A Finger in the Wound: On Pain, Scars, and Suffering

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Despite decades of clinical medical research using brain imaging, MRI, and CT scans to unravel the secrets of suffering, pain remains an elusive, ineffable, and highly subjective phenomenon. Pain is difficult to communicate. It is a complex experience that includes sensory, emotional, social, historical, and cultural components. Family practice doctors, emergency room doctors, and internists still ask their patients to describe their pain by a simple calculus: 1 to 10. The continuum of pain ranges from manageable (1 to 3), to moderate (4 to 6), to severe (7 to 10), this last category referring to pain that is intense, excruciating, and unspeakable. However, even patients who are diagnosed with comparable symptoms and diagnoses are likely to evaluate their pain quite differently. The unbearable pain of one patient is moderate pain to another.


3 Irving Kenneth Zola, “Culture and Symptoms—An Analysis of Patients’ Presenting
Patients describe pain with a broad lexicon of metaphors: pain is sharp as a knife, stabbing, throbbing, burning, itching, numbing, tingling, or like pins and needles. While some patients can point to the exact location of the pain—it’s in my stomach, my gut—others say that the pain starts “up here” or “down there,” or that it is not localized at all. Patients in different cultures identify pain and suffering with invisible spaces or floating organs. Labor pains vary both across the globe and from person to person, from those who cannot tolerate it without medication, massage, and/or self-hypnosis, to those who are capable of giving birth without any help at all.

Many clinical studies have explored perceptions of pain and pain-coping strategies of Black, Irish, Italian, Jewish, Anglo-Americans and Puerto Rican patients. In his book, *People in Pain*, Mark Zborowski carefully examined modes of emotion and expression of pain among Anglo-Saxon Protestant, Irish, Jewish, and Italian patients at a Veterans Administration Hospital. He reported that Jewish and Italian patients were more likely to express pain freely than either Irish or Anglo-Saxon patients. Jewish patients were concerned with the meaning and consequences of their symptoms while Italian patients simply wanted relief from the pain. At roughly the same time, Irving Zola, another early researcher, compared Catholic Italian, Irish, and Anglo-Saxon Protestant patients attending the Ear and Eye Infirmary at Massachusetts General Hospital in Boston. The Irish and Anglo-Saxon patients tended to minimize and even deny the presence of pain, while the Italian patients, once again, freely expressed their pain.

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African American patients have been found to be more likely to attribute their pain to something they have done wrong.⁴

**The Embodiment of Pain**

Margaret Lock’s and my 1987 essay, “The Mindful Body--a Prolegomenon to Future Work in Medical Anthropology,” emerged out of our profound dissatisfaction with the limitations of our discipline and field of inquiry.⁵ What good, after all, was a medical anthropology that was simply a convenient application of anthropological ideas and methods to clinical models of illness, pain, suffering and healing? We wanted our field to be transformative, both theoretically and in terms of praxis. So we began to sketch a framework suggesting what medical anthropology could do beyond an empathic handholding of doctors and patients. We questioned the body as a cultural, historical, medicalized, naturalized, and universal object. We introduced the notion of embodiment, or how people, individually and collectively, live in and experience the body-self. We devised a tripartite framework of the “three bodies”: the individual body/the body self; the social body; and the political body or the body politic. The three bodies represent three different, but overlapping, levels of analysis and theory: the existential/phenomenological/ontological individual body; the social structural/symbolic (the social body); and a feminist/neo-Marxist, Foucauldian body as a site of power/knowledge (the political body).

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The individual body is a given, bio-psychological, existential reality. It refers to the processes of becoming and being a person, an embodied self. In this instance, the body is seen as a singular, individual, and personally experienced. At the same time, this “individual” body--conceived as the center of perceiving, experiencing, thinking world--is always mediated through collective cultural meanings. The self-evident yet contradictory proposition is that humans both have and are bodies. Our bodies are simultaneously objects of and subject to our “selves.” We could say that we are at one and the same time insiders and outsiders to ourselves. The message of the American wellness movement at the time we were writing was rather crude: “It’s your body. Take care of it.” The body as property meant that you own it and you have the responsibility to take care of it. But on a deeper level, the body is proof of one’s existence. It is through one’s body and its sensory and perceptual circuits that we are able to experience and differentiate among other objects and things in the world. The body, wrote Marcel Mauss, is the “first and most natural tool” of humans. But here’s the rub: how can one simultaneously be “it” and own “it? In his classic work, The Phenomenology of Perception, Maurice Merleau-Ponty argued that although humans are not unique in being embodied, they may be the only species that is en-selved, endowed with self-consciousness, self-awareness, and self-reflection. As a result, they are often painfully conscious of the limits of being-in-the-world. Ludwig Binswanger, drawing on Edmund Husserl and Martin Heidegger, writes of “thrownness”: the idea that bodies are “thrown” into a particular world, place, history and existence without their choosing. Our genetic

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8 Merleau-Ponty, Phénoménologie.
inheritance, generation, environment, and society, our family, race, culture, and history, are thrown at us, as the raw materials out of which to create a life.

On the one hand, then, our bodies are the “tools” with which we perceive, think, and act in and on the world; on the other, bodies can seem to betray us, to defeat us. In extreme situations our bodies can even seem to be an obstacle to our freedom. Bodies can frustrate our basic needs and deepest desires. The suffering of transgender patients is just one example of a body betrayed. One might, like Albie Sachs, lose a limb in a political attack on one’s life. Or, like Diane DeVries, be born without any limbs at all. Or, like hundreds of trafficked kidney sellers, one might experience the pain of a phantom kidney: an organ they never noticed becomes rebellious only after it is removed.

**Nervous Rage- The Madness of Hunger**

In *Death without Weeping: the Violence of Every day Life in Brazil*, based on two decades of intimate fieldwork with a community of impoverished sugarcane workers in a shantytown of Northeast Brazil, I described a people living in a state of chronic hunger so intense that they often lost their physical and their mental balance. The hunger was not an episodic crisis as in a Sub-Saharan African country, but rather a relentless and chronic slow starvation. Often enough the people living in the shantytown of Alto do Cruzeiro, unable to bear the pain of gradual starvation, lost their minds and became irrational, angry and violent. The people of the Alto described this particular form of human suffering as *delerio de fome* – the madness of hunger.

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10 http://adriennemareebrown.net/tag/emma-deboncoeur/
12 Gelya Frank, *Venus on Wheels: Two Decades of Dialogue on Disability, Biography, and Being Female in America* (Berkeley, 2000).
Death from severe malnutrition is not a pretty picture. At death their faces become fixed in a grotesque grimace, one that is referred to as *agonia*, which in Brazilian Portuguese means the intensely painful transition from life to death. In the local idiom a death from starvation is described as a dog’s death because it resembles the symptoms of rabies which people call *raiva*—rage, fury, and madness. To die of starvation is to die as a dog.

