Introduction

During my first fieldwork visit to Mexico I found myself encountering the same striking story again and again, a story centered on a young boy in kidney failure, the son of a Mexican father and a German mother. Initially diagnosed in the city of Guadalajara, the boy was then taken by his (relatively affluent) parents to Germany for additional consultations. In both places they were told that a kidney transplant was the best hope for their son. In Mexico, a *living* donor transplant was all that was offered, given the local scarcity of organs obtained from brain-dead (or *cadaveric*) donors.[1] In Germany, however, physicians strongly advised a cadaveric transplant—a recommendation based, in part, on an aversion to the instrumental use of living bodies in the long aftermath of the Nazi era (Hogle 1999). After much consideration, the German mother decided to give a kidney to her increasingly ill son, motivated by the somewhat higher success rates with living donor transplants over cadaveric ones.[2] Once so decided, went the story, German physicians advised the couple to return to Mexico, deferring to the greater experience and expertise of their Mexican transplant colleagues with living donation. The mother's German natal family, by all reports, was horrified and angered by her decision, and vehemently opposed the donation. It seemed inconceivable to them that she would risk herself when another option existed. The mother, however, determined to do everything possible for her son, rejected their pleas that she reconsider. The family returned to Mexico

Downloaded from http://read.dukeupress.edu/books/book/chapter-pdf/582098/9780822374633-001.pdf by guest on 04 October 2024

where the donation and transplant were carried out successfully in a private hospital in Guadalajara.

This was a story that seemed nearly ubiquitous during that first field visit to Guadalajara, offered up in turn by many of the various transplant surgeons, nephrologists, nurses, and transplant coordinators I was making the rounds to meet in the several institutions where transplantation took place across the city. In each telling, it was almost invariably emphasized that the mother's decision to donate reflected the fact that she had become "*más mexicana*" (more Mexican) through her willingness to potentially sacrifice herself in order to save her son. Her German family's horror at her decision, in contrast, was used in the storytelling to exemplify a colder, more individualistic ethos. The key reading being offered here indexed a particular valence of national identity and pride, one that highlighted—and celebrated—an iconic vision of the self-sacrificial Mexican mother. For my interlocutors this was clearly not just a story about motherhood, but one about nationhood as well. That is, it was a story that reversed typical modernist narratives in which the technology and skill of the putative first world are always superior. It was a story in which what we might call the *cultural technology* of the Mexican family (and of that self-sacrificial mother in particular) was imagined as a resource that has enabled Mexico to develop its own kinds of expertise, its own forms of superiority both technical and moral. For the anthropologist, it was a story that forced me to think from the very beginnings of this project about the bodies of mothers, about the pull of suffering and the calculation of risk within families, and about the fashioning of both individual and national identity as they emerge and converge in the context of transplantation.

Both the content and the insistent recurrence of the story remained with me, and I have found myself returning to contemplate it again and again since those exhilarating, often bewildering early days of fieldwork. Over time, the story has come for me to both situate and condense many of the central concerns of this book. The tale of the German mother highlights the degree to which transplantation is a deeply cultural and biopolitical enterprise. An enterprise, that is, that both reveals and enacts situated notions of who can and should risk their bodies through organ donation, as well as who can and should benefit from that risk. After all, it is striking that it was the mother's—never the father's—body over which those debates about donation took place. Equally striking is the way that ideas about the desirability of living versus dead organ donors, as well as what constitutes

Downloaded from http://read.dukeupress.edu/books/book/chapter-pdf/582098/9780822374633-001.pdf by guest on 04 October 2024

acceptable risk and worthwhile gain, shift as the family moves between the Mexican and German contexts. Clearly neither the clinical practices nor the biopolitics of transplant are everywhere the same (Crowley-Matoka and Lock 2006). And indeed, it was precisely those differences that were so deftly leveraged in the service of national identity in the proud, repetitive recounting of the story that I encountered during those early days in the field. Moreover, such issues of national identity surface not only in the content of the story, but in the context of its telling as well. Perhaps it should not be surprising that so many of those transplant professionals shared a common impulse to be sure that one of the first stories this gringa anthropologist heard was *not* one that conjured "developing world" tropes of inadequate resources and incomplete expertise.[3] Instead, this was a story that deliberately touted cultural, technological, and even ethical triumph through the medium of transplantation.

Attending to the striking repetition of this story during my first field encounters seems telling in another way as well. For this insistent recounting seems to suggest a certain symbolic, representational power at work here, a way in which this particular story usefully captured and succinctly communicated something my interlocutors wanted to be sure that I grasped. Indeed, the emblematic nature of the story of the German mother who became más mexicana—emblematic both for those telling the story, and for me in hearing and continuing to ponder it—embodies another central concern of this book. That is, it crystallizes a concern with the way in which organ transplantation is so often made to stand for something—or for many things—larger than itself. And so, taking a cue from that recurrent, resonant figure of the German mother, in this book I am interested also in exploring how organ transplantation serves—more broadly and across a range of different registers—as a kind of *icon*.

