

THE INTERNATIONAL KIDNEY TRADE COMES TO LONDON: 1979-1990

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DEDICATION

To the memory of Professor Jerry Bentley, 1949-2012

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ABSTRACT

In 1980s suburban North London, a small coterie of medical professionals facilitated the sale of kidneys from impoverished live donors to critically ill recipients. Both donors and recipients were recruited from abroad. These arrangements were exposed in 1988, resulting in public scandal, professional disgrace, and the passage of legislation banning the buying and selling of human organs. Seemingly localized, these events in fact were a nexus of national and transnational phenomena related - but not limited - to the growth of commercial medicine in the United Kingdom, patterns of postcolonial migration, flows of international investment capital, the exacerbation of patterns of global wealth and poverty, the rapid advancement of the science of pharmaceutical immunosuppression and, most importantly, the growth of an international market in human tissue and a corresponding public fascination with the workings of that market. This dissertation attempts an explication of that nexus.

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INTRODUCTION

The work that follows is a sustained and multi-faceted attempt to address “organ trafficking” — the buying and selling of human organs for transplant — as a historical phenomenon. In this work I argue, ultimately, that organ transplantation and other high-technology prosthetic medical procedures that proliferated in the second half of the twentieth century are evidence of an epistemological shift that occurred in the medical profession after the Second World War. The biologist Joshua Lederberg described this shift as the movement from “eugenic” medicine (concerned with the alteration and “improvement” of human populations) to “euphenic” medicine, concerned with the alteration and improvement of individuals.¹

Given the flawed premises and ingrained bigotries of eugenic medicine, not to mention its historical outcomes, it is difficult not to see the euphenic as an unqualified improvement over the eugenic. In the work that follows, I do not question that this is the case. I do, however, by focusing on organ trafficking, call attention to a difficult byproduct of the epistemological commitment to the euphenic as an organizing principle for medicine and health: Raised expectations for life expectancy create demand for medical commodities (such as transplant kidneys) that have been, from the outset, deemed “scarce.” This pervasive scarcity has in turn created black and grey “markets” for transplantable kidneys. These markets have, as I will show, created relationships between

The first and most obvious barrier to writing a history of the practice of organ trafficking is the recentness of both the practice and the technologies that make it possible. The rudimentary techniques of vascular surgery are barely one century old. The first attempted — and failed — organ grafts took place in the early twentieth century. The first successful kidney transplant took place between identical twins in the 1950s. The knowledge of human immunology and the pharmaceutical innovations that sprang from such knowledge were barely in place at the end of the 1960s. Neither were the drugs that

¹ Joshua Lederberg, “Biological Future of Man,” in Gordon Wolstenholme, *Man and His Future*, Toronto: Little, Brown and Company, 1963, 263-273.

made selective immunosuppression — and by extension, successful organ donation between non-blood relatives — yet available.²

In the industrialized world, the first legitimate application of this technology was cadaveric donation — the removal of healthy organs from the dead, generally accident victims. Developed in parallel, however, on a global scale almost from the outset, was paid live donation, in which “donors” were recruited, matched by blood and tissue type with renal patients and ultimately paid to undergo a nephrectomy. Invariably, donors are poor and buyers are, in comparison, wealthy. For this reason, the historical unfolding of global organ trafficking as a process is inextricably tied to global movements of wealth and resources from the “global south” to the “global north” that themselves are a historical phenomenon rooted in the realities of transoceanic European colonialism and its successor: the webs of dependency established between former colonies and their former colonies, described, not without difficulty, as neocolonialism.³

Additionally, the technological possibility of unrelated donor transplantation occurred during a transitional period in what is still referred to — with all due ontological hesitance — as “the global economy.” In the broadly agreed upon narrative of post-war economic history, 1945 to 1973 is marked out as a period of wage growth and generally high economic productivity. Beginning with the “oil crisis” of 1973, the world economy is seen as having entered a period of stagnation, low productivity and inflation. 1978 is seen as the point of transition from demand-oriented Keynesian economic policies to monetary-oriented neoliberal economic policies which resulted, among other things, in transfers of wealth upwards, both within national economies and between them. It is at almost precisely this moment in economic history that global organ trafficking begins. Whether and to what degree this global shift in economic policy exacerbated the

² For a history of transplantation surgery writ large, Nicolas Tilney, *Transplant: From Myth to Reality*, New Haven: Yale University Press, 2003 is concise and relatively up to date. For an equally accessible history which focuses on the human kidney and treats kidney transplantation as part of the larger history of renal medicine, Steven J. Peitzman, *Dropsy, Dialysis, Transplant: A Short History of Failing Kidneys*, Baltimore: Johns Hopkins University Press, 2007, is excellent, and far more introspective regarding the nature of scientific progress than most histories of medical technology written by doctors.

³ For “global” histories of organ trafficking, see the works of the anthropologist Nancy Scheper-Hughes, discussed at greater length later in this chapter. For global histories of the nexus of nineteenth century imperialism and twentieth century capitalism, the field is crowded and somewhat fraught. The many variants on such histories are discussed in Chapter 4, but for now, Michael Hart and Antonio Negri, *Empire*, Cambridge: Harvard University Press, 2000 exemplifies the general approach.

pressures that cause poor people to undertake extreme and desperate economic decisions is beyond doubt, but for the historian, the matter is not that simple.⁴

At the core of this study is the convoluted narrative of a British nephrologist and his assistants — both lay and medical — who, for roughly a decade, facilitated the sale of kidneys from live donors to renal patients. Their business was overwhelmingly conducted from within the confines of private hospitals and clinics in and around London. Donors and recipients in virtually every known instance were foreign nationals or, in the parlance of the time and place, “overseas patients.” Their business was conducted in secret, so many important details are obscured. The practice came to light briefly in 1985 over a handful of surgeries performed on donors and recipients from India and Pakistan. A much more detailed expose took place in 1989 revealing the sale of kidneys from impoverished Turkish donors to patients from Greece, Israel, Libya and Afghanistan. In the barrage of investigations and hearings that followed over the next year, enough information emerged to suggest a coherent story, and that story forms the nucleus of this dissertation. Important questions remains out of reach however: To what degree were these widespread practices among the London medical establishment of the time period? Were Dr. Raymond Crockett and his associates — all outsiders within that medical establishment, for reasons that will be discussed — ultimately scapegoats?

More clearly explicated is the relationship between the practice of paid organ donation in London in the 1980s and the cautious but pervasive reforms applied to Great Britain’s tiny for-profit medical sector in the early 1980s. As with neoliberal globalization, easy narratives about the privatization of public services must be treated here with caution.

I will begin by surveying varied and overlapping academic literatures that are necessary to contextualize the questions asked by this dissertation. Most critical is a tradition I have called “transplantation ethnographies.” Generally produced by anthropologists, these works dive deeply and systematically into the life worlds of

⁴ It is the “World Systems” approach that has most succeeded in situating the transition from post-war “boom” to post-oil crisis “bust” in a coherent global economic historical narrative. World Systems analysis will also be discussed at greater length in Chapter 4, but for a general survey of this approach, Robert Brenner, *The Boom and the Bubble: The U.S. in the World Economy*, New York: Verso, 2003 is an excellent resource.

contemporary sellers, buyers, doctors and “kidney brokers” who collectively make up the local nodes in what one famous ethnographer has dubbed the global “traffic” in human organs.⁵ These ethnographies are an indispensable entry point into the contemporary ethical questions that swirl around the practice of kidney selling: Should the practice of organ-selling be illegal? If so, how should that illegality be enforced, and by whom? Should the practice be legal, and if so, should it be regulated? If it should be regulated, then by what, and by whom, with what means at their disposal and what limitations on their authority? Should it be legal and unregulated, or minimally regulated? If minimal or nonexistent regulation is the answer, is this because of a philosophical opposition to paternalism, or because of a conviction that the unfettered price mechanism will automatically correct the “shortage” of transplantable organs? These arguments are typically made by professional ethicists or economists and cast in universal terms. The tradition of the ethnographer in the dialysis center, the surgical hospital and the tissue-typing lab has evolved as an important counterpoint to this prescriptive tradition. Ultimately, the question will be whether such ethnographies provide a usable template for analysis of a time, place, group of people and institutional framework that have already slipped into the past. Although the economic reforms that serve as the backdrop to the story of Dr. Crockett and his patients are still with us in many respects, the 1980s can legitimately at this point be thought of as a historical moment.

Beyond ethnography, this chapter will explore a popular medico-scientific literature of the 1960s in which transplantation played an important rhetorical role as a marker of the promise of human perfectibility and, though generally stated more cautiously, immortality (a subject which is broached more openly in academic and scientific discussions of cryogenics.)⁶ Finally it will examine the dense and complex literature related to prosthesis, one which begins with the Freudian tradition and gradually wends its way through the traditional social sciences and critical theory, asking whether the very notion of the prosthetic — the negotiation and renegotiation of the relationship between the human body and its physical environment — isn’t merely

⁵ Nancy Scheper-Hughes, “The Global Traffic in Human Organs,” *Current Anthropology*, 41(2), 2000, p. 119-211.

⁶ Tiffany Romain, “Extreme Life Extension: Investing in Cryonics for the Long, Long Term,” *Medical Anthropology*, 29 (2) 2010, p. 194-215.

another way of asking what it means to be human. The idea of the prosthetic is essential for understanding the historical “stakes” of paid kidney donation, for reasons that will be clear by the end of this chapter.

Chapter 2 turns to the archival research that forms the basis of this dissertation. Assessing the evolution of British laws related to the use of body parts for medical purposes, principally dissection, in the nineteenth century, and turning to the role of Britain’s tiny private medical sector in relation to the much larger National Health Service, the first half of the chapter lays the political and economic groundwork for the cautious and incremental liberalization of restrictions on private medical practice that took place in the early 1980s.

Relying heavily on the transcripts of a 36-day hearing conducted by the Professional Conduct Committee of the General Medical Council (a United Kingdom-wide registry of physicians, whose authority is derived from Parliament), in addition to copious newspaper articles from the United Kingdom and Turkey, Chapter 2 attempts to meticulously reconstruct a narrative of events involving Dr. Crockett and his patients beginning in the early 1980s and continuing until 1990 when the aforementioned hearing concluded and Crockett’s medical license was revoked. In doing so it must navigate strategic silences, deliberate obfuscations and contradictory accounts.

Chapter 3 explores, in greater detail, the “business” background of both the “Turkish Kidneys” scandal, as it was sometimes referred to in the press, and the larger global economic trends of the 1980s and 1990s that serve as the backdrop to the rise of organ trafficking as a global practice. By necessity, this entails a discussion of “Thatcherism” as a set of political and cultural practices, not least because Margaret Thatcher herself makes multiple appearances in the story of the National Kidney Center, the dialysis clinic in North London that Dr. Crockett used as his base of operations.

Chapter 3 turns to a widespread sociological literature of the 1980s devoted to the economics of privatization of medical services and the influx of investment capital, principally from the United States, into a newly expanded private sector in the United Kingdom, with a focus on London. As a body, that literature is interesting and informative, though striking in its almost uniformly alarmist tone. This chapter will

conclude by inquiring into the source of that alarmism and its possible relevance for understanding the story of Dr. Crockett and his patients.

Chapter 4 examines the possible utility of existing theories of “imperial networks” as a way of understanding the events and institutions described in Chapters 2 and 3. Imported from the fields of Imperial History and Geography, with the strong influence of Postcolonial Studies and the constructivist philosophy of sociologist of science Bruno Latour, network theory offers intriguing an intriguing theory of “reterritorialization” to understand the relationship between private medicine and international finance capital in Britain in the 1980s.

Chapter 4 then goes on to examine the story of Dr. Crockett and his patients through the lens of “World History,” a largely American, relatively recent pedagogical and research strategy modeled upon the work of the earliest “professional historians” — Oswald Spengler, Arnold Toynbee, H.G. Wells, etc. — and relying on anthropological models of diffusionism and controversial sociobiological models of group evolutionary strategies to tell a “universal” story of human development. After considering multiple approaches to — and wholesale rejections of — World History, Chapter 4 then asks whether the story of the “Turkish Kidneys” scandal is, in a coherent analytical sense, global, as well as whether a “global” medical history is possible, or desirable.

Chapter 5 shifts continues with the theme of global movements of ideas and technology, but shifts focus to the dissemination of fictionalized narratives, examining the portrayal of live-organ donation, both voluntary and involuntary, as a trope in narrative fiction in television and film. Drawing upon the work of folklorists who have assembled and studied “organ theft legends,” this chapter examines the anxieties reflected in and explicated by film and television stories throughout the world featuring tales of murder, theft and exploitation in the name of the harvesting of usable human parts.

In vacillating between the historically and geographically particular — paid kidney donation in Istanbul and London — and the universal — be it claims to universal histories or universal medico-ethical principles, this dissertation attempts to assemble a historical ethnography of a practice. It also attempts to test and re-test the validity and the desirability of the “global” as an analytical entry point to a dense and multi-faceted

historical problem that has persisted into the present. In doing so I hope to position a small but interesting body of original research somewhere on the spectrum between the particular and the universal where it may rest securely, yet provocatively. Regardless of whether or not this succeeds, I hope the research may be of an interesting and productive nature. I will begin by situating my research in relation to the existing ethnographic, historical and philosophical literatures related live, paid unrelated-donor renal transplantation.

CHAPTER 1: TRANSPLANTATION AND HUMAN PERFECTIBILITY

International organ-trafficking is a decades-old problem that challenges the ability of national governments to enforce laws and to regulate the lives and well-being of their own citizenry. It is also an extension of challenges of global and regional inequality, as well as to issues of efficacy of access to medical treatment that plays out both within and beyond national boundaries. In this chapter I will survey the varied academic literatures that engage with organ trafficking, both directly and indirectly. In doing so I will establish the core premise of this work, that organ trafficking is one of the more difficult by-products of what I have previously described as the near-universal transformation of the epistemological orientation of the medical profession from a “eugenic” commitment to altering human beings on the level of population to the “euphenic” commitment to altering human beings on an individual level.

The buying and selling of kidneys has also, however, become a cipher: a handy real-world ethical problem upon which can be imprinted any number of issues of concern to ethicists, economists and philosophers, including issues of paternalism, choice, the workings of markets, and the nature of state interference in those markets. As such, the efficacy of organ selling has produced a voluminous academic literature, along with a wealth of ethnographic studies that probe the reality of organ selling “on the ground” — in hospitals, in dialysis clinics, in villages and slums over the last two decades.

This chapter will assess the voluminous secondary literature related to the practice of organ selling. In doing so, it will also explore the many questions of value, of the “commodification” of the human body and of the prosthetic nature of medical technologies related to transplantation and dialysis that radiate outward from these initial questions.

The Ethical and Professional Language of Live Donor Transplantation

Since organ donation became a clinical reality in the 1950s, there have been insufficient supplies of organs suitable for transplant in the United Kingdom.⁷ Transplant organs can come from two places: live donors and dead ones. Live donors are typically individuals who agree to donate an organ to a relative or loved one in need. Dead donors are typically individuals who become “brain dead” as a result of some internal or external calamity and who had agreed while alive to join a registry of organ donors, or whose family or loved ones agree to allow their organs to be harvested before they are removed from life support. There is a limit to what live donors can offer: bone marrow, a kidney, a lobe of their liver. There is theoretically no limit to what can be harvested from a brain dead donor.

Two solutions are periodically offered for the shortage of transplantable organs: a system of presumed consent from cadaveric donors, and the legalization of organ selling. Both are controversial. The latter is more so. Presumed consent means that individuals would be assumed to be willing cadaveric donors unless they went through a specific process of “opting out.” This is the opposite of current policy in the United Kingdom, where individuals are assumed to be unwilling unless they registered as organ donors while alive or their family has given permission after they become brain dead. Legalization of organ selling would mean the repeal of the 1989 Human Organs Transplant Act, which criminalized the selling of organs.⁸

Economists and bioethicists, intrigued by the problems of market efficiency (or inefficiency), paternalism, rational choice and autonomy suggested by a “market” for body parts, have embraced these debates, writing interesting and often provocative arguments in favor of or opposed to the legalization of organ selling. Medical historians, anthropologists and sociologists concerned with transplantation (“transplantation

⁷ Organ Donation Taskforce, *Organs for Transplant: A Report from the Organ Donation Taskforce*, London: Department of Health, 2008, p. 20. This reports and others like it typically treat the transplant organ “shortage” as a current phenomenon while tacitly acknowledging that, ever since transplantation became a practicable medical technology, there has never *not* been a shortage of transplant organs.

⁸ Human Organs Transplant Act, 1989, c. 31
<http://www.legislation.gov.uk/ukpga/1989/31/contents>

ethnographers” hereafter) have, for the most part, been drawn into the debate after its terms have already been established — for or against presumed consent, for or against commercial organ donation.

Transplantation ethnographies tend to fall into two categories: those concerned with cadaveric donation, and those concerned with live-unrelated donation. My dissertation is a transplantation ethnography, albeit a historical one, belonging to the latter category concerned with live-unrelated donation. In this chapter I will survey the existing body of transplantation ethnography and its antecedents, in hopes of establishing a place for my own work within it.

The intellectual space in which ethnographers, ethicists, journalists, politicians and doctors debate transplantation ethics is in some sense an international one, but the legal codes the debate potentially impacts are national ones. Therefore when I write about transplantation ethnography in this chapter, I will be writing about a geographically eclectic group. When I write about the bioethical literature, however, I will be writing specifically about the United Kingdom.

A reliable framework for the historian or ethnographer of medicine is to observe something — a disease, a diagnosis, a treatment — and to then argue that it is mutable rather than fixed, culturally and historically specific rather than universal, in short that it is inside society rather than outside of it. Making such a claim allows the historian or ethnographer to wrest some degree of authority away from the clinician and confer it upon themselves. By proving, in other words, that a psychiatric diagnosis reflects a social bias, the historian or ethnographer proves their discipline to be more disinterested and less distorted than the discipline they are studying. This is what Arthur Kleinman calls the anthropologist’s interpretive dilemma — they too are taking individuals’ experiences and repackaging them, not as medical or scientific knowledge, but as social theory. This is not inherently good or bad, but seen through this framework, the ethnographer, or the historian of science or medicine, has no more claim to disinterested intellectual authority than the doctor does to disinterested scientific authority.⁹ All of the transplantation

⁹ Arthur Kleinman, *Writing at the margin: discourse between anthropology and medicine* (Berkeley: University of California Press, 1995), 95-96.

ethnographies I will assess in this chapter handle this problem differently, with different implications.

Attempts to create an orderly structure in which to write about transplantation is very difficult, largely because there are so many typologies to choose from: live-related, live-unrelated, cadaveric, heart, lung, kidney, legal, illegal. On the periphery: blood banking, dialysis; immunology and gene mapping, to name a few. I have opted to divide my ethnographers into two manageable, if imperfect categories: ethnographers of “above board” transplantation — legal and generally accepted practices of cadaveric and live-related donation, and those who study “below board” transplantation, the generally illegal and ethically unaccepted sale of kidneys by live donors, or worse.

Antecedents: The “Gift” of Blood

Above-board and below-board transplantation ethnographies share an ancestor. Many of the recurrent themes in transplantation ethnographies appeared together for the first time in 1971 in Richard Titmuss’ *The Gift Relationship*, a revolutionary work of social policy analysis concerned with blood donation.¹⁰ *The Gift Relationship* was the culmination of a decade-long conflict between Titmuss’ employer, the School of Social Policy at The London School of Economics, and the Institute For Economic Affairs, a think tank with a distinct libertarian bent.¹¹

Ideologically rooted in the Fabian socialism that also dominated the Labor Party, The School for Social Policy counted among its faculty many of the architects of the British National Health Service and, more generally, the post-war British welfare state, including Titmuss. They saw the National Health Service as absolutely central to the healthy functioning and moral authority of the British welfare state.¹²

¹⁰Richard M. Titmuss, *The Gift Relationship: from Human Blood to Social Policy* (London: Allen and Unwin, 1970).

¹¹Philippe Fontaine, “Blood, Politics and Social Science: Richard Titmuss and the Institute of Economic Affairs, 1957-1973,” *Isis* 93, no. 3 (September 2002): 401-434.

¹²Fontaine, “Blood, Politics and Social Science,” 403.

Even during periods of conservative rule in post-war Britain (1951-1964), the National Health Service and the statist consensus underlying it remained well within the mainstream public opinion. Pro-market dissent from this position was muted, and expressed from the margins. Ideologically rooted in the writings of the Austrian economists Friedrich Hayek and Ludwig von Mises, the Institute for Economic Affairs was the highest profile dissident voice in this scene. The Institute's fundamental position on the National Health Service was that it was an inefficient monopoly, and that the introduction of competitive "market forces" into British medicine would make it more efficient. Throughout the 1960s, Arthur Seldon, the Institute's director, and Titmuss engaged — via position papers, newspaper editorials and pamphlets — in an increasingly polarized and occasionally nasty debate over the efficiency and efficacy of commercial blood banks.¹³

Like transplantation, blood transfusion had been made possible by advances in immunology. Perfected in army field hospitals, it was a medical procedure associated closely with the Second World War, and early blood donation campaigns were an important part of the "Home Front" — the civilian war effort. Also like transplantation, blood transfusion was portrayed by the media and the medical profession as hampered by perpetual shortage. This gave fuel to Seldon's argument that the British system of voluntary, altruistic blood donation was inadequate, and that only the creation of commercial blood banks could ensure adequate supplies of blood for transfusion.¹⁴

Titmuss saw commercial blood banking as anathema to values of the National Health Service. More intriguingly, he saw commercial blood banking as, from a public health perspective, less efficient. *The Gift Relationship* marshaled extensive data and field research from the United Kingdom, the United States, the Soviet Union and South Africa to demonstrate that widespread paid blood donation tended to depress voluntary donation and, more importantly, to increase the risk of blood supplies contaminated with hepatitis and other blood-borne diseases.¹⁵

¹⁴ Fontaine, "Blood, Politics, and Social Science," 426-428.

¹⁵ Titmuss, *The Gift Relationship*, 145-147.

To prove the former point — that paid blood donation was socially harmful — Titmuss drew upon the classic anthropological studies of “gift exchange”: the use of ritualized acts of generosity to establish and maintain social and political relationships. The earliest anthropological field studies — of potlatch ceremonies in North America, of *kula* exchanges in the Pacific — established a general consensus that systems of exchange in non-monetary, often stateless economies possessed a fundamental, organic quality that economies based on monetary exchange did not. This allowed Titmuss to make the argument that altruistic blood donation was a vital force for social cohesion in the public sphere.¹⁶ These two themes — of altruistic as opposed to self-interested behavior, and of socially embedded non-monetary exchange versus asocial monetary exchange — created a powerful organizational framework for the first ethnographers to venture into transplantation units in the 1970s.¹⁷

“Above Board” Transplantation Ethnography

In 1974, the sociologist Renée Fox and the historian Judith Swazey published *The Courage to Fail*, a vast sociological study of transplantation and dialysis in the United States. It was the first of its kind. Their research was conducted between 1968 and 1972.¹⁸

Fox and Swazey did their fieldwork during a period where advances in immunosuppression were relatively slow. Live-donor organ transplants almost always came from close genetic relatives. The kidney “markets” that would develop in India were still a few years away. But, as they were quick to point out, kidney donations between family members did not rule out varying forms of coercion, bribery and general psychological distress between family members. They classified this as the “tyranny of

¹⁶Titmuss, *The Gift Relationship*, 71-75.

¹⁷ Examples of such behaviors in Europe are plentiful as well. Natalie Zemon-Davis, *The Gift in Sixteenth-Century France*, Madison: University of Wisconsin Press, 2000.

¹⁸ Renée C. Fox and Judith Swazey, *The Courage to Fail: A Social View of Organ Transplants and Dialysis* (Chicago: University of Chicago Press, 1974).

the gift” — bonds created between donor and recipient that were “as likely to be mutually fettering to be as mutually self-transcending.”¹⁹

The Courage to Fail documented the treatment of End Stage Renal Disease (ESRD) before the commercial release of cyclosporine, a powerful immunosuppressant discovered in Switzerland in 1972. Their subsequent collaboration, *Spare Parts*, documented the treatment of ESRD after the introduction of cyclosporine.²⁰

According to Fox and Swazey, the general trends they had documented in *The Courage to Fail* — unrealistic attitudes towards aging and death, decreasing ethical stringency in organ procurement — had subsequently accelerated. *Spare Parts* ended with a starkly worded exit announcement that Fox and Swazey would author no more transplant ethnographies:

By our leave-taking we are intentionally separating ourselves from what we believe has become an overly zealous medical and societal commitment to the endless perpetuation of life and to repairing and rebuilding people through organ replacement — and from the human suffering and the social, cultural, and spiritual harm we believe such unexamined excess can, and already has, brought in its wake.²¹

As Fox and Swazey were exiting the field of transplantation ethnography, others were entering. In 1987, the anthropologists Margaret Lock and Nancy Scheper-Hughes published “The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology.”²² As its name suggests, it was programmatic. It called for social scientists and others engaged in the critical study of health and medicine to “deconstruct” received definitions of the human body and, more generally, of the Cartesian mind|body dichotomy. Like Donna Haraway’s “A Cyborg Manifesto,” published a few years earlier, “The Mindful Body” argued against a “naturalized” view of what it means to human. In doing so, both drew heavily upon the “biopolitics” thesis of Michel Foucault: that a style of governance exists in which states take an explicit interest in regulating the health and

¹⁹ Fox and Swazey, *The Courage to Fail*, 383.

²⁰ Renée Fox and Judith Swazey, *Spare Parts: Organ Replacement in American Society* (Oxford: Oxford University, 1992), 210.

²¹ Renée Fox and Judith Swazey, *Spare Parts*, p. 210.

²² Nancy Scheper-Hughes and Margaret M. Lock, “The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology,” *Medical Anthropology Quarterly* 1, no. 1 (1987): p. 6-41.

reproduction of their subjects, and that in such a regime the health of individuals is seen as contributing to the health of an overarching “body politic.”²³

In the 1990s, both Scheper-Hughes and Lock began to explore the world of organ transplantation. Their respective research led them to very different and, in some sense, conflicting positions in the public debates regarding legalized organ sales and presumed consent. Scheper-Hughes’ work concerned live donors, and will be assessed in the next section. Lock’s work largely concerned cadaveric donation, and the establishment and acceptance, or non-acceptance, of brain death as a legitimate medical state, one which makes cadaveric donation possible.

Lock’s work required her to confront the ethical problem of brain death — the legal status of a person whose vital organs continue to function while all higher-order brain activity has ceased, usually as a result of severe head trauma. The general acceptance of brain death as a legitimate state, by the medical profession, by religious leaders, by legislators, and by their constituents is absolutely essential for the feasibility of cadaveric transplant programs. Brain death was more or less legitimized in North America and Europe since the 1960s. Death was understood to occur at more or less the precise moment that conscious brain activity ceased, even if the heart continued beating.

Twice Dead, published in 2002, compared cadaveric transplantation regimes in Canada and Japan. It was already widely commented upon when Lock began her fieldwork that brain death was less widely accepted in Japan, and commentary on this lack of acceptance was generally framed as inquiry into the “cultural” reasons for it. In particular it was assumed that pre-modern attitudes and belief about death and bodily integrity were the cause. Lock’s major contribution to transplantation ethnography was to turn this question on its head. Rather than ask why Japanese society had proven resistant to the brain death diagnosis, she asked why North American society had not. Ultimately, her point was a constructionist one. The boundary between life and death is culturally and historically specific, and fluid.²⁴

²³Nancy Scheper-Hughes and Margaret M. Lock, “The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology,” p. 7-8.

²⁴Margaret Lock, *Twice Dead: Organ Transplants and the Reinvention of Death* (Berkeley: University of California, 2002)

The work of anthropologist Leslie Sharp is, in some respects, a continuation of Margaret Lock's. Published in 2006, *Strange Harvest: Organ Transplants, Denatured Bodies and the Transformed Self* begins with the complexities of brain death and the coordination of cadaveric transplants and concludes with an extended meditation on xenotransplantation, the grafting of non-human tissue into humans. The limited, therapeutic use of animal tissue for vaccines and other pharmaceutical materials is quite real. The harvesting of more complex organs from other mammal species — pigs and chimpanzees in particular — is frequently invoked in both scientific and lay circles despite the formidable immunological barriers that prevent it from becoming a therapeutic reality. For Sharp, publicly expressed anxieties over xenotransplantation are a continuation of similarly expressed anxieties over cadaveric transplants. Lock's particular concern is that, according to her fieldwork, scientific optimism about the life-extension possibilities of such technologies is increasingly divergent from non-scientific anxieties about bodily integrity.²⁵

The anxieties about cadaveric donation and the brain death diagnosis were synthesized and extended to an argument against presumed consent by the British historian Ruth Richardson. In an afterword to the second edition of *Death, Dissection and the Destitute*, her authoritative history of the 1832 Anatomy Act, Richardson drew explicit parallels between the Act, which dictated that anyone who died in penury as a ward of the state could be claimed by medical schools for dissection, and a proposed U.K. law that would have required citizens to formally “opt out” of being considered for cadaveric organ donation.²⁶

“Below-Board” Transplantation Ethnography

In the 1990s, Nancy Scheper-Hughes began to explore the world of paid-donor renal transplantation. While conducting fieldwork in Brazil's impoverished *Nordeste* region for

²⁵Lesley A. Sharp, *Strange Harvest: Organ Transplants, Denatured Bodies and the Transformed Self* (Berkeley: University of California, 2006)

²⁶Ruth Richardson, *Death, Dissection and the Destitute*, 2nd ed. (Chicago: University of Chicago, 2000)

her next major book, *Death Without Weeping: The Violence of Everyday Life in Brazil*, Scheper-Hughes repeatedly encountered rumors in Brazilian *favelas* of homeless children being abducted and having their organs removed. The rumors, she concluded, were baseless, but bodily and existential anxieties that produced them were highly relevant. In the process of testing their veracity, however, she discovered an organ market that *did* exist at the time — between renal patients in the Persian Gulf and hospitals in India, where members of India’s impoverished urban and rural proletariat sold their kidneys.²⁷

These “underground” kidney markets subsequently became the primary orientation of her work. Extensive fieldwork in South America, South Africa, the Philippines, Moldova, Turkey and elsewhere followed, summarized in publications in major journals. Collaborations with non-governmental organizations and journalists led to a far higher public profile than is typical for a social scientist working within the academy. Funding from the Soros Foundation’s Open Society Institute created the non-profit Organs Watch, which, in cooperation with the medical anthropologist Lawrence Cohen, continues to provide an institutional base for organ trafficking research.²⁸

As Scheper-Hughes’ work became more explicitly political and policy-oriented, the Foucauldian gestures of her pre-organs writing disappeared. They were replaced with a theoretical framework preoccupied with the “commodification” of the human body. This framework became increasingly popular among social scientists in the 1990s, partly because of the increased discussion of the social meaning embedded in material objects. Itself a product of a “cultural turn” in anthropology, “commodification” became more fascinating to social scientists progressively more interested in commodities and the exchange of commodities as objects of analysis.²⁹ Among social scientists explicitly concerned with medicine and health, the increased discussion of commodities and commodification was a predictable response to the patenting of genetic materials that began to occur in the 1990s. The notion that human parts, be they renewable or non-renewable, visible or microscopic, were acquiring monetary value, and therefore that

²⁷Nancy Scheper-Hughes, *Death Without Weeping: The Violence of Everyday Life in Brazil* (Berkeley: University of California, 1992)

²⁸Organs Watch website: <http://sunsite.berkeley.edu/biotech/organswatch/>

²⁹James Ferguson, “Cultural Exchange: New Developments in the Anthropology of Commodities,” *Current Anthropology*, 3(4), 1988, 488-513.

humans were becoming, in some sense, less human, gained traction throughout the 1990s, and continues to do so.³⁰

Meanwhile, in the academy, the news media and the non-profit sector, a multi-faceted and often vigorous discussion went on over what to do about the “shortage” of transplant organs. Every country with a developed transplant program — a system for coordinating patients with brain-dead donors according to autoimmune compatibility — had significant wait-lists, with hundreds, in some case thousands, of patients dying each year while waiting for a suitable donor. The organ “markets” described so viscerally by Scheper-Hughes were a spontaneous and very uneven stop-gap solution to the problem.

The countries with the smallest wait-lists were Spain and Belgium. Both had switched some years prior to a system of “presumed consent” in which members of the public were presumed to be willing donors upon loss of life, unless they went through a specific process of opting out. Two solutions were proposed: switch to presumed consent or legalize organ sales. Generally, however, the problem was not framed as presumed consent versus legalized organ sales; it was presented as a debate over the efficacy of the legalization of organ sales. Scheper-Hughes and Lock found themselves, at least superficially, on opposite sides of the issue. In 1998, Lock co-authored with, among others, the liberal-feminist philosopher Janet Radcliffe-Richards and the venerable transplant surgeon Robert Sells, “The Case For Allowing Kidney Sales.” Published in the *Lancet*, it took issue with the existing arguments against legalized sales: that the sellers’ poverty restricts them from having no option to escape poverty other than to sell a kidney, so therefore their choice is not actually a choice but a grim inevitability, and that donors frequently did not understand the risks associated with the procedure and therefore their consent was not informed.³¹

The article’s title was misleading. At no point did the authors make a case for the benefits of legalized kidney selling. They simply argued that opponents of legalization had not made their case sufficiently; if selling a kidney was, for many people, their only

³⁰Nancy Scheper-Hughes, “The Global Traffic in Human Organs,” *Current Anthropology* 41, no. 2 (April 2000): 191-224. “The Ends of the Body: Commodity Fetishism and the Global Traffic in Human Organs,” *SALS Review* 22, no. 1 (Winter-Spring 2002): 61-80.

³¹ Janet Radcliffe-Richards, AS Daar, RD Guttman, R Hoffenberg, I Kennedy, M Lock, RA Sells, N Tilney, “The Case for Allowing Kidney Sales,” *Lancet* 351 (27 June 1998): 1950-1952.

option for escaping poverty, then it hardly to made sense for a third party to foreclose it. What the authors were actually proposing is made clear by another article they published the same year, in the same publication, in favor of presumed consent.³²

In 2002 Scheper-Hughes and several prominent physicians authored “Ethical Incentives — Not Payment — For Organ Donation” in the *New England Journal of Medicine*, arguing that governments should encourage their citizens to identify as organ donors by offering such incentives as reimbursement for funerary expenses and a proposed “donor medal of honor.”³³

There were hints of acrimony. Scheper-Hughes described Lock’s collaborations with Radcliffe-Richards as “difficult.”³⁴ In 2005, in a review of two books by Mark Cherry and J.S. Taylor, economists concerned with making the case for legalized organ sales on the grounds of market efficiency and personal autonomy, Scheper-Hughes made the following admonition:

If “choice” and “autonomy” were all that mattered, then, indeed, the evidence shows there is no shortage of individuals poor enough, desperate enough, or foolish enough to sell their organs. Have we reached a world of no limits? Taylor’s strongly worded “moral imperative” for organ markets exposes the inroads already made by the stealthy growth on the margins of clandestine markets (black and grey) and market incentives into organ procurement. While defending the individual’s right to sell, neither author articulates the individual’s “right” to purchase “life” in the form of a kidney (or another organ) from a stranger. That “right” is treated as implicit, an assumed universal desire to live a longer or better quality of life at any cost.³⁵

However strongly worded, moral arguments against the commercialization of kidney donation up until this time conceded the most important point. Scheper-Hughes’ arguments conceded that legalizing kidney sales would solve the “shortage” of transplant organs, but that it was nonetheless wrong to do so. A different critique of the legalization argument came several years later from the historians Sheila and David Rothman,

³² Janet Radcliffe-Richards, AS Daar, RD Guttman, R Hoffenberg, I Kennedy, M Lock, RA Sells, N Tilney, “The Case for Allowing Kidney Sales,” 1950-1952.

³³ Francis L. Delmonico, Robert Arnold, Nancy Scheper-Hughes, Laura Siminoff, Jeffrey Kahn, Stuart Younger, “Ethical Incentives — Not Payment — for Organ Donation,” *New England Journal of Medicine* 346, no. 25 (20 June 2002): 2002-2005.

³⁴ Nancy Scheper-Hughes, “The Global Traffic in Human Organs,” 215.

³⁵ Nancy Scheper-Hughes, “The Ultimate Commodity,” *Lancet* 366 (15 October 2005): 1349-1351.

occasional collaborators with Scheper-Hughes and Cohen. Acting as investigators on a major research project on live organ donation funded by the Robert Wood Johnson Foundation, the Rothmans argued that legalized organ sales would likely lessen the number of individuals willing to donate their organs, whether as live donors of kidneys to loved ones, or as cadaveric donors after death. In making this argument they drew on the work of Richard Titmuss, who had argued in *The Gift Relationship* that the commercialization of blood donation would “crowd out” altruistic donation.³⁶

A highly nuanced critique of Radcliffe-Richards came from Lawrence Cohen in his essay “Where it Hurts: Indian Material for an Ethics of Organ Donation” in *Daedalus* in 1999. Drawing on fieldwork conducted primarily in the “kidney belt” of the Southern Indian state of Tamil Nadu and among prominent Indian renal surgeons, Cohen suggested that such theorizing “may not be adequate on the ground.”³⁷ Cohen begins by agreeing with Radcliffe-Richards that simple paternalist or “slippery slope” arguments against legalized kidney sales are insufficient, making comparisons between her critique and the anthropologist Paul Rabinow’s description of the public ethical debate over the human genome project in France as “purgatorial” — i.e., grounded in *a priori* suspicion and apprehension.³⁸

But, Cohen argued, analyses such as Radcliffe-Richards’ are contingent on the ability of the ethicist to reduce the sale of a kidney to a one-time transaction between a buyer and a seller: *X* needs a kidney. *Y* needs cash. *X* gives *Y* cash. *Y* gives *X* a kidney. If it can be established that *Y* is acting freely, and not being coerced into selling a kidney, and if second-order phenomena can be controlled, then a universal ethics of kidney selling can be satisfactorily established. The second order phenomena however, Cohen argues, not only cannot be satisfactorily controlled, it is absolutely critical to the outcome of most of the kidney selling transactions he observed. He offered six examples:

1. Not only was there no data on the long-term effects of kidney-selling on the sellers in India, the doctors he interviewed seemed stubbornly resistant to collecting such

³⁶ S.M. Rothman and D.J. Rothman, “The Hidden Cost of Organ Sale,” *American Journal of Transplantation* 6 (2006): 1524-1528.

³⁷ Lawrence Cohen, “Where it Hurts: Indian Material for an Ethics of Organ Transplantation,” *Daedalus* 128, no. 4 (Fall 1999): 135-165.

³⁸ Paul Rabinow, *French DNA: Trouble in Purgatory* (Chicago: University of Chicago, 1999).

data. Therefore it was difficult if not impossible to argue convincingly that the donors were not harmed by the process.

2. The sellers he interviewed were less likely to be raising cash for a future goal, and more likely to be attempting to pay off an existing debt. Because these sellers were typically small farmers from an area of India where small-farm debt was considered a structural problem, they were highly likely to go back into debt within a relatively short period of time.

3. Most people in India cannot afford dialysis or transplantation, so even if organ sales were legalized, most people with end-stage renal failure would still die.

4. Kidney buyers in India often find themselves unable to afford the cost of immunosuppressive drugs required afterward transplantation. When this happens, the kidney they have purchased adds little to the quality or duration of their life.

5. The proliferation of commercial transplant centers in India in the 1990s actually created a shortage of kidney buyers, as opposed to the traditionally conceived shortage of kidney sellers. This meant that prices had dropped, and would continue to drop.