The chronic hunger in the Northeast of Brazil in the 1980s forms the backdrop of my discussion of the folk syndrome, *nervoso*, and nervous rage. The agricultural wage laborers from the shantytown of Alto do Cruzeiro, on the margins of a large market town in the plantation zone of Pernambuco, Brazil, sold their labor for less than a dollar a day, resulting in hungry, angry, sick, and afflicted bodies. In addition to epidemics of parasitic infections and communicable diseases, there were outbreaks of unruly and subversive symptoms that could not be identified by the public health post microscope. *Nervoso* produced a cascade of symptoms: trembling, fainting, seizures, blackouts, and the paralysis of the face and limbs. It was accompanied by pain that made some victims mute. Local doctors in the municipal clinic as neurotics rejected the syndrome, as if starvation was a psychosis, a phantasmagoria, a delusion, rather than a painful reality. These nervous attacks were real but they were also coded metaphors through which the sugarcane workers expressed their chronic hunger and need, and also their defiance and dissent. And so, rural workers who have cut sugarcane since the age of seven or eight years will sometimes collapse, their legs giving way under an *ataque de nervos*, a

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nervous attack. They could not walk or stand upright. They were left, like Oliver Sacks, without a leg to stand on.\textsuperscript{19}

In the exchange of meanings between the body personal and the body social, the nervous-hungry, nervous-angry body of the cane cutter offers itself as metaphor and metonym for the nervous sociopolitical system and for the paralyzed position of the rural worker in the current economic and political dis-order. In “lying down” on the job, in refusing to return to the work that has over-determined their entire lives, the cane cutters’ body language signifies surrender and defeat. But it also enacts a drama of mockery and refusal. If nervos attacks the legs and the face, it left the arms and hands free for less physically ruinous work. Consequently, young men suffering from nervous attacks press their claims as sick men on their various political bosses and patrons to find them alternative work, explicitly “sitting down” work, difficult for men who are illiterate and therefore thought of as braceros, people who work with their arms and their legs.

Shantytown women, too, suffer from nervos de trabalhar muito, the overworked nerves from which male cane-cutters suffer. They also experience the gender specific, nervos de sofrir muito: the nervos attacks of those who have endured and suffered much, or have witnessed a violent tragedy. Widows of husbands and mothers of sons who have been abducted and violently “disappeared” are prone to mute, enraged, white-knuckled shaking. Here Michael Taussig’s concept of the “nervous system” as linking the anatomical and the sociopolitical is useful.\textsuperscript{20} The “nervousness” of shantytown residents remains as a response to the jittery and nervous democracy that emerged in Brazil after twenty years of repressive military rule when its presence was most often felt in the is the

\textsuperscript{19} Oliver Sacks, \textit{A Leg to Stand On} (New York, 1984).
late-night knock on the door, the scuffle, and the abduction of a husband or teenaged son. The epidemics of nervos constituted a form of resistance. It publicized the danger, the fright, the abnormality of the normal in a medicalized idiom that protects them from police retaliation. The political nature of nervous pain is only partly conscious and therefore a protected form of resistance.

These symptoms were embodied within a “somatic culture,” by which I mean to suggest that theirs is a social class and a culture that privileges the body and attends to the physical senses and to the language of the body as expressed in symptoms. Here I am following Luc Boltanski, who has argued that somatic thinking and practice is frequently found among the working and popular classes who extract their subsistence from physical labor. Boltanski noted the tendency of the French working classes to communicate with and through the body so that, by contrast, the body praxis of the bourgeois and technical classes appears relatively impoverished.

There have been many changes in Northeast Brazil since I first described the complex syndrome of nervoso. During the years of President Lula and PT, the Workers’ Party, the constant threat of hunger was ended. Nonetheless, to this day there is a fear that bad times could come again. There is a popular nostalgia for a return to an ‘orderly’ military dictatorship. Although access food is no longer a problem and the madness of hunger, delerio de fome, has disappeared from the popular lexicon, nervoso continues to erupt in response to new epidemics of violence by local gangs and gangsters, drugs and arms trafficking, and local death squads targeting poor and Black people from urban favelas.

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Consequently, to this day the people of the young men of Alto do Cruzeiro die young of intentional or stray bullets while their loved ones and their parents are paralyzed with pain and still paralyzed and immobilized by nervoso.

**Scars: Embodied Memories of Kidney Trafficking**

In the early 1980s, a new form of human trafficking, a global trade in kidneys from living persons, emerged in the Middle East, Latin America, and Asia. The first scientific report on the phenomenon was published in *The Lancet* in 1990, documenting the transplant odysseys of 130 kidney patients from three dialysis units in the United Arab Emirates and Oman.25 Those patients travelled with their private doctors to Bombay (now Mumbai), India, where they were transplanted with kidneys from living “suppliers” organized by local brokers trolling slums and shantytowns. The sellers were paid between $2,000 and $3,000 for a “spare” organ. On return, the “transplant tourists” suffered alarming rates of post-operative complications and mortalities, the result of mismatched organs, infections, HIV, and Hepatitis C. There was no data on the adverse effects on the kidney sellers. In 1997, I cofounded Organs Watch to draw attention to the then invisible population of kidney “suppliers.” Elsewhere I have described the criminal networks of kidney trafficking and how they operate.26 Here I will focus on the scars that are left not

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only on the ruined bodies of defrauded and deceived kidney sellers, but also on the geopolitical landscapes where the illicit transplant trade has taken root.

In the summer of 2009 I received a phone call that unnerved me. “Are you the Organs Lady?” a young man I’ll call Jim Deal asked me with a slight tremor in his voice. “Perhaps,” I replied.

“How can I help you?”

“I just found out that my kidneys are failing and my doctor wants me to start dialysis immediately.”

“Yes?”

“Well, I can’t attach myself to a machine three days a week. I’ve just started a new company and I can’t lose a minute. I need a kidney now. Where can I go to get one? Money is not an object.”

My suggestion that he ask his relatives (which included several siblings) was rejected; they were all busy with their careers and families. He could take the “Steve Jobs option” registering in multiple transplant centers in different regions of the US, increasing the possibility that his number would be called. “No cadavers,” Jim said. It would have to be a kidney purchased from a living stranger. Could I recommend a surgeon or a broker who could help? As he had a grandparent from Iran, I told Jim that he might be in luck. Iran had the only legalized and regulated kidney-selling program, but it was reserved for Iranian citizens and diaspora. “I’m not going to go to Iran,” Jim countered. “I want first world medicine.” There was no use trying to convince Jim that Iran had “first world” surgeons.

