Washington University School of Medicine in St. Louis, Missouri, fifty-percent of patients who developed an infection from an organ contaminated by the *Pseudomonas* bacteria had to have their new organ removed; ten-percent died as a result of the infection (ibid. 456). Transplant medicine, especially when practiced improperly, is not without risk and has the potential to *harm* the lives of not only the donor but also the recipient.

The most ethical action for doctors to take when a patient approaches him or her with plans to go abroad for a transplant would be to discourage this course of action, citing the health risks it could bring. If the patient states outright he or she is paying for the foreign organ, the doctor is put into an even more problematic scenario, deciding whether or not the next course of action should be to inform the police. Essentially, a patient engaging in commercial transaction will be committing a crime. However, given the observed right to privacy upheld by legal doctor-patient privileges, should the patient’s declaration be protected as a confidential matter? No definitive answer exists to properly answer that question; however, it is generally understood that unless the patient intends to inflict “direct or severe harm” on another being, a criminal case against him or her would be difficult to prosecute. A doctor would not, therefore, violate the professional secrecy oath and jeopardize his or her career unless he or she had sufficient knowledge proving that the organ would be taken from a “trafficked donor or a murdered donor” (Ambagtsheer et al. 2012 p.6). The same ethical and legal considerations would be taken for a patient returning from a presumably illegal foreign transplant. Since it is difficult to prove that an illegal transplant was a patient’s means of obtaining a new organ, most doctors understand

the limits of the law and choose to focus their efforts on providing proper healthcare to the patient, as is their duty.

6.2.2 Determining the Cessation of Life

The concept of death and the means of declaring it are highly controversial and ethically charged topics of debate. There is no international standardized definition of death and within individual countries the definition can vary depending on the region (Wijdicks 2007 p.21). The two most widely used definitions declare a patient dead when total brain function ceases, or when circulation of blood in the body stops, essentially meaning that the heart has stopped beating (Bagheri 2007 p.146).

A study published in 2007 by the American Academy of Neurology examined the usage of the former definition, brain death, in eighty countries. They found that in Europe, South America, and Asia, brain death criteria was either legally declared or routinely observed by doctors. In the United States, Central and South America, the law or observed practice clarified that cessation of function in the entire brain determined death. This stands in contrast to the United Kingdom's observation of brainstem death (Wijdicks 2007 p.21). Furthermore, the study revealed that some countries lacked any legal framework defining brain death and that others varied in their procedures for making a declaration of death. By taking a brief look at the lack of uniformity present in the case of brain death, we can see clearly that defining death by any means is complex.

When discussing transplantation in the context of determining death, it is essential to understand that organs must be procured from bodies before the loss of oxygen and blood supply causes damage. According to the informational transplant website published by the Swedish National Board of Health and Welfare, a heart needs to be transplanted into the recipient's body within four hours, kidneys up to thirty hours, a liver up to fourteen hours, and lungs around seven hours (Livsviktigt: Vanliga frågor). If a patient is declared dead due to cessation of brain function, it is often easier for secondary doctors to then come in and begin the organ extraction process, if the patient has consented to donation after death. Herein lies the proverbial rub: it is often more ethically difficult for many to accept that a person has died once brain function has terminated, but the heartbeat still persists. Patients who are kept alive using technology in an intensive care unit become what some have called "living cadavers" (Ekström von Essen 2012 p.147). They can perspire, urinate, and even sustain a growing fetus (ibid); but some claim that their capacity to keep fresh, transplantable organs gives them their greatest value. According to Scheper-Hughes, transplantation technology required a new definition of death so that organs could be harvested from what she calls the "neither completely dead nor yet still living" patient. She argues that this phenomenon has challenged modernist conceptions of "the body, the person, and the meanings of life and death" (Scheper-Hughes 2004a p.14)

In some Western countries, donation after cardiac death (DCD) has been implemented in an effort to increase the supply of transplantable organs. If a patient's prognosis is "hopeless" and he or she has not yet experienced a loss of blood to the brain, the respirators will be turned off, he or she will be declared dead and then a period of waiting will begin before any extraction can begin (Ekström von Essen 2012 p.154). One of the biggest ethical problems that this process presents is the mentioned period of waiting. In some countries the waiting time can be as short as two minutes or as long as ten (ibid). This method of obtaining organs after cardiac death has been used in the United States for over thirty years with a waiting time of five minutes (Southwest Transplant Alliance n.d. p.3). Critics of DCD worry that decisions can be hasty, and that there is a risk of patients being under-treated to increase the chances of procuring organs undamaged from oxygen deprivation. Historian Ulla Ekström von Essen explains that earlier arguments in support of "not over-treating" patients (i.e. stopping life-saving measures) have evolved into arguments calling for a "right to donate". This would infer that the patient's care is for the benefit of another, the donor recipient (2012 p.161).