6. The growth of private medicine in India in the 1990s had been one facet of a much larger trend of increased foreign investment. These were contentious, and transplant centers functioned as focal points of this contention. Legalization of kidney sales was likely to make this problem worse, not better.

In other words, where Scheper-Hughes met categorical ethical arguments in favor of organ sales legalization with categorical ethical arguments against them, Cohen's work met the same arguments with ethical arguments against organ sales legalization *in India*, with the strong implication that another ethnographer, studying the sale of kidneys in another place, might well come up with very different reasons why the practice ought or ought not to be legalized.³⁹ This specificity is most important in his final point — the rise

³⁹ As the philosopher Debra Satz has argued, the traditional libertarian argument in favor “free” markets in undesirable commodities and services neglects an obvious point: Markets are not homogenous. Debra Satz, *Why Some Things Should Not Be For Sale: The Moral Limits of Markets*, Oxford: Oxford, 2010.

of India's organ "markets" was inextricably linked with the liberalization of India's national economy in the 1990s.⁴⁰

Working in Istanbul in the early 2000s, the current home of the largest organs "bazaar" in the Middle East, the ethnographer Aslihan Sanal, drawing conclusions complimentary to Cohen's, argued that public indignation against Turkey's "organ mafia" was somewhat misguided: the practice of kidney selling was diffused throughout Turkey's entire renal medicine scene, both public and private, through referrals and brokers. Organ mafia scares, she argued, functioned to create the collective idea that kidney selling happened in a discrete, (non-)ethical space, and could be condemned safely without the condemnation spilling over to affect respectable individuals and institutions in the Turkish medical establishment.⁴¹

Much as Cohen argued about India in the 1990s, Sanal argued that Turkish medicine spent the decade receiving infusions of foreign investment that dramatically expanded the role of the private sector in the provision of medical services. The connection between this expansion and the growth of organ "markets" is two-fold. First, renal medicine is capital-intensive and thus tends to appear when and where foreign investment does. Where private renal clinics appear in countries with lots of poor people, kidney selling is rarely far behind. Second, the dramatic expansion of the private medicine tends to challenge existing rules, hierarchies and procedural norms within the medical establishment. Cracking down on "organ trafficking" is a way for the establishment to reassert its authority.

The work of Scheper-Hughes and of Cohen represent two very different approaches the problem of how to approach the ethnography of live-donor paid renal transplant surgery. In her determination to use organ trafficking as a symbol of global wealth inequality, Scheper-Hughes collapses the experiences of all kidney sellers everywhere into one of collective victimization and, more problematically, of all kidney buyers into one of collective vampirism. To maintain narrative coherence, this requires a very particular type of historicism, one which will be discussed in more detail later in this

⁴⁰Cohen, "Where it Hurts," 149-158.

⁴¹Aslihan Sanal, "Robin Hood of Techno-Turkey or Organ Trafficking in the State of Ethical Beings, *Culture, Medicine and Psychiatry* 28 (2004): 281-309.

chapter, in which the existence of a “global” market in human organs is postulated as evidence of a stage in the gradual reduction of the human body to a collection of monetized parts. This in turn is postulated as evidence of a moment in the history of capitalist expansion, one which, at least by implication, has a teleological endpoint.

By focusing on the particularities of live-donor paid renal transplantation in particular places, on the other hand, Cohen has no need for a historicist model to make his claims intelligible. Arguments for legalized kidney “markets” are assessed and dispatched with reference to real-world situations. The principle irony here is that Scheper-Hughes’ work on organ trafficking is, by definition, prescriptive, and yet it offers little to policy-makers in the way of implementable ideas, save that they should continue to attempt to enforce laws against organ trafficking that are in most cases, in most countries, currently proving unenforceable, not least because of the transnational component of these practices. Cohen, on the other hand, is much more reluctant to speak prescriptively, but by focusing on particularities of organ trafficking in India, offers much richer and more practical material to policy makers *in India*.

Extralegal Transplantation Facts and Fictions

The most interesting ethnographic treatment of the kidney trade — and far-reaching in its implications — comes from the French folklorist Veronique Campion-Vincent. In a sweeping study of popular rumors and recurrent news stories related to theft of organs from unknowing and unwilling persons, Campion-Vincent concludes that while stories involving organ removal coercion and trickery are all but universally untrue, the anxieties they give voice to are very specific and very real, and proliferate among specific communities at specific times for very real reasons. Rumors in Latin America of children being kidnapped from *favelas* to be murdered and have their organs harvested for the benefit of wealthy foreigners expressed palpable anxieties about the existential threats faced by the poor during an era of neoliberal economic reforms on the continent.

Similar rumors in Brazil, Campion-Vincent argues, expressed equally powerful bodily anxieties about the government's stewardship over the public health of the poor. Global rumors of kidney theft perpetrated upon drugged tourists in hotels expressed more widespread anxieties related to globalization.

Equally interesting is Campion-Vincent's treatment of the "Turkish Kidneys" scandal, and of Ahmet Koç in particular. She includes Koç's "story" of being lured to London with promises of employment, only to be sedated and wake up with one of his kidneys having been surgically removed in a larger subset of organ theft narratives.

Thus far I have spent much of this chapter describing a *scene* — of social scientists, sometimes collaborating with each other, sometimes at cross-purposes, affiliated with elite academic institutions, funded by large grant-giving bodies, all working, from different angles, on the problems associated with human organ transplantation. Because transplantation had been staked out before the social scientists arrived as an ethical problem, the social scientists discussed above have all been compelled to stake out an ethical position on the matter. Those working on cadaveric or live-related transplantation have generally position themselves *contra* high-technology medicine. Lock and Sharp both strongly suggest, as Fox and Swazey did before them, that cadaveric donation and its necessary antecedent, brain death, have come to be associated with promises of life extension that are dangerously unrealistic, and that a disconnect between advocates of transplantation and lay audiences exists and continues to grow. If one could extract a prescriptive statement from their writings, which bioethicists would like to do, it would likely be that transplantation cannot ultimately deliver what it offers — profound life extension — and that the money spent on it would perhaps be better spent elsewhere.

Scheper-Hughes' ethical position is more up front. She argues that kidney selling both reflects and exacerbates growing inequalities of global wealth and, as Titmuss did before her, that the commodification of the human body causes irreparable damage to a social framework based on altruism. Scheper-Hughes is not so much arguing for the abolition of organ markets (which are already illegal nearly everywhere in the world) as she is arguing in favor of collective indignation at the income disparities that make such

markets possible. While compelling, this framework compels Scheper-Hughes to shave away inconvenient details to present the reader with clear-cut stories of wealthy, decadent kidney patients journeying from Global North to Global South to harvest the organs of desperate farmers. Exploitation is a key element in the creation of kidney markets, but, as I hope to show, it is one element of several, all of which must be understood in their full complexity if one is to understand how, why, when and where kidney markets take shape.

Sanal's work, while challenging, abides by the same constructionist assertions as Lock's and Sharp's: The line between "organ mafia" and respectable renal medicine is not fixed but mutable, not eternal but historical, not outside society but inside it. It is more interesting when it, like Cohen's, situates an organ selling "panic" in a historical moment of capitalist expansion in a national economy. According to them, what happened in India and Turkey in the 1990s, bears interesting similarities to what happened in London in the 1980s, the subject of the remainder of this work.

Theorizing the Prosthetic

The more or less accepted definition of the prosthetic within the social sciences is an encounter between individual and environment that is meant to aid (but can just as easily impede) contact between the two. Obvious examples are artificial limbs and hearing aids. Less obvious examples are "cognitive" or "sensory" prostheses — a category that can include anything from photography to retinal implant systems.⁴²

This definition is bounded by its assumption of the modern: It assumes a past in which humans were fully human, and a future in which they may become fully inhuman. The present, in this understanding, lies on a negotiable point somewhere between the two. The chief feature of the present/modern in this understanding is its anxiety. The

⁴² The position is summarized — and refuted — nicely in Marquard Smith and Joanne Morra, *The Prosthetic Impulse: From a Posthuman Present to a Biocultural Future*, Cambridge: The M.I.T. Press, 2006, "Introduction," 1-16.

prosthetic impulse — the desire of humans to alter or augment their bodies — is both a cause and a symptom of this anxiety.⁴³

An alternative definition of the prosthetic takes what is useful from the first — like Donna Haraway’s fundamental rethinking of the “natural” in science in *The Cyborg Manifesto* — while jettisoning what is less useful — its teleology. It frames its opposition to this teleology with an idea from Freud by way of Lacan and Bernard Stiegler — that when we attempt to define prosthetic/post-human/non-human, we are really attempting to define what it means to be human.⁴⁴ It is not without reason that Mary Shelley’s proto-gothic novel *Frankenstein* has become the foundational text of Disability Studies. Doctor Frankenstein’s creation is not merely a Promethean caution, as the sub-title might suggest, but a challenge to biblical notions of what makes humans human that echo Shelley’s Enlightenment contemporaries.⁴⁵

But to understand where the former theorization of the prosthetic came from, and its allure, we must return to its origins — the “postmodern moment” that occurred in the social sciences beginning in the late 1970s and continued into the early 1990s. Its early proponents, Jameson and Baudrillard, were both theorists of capitalism with a deep intellectual investment in Marxism. As such they operated in an intellectual framework that assumed a necessary transition from capitalism to socialism. Both of these words were used to describe “modes of production” — a sort of engine room in which the gears of capital and manufacturing spin until, beset by internal contradictions, they stop. This is the “base.” Atop the base rests a “superstructure” consisting of everything from music to poetry to legal codes to architecture.⁴⁶

The important point here is that the relationship between base and superstructure is causal. A discrete set of human activities called “economics” causes another discrete set called “culture.” Baudrillard set to work on the base — by asking whether the

⁴³ Medically, of course, anxiety rests uncomfortably between the psychic and somatic in the Western medical tradition. In this context, however, anxiety is something that can be experienced collectively, a state of dis-ease that can be part of a collective response to rapid change.

⁴⁴ Donna Haraway, “The Cyborg Manifesto: Science, Technology and Socialist-Feminism in the Late Twentieth Century,” in *Simians, Cyborgs and Women: The Reinvention of Nature*, New York: Routledge, 1991, 149-181.

⁴⁵ Mary Shelley, *Frankenstein: A Modern Prometheus*, London: Penguin Books, 1992.

⁴⁶ Base|superstructure is laid out in Marx’s first explicitly economic work. Karl Marx, *A Contribution to the Critique of Political Economy*, New York: International Publishing Company, 1904.

relationship between “use value” and “exchange value” might in fact be something similar to relationship between “signifier” and “signified” in semiotic theory. Jameson simultaneously was at work on the superstructure — moving certain types of culture from “effect” status to “cause.” This, along with an increasing recognition in Western European Marxist circles that Soviet socialism was not long for this world (and thus that there was nothing inevitable about the transition from capitalism to socialism), resulted in a frantic negotiation over what constituted base and superstructure, and whether indeed the terms had any meaning at all.

The ultimate result of these negotiations was a change in the *periodization* of capitalism. Whereas their forebearers had sketched a map of history that looked something like this:

Feudalism → Capitalism → Socialism

With each proceeding necessarily to the next, and with capitalism doubling as an ontological state of modernity (characterized in Weberian terms by bureaucratization, efficiency and impersonality), the theoreticians of the 1980s inserted a stage between capitalism and socialism called post-capitalism, characterized by eclecticism, fragmentation and subjectivity. This is the context in which the prosthetic was first theorized, by Butler, Haraway, et al. With this in mind, the prosthetic may be theorized as a series of responses to contingencies, rather than manifestations of the determined. This condition will have special resonance if the particular manifestation of the prosthetic is the transplant organ.⁴⁷

⁴⁷ The process of dismantling the base|superstructure dogma began in 1972 with Jean Baudrillard, with *For a Critique of the Political Economy of the Sign*, Candor: Telos, 1980 and found its highest expression in 1991 with Frederic Jameson, *Postmodernism, or, The Cultural Logic of Late Capitalism*, London: Blackwell, 2000. But it was Judith Butler’s rethinking of the relationship between biological sex and gender that made it possible to jettison certain ontological assumptions about the body and to therefore begin the process of dismantling the connection between the proliferation of prosthetic technology and, by extension, the teleological narrative of the gradual de-humanization of the body. Judith Butler, *Bodies That Matter: On the Discursive Limits of Sex*, London: Routledge, 1993.

Transplantation and its utopian and dystopian futures

Beginning in the 1960s, as kidney, heart and lung transplant surgery accelerated their journeys from experimental to routinized procedure, a popular literature emerged, typically written by medical professionals, meant to build public support for the new procedures and to dispel misconceptions about them. Proclaiming an era of “spare part surgery” and “new parts for people” they spoke a deliberately futuristic language, evocative of science fiction, which ultimately — and while making a gainful effort to manage expectations — posited transplant surgeons as locked in conflict with human mortality, a conflict in which they were slowly but surely gaining the upper hand.⁴⁸ This optimism is captured in the many discussions of transplantation and transplant medicine which took place in London in 1962 at a lavish conference sponsored by a pharmaceutical company and attended by some of the most famous medical and scientific thinkers of the post-war era.⁴⁹

The name CIBA began as an acronym for Gesellschaft für Chemische Industrie Basel (Company for Chemical Industry, Basel), a Swiss-based manufacturer of chemical dyes, established as a joint stock company in 1884 in Basel, Switzerland. In 1900, Ciba began manufacturing antiseptic and anti-rheumatic pharmaceuticals. Throughout the next half century, its production and distribution capabilities expanded throughout Europe, absorbing competitors and gradually shifting its priorities towards drug development and manufacture.

In 1949, Ciba founded the Ciba Foundation, a scientific non-profit based in London, meant to “promote scientific excellence” through regular meetings of prominent scientists and public intellectuals. The decision to establish the Foundation in London was due to a unique provision of English Trust Law allowing charitable trusts near-total independence from their sponsors. The former director of the allied blood transfusion

⁴⁸ Donald Longmore, *Spare-Part Surgery: The Surgical Practice of the Future*, London, Aldus Books, 1968. Nancy Rosenberg and Reuven K. Snyderman, *New Parts For People: The Story of Medical Transplants*, New York: Norton, 1969. Longmore concludes “The evolution of organisms is a blind and fortuitous process. The evolution of social organization is a matter for conscious and purposive choice. It really is up to us.” The full rhetorical significance of statements such as this with regard to transplantation will become evident in Chapter 4.

⁴⁹ Gordon Wolstenholme (ed), *Man and His Future*, Toronto: Little, Brown and Company, 1963.

effort in Europe during the Second World War, Gordon Wolstenholme, a British doctor who had distinguished himself by overseeing the Allied blood transfusion effort in the Mediterranean during the Second World War, was hired as its director.⁵⁰

The Ciba Symposia became an important fixture of intellectual life in Europe and the United States from the 1950s onward. The first to be held on the topic of surgical transplantation was convened by Peter Medawar, a doctor and zoologist whose experiments with skin grafts led to major breakthroughs in immunology, in 1962.⁵¹ During these first thirteen years of the symposia, the topics chosen had been almost exclusively of clinical interest. (A 1956 meeting devoted to extrasensory perception was an exception.) In 1962, however, the Foundation undertook a self-conscious departure, using their newly built conference facilities on Portland Place in London to host a symposium entitled *Man and His Future*.⁵²

The biologist Julian Huxley, brother of Aldous, spoke first in a talk called “The Future of Man — Evolutionary Aspects.” He began with a classification of humanity’s three “habitats,” which closely mirrored Auguste Comte’s three branches of human science. Huxley in the pre-war era had been a passionate advocate of eugenic programs. As discussed here, he felt strongly that the lifesaving technologies of the last century — everything from penicillin to improved sanitation to corrective eyewear — were having an unintentionally deleterious effect on the collective resilience of humanity: individuals that in previous centuries would have been selected out through unfitness — whether in the form of weak immune systems or nearsightedness — were now surviving to adulthood and reproducing, ensuring that maladaptive traits were disseminated throughout human populations. The key to Huxley’s postwar respectability however — he was named the first head of UNESCO — was that in the pre-war era he had carefully distanced himself from the biological racism of many European and American geneticists, rejecting race as an indicator of either group or individual behavior or “fitness.” Huxley’s role as convener of this conference — attended by J.B.S. Haldane,

⁵⁰ Anthony Tucker, “Obituary: Sir Gordon Wolstenholme,” *The Guardian*, July 6, 2004.

⁵¹ James Barron, “Peter B. Medawar, Scientist, is Dead,” *New York Times*, October 5, 1987.

⁵² F. Peter Woodward, *The Ciba Foundation: An Analytical History, 1949-1974*. Amsterdam: Elsevier, 1974.

Carleton Coon, and many others — and the unapologetically eugenic remarks might seem out of place in the 1960s, but perhaps they were not.⁵³

In a paper entitled “Biological Future of Man,” the American biologist and Nobel Prize winner Joshua Lederberg discussed recent advances in molecular biology and immunology. Dismissing the eugenic programs of the pre-war era (discussed at greater length in Chapter 4) as the “transfer of animal husbandry to man,” Lederberg describes the technologies made possible by advances in molecular biology” — including, especially, transplantation — as “euphenic” procedures; whereas eugenics concerns itself with “improvement” at the nucleic level by controlling selection and reproduction, euphenics concerns itself with the improvement of the organism after the fact.

Lederberg attached great importance to transplantation as a euphenic technology, and spent most of his remaining remarks outlining predicted problems of allocation and efficacy for the burgeoning field, largely boiling down to problems of efficacy and allocation. As remedies he suggested the development of artificial organs, the synthesis of proteins that would aid selective immune response, the “eugenic” development of an animal species with harvestable organs for humans and the creation of an organ donation registry. Three out of four have largely come to pass and the fourth (xenotransplantation) has been the recipient of enormous amounts of funding and research that have not yet borne fruit.⁵⁴

The conclusion to be drawn from the CIBA transcripts should not be that transplantation and other prosthetic biological programs in some sense replaced eugenic programs in the realm of public health policy and scientific thought. Rather, Lederberg’s testimony, when situated within the larger intellectual framework of the conference and of the time period, does suggest that a shift has occurred. The quest for human perfectibility — bound within the sensibilities, the subtle (and not subtle) bigotries and the blind spots of whatever society it occurs in — shifted perceptibly after the Second World War, from the *a priori* human perfectibility of the eugenic to the *a fortiori* perfectibility of the prosthetic. It took the social sciences several decades to catch up to this monumental shift of priorities. The aforementioned ethnographies of transplantation

⁵³ Sir Julian Huxley, “The Future of Man: Evolutionary Aspects,” in Wolstenholme, *ibid.* 1-22.

⁵⁴ Joshua Lederberg, “Biological Future of Man,” in Wolstenholme, *ibid.* 263-273.

and critical studies of the prosthetic are examples of them finally having done so, as is the general move in the 1980s toward poststructuralist understandings of the human body as an uneasy and contestable combination of the biological and the social.⁵⁵

Organs as Commodities

In order for a thing (or a person) to literally become a commodity, it (or she or he) must become conceivable as bearing a monetary value, and therefore as representative of x amount of abstract labor, x being an amount that is simultaneously fixed (as implied by the fact that the parties involved in the exchange agree on it for the purposes of that exchange) and unknowable, in that abstract labor does not refer to anything in the corporeal world.⁵⁶

In the case of organ trafficking — the commoditization of human organs, usually from a live donor — this inspires resistance, but the resistance is uneven. For a professional academic or medical practitioner, charged with explaining (or advocating, or condemning) the practice of organ trafficking, this process can be interpreted in myriad ways. For someone who proceeds from an assumption of the universal subject (neoclassical edition) — rational, self-interested, value-conserving, profit-maximizing — the seller (or would-be seller) is autonomous, and the kidney is superfluous; its transformation into the commodity form is logical and unproblematic. The sale of the kidney is a spot transaction between firms. As with all capitalist exchanges there are risks — infection, lack of aftercare, later renal failure — but the rational individual is designed to weigh risks versus remuneration instantaneously and with full knowledge. One need only set the boundaries of the rational narrowly enough to exclude any conception of the

⁵⁵ The discussion that followed Lederberg's presentation was transcribed and included in the volume under the name "Eugenics and Genetics," during which Francis Crick, acting as discussant, proposes a global "one child policy."

⁵⁶ Marx on abstract labor: "Human labor-power in its fluid state, or human labor, creates value, but is not itself value. It becomes value in its coagulated state, in objective form." Karl Marx, *Capital: Volume I: A Critique of Political Economy*, trans. Ben Fowkes, New York: Penguin Classics, 1990, p. 142.

individual that does not conform to this model, and one has rendered opposition to organ trafficking irrational by definition.⁵⁷

Opponents of organ trafficking, like the opponents of paid blood donation before them, have rated paid donation unfavorably against altruistic donation — the decision to donate an organ out of a sense of social responsibility or general goodwill. More precisely, the ideal donation relationship in *The Gift Relationship* corresponds most closely to Malinowski's totally selfless "pure gift" — the category that Mauss (Titmuss' main theoretical point of reference) explicitly rejected! This is not to argue that the argument is problematic because it relies on a theory that was criticized by another theorist; there are other, more important reasons.

For Malinowski, Mauss, Levi-Strauss (and perhaps the whole tradition of French structural anthropology), the difference between the kinship-based societies in which anthropologists derived the rules of gift exchange and the industrial societies in which they lived and worked was not established by an accumulation of observed behaviors and characteristics; they were different by prior assumption. According to the rules of the game, one first divined whether one was dealing with a traditional society or a contemporary one, and then applied the appropriate rules of observation: *idiographic* for modern, literate societies, *nomothetic* for primitive, non-literate ones. These categories and their applications were laid out quite specifically by the British anthropologist A.R. Radcliffe-Brown in *Structure and Function in Primitive Society*.⁵⁸

Thus, when Mauss and Levi-Strauss occasionally mentioned the presence of reciprocity-based customs in their own society, they always presented them as paradox:

⁵⁷ In its most floridly extreme form, this argument is explicated in Simon Rottenberg, "The Production and Exchange of Used Body Parts" in F.A. Hayek, Henry Hazlitt, Leonard E. Read, Gustavo R. Velasco, F.A. Harper [eds.], *Toward Liberty: Essays in Honor of Ludwig Von Mises vol. 2*, Menlo Park: Institute for Humane Studies, 1971.

⁵⁸ A concise history of the anthropology of gift exchange can be found in Colin Danby, "The Curse of the Modern: A Post-Keynsian Critique of the Gift|Exchange Dichotomy," *Research in Economic Anthropology*, 21, 2002, 13-42. Danby might very well not agree, but for the purposes of this argument, Radcliffe-Brown's idiographic|nomothetic schematic is important for the purposes of this dissertation for understanding how and why anthropologists of the twentieth century used literacy as the milemarker for distinguishing between "primitive" and "modern," a distinction that is hugely important for understanding how non-literate societies are incorporated into world historical narratives, as well as how their collective experiences are grudgingly granted temporality while still being denied historical agency. A.R. Radcliffe Brown, "Introduction" in *Structure and Function in Primitive Society*, Glencoe: The Free Press, 1952, p. 1-2.

either as an inexplicable occurrence of the antiquated within the contemporary, or as cultural DNA: The European middle classes spend the extra income they have accumulated throughout the year on Christmas gifts in much the same way that Malinowski's Trobriander islanders destroy wealth in potlatch festivals; ergo, the modern can occasionally glimpse its primitive roots. Mauss shared the view with the economic historian Karl Polanyi that human societies had moved from the primitive and reciprocal to the modern and calculating, and expressed hope, again with Polanyi, that they were now moving towards a synthesis of the two. Thesis-Antithesis-Synthesis.⁵⁹ This perceived tension haunts the work of Titmuss, mentioned earlier, and virtually everyone who has attempted to write prescriptively about the problem of paid organ donation. The problem, however, may not lie in theorizations of pragmatism versus idealism, or selfishness versus communality, or paternalism versus autonomy, but rather in the theorization of the live-donor kidney as a commodity.

So slippery is the question of the commodity and value when applied to human tissue that it is best to return momentarily to Marx in *Capital*: Whereas the "use value" of a commodity was a fairly straightforward matter, the exchange value — what a commodity is worth in relation to another commodity, as mediated through currency — was, to Marx, extraordinarily opaque. He even went so far as to describe it as "mystical," its value ultimately determined by an erratic combination of desire and of the perception of scarcity. The problem, he added, was quickly compounded when applied to the commodity with which Marx was most preoccupied, that of wage of labor. The exchange value of commodities was "mystical," Marx concluded, because it contained within it the value of labor, and labor contained within it the social relationships of capitalism — between worker, owner and consumer. Because Marx saw social relations within capitalism as deeply fluid — and deeply irrational — he saw this fluidity and irrationality as being embodied within the commodity form. This is what has come to be called "commodity fetishism."⁶⁰

If we accept that the value of a commodity contains, embedded within it, the social relations of the society that produced it, then it is not a great reach to apply this

⁵⁹ Karl Polanyi, *The Great Transformation*, New York: Reinhardt, 1944.

⁶⁰ Marx, *ibid*, 163-164.

principle to commoditized human organs. If so, these implications are troubling. The social relations embedded within are deeply one-sided and hierarchical. It is not difficult to see why then, anecdotally at least, the going rate for a kidney has dropped noticeably since live unrelated donation was routinized in the 1980s. However if we take the “value” of a kidney to be equivalent to the “value” of life itself then we are compelled inevitably toward comparisons with Marx’s notion of the value of a commodity somehow being the solidification of the value of the labor that produced it. It is here we arrive at Marx’s idea of “abstract labor.”

Using the example of a coat as a commodity which requires multiple types of labor in order to produce it (weaving, tailoring, etc.), Marx postulates that exchange value of the coat is only made intelligible through the genericization of these different types of labor into a single abstracted human labor power.⁶¹

It is this process of abstraction, Marx implies and the historian Dipesh Chakrabarty (discussed at greater length in Chapter 4) explicates at length, that makes possible the accumulation of surplus value through wage labor. Without a sort of generalized cultural acceptance of this idea of a generic human labor that can be quantified and — more important — accumulated, capitalist relations and capitalist accumulation are esoteric fictions.⁶²

In a better-known (and more straightforward) section of *Capital*, Marx explains the basic premise of surplus value. The wage laborer devotes a percentage of the working day to meet basic needs. Whatever the remainder of the day’s shift produces is extra, or, in the language of classical political economy (the language in which Marx was consciously writing), “surplus value.” Class struggle manifested itself in the workplace as a struggle over how that surplus value was to be shared out between laborer and employer.⁶³

But for Marx, again, the underlying idea of accumulation in this formulation is only possible if one can conceive of a generic form of human toil that can be measured, extracted and accumulated. One reason the ongoing debate over organ sales strains

⁶¹ Marx, *ibid*, p. 143-150.

⁶² Dipesh Chakrabarty, *Provincializing Europe: Postcolonial Thought and Historical Difference*, Princeton: Princeton University Press, 2000, p. 50-58.

⁶³ Marx, *ibid*, p. 283-292.

against our existing analytical apparatus is because, when thinkable as a commodity, when assigned an exchange value, the body part reveals itself not just as a repository of an abstracted human labor, but as a repository of life. Put more simply, the reason the human organ resists our understanding as an object of exchange is because we cannot figure out whether it is alive or not.

In *Tissue Economies: Blood, Organs and Cell Lines in Late Capitalism*, Catherine Waldby and Robert Mitchell work to problematize the distinction between “gift exchange” and “commodity exchange” that has been considered an ontological assumption in the debate over the sale of body parts. As technology has increased the range of body parts that can be exchanged, from blood to organs to stem cells to DNA sequences, existing legal and ethical frameworks devised to cover the exchange of organs have proved inadequate. They observe that each newly commodifiable entity from within the human body produces new forms of commodification, but also new forms of “biosociality” — the strengthening and deepening of existing social bonds and the creation of new ones. Still, as the title suggests, the work of extrapolating the politico-medico-technical realities of organ trafficking from its dystopian historicism continues.⁶⁴

Conclusion

To understand the application of this principle — that new technologies create new complexities with regard to the buying and selling of body parts, but also (and perhaps equally) to new “biosocial” forms of reciprocal, non-monetary relations — to the buying and selling of human kidneys from live donors, the idea of the prosthetic is indispensable. Unleashed by Donna Haraway in the early 1980s, the prosthetic became an important analytical tool within Disability Studies, the Philosophy of Science and many other fields. As discussed earlier its traditional definition — as a point of encounter between the body and the environment, or, read differently, the individual and society — implies a teleology: a past in which we were fully human, and a present in which we will be fully

⁶⁴ Catherine Waldby and Robert Mitchell, *Tissue Economies: Blood, Organs and Cell Lines in Late Capitalism*, Durham: Duke University Press, 2006.

inhuman. To make sense of the complex, overlapping and hierarchical relationships that make up a network of organ sellers, buyers, brokers, clinics, hospitals and doctors, this jettisoning of historicism is necessary. It is equally necessary in order to understand the global and transnational spaces in which these intersections occur, marked as they are by imperial histories and present-day capitalist social relations. This act of jettisoning is perhaps most important in order to understand what happened when the medico-technological community of the industrialized world emerged from the intellectual ashes of the first half of the twentieth century, abandoning its eugenic ambitions for prosthetic ones.

This is the context in which this dissertation will explore its principle subject: the development of an organ trafficking ring in 1980s London in which kidneys were removed from impoverished Turkish donors and implanted in renal patients from various countries, under the supervision of medical professionals working in a newly expanded “privatized” medical space created by neoliberal economic reforms. The task of the next chapter will be to explicate the “Turkish kidneys scandal” (as it was named in the British press) in thorough detail, from its beginnings in a private dialysis clinic in the 1960s to the massive public spectacle in which it culminated in 1990.

CHAPTER 2: KIDNEYS FOR SALE IN LONDON IN THE 1980s

This chapter concerns what came to be known in the British press as the “Turkish Kidneys Scandal” in which a group of medical professionals based in London were accused of facilitating the removal of kidneys from impoverished Turks for transplantation into patients at a North London dialysis clinic. The case reverberated throughout the medical profession, and the evidence suggested at times that the doctors who were implicated were just a handful of a much larger group engaging in similar practices. On a national level, the most enduring result of the 36-day hearing was the passage of legislation specifically prohibiting the buying and selling of human organs. In addition to documenting and contextualizing an extremely convoluted and opaque moment in the history of the British medical profession, I hope that this chapter will support my earlier assertion that the practice of organ trafficking is in many ways a by-product of an intellectual commitment by the medical profession worldwide to the *a fortiori* perfection of the individual human body via prosthetic technology.

According to the records of the General Medical Council of the United Kingdom, when nearing the end of his first day of testimony before that organization’s Professional Conduct Committee, the renal transplant surgeon Michael Bewick became agitated. Along with two other doctors, Bewick was accused of participating in live-donor transplants in a private London hospital in which the donors were paid. Asked whether he thought the desire to save his patients’ lives made him neglect the interests of the donors, Bewick responded: “I cannot say to someone where I know that I might be able to help them, ‘Go away. I cannot help you. Go away, Mr M, and die in Afghanistan. Go away Miss CT, and let the diabetes eat your heart out and your eyes out and your kidneys and die of urinaemia.’ I just cannot physically do that.”⁶⁵

Little is known about “Mr M,” an Afghan national, whose confidentiality was protected throughout the hearing. He received a kidney from Çoskun Yeniçi, a 28-year-

⁶⁵ General Medical Council Professional Conduct Committee. *Hearing of Crockett, Bewick and Joyce*, 21 Feb 1990, Day 23, p. 79. The transcription of the 36-day hearing was obtained under the UK Freedom of Information Act in 2007.

old laborer from Istanbul. More was revealed about “Miss C T,” in fact Cleo Tsirikis, a Greek lawyer. Her kidney came from Hatice Anutkan, 38, a domestic worker, also from Istanbul.⁶⁶ Anutkan’s kidney failed after it was transplanted into Tsikritis, and Bewick undertook a second transplant operation, this time with a kidney taken from the cadaver of a motorcycle accident victim. That kidney had originally been intended for a patient of Britain’s National Health Service. Of all the factors leading to Bewick’s public censure, it was this act of appropriation, from public to private, which rallied his colleagues against him.⁶⁷

Michael Joyce, the surgeon who performed the donor nephrectomies in each instance — removing the kidneys that Bewick would then transplant — was more conciliatory on the witness stand; he broke down in tears. When asked how hearing the evidence given by the four Turkish donors around whom the charges revolved made him feel, Joyce began to weep.⁶⁸

Raymond Crockett, the London nephrologist who ultimately bore the brunt of the charges, took a different tack from Bewick or Joyce; he declined to give evidence. As the Director of the National Kidney Centre, the private dialysis facility through which both the donors and recipients were processed prior to surgery, Crockett briefly became the public face of organ trafficking in Britain. On the same day he was struck from the medical register and thus barred from practicing medicine in Britain, Crockett told the *Times*, “Some would allow a patient to die before they would accept an unrelated donor. My conscience does not allow such a view. If these actions in saving the lives of my patients represent misconduct, then the moon really is made of cheese.”⁶⁹

Crockett, Bewick and Joyce were accused of performing four operations in total, all involving donors and recipients who were foreign nationals. But it was clear from the beginning that there had been other donors, recipients, physicians and surgeons involved in these practices. This question haunted the GMC hearing, as well as public coverage of the debate. It is worth considering the words of the attorney representing the committee:

⁶⁶ Ibid., December 4, 1989, Day 1, morning, 23.

⁶⁷ Ibid., January 10, 1990, Day 13, 26-29.

⁶⁸ Ibid., January 18, 1990, Day 19, 35.

⁶⁹ John Young and David Sapsted, “Kidney doctor defiant after being struck off,” *The Times*, April 5, 1990, 1.

An error into which one could quite easily slip, and which I would like to warn myself against, would be to treat these four in isolation, because it is entirely clear from other evidence that many Turkish citizens were coming in 1988 to the National Kidney Centre, perhaps some two dozen or more, and that many other foreign nationals were also coming to that Centre, though I think fewer from any different country. Equally it is clear that there were many people from other countries who were undergoing renal transplant patients with whom these doctors were deeply and much concerned.⁷⁰

I will argue in this chapter that the practice of paid live donor renal transplantation, as well as the events and practices connected with it in these instances, were closely linked to the growth of private medicine in Britain in the 1980s — itself but a small part of the suite of privatizations, removal of import tariffs and reduction of welfare programs that collectively comprised the “liberalization” of the British economy during this period — and that private hospitals provided the necessary conditions for exploitative practices to take place.⁷¹ This is not to absolve the doctors, surgeons or recipients of culpability. But, as Chisholm Ogg, an NHS colleague of Bewick’s, phrased it on the witness stand, transplant teams working with live donors in private hospitals during this period found themselves in “tiger country” — a place where the rules were hazy, and the cost of both action and inaction could be very steep.⁷² As I will describe, the private facilities in which the kidneys were removed largely existed because of the liberalization measures contained in the 1980 Health Services Act. The minimal oversight that took place in the hospitals was the product of pressure for profitability — which reduced staff and encouraged supervisors to look the other way at questionable practices — and the ambiguity of the regulatory relationship between the privately owned hospitals and the local health authorities (in many respects the atomic units of the National Health Service) in which they resided. Attempts to increase the size and scope of private medicine in the United Kingdom in the 1980s created medical “spaces” in which the rules were unclear and in which ethically questionable activity could — and did — take place.

⁷⁰ General Medical Council, Day 1, afternoon, 15.

⁷¹ For an overview of the rapid growth of private hospitals in the early 1980s see Joan Higgins, *The business of medicine: private health care in Britain* (Basingstoke, MacMillan Education, 1988).

⁷² General Medical Council, Day 26, 94.

Regulating Bodies

There is little doubt that the “Turkish Kidneys Turkish Kidneys” affair was a decisive factor in the passage of the Human Organ Transplant Act of 1989. The act was both a continuation of and a departure from almost five centuries of legislation intended to regulate the use of human bodies — both alive and dead — for medical usage. The earliest acts were concerned with the use of the bodies of executed criminals for medical dissection. As social historian Ruth Richardson has shown, the cultural context in which the medical use of bodies for non-healing purposes prior to the late nineteenth century was different for two important reasons: first, surgical practice was viewed with suspicion and given little institutional support. Second, popular religious and philosophical attitudes at the time attached considerable importance to bodily integrity and observance of burial rites after death; to condemn someone to dissection after death was a double ignominy.⁷³

The rise of anatomical medicine and of the surgical profession in the late eighteenth century, however, ensured a demand for corpses for dissection by surgeons and their students that could not be met through legal channels. Instead, an underground economy evolved between medical schools and “resurrection men” who would exhume bodies from graveyards and, in a few highly publicized instances, dispatch living persons. Public opprobrium toward these practices contributed to the passage of the Anatomy Act of 1832, which expanded the pool of candidates for dissection to include anyone who died in the care of the state. It also formalized and codified a system of licensing for practitioners.⁷⁴

The Anatomy Act remained the cornerstone of legal thought on the matter of medical research and human bodies until 1961, when Parliament passed the Human

⁷³ Ruth Richardson, *Death, Dissection and the Destitute* (Chicago: University of Chicago Press, 2000), 3-29. For a vivid illustration of public attitudes toward the surgical profession, see Peter Linebaugh, “The Tyburn Riot Against the Surgeons,” in Douglas Hay, Peter Linebaugh, John B. Rule, E.P. Thompson, *Albion’s Fatal Tree: Crime and Society in Eighteenth Century England*, London: Verso, 1976, p. 65-117.

⁷⁴ Ruth Richardson, 30-51.

Tissue Act, largely in response to anticipated ethical concerns over the relatively new field of human organ transplantation. The first successful kidney transplant in the United Kingdom had taken place in 1960 in Edinburgh.⁷⁵ Principally, the Human Tissue Act affirmed the legality of cadaveric donation, attempting to clarify its place in the larger and older legal and cultural space set aside for medical dissection, while at the same time placing a legal burden upon the clinician to determine the absence of objections from whoever had legal responsibility for the deceased. The Act contained no direct reference to live-donor transplantation, which was still in its infancy.⁷⁶

In 1984, a new Anatomy Act was passed into law, placing new strictures on the length of time after death during which tissue could be procured. It again contained no reference to live transplantation.⁷⁷ Indeed, during the 1980s, as Bewick, Crockett, Joyce and unnamed others participated, wittingly or unwittingly, in the sale of live-donor kidneys, such acts were not formally outlawed. Professional medical associations formally condemned such practices, but it was not until 1989 that the sale of human tissue was banned in the United Kingdom under the Human Organ Transplants Act. As legislative language it was uncharacteristically pointed: “to prohibit commercial dealings in human organs intended for transplanting; to restrict the transplanting of such organs between persons who are not genetically related; and for supplementary purposes connected with those matters.”⁷⁸ Over a decade later, a much larger conflagration over the improper harvesting of tissue from deceased children at a hospital in Liverpool would inspire a new Human Tissue Act, designed to streamline all of the existing related legislation.⁷⁹ In the meanwhile, the passage of the 1989 Act meant that buying and selling kidneys was now an unambiguously illegal activity.

If the legal space in which the “Turkish Kidneys” drama unfolded was an ambiguous one, its place in the political economy of British medical practice was doubly

⁷⁵ David Hamilton, *A History of Organ Transplantation*, Pittsburgh, University of Pittsburgh Press, p. 277.

⁷⁶ Human Tissue Act 1961/54. <http://www.legislation.gov.uk/ukpga/Eliz2/9-10/54/contents>

⁷⁷ Anatomy Act 1984/14. <http://www.legislation.gov.uk/ukpga/1984/14/contents>

⁷⁸ Human Organs Transplant Act 1989/31. <http://www.legislation.gov.uk/ukpga/1989/31/contents>

⁷⁹ Waldby and Mitchell, 37-38.

so. I will now explore the unstable intersection between private and public medicine in which these events occurred.