A few weeks later Jim called to tell me that his family had found several local, willing kidney providers through Craigslist. He chose the least expensive “option”: a kidney from 19-year-old community college student Ji-Hun, an immigrant from South Korea who could not afford his tuition, books, room and board, and who feared deportation if he dropped out. The deal was secured for $20,000. By the time I arrived at the famous “hospital for the Hollywood stars” in Beverly Hills, the surgery was over and Jim was out of the recovery room. His private room was festive with well-wishers, flowers, gifts, smiles, and prayers for Jim’s recovery. Nurses popped their heads in and out to see if everything was going well. It took some sleuthing to locate Ji-Hun, who was tucked away in a corner room several flights above the regular postop recovery rooms. He was a delicate young man, weighing no more than fifty-five kilos. The young man was doubled over with pain, and blushed when I introduced myself to him as an informal “kidney donor” advocate. The nurses laughed anxiously when I presented my calling card with its Organs Watch logo. They told me that Ji-Hun would be released that same day, although he had not yet seen a doctor following his kidney removal. He was worried about returning to his one-room bedsitter apartment in a dodgy section of Los Angeles. Before leaving the hospital Ji-Hun gave me his cell phone number.

A few days later Ji-Hun reported that he was still in bed, immobilized with pain, and unable to eat, urinate, or defecate. His older brother, a surly young man who worked as a dishwasher in a fast-food restaurant, was angry with him. He had no medical insurance, and the $20,000, which had been handed over to his brother in a public toilet on the surgical ward, was already all but gone after settling unpaid bills, student tuition, and remittances for their parents in Korea. After a few brief calls, Ji-Hun’s cell phone
went dead. Jim, anxious about disclosure, emigrated to another country and on last report was married and able to work. The head of the surgical staff of the complicit hospital refused to discuss the case, citing patient confidentiality. The consulting nephrologist who worked shifts at the private hospital contacted me to say that he had seen many other instances of bartered kidneys, but was loath to be a “whistleblower.”

While most illicit and black market kidney transplants take place in the global South and East--India, Pakistan, Bangladesh, Egypt, China, the Philippines, Turkey, Central Asia, Eastern Europe, the Middle East, and Central and Latin America--they also take place in some of the most elite hospitals in the United States. For several years I followed an Israeli broker who organized a huge international network to provide transplant tourists from Israel with “fresh” kidneys from abroad, most of them trafficked minority Israelis and immigrants to Israel from Eastern Europe. I had tried to report the kidney racket to the United Network for Organ Sharing, the Justice Department, Health and Human Services, Visa Control, and Medical Commissioners with no luck. Finally, I did the impossible for a leftist anthropologist: I contacted the FBI and in August 2002, I met in the Roosevelt Hotel with several agents. I shared my fieldnotes and taped interviews, as well as letters, emails, and bank accounts that I had been given by some of the kidney transplant patients, the kidney sellers, the doctors, and the brokers themselves.

27 Elsewhere I have explained the complicated ethics of engaged research and human rights documentation. The Organs Watch project was supported by multiple grants from the Open Society Foundation and from the University of California, Berkeley. See Nancy Scheper-Hughes, “The Ethics of Engaged Ethnography: Applying a Militant Anthropology in Organs Trafficking Research,” Anthropology News September (2009): 13–14.
This information led, in 2008, to federal agents catching Levy Isaac Rosenbaum, in a large police sting in New Jersey.\textsuperscript{28} The police involved had no idea what a “kidney broker” was. The prosecutors could not believe that prestigious US hospitals and surgeons had been complicit with the scheme, or that the trafficked sellers had been deceived and at times coerced. The federal case ended in a plea bargain in 2011 in which Rosenbaum admitted guilt for just three incidents of brokering kidneys for payment, although he acknowledged having been in the business for over a decade. At the sentencing in July 2012, the judge described being impressed by the powerful show of support from the transplant patients who arrived to praise the trafficker and beg that he be shown mercy. Just one of several hundred victims of Rosenbaum’s scheme, Elan Quick, was presented as a surprise witness for the plea bargain sentencing, with my urging. Mr. Quick was a young black Israeli, who had been recruited to travel to a hospital in Minnesota to sell his kidney to a seventy-year-old man from Brooklyn. Although Mr. Cohen had several adult children, not one of them was disposed to donate a life-saving organ to their father. They were, however, willing to pay $20,000 to a stranger.

Elan Quick testified that he had agreed to the sale because he was unemployed at the time, alienated from his community, and had hoped that doing a “meritorious act” would enhance his social standing in Israel. On arrival at the US transplant unit, he began to have grave misgivings. He asked his so-called “buddy,” Ito, who was actually an enforcer for the Rosenbaum kidney selling network, if he could get out of the deal. Those were the last words he uttered before going under anesthesia. His testimony, including the lies he had been told and the manipulation by Rosenbaum’s enforcer, had no impact.

The judge concluded that it was a sorry case. She hated to send Rosenbaum to a low-security prison in New Jersey for two-and-a-half years as she was convinced that deep down the trafficker was a “good man.” She argued that Élan Quick had not been defrauded; he was paid what he was promised. “Everyone,” the judge said, “got something out of this deal.” Six years after the sentencing of Mr. Rosenbaum, Mr. Quick shared with me his years of social, psychological, and physiological pain. His family is angry with him, his friends have ridiculed him, his work colleagues tease him, and he has suffered from depression, anxiety, and self-hatred.

The international kidney trafficking syndicate that deceived Élan Quick had been operation since 1999. On a field research trip to Tel Aviv in 2001, an active kidney broker told me that she had moved her base of operations from Israel, Russia, and Turkey to South Africa and Brazil having read the Organs Watch website. The site described how foreigners were trickling into private and public hospitals around the world, including South Africa. After the fall of apartheid, South African transplant teams were left on their own, without the government support that they had received under apartheid. Following the election of President Mandela and the ANC party, transplantation was shifted to private enterprise. Suddenly, transplant surgery, if it was to survive, required international transplant tourists who could afford to pay for the procedure. Meanwhile, the site also described Brazil as having an internal kidney trade and poor people who advertised in local newspapers their willingness to sell “any organ of which I have two, and the removal of which will not cause my immediate death.”

African Netcare Medical Corporation kidney trafficking scandal was derived from the medical human rights activist. As my Brazilian colleagues liked to say, “No one is innocent,” but I would say that “some are very naive.”

**The Body Torn Asunder**

I know quite well that back there is only “darkness crammed with organs.”


In order to lift the curtain on that “darkness crammed with organs” as Merleau-Ponty described the secret interior of the human body, I will describe here a normative case of living donor transplant between family members. The following is taken directly from my fieldnotes at the Royal Portuguese Hospital in Recife, Brazil in July 2006. Despite being a hospital where many ethical gray zone transplants were arranged between wealthy landowners and their impoverished domestic and rural laborers, in this instance the transplant candidate was also poor, and the organ donor was his aged mother. I met the patient Adriano Rodrigo, a twenty-eight-year-old man who was mortally ill with end-stage kidney disease and lying bare-chested and stretched out on a rusty metal gurney. Next to him was his sheet-draped mother, Adriana, her son’s namesake and his potential lifeline. I was asked to wheel the son’s gurney into an elevator and into one of the two coupled operating rooms that would separate the donor from the recipient. Dr. Williams, the head of the transplant unit, was dubious about the surgery he was about to perform. The x-rays indicated that Adriana had one healthy kidney and one slightly smaller and

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atrophied kidney. The old woman insisted that her healthy kidney go to her caçula, her favorite and last born son.