The lack of an internationally agreed upon stance for the determination of death, compounded with the ethical debate concerning the treatment of patients going abroad for or returning from a paid transplant widen the so-called grey area between what we can declare right and wrong. These grey areas complicate the already complex problem of increasing domestic organ supply and discouraging commercial transplantation, creating a vulnerable situation in which proper behavior goes undefined and persons are left deciding which course of action is best on an individual level.

6.3 Corruption

Corruption plays an incredibly significant role in not only facilitating but also fueling the commercial trade in human organs. Often driven by greed and profit, governmental officials, members of law enforcement, rogue surgeons and medical professionals, and even trusted members of religious communities violate their moral and legal duties to participate as actors in this underground economy. The by-product of their actions is an environment void of transparency, trust, or accountability that allows criminal networks and organized crime syndicates to thrive. The Council of Europe has acknowledged the importance of recognizing corruption's role, declaring that it plays an integral part in the illicit trafficking of any "good", whether it is drugs, weapons, or human organs (Aronowitz 2009 p.62). This chapter will investigate the extent to which corruption permeates the processes of organ trafficking and transplant tourism by discussing three major cases: the Netcare case in South Africa, the Medicus case in Kosovo, and the prosecution of Rabbi Levi Rosenbaum in the United States. Using theory and discourse provided by literature on the topic of corruption

and from interviewed first-hand sources, the discussion will highlight the large role that it has in increasing the capacity of the organ trade to thrive.

6.3.1 Defining Corruption and Acknowledging Its Various Forms

In order to discuss the link between corruption and the black market in human organs, a proper definition is needed to explain what is meant by “corruption”. The Criminal Law Convention on Corruption drafted in 1999 by the Council of Europe defines corruption as “requesting, offering, giving or accepting, directly or indirectly, a bribe or any other undue advantage or prospect thereof, which distorts the proper performance of any duty or behaviour required of the recipient of the bribe, the undue advantage or the prospect thereof” (Council of Europe 1999). Global watchdog and non-governmental organization, Transparency International, echoes those words in its brief yet effective description of corruption as “the abuse of entrusted power for private gain” (Transparency International). No matter the source, corruption is recognized by most organizations as well as national and international legislation as improper conduct by a public official for which he or she is rewarded, whether by monetary compensation, promotion, or similar.

Corruption can exist in two forms: proactive and passive. The former would be a deliberate act like “actively assisting traffickers in procuring travel documents” or a hospital director designating specific rooms for illegal transplants to be performed in (Aronowitz 2009 p.62). Passive corruption is demonstrated by an act like “turning a blind eye” to illegal activity. A real-world example could be an Indian official failing to report his suspicions over the validity of a familial or friendly relationship between a living organ donor and his or her recipient. Passive and proactive corruption can exist together or separately in a given country or context. The presence of corruption in any form is a problem worthy of addressing, as it “hurts everyone whose life, livelihood or happiness depends on the integrity of people in a position of authority” (Transparency International). In the case of the organ trade, those hurt the most by corruption are the sellers who live their post-transplant lives with physical and emotional scars.

6.3.2 The Medicus Case: Kosovo

The initial decision to investigate the role of corruption in the organ trade, came from a review of a 2011 Council of Europe (COE) resolution written by member Dick Marty calling for appropriate parties to support an investigation into the roles of the Kosovo Liberation Army and Kosovo President Hashim Thaci in an alleged organ ring (US prosecutor to investigate Kosovo PM for organ trafficking: Jurist). The accusations gained media attention and stirred up controversy when the former head prosecutor for the International Criminal Tribunal for the former Yugoslavia (ICTY),