Private Medicine in the United Kingdom

“Private medicine” is generally used as a blanket term referring to all professional medical activity that takes place outside of the National Health Service, the United Kingdom’s universal, free-at-point-of-service healthcare system. Enacted in 1948, the National Health Services Act nationalized at a stroke more than 90 percent of the United Kingdom’s medical facilities. What remained became the private sector. This included a collection of pre-war private insurance schemes, consolidated as British United Provident Association, a collection of non-profit hospitals owned by the Nuffield Trust, a handful of “pay beds” in NHS hospitals where patients received more privacy, more amenities and, more controversially, the ability to “jump the queue” for non-acute treatment, a few private facilities registered as charities and, finally, a handful of for-profit hospitals, catering to wealthy patients, often from abroad.⁸⁰

The events discussed in this essay take place in institutions belonging to the last two categories. The National Kidney Center was registered as a charitable institution. Clementine Churchill and Humana Wellington were private, for-profit hospitals that were owned, during the relevant time periods, by foreign companies. The purchase and management of these companies is of some interest for understanding how they came to be nodes in the international kidney trade.

The American companies that invested in British private hospitals, beginning in the 1970s and accelerating dramatically in the 1980s, were products of a post-war healthcare industry very different than that of the United Kingdom. Attempts to rationalize health care in the United States into a cohesive, non-overlapping and comprehensive in the post-war years were met with fierce and sustained opposition, often couched in ideological opposition to “socialism.” As a result, by the 1970s, the only

⁸⁰ Ben Griffith, Steve Iliffe, Geof Rayner, *Banking on Sickness: Commercial Medicine in Britain in the USA* (London: Lawrence and Wishart, 1987). See also Higgins, *The Business of Medicine*, 104-108.

groups of people eligible for government-funded medical care were senior citizens, the very poor and veterans. Hospital care remained a mixture of non-profit and for-profit activity. Most Americans received health care through employer-funded insurance schemes.⁸¹

Beginning in the 1970s, independently owned for-profit facilities began to be absorbed by investor-owned corporations. In 1979, a decade of shareholder-financed merger, acquisition and construction of for-profit hospitals came to a halt. Simple overreach was one reason for this. The expansion of Health Maintenance Organizations — third-party healthcare providers that contracted with hospitals to provide care for subscribers — was another. Faced with declining profits, many of these companies began to acquire and build facilities abroad. Two of the largest — American Medical International and Humana — looked to the United Kingdom.⁸²

They were buying into a market that had existed for some time: expensive private hospitals in London catering to a wealthy overseas clientele, travelling to the United Kingdom for medical procedures unavailable elsewhere, and/or for a level of care considered to be among the best in the world. The following passage, from a *Fortune* profile of Humana, is instructive:

King Khalid of Saudi Arabia has been there. So have Elizabeth Taylor and Maurice Gibb of the Bee Gees. But they're just ordinary folks to Humana's Wellington Hospital in London. By catering to the super-rich in the land of socialized medicine, Wellington achieves double those of Humana hospitals in the U.S. Last fiscal year, Wellington earned 4.3 million before taxes on revenues of 15 million.

One of England's few private hospitals, Wellington attracts the elite who want to choose their own physicians and escape the delay and overcrowding of the National Health Service. Humana paid \$12 million in 1976 for the hospital, a travertine ziggurat overlooking Lord's Cricket Ground. Though filled with patients, Wellington had been losing \$50,000 a month. Humana cut staff by a quarter, automated the book-keeping and raised charges 50 % — which affected demand “not a twit,” says President Wendell Cherry. More than half the 99 rooms are taken by Arabs, who pay plenty to be sick in style and labored over by some of the best doctors

⁸¹ Paul Starr, *The Transformation of American Medicine* (New York: Basic Books, 1982).

⁸² Vince DiPaolo, “Gloomy economic prospects will spur hospital acquisition market,” *Modern Healthcare*, January 1982, 70-72.

in London. Patient charges average \$575 a day vs. \$241 in Humana's U.S. facilities. The gift shop sells \$10,000 ruby-and-diamond necklaces. "We're London's most expensive hospital," says David Laird, Humana's director of British operations, 'and we make no apologies for that.'⁸³

While it is certainly true that the Wellington catered to expensive tastes, the article is misleading both in its boisterous confidence and in its implication that the hospital's dominant client base is growing. As will be discussed further in Chapter 3, the opposite was true.

With a newly elected Conservative government that had put privatization high atop its agenda, and an established market for private medical care for overseas patients in place, hospitals like the Wellington seemed an ideal investment. But a problem existed: private medicine in the United Kingdom, in all forms, was politically controversial. The aforementioned "pay beds" in NHS hospitals were very unpopular and had been a central point of contention in multiple hospital worker strikes during the 1970s, in which strikers called for their abolition. The political compromise arrived at prior to the election of 1979 had been to reduce the number of pay beds in NHS hospitals while reducing restrictions on the building of private hospitals. The overall effect of this compromise was to move a significant percentage of private medical practice further away from the public eye. An additional consequence was to also move it further away from the oversight of the typical bastions of NHS regulatory oversight: the hospital and the local health authority.⁸⁴

When the Conservatives took power in 1979, their agenda for private medical practice was to incrementally increase its scope. This included changes in NHS consultancy contracts that made it possible for doctors to work virtually unlimited hours in the private sector while maintaining full-time employment in the NHS. It also reduced restrictions on overseas investment in private hospitals, and on the building of private hospitals.⁸⁵

⁸³ Gwen Kinkead, "Humana's Hard-Sell Hospitals," *Fortune*, November 17, 1980, 68-81.

⁸⁴ Rudolph Klein, *The New Politics of the NHS: From Creation to Reinvention* (Oxford: Radcliffe Publishing, 2010. 76-104.

⁸⁵ Rudolph Klein, *The New Politics of the NHS*, 105-139.

It is important to remember, however, that private, for-profit hospitals were the smallest part of the private medical sector in the United Kingdom, and they were highly dependent on overseas patients, who by 1980, were beginning to go elsewhere. 1699 patients from Saudi Arabia were treated in London in 1980, compared with only 398 in 1983. This was exactly the same time when the “boom” in private hospitals was occurring. This was partly due to competition — from New York City, mostly, but also from several cities in India, where groundwork was being laid for medical tourism infrastructure. The United Arab Emirates, another traditional source of overseas patients for London hospitals, was undertaking massive hospital building projects, as well. As the overseas investment was arriving in the for-profit hospitals, the overseas patients were leaving.

A more awkward reason for their departure however, was that, slowly, the doctors and hospital staff of the city of London had developed a reputation for making their overseas patients feel unwelcome. There were allegations of over-charging and poor service. Worse, disparaging comments were made by BUPA’s chief executive regarding “the Middle East contingent, who come in with their retinues.” The same individual also admitted freely to attempting to steer overseas patients away from Nuffield-run hospitals, and towards private, for-profit ones.⁸⁶ The relationship between the overseas patient and British private medicine is complex, however. The founding of the National Kidney Centre is a helpful point from which to begin to understand it.

Dialysis and Transplantation

The histories of renal dialysis and renal transplantation in the United Kingdom are, of course, intertwined. Both treat renal disease. Both were conceptualized in earlier centuries but came to fruition as treatments in the technological boom of the post-war years. Both were controversial due to the aura of scarcity surrounding them, albeit scarcities of different natures. Stanton has described U.K. dialysis allocation policy in the

⁸⁶ Higgins, 104-108.

1970s as one of “covert” scarcity — one wrought largely by resistance to the establishment of a formal policy. Local health authorities would resist purchasing dialysis equipment because of its expense, and the government did not mandate them to do otherwise.⁸⁷ Scarcity in renal transplantation was a matter of lack of available cadaveric kidneys. Despite this, the U.K. remained an “opt-in” country, asking citizens to formally identify as organ donors, as opposed to an “opt-out” country where citizens were assumed to be organ donors unless they self-identified otherwise.⁸⁸ This — the need for people to voluntarily become organ donors — became a major rhetorical feature of U.K. health discourse in the 1980s. The chair of General Medical Council committee that tried and sentenced Crockett, Bewick and Joyce even used his closing remarks as an opportunity to implore people to become organ donors.⁸⁹

Dialysis and transplantation were also very different: dialysis entered the mainstream therapeutic lexicon a decade earlier than transplantation. Further — if one chooses to look at it as a competition — transplantation eventually won.⁹⁰ By the 1980s, dialysis came to be seen as something one endured while awaiting a suitable transplant kidney, which is precisely what Crockett’s overseas patients were doing at the National Kidney Center while prospective donors were recruited in Turkey.⁹¹

Furthermore, as the historian Ayesha Nathoo has argued in a compelling work about heart transplantation in the Britain, public discussions about the efficacy of both dialysis and transplantation were conducted in an era of mass media and thus politicized in a way that previous medical innovations had not been.⁹² In this respect, the story of Raymond Crockett and his patients can be seen as critical episode in the gradual diminishment of medical authority in Britain from its post-war heights.

⁸⁷ Jennifer Stanton, “The Cost of Living: Kidney Dialysis, Rationing and Health Economics, 1965-1996,” *Social Science and Medicine*. 49, no 9, 1999.

⁸⁸ The topic is revisited tirelessly by both the popular media and the medical establishment. A succinct overview of the history and primary problems can be found here: Danielle Hamm and Julie Tizzard, “Presumed Consent for Organ Donation,” *British Medical Journal*, 336, 230, Jan 31 2008.

⁸⁹ “Struck off specialist defends kidney sale,” *Guardian*, April 5, 1990.

⁹⁰ Stanton, 1179-1180.

⁹¹ “Surgeon ‘broke transplant rules,’” *Guardian*, Feb 28, 1990.

⁹² Ayesha Nathoo, *Hearts Exposed* (Basingstoke: Palgrave-MacMillan, 2009)

Setting up shop

The National Kidney Centre was not originally intended to be a place where overseas patients would convalesce while waiting for a suitable kidney donor to be located via a classified advertisement in a foreign newspaper. Its first director had been Stanley Shaldon, a talented and temperamental nephrologist at Royal Free Hospital in Hampstead in the early 1960s. Frustrated with perpetual shortages of dialysis equipment and beds, Shaldon became a passionate advocate of home dialysis. In 1966 Shaldon resigned from the Royal Free and, with the help of a local politician and businessman, established the National Kidney Centre in Finchley, North London. Registered as a charitable organization, the Centre's intended purpose was to take patients with chronic kidney failure on a contract basis from the NHS, train them to self-dialyse and release them back to the NHS after a short period.

Caught up, however, in a public backlash against the presence of "pay beds" in NHS hospitals, the Centre's overtures were rejected by the Labour government of Harold Wilson. The Centre continued on a more modest basis, with almost exclusively overseas patients.⁹³ In 1974, Shaldon left for a sabbatical in France and, during his absence, was replaced as Director by his sometimes assistant, a nephrologist named Raymond Crockett.⁹⁴

In 1979, a newly elected Conservative government set to work drafting a new Health Services Act, offering many new opportunities for private medical practice in the United Kingdom. Full-time NHS consultants were now allowed to work essentially unlimited hours in the private sector. Restrictions on foreign investment in U.K. private hospitals were relaxed. Together, these two changes meant that new, lavishly-funded private hospitals and clinics appeared throughout the UK, particularly in London, within

⁹³ The story of the founding of the National Kidney Centre and its relationship with the NHS is fascinating and deserves more attention than it is given here. For a succinct and interesting account see: Pat Gordon, "New kidneys for old: a study of the development of dialysis and transplantation services in Britain," MSc thesis, London School of Economics, 1973.

⁹⁴ David Sapsted, "A doctor few claim to know; Dr. Raymond Crockett," *The Times*, December 15, 1989.

a relatively short time.⁹⁵ Crockett, who practiced exclusively in the private sector, was in a better position to understand and make use of these developments than most.⁹⁶

In 1981, Crockett was hired by Ken Westhall, a business consultant who worked for several multinational corporations invested in London private medical facilities, to run a dedicated renal unit at Clementine Churchill hospital, owned by Westhall's employers American Medical International.⁹⁷

By 1983, Westhall had moved onto his next employer, a Kuwaiti company that had purchased Devonshire Hospital.⁹⁸ He was asked to develop a similar unit there. It was there that Westhall met Michael Bewick, a prolific transplant surgeon and pioneer in the U.K. of pediatric kidney transplants. Bewick maintained a fulltime NHS consultancy at Dulwich Hospital, but worked extensive hours operating on private patients, many from overseas, at the Devonshire and several other hospitals.

At this time, Bewick found himself acting as physician in addition to surgeon for many of his private patients, a state of affairs he did not enjoy. When Westhall introduced him and Crockett in 1984, they quickly began to collaborate, with Crockett assuming responsibility for recruiting, dialysing and "working up" patients upon whom Bewick would then operate. Many of the kidneys they used came from the bodies of accident victims. These were either "surplus" NHS kidneys, for which no suitable match could be found within Health Service transplant waiting lists, or kidneys purchased from UNOS, the American organ-sharing network. In some cases the patients would receive kidneys from live donors — generally a blood relative or spouse or in-law with suitable blood and tissue-typing results.⁹⁹ Or at least this appeared to be the case.

⁹⁵ Higgins, *The Business of Medicine*, 84-89.

⁹⁶ Bewick testified before the GMC "There is always this funny feeling in the Health Service about doctors who are full-time in private practice." General Medical Council, Day 23, 18.

⁹⁷ General Medical Council, Day 8, afternoon, p. 23.

⁹⁸ *The Economist*, "London Bridge; city in the dock," Oct 22, 1983, 36.

⁹⁹ General Medical Council, Feb 21, 1990, Day 23, pp. 17-19

Kidneys for sale in 1985

On May 10, 1985 Bewick transplanted a kidney from Akhtar Mohammed Hameed, a male in his 20s from Lahore, Pakistan, into Saqib Najam, also from Pakistan. Shortly after the surgeries were completed, a photographer from the *Mail on Sunday*, a weekly tabloid, gained entry to the hospital and photographed both donor and recipient. On Sunday May 12, these photographs, along with others, were featured as part of an expose by the *Mail on Sunday* of organ trafficking in London hospitals, “Operation Despair.” Bewick’s patients wound up receiving second billing to a donor and recipient at Clementine Churchill, another private hospital with a transplant ward. The surgeons in this instance, Michael Slapack and Christopher Rudge, had transplanted a kidney from Ramesh Kumar, a warehouse worker from Delhi, India, into his employer’s wife. Kumar, the *Mail* discovered, had been effectively press-ganged into donating, and then fired afterwards.¹⁰⁰

Although Bewick’s donor/recipient duo had been of lesser interest to the *Mail* than Slapack’s and Rudge’s, it was he who accepted the newspaper’s invitation to travel to India later that year to witness organ trafficking in a Bombay hospital with a hazy connection to the organ trade in London. This was in keeping with Bewick’s general approach to the news media. Seeing himself as a propagandist for the cause of organ donation, his policy since the 1970s had been to cooperate with and speak at length with journalists whenever asked to do so. Bewick’s visit to India became the subject of a front-page story in November, “‘I was duped’ says kidney surgeon.” As part of their itinerary for Bewick in India, the *Mail* engineered a confrontation between him and Ansuya Bagla, an Indian patient whom Bewick had agreed to transplant earlier that year based on a referral from Jai Kanodia, an Islington GP. At a Bombay hospital where Bagla was ‘having tests and meeting the potential donors,’ she and Bewick came face to face. Bewick also met with a doctor who handed him a signed affidavit stating that the donor had known Bagla his entire life and saw her as “his mother.” The doctor then reportedly

¹⁰⁰ Barbara Jones, ‘Operation despair: exposed: the horror of a trade in life itself’ and “Give My Wife Your Kidney and I’ll Buy You a Holiday in England: How Ramesh Kumar Was Made an Offer He Couldn’t Refuse,” *Mail on Sunday*, May 12, 1985.

told Bewick that, should he prefer a different donor, the name on the document could be changed. Bewick was then brought face to face with Bagla, whom he told angrily that her operation was cancelled. The donor, according to the *Mail*, had been promised between £2,000 and £4,000. He had been chosen from a pool of 650 would-be kidney sellers.¹⁰¹

Bewick was observing firsthand the international kidney trade that had begun in India in the late 1970s or early 1980s and, more recently, spilled over into his own private practice. In a letter addressed to Peter J. Morris, President of the British Transplantation Society, Bewick would recall the trip to India as the most harrowing experience of his life. He described seeing large numbers of people from the Middle East flown to Bombay for transplants from paid Indian donors. Doctors worldwide had already known about this practice for quite some time. While Bewick was in Bombay, A.S. Daar and a group of renal physicians in Oman were conducting a long-term study of Omani and Saudi Arabian patients who had travelled to Bombay for paid donations. Their findings, published in *Lancet* in 1990, were devastating. Although 81.5 percent of the patients survived the first year, rates of infection were high, post-operative care was minimal, and their home physicians were given no information.¹⁰²

Selling body parts was still not illegal in the U.K. at this point, but the British Transplant Society drafted guidelines unequivocally forbidding its members from taking part in such practices.¹⁰³ The Independent Hospital Group sent a letter to all its member hospitals instructing them that in any facilities performing live donor transplants, hospital staff were to take strict precautions to insure that live donors were related to their recipients and that no coercion had taken place. At the Wellington, another private hospital in Saint John's Wood where Bewick had operated on Crockett's patients on a few occasions, the *Mail* story was read with alarm by Elisabeth Birnie, the hospital's head matron. Shortly afterwards she approached Crockett and told him that, while she was quite certain that nothing of this nature would ever happen at the Wellington,

¹⁰¹ Barbara Jones, "'I was duped' says kidney surgeon," *Mail on Sunday*, November 12, 1985.

¹⁰² AK Salahudeen, HF Woods, A Pingle, M Nur-El-H uda Suleyman, K Shakuntala, M Nandakumar, TM Yahya, AS Daar, "High Mortality Among Recipients of Bought Living-Unrelated Donor Kidneys," *Lancet*, September 22, 1990, 725-728.

¹⁰³ Council of the Transplantation Society, "Commercialization in Transplantation: The Problems and Some Guidelines for Practice," *Lancet*, Sept 28, 1985, 715.

nonetheless she had taken steps to introduce a consent form which kidney donors would be required to sign prior to surgery.¹⁰⁴

It is worth noting at this point that hospitals such as the Devonshire and the Wellington were run almost exclusively by their nursing staff. A private hospital would typically have one doctor employed full-time as a medical director. Other than that, the doctors and surgeons who set foot on the premises would have initially gone through an application process to gain admitting rights and thereafter simply rented hospital facilities and staff support to treat patients as needed. The frequency of non-English-speaking patients, along with the transitory presence of physicians put tremendous pressure on hospital staff. Interpreting services were often provided by staff employed in some other capacity who happened to speak the language required in a particular situation. Furthermore, doctors who maintained full-time consultancies in the NHS tended to do their NHS work during the normal workday, which meant that private practice tended to happen very early in the morning or very late at night. Private, for-profit hospitals were quiet and sparsely populated compared to their NHS counterparts.¹⁰⁵

After returning from India, Bewick's "physician-based" approach to his private practice continued largely as before. He continued to divest responsibility onto Crockett and the many other clinicians with whom he had similar arrangements for the screening of donors to make sure there was no coercion or payment.¹⁰⁶ Simultaneously, the availability of cadaveric kidneys went into decline, partly as a response to the 1985 scandal, which led to tighter restrictions on the purchase of cadaveric kidneys from the United States and Europe, and partly due to a declining rate of organ donation, itself a reflection of public unease about the brain death diagnosis applied to accident victims, by far the largest source of transplantable organs.¹⁰⁷

¹⁰⁴ General Medical Council, Jan 11, 1990, Day 14, pp. 2-4.

¹⁰⁵ *Pulse*, 12 May 1979, 12-13. Birnie's testimony and the testimony of other full-time nurses at the Wellington is instructive: General Medical Council, Jan 11, 1990, Day 14, pp. 2-80, General Medical Council, January 17, 1990, Day 18, pp. 32-42 and 71-89, January 18, 1990, pp. 2-7.

¹⁰⁶ General Medical Council, Day 24, February 23, 1990, pp. 59-61.

¹⁰⁷ The name of the program was "Transplantation: Are the Donors Really Dead?" Kelly Loughlin, "The History of Health and Medicine in Contemporary Britain: Reflections on the Role of Audio-Visual Sources," *Social History of Medicine* 13, 1, 131-146.

New Arrangements

In 1987, Westhall took a new job with Medical Centres International, owners of a new clinic in Ealing. Crockett began to dialyse large numbers of patients there, many of whom would go on to receive kidney transplants by Bewick, generally at the Humana Wellington, another private hospital. This same year Westhall struck up a lucrative arrangement with Utku Unsal, the new medical director at the Turkish embassy in London. The Turkish government at the time was in the habit of paying for medical treatments abroad for many of its better-connected citizens. London at the time was still one of the foremost cities in the world for overseas patients to travel for expensive medical procedures not available in their home countries. Dialysis and transplantation were two of these. As medical director of the London embassy then, with the Turkish government prepared to pay tens of thousands of pounds for kidney transplants and related costs, Unsal held the key to an extremely large revenue stream for Westhall and Crockett, and Westhall was eager to please him. By the end of 1987, Turkish patients were coming to MCI Ealing to be dialysed by Crockett and transplanted by Bewick on a regular basis.¹⁰⁸ Many did not speak English, so interpreting duties were initially handled by the Centre's secretary. She quickly became overwhelmed and enlisted the help of Atanur Kunter, an employee of the travel agency where her husband worked.¹⁰⁹

Kunter became a regular presence at MCI Ealing. In addition to his interpreting duties, he often acted as an intermediary for the patients and their relatives, assisting them in finding accommodation, shopping, etc. It was here he got to know Crockett. The Centre's director Amin Saliba would later tell the General Medical Council that he recalled seeing Crockett and Kunter speaking to each other for hours in the clinic's conference room.¹¹⁰

¹⁰⁸ General Medical Council, Day 8, afternoon, December 13, 1989, 24-26.

¹⁰⁹ General Medical Council, Day 8, afternoon, December 13, 1989, 35-36.

¹¹⁰ General Medical Council, Day 12, January 9, 1990, 58.

Kidneys wanted in Al-Ahram

Shortly after Christmas in 1987, Saliba was paging through a copy of the international edition of *Al-Ahram*, an Egyptian newspaper, when he discovered the following classified advertisement:

Urgent appeal to those of merciful heart: a kidney donor, with blood group A or O, is required for a patient. We are prepared to pay all costs in addition to the sum of £10,000 once the operation is complete. Please contact Dr. Crockett, 486 4742, Dr. Ali-al-Mashani, 723 8012, London.

Crockett's and Mashani's names were in English. The rest of the advertisement was in Arabic. Crockett, Saliba was aware, saw patients in his surgery on Harley Street and at the National Kidney Centre in addition to the Ealing clinic. What, he wondered, was Crockett getting up to? He decided to phone the number listed in the advertisement — the number for Crockett's surgery — and impersonate a potential kidney donor responding to the appeal. Crockett's long-time secretary, Anne Whatley, answered the phone. In the conversation that followed, Saliba would later tell the General Medical Council, he impersonated an Egyptian inquiring about the advertisement. Would the £10,000 be issued in Sterling or some other currency, he asked. Sterling, replied Whatley. Was there any medical danger in donating a kidney? No, Whatley responded. Who was the kidney for? An Omani, responded Whatley. (Whatley would later deny these responses.) Incensed and alarmed, Saliba confronted Crockett a few days later. Crockett responded that he had no knowledge of the advertisement and that it was none of Saliba's business.¹¹¹

¹¹¹ General Medical Council, Day 12, January 9, 1990, 59-60.

Kidneys for sale in 1988

The Ealing clinic, meanwhile, was having financial difficulties, and Unsal expressed displeasure with the clinic's management to Westhall in early 1988. Shortly afterwards, Westhall and Crockett divested themselves of the clinic and made plans to begin treating their Turkish patients at the National Kidney Centre and transplanting them at Humana Wellington. Westhall resigned from MCI Ealing and was employed by Crockett on a provisional basis as a development consultant at the Centre. Atanur Kunter followed them, continuing in his capacity as a translator and liaison.¹¹²

As the move from Ealing to the National Kidney Centre was commencing, Atanur Kunter's brothers Rizanur and Tuncay, both based in Istanbul, were regularly scanning the classified pages of Turkish newspapers, looking for advertisements placed by impoverished Turks offering to sell one of their kidneys. The first of these advertisements was placed by Ferhat Usta, a printing press worker who lived in a *gecekondu* ("night house") in a slum on the perimeter of Istanbul with his wife and three children. The previous year one of Usta's daughters had been diagnosed with a rare bone disease, one whose treatment Usta could not afford. After a previous attempt to sell a kidney had come to nothing, Usta placed the advertisement in *Hurriyet*, Turkey's newspaper of record in May 1988. Shortly afterwards he was contacted by Rizanur Kunter, who told Usta he had a brother in London who was critically ill with kidney failure. Kunter paid for Usta to have blood and urine samples taken at a private clinic in Istanbul. Soon afterwards, Kunter contacted Usta and told him that the blood and tissue types were a match and that he should start preparing to travel to London. They agreed on a price of six million lira, approximately £2500 pounds. On July 10, 1988, Usta and Rizanur Kunter travelled to London. Usta wore clothes purchased for him by Kunter. He was given a letter on National Kidney Centre letterhead to present to the immigration officer at Gatwick, stating that Usta was going to London to visit a relative who was critically ill and required a kidney transplant.

¹¹² General Medical Council, Day 9, December 14, 1989, 17-18.

Upon arriving in London, Usta was introduced to Atanur Kunter and taken to a pension where he stayed until he entered the hospital. In the interim, he was taken to Crockett's surgery, where he was 'worked up' by Crockett. Atanur Kunter acted as interpreter. On July 16, 1988, Usta's kidney was transplanted into Colin Benton, a critically ill accountant who lived in Haifa, Israel and maintained joint British and Israeli citizenship. Benton had previously been rejected as unsuitable for a transplant by both Israel's transplant service and by the transplant unit at Royal Free. He died shortly after receiving Usta's kidney. His widow met Usta briefly afterwards and attempted to thank him. Usta received £2500 and was sent back to Turkey.¹¹³

A similar advertisement was placed in *Hurriyet* by Ahmet Koç, a native of the Kurdish village of Gulluce in the Doğu Beyazıt province of Eastern Turkey. Koç split his time between Gulluce, where his family owned a small farm, and Istanbul, where he spent part of each year as an itinerant construction worker. His advertisement appeared on April 25, 1988. A few days later, Tuncay Kunter, the third Kunter brother, responded. Like Usta, Koç was sent for blood and tissue testing in Istanbul. He did not hear from Tuncay Kunter again until August, when he was instructed to go to Agri, the closest major city to Koç's village, and apply for a passport. On September 4, 1988 he travelled with Tuncay Kunter to Istanbul. On September 9, 1988 his kidney was removed at Humana Wellington and transplanted into a Libyan physician about whom little is known, save that he suffered from hepatitis and had ended up at the National Kidney Centre after being treated at a number of dialysis centres in Europe. On September 15, 1988 Koç was discharged from Humana Wellington and returned to Turkey.¹¹⁴

On October 27, 1988, Hatice Anutkan and Coskun Yeniçi travelled to London under similar circumstances. Anutkan, a divorced mother of two, and Yeniçi, a chauffeur and factory worker, both had placed advertisements offering to sell a kidney. Yeniçi's

¹¹³ General Medical Council, Day 4, morning, December 7, 1989, 4-26.

¹¹⁴ General Medical Council, Day 4, afternoon, December 7, 1989, 17-35, Day 5, morning, 8 December 1989, 3-35. The question of Ahmet Koç's testimony is a difficult one, as he insisted throughout his three days on the witness stand that his kidney had been removed without his knowledge. But the evidence, particularly the advertisement placed in *Hurriyet* under his name in 1988, as well as his conviction by a Turkish criminal court, overwhelmingly suggest otherwise.

kidney was transplanted into an Afghan who also suffered from hepatitis.¹¹⁵ Anutkan's kidney was transplanted into Cleo Tsikritis, a Greek solicitor.¹¹⁶

"NHS kidneys" for sale

Tsikritis' transplant failed almost immediately. She returned to dialysis a "biomedical shambles" as Bewick would later describe her, awaiting another kidney. A suitable kidney had still not been located by November 19, when Bewick found himself en route between Lewisham and Dulwich, transporting the kidneys of a 26-year-old accident victim. Both had been earmarked for use by NHS patients at Dulwich. They were also, however, immunologically a suitable match for Tsikritis, who was near death. Bewick decided to travel to the Wellington instead, hastily arranging an operating theater and staff support to operate on Tsikritis. Arriving at the Wellington and preparing for surgery, he removed Anutkan's kidney from Tsikritis' body and replaced it with one of the kidneys he'd obtained from the accident victim in Lewisham. The transplant was successful. Bewick then headed to Dulwich to begin his normal rounds.

It proved to be a hectic day at Dulwich. The woman who was supposed to receive the Lewisham kidney was instead transplanted with a kidney from another, older accident victim in Belfast. Her transplant was successful, although her physician, David Taube, had expressed concern about the quality of the Belfast kidney. Another NHS patient died of haemorrhage during surgery. The details of Bewick's decision early that morning were overshadowed by these events and others.

It wasn't until Monday morning that Taube and the regional transplant coordinator, Julie Hartley-Cooper, realized that something was amiss. Confronted by each separately, Bewick acknowledged that he had, in fact transplanted a kidney that

¹¹⁵ General Medical Council, Day 6, morning, December 11, 1989, 15-20, Day 6, afternoon, December 11, 1989, 1-20, Day 7, December 12, 1989, 37-58.

¹¹⁶ Tsikritis' and Benton's full names were inadvertently revealed during the hearing. The identities of "Dr. AK" (sometimes, confusingly, referred to as "Dr. KAS") and "Mr. M" were not. At least definitively — Dr. AK was referred to as Dr. Karim at one point. An earlier report in the *Times* listed the recipient as a Dr Haji Ali. Rasit Gurdilek, "Denial of kidney charges; Tunc Ay Kunter," *Times*, March 30, 1989.

“belonged” to the NHS into a private patient. It appears that this was the last straw for many of Bewick’s colleagues at Dulwich. Although his unusual work ethic and tireless advocacy of organ donation programs had done much to advance the field in their region, his flamboyant behaviour had been a source of consternation.¹¹⁷ In 1980, he had caused financial difficulties for Camberwell Health Authority with purchase orders for a new immunosuppressive drug.¹¹⁸ In 1985 he had been at the centre of the *Daily Mail* report on paid kidney donors from the Indian sub-continent. Most recently he had made headlines again by revealing details of an enormous research project intended to produce transgenic pigs that would make suitable organ donors for humans.¹¹⁹ It was perhaps with all this in mind that Bewick’s colleagues at Dulwich reported his use of the Lewisham kidney to the Camberwell Health Authority, which immediately began an investigation.

Going out of business

Meanwhile, in Turkey, Ahmet Koç sought out the help of a local solicitor. He told the solicitor that a terrible crime had been committed upon his person: He had gone to London with Tuncay Kunter under the impression that he was to be given a job in a hotel. Upon arriving he was given a battery of what he was told were necessary medical tests for him to receive a work permit. During one of those tests he lost consciousness, and awoke sometime later in great pain. It was then that he learned that one of his kidneys had been removed. The solicitor pointed him towards an investigative reporter from *Hurriyet*, the same newspaper in which Koç had advertised his kidney for sale the previous April. He repeated his story to the reporter, who made it the subject of a front-

¹¹⁷ General Medical Council, Day 24, afternoon, February 23, 1990, 2-26, Day 13, January 10, 1990, 13-28.

¹¹⁸ Nicholas Timmins, “Can we afford the welfare state?” *Independent*, September 24, 1985.

¹¹⁹ Neville Hodgkinson, “Ostracised; the surgeon who talked too soon,” *Sunday Times*, August 7, 1988. The “pig kidneys” controversy, although it came and went much more rapidly, was nearly as controversial as the “Turkish Kidneys” scandal, and actually led to Bewick’s resignation from his consultancy at Dulwich.

page investigative piece. In Britain, the story was picked up by the *Telegraph*, who ran it on January 22, 1989.¹²⁰

An editor at the *Times* saw the *Telegraph* story and assigned an investigative reporter named David Sapsted to check out Crockett and the National Kidney Centre. After making little headway with Crockett, Sapsted managed a long phone conversation with Bewick that revealed relatively little. Soon after, Bewick was approached by a disgruntled Ken Westhall. Relations between Crockett and Westhall had soured when Westhall left MCI to work at the National Kidney Centre. The full-time appointment he said he had been promised never materialised, and a repossession company had been showing up at the National Kidney Centre, attempting to reclaim what had been Westhall's company car while at MCI Ealing. Crockett, Westhall claimed, had promised to make payments on the car and had not done so. Westhall revealed to Sapsted that he had been asked by Crockett and Kunter to produce documentation to ease Usta's passage through U.K. immigration. Westhall produced a document on National Kidney Centre letterhead stating that Usta was entering the U.K. to visit an ill relative. This revelation became the basis of the many subsequent articles Sapsted produced regarding Crockett, Kunter and the NKC. An attempt by Sapsted to affix Westhall with a hidden microphone prior to a meeting with Atanur Kunter was foiled when the recording proved inaudible.¹²¹

In Turkey, where the buying and selling of body parts had been explicitly illegal since 1989, a criminal hearing was already underway. Ultimately, Usta, Koç, Atukan and Yeniçi were given suspended sentences. Tuncay Kunter was sentenced to two years in prison.¹²² Usta et al were approached by a Turkish solicitor based in London and encouraged to file civil suits against Crockett.¹²³

By the end of January, investigations were under way by the Camberwell Health Authority, responsible for Dulwich, the Bloomsbury Health Authority, responsible for the Wellington, and the Barnet Health Authority, responsible for the National Kidney Centre.

¹²⁰ Almost from the outset, newspaper coverage in Turkey focused on the role of Utku Unsal, the medical attaché of the Turkish embassy in London. Selma Tukul, "Eyes are on healthcare advisor," *Hurriyet*, Feb 1, 1989.

¹²¹ General Medical Council, Day 11, January 8, 1990, pp. 1-18.

¹²² Rasit Gurdilek and David Sapsted, "Turk is jailed for transplant trade," *Times*, May 19, 1989.

¹²³ John Young, "Turkish kidney donors 'told lies,'" *Times*, March 27, 1990.

In July, Parliament passed the Human Organ Transplants Act, which made the buying and selling of body parts explicitly illegal.¹²⁴

“Your personal and professional tragedy”

Soon afterwards, Crockett, Bewick and Joyce received summons from the Professional Conduct Committee of the General Medical Council. After months of closed-door depositions, interviews and negotiation between the legal teams of each defendant and that of the committee, a public hearing was set to commence on December 4, 1989.

Crockett, Bewick and Joyce faced different, but frequently overlapping charges. In essence, Crockett, Bewick and Joyce were both charged with failing to establish consanguinity or a “close and enduring” relationship between Usta, Koç, Anutkan, Yeniçi and their respective recipients; with failing to establish that payment had not been made, that the patients understood the risks of the operation; and, failure to establish valid consent. Additionally, Crockett faced charges of having arranged the surgeries and, more seriously, of having arranged the payments to the donors. He also was charged with having sanctioned or condoned the *Al-Ahram* advertisement. Bewick was additionally charged with having transplanted a kidney meant for an NHS patient into a private one, and having deceived his colleagues both at Dulwich and the Guy’s Hospital tissue-typing lab in doing so. Cumulatively, each faced accusations of serious professional misconduct, a charge that could result in the revocation of their licenses to practice medicine.¹²⁵

Conducted over 36 non-continuous days and not concluding until April 1990, the hearing was unlike any that occurred before in the history of the Committee. Media interest peaked during the first two weeks when Usta, Koç, Anutkan and Yeniçi were flown back from Turkey to testify. Extreme difficulties emerged over the accuracy of interpretation, discrepancies in their depictions of events and, most distressingly, witness

¹²⁴ Human Organ Transplants Act 1989/31

¹²⁵ General Medical Council, Day 1, morning, 4 December 1989, 1-5.

intimidation.¹²⁶ The collective appearance and disposition of the Turkish witnesses was clearly dramatic, as evidenced by Joyce's sobbing breakdown under examination by his own attorney. Bewick's exhaustive appearance lasted for four days. His performance, combined with the testimonies of his colleagues, created a composite portrait of an intense man obsessed with the acquisition and transplantation of cadaveric kidneys. At one point he even argued that his use of the Lewisham committee was justified by the fact that on 17 previous occasions he had obtained kidneys from the private sector for use in NHS patients.¹²⁷ Odd then, given the circumstances, that he was much less interested in his private practice than his NHS practice, and that he was vastly more interested in cadaveric than live donor donation. That his transplantation of the kidneys of the Turks into private patients became his "personal and professional tragedy" — in the words of the Committee chairman — was no small irony.¹²⁸

Much was made in the media of Crockett's personal wealth: houses in Switzerland and Italy in addition to a £750,000 Thames-side home in Henley.¹²⁹ Whereas Bewick would speak endlessly with reporters, Crockett treated them with barely-concealed hostility. This pattern continued into the hearing with Bewick speaking on four consecutive days and Crockett refusing to testify at all. In the end it was Ken Westhall's and Ferhat Usta's evidence that proved the most damning to Crockett, the former proving that Crockett had knowingly facilitated Usta's entry into Britain under false pretenses and the latter proving that Usta's payment had come from a bank account owned by Crockett.

By the time the hearing ended in April 1990, it was the longest in the history of the General Medical Council. Although not all of the individual charges stuck, Crockett and Joyce were all found guilty of serious professional misconduct. Their sentences varied widely. Crockett was struck from the medical register, prevented permanently from practicing medicine in the United Kingdom. Joyce was given a probationary period in which he was not to perform nephrectomies. Bewick, whose chief offence was the

¹²⁶ At the end of the hearing's fifth day, in the midst of Koç's testimony, Roger Henderson announced the Committee that vehicle's were parked outside facing in opposite directions, with the probable intention of following witnesses, and that a similar attempt had been made the previous evening. General Medical Council, Day, afternoon, December 8, 1989, 22-23.

¹²⁷ General Medical Council, Day 26, February 27, 1990, 59.

¹²⁸ General Medical Council, Day 36, April 4, 1990, 6.

¹²⁹ David Sapsted, "Downfall of a man who dealt in high stakes," *Times*, April 5, 1990.

appropriation of a kidney “belonging” to the NHS for use in a private patient, was told that he could not practice in the private sector for a period of three years. The General Medical Council, in other words, countered Bewick’s act of appropriation from public to private with one of their own, from private to public.¹³⁰

According to a spokesperson at the time for the General Medical Council, Atanur Kunter was considered an “inappropriate” witness and thus was not called to testify. On the final day of the hearing, Kunter told a *Guardian* reporter:

“Do you know how many Arabs bought kidneys? Go and sit in the [name withheld by newspaper] hospital for a couple of days and see them coming in with donors. None are related, of course. If you have the money, you can buy a kidney.”¹³¹

If Atanur Kunter had been allowed to testify before the Committee, more might be understood now about the practices that brought people from Istanbul to London to sell their kidneys in the 1980s.¹³² More might be known about why, upon returning to his home village in Eastern Turkey, Ahmet Koç was set upon and stabbed repeatedly one night while walking from his home to a café. We might be better able to assess Koç’s claim that his assailants, one of whom he knew socially, had been paid by the “kidney gang” to kill him in retaliation for his role in the exposure of the trafficking of paid kidney donors between Istanbul and London in 1988.¹³³

Given the presence of Turkish criminal syndicates in London since the 1960s, the well-organized system that Atanur Kunter and his brothers apparently had in place for recruiting organ donors, the intimidation of the Turkish donors that took place during and after the hearing, and, in subsequent decades, the well-documented role played by international criminal syndicates in organ trafficking, it is tempting to suspect the role of organized crime throughout the affair. This is one reason why the decision not to allow Kunter to testify is, for historians, a disappointing one.¹³⁴ Another reason is that, had

¹³⁰ General Medical Council, Day 36, April 4, 1990, 8.