Now, she was fully anesthetized and rolled over to her left side with her right arm lifted high over her head and taped to a metal swing, fully exposing her right flank where the large surgical incision would take place. The surgeon marveled about the old woman’s body: even her breasts, following eight births, were still firm, and her skin (except for her face) un wrinkled. “Hard workers, like these, keep their shape,” the surgeon commented approvingly, giving the donor’s rump a friendly thwack. “Thank heavens she wasn’t a gordinha” (a fatty) he said, which makes rubber gloves and scalpel slippery.

The scrub nurse arranged the surgical instruments in a precise order so that the surgeon could instantly take what he needed without looking up from the operating table. The bisturi, the scalpel, occupies place of honor. As Richard Seltzer explains, “The scalpel is in two parts, the handle and the blade. Joined, it is six inches from tip to tip. . . . Without the blade, the handle has a blind, decapitated look. It is helpless as a trussed maniac. But slide on the blade, click it home, and the knife springs instantly to life.”

“To hold it above a belly,” he continues, “is to know the knife’s force—as though were you to give it the slightest free rein, it would pursue an intent of its own, driving into the flesh, a wild energy.” The surgeon’s power over life and death separates him from the murderer by only a thin line. “Now the scalpel sings along the flesh . . . a barracuda spurt, a rip of embedded talon . . . the whine—nasal, high, delivered through the gleaming

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32 Ibid., 100.
metallic snout. The flesh splits with its own kind of moan. It is like the penetration of rape."

The first sharp slice into the kidney donor’s side sends shivers down my spine. The layers of flesh are sliced and drawn back like heavy curtains, and secured with hard metal clamps. The electric cauterizing knife is brought out and the surgeon sets to work severing the old woman’s ribs to make room for the kidney removal. Like Eve, Adriano’s Mum will be permanently missing a rib. The smell of smoke and burnt flesh, and the squeal of bone fill the room. Now the surgeon reaches down deeply into Adriana’s soft, warm, dark, pulsating inner sanctum and I hear the tinkling sound of ice and ice water poured into her abdominal cavity and then suctioned out with a loud slurp.

I steel myself to go next door into the transplant theatre where Adriano, the son, is being prepped to receive his old mother’s kidney. Dr. Williams and his team are hard at work. I navigate the edges of the table, trying to find a space where I can see and not be in the way until the female anesthesiologist pulls over a high stool and positions it at the head of the operating table. From my parrot’s perch, with Adriano’s head just slightly butting into my stomach, I can, indeed, see everything. Using what look like giant metal shoehorns, the surgeons pull back Adriano’s flesh back and secure it with metal clasps. A large round metal brace, that looks like it was lifted from a curbside auto repair shop, encircles and holds open the patient’s cavernous abdomen. The crater I am staring down into is a huge, red, gaping hole, large enough, as the surgical joke goes, to drop an alley cat (or two) into. At one point there are three pairs of surgical gloves and several pieces

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33 Ibid., 104.
of “heavy metal” inside or at the rim of Adriano’s abdominal well. From time to time I pat the young man’s head softly and wish him courage, courage, meu filho, my son.

The nephrologists-surgeon sends word to the transplant theatre that that he is ready to remove the old woman’s kidney. For now, it is sitting in its owner’s “pocket” detached from everything except its blood supply. Dr. Williams is surprised. “That was quick!” he says to me and sends word back that his team is not yet ready to receive the organ. He and his team redouble their efforts so that in another twenty minutes they are ready. I follow the transplant team into the donor’s operating room and we hover around the operating table as the surgeon and his assistants begin the final severing and removal of the kidney taking care that the arteries are properly tied off so that the donor doesn’t bleed to death. There is some coaxing: “Tira, Tira! E Isso! E Isso!” Grab it! Take it! That’s it! That’s it! And a cautionary. “Hold it--not just yet, not now.”

The “delivery” of the kidney from Adriana’s kidney resembles childbirth, as the old lady’s kidney is “caught” in the surgeon’s hands and delivered to her son’s expectant body. Aye! She is giving birth to her son for a second time! The “newborn” kidney is gently lifted and placed into its kidney shaped pan and sprinkled with ice water, a baptism of sorts, before more ice water is poured on it. Dr. Williams is the first to have a good long look at the little fellow which he lifts out of the pan in his gloved hands. My God, something is not right, he says, and he shakes his leonine head. The visiting surgeons from the rural state of Paraiba also have a look, pulling on the detached kidney’s connective veins and arteries. They inject the kidney with a chemical solution, cover it with ice and sterile pads. The surgical team makes a solemn procession carrying
the kidney into the adjacent operating room where Adriano the son waits, his body inert, his abdomen flayed and exposed like the carcass of a cow hanging from a meat hook.

Now five people—the surgeon and his assistants—are examining the little pink fellow, anxiously, as if a listless neonate had come into the world. It is “muito pekeno,” they cluck, awfully little, referring to the kidney. Dr. Williams criticizes the handiwork of his colleague in the next room, who is busy suturing up Adriana’s abdomen with her lone inadequate kidney, the atrophied one that “wasn’t worth anything” according to the doctors. “Take the best one,” she had insisted before being put down to sleep.

The most delicate part of the operation begins, as the kidney is introduced into Adriano’s organ well and the laborious task of attaching it begins. There is a great deal of snipping and sewing. The operating room is turned into a tailor’s shop and the seamstress-surgeons adopt a fussy, maternal air. The delicate, fine stitching requires sharp eyes and nimble fingers. Dr. Williams, a man in his sixties, is sweating profusely and struggling with the needlepoint; his large hands shake perceptibly. When a younger colleague tries to direct his fingers, Dr. Williams brushes his hand away. Another calms the senior surgeon down: “OK, go easy, go easy now.” Finally, the stitching is completed and the coaxing and prodding of the pale little fellow begins:

“Come on, come on, wake up, and wake up!”

“It’s lazy and soft.”

“It’s not working.”

“Look, (says Dr. Williams) he works OK when he’s sitting up.”

“But he has to lie down!”

Silence.
Dr. Williams pulls the kidney up, rubs it, pats it, encourages it:

“Come on, now. Wake up!”

“Is it any better?”

“I think he’s improving!”

“But he’s still not making chi-chi (pee-pee).”

Adriano’s head, still at my fingertips: “Hang on, hang on,” I whisper.