Carla del Ponte, made claims in her book that Serbian and non-Albanian prisoners had their organs forcibly-removed for the purpose of trafficking, during the 1998-1999 Kosovo War (Zebley 2011). After a two-year investigation into the scandal, Marty drafted a report describing the details of the organ-trafficking ring, including the location of the surgical clinics, figures involved, and the manner in which captives were executed in order to harvest their organs (BBC 2010). His suggestions were eventually drafted into a COE Resolution that encouraged the judicial body, as well as Albanian and Serbian authorities, the European Union, and the European Union Rule of Law Mission in Kosovo (EULUX), to work together and individually to address these allegations (Marty 2010). One of the most alarming points of the report are accusations that Kosovo's Prime Minister Hashim Thaci was a key player in organized crime and a member of the "Drenica Group", whose alleged crimes including deciding the fate of captive prisoners smuggled into Kosovo (Marty 2010). Before Marty's report concludes, he acknowledges that during their investigation, his colleagues and he found plausible evidence pointing to a connection between the prior trafficking crimes he discusses and a more recent case: the Medicus Clinic. "In particular, we found a number of credible, convergent indications that the organ-trafficking component of the post-conflict detentions described in our report is closely related [...] not least through prominent Kosovar Albanian and international personalities who feature as co-conspirators in both" (id.). In light of the ongoing investigation regarding the Medicus Case, Marty refrains from commenting further. Though the crimes alleged in the Medicus Case are not directly related to those committed during the Kosovo War, they are of the same nature and were, arguably, made possible due to the political atmosphere and heightened levels of corruption. In his concluding remarks, Marty states that organized crime has had a presence in Kosovo for some time now, and that the connections between these crime groups and politicians can no longer be ignored.

In 2008, the Medicus Clinic in Pristina, Kosovo was raided on grounds that illegal transplant surgeries were being performed there. Following the physical collapse at Pristina Airport of a Turkish national who reported having donated one of his kidneys to an Israeli, authorities stormed the building and began an investigation into the allegations of commercial transplantation. In 2010, the prosecutor for the European Union Rule of Law Mission in Kosovo, EULEX, filed indictments against seven people including six physicians and a former senior level official in the Ministry of Health (Sándor et.al. 2012 p.102). The prosecution alleges that brokers promised the Turkish, Russian, Moldovan, and Kazakhstani victims roughly 14,500 Euros for their organs, while recipients paid anywhere from 80,000 to 100,000 Euros per organ (ibid p. 103). The trial officially began in October of 2011 and the charges include: trafficking in persons for the removal of organs for transplantation; "recruitment, transportation, transfer, harboring, or receipt of persons for the purpose of exploitation"; "trafficking in persons within a structured group in order to obtain, directly or indirectly, a financial or other material benefit"; "carrying out medical treatment or engaging in any other medical activity for which specific qualifications

are required by law, without possessing professional qualifications of legal authorization” (ibid). The latter charge is against three defendants, while the trafficking charges apply to four defendants (Emg.rs 2011). The final allegations included in the indictment charge a medical doctor and a “former Permanent Secretary for the Minister of Health” in Kosovo with “abusing official authority”, made punishable by the Criminal Code of Kosovo (Sándor et al. p.103).

According to several media sources, the prosecution in the Medicus Case has alleged that one of the defendants, lead surgeon Lufti Dervishi, was assisted in his efforts by Turkish doctor Yusuf Sonmez and an Israeli organs broker, Moshe Harel (CBS News 2010). A 2011 report by the Associated Press stated that the two were charged separately for their involvement by EULEX and that Harel was detained by authorities in 2008 but allowed to return to Israel until further legal proceedings took place (Qena 2011). Sonmez has been a prominent character in Nancy Scheper-Hughes’ investigation and research into the organ trade. She dates Sonmez’ involvement in international commercial organ transplants back to the early days of transplant tourism for Israeli patients (Scheper-Hughes 2011 p.66). Several undercover investigations by Romanian police and Turkish journalists and authorities resulted in the public ridicule of Sonmez, as well as his arrest multiple times. He was however released following those arrests and continued to perform transplant surgeries, even receiving honors and praise by some for his efforts. One source of praise was, according to Scheper-Hughes, the Israeli Ministry of Health for “services rendered to the state of Israel, saving the lives of countless kidney patients” (ibid p. 71). Not all governments or international bodies praise the “services rendered” by Mr. Sonmez, however. As of May 2012, Yusuf Ercin Sonmez and Moshe Harel are wanted by Interpol on charges of human smuggling, trafficking, and illegal immigration (Interpol).