¹³¹ Gareth Perry, ““Broker” accuses other doctors,” *Guardian*, April 5, 1990.

¹³² Gareth Perry, ““Broker” accuses other doctors.”

¹³³ Ahmet Ozturk, “Ahmet Koç, who exposed the kidney scandal, attacked,” *Hurriyet*, January 15, 1990.

¹³⁴ Yücel Yesilgöz and Frank Bovenkerk, “The Turkish Mafia and the State,” *Studies of Organized Crime*, 4,2, 585-601. References to a North London-based “Turkish Mafia” abound in

Kunter been allowed to testify, we might be able to say with some confidence whether Raymond Crockett's practices were those of a lone rogue, or if they were part of something larger, in which others besides Michael Bewick and Michael Joyce might be culpable.

A decade earlier, after the 1979 General Election, shortly before the reforms that would increase the size and scope of for-profit medicine in the United Kingdom, Michael Bewick complained to a reporter: "Private transplants are a bloody nuisance. They worry you to death. If you could put them all into the transplant unit, there would be no problem."

Bewick went on to complain about the isolation endemic to hospitals operating outside of the infrastructure of the National Health Service:

I think anyone in the country who wants to go into a private hospital has to be very careful about their reasons. If you want a private room and telephone to carry on your business and you're in for a simple surgical procedure, by all means spend your money in that direction. You earned it, you can spend it.

If on the other hand you have something complicated, for Christ's sake go into the NHS. You may not like living in a 30-bed ward, you may not like the fact the chap next door to you is moaning and groaning all night. But at least you're alive and at least you're getting better.

At least if anything does go wrong there are experienced people on the spot who can treat you instantly."

He bemoaned the reduction of pay beds in NHS hospitals and the proliferation of for-profit hospitals:

Private hospitals are springing up all over London and consultants are spending less and less time in the NHS. With bigger hospitals and an expansion in pay beds, consultants would be on site and would be giving more time to NHS patients because they won't be spending 20 hours a week nipping back and forth to Harley Street.

Bewick defended his own private practice, however, on retrospectively interesting grounds: "Just because you were born in, Saudi Arabia, say, doesn't mean you should die

British newspapers, but are of an ephemeral nature. The website www.londonstreetgangs.com devotes considerable attention to the subject but contains minimal references.

because you've got kidney failure and there's no set-up to treat you."¹³⁵ With all of the words above, Bewick unintentionally summarized the travails awaiting himself, Michael Joyce, Raymond Crockett and their patients over the next decade.

After the Hearing

If the ultimate the goal of the Professional Ethics Committee of the General Medical Council was to banish the practice of kidney-selling from within Great Britain, it appears to have largely succeeded. Since 1990 no cases of paid live-donor transplants taking place in British hospitals — public or private — have come to light and, more than two decades on, it is tempting to conclude that this is because none have happened.

What have periodically emerged instead are isolated cases in which British doctors have tacitly referred patients to organ sales “brokers” abroad, or in which British renal patients have sought out such brokers without the knowledge of or against the advice of their doctors.¹³⁶ And on a larger, geopolitical level, the British government has been accused on one occasion of “turning a blind eye” to a particularly grizzly organ trafficking ring connected to a former Kosovar Prime Minister who had been a well-connected NATO ally during its war with Serbia.¹³⁷

What has loomed most conspicuously over public debates concerning organ trafficking in Great Britain since the conclusion of the Crockett case, however, is what has collectively become known as the “Alder Hay” scandal, named for the Liverpool hospital at its epicenter. This deceptively concise umbrella term refers to the unauthorized removal of organs and tissue from human corpses by pathologists at a children’s hospital in Liverpool between 1988 and 1995. Much of the tissue was removed from children, many of whom were infants.¹³⁸

¹³⁵ Nick Wood, “Will New Tory Cabinet Help Mick Bewick?” *Pulse*, 38, 19, May 12, 1979, 12-13.

¹³⁶ Randeep Ramesh, “Doctor arrested over Indian kidney racket,” *The Guardian*, Jan 14, 2008, p. 30.

¹³⁷ Adam Sage, David Charter, “Britain ‘turned a blind eye’ to murders and organ trafficking,” *The Times*, Dec 17, 2010, p. 13.

¹³⁸ A widely cited summary of the Redfer Report’s main points: *The Guardian*, “Main findings of the Redfer Report,” *The Guardian*, Jan 30 2001, <http://www.guardian.co.uk/uk/2001/jan/31/alderhey1>

It was clear the events that took place at Alder Hey were not sufficiently anticipated by any of the existing legislation: neither the 1961 Human Tissue Act, drafted in response to the earliest successful organ transplants, nor the 1989 Organ Transplants Act, drafted in response to the allegations against Crockett, Bewick and Joyce. The 2004 Act, drafted in response not only to Alder Hey but to the proliferation of gene and stem cell-related technologies described in Waldby and Mitchell's *Tissue Economies* (see Chapter 1) introduced a whole new array of human materials — from stem cells to DNA sequences that previously had been technologically beyond the pale of human exploitation. In each instance, the necessity of consent for cadaveric donation was carefully reiterated.¹³⁹

Paradoxically, however, each new tightening of the procedure for consent creates a new perception of scarcity, echoing not only the General Medical Council's admonition at the end of the Crockett/Bewick hearing for people to fill out organ donor cards, but reverberating all the way back to Lederberg's forecast of perpetual organ shortages in 1961. Indeed, in 2008, during his brief tenure as Prime Minister, Gordon Brown called publicly for "presumed consent" in organ donation, citing shortages of cadaveric organs as his principle concern. He was, by and large, met with derision. This was probably partly due his ailing political fortunes at the time (he went on to be one of the shortest-seated Prime Ministers in U.K. history) but also, likely, due to the still very fresh public memories of Alder Hey.¹⁴⁰

As for the principle act with which this chapter — and this dissertation — are concerned, live-donor kidney transplantations in which the donors are paid, the General Medical Council, as well as whatever set of codes and norms it protects, seems to have succeeded, if success is defined as banishing the practice of paid kidney donation from Great Britain. A few years later, however, in 1994, the *Times* reported extensively on cases of British renal patients, primarily from the Midlands, travelling to India for kidney transplants from paid donors.¹⁴¹ In 2002 a family doctor from Lewisham was caught on

¹³⁹ Human Tissue Act 2004/2-3

¹⁴⁰ Stephen Adams, "Bishop attacks PM's 'presumed consent' plan for organ donors," *The Daily Telegraph*, January 14, 2008, p. 6.

¹⁴¹ Ramesh, *ibid.*

tape telling an undercover journalist he could procure a kidney donor from India for him. Like Crockett, he was struck from the register.¹⁴²

The proliferation of the World Wide Web marginalized the role of physicians in the brokering process. By 2002, websites such as www.liver4you.org functioned as intermediaries between buyers in Europe and North America and sellers in South and Southeast Asia.¹⁴³ In 2007, the *Daily Mail* published an expose on Scottish renal patients traveling in large numbers to Pakistan.¹⁴⁴ In 2009, reports appeared of private citizens in both Spain and the United Kingdom attempting to sell one of their kidneys via advertisements on the internet. In each instance where these became news stories, the stories emphasized personal hardship in the aftermath of the 2008 financial crisis.¹⁴⁵

Globally, a report issued in 2010 by the World Health Organization suggested that the international kidney trade, beaten back briefly in 2006-2007 by combined international law enforcement efforts, had returned to levels previously attained in the early 2000s.¹⁴⁶ Having begun in the “global south” in the late 1970s or early 1980s, it appears to have quickly returned there after the “Turkish Kidneys” scandal, if indeed it ever truly left.

¹⁴² Greg Swift, “Doctor offered to supply kidney from live donor; organ sale GP to be struck off,” *The Express*, August 31, 2002, p. 14

¹⁴³ Jeremy Laurance, “IOS Investigation: Revealed: Website that sells organs from poor foreigners to rich Britons; Shortage of Kidney and Liver Donors Creates New International,” *The Independent on Sunday*, June 8, 2003, p. 17.

¹⁴⁴ Kizzy Taylor, “Scots fueling overseas trade in donor organs,” *The Daily Mail*, May 21, 2007, p. 5.

¹⁴⁵ Matthew Campbell, “Jobless Spaniards sell kidneys to transplant tourists,” *The Sunday Times*, May 10, 2009, p. 23. Georgia Warren, Robert Watts and Kevin Dowling, “I’ve got debts: please buy my kidney,” *The Sunday Times*, September 27, 2009, p. 8. It is worth noting that the subjects of these articles are engaging in the same behaviour as Crockett’s Turkish kidney sellers a decade earlier, albeit with different results. Such comparisons invite speculation of course, about broader economic patterns and the immiseration of the middle classes in the industrialized world after the 2008 financial crisis.

¹⁴⁶ Denis Campbell, Nicola Davison, “Illegal kidney trade booms as new organ is 'sold every hour': World Health Organisation estimates 10,000 organs now traded each year,” *The Guardian*, May 28, 2012, p. 1.

Conclusion

The commodification of body parts and the exploitation of the poor are helpful concepts for understanding the process by which Ferhat Usta *et al* found themselves in London, selling their kidneys. And although before and during the hearing commodification was often invoked as marker of public opprobrium or a warning of inhumanities to come, commodification was clearly not what was on the minds of the Professional Conduct Committee as they formulated the charges. Had it been, it surely would have been Michael Joyce who faced the most serious charges. Joyce, after all, by performing nephrectomies on the four Turkish donors, had literally inflicted physical harm upon them, and removed a kidney from each. But Joyce in fact received the least attention of the three accused and incurred the most lenient penalty. The commodification of the human body was not what the General Medical Council was concerned with preventing or regulating, but the general confusion, opaqueness and breakdown of authority within the medical profession that the situation represented. And all three of these qualities, it seemed, were directly related to the expansion of the private medical sector and its increased autonomy in the 1980s. Hospitals such as Humana Wellington were minimally staffed, isolated from conventional regulatory frameworks, and obligated to produce profits for owners and shareholders located on another continent. Companies such as Humana and American Medical International invested in a market that had traditionally been profitable because of the demand for private medical care from overseas patients, precisely at the moment that market was eroding.

The hearing and the passage of the 1989 Human Organ Transplants Act were powerful reassertions of authority by both the British medical profession (as represented by the GMC) and the government (as represented by the legislation.) For the transplant community as a whole, of which Bewick was ironically a founding and pivotal member, it was an exercise in damage control, as well as yet more proof that further efforts were needed to encourage more members of the public to identify themselves as post-mortem donors.

As for the donors, whatever the veracity of their claims about the circumstances under which they came to have their kidneys removed and the effects on their health afterwards, it is abundantly clear that their collective experiences were of pain, confusion, fear and general misery, and that their return to London to appear as witnesses compounded the latter three. Their tales are difficult to reconcile with the rational and perfectly informed choice-making consumer depicted by neoclassical economists. Their experiences in the Turkish court system, which regarded them not as victims but as co-conspirators, was little better. The desperation that drove them to attempt to sell their kidneys was complemented by the different sorts of desperation by the recipients of their kidneys. Careful readers will have noticed, incidentally, that none of them (with the possible exception of Mr. M) were particularly wealthy. Conventional frameworks of the rich preying upon the poor are not sufficient for understanding what happened in and around the National Kidney Centre and Humana Wellington in the 1980s. The stories of Raymond Crockett and his patients are deeply entwined with the story of the expansion of private medicine in the United Kingdom during that period. And while the General Medical Council, by making an example of Crockett, Bewick and Joyce, may have removed the practice of paid kidney donation from the United Kingdom, the practice has continued unabated elsewhere.

In this chapter I have presented what I believe to be a powerful case study of prosthetic or “euphenic” medicine at its most fraught. Doctors Crockett and Bewick and their patients operated in an ethically complex territory, the boundaries of which were dictated by scarcity. In the case of the donors, it was material resources that were scarce. In the case of the recipients, it was a potentially lifesaving medical commodity. Prosthetic technology and economic inequality combined to draw them together in mutual desperation.

In the next chapter I will turn to the larger economic climate of privatization in Britain and the political and cultural atmosphere of “Thatcherism” in which it was cultivated. Further attention will be paid to the origins of the National Kidney Center. It is not entirely coincidental that Margaret Thatcher makes multiple appearances in the history of the Center, first as a young backbench MP, participating in the municipal-

political circumstances that would lead to its founding, and later through a rhetorical intervention made as Prime Minister, one that certainly contributed to the National Kidney Center's demise. I will attempt to prove that this is not mere coincidence. On the contrary, the founding and the demise of the National Kidney Center are two of the very few corporeal political events that connect Margaret Thatcher the individual political operative to the larger political praxis of Thatcherism, in all of its rhetorical power.

CHAPTER 3: MARGARET THATCHER, THE NATIONAL KIDNEY CENTER AND THATCHERISM

In the previous chapter I outlined in considerable detail the historical case study at the center of this work: an “organ trafficking ring” operated out of private hospitals and clinics in London in the 1980s. In this chapter, I will attempt to place these events in the larger context of the climate of privatization – both rhetorical and actual – that pervaded Britain in the 1980s. In doing so, a discussion of former Prime Minister Margaret Thatcher is inevitable, partly because of the specific economic interventions of Thatcher herself, and partly because of the larger political praxis of “Thatcherism,” the philosophy of society and government associated with Margaret Thatcher. Greater attention will be given to the establishment of the National Kidney Center, not least to Thatcher’s role in the events leading to the establishment of the Center as young Conservative MP, and her role in its closure nearly three decades later.

On February 16, 1989, as the full weight of the allegations against Raymond Crockett, Michael Bewick and Michael Joyce was becoming known, Conservative Prime Minister Margaret Thatcher, decried the not-yet-illegal trade in human kidneys during Prime Minister’s Question Time. Asked by Labor minister Derek Fatchett why her government had not introduced legislation to formally ban the practice, she responded: “I think that the sale of kidneys or any organs of the body is utterly repugnant and that most people would take that view.”¹⁴⁷

Legend has it that, in a parliamentary session early in her tenure as leader of the opposition, Margaret Thatcher brandished a copy of Friedrich von Hayek’s *The Constitution of Liberty* and exclaimed “This is what we believe in.”¹⁴⁸ The Austrian’s

¹⁴⁷ Hansard HC [146/422-26]. This quotation has been widely cited as an example of paradox or hypocrisy by an avowed champion of free markets. One recent example: James Stacey Taylor, *Stakes and Kidneys: Why Markets in Human Organs are Morally Imperative*, Farnham: Ashgate, 2005.

¹⁴⁸ John Ranelagh, *Thatcher’s People: An insider’s Account of the Politics, The Power and the Personalities*, London: Harper Collins, 1991.

1960 political treatise argued that political freedom was a necessary precursor of economic growth.¹⁴⁹ Assuming this event actually took place, its message was twofold:

1. The leader of the Conservative opposition is not merely a pragmatist, adopting and discarding ideological positions to advance the interests of a particular class, or simply of her immediate allies and benefactors. Rather, the leader of the Conservative opposition is the sort of person who believes in things, who is capable of a) comprehending a philosophical abstraction and b) making important decisions based on that abstraction, rather than on mere, fleeting self-interest.
2. The particular belief held by the leader of the Conservative opposition is a belief in a concept of the freedom of the individual rooted in classical liberalism, but grounded immediately in a twentieth century critique of Soviet socialism and European fascism made by an “Austrian School” economist, popular amongst thinkers who felt alienated from the post-war “Keynsian consensus.”¹⁵⁰

Why this message? At a time of high unemployment, high inflation, strikes and fuel shortages, why not precisely the opposite message:

1. The leader of the Conservative has difficulty thinking in abstractions, and prefers instead to concentrate on solving specific social and economic problems that affect the day-to-day welfare of British citizens, and is happy to cooperate with members of the Labour Party and with Trade Union Leaders to do so.

¹⁴⁹ F.A. Von Hayek, *The Constitution of Liberty*, Chicago: University of Chicago Press, 1960. Hayek is the central figure of “Austrian School” economics, and somewhat less an economist and more a political philosopher than his immediate counterpart, Ludwig von Mises. The Thatcher story may well be apocryphal, but read backwards from her, there is immense fascination in Hayek’s statement in the preamble: “If politics is the art of the possible,” he writes, “political philosophy is the art of making politically possible the seemingly impossible.” (Quoted in Corey Robin, “Nietzsche, Hayek and the Austrians: A Reply to My Critics,” <http://coreyrobin.com/2013/06/24/nietzsche-hayek-and-the-austrians-a-reply-to-my-critics/>, June 24, 2013.) In a way, this is precisely what Thatcher did, lending credence to the historian Peter Gran’s assertion that Thatcher’s real skill lay in saying one thing while doing the opposite. Peter Gran, *Beyond Eurocentrism: A New View of Modern World History*, Syracuse: Syracuse University Press, 1996. 263-274.

¹⁵⁰ There are many possible entryways to understanding the shape and nature of “Keynsian” on post-war Britain, and its collapse in the 1970s (after all, as an economic prescription it was designed precisely with post-war Britain in mind), but the most concise and powerfully argued is Andrew Gamble, *The Free Economy and the Strong State: The Politics of Thatcherism*, Houndmills: MacMillan Education, 1990, 39-44.

2. The particular quality of life issues the leader of the Conservative opposition will go about solving are high interest rates, high fuel prices, high unemployment and frequent strikes.

But that had been more or less the message of the Heath government, whose defeat in the 1974 general election was the reason that Thatcher was now the party leader. Thatcher's decision to broadcast an image of herself as an ideological libertarian worked, or so the high margins of the Conservatives' 1979 general election victory would seem to indicate.¹⁵¹ Any statement about why Thatcher's positioning of herself as a radical worked (or whether, indeed this was even the key factor in the 1979 election results) is ultimately non-falsifiable and therefore less than helpful. What is more interesting is the proximity of that image to the way that her government governed over the next decade. Again, any final verdict on that matter is contestable.

Some scholars have treated Thatcher's stated opposition to organ trafficking as paradoxical, perhaps even hypocritical. Thatcher, after all, as well as the political philosophy of "Thatcherism" was rigorously committed to the principle of minimal interference in the workings of the market, as articulated by Austrian School economists such as Hayek and Von Mises. If one accepts that this principle formed the basis of Margaret Thatcher's policy-making, then her opposition to kidney selling is inconsistent at best, hypocritical at worst, interfering as it does with both the price mechanism and with principles of individual autonomy that constitute the core principles of post-war libertarianism which Hayek supposedly represents and which Thatcher supposedly successfully co-opted. At the very least, a closer look at the Thatcher government's response to the "Turkish Kidneys" scandal might give some insight into the relationship between theory and practice in the decade-long unfolding of "Thatcherism" as a political project.¹⁵²

¹⁵¹ Thatcher's former chancellor Nigel Lawson observed in his political memoir that, while Thatcher's victory within the conservative party in 1975 was likely more a rejection of Ted Heath personally, her ideological posturing was borne of something very different: "Margaret instinctively realized the need to regain the moral as well as the practical initiative from collectivism." Nigel Lawson, *The View from No. 11: Memoirs of a Tory Radical*, London: Bantam, 1992, p. 13.

¹⁵² According to the political scientist Patrick Dunleavy, the ultimate legacy of Thatcherism as a political project has been to shift the United Kingdom's political mainstream decidedly rightward, to the point where all three major political parties to some extent now express "Thatcherite" policy views. So to

Medicine and public health are excellent vantage points from which to see the ideological ambiguity of Margaret Thatcher at work. As a cradle-to-grave public entitlement program, tax-funded, centrally administrated, and exempt from anything that could reasonably be described as a market mechanism, it ought to have been within her government's ideological crosshairs from the moment they entered office. This is all the more true when you consider the amount of early intellectual support she received from the Institute for Economic Affairs, a think tank which had advocated the breakup and privatization of the NHS since its earliest pamphlets.¹⁵³

The previous chapter attempted to view the case of Raymond Crockett and Michael Bewick and their participation paid-donor kidney transplantation in the context of a newly expanded private medical center in Britain in the 1980s. This chapter, on the other hand, will take Britain's tradition of post-1948 private medical practice as its subject, examining the historical realities of its expansion in the 1980s through the lens of "Thatcherism" as a political and economic ideology. The focus, by necessity, as in the previous chapter, will remain, where possible, on the practice of renal medicine in general, particularly dialysis and transplantation.

Finally, this chapter will argue that to see Thatcher's condemnation of Crockett *et al* as incompatible in some sense with "Thatcherism" is to misunderstand both what Thatcher did, and what she represented. An exploration of alternative understandings of the Thatcherite political project, particularly its approach to the National Health Service and to the medical private sector, will follow.

whatever degree "Thatcherism" might have been occluded by the sort of incoherence or opportunism described in this article, it has been, in the long term, an ideological success. Patrick Dunleavy, "The Lasting Achievement of Thatcherism as a Political Project is that Britain Now Has Three Parties of the Right, Instead of One." *British Politics and Policy at LSE*. April 17, 2013.

<http://blogs.lse.ac.uk/politicsandpolicy/archives/32866>

¹⁵³ Institute of Economic Affairs, *Monopoly of Choice in Health Services? Contrasting Approaches to Principles and Practices in Britain and America*, London, Institute of Economic Affairs, 1964.

The Medical Welfare State in Britain and the United States

The history of entitlement programs in postwar Britain follows a similar pattern to the United States: programs are hotly contested on ideological grounds right up until the moment they are signed into law, at which point they become an immovable part of the political consensus. The difference is one of scale; the British have many more such programs, and the ones they have are much more comprehensive. Whereas the U.S. system is designed to provide comprehensive health care and a limited pension to those over 65 and those deemed unable to work, the U.K. system is designed to provide free-at-point-of-service health care to everyone, and a more comprehensive pension system to those unable to work.¹⁵⁴

While pension systems for those unable to work are primarily the province of the poor, and thus open to attack politically, the National Health Service is used by the vast majority of the population. Additionally, its establishment is closely associated with the ideology of collective self-sacrifice during and after the Second World War.

In other words, the British middle classes have a strong material and sentimental attachment to the Health Service. No politician, Labor, Conservative, or Liberal, who talks about wholly or partially privatizing the NHS, is likely to be elected.¹⁵⁵

The Thatcher government never attempted to “privatize” the National Health Service. For all the reasons above, this would have been a fantasy political program, not a practical one. And while it might have formed the basis of an extensive literature produced since the 1960s by the Institute for Economic Affairs, a libertarian think-tank

¹⁵⁴ For the United States, Paul Starr, *The Social Transformation of American Medicine*, New York: Basic Books, 1982, p. 335-379. For Great Britain (principally England), Eckstein reminds us that the Health service had broad support from across the political spectrum, and that its most serious resistance in fact came from doctors. Eckstein, *The English Health Service*, p. 161.

¹⁵⁵ Eckstein also points out, provocatively, that prior to the establishment of the NHS, public subsidies for health care flowed principally to the poor. The wealthiest tiers of society paid for treatment, as they continued to do after the foundation of the NHS. In terms of distribution of services, Eckstein argues, the NHS brought subsidized health care to the middle classes in an unprecedented manner. This may go some ways toward explaining middle class attachment to the NHS to the present day. Ekstein, *The English Health Service*, p. 9-10.

from which Thatcher drew her intellectual credentials, it was never the basis for a plausible political program.¹⁵⁶

What the Thatcher government did instead was cautiously and quietly attempt to expand the size and scope of the U.K.'s small private medical sector. In 1979, the "private sector" consisted of more or less five separate and occasionally overlapping segments: "pay beds" in NHS hospitals, not-for-profit facilities, often run by religious organizations, private and employer-based insurance schemes, often with their own hospitals, and finally, private, for-profit hospitals, clinics and surgeries.¹⁵⁷

It was primarily this last sector that was targeted for expansion by the Thatcher government's cautious and incremental health care reforms during its first term. Doctors' NHS consultant contracts were liberalized, allowing them to work unlimited hours in private practice while maintaining full-time status in the NHS. Regulations on the building of new private facilities were eased, as were capital controls on foreign investment in such hospitals. Together these three policy moves created a legal framework in which foreign — largely American — investment capital could land in the United Kingdom and begin new hospital building projects, largely unhindered. The changes to consultant contracts ensured the necessary labor force would be in place to staff them. The demand for the services they would provide, however, was assumed to be static, if not growing. As detailed earlier, however, the foreign patients upon which the existing private, for-profit sector was based, were rapidly disappearing, at the precise moment the facilities designed to cater for them were expanding.¹⁵⁸

The 1979 Conservative election manifesto called for the return of pay beds and decried Labor's "vendetta" against private medicine.¹⁵⁹ In 1983, the Conservative Party largely restricted the discussion to private insurance, arguing that it eased the burden on

¹⁵⁶ Arthur Seldon, *After the N.H.S.*, London: The Institute of Economic Affairs, 1968.

¹⁵⁷ The Economist Intelligence Unit, *Private Health Care in the U.K. A Review*, London: The Economist, 1986. This is a detailed and historically rooted assessment of the private healthcare scene which is, as its authorship suggests, a partisan voice in favour of an expanded private sector, yet, seven years into Thatcher's reforms, pessimistic about the prospects of the for-profit sector.

¹⁵⁸ Higgins, *The Business of Medicine*, p. 185-186. On market contraction, see Terry Dodsworth, "For-Profit Hospitals Feel the Pinch," *Financial Times*, January 22, 1986, p. 6.

¹⁵⁹ The Conservative and Unionist Party, "Conservative Party General Election Manifesto 1979," in Iain Smith (ed.), *Volume One: Conservative Party General Election Manifestos 1900-1997*, Milton Park: Routledge, 2000, p. 279.

the NHS and generally made more health care available.¹⁶⁰ The 1987 manifesto did not mention it at all.¹⁶¹

Much was made of the 1983 Griffiths Report, which called for a complete reorganization of the NHS along management lines, urging methods of streamlining and incentivizing borrowed from the private sector. These proved difficult to implement. This is often attributed to the idea that the NHS is not a business, and its functions cannot be reduced to clearly delineated goods and services meeting criteria for quality and quantity.¹⁶²

Private medicine in the 1980s remained a small part of medicine in the U.K. overall. And private for-profit hospitals and clinics remained small in relation to private medicine overall. Compared to the government's ragnarök with organized labor, culminating in the miners' strike of 1984, its attempts to expand the scope of private medicine in the U.K. were inconsequential.¹⁶³ The real legacy of Thatcherism upon health policy and the National Health Service, as the historian Alex Mold has argued, was to place a rhetorical emphasis on the patient as consumer of health care, rather than the patient as recipient of a public good. This, Mold argues, made relatively little impact upon the Health Service in Thatcher's time, but exercised considerable influence on a longer-term shift in the organizational model of the NHS from centralized bureaucracy to locally and regionally coordinated bureaucracies.¹⁶⁴

Understanding the political project of "Thatcherism" is additionally confusing because Margaret Thatcher was an intensely polarizing political personality. Her legacy since 1990 has been equally polarizing. This was not unrelated to her gender. She entered politics at a time when female MPs were extremely rare, and female cabinet ministers even more so. Even early in her career, when by all appearances she was an

¹⁶⁰ The Conservative and Unionist Party, "Conservative Party General Election Manifesto 1983," in Iain Smith (ed.) *Volume One: Conservative Party General Election Manifestos 1900-1997*, Milton Park: Routledge, 2000, p. 298-299.

¹⁶¹ The Conservative and Unionist Party, "Conservative Party General Election Manifesto 1987," in Iain Smith (ed.) *Volume One: Conservative Party General Election Manifestos 1900-1997*, Milton Park: Routledge, 2000, p. 313-354.

¹⁶² Rudolf Klein, *The Politics of the NHS*, p. 208-209.

¹⁶³ Terry Dodsworth, "For-profit hospitals feel the pinch," p. 6.

¹⁶⁴ Alex Mold, "Making the Patient-Consumer in Margaret Thatcher's Britain," *The Historical Journal*, Cambridge, 54(2), June 2011, 509-528.

ideologically unremarkable conservative politician, opposition to her, both from within and without her own party, was often couched in explicitly sexist terms. Paradoxically, her political experiences in this respect were most analogous to those of the Labor MP and ardent socialist Barbara Castle. A political disciple of Harold Wilson who spent much of her cabinet career attempting to reign in what she perceived as gratuitous and excessive industrial actions, Castle was hated on the right for her socialism and on the far left for her commitment to trimming the excesses of the labor movement. Throughout her career, both sides, from time to time, expressed their contempt in overtly sexist terms. Upon her death, virtually all of her obituaries made extensive reference to Margaret Thatcher.¹⁶⁵ To speak of Thatcherism as a political phenomenon is to speak of its political and social constraints, and seemingly universal sexism of this nature is clearly one of the more significant constraints.

Up until this point, this chapter has attempted to assess growth of private for-profit medicine in Great Britain in the 1980s and found it to be present, although not as a function of an irascible and ever-growing international capitalism. Rather, the evidence suggests private-sector growth to be a function of the reduction of pay-beds in public hospitals (itself a byproduct of a labor dispute from a previous decade) and a temporary and somewhat irrational influx of finance capital into Britain's tiny private hospital market. In these final sections, this chapter will examine the public reaction to the growth of the private sector in the 1980s, itself a subset of the larger reaction to the rhetorically radical nature of the Thatcherite project.

¹⁶⁵ Anne Perkins, "Barbara Castle: Obituary," *The Guardian*, Friday, May 3, 2002, p. 1.

The National Health Service and its Fringes

The National Health Service came into existence in 1948, nationalizing the vast majority of British hospitals and medical facilities, and turning the vast majority of doctors and medical professionals into public employees. While other Western European countries made Herculean efforts to provide medical care for their citizenry, only the United Kingdom opted to do so with a centralized and free-at-point-of-service system, rather than through multiple and overlapping insurance systems.¹⁶⁶ In other words, according to the preeminent historian of the NHS, Rudolph Klein, while France and Germany had pluralistic systems of health provision to match their pluralistic political systems, and the Soviet countries had monopsonistic health systems to match their monopsonistic political systems, the United Kingdom was unique in having a monopsonistic health system and a pluralistic political system.¹⁶⁷

This paradox, according to Klein, is the key to understanding the way the NHS evolved and the problems it encountered over the next half century: when the NHS began, long waits and rationing of both goods and services were symbols of public solidarity. By the 1960s, the United Kingdom had become an individualistic consumer society. While the NHS still held tremendous symbolic power, scarcity within it became something that inspired complaint and indignation. For many who could afford it, the solution was to exit the NHS and seek medical care from the private sector.¹⁶⁸

The “private sector” in the United Kingdom is an umbrella term; underneath it are a number of diverse and often unrelated practices and institutions: hospitals run by charitable and religious organizations, “pay beds” within NHS hospitals, private insurance schemes and their affiliated hospitals and clinics, providers of medical services

¹⁶⁶ The earliest attempt at a comprehensive analysis, at least one written by a putative outsider, of the National Health Service, is Harry Eckstein, *The English Health Service*, Cambridge: Harvard University Press, 1958. A Princeton sociologist, Eckstein was writing for an American audience inclined to evaluate and understand the NHS through the lenses of a debate over the comparative merits and demerits of economic planning. His attempts to reframe the debate are admirable.

¹⁶⁷ Rudolf Klein, *The Politics of the NHS*, London: Longman Group, 1983, v. Klein is the *de facto* official historian of the National Health Service and published multiple volumes dealing with the NHS from multiple angles.

¹⁶⁸ Klein, p. 154-156.

largely outside the remit of the NHS (optometry, dentistry, geriatric care) and, finally, privately owned, for-profit hospitals and clinics.¹⁶⁹

When the curtain rose on the NHS, the private sector largely consisted of hospitals that the NHS had, for reasons of age or scale, simply not wanted, and a limited number of “pay bed” wings within NHS hospitals. Pay beds were there less because of consumer demand and more because doctors wanted them there. For doctors, they were symbols of the autonomy they had enjoyed prior to 1948, when their business model had been — in popular memory anyway — that of the small town shopkeeper. Pay beds were typically located in private rooms in separate wings of NHS hospitals. They allowed paying patients privacy and a few amenities and, occasionally, a shorter wait for treatment. They allowed doctors greater discretion in limited instances in how treatment was allocated and along with that, perhaps, a feeling of independence which may have been of greater symbolic value than anything else.¹⁷⁰

In practice, however, pay beds were underutilized. To make matters worse, if they were positive symbols for doctors, they were strongly negative symbols to others: nurses and other hospital staff and, in some cases patients, who were inclined to view pay beds as symbols of visceral inequality — contaminants in the ideological ointment of a system which, since its outset, had been articulated in explicitly egalitarian and ideological terms.¹⁷¹

Medical workers’ unions, in keeping with the national trend, grew more militant in the 1970s. In the strikes of 1970 and 1974, the elimination of pay beds was a key demand of the strikers. In 1974, an electorally weak and defensive Labor government adopted a policy of phasing pay beds out of NHS hospitals. This required a concession to doctors, however, who were becoming increasingly militant themselves. This concession

¹⁶⁹ It is difficult to find histories or ethnographies of private sector medicine in Britain that attempt to be disinterested, let alone succeed. This fact alone is of historical interest however: it speaks to the perceived “stakes” of health care for consumers, voters, activists, and politicians during the Thatcher era. One gainful attempt at comprehensive analysis, however, comes from Eugene Vayda, “Private Practice in the United Kingdom: A Growing Concern,” *Journal of Public Health Policy*, Autumn 1989, p. 359-376.

¹⁷⁰ Prior to the 1970s, the acrimony over pay-beds was consistent, but comparatively placid. The NHS’s architect, Aneuryn Bevan, famously used the analogy of a theatre with different priced seats to justify the existence of pay beds. Samuel Menscher, *British Private Medical Practice and the National Health Service*, Pittsburgh: University of Pittsburgh Press, 1968, p. 51-54.

¹⁷¹ Joan Higgins, *The Business of Medicine: Private Health Care in Britain*, Houndmills: MacMillan Education, 1988. 57-59.

was the easing of restrictions on the building of private hospitals. Private medical care was, in effect, being moved out of the NHS and, in some sense, further out of sight altogether.¹⁷²

With all this in mind, the interview given by Michael Bewick to *Pulse* magazine — a trade magazine catering to medical professionals — is illuminating. As discussed in the previous chapter, the piece portrays Bewick as a dedicated surgeon, fanatically committed to transplanting as many kidneys — and saving as many lives — as possible. While deeply committed to the NHS, he devotes as much time as his consultant contract allows to his private patients. He does this for two reasons: out of an unwillingness to discriminate against foreign nationals, and out of financial necessity. Because of his self-appointed duties as a nationwide transplant coordinator and all the travel it entails, his NHS salary is barely enough to allow him to support his family.¹⁷³

Bewick compares the private sector unfavorably to the NHS, advising whoever might be reading the article to choose the NHS over private hospitals for serious medical care wherever possible. He also makes it clear that he deplores the policy of phasing out pay beds:

Private hospitals are springing up all over London and consultants are spending less and less time in the NHS. With bigger hospitals and an expansion in pay beds, consultants would be on site and would be giving more time to NHS patients because they won't be spending 20 hours a week nipping back and forth to Harley Street.¹⁷⁴

Bewick's remarks are evocative of a perceived crisis within the National Health Service during a period of prolonged social and economic tension on the eve of what is often regarded as an epochal shift not just in Great Britain but in the global economy as a whole. Recession, inflation and industrial action both within and without the NHS characterized the 1970s, from the OPEC crisis of 1973 onwards.¹⁷⁵

¹⁷² Higgins, 66-72.

¹⁷³ Nick Wood, "Will New Tory Cabinet Help Mick Bewick?" *Pulse*, 38, 19, May 12, 1979, 12-13.

¹⁷⁴ Nick Wood, p. 13.

¹⁷⁵ More than three decades after publication, the sociologist Stuart Hall's politico-ethnographic treatment of Britain in the 1970s is still indispensable. Stuart Hall, *Policing the Crisis: Mugging, The State, and Law and Order*. New York: Holmes and Meier, 1978. *Policing the Crisis* is also a salient reminder that in 1970s Britain, the political left considered the Labour government of James Callaghan to be a profoundly

The Conservative party won a decisive general election victory on May 3, 1979, bringing Margaret Thatcher to power as Prime Minister and ushering in several decades of neoliberal reform. Thatcher stepped down in 1990, but her party remained in power for another seven years and in many respects the policy course she charted was continued by the Labor party when they were in power from 1997 until 2010.¹⁷⁶

Thatcher was a divisive figure while in power, and her legacy has been equally divisive. The political project with which she is associated, “Thatcherism,” has been associated at different times, by different critics, with privatization, anti-welfarism, anti-unionism, militarism, nationalism, racism, xenophobia, Europhobia and Atlanticism. By supporters it is generally seen as a program of modernization and the restoration of order. Both supporters and detractors are guilty of imposing a degree of coherence on it post-fact.¹⁷⁷ Once committed to destroying an opponent, the Thatcher government could be utterly ruthless — as the National Union of Mineworkers learned in 1984-85 — but it chose its battles in a cautious and pragmatic manner, and their overarching goal appears to always have been short-term political survival. Indeed, the one time Thatcher truly refused to back down — over the hated “Poll Tax” imposed in 1990 — she quickly found herself removed from office.¹⁷⁸

reactionary force in British society. The Thatcher government — with its fiery rhetoric and the equally fiery reaction it inspired — has served to obscure this fact retroactively.

¹⁷⁶ Andrew Gamble, again, is helpful on all these points, but dense and readable political biographies of Thatcher abound. The most recent is Charles Moore, *Margaret Thatcher: The Authorized Biography Volume I: Not For Turning*, London: Allen Lane, 2013. Prior to Moore, the definitive volume on Thatcher’s premiership was John Campbell, *Margaret Thatcher: The Iron Lady*, London: Jonathan Cape, 2003.

¹⁷⁷ One of the first volumes that might be considered guilty of this — and indeed, of coining the term “Thatcherism” is Stuart Hall, Martin Jacques (ed.), *The Politics of Thatcherism*, London: Lawrence and Wishart, 1983. On the ambiguities of Thatcherism, again, Gamble, *The Free Economy and the Strong State*, *ibid.*, p. 158-173. While remaining sceptical of the meaningfulness of the term, Gamble ultimately identifies Thatcherism as a philosophy of statecraft, specifically on of “high politics,” a tradition of conservative governance that Gamble, citing the political scientist Jim Bulpitt, dates back to Disraeli.