In one register, organ transplantation clearly stands as icon for the wonders of science, as well as for its dangers. Lesley Sharp, for example, has described transplantation as an "icon of medical achievement," in which the considerable powers of biomedicine to repair ailing bodies and defy death are dramatically manifest (Sharp 2006: 1).[4] Not always triumphal, however, transplant has also frequently played a more sinister role in the scientific imaginary, serving as iconic of the processes of bodily commodification and neoliberal exploitation made visible in what Nancy Scheper-Hughes has so vividly termed the "neo-cannibalism" of global organ trafficking (1998a: 14). In another register, the ability to wield transplantation often figures

Downloaded from http://read.dukeupress.edu/books/book/chapter-pdf/582098/9780822374633-001.pdf by guest on 04 October 2024

as an icon of national progress and pride; this is much the way it is made to work in that story of the German mother who becomes más mexicana. Yet transplantation—when it is perceived to go awry—has also often stood as emblematic of developmental failure and even national shame, as in the global media frenzy over India's black market "organs bazaar" (Cohen 1999; Das 2000). And within anthropology itself, organ transplantation has become iconic of a certain set of theoretically central and often politically charged divides between nature and culture, self and other, life and death, gift and commodity, science and spirituality (see Ikels 2013 for a recent overview of the burgeoning anthropology of transplant).[5]

In each of these registers it is intriguing to ask, why does transplant seem so readily to condense and capture a core set of meanings about biomedicine, about national identity, and even about anthropological theory? To draw on Claude Levi-Strauss's famous formulation, why are organ transplants not just so good to think (with), but so good to symbolize with (Lévi-Strauss 1962)? And further, what might be the localized, material effects of being pressed into such symbolic service for how organ transplantation is enacted and experienced—as well as for how it is analyzed? Such questions of iconicity resonate with Judith Butler's notion of *coming to matter* as a process of acquiring both materiality and importance through repetitive acts of meaning-making (Butler 1993). Indeed, we might think of those eager tellings and retellings of the story of the German mother in just this way, providing initial insight into how transplantation has come to matter in Mexico both through the materiality of living donor bodies and as a sign of national identity and pride. Taking transplant as a kind of icon helps to illuminate these processes of signification and materialization, focusing our attention on how organ transplantation operates as both an idea and a practice.

I take up the notion of the icon advisedly here, aware that the term has a rich and varied history of usage, from its most prosaic employment as simply a kind of symbolization, to its precise deployment in semiotic analyses as a form of representation specifically based on likeness and similarity, to its religious meaning as an artistic representation of a sacred Christian figure. Mindful of this range of meanings, I find that each of these incarnations of the notion of the icon lends a useful analytic—and sometimes affective—dimension to the way I use the term throughout this book. In exploring the representational resonance that organ transplantation seems

Downloaded from http://read.dukeupress.edu/books/book/chapter-pdf/582098/9780822374633-001.pdf by guest on 04 October 2024

to bear, it will be critical to ask a set of semiotics-inspired questions about what key features, what specific forms of likeness are foregrounded when transplant is made to stand in for biomedical achievement, for national aspirations, or for particular kinds of anthropological problems (Mertz 2007; Peirce 1974). Equally important will be the question of what gets lost in such foregroundings—that is, what complexities are elided in the simplifying processes of symbolization? Beyond this, the religious form of the icon usefully evokes a sense of both the sacred and the profane, as the fervent devotion that icons inspire is so often tempered by fears about their tendency to become a form of false god (Vrame 2003). Such moral duality, such a simultaneous sense of both the miraculous and the potentially corrupt, is aptly attuned to the complex ways in which transplantation is both enshrined as a pinnacle of biomedical (and sometimes national) achievement *and* persistently haunted by intimations of profiteering, criminality, and butchery.

As Lynn Morgan has pointed out in her recent work on the figure of the fetus as icon in American culture, the most powerful icons are often the most polysemic ones, those which can be read to divergent effect by different constituencies (Morgan 2009; see also Nelkin and Lindee 1996; Taylor 2008; Verdery 1999). In such readings and counterreadings icons are rendered not just representational but deeply political, a site of both assertion and contestation. An analysis of the iconic thus requires remaining alert to the particular stories of the way things stand being put forward in such condensed representations, as well as to the other sorts of possible stories they work to quell. Listening carefully for both the stories voiced and the stories silenced in iconic renderings of transplant is an approach that borrows also from Homi Bhabha's insight into stereotypes as a "complex, ambivalent, contradictory form of representation, as anxious as they are assertive" (Bhabha 1994: 70). And in retaining a feel for the exertion as well as the anxieties of power at work in symbolizing processes I draw too W. J. T. Mitchell's ruminations on representation. For Mitchell, the icon as a form of representation is never (just) an object but is always an act, a process, that is at once aesthetic and political (Mitchell 1986).

Exploring the polysemy of transplant as icon in the pages to come requires attending to *what* transplant is held to symbolize: what are the particular images, figures, objects, ideas that are made to emerge out of and stand in for the diverse network of practices, actors, and forms of relation

Downloaded from http://read.dukeupress.edu/books/book/chapter-pdf/582098/9780822374633-001.pdf by guest on 04 October 2024

that constitute transplantation? How do the particular aesthetics and histories of those images and figures matter? What are the interests, values, constituencies, and hierarchies that are served—or undermined—in the process? These are the questions that the notion of organ transplantation as icon serves to foreground. I take these questions to the ethnographic ground of Mexico—a place where transplant is dependent on living kidney donors and informed by a rich religious and political iconography of bodily sacrifice. In doing so, the chapters that follow explore how transplant gets caught up in particular ways of imagining and enacting both individual and national selves—and how such imaginings, in turn, materialize transplantation in locally specific ways.