6.3.3 The Netcare Case: South Africa

In 2010, Netcare Kwa-Zulu, a private South African medical company, pleaded guilty to 102 counts related to 109 illegal kidney transplants that took place between June 2001 and November 2003 (Allain 2011 p.1). The case, *The State vs. Netcare Kwa-Zulu (Pty) Limited*, also known as “Kidneygate” in South Africa (Mail and Guardian 2011), broke precedent as one of the first of its kind to implicate a hospital and its staff for such heinous crimes. One of the most shocking and noted aspects of the case was the earlier revelation by investigators that nine out of the 109 illegal procedures were conducted on children, whose kidneys were removed for transplantation into the bodies of paying recipients. These recipients paid anywhere from \$100,000 to \$120,000 to an Israeli broker who recruited kidney donors first from Israel, then later from Romania and Brazil. The change in donor nationalities was to maximize profits, since Romanian and Brazilian kidneys could be bought for a lower cost (Allain 2011 p.2). According to a report by Al Jazeera, the broker, Ilan Perry, was not charged with

any wrongdoing after he took on an informant role with South African police that allowed them to gain further information on suspected criminals working in and around the nation's hospitals (Al Jazeera 2010).

In the same 2011 piece by Nancy Scheper-Hughes, in which she discusses the long career of Yusuf Sonmez, charged in the Medicus Case, Perry is acknowledged as one of the original brokers in the transplant tourist packages sending Israelis abroad to obtain kidneys from “poor, displaced or debt-ridden Turks, Ukrainians, Moldovans, Romanians and new Israeli immigrants, and trafficked Moldovan and Romanian kidney sellers” (2011 p.65). This time around, in Durban, South Africa, Perry arranged for his original Israeli suppliers to receive \$20,000 and the Romanians and Brazilians to receive somewhere around \$6,000 (Allain 2011 p.1). In an act that would ultimately become police investigators’ “smoking gun”, one of the arranged suppliers, an Israeli named Shlomo Zohar, escaped the hospital immediately before surgery, deciding he could not go through with the operation. He called his wife to meet him at the airport at the same time that another local broker called the police at Johannesburg airport, claiming that a man was attempting to board a plane for Israel with a stolen sum of \$18,000 (Scheper-Hughes 2011 p. 77). Police had monitored the Netcare facility, called “St. Augustine’s”, for months before the incident, and upon the arrest of the escaping Israeli, police entered the hospital and arrested eleven people (id.).

In likeness to the previously discussed laws of India and the Philippines, South Africa requires valid proof of a kinship between a potential transplant donor and recipient pair. In order to evade this legal requirement, kidney suppliers and recipients were ordered to sign documents that falsely stated that each was related to the other. The company itself escaped charges of fraud and forgery in association with actions like falsifying documents, by entering a plea deal and paying 7,820,000 rand (the Telegraph 2010). The plea agreement stated that Netcare employees were aware that suppliers in the transplants could not have been related to recipients. The agreement supports this notion by pointing out that most of the suppliers were Portuguese-speaking Brazilians with Portuguese names, donating to Hebrew-speaking Israelis with Israeli names (Mail and Guardian 2011).

In an article featured on South Africa's Mail and Guardian online news site (2011), claims are made that Netcare was warned numerous times about the activities taking place at not only the Durban clinic but also at hospitals in Cape Town and Johannesburg. Several of these warnings came from the head of surgery at the medical school at the University of Cape Town, Del Kahn, who stated that he was approached by Ilan Perry as early as 2000 about the demand for organs by Israeli patients. Netcare approached Kahn in regards to his concerns that illegal transplants were occurring, and said that any transplants taking place were not in violation of the Human Tissue Act 1983 (id.). Kahn's concerns were, however heeded by the head of transplant surgery at a Netcare clinic in Cape Town. After investigating the origins of donors and recipients involved in forty surgeries, the clinic realized that every one of them was an Israeli citizen. Probing further into the curiousness of the situation, they

looked for answers and were told by the Israeli Ministry of Health that all the transplants were legal and ethical. Doubting the validity of this point and trusting the words of Kahn, they stopped the transplant program and declined to restart it at the request of the then Netcare CEO (id.).