“Look, it’s beginning to pink-up!”

“Yes, it looks a bit better!”

But hanging in the air is the question: Is it good enough, is it going to do the trick?

Throughout the afternoon the mood in the operating room has shifted back and forth from loud, playful, and boisterous, to quiet, tense, sharp, tired, frustrated, almost angry, until now when things seem to be going downhill, it is silent. Dr. Williams is totally exhausted, and another surgeon takes over for a bit. A nurse comes over to help him remove his gloves and the blood-splattered apron covering his surgical pants. As the surgeon walks out of the room, his head bowed, I see a large wet stain between his legs.

While Dr. Williams washes and rests, the visiting surgeons continue to struggle inside Adriano’s abdomen for another endless forty-five minutes. When the surgeon returns to the operating room there is a heavy air hanging thickly over the room. The “newborn” kidney is still not up and kicking. When probed, it is soft. Dr. Williams tries to hold the kidney “sitting up” for a while longer. The other surgeons and assistants disagree, saying that the time has come to let him go. “Tuck it in,” they say. The time has also come to close Adriano up. “It’s over. Let’s go,” said a disheartened Dr. Williams, in English, as he put his hand on Dr. Marcelo’s shoulder. “Vamos ver, we’ll see what
happens.” As we leave the hospital Dr. Williams apologized to me, saying that the transplant that was not “bem-bonita,” not real pretty. “There were problems”, he said’. “I I’ll stay up all night thinking about it.” And so would I. He asked me not to return to the hospital on the next day. It was not the first time that I began to see living donor transplant as a form of torture, not one that was intended, but torture all the same.

**Operation Scalpel**

Between 2001-2003, an international trafficking scheme led by two retired military men--one a Brazilian, Captain Ivan, the other, from Israel, Captain Gaddy Tauber--put feelers out in the bars, back alleys, open air markets, and curbside car repair shops to recruit young mostly Afro-Brazilian young men to travel to Durban, South Africa to provide a spare kidney to one of the 100 plus Israeli transplant tourists who arrived in groups, week after week, filling the hospital beds at the private NETCARE Corp clinic at the old and prestigious St. Augustine’s hospital, in Durban, South Africa.

On arrival from their countries, the elderly and sick Israeli patients, some in wheelchairs, were housed in large and comfortable suites with windows facing the ocean at the Holiday Inn at the luxurious Durban Parade. The kidney providers from the slums of Recife were housed in a dark and dreary “safe house” with bunk beds shared with kidney sellers trafficked in from rural Molodova and Romania. The Brazilians were incensed to learn that a handful of Israeli sellers were housed at the Holiday Inn with the Israeli transplant tourists, and were paid $20,000, while the Brazilians were kept in “kidney hostel” and were paid only $10,000. Some, like Alberty da Silva, got only $6,000, the same amount paid to the Romanians. Soon fights broke out among the kidney sellers. One of sellers complained to the police after he returned to Recife, saying that the
brokers had cheated him. Gervasio asked the judge: “Isn’t my body, my organs worth the same as the others?” The sellers were also mistreated and sent home before they had recuperated, their bandages seeping with blood and pus. As they were dropped off at the airport they were told to shut their mouths because what they had done was a crime for which they could be arrested and sent to prison for many years. It wasn’t long before Brazilian and South African police waged police stings—“Operation Scalpel” in Brazil, and “Operation Life,” in Durban—resulting in multiple arrests and prosecutions in Brazil, and a long and intense but failed attempt at prosecution in South Africa.

The Brazilian meninos—referred to as the “boys” by the local media—who were arrested on arriving home, had to defend themselves before Judge Amanda in the federal court of Recife in 2004. The sellers were caught in a double bind. To avoid being mocked by their families and in the media, the defendants chose to say that it was their “choice,” their decision, even telling the judge that if they were trafficked they had “trafficked themselves”: they did not want to be compared with trafficked sex workers who were mostly women. At the same time, to stay out of jail, they had to admit that they had been deceived about the legality of what they were doing.

In court and before the congressional investigators they did testify to the pain and risks of the rogue surgery. So, for example, Rogerio Bezzeira told of being put under anesthesia for the first time in his life and how he awoke in the South African hospital with a searing pain that began at his ribs and wound itself across his trunk. “It hurt like hell,” he said, but the South African nurses were so kind, so attentive, and so unlike any nurses he had ever encountered in Brazil, he tried to suppress it. But sometimes, he said, he just had to yell out loud and when he did he used one of the only words he learned in
English while in Durban—“PAIN!”—so that the nurses in their crisp white uniforms would come and give him another injection.

As soon as he was able to get out of bed, Rogerio wanted to meet his recipient, a middle-aged Israeli man named Agiana Robel. The man was so weak, so anemic, so pale that his thin skin seemed translucent and he only smiled faintly at Rogerio. The man, whose name sounded like agonía (agony) to Rogerio, had gone through a great deal to get the kidney he needed. He was supposed to have been transplanted with a kidney from a young Israeli man who was deep in debt in Tel Aviv and who agreed to “donate” his kidney for $20,000 dollars (more than twice what Rogerio was paid). However, the young Israeli had a change of heart just as he was being prepped for surgery. He called his wife, ducked out of the hospital by a back stairwell, and grabbed a cab to meet his wife at the airport. When the local kidney broker found out that the donor had slipped away with the cash, he notified the airport police that a thief was about to make off for Israel with $20,000 that was stolen from the broker.

Meanwhile, Agiana Robel, was prepped and ready for his transplant. The broker ran to the safe house where the trafficked kidney sellers were kept under surveillance by the “company,” as the traffickers defined themselves, grabbed Rogerio, and had the South African surgeons prepare him for the nephrectomy (kidney removal). After he came out of the surgery and recovered his consciousness, Rogerio said that he was tossing and turning with pain in the recovery room when one of the trafficking scheme’s associates, Dalia, rushed to his bed in the recovery room, her face pinched with anxiety. “Get up! You’ve got to leave here as quickly as you can,” she told him. “The police are after us!” Rogerio was paralyzed with pain. Dalia called one of the nurses gave him
another injection and rubbed some ointment near his bandaged wound. They forced him
to get up and use the toilet and Dalila stepped inside the cubicle and began stuffing crisp
ew dollar bills—6,000 of them--into his hands. “Take this and hide it,” she said. “Quick,
put it under your bandages,” she said. “I hurt!” Rogerio said. “Aye! Aye! Aye!” he
groaned, as he did what the trafficker told him.

It didn’t take the Durban police long to find Rogerio hiding out at the safe house,
and to relieve him of his kidney-cash. He was one of eleven kidney sellers who were
arrested and deported back to Recife. Rogerio hardly knew what felt worse, his oozing,
excoriated kidney wound, or the end of his dreams of self-improvement. Not only would
be returning home ill and weak, he would be arriving as a felon. On arriving in Brazil,
Rogerio and his brother appeared on the front pages of the *New York Times* and the
*Diario de Pernambuco*. Soon his face was on local TV. He would return to work as a
poor curbside car repair man.