More broadly, focusing on iconicity provides a useful angle of inquiry into a range of issues—conceptual, political, and ethical—that emerge at the intersections of embodied experience, subjectivity, medical practice, and state power. Moving organs from one body into another inescapably poses a set of thorny questions with reach beyond the boundaries of transplantation itself, questions of the relation between self and other, of the biotechnical possibilities for human connection and exploitation, and of the rights and responsibilities we have both *in* our own bodies and *to* the bodies of others. Locally specific arrangements governing from whom organs come and to whom they go—as well as who gets to decide and who gets to profit—are consequential at the level of individual, lived bodies as well as for how the wider social body operates as both symbol and site of governance (Scheper-Hughes and Lock 1987). The transplant endeavor is literally dependent on making some bodies give up organs in order to provide treatment for others, thus providing a starkly immediate and material example of how ailing physical bodies and the larger sociopolitical body pull upon and shape one another. In tracking how transplant, as an iconic form of medicine, has come through particular kinds of meaning into particular kinds of being, I am informed by the long trajectory of scholarship that has illuminated the body as a potent site and source of social meaning (see, among many examples, Douglas 1966, 1970; Foucault 1963, 1976; Haraway 1991; Lindenbaum and Lock 1993). Understanding the body as a fundamentally contested terrain, constituted by ever-shifting relations between power, knowledge, and practice, I take organ transplantation as an analytic site where those contestations are rendered unusually, usefully visible.

Downloaded from http://read.dukeupress.edu/books/book/chapter-pdf/582098/9780822374633-001.pdf by guest on 04 October 2024

Technology Out of Place?

> Organ transplantation in Mexico—interesting . . . So you're studying black market stuff, organ selling, that kind of thing?
> —Anthropology colleague, United States

It has been a common initial response to my research, an assumption fielded time and again from academic colleagues and nonacademic friends and family in the United States. I found the response first amusing, then irritating, and then—as it became utterly predictable—intriguing in the regularity with which so many assumed that research on transplantation in Mexico must involve the illegal, must invoke a story of transplant gone awry in some dangerous and disordered way. Engaging what Stuart Youngner has called the "dark side" of transplant's iconic image (1990), such assumptions were surely fueled in part by influential work on the global organ trade by anthropologists Lawrence Cohen, Nancy Scheper-Hughes, and others (e.g., Cohen 1999, 2002, 2005; Moniruzzaman 2012; Scheper-Hughes 2000, 2002a, 2002b, 2004, 2005). Recurrent and unsettling stories in the popular media about organ sales and organ theft also surely colored such reactions (e.g., Finkel 2001; Rothman and Rothman 2003; Sack 2014; Schemo 1994). But Mexico, notably, has never featured centrally in either academic or more popularized versions of such accounts. Indeed, this explanation seems insufficient to explain the pervasiveness of this assumption that organ transplantation in Mexico must not work in the expected and respectable ways. The implicit subtext here, of course, is that transplantation in the developed, postindustrial world *does* work in ways (at least reasonably) proper and just. Mention of cross-cultural research on organ transplantation in Japan and Germany (Hogle 1999; Lock 2001), for instance, typically elicited expectations of cultural difference, but not this knee-jerk assumption of illegality and exploitation.

We might think of the underlying logic here in terms borrowed from Mary Douglas's famous formulation of dirt as "matter out of place" (Douglas 1966: 36): in an almost automatic sort of way transplantation in Mexico seemed to strike many of my U.S. interlocutors as *technology out of place*. This borrowing seems helpful for capturing how transplantation in Mexico was thought (by some) to transgress the boundaries of an implicit global hierarchy, violating the imagined geographies and chronologies of a developed versus developing world divide. "Out-of-place-ness," of course, is

Downloaded from http://read.dukeupress.edu/books/book/chapter-pdf/582098/9780822374633-001.pdf by guest on 04 October 2024

always a relative matter, and so the presumed dangerous *dis*order of transplantation in Mexico necessarily invokes a moral and social order that it has contravened. Captured also in this notion of technology-out-of-place is the powerful pull of not just fear but fascination contained in those (often almost eagerly made) black market assumptions. For as Mary Douglas explored long ago, both danger *and* desire are often compellingly commingled at the fertile site of such transgressive boundary crossings.

At work in those technology-out-of-place reactions seemed to be a set of assumptions about both Mexico as a place, and transplantation as a particular form of medicine. On the one hand, such responses resonated strongly with Nancy Stepan's analysis of the ways in which science and technology are so often presumed to move from a (Western) center outward to a "problematic periphery," such that Latin America historically has figured typically as a (faulty) receiver of scientific knowledge and practice, rather than a producer of such in its own right (Stepan 1991: 3; see also Soto Laveaga 2009). Such flows of technology from center to periphery are reversed in the way people in search of the stuff of life (both jobs and health care) are often understood to move instead from periphery to center. This is a dynamic and a set of expectations that operate with particular power in the context of the highly charged and hierarchical history of U.S.-Mexico relations (Chavez 2013; Wailoo et al. 2006).[6] Such entrenched expectations about flows of both technology and people are precisely the context against which that proudly told story of the German mother deliberately spoke back, asserting the expertise of Mexican over German transplant surgeons in the use of living donors and tracking the family's surprising, circular movement first away from and then back to Mexico.