Although the charges against Netcare Kwa-Zulu (Pty) Limited and CEO Richard Friedland were dropped, further employees including a nephrologist, four transplant surgeons, and two transplant administrative coordinators were charged. The first five counts in the affidavit were in conjunction with the “use of five minors as organ suppliers in violation of the Human Tissue Act 1983”; this act prohibits the purchasing of tissue, requires consent be obtained for a transplant to occur, and forbids the use of minors for transplantation of tissues. The next five counts hold the defendants accountable for receiving payments from the transplants involving the five children. Charges eleven to 102 of the indictment were for the violation of terms set forth in the South African Prevention of Organised Crime Act 1998. (Allain 2011 p.2)

6.4.4 The Rosenbaum Case: USA

In 2009, Rabbi Levy-Izhak Rosenbaum was arrested in New Jersey, USA in what was to become the largest corruption sting in the history of the state. The charges brought against him, which he later plead guilty to, were “conspiracy to acquire, receive and otherwise transferring human organs for valuable consideration” and “acquiring, receiving and otherwise transferring a human kidney for valuable consideration” (United States of America v. Lezy Izhak Rosenbaum). Rosenbaum had brokered numerous kidney transplants in exchange for roughly \$120,000 or more (Haaretz 2011). Rosenbaum was taken down during the sting operation after an FBI informant posing as a businessman introduced his “secretary”, actually an undercover FBI agent, who claimed she was in need of an organ for her sick uncle. While being secretly recorded by the FBI informant, Rosenbaum boasted of his success and explained that one of the reasons that brokers have to charge so much from recipients is that doctors, visa-preparers, and smugglers needed to be paid off. According to an article published on Haaretz by the Associated Press, Rosenbaum stated that “you have to shmear others all the time”, “shmear” referring to an act of payment (id.).

During the trial, Rosenbaum’s lawyers issued a statement on their clients’ behalf echoing Rosebaum’s earlier claims that he was a sort of “matchmaker”. They essentially praised him for bringing new life to persons who were otherwise doomed as they were burdened to analysis and ultimately kidney failure (New York Times 2011). Their statement did not mention the situation that their clients’ actions put the organ sellers in. Considering the recipients of these illegal organ transplants as the biggest victims is not a unique problem to this case. In a conversation I had with Susanne Lundin, she explained that many persons in need of an organ see themselves as the victim. They say that “they are sick, they are dying, they are also the victims because our society doesn’t take care of them [...] and they are the victims because

they themselves have to take the responsibility to go abroad and buy a new organ” (Lundin 2012). She explains that it is a means of legitimizing their actions. We can see this as another example of an evolving standard of social ethics as well as a degradation of social cohesion.

6.4.5 The Red Thread

Despite their differences, each of the given cases in this chapter demonstrates the impact of corruption on the proliferation of the illegal market in human organs. They are among countless other cases that could be mentioned here for the purposes of showing that impact. In China, accounts of prisoners being strategically executed for the purposes of harvesting their organs hold serious clout worldwide (Panjabi 2010 p.91). In Egypt, dismembered bodies of East African refugees are found scattered in the desert of North Sinai with professionally stitched sutures down their abdomens (Al-Azazy 27 April 2012). The exploitation, violation of ethics, and breach of professional trust that embodies each of these cases bears witness to the truth that not enough is done domestically nor internationally to fight corruption and protect its most vulnerable victims. In most societies, religious figures, doctors, and nurses are persons in whom we are told to instill trust from a young age. To risk the potential tarnishing of such a respected position, it should be assumed that persons of this stature would have to be tempted into engaging in corrupt, illegal, unethical practices by the promise of a large reward. Driven by greed, their corruption “fuels and feeds on the whole nefarious activity of organ trafficking” (Panjabi 2010 p.22-23).

7 Conclusion

7.1 Where Does This Leave Us?

At the time of this report's publication in May 2012, 114,247 persons were on the national organ waiting list in the United States (Organ Procurement and Transplantation Network 2012). In 2010, in an effort to bring further attention to the issue, President Obama declared the month of April as National Donate Life Month, calling on Americans to register to become an organ, tissue, blood, and stem cell donor (Panjabi 2010 p. 14). The social media giant Facebook recently brought about awareness to the need for donors by inviting users to register and publish their wishes to fellow users. The action created an instant increase in registration (Satel 2010), but it is still too early to tell if the inspiration it generated will be sustained. As we wait today, tomorrow, and in the near future to see if public actions like these will have an effect, another name will be added to the list every ten minutes. Seventy-nine persons will receive a new organ daily, while eighteen will die because they did not. These names represent Americans from every race, gender, and socioeconomic group present in the country. National transplant waiting lists do not discriminate; the illegal pathways constructed to alleviate their waiting times, however, do. Transplant tourism and organ trafficking exploit one of the most innate desires we have as human beings: to live. As long as states, like the US, fail to effectively and continually increase organ donation rates, the rogue, underground world of organ trafficking will remain as an option for the most desperate patients with the economic means to pay their way to what they hope is a second chance at life.