The judge tried to sway Rogerio and his kidney selling *companheiros* by offering
them the chance to be released if they would only admit that they had trafficked. But the
men persisted in denying they had been coerced. I served as a consultant to the
congressional investigation and I assured the judge and the congressmen that the men
who sold their kidneys were classic victims of human trafficking. Pedro, one of the
sellers who was lucky to get home safely with his kidney loot, was present at the hearing
and begged to disagree: “No matter what that woman, Dona Nanci, has to say, it was me,
Pedro Nascimento, who trafficked myself! Nobody put a knife to my throat, nobody
forced me to get on that plane. I did it freely and even if I have to spend the rest of my
life in jail, even if I have to suffer for it, I can rest easy knowing that with my kidney I
was able to buy a little house so that my wife and children can have some security. I will
die satisfied, no matter what I have to face.” The judge dismissed the charges for all but
five of the thirty-eight sellers who on return had agreed to join the scheme as “kidney
hunters” convincing others to sell their kidneys.

The Fourth Body and Phantom Organs

Beyond the three bodies there is another body, a fourth body, a body that goes
without saying.34 I refer to a body unmediated by language or representation. It resonates
with Ludwig Wittgenstein’s perception that all knowledge and all certainty begin with the
“unquestionability” of the body. “If you know that here is one hand,” Wittgenstein began
his last book, “we will grant you the rest.”35 This perception of the givenness and
thrownness of the body came to Wittgenstein while he was working as a volunteer with
patients hospitalized during World War I. Wittgenstein’s essay is a reflection on the
circumstances that might take away one’s unconscious certainty of the body and all that
this implies. “If here you know there is no hand . . . no leg . . . no kidney,” the result is a
profound sense of malaise, of loss, of grief, of existential insecurity in one’s body and in
the world.36

Merleau-Ponty’s description of the “phantom limb” stands as the most cogent
description of the attachment of individuals to an existentially given and complete
anatomical schemata in those who have suddenly experienced an amputation.37 The ghost
limb--the limb that is gone--returns to haunt the body with its ethereal but deeply felt
presence. The phantom limb--arm, foot, leg or fingers--retains the position of the original

35 Ludwig Wittgenstein, Uber Gewissheit, my translation.
36 Ibid.
37 Merleau-Ponty, Phénoménologie de la perception, my translation.
body part at the moment of the injury or trauma. The pain can be unbearable but even “anesthesia with cocaine does not do away with [it].” The clinical and psychological literature contains many cases of phantom limbs without amputation, resulting from a brain injury, and people who suffer the absence of limbs who were born without them. Phantom limbs appear in paraplegics and in those who have suffered a complete break in the spinal cord, who nonetheless insist that they experience feeling in their legs and lower body. Merleau-Ponty writes: “To have a phantom arm is to remain open to all the action of which the arm alone is capable; it is to retain the practical field which one enjoyed before mutilation . . . The body is one’s vehicle in the world and having a body is, for a living creature, to be intevolved in a definitive environment, to identify oneself with certain projects, and to be continually committed to them.” Thus, even when a limb is suddenly gone forever the person retains the memory and possibilities for its use. The phantom limb is a symbol of corporeal intactness and of the person’s “total awareness of their posture in the inter-sensory world,” akin to Bourdieu’s “habitus.”

Buried in my fieldnotes and interviews with kidney sellers in/from Brazil, Moldova, Israel, Syria, Egypt, Turkey, the Philippines, and the US, I discovered a variation of the phantom limb, the “phantom kidney.” What distinguishes the phantom kidney is the sudden apparition and presence of what was, prior to the nephrectomy, an invisible, absent, even covert organ. I have argued that the “phantom kidney syndrome” deserves a space in the latest revision of the DSM-IV. It belongs under the broader category of “Somatoform Disorders,” physical symptoms that are disabling and even

38 Ibid.
39 Ibid.
40 Ibid.
occasionally life-threatening but that cannot be explained by organic/medical conditions. Thus, they are categorized as pathological mind-body-social (I would add, political and economic) relations.

Prior to surgical removal, kidney sellers often dismissed the kidney as a thing of little value of worth, as a supernumerary, “stupid,” “dirty,” “little thing.” Once the “redundant” kidney was excised, however, the “empty nest” or “empty pocket” suddenly became the locus and explanation for everything that had gone wrong in the lives of the vendor. Some young men in rural Moldova described an absent kidney that wiggles or hops, itches or stings, contracts or expands. They described the phantom kidney as bloated and needing to urinate. The missing kidney was understood to inflict pain, turn one’s eyes or skin yellow, and was described by some villagers as a cause of premature death. (“He sold the organ that makes the urine flow.”) The lonely remaining kidney was also imagined to suffer. It was described by some kidney sellers as “old before its time,” “used up,” or simply “tired” as a consequence of being forced to do the work of two, to work overtime.

Among agricultural workers in Moldova, the allusion to overwork and overtime, and to doing the work of others, is a critique of the men who went abroad to sell a kidney and who returned to their villages lacking their strength and health. A man who sold a kidney was seen as stealing the labor he owed to the kolkhoz, or model collectivist farm—a form that was still highly valued. “I never knew how much the little thing (coisinha) meant to me, until he was gone,” a kidney seller, Paulo, from Recife, told me. “That damn kidney keeps me up at night. I can feel it drumming inside the empty pocket.” Niculæ Bardan of Mingir, Moldova expressed his fear of imminent death,
wiping a tear from his eye with dirt-encrusted fingers. “What if I die for the loss of my kidney?” This fear is complicated by the village agricultural cooperative’s charge that if he were to die, it would be for “naught,” for “nothing,” for a mere payment of $2,700. A “stupid peasant,” he took his “kidney” to the market and had exchanged it for a “basket of rotten apples.” “Stupid donkey,” Dom Vasile upbraided his sick-to-death son, Validimir, who did, in fact, die of an infection following his illicit kidney removal surgery in Istanbul. “You came home weak and yellow like a wax candle. You have no strength. How will you work in our vineyards? Who will want to marry a half man such as you are?” “The kidney belongs to God,” chastised the local Eastern Orthodox prelate in Mingir, hinting at Divine retribution.

Monir Moniruzzaman has described something similar among the kidney sellers he interviewed in Bangladesh. Prior to their kidney removal surgery, Bangladeshi sellers surrendered their bodies to repeated clinical pre-screening of their blood, tissue, and urine. On the day of the operation, they were washed down like animals, shaved of their body hair, and trussed and bound to their surgical gurneys, “like cows strapped down for the slaughter.”