¹⁷⁸ Gamble on the operational logic of the government’s response to the miners’ strike: “It was enormously costly for the Government, but it ended in complete defeat for the miners, once they had been split and successfully isolated from the rest of the Labour movement. By crushing the miners, the Government was able to demonstrate to the whole Labour movement that nothing was to be allowed to stand in the way of restructuring industries to make them profitable again and internationally competitive.” *The Free Economy and the Strong State*, p. 116. Lawson — who began as Thatcher’s energy secretary and by the time of the strike was Chancellor of the Exchequer — wrote, revealingly, “The miners’ strike was the central political event of the second Thatcher administration. Just as the victory in the Falklands War bolstered long-flagging feelings of military pride, so the eventual defeat of the NUM etched in the public

Thatcher's target was not the political left per se, but the industrial sector of the British economy, where the left had its strongest organizational base. By the removal of protective tariffs, Thatcher exposed the British steel, automotive and textile industries to foreign competition with which they could not compete. This hurt the trade unions as much if not more than the crushing blow they received during the miners' strike. One might even speculate that, from the vantage point of the office of Prime Minister, both industrial workers and their bosses looked like "special interests" which needed to be crippled lest they impede the United Kingdom's transition from a mercantile to a service economy.¹⁷⁹

The other side of this process was the creation of "The City," the London-based financial services sector that grew throughout the 1980s, particularly after the 1986 "big bang," the sweeping away of banking regulations that in some cases had existed prior to the nineteenth century. Financial markets were opened to foreign investment and the traditional legal distinction was abolished between individuals and institutions that owned shares and those who simply traded them, with all of the predictable effects.¹⁸⁰

Thatcher's other major political project was privatization of public industries. This was taken to an extreme. During her premiership, vast swathes of public utilities and transport were essentially sold into the private sector. This was a murky and not always competitive process that, to a cynic, might look like a handful of connected individuals using the authority of the state to enrich their friends, families and associates. It is even tempting to wonder if the primary purpose of Thatcher's libertarian rhetoric was to give political pundits, both friendly and hostile, the impression that something altogether different was happening.¹⁸¹

mind the end of the militant trade unionism which had wrecked the economy and twice played a major part in driving elected governments from office." *The View From No. 11*, p. 161.

¹⁷⁹ This position is nicely summarized in the obituary of Thatcher written by the economist Martin Wolf, a qualified admirer. Martin Wolf, "Thatcher: The Great Transformer," *The Financial Times*, April 8, 2013.

¹⁸⁰ Hall, Jacques, et al perhaps overemphasized the degree to which the decline of British industry and the creation of "The City" were indicative of an epochal shift in global economic structures. These two economic modes, in a nod to the Italian communist philosopher Antonio Gramsci, were dubbed "Fordist" and "post-Fordist." Michael Rustin tempers this position nicely in Michael Rustin, *The Politics of Post-Fordism or, the Trouble With 'New Times'*, *New Left Review*, 1/175, May-June 1989, p. 55-57.

¹⁸¹ Gamble, *The Free Economy and the Strong State*, p. 124-125.

Thatcher was a vocal supporter of monetarism: the restriction of currency supply as an anti-inflationary measure (although her record is not one of a strict monetarist.) It is difficult to say for certain, however, to what extent this was motivated by fear of inflation (although there was plenty of this) and to what extent it was simply another weapon in her arsenal to use against British industry; tight monetary policy meant an overvalued pound sterling, which effectively crippled already struggling industries' potential for export. Monetarism also meant high unemployment and reduced government spending. There is ambiguity on this point as well: spending did not actually decrease during the Thatcher years. This was possible largely because it was on Thatcher's watch that tax revenues from North Sea Oil profits began to appear in government coffers.¹⁸²

Rhetorically, Thatcher introduced neo-Victorian themes of self-reliance, individuality, and the virtues of competition into a political culture from which they had been somewhat marginalized since before the First World War. This was one important part of how she shifted the political center rightwards, where it has since remained, but again the question remains of whether such themes were adopted for short term or long term objectives. If there is such a thing as Thatcherism, its nature is only understood by the person for whom it is named.

The private sector, as it existed in 1979, by the rhetorical logic of Thatcherism, should have been something to extol the virtues of publicly and extend growth opportunities to privately. There was, in fact, surprisingly little of either. The expansion of private hospitals that occurred in the early 1980s owed as much if not more to the strategies employed by the previous government to reduce the number of pay beds in NHS hospitals without incurring the wrath of doctors.¹⁸³

Having said that, the 1980 Health Services Act did facilitate private practice in a piecemeal manner, largely by making it easier for doctors to work expanded hours in the private sector while maintaining full-time status in the NHS.¹⁸⁴ Michael Bewick, despite his protestations outlined earlier, took full advantage of this. Furthermore, Thatcher's fiery pro-market rhetoric certainly helped to create the perception among U.S. companies

¹⁸² Guy Lodge, "Thatcher and North Sea Oil: A Failure to Invest in Britain's Future," *New Statesman*, April 15, 2013.

¹⁸³ Higgins, *The Business of Medicine*, p. 70-75.

¹⁸⁴ Great Britain, *Health Services Act*, London: Stationary Office, 1980.

such as Humana and American Medical International that the U.K. was a friendly business environment for them.¹⁸⁵

More importantly, however, the NHS remained the centerpiece of the U.K.'s postwar social consensus, even as the country shifted rightward in other respects. And as the right wing party, the Conservatives were viewed with more suspicion by the electorate with regards to health policy. Political pragmatism required Thatcher, like other Conservative prime ministers before and since, to pay regular homage to the NHS, whatever any otherwise quotable Austrian economists might have to say about the matter. Any thought of making serious alteration to the NHS was dispensed of after a minor political crisis in 1982: When Thatcher commissioned the Central Policy Review Staff — the cabinet's think tank, established by Edward Heath in 1970 - to assess options for cutting public spending. Like all CPRS review papers, it was intended for use by cabinet members only.

Thatcher's cabinet at the time was understood to be divided between "wets" who were socially conservative but broadly sympathetic towards the welfare state, and "dries" who were intellectually hostile towards it. Both sides were shocked by the CPRS paper, which suggested, among other things, replacing a significant portion of the NHS with a system of compulsory insurance. In the ensuing response (which then-chancellor Nigel Lawson described as a "riot") the paper was leaked to the *Economist* which reported that the Thatcher government was intent on dismantling the welfare state. Throughout the next election, Thatcher was compelled to reiterate her government's commitment to funding the NHS. Had the Thatcher government ever been serious about privatization of any aspect of the NHS, it ceased to be from 1983 onward.¹⁸⁶

There is a tendency in the United States to invoke "socialized medicine" as a generic descriptor of what goes on in European countries. In fact national health care systems vary greatly from country to country in Europe. The most pronounced difference, however, is between systems based on insurance and systems based on centrally-financed provision. Germany is the best-known example of the former. This is hardly surprising as

¹⁸⁵ Marilyn Mannisto, "Hospital Management Companies Expand Foreign Operations," *Hospitals*, February 1, 1981, 52-56.

¹⁸⁶ Nigel Lawson, *The View From No. 11*, p. 303-305.

the basic premise of social insurance was devised in the early welfare state designed by Bismarck.¹⁸⁷ According to Rudolph Klein, author of the definitive political history of the NHS:

When confronted by the muddle of health care, men started thinking about possible solutions, they had before them two models — either of which could have been developed into a fully-fledged national system. The first model was that of Lloyd George’s insurance scheme for general practice: an import from Bismarck’s Germany. In theory there was no reason why such a model could not have been elaborated into a comprehensive national insurance scheme: the road followed by nearly all other Western societies in the post-war period, and advocated by the BMA not only in the 1930s but also subsequently. The other model, however, was that of the public health services, developed and based on local authority provision in Britain in the nineteenth century: a model based on seeing health as a public good rather than as an individual right. While the first model emphasized the right of individuals to medical care — a right to be based, admittedly, on purchasing the appropriate insurance entitlements — the second model emphasized the obligation of public authorities to make provision for the health of the community at large. While the first model was consistent with individualistic medical values — given that the whole professional ethos was to see medical care in terms of a transaction between the individual patient and the individual doctor — the second model was consistent with a collectivist approach to the provision of health care.¹⁸⁸

The latter prevailed, for reasons that were particular to the political realities of Britain in the 1940s. These political realities are best encapsulated by the Beveridge Report, a policy paper commissioned by the Labor Party in 1940 and released in 1943. The Beveridge Report named five “giant evils” in society: squalor, ignorance, want, idleness, and disease. The report advocated the creation of comprehensive welfare institutions to alleviate them, and was frequently cited by supporters of the National Health Service.¹⁸⁹ It is not an overstatement to say that the latter was more radical, and the triumph of the more radical approach was at least in part due to the invocation of collectivist rhetoric as part of the “home front” mobilization effort during the war.

¹⁸⁷ Katherine H. Leith, Astrid Knott, Alexander G. Mayer, Jorg Westermann, “Germany” in James A. Johnson, Carleen Iarriot Stoskopf, eds., *Comparative Healthcare Systems: Global Perspectives*, Sudbury: Jones and Bartlett, 1980, p. 154.

¹⁸⁸ Rudolf Klein, *The Politics of the NHS*, p. 5-6.

¹⁸⁹ *Social Insurance and Allied Services*, Cmd 6404, London: Stationary Office, 1942.

Rationing and queues, it has been argued, served during and after the war as symbols of collective solidarity in the face of collective privation. It was only in the more affluent 1960s that they came to be seen as a function of the failure of the state to provide services in a timely and pleasing manner (which is how critics of the NHS would later treat them). Implicit in this spirit of collective solidarity was a principle of equality. Philosophically, the NHS required the principle of equal access in order to be ideologically comprehensible.¹⁹⁰ Still, the primary critics who needed to be placated during the formation of the NHS were the leaders of the British Medical Association, the doctors' professional association, who feared the loss of autonomy and income that might be brought about by the nationalization of their services. The doctors' collective concerns were subsumed in a larger discussion over the role of centralized planning versus local control in the allocation of health care. And ultimately the doctors' concerns were addressed in a piecemeal fashion, partly through allowing private care outside of the National Health Service to continue. For doctors, the private sector was a largely symbolic assurance of their autonomy. For patients and for other medical workers, it was increasingly seen as a symbol of inequality that violated the principles of the National Health Service.¹⁹¹ Many of the philosophical problems of equality of access, public versus private provision and the practical problems of local versus centralized control are embodied in the story of renal dialysis in Britain beginning in the 1960s. Further, as the case of Raymond Crocket and his patients, discussed in the previous chapter, illustrates, problems related to renal dialysis and those related to renal transplantation are inextricably linked. And finally, all of the above are, at their core, issues of equality of access to healthcare, an issue toward which the Thatcher government took an extreme and iconic position.

¹⁹⁰ Although not concerned with presenting a comprehensive history of the National Health Service, the sociologist Richard M. Titmuss articulates these principles succinctly in the work for which he is most famous, an impassioned polemic against paid blood donation in the United Kingdom. Richard M. Titmuss, *The Gift Relationship: From Human Blood to Social Policy*, New York: Vintage Books, 1972, p. 238.

¹⁹¹ Rudolf Klein, *The Politics of the NHS*, p. 128.

Dialysis and the Private Sector: The National Kidney Center and Beyond

Renal dialysis is a lifesaving medical procedure developed by a Dutch physician in the 1940s. Dialysis in its earliest form “cleaned” the blood of patients suffering from kidney failure in a way that their kidneys were temporarily incapable of doing. Requiring highly destructive surgical grafting of blood vessels however, it was not a workable technology for patients suffering from chronic kidney failure.¹⁹²

This problem was solved in the 1960s by the development of surgical shunts which could be attached to superficial arteries, creating a semi-access point for machine dialysis. It was at this point that dialysis entered the mainstream therapeutic lexicon in Britain and elsewhere, although not, as the story of the nephrologist Stanley Shaldon will suggest, without problems. To fully contextualize the story at this point however, it is necessary to return to Margaret Thatcher’s condemnation of paid live donor kidney donation, uttered in 1989 and discussed at the beginning of this chapter. Thatcher’s first run-in with the founder of the National Kidney Center occurred in 1964.

In 1964, Stanley Shaldon was a young nephrologist struggling to implement a dedicated dialysis ward within the Royal Free, a National Health Service Hospital in North London. Understaffed, underfunded and consistently at odds with the Head Matron, Shaldon was forced to seek charitable funding to finance dialysis sessions for many patients.¹⁹³ One of them, a nineteen-year old student-teacher named Malcolm Sweet, attracted the attention of his mayor, Murray Medway, a Liberal representing Finchley, a district of Barnet in North London. Medway approached Shaldon with ideas about private funding for Sweet’s dialysis. Margaret Thatcher, serving her first term as Finchley’s Member of Parliament (and perhaps sensing a future electoral challenge from Medway), intervened.

Thatcher used the case of Malcolm Sweet and of the Royal Free’s dialysis patients to attack the National Health Service for failing to treat dialysis as a conventional medical procedure to which all in need were entitled. Although the public appeal for

¹⁹² For a thorough history of dialysis, Steven J. Peitzman, *Dropsy, Dialysis, Transplant: A Short History of Failing Kidneys*, Baltimore: Johns Hopkins University Press, 2007.

¹⁹³ Pat Gordon, “New Kidneys For Old: A Study of the Development of Dialysis and Transplantation Services in Britain,” MSc Thesis, London School of Economics, June 1973, p. 7-9.

donations that would allow the Royal Free to purchase a new dialysis machine had already exceeded the £850 requested, Thatcher announced on November 22, 1964 that she had secured the cooperation of the National Health Service to pay for the machine, through a meeting with the Parliamentary Secretary to the Minister of Health. Shaldon and his staff, based at a hospital outside of Thatcher's constituency, felt they had been victims of a political stunt. Slightly over a month beforehand, the Labor Party, under the leadership of Harold Wilson, had won a sweeping victory in the general election. Margaret Thatcher made her move on the Royal Free against the backdrop of the normal political maneuvering that takes place within a party returning to opposition.¹⁹⁴ Although the transition from Thatcher's ministerial career to her premiership were marked by an increasing radicalization of rhetoric, her speech, writing and actions in relation to the NHS were ambiguous (and arguably self-serving) throughout, as this anecdote suggests.

From this tumult was born the National Kidney Center, formally registered as a nursing home and located in Finchley, North London. As the Center's director, Shaldon initially envisioned a facility that would take NHS patients suffering from renal failure, treat them on a contract basis, teach them to self-dialyze using a shunting technique Shaldon had learned from Robert Scribner in Seattle, and a simple auto-dialysis procedure he had devised himself. Ultimately, the Center was rejected by the National Health Service, partly due to the perceived expensiveness of the procedure, partly due to reticence about public-private partnership, and partly, the evidence suggests, due to Shaldon's personal unpopularity.¹⁹⁵

Shaldon and the Center's board of directors briefly announced their intention to close in 1967, but instead continued on as a dialysis center for private, fee-paying patients, generally from abroad.¹⁹⁶ During a sabbatical in 1975, Shaldon was replaced as

¹⁹⁴ Finchley Press, "The National Health Service Pays for Kidney Machine: Member of Parliament's Quick Action After Reading Appeal," *Finchley Press*, November 27, 1964.

¹⁹⁵ Shaldon characterized himself as "ruthless, rude and unscrupulous." Quoted in Gordon, p. 15.

¹⁹⁶ British Medical Journal, "Closure of Kidney Center," *British Medical Journal*, September 9, 1967, p. 631. What came after the non-closure is the murkiest period in the Center's history. Shaldon continued to be a public advocate for home maintenance haemodialysis, even as transplantation eclipsed it in relevance as a treatment for End Stage Renal Disease. Stanley Shaldon, "Independence in Maintenance Hemodialysis," *The Lancet*, March 9, 1968, p. 520-521.

the Center's director by his former assistant, Raymond Crockett, who continued treating a largely overseas clientele.¹⁹⁷ As the 1970s progressed, dialysis became more of a conventional presence in NHS hospitals, but it also became less of an end in itself and more of a bridge treatment for kidney patients awaiting a suitable transplant.¹⁹⁸

The Americans Are Coming

Much of the animus against pay beds in the National Health Service reinvented itself as opposition to the Thatcher government's limited privatization plans. As discussed earlier, these plans created space for foreign — largely, but not exclusively American — investment in the British medical private sector. As such, much of the opposition to increased privatization had a distinctly anti-American rhetorical bent. Many writers and activists argued that increased healthcare privatization constituted the “Americanization” of the British healthcare system and, by extension, the opportunity for private interests to capitalize upon human suffering. The underlying anxiety appears to be that introducing market mechanisms into healthcare — however peripherally — will somehow create more sick people or, somewhat more plausibly, erode the social contract as embodied in the postwar welfare state.¹⁹⁹

One essay in the edited anthology *Banking on Sickness: Commercial Medicine in Britain and the USA* described the influx of investment from American healthcare providers into the United Kingdom's private healthcare market as an “invasion,” ending with a dire warning that, having successfully absorbed a majority of the indigenous British for-profit hospital companies, American providers such as American Medical

¹⁹⁷ David Sapsted, ‘A doctor few claim to know; Dr. Raymond Crockett, *The Times*, 15 December 1989.

¹⁹⁸ Thomas Halper, *The Misfortunes of Others: End-Stage Renal Disease in the United Kingdom*, Cambridge: Cambridge University Press, 1989, p. 91-93.

¹⁹⁹ This is a difficult anxiety to explicate but it is perhaps best illustrated in Jonathan Coe's 1995 comic-dystopian novel *What a Carve-Up!* in which a fictional British aristocratic family conspires to immiserate the British public through a variety of their financial concerns, including a holding company that closes hospitals and replaces them with parking garages and another that produces commercial beef drugged with chemicals that retard brain function in consumers. Jonathan Coe, *What a Carve Up!* London: Penguin, 1995.

International were setting their sights on the National Health Service. The editors of the volume (published in 1987) were more cautious:

This book mostly concerns itself with private medicine in Britain, but it also looks at the USA, both because many of the new commercial hospital companies originated there, and because, as we suggest, U.K. private medicine is undergoing a transformation similar in form, if not in scale, to changes occurring in America. We identify this trend as the substitution of charitable activity by commercial activity.²⁰⁰

More soberly, the author of *The Business of Medicine: Private Healthcare in Britain* took a similar view in 1988:

The growth of for-profit facilities in Britain has been a by-product of American attempts to control rising costs and maintain profitability in the USA. It is essential to see these developments in a broader international context, where there have been significant changes in the ways in which the burden of health care provision and financing have been shared between employers, individuals and the State.²⁰¹

The dates of publication of the above are significant, however. By 1986, the limits of consumer demand in the United Kingdom for the services provided by hospitals like the Wellington and Clementine Churchill had clearly been reached, and it is in an atmosphere of declining profits that these enterprises operated for the remainder of the decade. Critics and alarmists, looking at the “rise” of private medicine in the United Kingdom from the early 1980s saw a time’s arrow veering inexorably toward a free-market healthcare dystopia, but what seems to have happened instead is that the for-profit private sector, enjoying its new freedoms, swelled with new investment capital until the mid-1980s and then immediately began to shrink to its pre-Thatcher size.²⁰²

²⁰⁰ “Introduction,” by Ben Griffith, Steve Iliffe and Geof Rayner in Griffith, Iliffe, Rayner, *Banking on Sickness: Commercial Medicine in Britain and the USA*. London: Lawrence and Wishart, 1987, p. 13-14.

²⁰¹ Higgins, *The Business of Medicine*, p. 3.

²⁰² Terry Dodsworth, “For Profit Hospitals Feel the Pinch,” p. 6.

Viatical Settlements and Organ Trafficking

This chapter has ultimately described a small and largely localized illustration of the larger philosophical relationship between markets and healthcare. The implications of this will be discussed at greater length in the conclusion, but before doing so, it may be productive to examine another flurry of commercial activity that took place more than a decade later in the realm of transplant medicine, but has precedents in the 1980s: the use of “viatical” settlements to finance the purchase of transplant organs on the grey or black market. Viatical settlements are a fiscal instrument in which an individual signs over their life insurance policy to a lender in exchange for a cash settlement, typically used for a medical procedure.

The activities of the Philippines-based organ transplant broker who maintains the website www.liver4you.org have been well-documented by critics of organ trafficking.²⁰³ A subsequent development, however, is the following message, appearing on the website since sometime in 2005:

We have found this Florida company (1-877-227-4484) who have the right way to assist many people who need a liver, kidney or bone marrow transplant. While we are unrelated to each other, it appears that they have what it takes for this financial problem of paying for your rapid transplant.

Below, if one clicks on the phrase “Turning Assets into Cash for Medical Needs,” one is taken to the website of Welcome Funds, a “Viatical and Senior Life Insurance Settlement Company” based in Boca Raton, Florida. The web page features a lengthy definition of human liver failure copied (legally) from Wikipedia, an online, user-written encyclopedia, under its free documentation license.

In response to the question, “Can the money from a viatical settlement be used for a potentially life-saving procedure, such as a bone marrow transplant or heart transplant,” on the website of Viatical Settlement Professionals Inc., Steve Arenson, Vice President of Viaticus Inc., answers, “Yes, there are no restrictions on how the funds may be used.”

²⁰³ Scheper-Hughes, Nancy, “Keeping an Eye on the Global Traffic in Human Organs,” *Lancet*, 361, 2003, 1645-1648.

Viatical settlements have a short but remarkable history, and Welcome Funds, by offering settlements to U.S. life insurance holders experiencing liver or renal failure so that they may receive a transplant organ in a private hospital in the Philippines paid approximately \$1300²⁰⁴, has opened an interesting new chapter in that history.

The generally acknowledged pioneer of the field is a New Mexico-based insurance agent named Rob Worley. In 1986, Worley began to attempt to purchase the life insurance policies of terminally ill AIDS patients. By 1989, hurdles placed in his way by state and federal insurance regulators had been sidestepped, and he began to buy life insurance policies. A lobbying organization, the Viatical Association of America, followed, and by the mid-90s, viatical companies brokered nearly \$400 million per year in sales of life insurance policies. The very existence of such an arrangement speaks to the pernicious cross-class nature of AIDS as it was perceived in the 1980s, striking at the affluent as well as the poor and the young as well as the old. Finally, it is striking in that the relationship between a paid-donor transplant and a viatical settlement on a life insurance policy to be used to finance a paid-donor transplant is not dissimilar to the relationship between a home mortgage and a financial derivative based on the success or failure of that mortgage.

Conclusion: Supply and Demand

It is not demonstratively true that if a service is offered for free, demand will invariably outpace supply. This has been a frequent criticism of the National Health Service since its inception, and is generally offered commonsensically. The idea is believable only if one accepts the principle of neoclassical economics that, in a hypothetical “pure” market, free of interference from either the state or from monopolistic competitors, supply equals demand. And indeed, neoclassical principles were part of the intellectual orthodoxy among planners and policy makers in the Anglo-American world in the 1980s and 1990s. Disproving its validity is vastly beyond the scope of this dissertation, but it is entirely

²⁰⁴ Scheper-Hughes, 1647.

reasonable to assert that the precepts of neoclassical theory are ideological: unproven, non-falsifiable and, like most dominant ideologies, masquerading as something other than an ideology. If supply and demand are perfectly equivalent, then a free service — from the consumer’s perspective, an infinite service — leads to endless consumer demand.

This is not to argue that consumer cost is not a restraining factor in demand for healthcare services. Indeed, during his tenure as Conservative party Health Minister in the early 1960s, Enoch Powell (a pre-Thatcher advocate of free markets, better known for his itinerant flirtations with fascism and political xenophobia) famously argued that “there is virtually no limit to the amount of medical care an individual is capable of absorbing.”²⁰⁵ Powell’s quote is frequently cited and its assumptions are deep at the heart of frequently invoked arguments about the fragility of publicly financed healthcare, both in the United Kingdom and elsewhere.

In London in the 1980s, however, the capacity of the public to absorb private health care proved to be quite limited. Further the “laws” of supply and demand referenced above are as hard-pressed to explain the patterns of consumption created by the expansion of for-profit private care as they are the seemingly unbridled capacity for consumption of free care in the National Health Service. What appears to have happened instead is as follows:

The presence of “pay beds” in NHS hospitals was intended as a symbol of the autonomy of physicians, assuring them that they could still exercise preference and discretion in how they treated their patients and had not, through the nationalization of health care in 1948, become simple functionaries of the state. Pay beds, however, took on a different symbolism for the general public and for other, non-physician NHS employees such as nurses and orderlies. For them, pay beds were symbols of class-based inequality that belied the very premise of the National Health Service.

As labor militancy became more common and strikes more frequent in the NHS in the 1970s, pay beds became more of a front line issue. In 1976, a Labor government agreed to a reduction in the number of pay beds in order to placate striking health care workers. To placate doctors, they agreed to a mild easing of restrictions on for-profit

²⁰⁵ Quoted in Roy Porter, *Blood and Guts: A Short History of Medicine*, New York: Norton, 2002, p. 153.

healthcare facilities outside of the NHS. As all of this was happening, however, the general use of pay beds in NHS hospitals was declining, while the traditional patient base for private hospitals — overseas patients — was declining as well, instead seeking medical care in a new breed of private hospitals in the Persian Gulf and the United States.

As the ideological rhetoric and demographic realities of private healthcare in the U.K. continued to diverge, a new Conservative government, led by Margaret Thatcher, took office in 1979. In legislation issued in 1980, they made changes to the standard NHS consultant contract which made it easier for doctors to practice in both the public and private sectors. These contractual changes combined with the liberalization of zoning restrictions happened at a seemingly auspicious time: Across the Atlantic, private hospital investment companies such as Humana and American Medical International, facing decreasing returns due to stagnant demand in the U.S. market, were sufficiently convinced by the Thatcher government's "open for business" signals on health care to invest in U.K. private hospital acquisition in a dramatic fashion, right at the moment the traditional patient base was declining.

By the mid-1980s, it was clear that American corporations had over-invested. New — and newly renovated — hospitals such as Clementine Churchill and Humana Wellington — were where the covert transplant surgeries described in Chapter 2 took place. Understaffed and located both geographically and administratively outside of the protective framework of the National Health Service, with a middle-management strata beholden to investors and under pressure to make an underutilized facility profitable, private, foreign-owned hospitals such as Clementine Churchill and the Wellington were ideal locations for such activities — widely recognized as unethical, though not, as yet, illegal — to take place.

Perhaps then, private medicine in Great Britain in the 1980s and in general in particular the handful of private facilities in which Crockett, Bewick *et al* treated their overseas patients is not a bad vantage point from which to understand the political nature of "Thatcherism" in all its ambiguity. Thatcher's attitudes toward the National Health Service early in her career, as evinced by her intervention in the case of Malcolm Sweet and the Royal Free, were not unfriendly, or at least not so unfriendly as to disqualify it as

a target for her political opportunism. And to whatever degree, subsequently, she might have embraced the policy prescriptions of the Institute of Economic Affairs levelled at the NHS, her government's steps toward expanding the private sector in 1980 were timid and incremental and in many respects a continuation of actions taken by the previous Labor government. And her final run-in with these people and places — her condemnation of paid live-donor kidney transplants as “morally repugnant” from the floor of the House of Commons — betrays a similar ambiguity.

It seems clear, in all, that her most significant contribution to the landscape of private, for-profit medicine upon which the events in Chapter 2 take place, was helping to create, via fiery pro-market rhetoric, the perception that Great Britain was a hospitable place for overseas investors in the hospital acquisition market, a perception which, as it turns out, far outpaced the realities of demand for private hospital care and led directly to the half-empty hospitals in which paid donor kidney transplants were performed. Perhaps this rhetorical manipulation of the perceptions of investors was one of Thatcherism's most important components. The rhetoric of a Great Britain that was “open for business” was apparently deeply persuasive, so much so that it was carefully repeated by the Labor government that took office in 1997.

The specter of the global or transnational — global flows of people in chapter 2 and global flows of capital in Chapter 3 — has been a persistent, if peripheral in this dissertation so far. In Chapter 4, the global/transnational will take center stage. Questions of the viability of World History as a medium for understanding global flows of people, capital and medical technology will be asked. Questions of the viability of “globalization” as a medium for understanding these same phenomenon will be asked as well. And, as throughout the rest of this dissertation, the international traffic in human kidneys will serve as the test case for such questions. Chapter 4 will consider to what extent the movement of people, capital and ideas across national borders constitutes a global *topos* and to what extent the assumptions required by such an idea are analytically productive.

CHAPTER 4:
THE DISTINCTION BETWEEN ORGAN THEFT AND ORGAN SALES ON
CINEMA AND IN TELEVISION:

Real-life stories of grave-robbing and “resurrection men” provided fodder for nineteenth-century novelists and dramatists, chief among them being Mary Shelley’s Victor Frankenstein. Similarly, tales of organ selling — both voluntary and involuntary — have been a source of inspiration for screenwriters from the 1990s onward.²⁰⁶ In both cases, a continuum existed from news stories that followed generally accepted rules of observation and confirmation, to news stories whose authors embellished or imagined some or all details, or simply printed unverified rumors, to fiction presented as fiction.²⁰⁷ That last category — the history of the organ-selling narrative trope — is the subject of this chapter.

In *Time and Commodity Culture: Essays in Cultural Theory and Postmodernity*, John Frow classed the organ-selling news stories of the 1980s in three “paradigms”: the “authoritarian state”; “First World free enterprise” (where he places the coverage of Raymond Crockett and Michael Joyce); and, the “oriental bazaar.” In the first, readers are confronted with a monolithic and intrusive government that harvests organs from its prison population. In the second, readers are encouraged to see organ selling as a symptom of wider global inequalities, in which kidneys are yet another resource being extracted from the developing world for the benefit of wealthy, industrialized countries. In the third, the developing countries are sites of chaos and lawlessness where life is cheap and organ selling is one of many humiliations the poor are forced to endure. According to Frow, although they work differently, their collective function is to configure the “Third World” as “a site of disorderly otherness.”

The tropes Frow cites are indeed pervasive. Reading through the news coverage of the organ-selling scandals of the time-period, it is noticeable how images and ideas stick persistently to places: China’s state-run hospitals and prisons portray the inhumanity of the state; India’s organ “markets” (in reality systems of brokers and clinics) portray the

²⁰⁶ Ruth Richardson, *Death, Dissection and the Destitute*, Chicago: University of Chicago, 2001.

²⁰⁷ Veronique Campion-Vincent, *Organ Theft Legends*, Oxford: University of Mississippi, 2005.

inhumanity of developing world overpopulation and immiseration. And tales like that of Crockett and his Turkish patients portray the inhumanity of a soulless capitalism. *The Mail* photographed Bewick standing on a high wall overlooking a network of teeming and overlapping slums. The article contains an extensive account of his confrontation (arranged by the paper) who had referred both donor and recipient to him, claiming they were related, as well as his non-comprehension and horror at the sheer volume of willing would-be paid donors clamoring for the opportunity sell a kidney. Frow might have named this fourth “paradigm” the “heart of darkness”: the white explorer leaving safe terrain and encountering the horror and irrationality of the colonial (or in this case, postcolonial) world.²⁰⁸

As Campion-Vincent has pointed out in her ethnography of “organ theft legends,” tales of kidney theft (a related if not identical genre of news story to those of kidney selling), had a political context: the late Cold War. While, geopolitically, the United States and Soviet Union continued the “minuet” they had begun once the Cuban Missile Crisis had reached its end, the related ideological rhetoric reached a new peak in the 1980s, particularly in Europe and the United States, where tightening up of monetary policy, reduction of public spending, the “Star Wars” program, and the anti-collectivist rhetoric of Ronald Reagan and Margaret Thatcher were ubiquitous.²⁰⁹ In this light, Frow’s three “paradigms” for organ-sales stories begin to look like an ideological menu: “authoritarian state” for the anti-collectivist, “First World free enterprise” for the anti-capitalist and “oriental bazaar” for the xenophobe.

Throughout the 1980s, then, collective imaginings of organ theft (hotel bathtubs filled with ice, children kidnapped from Sao Paulo *favelas*) combined with verifiable — if sensationalized — tales of organ selling in India, Pakistan, China and, for a brief moment, the United Kingdom. Together they created a rich tapestry of cultural anxieties: the reduction of the body to a collection of commoditized parts, the continued proliferation of state power into the bodies of its citizenry, collective guilt over the immiseration of the developing world and collective anxieties about revenge for said

²⁰⁸ John Frow, *Time and Commodity Culture: Essays in Cultural Theory and Postmodernity*, Oxford: Oxford University Press, 1997.

²⁰⁹ Campion-Vincent, pp. 95-142.

immiseration enacted upon individuals. Beginning in the late 1990s, these became the basis for a powerful narrative tradition of organ theft and organ trading, often jumbled together, in cinema and on television worldwide. This chapter will examine these narratives through a distinction: between portrayals of “voluntary” organ selling and portrayals of organ “theft” through explicit coercion. Readers are asked to consider whether hermeneutic distinction between organ selling and organ stealing is primarily of value in moments where it breaks down, and no longer clearly belongs to one category or the other. Readers are further asked to consider whether the limitations of this distinction might be exported to other scholarly discussions that make use of the distinction between the use of naked force by states or corporations and the generation of consent via hegemony.

“Voluntary” organ donation in cinema

It is not hard to imagine that writer Stephen Jones and director Stephen Frears drew inspiration from the story of Raymond Crockett and his patients for their 2003 feature film *Dirty Pretty Things*, a harrowing story of refugees from Africa, the Middle East and Asia, living and working in various states of legality in London’s black and grey economies. At the outset, Okwe and Senay, the films’ principle characters, are employed respectively as a porter and a cleaner in a hotel, where one evening Okwe discovers a human heart clogging a toilet. Okwe, a disgraced doctor in exile from his native Nigeria, follows a series of clues — each more disturbing than the last — to discover that Juan, the hotel’s manager, has established a lucrative business providing forged passports to undocumented workers (largely drawn from the hotel staff) in exchange for the removal of a kidney for transplant. Okwe’s investigation ultimately causes Senay — a refugee from Turkey who has been granted political asylum but placed in an impossible Catch 22 where she cannot legally work — to lose her job at the hotel, which leads to a series of grim misfortunes for her. Without Okwe’s knowledge, she approaches Juan and agrees to sell her kidney. Shortly afterward Juan learns of Okwe’s medical credentials and attempts

to blackmail Okwe into performing Senay's surgery himself. The previous surgeon, it seems, has botched several operations, a fact that accounts for the grisly clues Okwe encounters earlier in the film.

Ultimately, Okwe and Senay turn the tables on Juan, drugging him, removing his kidney and handing it off to Juan's middlemen in the hotel's underground parking garage in exchange for the cash and new passports that will allow them access to second chances and new lives. "Why have I never seen you before?" asks one of the middlemen. "Because we are the people you do not see" replies Okwe. "We are the ones who drive your cabs. We clean your rooms. And suck your cocks." *Dirty Pretty Things* is not a film that shies away from moralism, and it is with these lines that the film's moral is clearly underlined: that in cosmopolitan capitals like London, globalization has created a permanent international underclass that is simultaneously relied upon and persecuted by both the state and the native citizenry. Hypocritically, London cannot tolerate them, nor can it exist without them.

Frears uses what can best be described as a gothic hyperrealism to underscore the film's gnarly subject matter: fluorescent lights glow a little too brightly, an oppressive white noise substitutes for silence, and the hotel which serves as the background for much of the film is decked out in late Edwardian trappings that are both oppressive and familiar. Indeed, early on the hotel itself comes to life in a manner reminiscent of the fictional Overlook Hotel in Stanley Kubrick's 1980 adaptation of Stephen King's *The Shining*.

While the plot of *Dirty Pretty Things* turns on an epidemiological absurdity, clearly drawn from the collective imaginings from the 1980s of kidneys removed in hotel rooms, its demographic profile of the sort of people driven to sell a kidney is almost too real: undocumented workers from an underdeveloped country. The story of Ahmet Koc, with or without Koç's own embellishments, told to the General Medical Council more than a decade before *Dirty Pretty Things* was released, is not so different from the story of Senay, or Okwe, or many of the film's more ephemeral characters.

Dirty Pretty Things briefly engages with the ethical arguments regarding organ selling as framed by British philosophers and medical ethicists (see Chapter 1) in the

1990s: Senay's kidney, it seems, will go to a young child who will die without it. But the point is not elaborated, and the protagonists of *Dirty Pretty Things* ultimately skirt the issue by turning the tables on Juan and removing his kidney. Everyone wins: the unseen donor, an innocent child, gets her life-saving kidney; Okwe and Senay get their passports; and, their would-be exploiter gets his comeuppance — a plot point that has raised the eyebrows of many academics who have attempted to write critically about the film.²¹⁰

If the protagonists of *Dirty Pretty Things* are more plausible than the story in which they find themselves enmeshed, the protagonists of *Never Let Me Go* are equally as fantastical as their surroundings. Adapted from Kazuo Ishiguro's obliquely dystopian novel of the same name, director Mark Romanek's *Never Let Me Go* follows the story of a handful of students at an English boarding school who, we learn eventually, have been cloned specifically as sources of transplant organs. The film takes place in an alternate version of the present where human cloning has been perfected and channeled ruthlessly toward the goal of life extension for non-cloned humans. The school, a gentle but eerie place, is the product of a compromise between sections of society who see cloning for transplant as an absolute good and those who see it as an absolute evil. The compromise is as follows: the clones will be treated gently and humanely, educated and adequately cared for until adulthood, when they are gradually moved into positions of responsibility for clones slightly older than them who are in the process of having their organs removed. Finally, these guardians will themselves be harvested.

Ultimately the film guides the viewer to see a society that has deceived itself to the point of psychosis, through the eyes of the victims of the deception; in order to maintain the fiction that the clones are not fully human, the clones must be sequestered. Prolonged contact between clones and non-clones causes the lie to collapse, as evidenced by the depressive fugue that gradually overtakes the clones' teachers and supervisors. In more fleeting contacts with the outside world — lunch in a café, a visit to town — they are treated as a despised underclass: ignored, avoided, murmured about. Disproving the other illusion — that clones' short lives are relatively pleasant — is the film's primary

²¹⁰ Stephen Frears, *Dirty Pretty Things*, London: BBC Films, 2003. Nancy Scheper-Hughes, "Parts Unknown: Undercover Ethnography of the Organs Trafficking Underworld," *Ethnography*, 5, 1, March 2004, p. 29-73. Tom Whittaker, "Between the Dirty and the Pretty: Bodies in Utopia in *Dirty Pretty Things*," 14, 2, March 2011, 121-132.

concern. The clones are vague, moody and passive — so much so that it is even implied the passivity may be the result of genetic engineering. Nonetheless, once aware of their intended purpose — and fate — the clones’ lives are permeated by a deep and unmistakable sadness. Their education is overwhelmingly geared toward art, and their art reflects their awareness of their situation.

The film’s narrative universe is a complex affair. Based on a novel published in 2005, it fits somewhat awkwardly at a cross-section of genres: “alternate history” science fiction, best exemplified by Philip K. Dick’s 1962 novel *The Man in the High Castle* — set in a post-war Nazi- and Japanese-occupied America where the former Axis powers vie for strategic advantage and an underground network of forgers produce icons of pre-war Americana for sale to obsessive collectors — and a more conventional dystopian reminiscent of Margaret Atwood’s *The Handmaid’s Tale* or Anthony Burgess’ *The Wanting Seed*. The differences between these narrative universes and our own are far less subtle than those of *Never Let Me Go*. All three share the same the fundamental conceit of most dystopian fiction: If we allow x to continue, then it will eventually expand into x^y .