7.2 Proposed solutions

Upon digesting all of this material and the discussions that go along with it, we come to a point where we ask ourselves "what can be done to remedy this situation?" Countless proposals exist for how to maximize the potential for equilibrium in supply and demand. These include legalizing an open market in organs, encouraging live donor transplants, and even rewarding citizens for registering on a national donor list through non-monetary compensation. Some options are better than others in terms of achieving the intended goal, however very few proposals are met without ethical debate.

7.2.1 Compensation

In a 2003 article featured in the Journal for Medical Ethics, professor L D de Castro claims that the opponents of a system in which donors are financially compensated for their organs formulate their arguments on “weak rational grounds” (2003 p.142). In a very concise and clear manner, he acknowledges these arguments by systematically going through many of them and countering their focal point. In defense of the concern that donor compensation aids in the commodification of an organ, he argues that there are already many occasions in which society rewards citizens of the community for their “noteworthy accomplishments” (ibid. p.143). His examples include rewards to persons who help the police catch a criminal and monetary compensation to the relatives of a killed soldier. He also points out that money is given as a gift to the parents of a baptized child, or to a bride and groom on their wedding day; an exchange of money in these circumstances is not perceived as “suspicious” (id.). It should be noted that his justifications are outlined in a piece that the journal classifies under the topic: “controversy”.

Israel recently became the first country to offer compensation for registration as an organ donor, by promising a higher position on the national wait list. If a person signs a donor card, “opting-in” to the system, then he or she and his or her relatives or spouse will be placed higher on the list should he or she be in need of a transplant in the future (Brimelow 2009). The law was changed in an effort to increase the number of organ transplants every year, by offering an incentive. Critics of the law suggest that it could have the potential of offering life-saving treatment to someone who needs it less than someone who is considerably sicker (Ofri 2012).

7.2.2 Legalization

Although de Castro’s suggestions fall short of what he himself would likely consider a promotion for a commercialized trade in organs, his suggestion that non-related and related donors should be cut a deal for their “gift” is still morally questionable by many. It still puts a price on part of the body. Advocates who stand firm in their support for a legal market in human organs do so by saying that such a market would reduce the level of exploitation faced by the present sellers in the organ trade (Voo et al. 2009 p.3620). They propose a national body or agency that would be in charge of matching donors and recipients and transferring payments, similar to the system in place in Iran. This agency would also oversee the post- and pre-operative care of the donor, thereby reducing his or her likelihood for developing problems as a result of the surgery (id.). Other advocates point to the notion that *we* are the owners of our bodies, and should therefore have control over what we choose to do with it. Scheper-Hughes rejects that argument as “one based on Euro-American notions of contract and ‘individual choice’”. This “choice”, to which she mockingly refers, is hardly voluntary for a person selling a kidney “in an urban slum of Calcutta, or in a Brazilian favela or Philippine shantytown”. The choice is “anything but a ‘free’ and

‘autonomous’ one” (2002 p. 78). She suggests that the defense by some that we have agency over our own bodies and therefore the right to sell a piece of it, can be combated with a response highlighting the ineligibility for an organ to be a candidate for commodification (id.).

Organs are unlike other parts of us, like hair or fingernails, as they sustain life. Following this line of opposition, many philosophers, anthropologists, and researchers of the trade from other faculties reflect on Kantian ideals that assert the dignity of the human being as reliant on the protection of the whole being. The body cannot be separated from the self (Cohen 1999 p.292).

“We are organic wholes whose kidneys, hearts, and eyes are a part of *us*, not isolated organs. Dignity does not just accrue to certain distinctive features of humans, such as self-consciousness, freedom, and rationality, but to all of their integral aspects. Our embodied integrity is not an object that we own in the way that we own such discrete things as cars. It is not something that can be separated off and sold while leaving our self intact. Thus, any body part that is necessary for the functioning of the whole person, Kant asserts, is endowed with the dignity of that person.” (id.)

This argument does not, however, suggest that a donation is an act of disgrace upon the body or the self. Opponents of a market in human organs do not implicate themselves as hypocrites as donation is viewed as an act of solidarity that brings new life and new health to another person.