Dildar, a 32-year-old kidney seller told Monir: “When a fox catches a chicken, the little one cries. I was the chicken, and the buyer was the fox. On the day of the operation, I felt like a kurbanir goru, a sacrificial cow purchased for slaughtering on the day of Eid [the biggest celebration in the Islamic world].”

The Bangladeshi sellers asked themselves the question that I heard from kidney sellers in several languages, Spanish, Portuguese, Romanian, Hebrew and English: “What have I done to myself?”

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42 Ibid., 69.
In the watery slum of Banong Lupa, Manila, a site of active kidney selling, I stumbled on a troubling phenomenon of family obligations and pressures that gradually turned every adult body in the household into a living kidney bank. At first, the obligation to sell a kidney to supplement sub-subsistence wages fell on male heads of households. Over time, kidney selling became routine and was generally perceived as a meritorious act of self-sacrifice, demonstrating the lengths to which a good husband and father would go to protect his family. On a second fieldtrip to Manila as part of a documentary film team, I observed many more scarred bodies among young men and boys, including underage teenagers, who had lied about their age to be accepted as paid kidney donors in both public and private hospitals in Manila.

Sixteen-year-old Faustino was recruited by his maternal uncle, Ray, a former kidney seller. “It’s your turn,” Ray told the boy, reminding him that Faustino’s father and his two older brothers had already sold a kidney. The $2,000 earned per kidney never got these families out of trouble, and dozens of former kidney sellers collapsed as a result of the experience. Andreas was seventeen years old when his mother begged him to sell a kidney so she could purchase the cases of beer, cokes, and hard liquor that she sold out of her shack. As a good son, Andreas could not refuse his mother’s request. Kidney selling had become a rite of passage among adolescents, and the kidney scar across the torso of a teen in Banong Lupa was as common as a decorative tattoo. The scar carried many different meanings—it was a symbol of loyalty to their parents, but also a sign of weakness, of likely impotence, and ignorance. Two young men who had lost their health after selling a kidney asked me to take them to the hospital in Manila for an X-ray that would reveal whether or not their poor health, their wasted bodies, and their weakness
and chronic pain were the result of a mishap or a scheme in which the surgeons had removed more than one kidney. One of the young men said: “I am so pale, so wasted, so empty since the surgery, I need to know what happened to me.” He told of his attempt to speak to the wealthy Chinese man who was the recipient of his kidney. The man lived in a gated community. The suffering provider went to his home and knocked on a back door. The adult son of the recipient warned the kidney seller to leave or he would call the police. When the kidney provider insisted on telling the story of his weakness and frailty since the surgery, the son shooed him away saying, “You are right, my father took more than your kidney; he also took part of your liver and that’s why your skin is so green.” It was not the first nor the last time I had to take a kidney seller to a clinic or hospital to make sure that his remaining organs were still intact.

When I met first Alberty da Silva in the mud hut he shared with several other unemployed relatives and children, in a slum in Recife, he defended his honor saying that although he was given a little something ($3,000) for his kidney, it was still a priceless “gift.” “Isn’t a human life worth much more than a few thousand dollars?” he asked. Alberty insisted that something more was wrong with him, and that had problems with sex and with urination. “Do you think the surgeons were there inside me, they might have taken part of my liver as well?” I had heard similar fears from kidney sellers in the Philippines and in Moldova where there were rumors that kidney men were unable to satisfy their wives and would suffer from sterility. I took Alberty, just as I had taken other kidney sellers in distress, to the public hospital for an X-ray to confirm whether his liver was whole. On the way back to his shack Alberty raised a new concern, whether his orphaned kidney, now that it had to do the work of two, had affected his sexual potency
or his fertility. I reminded Alberty that he had two “wives” and several children who needed all of his support. “And isn’t that why I sold my kidney and went through all this suffering?” “Alberty, I scolded, you told me that you sold the kidney to pay off a car debt.” “Well, that’s also true, but the mothers of my children got to me first, and I had nothing left except enough to buy a used bicycle.”

His distress was such that he implored me to deliver a letter that he had dictated to me to the Brooklyn woman who now had his kidney. “I saved her life, now she needs to know that I am suffering and in pain,” Alberty told me. Alberty had lost his job in the open-air market and took a part-time job as a night watchman. His boss at the market told him his job required too much heavy lifting for anyone with one kidney. He was willing, he said, to work as anything--a painter or as a bellhop in a hotel--if his recipient could help him find a job. His “kidney kin,” Lucia, had sent Alberty a Christmas card that I translated for him:

Dear Alberty, How are you feeling? I hope and pray that all is well with you and your family. My husband and myself are doing well and putting our faith in God to keep us well. I hope you haven’t forgotten me, because I’ll never forget you for giving me my life back. I was close to death and you gave me your kidney. I wish I could send you a little gift for Christmas but I am not sure this is even your correct address. . . God Bless you, Lucia

Alberty dictated the following response which I did deliver to Lucia and her husband in Brooklyn, New York:

Dear Lucia, I hope that you are happy and safe among your family. I am here rooting for your happiness. My life is normal despite the disruptions caused by
this donation of my kidney. My greatest happiness is to know that you are well. I hope that one day we will see each other again now that we are one. I miss you and when I see you again we will share a meal together. I will never forget the short time we spent together. I believe that by the grace of God I will be reunited with you. We will blow out the torch of the statue of liberty together. We will walk hand in hand through the forest of Central Park like two children without a care in the world. May God be with you and may you have health and peace for you and your husband. Please write back to me at this address: Alberty Jose da Silva, Rua da Cacamba, Areias, Recife, Pernambuco, Brazil.  

After that, there were no more communications between the buyer and the seller. I told Alberty that Lucia was not thriving and that was why she did not reply. He was philosophical, saying that he knew how sick Lucia was. He had seen her in the hospital and she could barely walk.

**Perpetual Scars**

Twenty years into my ‘Organs Watch’ project there are no easy answers to the basic questions: How do kidney sellers, trafficked or self-trafficked, view their position in illicit transplants? As victims? As survivors? As heroes? In the economically demolished villages, slums, and shantytowns of the “third world” that provide the more affluent world with surplus kidneys, the meanings of buying and selling an organ are, of course, always context specific. A kidney is never just a kidney. And the large, disfiguring saber-like scars running across the torsos of kidney sellers worldwide have very different meanings in different locations. In the Philippines, kidney sellers lined up for photo ops

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in exchange for a few dollars. I felt like a pimp each time I handed a ten- or twenty-dollar bill to an impoverished kidney seller in a favela of Brazil, or in a watery slum in the Philippines, or in a small village in Moldova or Romania. It wasn’t good practice and it often made things worse. The sellers’ masculinity was already shaken by the false rumors about them, and giving them money to help them through the almost universal unemployment that followed their surgery, compromised them all the more. Two kidney sellers from the capital city of Chisenau in Moldova said that they were seen as prostitutes by their families and friends. “No, even worse than prostitutes,” Viorel explained. “Prostitutes can work again and again and feed their families. We are stupid peasants who sold our kidneys for nothing and now what can we do about it? We can’t sell the second one.”