That said, it is difficult to isolate precisely the social ill around which *Never Let Me Go* is organized. It could plausibly be an expression of anxiety over scientific inquiry galloping ahead of medical ethics, or of the creation of a demand for transplant organs and other life-extension commodities that will eventually come to override any and all ethical concerns. Or perhaps like HG Wells’ *The Time Machine* it is an expression of anxiety about social and economic inequality: once the inferiority or superiority of a group or groups is accepted and enshrined, a slow, nightmarish divergence begins. Or perhaps it’s an expression of the anxiety often given in religious terms in opposition to embryonic cloning and stem cell research: that such technological innovations constitute “playing God” and will lead to a spectacular Promethean fall. It could be an elaborate and extended metaphor for the very late 1990s/early 2000s debate over the treatment of livestock. It is not difficult to imagine that what is being grimly satirized in *Never Let Me Go* is the conceit that animals can be raised “humanely” in preparation for slaughter, and

that through this, the ethical debt of the meat eater to the food source is somehow squared.²¹¹

Practically speaking, however, *Never Let Me Go* traffics, albeit obliquely, in “lifeboat ethics,” an artificially constructed scenario which forces participants to establish criteria for who should live and who should die. (In the traditional form of the argument, a lifeboat is surrounded by swimmers, and those aboard the lifeboat, which only contains room for a few more, must establish criteria for who is and isn’t permitted to board.) *Never Let Me Go* poses its question in terms of resource distribution, and uses the clones as a way of problematizing it. There are not enough transplant organs. Can the harvesting of organs from one population for the benefit of another ever be justified? What if the harvestees, it can be argued, are not fully human? This is the argument that British (and perhaps) world society has accepted both *de facto* and *de jure* in *Never Let Me Go*. But on a visceral level, the humanity of the clones is undeniable. Thus, strategies (sequestration), rationales (the clones are stupid and unlikeable) and compromises (the clones are treated compassionately and have pleasant lives) have emerged. It is strongly hinted that the clone “schools” are part of a reform effort, enacted in response to some off-screen scandal involving clones being warehoused in brutal and horrifying conditions.

An earlier exploration of the cloning-for-organs concept is given in *The Island*, a 2005 science-fiction thriller that takes many aesthetic clues from H.G. Wells’ 1896 novel *The Island of Doctor Moreau*, the story of a scientist who creates animal/human hybrids through brutal acts of live taxidermy.

Directed by Michael Bay, known for his ostentatious and accessible action films, *The Island* is an uncharacteristically complex and plotted dystopian thriller, in which residents of a strictly governed and isolated community gradually learn that they have been cloned to provide organs for their DNA doubles in the outside world. The administrators of the compound have fostered the belief among residents that they are survivors of a systemic failure that has left the outside world poisoned by an unspecified contaminant, with the exception of an unseen safe zone called “the island.” Community residents who win a lottery are “rewarded” with much-coveted one-way passage to the

²¹¹ Mark Romanek, *Never Let Me Go*, London: DNA Films, 2010.

island. Lincoln, the film's protagonist, learns that lottery "winners" are actually killed to have their organs harvested for their genetic doppelgangers in the decidedly uncontaminated outside world.

Lincoln and his cloned confederates stage a rebellion with the help of sympathetic outsiders. In the film's final scene, the clones pour frantically into the outside world beyond the gates of their community. The strong implication of the film is that science has created a new underclass and that underclass has, through protracted struggle, taken its first step toward the attainment of civil rights. The transplantability of human organs has both created the clones and served as the crucible in which their basic humanity is acknowledged.²¹² *The Island* is strikingly similar in this respect and others to the 1979 American b-movie *Parts: The Clonus Horror*.

Two more conventionally transactional (but still fantastical) imaginings of organ selling are presented in the 2008 "rock musical" *Repo! The Genetic Opera* and the 2010 thriller *Repo Men* (neither to be confused with Alex Cox's cult 1984 film *Repo Man*), both set in a near-future United States where artificial organs can be repossessed from recipients who have fallen behind on payments. Repossessions are conducted by violent and ruthless "repo men" and generally result in the death of the hapless owner. Like *Never Let Me Go* and *The Island*, these films combine anxieties about scientific progress with anxieties about market-based social interactions. Unlike those films however, they posit a near future in which economic pressures (and, in the case of *Repo! The Genetic Musical*, epidemiology, in the form of a global organ failure epidemic) have created a permanently debt-leveraged underclass of transplant recipients whose lives are deemed less valuable than the monetary value of the transplant organs they possess.²¹³ Like the prisoners and concentration camp victims of the philosopher Giorgio Agamben's *Homo Sacer*, condemned to "bare life" (the Greek *zoe*) of the slave — who has a right to continued biological existence, but little more — rather than the "good" life of the social and political citizen (*bios*).²¹⁴

²¹² Michael Bay, *The Island*, Los Angeles: Dreamworks, 2005.

²¹³ Darren Lynn Bousman, *Repo! The Genetic Opera*, Los Angeles: Twisted Pictures, 2008, Miguel Sapochnik, *Repo Men*, West Hollywood: Relativity Media, 2010.

²¹⁴ Giorgio Agamben, *Homo Sacer: Sovereign Power and Bare Life*, Palo Alto: Stanford University, 1998.

It is difficult to say whether the organ debtors of the *Repo* films are entitled to more or less “bare” life than Mr. Brown, played by Terry Gilliam, the principle actor in a sketch at the heart of *The Meaning of Life*, the 1983 film by British existential comedy troupe Monty Python. In the sketch, Brown, a card-carrying voluntary organ donor answers the door of his home and is greeted by two aggressive transplant coordinators who inform him that his liver is needed immediately. When he protests that he did not intend his liver to be donated until after he had died and that he still “needs it,” they confront him with his own organ donor card, saying “What’s this then?” They force him into a prone position, just off camera, and begin to gut him open, sending blood spraying around the room as Mr. Brown screams. As they begin removing his organs, his wife enters the room and demands to know what is going on. They inform her that he is an organ donor. She rolls her eyes and begins to castigate her husband’s naïve idealism. “It’s all for the good of the country,” one of the transplant coordinators, played by John Cleese, tells her. “That’s just what he used to say,” she replies. “It’s all for the good of the country.”²¹⁵ It is difficult not to think of the admonition given by the head of the professional conduct committee of the General Medical Council at the conclusion of the hearing of Crockett, Bewick and Joyce. And yet, as always with Monty Python, it is impossible to tell whether it is progressive pieties that are being skewered, or reactionary perceptions of those pieties. As in Kurt Vonnegut’s “Harrison Bergeron,” where it is unclear whether Vonnegut is executing an anti-collectivist dystopia, or a parody of anti-collectivist dystopias, it is impossible to say whether in *The Meaning of Life*, Monty Python is skewering the “all together now” popular ethos of Britain’s National Health Service, or the traditional tory response to it.

The ethical lines are equally blurry in Korean director Park Chan-wook’s semi-absurdist 2002 thriller *Sympathy For Mr. Vengeance*, in which a speech and hearing-impaired factory worker is confronted with the imminent death of his sister, who is suffering from chronic and terminal kidney failure. His own blood and tissue types do not match hers, so he turns to the black market and strikes a deal with a broker: his kidney

²¹⁵ Terry Jones, *Monty Python’s The Meaning of Life*, Universal City: Universal Studios, 1983.

will be removed and he will use the cash to purchase a tissue-matched kidney for his sister.

Instead he wakes to find his kidney has been removed and the gangsters have disappeared. Shortly afterward, a suitable donor is found for his sister. Without cash, however, the kidney cannot be procured. Desperate and now laid off from his factory job, Ryu sets out for revenge against the criminals who have taken his kidney, with the aid of his girlfriend, Yeong-mi, an anarchist who, it is strongly suggested, is a fantasist and/or compulsive liar, imagining herself to be part of violent and radical group of underground revolutionaries.

Together they kidnap the daughter of Ryu's former boss, hoping her ransom will provide money for the desperately needed kidney. Their plan, however, proves disastrous. The daughter dies after they have collected the ransom money and Ryu learns that his sister has committed suicide, not wanting to be complicit in his kidnapping plan. Ryu and Yeong-mi die at the hands of his former employer. In a final twist, the employer himself is executed at the hands of Yeong-mi's revolutionary comrades who, it turns out, are very real indeed. Ryu's kidneys, and his sisters, are metaphors perhaps for the futility of "market" solutions to the problem of transplant shortages: they are, or should be, *ceterus paribus*, sufficient for the rational exchange of goods to take place, but the logic of the market is short-circuited repeatedly by greed, avarice, mistrust and poor timing, resulting in the deaths of everyone involved.²¹⁶

The logic of rational exchange in the realm of transplant organs is presented in a less horrific but equally resigned manner in the 1995 Japanese crime thriller *Shinjuku Triad Society* by director Takashi Miike. As a Taiwanese policeman explains to the film's protagonist, a Japanese detective (of mixed Chinese/Japanese descent) who is investigating the illegal sale of kidneys from Taiwanese children to Japanese citizens: "There are people who need organs. There are those who want to sell them. What can we say when both sides benefit?"²¹⁷

²¹⁶ Park Chan-wook, *Sympathy for Mr. Vengeance*, Seoul: Studio Box, 2002.

²¹⁷ Takahashi Miike, *Shinjuku Triad Society*, Tokyo: Daiei Motion Picture Company, 1995, Isolde Standish, *A New History of Japanese Cinema*, New York: Continuum, 2006, pp. 332-334.

Independent cinema, with its worldwide reach and relative aesthetic and commercial freedom, has provided fertile ground for a wide-reaching and at times provocative staging ground for the exploration of themes related to the “voluntary” commercial exchange of human organs. As we will see in the next section, television drama, more regionalized and more constrained, has explored the same theme with different approaches and different results.

“Voluntary” exchange of organs on television

It is difficult to find a single narrative point of entry into *Lost*, the surreal drama that ran for seven seasons on American network television. A group of survivors of an airplane crash find themselves stranded on an uninhabited island where the traditional rules of physics and temporality appear to be suspended, or at least itinerantly enforced. Extended subplots take place before the plane crash, exploring the previous life circumstances of the primary characters, after they have been rescued, and in “flash sideways” sequences that explore alternate realities in which different characters chose not to, or were not compelled to board the plane and thus avoided the crash.

In the episode “Deus es Machina,” one of the passengers who survives the crash, John Locke (named for the seventeenth century English philosopher, at one point in the show instructed to take the alias “Jeremy Bentham”), an autodidact raised in a series of foster homes is seen in his pre-crash life working at a discount dry-goods store. Locke confronts a woman who has been observing him from the parking lot, who reveals herself to be his biological mother.

Utilizing clues from her, Locke hires a private investigator in hopes of tracking down his biological father. This leads him to the home of a wealthy businessman, Anthony Cooper, who acknowledges that Locke is indeed his son. The two bond over several hunting trips before Cooper reveals that he is suffering from kidney failure, languishing on dialysis, and despairing of ever finding an appropriate kidney transplant.

Locke, overcome with emotion, offers one of his own kidneys, knowing it will be a match, and Cooper gratefully agrees.

Waking from his nephrectomy, Locke is confused to learn that Cooper has been discharged prematurely from the hospital. He attempts to visit him at his palatial home, where is turned away by a previously friendly security guard. Later, his biological mother admits to him that Cooper's interest in him did not extend beyond obtaining his kidney.

The betrayal commences a chain of events for Locke which ultimately result in an accident that leaves him a paraplegic. Stubbornly persistent, iconoclastically spiritual, and cautiously optimistic, Locke eventually signs up for a "walkabout" organized by an Australian tourism company, but is turned away once reaching Australia, when the tour organizers learn that he is confined to a wheelchair. He boards the airline flight around which *Lost* is organized, Flight 815. After surviving the crash, Locke inexplicably regains the use of his legs and becomes a pivotal figure amongst the crash survivors on the island.²¹⁸

As discussed in Chapter 1, Renee Fox and Judith Swazey wrote in their groundbreaking ethnographic studies of live-related donor kidney transplants, of the "tyranny of the gift," in which the recipients of transplant kidneys from relatives or loved ones are placed in a relationship of permanent emotional (and in some cases, financial) bondage to their donors. Similarly it can refer to the immense psychological pressure placed on a potential kidney donor to save the life of a loved one. Locke's plight in "Deus Ex Machina" provides an especially convoluted *dramatis personae* of both. Despite his money, Cooper cannot obtain the kidney that will save his life without committing an extraordinary act of emotional cruelty against his estranged son, an act in which Locke's mother is compelled to participate as well, due to financial exigencies. Locke is the ultimate victim however. In terms of "pure" exchange, Locke is willing to trade his kidney for an emotional relationship with his biological father. The father is aware of this desire and leverages it, heavily. Once the kidney has been exchanged, Cooper feels no pressure — and strictly speaking, is under no formal obligation — to clear the debt. He merely absents himself from the situation. But in the extraordinarily complex ethical

²¹⁸ Lost, "Deus Ex Machina," *Lost*, 43:00, March 30, 2005.

universe of *Lost*, where actions have consequences that reverberate not only across a maddeningly non-linear timeline, but also through interlocking narrative cosmoses reminiscent of William James' "multiverse," Cooper cannot escape his actions. He ultimately finds himself, through inexplicable turns of events, on the same island where Flight 815 has crashed, where he is murdered by a fellow passenger of Locke's.

If "Deus Ex Machina" recalls the deliberate surrealism of television shows like *The Prisoner*, and in doing so sidesteps all of Frow's paradigms (perhaps to operate in a different, as-yet unnamed one), then "Hell Money," an episode from late in Season Three of the groundbreaking paranormal procedural drama *The X-Files*, lands squarely in Frow's "Oriental Bazaar" paradigm. *The X-Files*, the story of a duo of FBI agents tasked with investigating paranormal activity, ran for nearly a decade on network television in the United States, and profoundly expanded the willingness of network executives to green-light high-concept, multi-season storylines dealing in unusual subject matter. "Hell Money" is an unusual episode in the overall tableau of the series, its story arc confined within a single episode containing no overtly supernatural activity.

Set in San Francisco's Chinatown, presumably in the 1990s, "Hell Money" tells the story of Cantonese immigrants immersed in a dangerous lottery run by an organized criminal syndicate. Winners receive desperately needed cash. Losers have their organs removed. Those who have exhausted their usefulness — or attempt to break the rules or leave the game once they've entered — are burned alive in a funeral home crematorium.

It is these deaths by incineration that attract the attention of the FBI, causing the show's principle characters, agents Fox Mulder and Dana Scully, to be dispatched to San Francisco. Their interlocutor with the Cantonese new immigrant community there is Chinese-American detective Glen Chao. Through Chao, the agents discover another lottery participant named Hsin who is motivated by a desire to obtain an organ transplant for his daughter, who has leukemia.

"Do you know how much the human body is worth?" Agent Scully asks her partner as she prepares to perform an autopsy on a recent lottery victim, his body discovered in a fresh burial plot in a Chinatown cemetery. Upon inspection, the corpse is missing a kidney, a cornea, a portion of his liver and, finally, his heart.

The remainder of the story follows Hsin, as he tries and fails to leave the lottery after drawing an unlucky tile and having his left eye removed, Scully and Mulder as they chase down leads through Hsin's daughter and through a tissue typing lab in downtown San Francisco, and Chao as his complicity in — and ambivalence toward — the lottery and the immigrant community are gradually revealed. Mulder and Scully learn that lottery participants are taken to a tissue typing lab, introduced as potential donors for loved ones, profiled, and then quickly taken off the radar. Chao, disturbed by the plight of Hsin and his daughter, confronts the lottery's officiants, overturning the table and revealing the lottery to be fixed: once selected, all participants draw an unlucky tile.

Once in custody, the transplant surgeon at the center of the lottery is confronted by Scully. He rebuffs her, arguing that the lottery provides its victims, for a brief time, with the hope of escaping poverty. Death — the inevitable outcome for all the lottery participants — is nothing to be feared, he argues, but a life without hope is “hell on earth.”

His arrogance is quickly justified. Mulder informs Scully that because none of the lottery participants will testify to the police, the surgeon will not be prosecuted. The viewer's sense of fairness is satiated by the fact that Hsin narrowly escapes death and his daughter, we are informed, has been placed on a transplant waiting list. Chao is not so lucky. The episode's final scene is of him being burned alive in the same crematorium seen at the beginning of the episode.

Critically, “Hell Money” is two things: a poetic dramatization of the existential plight of organ sellers, and a heavy-handed exoticization of San Francisco's Cantonese community. Synthesizer melodies based on partially understood Chinese operatic themes occupy the background as characters wend their way through a mysterious and darkly lit rendering of San Francisco's Chinatown. The heavily plotted story puts tremendous emphasis on the irrational and superstitious nature of the immigrants. Chao's resentment toward the FBI agents and angst over being an “American-born Chinese” are over-exposed, and the episode drapes itself in a folk-religious imagery of ghosts and lunar calendars that seem an awkward fit with the economic motivations of the lottery participants.

On the other hand, in many respects, the lottery crystalizes the experiences of the Turkish organ sellers discussed in Chapter 2 and the broader ethnographic tableau of worldwide organ sellers discussed in Chapter 1. Driven by the hope of a one-time cash payout and reassured by the technical redundancy of one of their kidneys, kidney sellers wager their bodily integrity, “betting it all” that their surgeons will be competent, their procurers will be ethical, and that whatever investment strategy they have planned for their payout, whether an investiture in farm equipment or a plane ticket, or the clearance of an oppressive debt or a medical procedure for a loved one, will be enough to move them beyond whatever station life has placed them in. But as “Hell Money” suggests, this is almost inevitably, across a wide range of times and places, for a wide variety of reasons, a bad bet.²¹⁹

There are many medical and legal “procedural” dramas that have dedicated whole episodes to the theme of legal live-donor kidney transplants, as well as legal cadaveric donation. In the case of the former they have largely echoed the theme of the “tyranny of the gift” laid out decades ago by Fox and Swazey. In the case of the latter they have occasionally touched on the ambiguity and cultural variability of the “brain death” diagnosis upon which cadaveric transplantation relies. These themes have been examined thoroughly by the anthropologists Margaret Lock and Lesley Sharp, both discussed at length in Chapter 1. Despite limitations of form, when dealing with the theme of commercial yet voluntary organ donation, television dramas have treaded effectively in the very considerable grey area between consent and coercion in commercial organ donation. Next we will turn to film and television’s much more potent and visceral treatment of the more horrifying — and more fictive — phenomenon of organ theft.

Organ Theft in Cinema

As discussed in Chapter 3, human organ transplantation became plausible in the early 20th century, possible in the 1950s, practical in the 1960s and, with the advances in

²¹⁹ The X-Files, “Hell Money,” *The X-Files*. 44:48, March 29, 1996.

immunosuppression, widespread in the 1970s. It is the universality of the practice made possible by immunosuppressive drugs that laid the groundwork for the proliferation of the organ theft rumors of the 1980s, which in turn laid the groundwork for the widespread dramatization of these rumors in the 1990s. The search for antecedents, however, is fruitful, beginning with the 1942 horror film *The Corpse Vanishes*.

Primarily a vehicle for Bela Lugosi, the film draws on the legends of the 16th century Hungarian aristocrat and — by contemporary standards — serial killer Elizabeth Báthory de Ecsed. Though never convicted, Báthory was charged with the brutal torture and murder of at least 80 and as many as 650 women. After her death in 1614, Báthory became the subject of an extraordinary legend: that she bathed in the blood of her victims. *The Corpse Vanishes* is a mid-twentieth century update of the Báthory legend, concerning a scientist, played by Lugosi, who kidnaps young women and extracts their “fluids” in order to preserve the youth of his wife. Themes of vitality and the predation of the aged upon the young are present.²²⁰

Predation is a more convoluted affair in the 1959 horror film *The Brain That Wouldn't Die*, in which a rogue transplant surgeon attempts to keep his fiancé alive after she is beheaded in a car accident by transplanting her head onto the body of a woman he has kidnapped. Transplant surgery in the 1950s was highly experimental and the occasional attempted kidney graft between identical twins was highly sensational national news. The anxieties its problems and potentials invoked are fully in evidence in *The Brain That Wouldn't Die*.²²¹

More pointed expressions of the organ theft legend appear almost concurrently with the appearance of effective pharmacological immunosuppression in the late 1970s. Chief among them is the adaptation of medical thriller writer Robin Cook's novel *Coma*. Directed by Michael Crichton, better known for his novel *Jurassic Park*, *Coma* played upon contemporary anxieties regarding the “brain death” diagnosis discussed in Chapter 2. The anxieties are complex and interlocking: once limited by immunological compatibility, sophisticated immunosuppressive drugs meant that, for the first time,

²²⁰ Wallace Fox, *The Corpse Vanishes*, Hollywood: Monogram Pictures Corporation, 1942.

²²¹ Joseph Green, *The Brain That Wouldn't Die*, Los Angeles: American International Pictures, 1962.

transplant organs could be “matched” between unrelated individuals with levels of histocompatibility that previously would have been unacceptable. (The earliest transplants, for this reason, were between identical twins.) Once selective immunosuppression removed this barrier, there were no longer, in public imaginings, any limits on the “harvestability” of the human body. As the transplant profession grew into a distinct group of surgeons, nephrologists, dialysis technicians, nurses and, most distinctive of all, transplant “coordinators,” questions were asked. Who pronounced an accident victim dead? How objective was their criteria? Was their ambiguity? Were there “borderline” cases? Could they not be subjected to undue influence by the transplant coordinators, who had an incentive, in a sense, to produce as many cadaveric organs as possible?²²²

The plot of *Coma* is driven by an exaggeration of such dis-eases: a resident surgeon at a New England hospital becomes suspicious of a number of cases in her ward of patients being treated for accidents and serious ailments who inexplicably fall into irreversible comas while under care. The comas, she learns, are being deliberately induced in young and generally healthy patients so that their organs may be harvested and sold through a complex system of bidding by wealthy patients. The victims are covertly dosed with carbon monoxide and their condition is then declared irreversible. In the process of uncovering the plot, the protagonist very nearly falls victim to the plot herself when she receives an appendectomy in the same hospital.²²³

More visceral, and stranger, is the German B-movie that appeared the following year, *Fleisch* (translated as “Spare Parts”), in which a German couple vacationing in the American Southwest are pursued by a rogue and relentless team of paramedics who wish to harvest their organs on the black market. The paramedics pursue their victims in an ambulance, a singular evocation of the suspicion of medical authority underlying many organ trafficking myths, as explicated by Scheper-Hughes in *Death Without Weeping*, her ethnography of the impoverished residents of Northern Brazil.²²⁴

²²² Margaret Lock, *Twice Dead: Organ Transplants and the Reinvention of Death*, Berkeley: University of California, 2001.

²²³ Michael Crichton, *Coma*, Beverly Hills: Metro-Goldwyn-Mayer, 1978.

²²⁴ Rainer Erler, *Fleisch*, Mainz: ZDF, 1979, Nancy Scheper-Hughes, *Death Without Weeping: The Violence of Everyday Life in Brazil*, Berkeley, University of California Berkeley, 1993.

In the 1990 film *Hansel e Gretel*, the child victims of shadowy networks of the criminals that populate the collective fantasies detailed by Campion-Vincent are allowed revenge against their tormentors. Produced by the Italian horror auteur Lucio Fulci, *Hansel e Gretel* depicts a young brother and sister who are murdered by an organ harvesting network. They are reanimated by unexplained forces and spend the majority of the film, emotionless and with zombie-like slow persistence, hunting down their tormentors and dispatching them in a variety of gruesome and inventive ways, none of which are unfamiliar in the genre of low-budget Italian horror films to which *Hansel e Gretel* belongs.²²⁵

The dystopic sensibility underlying the traditional organ theft narrative was foregrounded in the 1992 “cyberpunk” (a youth-oriented, technology-fixated genre of literature popularized by the writer Douglas Copeland) film *Freejack*. *Freejack* depicts a future society so wracked by pollution and narcotic abuse that even the wealthiest citizens are heavily debilitated by the time they reach middle age. Time travel — a technological reality in this society — provides a solution: shortly before their deaths, individuals in possession of healthy bodies are “harvested” from the past and brought to the present by a class of professional bounty hunters. Occasionally, a harvestee escapes and is compelled to join an underground network of other escaped harvestees. As a group they are denied citizenship and protection under the law, in a manner again reminiscent of Agamben’s *homo sacer*. *Freejack* also offers a bizarre problematization of the anxious critique of Cartesian mind-body dualism underlying much of the public debate over organ harvesting and the “brain death” diagnosis: the film’s principal antagonist is literally disembodied. His consciousness, or “soul” as the characters refer to it, is suspended, with the use of an unexplained technology, and is able to communicate with the more corporeal characters via hologram as he awaits his new organs.²²⁶

In the 1990s, fictional organ theft narratives began to be sited, like the rumors from which they were derived, in the Global South, particularly Latin America. Such is the case with the 1992 thriller *The Harvest*, in which a screenwriter is sent to Mexico at the behest of his editor in order to do last minute development work on a film set. Once

²²⁵ Giovanni Simonelli, *Hansel e Gretel*, Italy: Cine Duck, 1990.

²²⁶ Geoff Murphy, *Freejack*, Los Angeles: Morgan Creek, 1992.

there, he is drugged and wakes to find a surgical scar from where his kidney has been removed. He spends the remainder of the film unsuccessfully trying to track down and expose the criminal syndicate responsible. In a unique inversion of the “tyranny of the gift” depicted by Fox and Swazey, the audience learns in the final scene that the protagonist’s kidney was intended for his editor, who sent him to Mexico as part of a set-up. Intentional or not, *The Harvest*’s surprise ending is a vivid, if exaggerated, exposition of the erosion of civil and social relationships of trust and reciprocity, as well as hierarchical relationships between employer and employee.²²⁷

The 2006 horror film *Turistas* builds further upon these imaginings of Latin American organ theft, as well as Latin America as a site of danger for American innocents abroad. Further, like *Hansel e Gretel*, it is a story of revenge, although in this instance the revenge is of a sociopolitical nature. American and European tourists travel overland to the beaches of Northeastern Brazil and find themselves marooned after a bus accident. A conflict with local villagers over a stolen passport draws the attention of regional authorities, and the tourists soon find themselves caged in a makeshift operating room, where the film’s surgeon-antagonist explains to them that wealthy tourists have preyed on Brazil’s rural and indigenous poor for years as a source of transplant organs and that he has devised a way to even the score, harvesting organs from tourists for use by the patients of a nearby charity hospital. A handful of the film’s protagonists manage to escape after inciting their tormentor’s henchman to shoot him, having learned little, it appears. *Turistas* ultimately achieves resolution, like the organ theft legends it dramatizes, by reducing themes of north-south inequality to cartoonish pathologies, springboards for depictions of senseless violence. Arguably, they go a step further, and as with the FARC guerillas in the 2002 Arnold Schwarzenegger vehicle *Collateral Damage*, suggest that complaints of global injustice are inevitably mere rationalizations for greed, avarice or simple sadism.²²⁸

Turistas is indicative of a shift in film depictions of organ theft that occurred during the mid-2000s. While earlier films discussed in this section explore a variety of themes through a variety of genres and vary greatly in their degree of attention to the

²²⁷ David Marconi, *The Harvest*, Los Angeles: Curb Musifilm, 1992.

²²⁸ John Stockwell, *Turistas*, Dallas: 2929 Entertainment, 2006.

visceral anatomical realities of the surgical process, from *Turistas* to the present, “organ theft” has become almost exclusively a trope within an extraordinarily influential genre within a genre: “splatter” films, or as they are sometimes called by detractors, “torture porn.” A genre that arguably dates back to the 1970s and the *Texas Chainsaw Massacre* franchise, “splatter” films are unique within the wider genre of the horror film for their meticulous depiction of the anatomical realities of torture and dismemberment, as well as their fixation on human suffering. Beginning in the early 2000s, these films, propelled by the *Hostel* and *Saw* franchises, moved into wider networks of cinema distribution and found wider audiences. The “cultural” meaning of this widespread dissemination of extreme graphic violence — often, as with the *House of 1000 Corpses* franchise, coupled with graphic, occasionally violent sexual imagery — has been debated in a variety of forums, but the affinity with traditional pornography is obvious: plotting and characterization are perfunctory and minimal, as their primary function is table-setting so the anatomical display can begin. Pornography, however, seems almost gentle in comparison, as it simply requires its anatomical subject to be, not to be destroyed. From *Turistas* onward, the “organ theft” narrative has become wedded inextricably to horror films of this nature. With its inevitable orientation on the real-life controlled mutilation that is modern surgery, the separation of the body into constituent parts, and the themes of deception, alienation and cruelty that are necessary parts of the “classic” organ theft narrative, the coupling of the organ theft narrative and the “splatter” horror film has an aura of inevitability. It remains to be seen whether an uncoupling is likely, or even possible.²²⁹

A process of erosion similar to that alluded to in *The Harvest* is depicted in 2008’s *The Harvest Project*, in which an ethically-intended and perfectly legal transplantation program degrades into a black market network in which unwitting “marks” are selected from among the host hospital’s patient base, with occasionally fatal results. Upon discovering the nefarious doings, the police detective who serves as the film’s protagonist must make a horrific decision, as one of the project’s intended

²²⁹ Jeremy Morris, “The Justification of Torture-Horror: Retribution and Sadism in *Saw*, *Hostel* and *The Devil’s Rejects*” in Fahy (ed.) *The Philosophy of Horror*, Lexington: Kenucky University, 2010, p. 42-56.

transplant recipients is his desperately ill daughter. The near-pornographic stupidity of the dialogue and performances are indicators of an important shift, however: like *Turistas*, *The Harvest Project* is evidence of the cooptation of the organ theft narrative into a larger and more radical aesthetic of violent exploitation of human suffering, whose cinematic “gaze” is one of bored indifference to the most spectacular extremes of human emotional fear and anguish. It is striking how frequently characters in these films are left alive, yet bearing some very visible and permanent mutilation, at story’s end.²³⁰

The same is true of the 2008 horror film *Train*, in which American college wrestlers on a tour of Eastern Europe find themselves trapped aboard a passenger train which has been converted to a mobile torture chamber/surgical theater in which unwitting passengers are brutally tormented before having their organs surgically removed. One of the wrestlers is castrated; another is vivisected. Though a lone survivor from their group is granted the opportunity for revenge, the victory is hollow; she has watched all of her companions die horrible deaths.

Like *Hostel*, *Train* is set in post-Soviet Eastern Europe and, like *Hostel*, its fundamental conceit is xenophobia. The horror of the story and the duplicity and cruelty of the antagonists is inextricably bound up with the foreignness — and industrial decay — of the tableau. And, like *Turistas*, it plays with the theme of American innocents abroad. Somewhere between *Turistas* and *Train*, however, the relationship between the organ theft narrative and the “torture porn” film has changed. Whereas *Turistas* invested heavily, if superficially, in the themes of global inequality and exploitation coded into the organ theft rumors of the 1980s, *Train* all but dispenses with them. No explanation is given, or asked, for the existence of the organ theft ring. It is merely posited as an expression of the seemingly boundless extent of human cruelty. Nearly identical in premise to *Hostel*, *Train* features another wrestling team, this time travelling through Russia. After an unexpected stop in a small town, several members of the team find themselves aboard a moving train where a group of doctors vivisect unwitting tourist victims, harvesting their organs for sale on the black market. Once again, the plot is a formality, meant to provide cohesion between scenes of visceral dismemberment of live

²³⁰ Darren Rozak, *The Harvest Project*, Canada: Harvest Project Films Inc., 2008.

humans. Organs are removed from live, conscious victims, using methods that, even in the fantastical and intellectually stultified world of the film, make it difficult to imagine their suitability for transplant.²³¹ It is tempting to look for themes of post-Soviet economic and political collapse, perhaps even for themes of American complicity in such collapse, in films like *Hostel* or *Train*, but there is scant evidence that such themes informed either the writing or production.

More imbued with political pretense is the 2010 French horror film *Caged*, in which a medical worker in Kosovo is kidnapped by a ruthless gang of Serbian organ traffickers. Despite the more explicitly geopolitical trappings of the film — the still fresh wounds of the Kosovo war and its broader context in the dissolution of Tito’s Yugoslavia — the setting is once again established merely as a template for the exploration of an awfulness primarily surgical and sadistic in nature.²³²

The organ theft narrative is repurposed away from the pornographic violence to which it has been subverted in recent years by the 2012 film *The Traffickers*, a South Korean suspense thriller in which a middle-class Korean couple vacationing in China is kidnapped by brutal Chinese organ traffickers with ties to both the Chinese and South Korean governments. The twin themes of institutional corruption and the moral bankruptcy of the Chinese Communist Party that the film expounds gained it a great deal of support among Chinese expatriate populations with connections to dissident populations within the People’s Republic of China, such as Falun Gong. In 2006, the *Epoch Times*, a U.S. based English-language newspaper with ties to Falun Gong, published an exposé of organ trafficking in mainland Chinese prison hospitals, alleging that kidneys were harvested from Falun Gong prisoners. The exposé was followed by an official report from a member of the Canadian Parliament substantiating many of the newspaper’s claims.²³³

The trope of organ theft, whether perpetrated upon “innocents abroad,” by the strong upon the weak, or as retaliation for larger injustices, travelled from the labyrinthine world of the urban legends of the 1990s to the imaginings of popular cinema

²³¹ Gideon Raff, *Train*, Los Angeles: Millenium Films, 2008

²³² Yann Gozlan, *Caged*, France: Sombrero Productions, 2010

²³³ Kim Hong-seon, *The Traffickers*, Seoul: Cinus, 2012, Moon Yong and Angela Wang, “New Korean Movie Depicts Organ Harvesting in China,” *Epoch Times*, August 31, 2012.

of the 2000s. It quickly became subsumed within the larger sub-genre called “torture porn” by detractors, where it served to impose a slight narrative discipline upon what would otherwise have been an endless procession of increasingly graphic depictions of human vivisection. As will be seen in the next section, the organ theft narrative trope enjoyed a more subtle and varied existence within the world of broadcast television in the 2000s.

Organ Theft on Television

If organ theft themes in the popular cinema of the 2000s found themselves bonded intractably to human vivisection-oriented terrestrial horror films, then their counterparts in television drama were equally wedded to occult and science fiction themes. Much as the American auteur cinema of the 1970s popularized occult themes through films such as *Rosemary's Baby* and *The Omen*, network television of the 2000s showed an equal fascination with occult themes, although this time endowed with an ironic self-awareness which likely bears the influence of 1990s post-modernism. Organ theft themes inevitably found themselves subsumed in a larger dramatic framework of semi-ironic occultism. The earliest example of this marriage of themes is a 2000 episode of the adolescent-oriented television series *Charmed* titled “Astral Monkey.” *Charmed* follows the lives of three sisters who are endowed genetically with supernatural powers by virtue of their direct descent from a line of powerful witches. Upon discovering the family’s centuries-old “Book of Shadows,” the sisters learn that they are, in fact, the culmination of centuries of transmissions of supernatural power. Throughout the series, these powers are deployed to contain a variety of supernatural villains who surface regularly in the sisters’ seemingly placid town. In “Astral Monkey,” a doctor solicits a blood transfusion from the three sisters and through a random mishap injects it into himself, which endows him with supernatural powers. He uses these to attempt to “steal” a kidney from an unwitting patient in a desperate bid to save his sister, dying from kidney failure.

In many respects the story is incoherent, suggesting perhaps that the “classic” organ theft narrative was absorbed slowly and uneasily into the canon of dramatic television tropes. Ultimately the writers cast the doctor as a Promethean figure, cast into moral turpitude and, eventually, insanity by his inability as a human to handle the sisters’ “supernatural” blood within his own body.²³⁴

Charmed was widely seen as an imitation of the earlier, more popular and more conceptually challenging series *Buffy the Vampire Slayer*, based on a film of the same name, that aired from 1997 until 2003. Showrunner Joss Whedon subsequently created a science fiction series called *Firefly* which, despite critical acclaim and a fanatically dedicated core audience, was cancelled before a full season aired on FOX. Described by its creators as a “space western,” *Firefly* posits a future in which human beings have migrated to and terra-formed distant planets, under the control of a federated government controlled by the world’s only remaining superpowers, the United States and the People’s Republic of China. The overwhelming feeling of the stories and settings explored over *Firefly*’s one season is of a massive social and economic experiment that was, at some point in the past, abandoned by its creators, leaving the inhabitants to live and work within a half-completed, deserted, and fundamentally unworkable project. The quiet desperation embedded within such stories and scenarios forms the core of *Firefly*’s emotional and intellectual pallet.²³⁵

One of its final episodes, “The Message” contains a fascinating inversion of the organ theft narrative, in which Private Tracey, a young alliance soldier who agreed to smuggle human organs for transplant *in his body*. En route, Tracey is approached by a new buyer who offers a better price. Tracey agrees, only to find that the original buyers have discovered — and murdered — their competition. In a desperate bid to escape them, Tracey fakes his own death and has his “corpse” shipped to *Serenity*, the starship upon which much of the series’ action takes place.

“Awaking” violently from an attempted autopsy, Tracey explains his predicament to the *Serenity* crew, who initially agree to help him to his destination, but quickly find

²³⁴ *Charmed*, “Astral Monkey,” *Charmed*, 42:00, May 4, 2000.

²³⁵ *Firefly*, “The Message,” *Firefly*, 44:00, July 28, 2003. For a wide-ranging discussion of Whedon’s work and its cultural impact, see JM Richardson: *The Existential Joss Whedon: Evil and Human Freedom in Buffy The Vampire Slayer, Angel, Firefly and Serenity*, North Carolina: McFarland & Co, 2007.

themselves pursued by Alliance ships. Organ trafficking, in the peculiar sociopolitical world devised by Whedon, is illegal. The Alliance pursuit, however, is complicated by the fact that Tracey's original broker was Lt. Womack, a corrupt Alliance official and an ongoing antagonist throughout the series. Womack's complicity becomes clear when the Alliance officers board the ship, and Tracey frantically takes a hostage from amongst the *Serenity* crew in a last-ditch effort to avoid capture. Womack is ultimately deterred when the crew members threaten to expose his corruption. Tracey dies of wounds inflicted during the confrontation, and the episode ends with a haunting depiction of his military funeral.

"The Message" complicates the popular organ theft narrative in a number of ways. The original "owners" of the organs smuggled by Private Tracey go unmentioned. It is intriguing to speculate whether they were cadaveric organs, meant for a recipient on an intergalactic waiting list, organs sold by a desperate but consenting donor, enmeshed in debt at some lower tier of the profoundly dysfunctional socioeconomic system of the world that *Firefly*'s characters inhabit, or organs harvested from an individual who fell prey to a gang of futuristic murderers. Instead, it is the smuggler himself who becomes the site of the bodily anxiety that ultimately underscores all organ theft narratives. It is the "broker," the "middle-man" ensconced somewhere in the supply chain connecting willing or unwilling donor to the desperate — but not impoverished — recipient, who, while ethically complex and, at times, despicable, functions as the empathy object of the episode's complex inversion of the traditional organ theft narrative.

Further, "The Message" initially presents Tracey's plight as a function of individual hubris or pathology, only to abruptly shift the ethical orientation of the story from one of individual culpability to one of systemic corruption. Even while pursuing and persecuting organ traffickers in the name of justice and efficacy, individual Alliance officers profit from the trade, far more than they might if the practice were tolerated and regulated. Ultimately, the existential "buy or die" dilemma of organ buyers and the "sell or die" conundrum of sellers are made by the writers to dovetail with the existential plight of the show's regular protagonists: How are they to survive and remain ethically

whole while operating within a system which was designed for a purpose ultimately found wanting and left abandoned by its creators?²³⁶

Organ theft is posited as part of a larger narrative of bodily perfection and ethical corruption in *Nip/Tuck*, a drama that ran on the cable network FX from 2003 until 2010. Organized around a plastic surgery private practice initially located in Miami, Florida, *Nip/Tuck* darkly and cynically projects a negative imagining of the future envisioned in Donna Haraway's *The Cyborg Manifesto*, in which the possibility of plastic surgery — for those who can afford it — offers the possibility of a permanent prosthetic negation of human fallibility. Although set in the present day, it is dystopian in its projection of greed and avarice onto the hopes and vanities of both the show's practitioners and patients. Populated by the super-rich, the desperate, accident victims, violent criminals and — in the show's most painfully dated moments — the transgendered, *Nip/Tuck* presents its interlocking plots and subplots as a Bosch-like chaos of human vice. Fundamentally, the characters are engaged in a perpetual conflict with death and aging, propelling them erratically toward inevitable defeat.