Also surfacing in the conversations that stemmed from those initial technology-out-of-place reactions were questions not just of technological expertise, but of priorities as well. Underlying concerns about the wisdom of practicing transplantation in a country where other more basic life needs (such as clean water, adequate nutrition, and simple primary medical care) often go unmet was an assumption that such high-tech biomedicine is a luxury, one that ought to be permitted only after a certain level of general development and widespread well-being has been attained. This is a defensible critique, to be sure, but one easily leveled at the United States as well, a country that currently supports 245 transplant centers, yet until very recently has permitted some fifty million of its citizens to go without basic health-care coverage (UNOS 2014a).

Downloaded from http://read.dukeupress.edu/books/book/chapter-pdf/582098/9780822374633-001.pdf by guest on 04 October 2024

Yet in the context of such technology-out-of-place reactions, understanding transplantation as a form of inappropriate health-care luxury rests not just on the costly, high-tech nature of transplantation, but on a particular global health imaginary as well (Livingston 2012).[7] This is an imaginary in which Mexico—despite its relatively privileged positioning within the global South—is a place more likely to be characterized by illnesses of infection, malnutrition, and poverty, rather than those of aging and chronic disease so often associated with both first world status and transplantation itself. Yet a vision of transplantation as something most needed in places where people are able to live long enough and, in some sense, healthily enough for their organs to wear out and need replacement is distinctly out of sync with the epidemiological shape of kidney disease in Mexico. For chronic disease is hardly a first world prerogative. Diabetes—which leads to kidney failure—is a public health problem of epidemic proportions in Mexico: it is the leading cause of death among women (Rull et al. 2005), and afflicts one quarter of all those between twenty-five and forty years old (Correa-Rotter and González-Michaca 2005). Indeed, chronic kidney disease specifically is among the top ten causes of death in Mexico (García García et al. 2010). A key contributor to this massive disease burden are toxic exposures to kidney-damaging chemicals from a range of poorly regulated agricultural, manufacturing, and pharmaceutical sources—exposures only on the rise under the privatizing pressures of deregulation in Mexico, as in many other places around the world (Hamdy 2012; Kierans 2015; Ramirez-Rubio et al. 2013).[8] And in many such places, as in Mexico, a medical treatment like transplant that relies so intimately on the readily available bodies of family members may come—as we shall see—to register more as pragmatic necessity rather than high-tech luxury.

Ultimately, encountering those recurrent technology-out-of-place reactions—and the set of assumptions that underlay them—reinforced the disquiet I felt over the way that the "problematic periphery" so frequently figured in accounts of transplantation primarily as the exploited source of organs for transplant. Troubled by the sometimes sensationalistic, even orientalizing, affects and effects of such accounts, this project was thus motivated in part by a commitment to asking not just what happens when people in "Other" places give (or sell or are robbed of) their organs, but to following closely what happens when they get them as well. In the process of asking such questions, the notion of technology-out-of-place serves as a sort of mnemonic device, a reminder to stay always alert, à la Mary Douglas,

Downloaded from http://read.dukeupress.edu/books/book/chapter-pdf/582098/9780822374633-001.pdf by guest on 04 October 2024

to how particular categories are being constituted and to the boundaries thus delineated, defended, and sometimes disrupted.

Iconic Mexico

It is within the context of such technology-out-of-place assumptions that the story of the German mother with which I began signified so strategically. Acutely aware of the particular, privileged gaze from the North given voice in those initial reactions to my research, both the moral power of the más mexicana mother and the prowess of Mexican transplant surgeons highlighted in that story speak back with pointed precision to such assumptions. Such speaking back asserts that transplantation in Mexico cannot be presumed to be merely a flawed reproduction of what occurs in higher income countries, but has its own forms of expertise and merit. Not merely reactive, however, such speaking back also works to highlight some of the key dimensions of the local context critical to the particular ways in which organ transplantation has come to matter in Mexico.

The story of the German mother who gave a kidney to her son has already alerted us to one of the most distinctive features of transplantation in Mexico—an overwhelming dependence on living *related* organ donors. In fact, upward of 80 percent of kidney transplants in the programs I studied were performed using organs from family members. This stands in sharp contrast to other settings where reliance upon cadaveric donors is far greater (such as the United States or, even more markedly, Spain), or where the use of living *un*related donors/sellers is more common (such as India, Egypt, or Israel). One effect of this dependence was to render kidney transplants the only routine form of solid organ transplantation then practiced in Mexico, because hearts, livers, and lungs from brain-dead donors generally were too rarely available to support active transplant programs.[9] As such, kidney transplantation (with its organ-specific set of physiological, institutional, and imaginative dimensions) often functioned in Mexico as an icon of the transplant endeavor as a whole in local imaginings and politics.