In Manila, selling a kidney was so expected, so normalized, that men did not try to hide the scars and often joked among themselves as to who had the longest scar, as if it was their own version of a red badge of courage. While the scar could be a sign of weakness or strength, of shiftlessness, or hard work, it could also signify either greed or generosity, depending on local norms. The scar could signify a prodigal son or a good one, or a foolish, dumb, exploited, worthless, or adventuresome and enterprising person. The sellers of Mingir, Moldova, still suffer the consequences of their bioavailability: they are stigmatized and shamed, excluded from marriage, and prone to psychological and medical disorders.

When, a few years later, I returned to Recife to check in on the notorious “boys of Brazil,” I met with many of them. Geremias, Pedro, Paulo, Albert, Joao, Garson, Hermani, and others who were now trying to sort out their lives. Several had lost their jobs and
others lost their wives and their families. They talked among themselves about organizing a non-governmental organization, an Association of Disillusioned (or Disenchanted) Organ Donors—Associacao de Doadores Disilusionados (or Disencantados). The name was still under debate. At their meeting, the disenchanted sellers aired their complaints: loss of work, loss of income, loss of strength, loss of family and friends, and worst of all, a loss of honor, of reputation. They still described chronic pain, anxiety, depression, family discord, and rejection, all attributed by them to their missing kidney.

They returned from their African “kidney safari” as they called their adventure, weaker but wiser. At least they had traveled across continents in jet planes. They had visited and learned about Africa, the land of their forefathers. They marveled at how different South African Black people were compared to Afro-Brazilians like themselves. The “Negros” in South Africa they said were bigger and stronger because they were closer to their roots. “They had never been slaves,” Alberty said, which opened a debate on whether they had been kept in the Durban safe house like slaves. “None of us were told how hard it would go for us,” Cicero said. Paulo agreed: “The pain was so bad that for three days in the hospital I was praying to be the next one to die,” Geremias said. He noted that the doctors got what they wanted from them, and after the surgery they were thrown out like lixo (garbage), and put back on a plane. It was a long flight home and the Durban broker warned each of them not to complain, not to show they were in any pain, because the immigration people might be suspicious. They were told for the first time that what they had done was a crime and the wad of dollar bills they would be carrying in their backpacks was evidence that could be used against them.
The displaced agricultural workers of Moldova who were trafficked to Turkey and Russia to sell a kidney understood their bodies differently than the “boys” from Brazil. Some had come of age under the old Soviet state and they put their agricultural cooperatives and their coworkers above their own individual desires and saw their body as belonging to the village collective. The body was not theirs to mutilate or to weaken, for it would harm the whole body of the village. Older villagers used that argument to punish them when they returned after selling a kidney. The young men avoided public places, they visited with each other in their homes or in small, dark wine cellars. They felt that they could not go to church. They hid their story from the confessional just as they hid it from their friends for as long as they could. In fact, they knew that everyone in the village knew who had sold a kidney, and it was seen as disgraceful, a moral failing, and a mortal sin. During a Sunday Mass in Mingir the local Russian orthodox priest, Andreas, gave a homily about the sacredness of the body and the importance of keeping one’s body clean inside and out. He scolded his parishioners (mostly old women and a smattering of old men). In a Sunday sermon he said:

Health is the goodness that God has given us. Certain of our brothers have sold their body and committed a very serious sin. By selling their body, they are also selling their soul, because by this action they are ignoring God’s existence and they have turned toward evil. Many of our young men have sold a kidney. Do they ever think about the future? They hoped to get rich, but now they are poorer because they have lost their good health. In losing their health they have also lost their redemption because they think they can no longer pray. . . What will their children think when they will have to take care of a sick parent who is still
young? The people who buy kidneys are attacking Christianity and Christians [a reference to the Turkish surgeons and the Israeli brokers]. I pray for those who have committed this sin in ignorance and error. May God protect us all and give us strength to fight against this evil. May God protect our children so that no others will fall into the same trap. In the name of the Father, the Son, and the Holy Ghost. Amen.

After Mass, Father Antoine told me that he understood that the men who went abroad looking for work did not know what work they would be doing. I asked him who owns the body? Father Antoine replied that the body belonged to God and to God alone. He wished that the men would come to Church and be forgiven, but they did not come. They hid themselves. He feared that some might commit suicide, because they were seen as fools and ne’r do wells. In fact, I learned of five Moldovan kidney sellers who died soon after they returned--one died of an infection from his surgery, one was beaten to death by a mob of villagers as punishment for his sins, one died working in Russia, one died by his own hands, and two died at home without any known cause of death.

The trafficked Brazilian men were raised Roman Catholic; some converted to Protestant Evangelicalism. But whether they identified as Catholic or Evangelical Christians, religious teaching for them stopped at the body. As they saw it, their body was theirs to dispose of as they saw fit. Pedro, Paulo, and Joao used a familiar Brazilian idiom stating that they were “the master, the owner of their own bodies,” no matter what anyone else said. Nonetheless, Paulo, a house painter, chided himself for selling his kidney. He said that he never knew how attached he was to the “little thing” until it was gone and began to announce its absence as a constant itching at the site of his wound, even three
years later. “I’ve learned one thing,” he said. “Even though I have two of them, I will never sell one of my hands.”

On my most recent trip to Brazil, I finally got out to the distant rural suburb of Recife to visit Geremias and his new home and to meet his family. While the house was not so fine as imagined by the neighbors he had left behind in the slums, Geremias was still proud of it and he smiled broadly as ushered me inside the gate and quieted the skinny puppy yapping at my heels. He pulled himself up to his full 5’4” height as he motioned for me to sit down on a kitchen chair: “Bem Vindo!” he said. “Welcome inside my kidney!” “What about your scar, Geremias?” I dared to ask, as the young man had fusssed so about the bumpy line across his abdomen. He once told me that his wife found his body ruined and less attractive because of it. “But I have the solution,” he said. “I’m going to a tattoo artist who will weave a beautiful Amazonian snake all around my scar so that this, [pointing to one end] will be the head, and this [pointing to the other end] will be the tail. It will be an expensive tattoo, in many colors, but it will be worth it. After all, eu sou meu corpo,” I am my body.

The presence of everyday violence and suffering, especially when expressed in the language of pain, exposes the gap between bodies that refuse to suffer quietly, and indifferent social, economic, and political orders. The task of bridging the three bodies--individual, social and political--remains missing from a larger critical discourse on the embodiment of human suffering and pain in the production of “social illnesses” that are the consequences of structural and political violence. A critically interpretive analysis of the existential-social representations and bio-politics of pain provides a theoretical and methodological pathway.