Other opponents of a legal trade in human organs express concern that it would do very little to eradicate the existence of a black market in organs, as some supporters suggest. Unless some sort of framework was implemented to tackle illegal brokering, buying, and selling, the underground trade would persist. A black market would “continue to target those with a lack of information or those who are more concerned with financial benefits than safeguards for their health and life” (Voo et al. 2009 p.63).

7.3 Final Remarks

The motives for selling a healthy, functioning piece of one’s body are often born out of a hopeful yet desperate attempt to make a sum of money capable of lifting the burden of poverty and the hunger, insecurity, and strife that it brings. The motives for buying that part are, in return, born in part from an ironically similar position of desperation and a desire to alleviate one’s self from the burden of illness and imminent death. It is difficult for any person not devoid of feelings or a conscience to hear the testament of a person on dialysis or undergoing organ failure and empathize with their condition and their desire to live. For them, a transplant represents the only hope for a life free of daily medical intervention or even for a life at all. The moment they choose to actively engage in commercial transplantation, however, they enter a world that thrives off of exploitation, corruption, and a violation of basic human

dignity. The benefits of the financial and medical transaction are one sided: the buyer loses something he or she can replace and gains something that has the potential to restore his or her body to a healthy state. The seller loses an organ and receives unjust compensation which, research has shown, very rarely alleviates his or her financial debt. Despite some professionals' rejection of the term "victim" when discussing the sellers of organs, it is hard not to see them as the overwhelming losers in this trade.

During the first discussion I had with Susanne Lundin, she said something in regards to the organ sellers that has remained figuratively "under my skin" ever since. Her comment was in line with the commentary given in her article "The Valuable Body", in which she quotes the sentiments of men in Moldova, a country that has been utilized as a major source for buyable kidneys. Lundin says that some of those men "say they see themselves as 'worse than prostitutes, since we can never get back what we have sold'" (2010 p.7). Scheper-Hughes' experiences have resulted in encounters in which sellers express similar regret and dismay. In a conversation between herself and a "disillusioned" kidney seller in Brazil, Scheper-Hughes states that the man "chided himself after the fact for selling his kidney" and expressed to her "I have learned one thing [...] Even though I have two of them, I will never sell one of my hands" (2011 p.85). Whether the procurement of a person's organs for the purpose of commercial transplant is done by force through trafficking or manipulation in a brokered scheme, it is an act worthy of addressing and effectively responding to by actors in the arenas of medicine, technology, national and international policymaking, and education.

As a researcher of organ trafficking and transplant tourism, the most difficult obstacle to overcome is synthesizing the information provided by literature written from the perspective of experts from different educational and professional backgrounds. The opinion of a bioethicist on what drives the organ trade will differ from the viewpoint of an expert in international law, or the position of a transplant surgeon. There are often different interests and conflicting agendas that create a lack of uniformity from which an efficient means of combating the trade can be proposed. By examining these interests then formulating them into a focused discussion and presentation of theory and empirical evidence, the implications of both legal and commercial organ donation in the realms of society, culture, politics, ethics, and law, can be comprehensibly demonstrated. This paper served to bring together the ideas and opinions, as well as the facts to answer the question of *how* the organ trade is sustained and what factors support its capacity to flourish. By demonstrating the aforementioned implications within various fields, the research underscores the many different, yet equally influential factors that support the underground trade in human parts. The organ trade is a viable one because of the shades of grey that exist in each given realm and an ever-changing stance of acceptance, rejection, justification, repulsion, rationalization, or indifference that leave it in an indeterminate state. The establishment of a picture characterized simply by black and white can only emerge when efforts made to hinder the trade are born out of an understanding of *all* of the elements involved.

Executive Summary

Calling attention to the illegal trade in human organs is essential to the reduction of the trade or any chance of creating an eventual end to it and the exploitation that it brings to the lives of so many. This paper is written in an attempt to show the factors fueling the force with which the trade flourishes, from a comprehensive perspective gained from reading the works of experts from the fields of classical medicine, bioethics, law, anthropology, sociology, and government. The underlying research question asking “what makes the trade viable?” is acknowledged as a question that is capable of producing valuable knowledge that can be used to answer the many various questions that one finds himself or herself asking when presented with the realities of the organ trade. The paper justifies its decision to use this question and also explains that a long-held frustration in the separation of topic-related content in already existing literature also justifies a need to cover several important topics in one concise forum.