Season 4 of *Nip/Tuck* finds a handful of previously peripheral characters ensconced, both wittingly and unwittingly, in a criminal organ trafficking enterprise that, over the course of the season, racks up a considerable number of victims. The season opens with the introduction of a new character: James, played by Jacqueline Bissett, the proprietor of an escort service that once employed the aforementioned plastic surgery practice's office manager, Michelle. In the season's opening episode, James uses her knowledge of Michelle's past to blackmail her into allowing her to use the surgical theater for her latest commercial venture, a transplant ring in which clients of her escort service are drugged and have their organs removed.

Further complicating matters is the revelation that James is operating under the control of *Nip/Tuck*'s perennial villain, a Colombian drug cartel chief, ensuring that whatever her personal reservations may be, she will be pushed into increasingly convoluted machinations to meet the organ quotas established for her. In one particularly grisly episode, she murders a homeless man on Christmas Eve and harvests his organs,

²³⁶ Firefly, *ibid.*

pausing to complain that the man's liver has lost its transplant value due to chronic alcohol abuse on the part of its host. Ultimately, when faced with an imperative from Escobar to murder one of the surgeons' adopted sons and harvest his organs, James commits suicide by shooting herself in the head.

In *Nip/Tuck*'s convoluted world of vanity and spleen that regularly spills over into violence, blackmail and murder, organ theft is presented as one of many of examples of caprices committed in the name of a bodily perfectibility that is by definition unachievable and destructive. But James, in a late season revelation, is understood to have lost a child at a young age to a kidney-related disease, propelling her by unknown means, it is implied, into the world of organ theft. The "buy or die" argument, it seems, is inexhaustible.²³⁷

No such argument is made in "The Man Who Smiled," an episode *Wallander*, a British Broadcasting Corporation procedural drama adapted from a series of popular Swedish crime thrillers. In "The Man Who Smiled," a series of seemingly unrelated murders lead the eponymous protagonist to a seemingly benign African charitable organization whose wealthy benefactor uses the organization as a front for organ harvesting, its victims being individuals displaced and in many cases mutilated by an unnamed civil war superficially reminiscent of the "diamond conflicts" that wracked Sierra Leone and Liberia in the 1990s. When confronted, the benefactor, safely removed from the criminality of his organization, angrily tells Wallander that his victims are, by virtue of their condition, unproductive and that it is his right to decide who lives and who dies. His speech and actions echo the themes of organ theft as avatar for neoliberal exploitation of the global south by the global north, as expressed in the organ theft legends that circulated globally in the 1990s.²³⁸

Murder for the sake of organ harvesting take an especially pitched and venal form in "The Devil You Know," an episode from Season 3 of *Justified*, an eccentric and stylized detective drama based on a short story by the famous pulp crime novelist Elmore

²³⁷ *Nip/Tuck*, "Burt Landau," *Nip/Tuck*, 45:00, October 17, 2006, *Nip/Tuck*, "Connor McNamara," *Nip/Tuck*, October 24, 2006, *Nip/Tuck*, "Diana Lubey," *Nip/Tuck*, 46:00, November 21, 2006, *Nip/Tuck*, "Reefer," *Nip/Tuck*, 46:00, November 28, 2006, *Nip/Tuck*, "Willy Ward," *Nip/Tuck*, 44:00, December 5, 2006.

²³⁸ *Wallander*, "The Man Who Smiled," *Wallander*, 90:00, January 10, 2010.

Leonard. Set primarily in Harlan County, Kentucky (whose legendarily brutal miners' strikes were the subject of the groundbreaking documentary, *Harlan County, USA*), *Justified* follows the career of United States Marshall Raylan Givens, whose record of distinguished service punctuated by incidents of excessive violence causes him to be transferred, much to his chagrin, to the Lexington bureau of the marshall's service, where he finds himself in frequent contact — and conflict — with his criminally violent family and childhood friends. All are now, to differing degrees, ensconced in the extensive black market in prescription drugs and prostitution that undergirds rural Kentucky's profoundly dysfunctional post-mining economy.

In "The Devil You Know," two of Raylan's former childhood nemeses, Dickey and Dewey, find themselves serving lengthy prison sentences, Dickey for a murder tied to a criminal syndicate run by his deceased mother, Mags, and Dewey for a variety of mishaps related generally to his peripheral role in Harlan County's extensive underworld. When a corrupt prison guard and medic learn of Dickey's claim on a considerable cash deposit held in trust for him by Limehouse, the criminal leader of Harlan County's beleaguered and insular African-American community, they contrive a prison break for Dickey and Dewey, hoping that the two will lead them to the money. The plan goes predictably awry and Dewey finds himself imprisoned in a motel room by the prison medic. Upon learning that he and his partner have no chance of claiming the money, the prison medic immediately begins preparing to harvest Dewey's organs, a grim outcome prevented at the last moment in a predictably violent manner by Givens, who returns Dickey and Dewey to prison.

In *Justified*, Dewey and Dickey are both presented as foot soldiers in a criminal army that performs a necessary, if brutal and distasteful, function in an Appalachian mining community that has been decimated by the vagaries of neoliberal movements of capital and labor. Having outlived their function in the broader context of American industrial capitalism, the residents of Harlan County eke out a living in an *ad hoc* vice economy that functions on the edges of the law in the American southeast. The most intelligent and most vicious of Harlan County's residents rise to leadership positions in its vice economies; the Dickeys and the Deweys, on the other, hand quickly find

themselves warehoused in the criminal justice system where, bereft of all but bare life, they are easy victims for those who would reduce their corporeality to a warehouse of saleable parts.²³⁹

On network and cable television, the traditional organ theft narrative has proven more versatile and viable than in film. Freed from the storytelling constraints of the 90-minute, three-part story arc, and constrained by prohibitions on extreme gore that are part and parcel of broadcast over public airwaves, television dramas proved fertile ground in which to explore the bodily anxieties and ethical dilemmas implied in stories of human bodies reduced to warehouses of usable parts. From stories of science fiction organ brokers using their own bodies as storage units for harvested organs — thus problematizing the conventional dualities of organ seller|organ buyer — to state prisoners whose bodily confinement leads inevitably to the reduction of their bodily integrity to the monetary value of their organs, television drama has proven a productive means to assess and reassess the narrative value of the organ theft legends of the 1980s.

Conclusion

Though disparate and multifaceted, the themes of both organ theft and organ selling, as mediated through the storytelling traditions of both commercial cinema and serialized television drama in the 1990s and 2000s, bear a clear debt to the folkloric “organ theft legends” that circulated globally in the 1980s and 1990s. These, in turn, show the distinct influence of the handful of actual cases of organ selling that began to be documented in the news media in the 1980s. Prominent among them was the “Turkish Kidneys” case with which this dissertation primarily concerns itself.

The verifiable tales of impoverished sellers in India and elsewhere that first appeared in newspapers in the 1980s captured imaginations in ways that resonated beyond their immediate sociopolitical or medico-technological impact. As stated earlier, depending on the political orientation of the consumer of such stories, they could be seen

²³⁹ Justified, “The Devil You Know,” *Justified*, 43:00, February 7, 2012.

as examples of the excesses of free-market capitalism, or of authoritarian statism, or as libertarian, anti-paternalist arguments for the efficacy of legalized organ sales, or as proof of a Promethean technological hubris that “goeth before a fall,” or as proof of an irrationality inherent in the developing world.

It is precisely this Rorschach-like quality that seems to have made the stories so powerful and enduring, and such rich material for writers of commercial cinema and television. The trope of the desperate organ seller can function as a template for well-tread dramatic commentaries on income inequality, or it can be inverted to ask ethical questions about the efficacy of life extension by varying means under varying circumstances. The trope of the organ thief can function as a template for equally well-tread dramatic commentaries on human greed, avarice and the capacity of money to erode social relationships and prohibitions. Both themes are underscored by the perennial angst and anxiety over the commodification of the human body that also underlies many of the organ-selling ethnographies discussed in Chapter 1. Finally, the flow of rumors, ideas and tropes across national boundaries have been in evidence throughout this chapter. In the next chapter, we will attempt to assess the role of the “global” in the present study of international organ trafficking.

CHAPTER 5:
IMPERIAL NETWORKS AND UNIVERSAL HISTORIES: TOWARD A
GLOBAL MEDICAL HISTORY

Up until this point I have explored the issue of organ trafficking from a variety of different angles. From each of these angles it has appeared, in different ways and to different degrees, as both a national and transnational phenomenon. In Chapter 2, the passage of people across national borders was integral to the success of a black market in human organs. In Chapter 3, the passage of finance capital from one national economy to another was vital for the expansion of private, for-profit hospitals in Great Britain. In Chapter 4, it is the passage of organ theft tropes or “legends” that passed effortlessly across national borders, themselves often expressing anxieties related to the passage of capital and resources from global south to global north. It is inevitable, therefore, that this dissertation must engage with the “global” as an analytic framework for understanding events and historical phenomena. This is a disciplinary and methodological question with substantial stakes for not just historical research but also historical pedagogy, for it is from this belief in the existence of an analytically meaningful global *topos* that the discipline of World History draws its considerable authority.

Since the 1970s historians have searched for a system of metaphors to adequately convey the complexity of neo-imperial, quasi-imperial and post-imperial relationships between multiple polities. World system analysis and dependency theory relied upon notions of core and periphery: economically strong countries that exerted political and military might against weak territories, as sources of raw materials and as captive markets. The core-periphery schematic is associated primarily with two people, both of whom will be discussed at greater length in this chapter. World-systems analysis is associated with the sociologist Immanuel Wallerstein.²⁴⁰ More conservative, traditional

²⁴⁰ Wallerstein’s theories were developed dozens of books and articles over several decades, but a helpful introduction can be found in Immanuel Wallerstein, *World-Systems Analysis: An Introduction*, Durham: Duke University Press: 2004. The sociologist Andre Gunder Frank is generally credited with the development of Underdevelopment Theory. Like Wallerstein, he developed it over decades. Unlike Wallerstein, these decades were characterized by occasional abrupt shifts and reversals. His historical vision is best understood through Andre Gunder Frank, *World Accumulation: 1492-1789*, New York City: 1978.

historians of empire might not have shared the political sensibilities of world systems and dependency theorists, but they were generally comfortable with their delineation of the world into strong societies that acted and weak societies that were acted upon.²⁴¹

Like all explanations based upon a dualism, core-periphery came under attack in the 1980s and 1990s. Imperial historians adapted by absorbing the complex metaphor of “networks” devised by sociologists of science.²⁴² Additionally, postcolonial theorists took issue with the passivity with which imperial subjects were portrayed. Some imperial historians, by adopting analytical strategies that emphasized the “agency” of colonial subjects, stressed the mutable nature of colonial hierarchies.²⁴³ Spatial metaphors of webs and nodes have been cautiously advanced as adequate for conveying the complexities of imperial history. The complexity of the colonial subject has been given attention once reserved only for the colonizer. It was through these two adaptive strategies that imperial history slowly and unevenly came to be reinvented as global history.²⁴⁴ These themes were further explored in the specific context of “decolonization” — the formal dismantling of colonial governments — by the British historian A.G. Hopkins.²⁴⁵

The British-dominated field of global history both overlaps with and stands as a counterpoint to American-dominated “World” history. Like World History, however, Global History has more recently been criticized for the “totalizing” and reductive nature of its project. It remains to be seen whether these criticisms will provoke a new round of

²⁴¹ The basic economic language of the “take-off” of Western Europe was developed by the economist Walt Whitman Rostow in W.W. Rostow, *The Stages of Economic Growth: A Non-Communist Manifesto*, Cambridge: Cambridge University Press, 1960. It then became central to arguments of conservative historians such as David Landes in his magisterial work, David Landes, *The Wealth and Poverty of Nations: Why Some are So Rich and Some So Poor*. It is also central to the thinking of historians less concerned with theorizing the global, such as Bernard Lewis and Niall Ferguson.

²⁴² The entry point for the methodology of “Actor-Network Theory” is generally considered to be the sociologist Bruno Latour, who is thought to have devised ATN in response to challenges to the sociology of science in France posed by poststructuralism. Bruno Latour, *Reassembling the Social: an Introduction to Actor-Network Theory*, Oxford: Oxford University Press, 2005.

²⁴³ Gyan Prakash, *After Colonialism: Imperial Histories and Postcolonial Displacements*, Princeton: Princeton University Press, 1994. The “rise” of postcolonial studies and of the Subaltern school and the sustained and multifaceted criticism of imperial history are contemporaneous.

²⁴⁴ Matthias Middell and Katja Naumann, “Global History and the Spatial Turn: From the Impact of Area Studies to the Study of Critical Junctures of Globalization,” *Journal of Global History*, 5, 1, 2010, p. 49-70.

²⁴⁵ A.G. Hopkins, “Rethinking Decolonization” in *Past and Present*, 200, 1, 2008, p. 211-247 and “Back to the Future: From National History to Imperial History” in *Past and Present*, 164, 1, 1999, p. 198-243.

adaptations. But for the moment, the complex metaphorical language (sometimes described as the “spatial” turn in global history)²⁴⁶ of networks and territories employed by global historians and historians of science and empire, provides a fascinating vantage point from which to examine in context the overlapping webs of sickness, technology, wealth and poverty in which Raymond Crockett, his patients and associates found themselves in the 1980s.

Turkey and the United Kingdom

At the core of Crockett’s operation was a relationship between private hospitals located in the United Kingdom and impoverished workers in the Republic of Turkey, recruited through Turkish newspapers and through Turkish middlemen in both countries. The donors geographical and diplomatic relationships between the United Kingdom and the Republic of Turkey directly, applying for visas, having plane tickets purchased for them, and being groomed for their interactions with immigration and customs officials. The political realities between the two countries in the 1980s are thus of interest, serving as nodes in a multinational network.²⁴⁷

Traditionally, historical relations between the United Kingdom and Republic of Turkey are seen as being dominated by two events: the collapse of the Ottoman Empire and subsequent formation of British “mandates” in its former Middle Eastern territories, and the invasion of historically British-dominated Cyprus by Turkish ground forces in 1974. In practice, however, throughout the Cold War, the British and Turkish governments enjoyed cooperative relations under the auspices of a U.S.-led anti-Soviet coalition. Further, North London played host to a large Turkish population that for the

²⁴⁶ Middell and Naumann, p. 49.

²⁴⁷ G.R. Berridge, *British Diplomacy in Turkey: 1583 to the present: A Study in the Evolution of the Resident Embassy*, Leiden: Koninklijke Brill NV, 2009, p 237-271. The principle point of diplomatic tension between the two countries from the 1960s to the present has been the smuggling of narcotics from Turkey into Britain. Turkey has been — and continues to be — an important transit point for heroin from Afghanistan to Europe. This provides some context for the overall experience of the individual kidney sellers described in Chapter 2 as they disembarked at Heathrow and stepped into the immigration line.

most part avoided the persecution meted out to larger South Asian and Afro-Caribbean communities. This mixed Turkish, Kurdish and Turkish Cypriot community has existed in significant numbers since the 1950s. Occasional newspaper articles about a “Turkish Mafia” aside, the community is by and large either ignored or, increasingly, viewed as a small and unproblematic subset of a larger social phenomenon of “British Muslims.”²⁴⁸ Istanbul, meanwhile, has hosted a large British Council office and British International School since the 1940s.

The 1920 Treaty of Lausanne dismantled the nearly five-century old Ottoman Empire, leaving much of its territory under the control of the British Empire, excluding the area surrounding the Ottoman imperial capital of Istanbul and much of the Anatolian peninsula. In 1923 this area became the Republic of Turkey, under the near exclusive control of the country's first President, Kemal Ataturk, an Ottoman General and the hero of the Battle of Gallipoli.

For the first decade of the Republic's existence, Ataturk's government took a limited interest in the country's largely agricultural economy and concerned itself instead with the Republic's "modernization." Collapses in world agricultural prices in the 1930s made this policy unworkable, and the government quickly implemented a series of five-year-plans and import substitution policies designed to rapidly industrialize the country. The results were geographically uneven, with relative success in Istanbul and the country's new political capital of Ankara, while the vast majority of Anatolia (including Eastern Turkey where, significantly, the country's large Kurdish minority was located) remained untouched.

This and institutionalized conflict between ultra-nationalist political parties (often with a significant presence in the military) and leftist political parties (often with a significant presence in the expanding, mostly urban trade union movement) exploded. A general election in 1977 failed to produce any clear results and quickly became a constitutional crisis, with no clear leadership emerging until 1980 when the military assumed full political control of the country.

²⁴⁸ Humayun Ansari, *The Infidel Within: Muslims in Britain Since 1800*, London: C. Hurst and co., 2004.

Once in power, the military government set to work dismantling the economic policies of the previous half century, replacing them with a structural adjustment program modeled very closely upon World Bank and International Monetary Fund prescriptions for "newly industrialized" countries.

By the time control was handed back over to a civilian government in 1983, the results of these economic reforms were becoming clear. Inflation had slowed, exports had risen dramatically and foreign investment had increased (although not as much as hoped). All of this happened at tremendous cost to the vast majority of the country's working population. Wage freezes, the dismantling of state-run industries and intense political persecution of labor unions meant that standard of living for both the urban and rural poor declined throughout the 1980s.²⁴⁹ This is the historical and intellectual framework we inherit for understanding the experiences and life-worlds of Usta, Yenici, Anutkan and Koç. As a group, they provide a surprisingly complete cross-section of what it meant to be poor and desperate in Turkey in the 1980s: urban, rural, male, female, Kurdish, Turkish, immigrant, farm worker, factory worker, squatter.

Turkey had its own organ donation landscape, characterized by the existence of two independent and mutually non-communicative systems for allocating cadaveric organs. As the anthropologist Aslihan Sanal has argued, Turkey's own kidney "black market" operated in a space created by the disconnect between them.²⁵⁰ If there is a connection, however, between it and the Kunters, Raymond Crockett's Turkish contacts, it remains unknown.

For its part, the United Kingdom in the 1980s was experiencing a relative lull in public opprobrium against immigrants and immigration. Since the 1940s, when large numbers of Commonwealth citizens from the Caribbean and South Asia were absorbed to fill gaps in the domestic workforce, the United Kingdom — particularly England — had oscillated between periods of relative indifference and periods of visceral anti-immigrant rhetoric. These were generally marked by events, such as the riots at the Notting Hill Carnival in 1958, Enoch Powell's "Rivers of Blood" speech in 1968, or the arrival of

²⁴⁹ An Fatma Müge Göçek, *The Transformation of Turkey: Redefining State and Society From the Ottoman Empire to the Modern Era*, New York: I.B. Tauris, 2011.

²⁵⁰ Aslihan Sanal, "Robin Hood of Techno-Turkey or Organ Trafficking in the State of Ethical Beings," *Culture, Medicine and Psychiatry*, 28, 3, 2004, 281-309.

large number of South Asians expelled by Idi Amin's diktat from Uganda in 1972. Immigration-related political conflict was at a stalemate for the most part in the 1980s, with attitudes continuing to harden, but little open conflict (The youths at the center of the urban riots in 1981 were generally acknowledged as acting out class conflict, even by those calling for their imprisonment). The tone for attitudes toward the non-British presence in Britain was set, or perhaps reflected, by a remark Margaret Thatcher made in a 1978 television interview, that British people feared being "rather swamped by people with a different culture."²⁵¹ Passive hostility of this sort is reflected in the resentments expressed by British hospital staff toward overseas patients "with their retinues" discussed in Chapter 2.

Chapter 2 details two paid-donor "scandals": one in 1989 featuring kidney-sellers from Turkey and kidney buyers from Greece, Israel, Libya and Afghanistan. Much was done to protect their identities, but the details that emerged suggested that each were at the end of a long and desperate process of international clinic-hopping. This was particularly true of Libyan "Doctor AK" whose case was complicated by his being positive for Hepatitis A, a fact which led to his removal from several dialysis clinics in continental Europe. Only Michael Bewick, immune to Hepatitis A after his exposure to it during the 1969 outbreak at Guy's hospital, was willing to treat him. The earlier "scandal" in 1985, featuring donors and recipients from India and Pakistan, was followed by Michael Bewick's press-paid fact-finding trip to Bombay to confront the realities of the kidney "markets" of India. The practice of paid donation had its genesis in India.²⁵²

India and the United Kingdom

The British Empire is synonymous with its 200-year economic and political dominance of South Asia. After independence in 1947, and the division of British India into India

²⁵¹ The great, largely forgotten works on the subject of post-war immigration and racism are Dilip Hiro, *Black British, White British*, New York: Monthly Press Review, 1973 and Ron Ramdin, *The Making of the Black Working Class in Britain*, Aldershot: Gower, 1987.

²⁵² Raj Chengappa, "The Organs Bazaar," *India Today*, July 31, 1990, p. 60-67.

and Pakistan (and later, Bangladesh) the United Kingdom remained intricately linked to both countries as a trade and diplomatic partner and hegemon.

Most hospitals and medical schools in India had been established in the early twentieth century and based upon British models.²⁵³ English remained the primary language of medical instruction and for the publication of medical research in India after independence. The strength of its institutions and its close connection to medical research in the United Kingdom and United States meant that India quickly adapted to sea changes in medical and surgical practice throughout the 1960s and 1970s. Renal medicine — first dialysis, then transplantation — were no exceptions.²⁵⁴

Given its highly developed medical infrastructure, dense population and pronounced wealth inequality, it is not surprising that India became the world's first hub of paid live-donor renal transplantation. By the time Michael Bewick traveled to Bombay in 1985 to confront the realities of the trade, it had developed into a complex, multi-sited affair full of doctors, brokers, hospital administrators and an inexhaustible supply of kidney sellers from largely rural, impoverished backgrounds. The system evolved to meet the needs of domestic buyers — frequently only marginally economically better off than the sellers — and overseas buyers, primarily from the Gulf States.²⁵⁵

By the end of the 1980s, the trade had been branded as India's "organ bazaar" and was frequently the subject of journalistic investigations and exposes. An article published in *Lancet* in 1990 made devastating claims about the post-operative fates of Gulf States patients between 1984 and 1988.²⁵⁶ Critics of organ-selling from within India's medical community argued that the trade had worked to suppress the development of a system of legal cadaveric donation. Defenders of organ selling — the most prominent being the urologist K.C. Reddy — argued that the imminent death of the kidney buyer outweighed other ethical concerns and that kidney selling presented the only possible escape from

²⁵³ Mark Harrison, *Public Health in British India: Anglo-Indian Preventative Medicine 1859-1914*, Cambridge: Cambridge University Press, 1994. Although concerned primarily with public health campaigns, Harrison's work addresses hospitals.

²⁵⁴ Chengappa, *ibid.*

²⁵⁵ AK Salahudeen, HF Woods, A Pingle, M Nur-El-H uda Suleyman, K Shakuntala, M Nandakumar, TM Yahya, AS Daar, "High Mortality Among Recipients of Bought Living-Unrelated Donor Kidneys," *Lancet*, September 22, 1990, 725-728.

²⁵⁶ Salahudeen, *ibid.*

poverty for many people. A study published in 2004 marshaled considerable statistical evidence that the latter was not the case.²⁵⁷ As the Indian government continued to attempt to reign in the practice of kidney selling, the trade then moved to other South Asian countries such as Pakistan and Nepal.²⁵⁸

The relationship between the British and Indian medical establishments is far too complex to be sufficiently captured as “center” and periphery.” Indeed, while the transnational movements of people and capital are so vital a part of the international organ trade, I wish to argue for a different sort of “geographic” understanding of the trade in human organs. I wish to focus on the shifting geographies of “public” and “private” medical practice.

Public and Private Spaces

In a compelling examination of Victorian regulatory strategies toward prostitution throughout the British Empire, the geographer Philip Howell argues for “geographies of regulation” — the spatialized nature of colonial regulation. In other words, Howell borrows the Foucauldian idea of the expanding “regulationist” state — the state organized around the deeper and more comprehensive management of the health and sexuality of its subjects — and turns it outward toward nineteenth century imperial places. By careful examination of the local specificities — in Manchester, Liverpool, Gibraltar and Hong Kong — Howell attempts to use the idea of the “local” to validate the continuing existence of the “global” as a subject of intellectual inquiry.²⁵⁹

Other historians and geographers of empire take different tacks in the defense of the study of empire. In the collection *[Dis]placing Empire*, Proudfoot and Roche attempt to turn the tables on postcolonial and post-structural critiques of imperial history, arguing

²⁵⁷ Vivekenaand Jah, “Paid Transplants in India: The Grim Reality,” *Nephrology, Dialysis and Transplant*, 19, 3, 2004, 541-543.

²⁵⁸ Yosuke Shimazono, “The State of the International Organ Trade: A Provisional Picture Based on Integration of Available Information,” *Bulletin of the World Health Organization*, 85, 12, 2007, p. 15.

²⁵⁹ Philip Howell, *Geographies of Regulation: Policing Prostitution in Nineteenth-Century Britain and the Empire*, Cambridge: Cambridge University Press, 2009.

that such critiques have “essentialized” the settler-colonialist experience, and that it is now the settlers themselves, and the corollary notion of whiteness that must be “problematized” and “de-centered.”²⁶⁰

While it is interesting to speculate about the degree to which Raymond Crockett’s Irish Nonconformist background impacted his treatment at the hands of his colleagues and his role on the periphery of the British medical establishment, its mention in the media of the time period and in the transcripts of his hearing before the General Medical Council is so sparse as to be nearly nonexistent. Bewick’s interactions with his South Asian (in 1985) and Turkish (in 1988) surgical patients, however, reflect the ambiguities of Britain’s imperial history a bit less faintly. Tasked with verifying the willingness and cognizance of his donor-patients prior to removing their kidneys, the image of Bewick — sans translator — waving a £5 note before them (as he claimed to a journalist) is not without resonance. If it actually happened as Bewick described, it is a remarkably poor substitute for a professional translator in a situation where a human being is about to have major surgery. If it didn’t happen, the neglect is even more profound.

A much clearer analog with the problematization by imperial historians of the colonizer|colonized duality can be seen by countering the experience of donors to recipients in the “Turkish Kidneys” scandal. The “traditional” narrative of kidney selling ethnography — a political economy of vampirism in which the old and powerful literally harvest the vitality of the young and vulnerable with the aid of corrupt doctors, nurses and brokers — does not quite hold, for reasons discussed in Chapter 1. The structurally inflicted misery of the kidney sellers is not under question; rather it is complicated and complemented by the physiological — and existential — misery of the recipients. Chapter 2 details the circumstances of the despairing minuet in which the two were forced together.

In a magisterial article published in 2004, Glaisyer argues for a stronger connection between British history and the history of the British Empire, and it is with this argument that a broad framework for how to best understand the story of Raymond Crockett *et al* through the lens of Imperial history emerges. In general, Imperial history’s

²⁶⁰ L. Lindsay, J. Proudfoot, Matthew Michael Roche, *(Dis)placing Empire: Renegotiating British Colonial Geographies*, London: Ashgate, 2005.

spatial metaphors, and specifically, Glaisyer's language of transnational trade and kinship ties, can be much more readily adapted to the public and private spaces in which medicine was practiced in 1980s Britain than they can to the geopolitical relationship between Britain and Turkey.²⁶¹

As described in chapters two and three, British private medicine post-1948 refers to overlapping sectors of mostly non-profit hospitals, clinics, insurance schemes, non-primary specialties such as dentistry or optometry only partially covered by the NHS, "pay beds" in NHS hospitals and a small number of private, for-profit clinics and hospitals. The nephrectomies and transplantations at the heart of the "Turkish Kidneys" scandal took place in the last category, private for-profit hospitals. These hospitals, as discussed in Chapter 3, were themselves the product of a period of expansion, brought on first by the popular attempts to remove "pay beds" from NHS hospitals: the liberalization of rules governing the building of private for-profit hospitals was a countermeasure meant to appease doctors who, with the reduction of pay beds, lost a source of additional income.

Demand for private hospitals was limited, however, just as it had been for pay beds. The expansion of the private sector was due to a largely accidental influx of American investment capital into Britain's tiny for-profit medical sector. This was not so much driven by a perceived demand for the services of private for-profit hospitals as it was by market saturation in the United States, leading to investment capital restlessly searching abroad for investment opportunities. And it is precisely in these new spaces of private practice that the "Turkish Kidneys" scandal took place.

In a broader sense, "public" is used here to denote spaces which are direct extensions of state power and state resources in which the state is the principle organizing and regulating force. "Private" here denotes spaces which are called into existence by the perceived existence of consumer demand, wherein the state may exercise regulatory power but is kept at bay by the presence of private ownership.

In the broader literature of imperial networks, it is generally agreed that the relationship between imperial networks and regulatory frameworks is decisive and

²⁶¹ N. Glaisyer, "Networking: Trade and Exchange in the Eighteenth-Century British Empire," *The Historical Journal*, 47, 2004, p. 451-476.

instructive. This is a challenging lens through which to view the story of Raymond Crockett and his patients. The networks are post-imperial; the regulatory frameworks are either absent (in the case of laws expressly prohibiting the sale of organs in the United Kingdom) or malfunctioning (in the case of regulations governing the management of private hospitals). Into this ambiguous and malfunctioning regulatory space poured foreign investment capital, followed eventually by the grey market in live-donor kidneys.

Toward a global medical history

The complicated interplay described above between imperial history and postcolonial studies has with increasing frequency been portrayed as “Global History,” a simultaneous reimagining and rebranding of the old Imperial History, and a British (and antipodean) counterpart to the largely American-dominated field of World History.

Unlike most other historical sub-disciplines, World History is driven primarily by pedagogical mandate rather than the research priorities of government funding agencies. Therefore, any historiographical question related to World History as a mode of intellectual inquiry, or any institutional-sociological inquiry as to World History’s role in the larger picture of production of knowledge in American universities, should begin by examining the “career” of World History in the classroom and then move on to World History as a site of knowledge production within the discipline of History.

The current World History/World Civilizations curriculum evolved out of a desire to make the traditional Western Civilization curriculum more inclusive. Western Civ, in turn, was adopted from the general education requirements made upon university-bound secondary students during the late nineteenth and early twentieth centuries, a time when a very small percentage of Americans matriculated to tertiary education. At that time, it was expected that when a student began at an Ivy League university that they would have already received instruction in Greek and Latin, as well as having read canonical works in both languages. Exposure to this canon was considered a necessary moral and intellectual prerequisite for future leadership. This was perfectly logical, considering that

a place in an Ivy League university essentially meant a future place in America's economic and political elite.²⁶²

In the early twentieth century, these universities began to receive larger and larger numbers of students born outside of America's traditional elite. Many of them came from families who had emigrated from Eastern Europe and Russia. Columbia University (then Columbia College) was at the forefront of this trend. Out of a generalized anxiety on the part of the school's faculty and administration was born the "Columbia Course" — essentially a nineteenth-century gentleman's education condensed into two semesters, in which students were exposed to the Greek/Roman classical canon in English. When adopted by other Ivy League universities, this curriculum came to be called Western Civilization, or Western Civ — a crash course in "Western" values, as defined by the American academy of that time.

After the Second World War, a profound demographic shift occurred in American higher education. Unprecedented numbers of students from working class backgrounds were able to attend four-year universities, thanks largely to the G.I. Bill. Existing institutions expanded to meet this demand, with what had previously been agricultural, technical and religious vocational institutions expanding to become the public universities that they are today. The Western Civ curriculum in one form or another was adopted by nearly all of them as an undergraduate requirement.

In the 1960s and 70s another demographic shift occurred, with both women and previously underrepresented minorities entering universities in unprecedented numbers. This demographic shift intertwined with a cultural shift occurring simultaneously in the country as a whole, one that, broadly defined, encompassed the Women's Movement, Black Power, Gay Rights, opposition to the Vietnam War, and many others. Out of these two shifts, a searing critique of Western Civ developed, one that characterized it as a Whiggish narrative of uninterrupted civilizational progress beginning in ancient Athens and continuing through the Christianization of the Roman Empire, the Renaissance, the Enlightenment, the Scientific Revolution of the nineteenth century and finally

²⁶² The official history of the course is laid out in Timothy P. Cross, *An Oasis of Order: The Core Curriculum at Columbia College*, New York: Columbia 1995 and provides an important insight into how defenders of the Western Civ tradition understand what they are doing and why they are doing it. Critics — and defenders against critics — abound, and are cited in subsequent notes.

culminating in American constitutional democracy, at every step presented through exclusively male voices.²⁶³

Out of a general recognition that Western Civ was lacking, two new curricula were born: the Humanities survey course and the World Civilizations course. The latter is what concerns us. The World History course was not without precedent. It drew upon the “universal histories” produced in the early twentieth century by Arnold Toynbee, Oswald Spengler, H.G. Wells, and others. These histories drew heavily upon Hegel’s *Philosophy of History*, which in turn took its underlying structure from ecclesiastical histories, which in turn were organized around the Aristotelian principle of *telos* — a generalized purposiveness inherent in the human record. In other words, it was rooted in the same philosophical assumptions that informed the Western Civ curriculum and the classical canon underlying it.²⁶⁴

Further difficulty was caused by World History’s methodological reliance on diffusionism, a theoretical model associated with early anthropologists — particularly Franz Boas. Maturing into a school of anthropological thought with British, German and American variants, diffusionism essentially posited as natural law that change — particularly technological change — was implemented by large, complex, dynamic societies upon smaller, less complex, less dynamic societies, and that this was the mechanism through which the human progress occurred globally over time. Largely discredited within anthropology by the 1960s, diffusionism remained a legitimate theoretical underpinning for World History, primarily because of the overwhelming success of William McNeill’s *The Rise of the West*, which became the discipline’s canonical text. Diffusionism is helpful for doing what the authors’ of World History textbooks are charged with doing — folding the entire archaeological and historical record into a comprehensive “human story.” If this story is assumed to be that of the gradual mastery of humans over their environment, then diffusionism is a handy explanatory tool, explaining how ideas spread, gradually, to everywhere on the planet. Unfortunately, this gives lie to the stated premise of World History — its increased

²⁶³ This line of criticism is outlined thoroughly in Ruth Sidel, *Battling Bias: The Struggle for Community and Identity on College Campuses*, New York: Penguin, 1995.

²⁶⁴ Vinay Lal, “Much Ado About Something: The New Malaise of World History,” *Radical History*, 91, 2005, 124-130.

inclusiveness. Places outside of the major Eurasian *oikumenes* — Egyptian, Greek, Roman, Chinese, Vedic, Islamic, etc. — only become meaningful when they are forced into contact with larger neighbors. This mimics almost perfectly the narrative strategy of Western Civ.

World Civ expressed a general desire to take the Western Civ curriculum and make it more inclusive, adding extended discussions of historical entities that had traditionally been outside the rubric of Western Civ, namely China, India, the Middle East and Africa. These efforts were bolstered by increasingly detailed archaeological and historical records of these places, records that challenged in particular the received wisdom that Western Europe — and in turn the United States — had been the single beneficiary of classical learning. In incorporating elements of all of the above named places, World Civ was successful. In challenging the underlying structural logic of Western Civ — that history is a single narrative with a cohesive outcome — it was less so.²⁶⁵

The obvious response to the above argument is that World History is the history of a species — *homo sapiens sapiens* — or, more broadly defined, a genus — *homo*. The idea of a biological history of humanity, however, in a post-World War II, context, sets off multiple alarms, reminiscent of everything from Galton’s eugenics to Mengele’s anthropological horrors. As such, World History has set itself at a strict distance from anything that might be construed as Social Darwinism, however remotely. Given the widespread intellectual consensus in favor of eugenic and racial “sciences” and “evolutionary” analyses of the interactions between social groups prior to the Second World War, however, it is not surprising that a public appetite for these forms of analysis remained, even after their intellectual credibility had been revoked. Simultaneously, these intellectual traditions were compelled to reinvent themselves after the Second World War, creating new disciplines such as Evolutionary Psychology or Sociobiology, or with individual practitioners migrating to existing disciplines such as Evolutionary Biology, beginning a decades-long *methodenstreit* over the interpretation of evolutionary process. This conflict was best characterized by the competing claims of “punctuated equilibrium”

²⁶⁵ William McNeill, *The Rise of the West: A History of the Human Community*, Chicago: University of Chicago Press, 1963.

and “evolutionary gradualism” debated very publicly by the paleontologist Stephen Jay Gould and the biologist Edward Wilson. The former advocated a vision of biological evolution where species, having achieved a relative equilibrium with their immediate environment, remained relatively biologically stable for the duration of that equilibrium. Biologically significant mutation, the argument goes, occurs in response to environmental shifts, whether in the form of climactic change, the appearance of new predators, etc., and once triggered tends to happen rapidly and dramatically. Evolutionary gradualism, on the other hand, argued for a stable and predictable evolutionary pattern, in which significant mutations occur on a nearly invisible scale in relatively predictable increments, driven, it is strongly implied, by internal process rather than external shocks.²⁶⁶

Methodologically and philosophically, this is an argument in which historians should find much that is familiar. First of all, the implied historicism of the gradualist argument: biological evolution is driven by a process which is not readily identifiable or explainable, but is highly persistent and, by implication, precedes biological evolution. Second, the implication of the gradualist argument that evolutionary change is largely endogenous should remind economic historians of the Brenner/Wallerstein debates of the 1960s, over whether the accumulation of relative (as opposed to absolute) surplus value in the feudal economies of pre-sixteenth century Europe were sufficient to generate the economic “take-off” that led first to the development of a world economy and eventually to the industrialization of Northern Europe.²⁶⁷ In other words, part of the argument between evolutionary gradualism and punctuated equilibrium is an argument over whether evolutionary change is endogenous or exogenous. Finally, historians who are familiar with the “problem” of historicism and teleology as modes of historical interpretation will recognize that this is, at its core, a debate over whether Darwinian evolution is to be understood as a determined or contingent process.²⁶⁸

²⁶⁶ The argument for evolutionary gradualism is laid out most thoroughly in *Sociobiology: The New Synthesis*, Cambridge: Harvard, 1975. The case for punctuated equilibrium is made most succinctly in Stephen Jay Gould, *Full House: The Spread of Excellence From Plato to Darwin*, New York: Harmony, 1996.

²⁶⁷ A summary is more than sufficiently adequate. Robert A. Dennemark and Kenneth P. Thomas, “The Brenner-Wallerstein Debate,” *International Studies Quarterly*, 32, 1, 1988, p. 47-65.