Thus it is that transplantation in Mexico was not only itself iconic in important ways but was deeply bound up with—indeed dependent on—one of the key iconic features of Mexican culture, *la familia mexicana*. Much has been written about the central place of the family, both in the political economy of the Mexican state and in the symbolic imaginings of Mexican national identity (Diaz-Loving 2006; Keller et al 2006; Lester 2007; LeVine

Downloaded from http://read.dukeupress.edu/books/book/chapter-pdf/582098/9780822374633-001.pdf by guest on 04 October 2024

1993; Lewis 1959; Lomnitz and Pérez-Lizaur 1987). Often posed in explicit contrast to the cold individualism thought to characterize the United States, la familia mexicana is typically imagined as large, multigenerational, cohesive, and intensely loyal, a collective body that serves as the center of social, economic, and moral life. The notion of la familia mexicana indexes a social world where individual autonomy is not enshrined as both social good and personal goal, but rather where personhood is most meaningfully enacted and experienced through relatedness, materialized through dense ties of love, responsibility, and interdependency and the endless give-and-take of family obligation. This is, of course, an idealized (and ideological) imagery, but one that nonetheless retained considerable cultural force in the making of both Mexican identity and Mexican transplantation.

Powerful ideas not just about family but about mothers in particular emerge in the story of the German mother, of course, and indeed the image of *la mujer sufrida* or *la mujer abnegada* (the suffering or selfless mother) was also both an iconic one in Mexican culture writ large and crucial to the way transplantation was locally enacted and interpreted. Clearly bound up with highly gendered notions of kinship, la mujer sufrida is also a deeply religious figure, inevitably invoking the image of the Virgin Mary whose sorrowful pain is linked to human salvation. The frequent subject of religious iconographic paintings throughout the Christian world, the Virgin Mary offers a vision of Mexican motherhood with considerable cultural currency in a setting so thoroughly (though sometimes contentiously) suffused with both Catholicism and newer forms of evangelical Christianity.[10]

Yet feminine self-sacrifice is hardly all that the Virgin Mary may be made to embody. In the distinctively Mexican figure of *La Virgen de Guadalupe*, whose exuberantly ubiquitous image adorns not only church altars but community murals, cars, flags, belt buckles, and vivid tattoos throughout Mexico, she is also a powerful and empowering symbol of deep national pride (Baez-Jorge 1995; Brading 2001; Lafaye 1976; Wolf 1958). La Guadalupe's miraculous sixteenth-century encounter with an indigenous peasant outside of Mexico City marked an unprecedented appearance of the Virgin on New World soil, signaling the emergence of the Mexican people and nation into "full-human" status at a colonial moment when there was little room for either Indians or mestizos ("mixed blood" descendants of Indian and European parents) in the existing spiritual, social, or legal orders. This deep history renders La Guadalupe a richly polysemic figure in Mexico, signifying self-sacrifice and self-assertion, cherished tradition and

Downloaded from http://read.dukeupress.edu/books/book/chapter-pdf/582098/9780822374633-001.pdf by guest on 04 October 2024

Figure I.1 *La Virgen de Guadalupe* hangs on a truck; image from pilgrimage to the Basílica of Guadalupe, December 2014. Photo by Miguel Tovar, Getty Images.

aspirational modernity all at once. As such, she retains a contemporary currency distinctive from the way other situated incarnations of the Virgin Mary may be waning in relevance, as Jane Collier has explored in rural Spain, for example (Collier 1986). Also signaled in her much-reproduced figure is the vibrancy of a popular Catholicism in Mexico that has since its very beginnings been engaged in the lively creation of new saints of all kinds—including a compelling contemporary figure known as *El Niño Doctor de los Enfermos* (Baby Jesus, Doctor of the Sick), whom we will meet in the pages to come. As we shall see, such saintly figures of La Guadalupe and El Niño Doctor form part of a local grid of intelligibility through which both women and men made sense of—and hence made possible—the bodily sacrifices required by transplantation.

Not merely a sanctified, celebrated figure, however, La Guadalupe in Mexico is always shadowed by a darker double as well, a double given flesh in another iconic representation of Mexican womanhood consequential for local interpretations and materializations of transplant: *La Malinche*. La Malinche, the indigenous woman who stands accused of having betrayed her people by enabling the Spanish conquest through her relationship with Hernán Cortés, represents the other side of the feminine coin in Mexico

Downloaded from http://read.dukeupress.edu/books/book/chapter-pdf/582098/9780822374633-001.pdf by guest on 04 October 2024

(Alarcón 1981; Diaz del Castillo 1956; Glantz 1995). As such, she is also linked with other powerful, painful images of womanhood, such as *La Llorona* (the Weeping Woman), a famous ghost in Mexican folklore burdened with guilt over killing her own children for the sake of a lover, said to appear on lonely roads late at night to terrify unwary travelers (Candelaria 1993; Ingham 1986; Paz 1959). If the Virgin Mary represents woman's potential for nurturance and self-sacrifice, this shadow figure reveals the simultaneous potential for betrayal and destruction also inherent in the roles of wife and mother. In the chapters to come we will find the suffering, powerful figure of La Guadalupe (as well as her dangerous twins) echoed in the complexities of the role played by—and expected of—mothers in the processes and politics surrounding living organ donation.