The distinction between transplant tourism and organ trafficking is made in the early stages of the report, in order to clarify the concepts and prepare the reader for the following chapters. Transplant tourism is treated as the act of going abroad for transplantation that one has paid for and involves a “donor” or seller who receives a fraction of that payment. Organ trafficking is viewed as the process of transporting a person or his or her organs in order to sell them on the black market. They are both considered when the term “organ trade” is used. The study investigating this trade uses qualitative research methods including open-ended interviews, a literary analysis and summation of important documents and articles, and what is referred to in the text as “minor” case studies. The justification for calling these cases is the feeling that each was treated as they would be if the entire research was based on a case study; they were compared and contrasted during the research process and the existence of their similarities is demonstrated in a section of the chapter focused on uncovering ideas pertaining to one system: corruption. The cases are not, however, the main focus of the overall research and it is therefore important to acknowledge their role as simply supportive pieces within the text. The weaknesses and the downfalls of the open-ended interview method are discussed in accordance with the third interviewee, with whom emotional distraction discouraged any chance for non-biased results. His accounts of the alleged trafficking of human organs in North Sinai, Egypt did, however, remind me that at the heart of this issue is exploitation and degradation of human lives. That sparked a fit of motivation that encouraged the research and the writing process further.

The information obtained from the interviews and the extensive reading and constant reviewing of the literature allowed me to take a vantage point from which I

could clearly equate several important factors to parts of the puzzle in answering the overarching research question. As given in the main body of the text, following the methodological framework, the factors include cultural considerations, ethical implications, and international and domestic laws and policies. Within the greater topic of culture, the topics of nationality and religion are discussed in order to explain how beliefs or ideologies can affect the organ trade on many levels. These concepts are often found at the heart of social science inquiry as well as likely sources for debate and disagreement. Religious and cultural ideas about the body while alive and after death limit the number of persons willing to offer their organs for the purpose of transplantation. Other relevant points discussed in the culture chapter pertain to the abuse of the religious argument by those who try to draw sympathy from cultural relativists who would treat someone's objection to donation as simply part of his or her beliefs. Although the research does show that some religious leaders object to the removal of organs after death, the overwhelming majority of them sanctions it and encourages it. This undermines the protest of many to donation or transplantation.

The cultural reflections also discuss the phenomenon of certain social groups—namely first-generation migrants in Europe—going abroad for a commercial transplant. Their distrust in the state and feelings of isolation are both proposed reasons for why they rationalize the choice to engage in transplant tourism.

Legal framework and the presentation and discussion of international and national policies discussing organ trafficking as well as organ donation are presented in order to show the shortcomings of most acts of legislation. National policies highlight the need to encourage donation in order to increase the supply, whereas international policies are discussed to demonstrate the international condemnation of the trade.

The theoretical framework presented in the report revolves around the basic concepts of ethics and commodification of goods. Ethical theories are presented within the context of the erosion of social values and camaraderie, bioethical deficiencies, and the role of doctors and professionals in regards to both ethics and corruption. The ability to objectify another person and see him or her as something that can be broken into parts for the consumption of another was central in wanting to know more about theory that existed to explain such processes. Additionally, the abuse of power in order to gain financially or otherwise also has the potential to create an environment in which the exchange of those parts is made possible.

The paper concludes by briefly sharing the ways in which several prominent figures in the discussion have suggested we combat the trade, including the push to legalize it and the push to compensate live donors in cash or kind. The underlying focus of the research is reiterated to show the importance of every major topic investigated in the purpose of answering the question. The insistence that the literature is scattered and particular to the field studied by individual writers is reiterated to show the contribution that the compilation of this research has provided to the chosen topic.

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Appendix 1 Graphs

Indicator	Moldova	Egypt	Pakistan	Philippines
Voice and Accountability	-0.31	-1.12	-0.1	-0.12
Political Stability	-0.5	-0.63	-2.76	-1.42
Control of Corruption	-0.74	-0.41	-1.1	-0.71
Press Freedom	65	60	61	48
TI Ranking (2011)	112	112	134	129

Table 9.1

Indicator	Israel	United States	Saudi Arabia	South Korea
Voice and Accountability	0.58	1.11	-1.77	0.69
Political Stability	-1.45	0.41	-0.37	0.21
Control of Corruption	0.78	1.18	0.15	0.52
Press Freedom	29	18	83	30
TI Ranking (2011)	36	24	57	43

Table 9.2

Sources: Transparency International; World Bank