²⁶⁸ The relationship between the teleology of first Greek and then Christian metaphysics, the historicism of Hegel, and the determinism espoused by some schools of evolutionary biology has never, to

It is necessary to understand the fundamentals of this debate within evolutionary biology in order to understand the contributions that evolutionary biology has made indirectly to the field of World History and directly to the popularization of World History beyond the academy. Because historians have generally been unwilling to engage with a biological human history, successful “hard” scientists with literary ambitions have stepped in to fill the void. The best known of these in recent decades is the physiologist Jared Diamond, author of *Guns, Germs and Steel*, an extremely popular World History text which begins by asking why “Western” societies have accumulated significantly more wealth and power than “non-western” societies. In the historical-anthropological milieu in which Diamond was writing, this was a question that had a history of its own. Prior to the Second World War, biological inferiority along racial lines had been an acceptable answer. When it ceased to be so, two opposing answers replaced it. These answers had visceral and immediate political implications. To argue that “culture” was the “cause” of underdevelopment was to argue that poor countries were poor due to internal cultural deficiencies. To argue that “economics” was the cause of underdevelopment was to argue that poor countries were poor due to decades, if not centuries of systematic resource appropriation by former colonial or neocolonial powers. These arguments resonated heavily with policymakers because they elided easily from diagnosis to prescription: if “culture” was the cause of poverty, then no amount of foreign aid would fix it. If, on the other hand, poverty was caused by colonialism, then there was a debt to be paid — moral, economic or otherwise. As discussed earlier, the cultural argument for underdevelopment found its highest expression in *The Wealth and Poverty of Nations* by the conservative economic historian David Landes. The economic argument found its highest expression in the writings of the Marxist sociologist Andre Gunder Frank. The outcome varied from discipline to discipline. “Culture” was largely banished from respectable anthropology journals until its partial rehabilitation in less

my knowledge, been the subject of a single work. It is a vast topic with high stakes for cultural understandings of the relationship between religion and science. Gould outlines the anti-determinist position in evolutionary biology in Stephen J. Gould and Richard C. Lewontin, “The Spandrels of San Marcos and the Panglossian Paradigm: A Critique of the Adaptionist Programme,” *Proceedings of The Royal Society of London, Series B. Biological Sciences*. 205, 1161, September 21, 1979, p. 581-598.

overtly political form by Arjun Appadurai in his 1986 edited anthology *The Social Life of Things*.²⁶⁹

With the 1997 publication of *Guns, Germs and Steel*, Diamond devised a new answer to the venerable question. His answer was “environment.” The book paints a dramatic historical panorama of human societies, beginning in the late ice age and continuing through the present, deposited into sometimes changing, sometimes static micro-environments in which they adapt — or fail to adapt — and compete with proximal groups for scarce resources. In this respect, Diamond’s thesis differs little from McNeill’s, H.G. Wells’, *et al.* Diamond’s thesis distinguishes itself by privileging physical terrain as a determiner of outcomes. Eurasia, he argues, is spread latitudinally over more than half of the Earth’s surface, whereas the Americas are comparatively latitudinally narrow but longitudinally pronounced. The implication, for Diamond, was that technologies generated by the Neolithic revolution in Eurasia spread easily along latitudinal lines, from North Africa to the Middle East and Southwest Asia. These technologies included metallurgical techniques and animal husbandry. Metallurgy laid the groundwork for, among other things, the martial technologies that, thousands of years later, would be decisive in Western military dominance of the planet. Animal husbandry, via “herd diseases” guaranteed that certain levels of immunity would build up over long periods of time among Eurasian populations.

The Americas, in Diamond’s analysis, fare very differently. Because they are spread longitudinally rather than latitudinally, the Americas contained only a handful of zones where agriculture could develop in a meaningful way, and virtually none suitable for animal husbandry. Spread from north to south, rather than east to west, the Americas were doubly damned: fewer areas suitable by latitude for agriculture, and less hope for the spread of technological innovation from one area to another. In the latter respect, Diamond mimicked early diffusionist theorists, adding to the diffusionist formulation an overarching topographical thesis. Diamond has frequently since the publication of *Guns, Germs and Steel* been accused of “environmental determinism — the over-determination

²⁶⁹ Arjun Appadurai (ed), *The Social Life of Things: Commodities in Cultural Perspective*, Cambridge: Cambridge University Press, 1988.

of complex historical outcomes to a single cause: geography. In fact, the cause he posits is even more narrowly focused: the triumph of latitude.

This triumph of latitude, however, is predicated upon other assumptions that speak to older ideas about science and the acquisition of knowledge. *Guns, Germs and Steel* begins with a vivid description of the Battle of Cajamarca in 1532, in which a Spanish expedition led by Francisco Pizarro massacred an exponentially larger force led by the Inca ruler Atahualpa. For Diamond, whatever the underlying cause, the battle and its outcome are self-evident markers of evolution in action. The “old world” forces, thanks to the technological and epidemiological toolkit they carry with them, were placed at such a decisive advantage that the Inca forces collapsed almost instantaneously.²⁷⁰ The broader conceit, for Diamond, for E.O. Wilson, and for many others like them, involves competition. Theirs is a unique and radical interpretation of Darwinian theories of selection, which departs from Darwin’s canonical writings in two important ways: their embrace of competition as the sole modality through which selection (and therefore, evolution) occurs (a point with which Darwin flatly disagreed) and their assumption that principles of selection can be applied in macro-settings to large social groups (a point on which Darwin was ambivalent.)²⁷¹

As a public intellectual, Diamond has made repeated pleas for the study of history to be more interdisciplinary and more “scientific.” By “scientific,” he has explained, he means that history should be concerned with the search for underlying historical “laws.” The value in this proposition, Diamond explained in a subsequent book, *Collapse*, a comparative study of agricultural societies that have experienced state and social dissolution, is to predict. Historical laws, Diamond argues, will be of use in preventing future calamities. Unlike historians in the Rankean tradition, he is not merely calling for history to be treated as a social science, but as a wholly deductive one.²⁷²

²⁷⁰ Jared Diamond: *Guns, Germs and Steel: The Fate of Human Societies*, Los Angeles: UCLA University Press, 1997.

²⁷¹ Darwin’s most succinct expression of this principle was in his assertion in *The Descent of Man* that human morality has its origins in the social behavior of animals. Charles Darwin, *The Descent of Man*, London: Watts and Company, 1930, p. 231-232. On the latter point, Darwin’s reflections on the Fuegian islanders he encountered suggest more of an affinity with “Social Darwinism.”

²⁷² Jared Diamond, *Collapse: How Societies Choose to Fail or Succeed*, New York: Viking, 2005.

Finally, key to Diamond's historical vision in *Guns, Germs and Steel* is its historicism, and this is the point with which his would-be critics have struggled. Like Wilson, and like scientists in the gradualist tradition, Diamond sees the evolutionary process as moving toward greater efficiency, guided by an internal mechanism, a principle which can be neither proven nor disproven and therefore is largely metaphysical. This is not a particularly controversial or even interesting point. The problem is as follows: The battle of Cajamarca and, indeed, the wars of conquest fought between Spanish mercenary forces and the Mexica and Inca empires were wars that ultimately led to the foundation of the Spanish empire in the Atlantic. In turn they laid the groundwork for that gradual economic domination of China and Southeast Asia by European colonial powers. When dropped into a macro-historical analysis of global wealth inequality, conducted via pseudo-Darwinian principles of selection-via-competition and social Darwinian principles of evolutionary group behavior, they become what Stephen Jay Gould and his followers dubbed evolutionary "Just-so" stories. They begin with an outcome and work backwards, "proving" that no other outcome was possible.

In his essay on Diamond in his book *Eight Eurocentric Historians*, James Blaut struggled with Diamond's argument, ultimately pinning him with the charge of "environmental determinism," a charge with which Diamond would likely agree. Other critics have sensed — with the hints of group-ascribed superiority and inferiority in Diamond's thesis — the presence of nineteenth century racialism, but this accusation also falls on shallow ground. Diamond casts his argument in explicitly anti-racial terms, indeed, to the point where he has been attacked for doing so from more radical conservative quarters, where merit is still found in racial pseudo-sciences.

Diamond, a natural scientist with a populist body of work, could within reason accuse anthropologists and historians of excessive gatekeeping and boundary policing. Without a full understanding of Diamond's historicism, and the theories of the history of science and knowledge acquisition that underlie his work, these accusations might even seem credible.²⁷³

²⁷³ James M. Blaut, *Eight Eurocentric Historians*, New York: Guilford Press, 2000.

Mutual interest in the anthropological principle of diffusion aside, Diamond and McNeill actually conceived of history-writing quite differently in epistemological terms. While Diamond's work hews to the positivist tradition of Comte, McNeill struggled consistently with the epistemological implications of his work, finally calling publicly in 1986 for historians to embrace — critically, to be sure — the “myth making” component of their profession, which he cautiously dubbed “mythistory.”²⁷⁴ As Jerry Bentley wrote nearly two decades later in a far-reaching essay on the state of World History-writing, McNeill called for a break with the national historical mythologies of the past and the undertaking of a “mythistory” that encompassed humanity as a whole.²⁷⁵

Although he offers no explicit debt to Nietzsche, McNeill's argument is entirely reminiscent of Nietzsche's exhortations that national myths functioned as both sources of national cohesion and markers of the collective health or sickness of the societies that produced them. And while McNeill expressed concern about the obvious — and recent — capacity of national myths to wreak large-scale destruction, and, in many respects, later recanted his call for “mythistory,” the project has been carried on by others.

With the publication of Christian's *Maps of Time* in 2005, a sub-genre of World History calling itself “Big History” proceeded programmatically, advocating a world historical narrative framework that begins, quite literally, with the beginning: “big bang” cosmology, as it has developed since the early twentieth century. Big Bang cosmology developed first amongst experimental physicists attempting to incorporate the theory of relativity into what had been a Newtonian framework for understanding the size and shape of the universe, and then later by engineers attempting to trace the origins of errant microwaves and discovering with the help of physicists that they originated in a 14-billion year old explosion. Big History's master narrative proceeds from there to explain the instability of hydrogen and the role of that instability in creating the chemical building blocks of the universe as they projected outward. The narrative continues to the formation of the Milky Way, the solar system and the Earth. At this point, the earliest carbon-based life forms are introduced and evolutionary process is summarized. In *Maps*

²⁷⁴ William McNeill, “Mythistory, or Truth, Myth, History and Historians,” *The American Historical Review*, 91, 1, February 1986, 1-10.

²⁷⁵ Jerry H. Bentley, “Myths, Wagers, and Some Moral Implications of World History,” *The Journal of World History*, 16, 1, March 2005, 51-82.

of Time, as well as in the courses in “Big History” that have been taught at a handful of universities around the world by Christian and others since the late 1980s, *homo sapiens* traditionally does not enter the story until mid-way through.

From this point forward, Big History is unique amongst self-consciously world narratives in that it successfully refrains from falling into comparative civilizational histories, a task most world historical narratives set out intending but are unable to do. Big History relies on strict, if broad, periodization to provide its narrative structure, within each period beginning with a range of climactic data and then making broad inferences about what humanity as a whole was doing during that time with reference to demographic data and statistical models of energy production and consumption borrowed from physics. *Ad hoc* models for assessing rates of technological innovation are deployed as well. *Maps of Time* finally arrives thunderously at the present, glancing at the future in a manner historians do not normally allow themselves, soberly weighing the dangers of climate change against the capacity of human beings to solve problems and reinvent themselves.²⁷⁶

This is where it becomes clear that Christian has taken up McNeill’s call for a global mythistory, but with a subtly different arrangement of priorities. Big History is concerned with creating a secular version of ecclesiastical history, one that encompasses Big Bang Theory as well as Darwinian principles of evolution via selection. In other words, Big History is an attempt to create a secular historical vision that purports to do what religion does: explain, authoritatively and accessibly, what human beings are, where they come from, and where they are going. The project is conceived in response to a perceived intellectual threat from a combination of generalized scientific illiteracy (brought about by failures in the American educational system) and from religious fundamentalism in general and “biblical literalism” in particular.

In an article in *History and Theory* in 2010, Christian addressed these historiographical issues head-on, with a programmatic call for the return of “Universal Histories” reminiscent of Toynbee, Spengler and Wells, a genre he felt had fallen out of favor to the professionalization of the historical research and teaching in the late

²⁷⁶ David Christian, *Maps of Time: An Introduction to Big History*, Berkeley: University of California Press, 2011.

nineteenth century according to rules of research, evidence and specialization dictated by Leopold Von Ranke. Since then, Christian argues, historians became specialists, afraid to make overarching philosophical arguments, for fears that those arguments could not withstand scientific laws of proof. Whatever universal ambitions remained in the historical profession, Christian argues, were wiped out by the influence of literary postmodernism, which for him, writing in 2010, were still best embodied by the writings of the French philosopher Jean-Francois Lyotard, whose theory of the demise of “grand narratives” exercised considerable gravity upon literary theorists of the 1990s.

For Christian, this comes at the expense of the apprehension of “large patterns” in human development that are crucial for understanding humanity as a whole, and for apprehending its future. But curiously, on a programmatic level, the call for universal histories calls for two seemingly contradictory movements: the movement away from Rankean rules of evidence, and the move toward the synthesis of the historical profession with those of the natural sciences. These two movements are difficult to reconcile, and Christian does not attempt to do so.

Aware, however, thanks to his postmodern critics, of the charge of “essentialism” frequently leveled against totalizing projects such as his, Christian approvingly quotes a 2009 article by the postcolonial historian Dipesh Chakrabarty entitled “The Climate of History,” which, according to Christian, asserts that global histories needn’t be essentialist in nature.²⁷⁷ Taken in the fuller context of the complete article however, Chakrabarty’s meaning seems very different and, importantly, of direct relevance to the problems faced by historians attempting to assess what does, and does not, happen when a particular historical question responds to calls for historical questions to be situated “globally”: what is gained, what is lost, what ontological assumptions are made, and what are the costs and benefits of those assumptions.

Chakrabarty’s essay, like many before, engages with the question of whether an epistemological stance based on a universal is possible, or desirable. In *Provincializing Europe*, Chakrabarty made a powerful argument for the bifurcation of “history” into two distinct but intersecting ideas: “History 1” — the progressive advance of Hegel’s “World

²⁷⁷ David Christian, “The Return of Universal History,” *History and Theory*, 49, December 2010, p. 6-27.

Spirit,” i.e. a universal, teleological history, which subsumes particulars and “History 2” — corporeal history, time as experienced by individuals and societies in particular places. The purpose of *Provincializing Europe* was to situate “History 1” as an idea in a spatial and temporal location: that of Enlightenment Europe. This “denaturalizing” process then renders visible the influence of European intellectual currents upon the rest of the world during the colonial era, which in turn makes possible, when examining the contemporary world, to expose and extract the hidden ontological elements in political and social theory which render the postcolonial world seemingly static and unchanging.²⁷⁸

This relationship between the universal and the particular has been of ongoing interest to postcolonial theorists, many of whom have taken a less nuanced view than Chakrabarty’s. Such is the case with the historian Vinay Lal’s aforementioned essay “The New Malaise of World History” which attacked the enterprise of World History writing — in many ways the current embodiment in American scholarship of the search for a universal history — as Eurocentric and imperialist by its very design. In Chakrabarty’s 2009 essay “The Climate of History,” an alternative thesis cautiously emerges. The article is built around four theses related to the historical profession and the science of global climate change. Chakrabarty begins by acknowledging that, though a scientific layperson, he is sufficiently moved by the scientific literature aimed at educated laypersons on the subject of climate change, that he feels the historical profession owes it a response. This response, however, by necessity must address in a compelling manner the ambiguities, ambivalences and intellectual and political difficulties created by the idea of a universal history because, he argues, the reality of global climate change compels human beings to respond to it as a species. This species-wide response, he argues, compels historians to revisit once again the possibility — and desirability — of a “species history.” Prior to this, however, he encounters a controversy among climatologists which historians must address before proceeding: At what point did the anthropocene — the geological era in which human beings as a species developed the ability to negatively impact the Earth’s climate — begin, or indeed, has it begun at all? The issue is controversial, but Chakrabarty adopts the position which has increasingly

²⁷⁸ Dipesh Chakrabarty, *Provincializing Europe: Postcolonial Thought and Historical Difference*, Princeton: Princeton University Press, 2000.

become accepted: that the dawn of the anthropocene roughly corresponds with the earliest stages of the industrial revolution and, as such, histories of human-derived climate change and histories of the global movement of capital are inextricably linked.

He then advances the problem in four theses:

That climate change lays waste to the traditional distinction between human and natural history, the idea of the anthropocene demands drastic revisions to existing humanist narratives of modernity and globalization, the geological realities of the anthropocene require historians to link histories of climate change with history of capital and, finally, doing so will push the limits of historical understanding far past their current horizons.²⁷⁹

This is possible, Chakrabarty argues, by conceiving of a human history that is both universal and “negative” in the sense expounded by Adorno, in that it does not attempt to dialectically subsume contradictions but to maintain them. In other words, Chakrabarty calls for a history that is “global” but without “the myth of a global identity.” He marshals recent writings by the Nobel-prize winning economist Joseph Stiglitz, as well as E.O. Wilson, as examples of diverse and planetary-minded scholars who have sensed the urgency of climate change and its inextricability with the history of capital.²⁸⁰

This “negative” universal history has been described in more detail by the political scientist Antonio Y. Vázquez-Arroyo in his 2008 essay “Universal history disavowed: on critical theory and postcolonialism.” Vázquez-Arroyo engages directly with Chakrabarty’s “History 1” and “History 2,” as well as the Adorno’s extended meditations on Hegelian and Kantian conceptions of universal history, concluding that a negative universal history is the only place where academics might constructively engage with a problematic body of assumptions that have simultaneously “nurtured and curtailed” postcolonial theory.²⁸¹ A simpler idea advanced by the historian Timothy Burke is that perhaps particularism can itself be advanced as a “big idea” — one which

²⁷⁹ Dipesh Chakrabarty, “The Climate of History: Four Theses, *Critical Inquiry*, 35, 2009, 199.

²⁸⁰ Dipesh Chakrabarty, 197-222.

²⁸¹ Antonio Y Vazquez — Arroyo, “Universal History Disavowed: On Critical Theory and Postcolonialism,” *Postcolonial Studies*, 11,4, 2008, 451-473.

responds to the meta-narratives of sociobiology, evolutionary psychology and universal history.²⁸²

Global Medical Histories

Chakrabarty's richly historiographical understanding of the two-century span of attempts to create histories which are in some sense all-encompassing provides a better template to examine the possibility of a global history of health, illness and medical practice than might be found in the aggressive positivism of Diamond or the self-conscious mythmaking of McNeill or the curious hybrid of the two offered by Christian. To whatever extent "health" can be stretched to the same sort of species-wide status Chakrabarty grants "climate," it must then, like climate, be brought into conversation with histories of capital. If the overarching subject of this work — a transnational organizing ring operated from private hospitals and clinics in wealthy neighborhoods of London — is to be considered global in the sense demanded by World History as a field, then it must be held to the same standard as other non-medical world histories. First, however, some recent medical histories which claim — however ambivalently — to be global in scope can be examined.

The British medical historian Roy Porter's *The Greatest Benefit to Mankind* is an unambiguous attempt at a comprehensive "medical history of humanity." Its aim is not a history of medicine that is global in scope but rather a world-historical project told through the lens of medical discovery. Published in 1997, a few years before Porter's death, *The Greatest Benefit to Mankind* follows the traditional structure of most World History curricula taught in American college classrooms: Paleolithic humanity is presented as a more or less unified (though, beginning at least 50,000 years ago, geographically disparate) whole. From the Neolithic era onward, human societies are dealt with discretely, more or less following a pattern familiar from Spengler, Toynbee, *et*

²⁸² Timothy Burke, "Particularism as a Big Idea," *Easily Distracted*, February 20, 2013, <http://blogs.swarthmore.edu/burke/blog/2013/02/20/particularism-as-a-big-idea/> Burke has not as yet fleshed this idea out in a formal academic work.

al: emphasis is placed on the Eastern Mediterranean and, to a lesser extent, Northern Africa and Persia. In terms of medical knowledge, these areas are treated as a cultural complex, the repositories of an intellectual tradition that passes first to the Western Mediterranean and then, by the early modern period, to Northern Europe. China and India are dealt with in discrete chapters, the assumption being that while each developed a tradition of medical theory and practice that can be considered “great” in some historical sense, both ultimately dead-ended beginning with the ascension of Western Europe in the sixteenth century. From the sixteenth century onward, “global” medical history is taken to be an extension of European medical history, via the usual mechanisms of colonialism and technological diffusion via increasingly interconnected communications infrastructure.

Purely as a work of medical history, *The Greatest Benefit to Mankind* is a distinct methodological departure from nearly all of Porter’s work. When he entered the field, medical history was known for an old-fashioned Whiggish approach to historical process, in which demographic changes produced new public health problems, which belabored humanity until they were solved by forward-thinking and often iconoclastic individual practitioners, whose advances then made the further advances of future iconoclastic problem solvers possible, in what might be thought of as a dialectic of medical discovery, leading inexorably (although after the Second World War, it was acknowledged with some unpleasant detours) to a better future. Porter, taking a cue from the tradition of English social historians such as Christopher Hill and E.P. Thompson, advocated a medical history “from the patient’s perspective.” *The Greatest Benefit to Mankind* was a marked reversal from this approach, a fact about which Porter expressed some self-consciousness.²⁸³

In a specifically medical world history, the Neolithic revolution is of equal importance but for different reasons: sedentary existence, population growth and, most importantly, the domestication of animals all laid the groundwork for the spread of “herd” diseases among human populations, particularly in early urban settlements throughout Eurasia. The same is true of the Colombian Exchange, viewed principally

²⁸³ Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity*, New York: W.W. Norton and Co., 1997.

through the lens of the spread of smallpox throughout the pre-Columbian population of the Americas, and of the industrialization of Western Europe and North America, viewed principally through the lens of a suddenly and massively expanded urban population plagued by Yellow Fever epidemics and other diseases brought about through increased population density and poor sanitation.

Porter's treatments of India and China are interesting, if perfunctory, for the fact, conveyed in passing, that the Chinese and Ayurvedic traditions, like the "Western" tradition he distances them from, conceptualized health in terms of bodily "humours" — qualities like heat, cold, dryness and wetness that were required to be in relative balance in order for a human being to be considered healthy. In the humoral tradition, nearly all ailments were attributed to an excess of one humour or the deficiency of another.

According to Porter, "Western" medicine diverged from the humoral tradition principally because of vivisection. Out of the willingness of individuals like the Roman physician Galen — and his many Persian, Greek and Egyptian predecessors — to dissect and examine the corpses of humans and animals (in Galen's case, live animals), came not only detailed, firsthand anatomical knowledge, but a nascent empirical tradition of observation and experimentation that could be passed on from generation to generation. This tradition laid important groundwork over long periods that would eventually culminate in scientific divergence of the nineteenth century into the science of bacteriology, which itself was indispensable for the development of modern surgical medicine, the basic principles of hygiene and sanitation, and modern immunology and vaccination.

Porter ends on an ambivalent note, observing that human beings in the industrialized world in the 1990s are demographically healthier — longer life expectancy, less infant mortality, etc. — and yet more anxious about health than ever before. This ambivalence, he argues, has occurred because the western medical tradition has become a victim of its own success. Described as "impotent" from the Axial age until the end of the First World War, Porter argues that the developing tradition of anatomical medicine remained for the most part the province of elites and, with its relatively minor ability to

treat or prevent infectious disease, had little impact upon people's lives. As such, its practitioners enjoyed little authority or public prestige.²⁸⁴

During the twentieth century however, an era of unprecedented medical research and discovery, millennia-old scourges such as smallpox and polio were all but eliminated. As such, doctors enjoyed a powerful, albeit brief, period of social deference. This was quickly revoked, however, as rising expectations for health and life expectancy ultimately made doctors the targets of ire and mistrust, as they had been in the eighteenth century when they were associated with grave-robbing for medical dissection and “quack” medicines.

The blame, Porter finally finds, lies with “medical consumerism” — the “medicalization” of what had previously been considered part of the rhythm of daily life, coupled with the over-prescription of medications and, more generally, unreasonable expectations related to life expectancy. Porter saw no end to this process. In it, he saw a “Pandora’s box” not unlike the one commonly used to describe the unleashing of infectious “herd” diseases by the domestication of animals. By locating the genesis of an episteme that is both empirical in method and medical in content in the Ancient Near East and then moving it through the Mediterranean, the Middle East and, ultimately, Europe and North America, downplaying its extensive similarities with other medical traditions in other locations and temporalities in both the “new” and “old” words, Porter mimics the narrative structure of McNeill, et al. By mimicking the narrative structure of the dominant mode of World History, *The Greatest Benefit to Mankind* also mimics its ambiguities and paradoxes.²⁸⁵

All the works examined thus far have set out, in some sense, to be global or universal or nature. In doing so, all of them have encountered by now predictable limitations. On one hand, if they attempt to impose a coherent narrative upon humanity as a whole, they recreate hegemonic acts of inclusion and exclusion of populations, geographies and time periods. If, on the other hand, they take “universal” literally, they risk incoherence.

²⁸⁴ Ibid., 9.

²⁸⁵ Ibid., 710-718.

Alternative strategies exist, although they do not present themselves as overtly global. Increasingly in the last two decades, historical works have been written that take as their subjects events or phenomena that occur transnationally but within a more or less condensed time frame. As such, they mimic the narrative structure of a Frederick Forsyth novel, with events occurring simultaneously across great distances, with actors easily (or with difficulty) traversing national boundaries, and with problems and catalysts that are by nature multi-sited. These works do not purport to swoop up all of human history in a single narrative embrace, but they do present historical movement upon what, at least superficially, appears to be a global *topos*. One such work is Matthew Connelley's *Fatal Misconception*.

Fatal Misconception is at once a history of intellectual currents and of popular movements. The former begin with Thomas Malthus' eighteenth century theses on population growth, continue through the eugenic theories of Galton and his successors and their ultimate reinvention as demographic theories of overpopulation. The latter begins with the eugenics movement of late nineteenth and early twentieth centuries, elides into the movement for reproductive rights movement of the early twentieth century and ultimately arrives at the post-World War II movement to stem global population growth.

Connelley's thesis is that many of the early successes of the movement for contraception and reproductive health — which have since led to unparalleled improvement in the lives of both women and men — were attributable to widely held eugenic anxieties — often tinged with racism or xenophobia — about the reproductive habits of the poor. Key figures in the history of the reproductive rights movement — as well as the women's movement — such as Margaret Sanger, often framed their arguments in specifically eugenic terms. This, Connelly points out, is not intended as indictment of the movement itself, but is indicative of the overwhelming cross-spectrum support enjoyed by eugenic theories prior to the Second World War.

Fatal Misconception traces both of these intellectual and political movements over more than a century, as the eugenics movement wends its way from near-universal acceptance to near-universal dismissal and the reproductive rights movement goes from

being seen as a radical challenge to millennia-old social conventions to a widely (though not universally) accepted standard of public health and political empowerment.

These journeys are themselves intertwined with the demise of formal colonialism, the rise of American geopolitical power and the profound technological changes that characterized the twentieth century. Perhaps most important in understanding these processes are the proliferation of international organizations — be they strong or weak, binding or advisory — during the twentieth century, as well as unprecedented population growth. For these reasons, much of *Fatal Misconception* takes place at conferences held around the world, where activists, lawmakers and physicians cross paths while pursuing divergent agendas. It is for this reason that Connelley's transnational subjects and their convergent story come closer to being "global" than most works that explicitly attempt to do so.²⁸⁶

Conclusion

This chapter has surveyed a wide variety of strategies for theorizing the global, in hopes of determining whether "global" or "universal" or "human" is something that a work of medical history can — or should — be. Doing so has brought the larger work of which this chapter is a part into conversation with theorizations of empire that attempt to transcend traditional dichotomies of core and periphery, attempts to invent — and reinvent — "universal" histories that tell the story of humanity as a whole, imbuing it with meaning in ways traditionally associated with metaphysics, as well as the pedagogical tradition of "Western Civ." It has examined claims that such universal histories should mimic the natural sciences and concern themselves with the formation of historical "laws" which, presumably, can be used for predictive purposes by policy makers. The opposite claim has been made as well: that such universal histories perform an important collective mythmaking function, one imperative for the creation of a cohesive global identity.

²⁸⁶ Matthew Connelley, *Fatal Misconception: The Struggle to Control World Population*, Cambridge: Belknap, 2008.

This chapter has also examined trenchant criticisms, rooted in postcolonial and critical theory, of the very nature of a “totalizing” project like world history. The possibility of a universal history, however, is not fully discounted, provided it does not subsume particularities. If a global medical history is possible, it must take such provisos into account. It is perhaps in the transnational staging of events that Burke’s idea of particularism as a “big idea” finds fruition. The story of Doctor Crockett and his patients is made more intelligible through a similar act of transnational staging.

More generally, the question of the validity of World History is often posed as though, once answered, it will lead to a final acceptance or final dismissal of World History as both a field of study and an area of research. No institutional or intellectual mechanism exists to perform either task. World History makes “totalizing” claims in an intellectual era which has largely discredited such claims, and thus appears, when compared to other historical fields, under-theorized. Nonetheless, it persists. This is largely because, even if “totalizing” claims are no longer theoretically justifiable, there is still apparently a need for them that extends beyond the academy.

CONCLUSION

The primary purpose of this dissertation has been to detail as thoroughly as possible an incident in the brief history of the illegal trade in human kidneys that has up until now largely been ignored: a syndicate of private hospitals and clinics in 1980s in which impoverished individuals from Turkey, India and Pakistan were flown to the United Kingdom to be paid kidney donors for a client base largely composed of foreign nationals. I have contended throughout that, through its decade-long existence, this operation was a combination of greed, opportunism and blunder, made possible largely by the brief expansion of the private for-profit hospital sector in London, itself made possible primarily by a political bargain between doctors and hospital staff, brokered by the National Health Service, to relocate private care from special wings of publicly run hospitals — where the presence of “pay beds” was considered both offensive and irritating — to privately run hospitals. These hospitals, always a tiny sector of the already tiny private health care industry in Britain, underwent further expansion when a Conservative government took office in 1980 and undertook cautious and mild program of liberalization of health care services.

These reforms were enough to spark a flood of investment capital, largely from the United States, which quickly saturated itself in an environment where demand for private care was very limited. The transplant operations with which this dissertation is principally concerned took place in underutilized hospitals, far from the normal regulatory mechanisms of the National Health Service. The practice of buying and selling kidneys in this environment came to an abrupt halt in 1989 when it was discovered by journalists and the general public. What followed was a rapid and decisive reassertion of authority by the regulatory bodies upon whom the British health care system, both public and private, had traditionally relied.

While this rapid reassertion of authority largely managed to banish the practice of kidney donation from the United Kingdom, the practice itself simply returned to where it

had first appeared: South Asia and the Middle East, where it has by and large remained ever since.

If the above events are successfully added to the annals of the history of global organ trafficking, and properly contextualized, then this dissertation has achieved its primary purpose. Other questions remain, however, and these will be addressed below.

From the Eugenic to the Prosthetic

Within a decade of the publication of *The Origin of the Species by Means of Natural Selection*, the principles of what would eventually become evolutionary science (augmented by Mendelian genetics) were adapted to a complex and politically charged pseudoscience concerned with relative health and dis-ease of human populations. By the end of the nineteenth century, this pseudoscience of population health, generally referred to as “eugenics,” had begun to dovetail with the nascent pseudosciences of racial difference that would find their ultimate expression in the Nazi social sciences of the 1930s and their widely documented attendant social policies.

While not all strains of eugenic thought, research and planning were racially oriented, virtually all of them accepted, at least in principle, the idea that “inferior” physical and cognitive traits could and should be eliminated — and “superior” traits encouraged — through selective breeding. This selective breeding could either be positive in nature — encouraging the fit — or negative - discouraging the unfit. Further, it cannot be emphasized enough, in the early through the mid-twentieth century, eugenic thought had widespread support across the entire political spectrum, from far right to far left. Dissent was muted and considered a reactionary and reflexive phenomena, the biggest voice of which was the Catholic Church.

The end of the Second World War and the discovery of the full extent of programmatic genocide, rationalized in eugenic terms, set eugenic thought on the defensive, with seeming permanence. Too big, and with simply too much institutional support to simply fade away, eugenic thought and its practitioners dispersed over the next

few decades. Faint strains of eugenic thought could be heard on the radical fringes of the environmental movement and in studies of “overpopulation” that began in its wake.

Eugenics was above all about human perfectibility. Conceived and conducted on a macro-population level, steeped in the imperial prejudices of its day, it failed spectacularly, at a cost, some would argue, of many millions of lives. Banished from scientific respectability, it left a void. As I attempted to demonstrate in Chapter 1, there is strong reason to believe that what Joshua Lederberg referred to as “euphenics” — the *a fortiori* quest for human perfectibility, conducted on an already existing human being, and on an individual, rather than population level — is what came next.

The term did not catch on. Instead, critical theorists of the 1980s inspired by Foucault’s biopolitics, began to invoke the prosthetic, a term with many overlapping meanings to Lederberg’s notion of the euphenic. The prosthetic, as it has been generally understood, is not so much a thing that augments our humanity as it is an externality that allows us to define and redefine what it means to be human. This dissertation has attempted to make room for the fraught history of renal transplantation in the rich critical literature related to biopolitics of prosthesis.

If the eugenic sciences were a widely held social paradigm for biopolitical optimism, then so are the euphenic sciences. And, from the vantage point of the American academy in the early twenty-first century, the former appears to be a considerable improvement over the latter. But the euphenic worldview is not without its perils: Euphenic technologies have been conceived and executed in a state of permanent scarcity. From the moment renal dialysis entered the mainstream therapeutic lexicon, there were not enough dialysis machines. From the moment transplantation became an immunological possibility, there were not enough transplantable organs. If the eugenic worldview spoke to rigid and brutal hierarchies of worth, the euphenic worldview speaks to less brutal hierarchies of access.

Globalization and the Global History of Medicine

Attempts to frame history “globally” or as universal history are fraught with the perils of historicism, determinism or, worst of all, social Darwinism. This is largely because world historians have been unable to reconcile the tradition of writing human history as the rise and fall of civilizations with the need to present human history with the history of humans as the members of a Linnaean genus (*Homo*) and species (*Homo sapiens*). Civilizational history is in no sense “universal.” It is a collection of stories of rises and falls of different socio-geographic civilizational complexes, different ones of which are assigned primacy and/or treated as normative depending on the biases of the author. Whichever is assigned primacy then becomes the model for what constitutes a civilization, and the others are viewed in relation to it.

For human history to be universal in any meaningful sense it must be the history of all of humanity, ergo it must be the history of *Homo sapiens*. And it is here that the greatest cognitive dissonance occurs amongst historians, and all others charged with debating the global versus the local, structure versus agency, or any of the current crop of dualisms that the academic profession in Europe and North America inexhaustibly produces. The recognition that a history of humanity must be a history of a species sets off alarms, and it does so for a number of reasons:

First, it threatens disciplinary integrity, implying as it does that the roles of sources and evidence and analysis that typically govern historical research are insufficient and must be replaced with the less interpretive rules of evidence and method that govern research in the “hard” sciences.

Second, it harkens back to the bad old days where racism (or, at least biological racial difference as a determiner of social behavior) was a near-universal conceit of historians, or where, at the very least, humanity was divided into “races” whose biological reality was immutable.

Third, because of long-running disciplinary politics within the evolutionary sciences, the version of evolution that is exported to the social sciences is a highly simplified and deterministic one, one that assumes that evolutionary processes

axiomatically trend toward an end point of maximum efficiency and that principles of natural selection can be applied to social groups. Both are highly disputable, if not flat-out unprovable assertions. But the deterministic view of evolution by natural selection is also the one shared by most of the authors and scientists who have chosen to produce world-historical texts and to advocate for “scientific” histories of the world and its human inhabitants. Rarely does anyone attempt to export or popularize the more nuanced and contingent view of evolution via natural selection shared by most practitioners of evolutionary sciences to social scientists or historians.

Economic globalization, another key component of the narrative of the commoditization of the human body exemplified by paid-donor kidney transplants, suffers from the same problem. “Globalization” can be analytically meaningful if used to describe an arrangement of legal, political and economic circumstances spread unevenly across national boundaries at a particular time, overdetermined to a multiplicity of historical factors. If viewed as an inevitable “stage” in the history of capitalism, it becomes analytically self-defeating: a reductive trope that eclipses particularities in the name of establishing a dominant historical narrative to which facts must be fitted, or discarded if they don’t fit. As this dissertation has attempted to show in its assessment of Thatcherism as a political phenomenon of the 1980s, what is presented as a determined and deliberate ideological engine of historical change often turns out to simply be a series of contingent responses to both crises and opportunities, upon which coherence is imposed after the fact.

Global history is possible, and perhaps even desirable, if it can be performed not as a comparative history of “civilizations,” but as a study of what it means to be human, and how that meaning has changed over the course of thousands (since the origins of agriculture and written language), or perhaps hundreds of thousands (since the origins of *Homo sapiens*) or perhaps even over a million (since the origins of *Homo erectus*) years. That said, however, this expansive and inclusive vision of global history is only productive and intellectually honest if it avoids the deterministic and divisive conceits of sociobiology. Evolutionary gradualism is far from universally accepted by evolutionary biologists. Historians and anthropologists should not allow themselves to be intimidated

into believing otherwise. A meaningful global history can, and must, address humanity as a whole without resorting to imagining conflicts between human groups as reflecting an oversimplified vision of Darwinian principles of natural selection.

If medical histories like this dissertation are to be considered global in any sense, then these principles apply doubly. Concerned as it is with the biophysical realities of human existence, a global medical history must embrace the biological realities of human identity without falling into the many traps laid by biological determinism and Social Darwinism.

The Human Commodity

In the rich ethnographic literature devoted to the sale of kidneys and other human tissue, reference is invariably made to the “commodification” of the human body. In understanding the events with which this dissertation is concerned, this notion is challenging but ultimately unhelpful. To speak of commodification is ultimately to reproduce a conceit of economic theory and, indeed, of the entire ontology of “modernity”: that “the market” constitutes a set of relations devoid of social context. In other words, to argue that the buying and selling of human body parts reduces the human body, and humanity itself, to a monetized commodity, is to reproduce the fiction that market relations are wholly a-social.

This dissertation asserts otherwise: that capitalist social relations are precisely that: *social* relations, different, and perhaps more exploitative than other forms of social relations that exist and have existed in other economic regimes, but social nonetheless. To suggest otherwise is to reproduce the central fiction of the nineteenth century bourgeois intellectual: that capitalism (or “the west” or “modernity”) has a monopoly on rationality. Whether this argument is made by proponents or critics of that rationality makes little difference. This dissertation has chronicled the rise and fall of a set of largely *ad hoc* institutions and practices dedicated to the exploitation of human misery: both the misery of poverty and the misery of congenital organ failure. These institutions and

practices no more represent the triumph of “the market” or of a cold post-human rationality than they represent the triumph of medical ingenuity over kidney disease. Rather, they constitute a set of opportunistic and shortsighted maneuvers built upon a series of social relationships — classist, neoliberal, post-imperial — that made them possible.

Storytelling

Imaginings of fantastical transplantation scenarios predate real-life renal transplantation by many centuries. When concerning itself with fictions, however, as it does in its final chapter, this dissertation has largely confined itself to two types of fictional narratives of organ selling. In one, victims are compelled by desperation to sell a kidney or, in some cases, another less superfluous body part. These stories have plentiful real life analogs, as the bulk of this dissertation should make clear. In the other, victims are lured, tricked, duped and or manipulated into situations where their organs are forcibly removed. These have analogs in the “organ theft” legends tracked worldwide by folklorists since the 1980s. Both organ selling and organ stealing have been featured as narrative tropes in television and film dramas, thrillers and horror stories the world over for more than three decades.

Together, it appears, they form the two poles of collective anxiety related to commercial renal transplantation and, ultimately, they ask questions very similar to the questions asked by the philosophers, ethicists, ethnographers and economists discussed in Chapter 1 who are concerned with the efficacy of legalized organ selling: Can a person who sells a kidney out of economic desperation truly be considered capable of consent? Is the everyday, real-life structural violence of extreme poverty discussed in Chapter 2 truly different than the violence of the imaginary sadistic killer who murders unwitting victims and sells their organs in the countless film and television plots discussed in Chapter 5? Either way it is clear that the real-life organ selling scandals of the 1980s and the more existentially-rooted organ theft legends of the same period gave way to a

tapestry of imaginative fiction beginning in the 1990s where both scenarios will play out inexhaustibly on television and theater screens the world over until they are eclipsed by some other, greater anxiety.

Analytically, I have asked a great deal of Doctors Crockett, Bewick and Joyce, their patients, and most of all their paid renal donors: I have asked them to explicate larger historical trends and economic principles. I have asked them to serve as proof of some historiographical and ethnographic principles, and as disproof of others. In doing so, I am perhaps another in a long line of exploiters they have encountered, in my case mining their stories for intellectual and ethical capital. In doing so, however, I hope I have at least spared them the “enormous condescension of posterity” of which other historians have spoken.

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