La Malinche stands as a central figure in a national imaginary not just of gender in Mexico, however, but of race as well. For it is from the originary violence of her relationship with the Spanish conquistador Cortés that a new nation is imagined to have been born in the racially mixed figure of *el mestizo*. An image deliberately crafted as an act of political imagination in the aftermath of the Mexican Revolution in the early twentieth century, el mestizo figures the nation as a kind of hybrid body, incorporating both ancient indigenous and modern European selves into a vigorous new race (Alonso 2004; Knight 1990; Vasconcelos 1979 [1925]).[11] Meant to overcome the fragmentation of a vast cultural and geographic landscape torn apart after a decade of devastating civil war, the notion of Mexico as a mestizo nation has had enduring power, and the figure of el mestizo (which is, notably, typically rendered as a masculine figure) has been mythologized throughout Mexican art, literature, and political discourse. A site of both celebration and contestation, however, critiques of el mestizo abound. Contemporary indigenous Mexicans, for example, indict the way the discourse of *mestizaje* slyly celebrates heterogeneity as means of enforcing homogeneity, pointing out that they are *not* merely part of Mexico's past (Stephen 2002). Caught up in such disputes, the hybrid mestizo body nonetheless remains an iconic sign of Mexican national identity. And the specific politics and aesthetics of this figuring matter for the way the bodies wrought by transplant may—as in the story of the German mother—become similarly caught up in imaginings of a national self. For this is an imagery that brings particular inflections of race, of gender, and of underlying violence to the local shape of transplant practice. In the chapters to come we will see how the legacy of mestizaje may haunt the emergence of this new form of hybrid

Downloaded from http://read.dukeupress.edu/books/book/chapter-pdf/582098/9780822374633-001.pdf by guest on 04 October 2024

body in Mexico, a body wrought, this time, by the biomedical marvels and uncanny conjoinings of transplantation.

If imaginings of Mexico as a mestizo nation turn out to be somewhat ambivalent—born out of both colonial violence and hopes for postrevolutionary cohesion and peace—so too is the state itself an ambiguous figure in the story of how transplant has come to matter in Mexico. Following the decades-long single-party rule of the Partido Revolucionario Institucional (PRI), a period characterized by socialist ideals, authoritarian oppression, and the exertion of political power through a capillary-like system of patronage relations, the Mexican State has been facing a profoundly unsettled contemporary moment. Widespread neoliberal reforms enacted under the pressures of global capitalism in the late twentieth century—including the structural adjustment policies of the 1980s and the North American Free Trade Agreement (NAFTA) of the 1990s—have been followed by upheavals of various kinds: from the peasant uprising of the Zapatistas in southern Mexico, to the defeat of the PRI in the presidential election of 2000 for the first time in nearly seventy years, to the rising regime of a brutal drug economy in which Mexican police, military, and political officials have been deeply implicated (Campbell 2014; Gledhill 1999; Muehlmann 2013; Stephen 2002). It was amid such pervasive political uncertainties that transplantation in Mexico took root primarily in the *public* health-care system—a system that was at once one of the last remaining vestiges of the Revolution's commitment to the collective well-being of the people and a key site of recurrent public scandals about official abuses both physical and financial. The particular institutional shape and clinical practices of state-supported transplant in Mexico thus served as a site where the biopolitics of making live (or not) and risking life (or not) were sometimes starkly visible, condensed in the bodies of those chosen to receive organs and those called upon to provide them (Foucault 1976).

As such, I attend in the chapters to come to the notion of Mexico as a kind of *slippery State*, a deeply biopolitical body of governance that operated as a source of both life-giving, practical benefits and everyday experiences of insecurity and disillusionment. Such unsettled, unsettling political conditions rendered actors in the transplant endeavor often illegible to one another—as well as to a wider public—in both practical and moral terms.[12] This was a world in which the figure before you in the doctor's white coat might be dedicated healer, greedy profiteer, ambitious politician, groundbreaking scientist, or dangerous *traficante* (trafficker of drugs, of organs, of

Downloaded from http://read.dukeupress.edu/books/book/chapter-pdf/582098/9780822374633-001.pdf by guest on 04 October 2024

other coveted, illicit goods). Or he or she might, at different moments, in different relational contexts, inhabit some complex combination of those roles. These forms of illegibility and the pervasive political uncertainty that produced them also had, as we shall see, palpable consequences for how the transplant endeavor did—and did not—come to matter in the slippery State of Mexico.

Taken together, this series of figures—la familia mexicana, the suffering mother (who is both La Guadalupe and La Malinche), el mestizo, and the slippery State—animate a complex iconography of gender, ethnicity, religion, and nationalism in Mexico. They serve as evocative shorthand for some of the distinctive features of the Mexican setting that have shaped how transplantation there has taken clinical shape and produced meaning in both personal and political registers. Yet invoking such iconic figures is both useful and always an already compromised endeavor, for simply identifying their potency—the way they represent ideas that travel and carry force in the world—runs always the risk of reifying it. Contested, contradictory, and incomplete as they are, these figures nonetheless form part of a symbolic idiom upon which people—patients, families, medical professionals, politicians, and others—draw in diverse ways on imaginings of self and nation. And so, in the pages to come, we will watch for how these figures are evoked and instrumentalized in the stories, logics, expectations, and images with which people made meaning of transplantation—and hence *made* transplantation—in locally particular ways.

Tapatío Transplantation

While it is possible—and sometimes useful—to traffic in notions of culture and identity at a national level, Mexico is an immense, sprawling, and hugely diverse country, rife with sharply drawn and dearly held regional differences. The iconic figures of La Guadalupe, el mestizo, and others explored above operate as a set of widely shared symbols, a sort of national idiom on which people in different social and geographic locations draw in distinctive ways. Yet beyond these broad strokes of the larger context, the particularities of the local setting where this study was conducted are crucial as well. This research was based in the city of Guadalajara, Mexico, and the project has extended over a twelve-year period from 1998 to 2010, with the most intensive period of yearlong fieldwork occurring at the turn of the millennium. Guadalajara, whose inhabitants proudly refer to themselves

Downloaded from http://read.dukeupress.edu/books/book/chapter-pdf/582098/9780822374633-001.pdf by guest on 04 October 2024

as *tapatíos*, is Mexico's second-largest city. Located several hundred miles northwest of Mexico City, Guadalajara serves as a major resource and service hub to the six surrounding states (Jalisco, Michoacán, Nayarrít, Guanajuato, Colima, and Aguascalientes). Reflecting the extreme urban concentration of health-care resources in Mexico more generally, Guadalajara maintains two elite tertiary-level hospitals that draw people seeking specialized care—such as transplantation—from all over western Mexico and beyond.[13] At the time of this research, Guadalajara housed the most active kidney transplantation program in all of Mexico, an unusual coup over the typically dominant Distrito Federal of Mexico City. It was an achievement of which the local transplant community—composed of a diverse, unevenly articulated array of social actors including patients, donors, family members, clinicians, social workers, administrators, pharmaceutical salespeople, and government officials—was understandably proud.

Appealing as a research site for this reason alone, Guadalajara also occupies a very particular cultural and political economic space in Mexico. Although a major metropolitan area, Guadalajara at the turn of the millennium did not come close to either the sprawling growth or the high crime rates of the capital, something for which its inhabitants regularly pronounced themselves grateful. A common refrain in casual conversation was that Guadalajara was *más tranquilo* (more calm) than Mexico City, offering a more civil and gracious pace of life. Guadalajara is often represented both by its own inhabitants and by other Mexicans as a deeply traditional city, and the region has long served as the source of various emblematic symbols of "Mexican-ness" including mariachi music, tequila, and *charrería* (a form of rodeo known for its athleticism and dramatic showmanship). These are much loved—and also much caricatured—symbols of Mexican culture that signify and circulate powerfully both within and across national borders. In keeping with this image of traditionalism, Guadalajara is also widely known as a politically conservative and deeply Catholic city, one that has retained much of the gracious architecture and wide boulevards of the colonial era (Carrillo 2002). Simply riding a bus around the city could quickly reveal these characteristics—passing one of the many beautiful churches and cathedrals often elicited a startlingly immediate response as many on the bus would rapidly touch forehead, sternum, and each shoulder in the sign of the cross, sometimes murmuring a quiet prayer.

Yet the particular inflection of traditional Mexico conjured in commonplace representations of Guadalajara was a decidedly mestizo one—unlike

Downloaded from http://read.dukeupress.edu/books/book/chapter-pdf/582098/9780822374633-001.pdf by guest on 04 October 2024

the southern region of Mexico, there was a relatively small population in the Guadalajara region that was visibly marked or marked itself as indigenous. With the exception of a small contingent of Huichol people who were most visible in the city as street vendors of artisanal crafts, indigenous dress, customs, and language did not generally provide public lines of demarcation along an axis of race or ethnicity in Guadalajara. Such lines were marked out in more subtle ways, however, by reference to physical features such as the shorter stature, darker skin, and strong "Mayan" nose thought to place someone closer to the Indian than to the European end of the mestizo spectrum. Cowboy boots and hats on men, and long, full skirts and shawls used as both bodily wrap and modest head-covering for women comprised other such markers by which people in Guadalajara referred obliquely to notions of race or ethnicity via an idiom of urban/rural and class distinctions. During my fieldwork I only rarely heard anyone use the pejorative *indio,* however references to a particular patient as *muy típico* (very typical, very traditional) or *muy folklórico* (very folkloric) might be delivered in a somewhat sly aside, often meant to contextualize what might then be described as a "superstitious" mind-set or an "inadequate" living situation in the context of transplantation. Given this local context, race or ethnicity does not make the kind of overt appearance as a key axis of differentiation in this research that it surely would have made had this work been conducted in a more explicitly ethnicized setting like Oaxaca in southern Mexico. However, local assumptions about race or ethnicity are intimately bound up with the more commonly employed distinctions of class and urban/rural identity that recur throughout the book.

Despite being so powerfully imagined as a site and source of Mexican tradition, Guadalajara is also a profoundly global city with long-standing connections to complex flows of money, people, and technology from all over the world. Reflecting a trend of growing investment by multinational firms, for instance, Guadalajara at the turn of the millennium was the site of some 20 percent of IBM's world production (Napolitano 2002: 198). The city also boasts an excellent university and a well-known medical school, which attracts a large number of international (especially U.S.) students. In addition, the area is the site of a well-established U.S. retirement community centered on nearby Lake Chapala—a development that has enticed some Guadalajara physicians (including one of the transplant surgeons we will encounter in the pages that follow) to begin to contemplate entrepreneurial schemes for attracting the private health-care dollars of this aging

Downloaded from http://read.dukeupress.edu/books/book/chapter-pdf/582098/9780822374633-001.pdf by guest on 04 October 2024

population.[14] In fact, the retirement community's English-language newspaper ran an interview with this particular transplant surgeon in which he suggested that, in the not-too-distant future, North Americans might find the local health-care system a source of convenient and lower-cost organ transplantation (Miller 1999).[15] Global connections flow outward from Guadalajara as well, from the long-standing migration of manual laborers through the formal U.S. Bracero Program of the mid-twentieth century up to the present-day routinized but risky border crossings of undocumented workers. And elites from the region in business, politics, and science also circulate widely through international networks of training, employment, and leisure travel. Although the above-mentioned transplant surgeon's hoped-for future flow of transplant-seeking North Americans had not yet materialized at the time of this research, Mexican patients in fact proved to be quite adept at mobilizing global ties of various kinds in pursuing and managing their transplants. In the chapters to come we will encounter living donors who return from the United States in order to provide a kidney to a family member, as well as patients who rely on a constant flow of both money and information provided by family in the United States in order to negotiate the process of seeking a transplant.

Such global linkages carry transplant professionals away from Mexico in search of training, to elite centers of transplant medicine in the United States, Europe, and Japan, and also work to bring transplant experts in from elsewhere. During my research one of the local hospitals hosted two prestigious conferences organized around visits by transplant surgeons and organ procurement professionals from Spain—a country that served as an important model for the transplant endeavor in Mexico, not just because of the close linguistic, cultural, and historical ties between the two countries, but because Spain boasted the most successful cadaveric organ donation program in the world.[16] As a visiting American researcher, I sometimes found myself enrolled in the complicated politics of these global professional networks in unexpected ways. In one such instance, a rival department chairman arrived on the transplant ward to proudly (and pointedly) introduce a visiting American cardiac surgeon. Before I quite knew what had happened, I found myself being pushed forward by the transplant program director (in a parrying move) as "*his* American scientist" here to study and work with him. Hardly used to being summoned as a source of scientific prestige in quite this way, the moment felt to me like an edifying twist on the discredited anthropological habit of proprietary references to

Downloaded from http://read.dukeupress.edu/books/book/chapter-pdf/582098/9780822374633-001.pdf by guest on 04 October 2024

the places we have worked as "*my* community," foregrounding just one of the potential ways in which my gringa positioning might be instrumentalized by those I sought to study. Highlighted also in that slightly awkward, somewhat funny moment was the complexity of the multidirectional flows of people, ideas, and resources of all sorts that make up transplantation as a set of practices (and ideas) that are at once powerfully global in their circulations and inescapably local in their instantiation.

A Tale (Mostly) of Two Institutions

Transplantation in Guadalajara at the turn of the millennium was highly centered in the city's two elite tertiary-level public hospitals, both of which housed active kidney transplant programs (as well as nascent liver transplant programs). These hospitals represent the two major government-run health-care systems in Mexico, the Instituto Mexicano de Seguro Social (IMSS—Mexican Institute of Social Security) and the Secretaria de Salud (SSa—Ministry of Health).[17] Other key elements of the health-care landscape in Mexico, including private hospitals and the panoply of "alternative" health-care services provided by *naturistas*, *curanderos*, *homeopatas* (naturalists, folk healers, homeopaths), and others, are also part of the local story of transplantation and will make occasional appearances in the pages to come. And yet part of what was so striking about transplant in Mexico was precisely its emergence as a phenomenon primarily of the public health-care system, rather than of the profiteering private sector.[18] Private hospitals in Guadalajara at the time of this research engaged only passingly in transplantation as a matter of marketable prestige—trading on the iconic, high-tech mystique of transplant to bolster a hospital's cutting-edge reputation—rather than of direct profit (see also Cohen 1999 on the marketing allure of transplant in the Indian health-care landscape). As one private hospital director told me quite bluntly: "It's not worth it to us, from a financial perspective. We do a few for the prestige, but we're not really that interested in getting into the business of transplantation" (Dr. Alvarez). Transplantation in Mexico was thus fundamentally both a family matter, deeply dependent on the bodies of those living related donors, and a public affair, rooted in the institutions of an increasingly eroded but still essential national health-care system.

Broadly speaking, the IMSS system at the time of this research was the largest of the federal health-care systems, providing coverage for slightly

Downloaded from http://read.dukeupress.edu/books/book/chapter-pdf/582098/9780822374633-001.pdf by guest on 04 October 2024

over half of the Mexican population and serving primarily working- to middle-class people whose employment in the formal sector paid into the national Social Security system (INEGI 2000).[19] Nationally, the IMSS possessed the best-developed infrastructure of clinics, hospitals, and specialized equipment of any of the Mexican health-care institutions—including the private sector. Yet the IMSS clinics and hospitals were typically overburdened and undersupplied, and many patients who had rights to the system often opted for private care for minor ailments when they could afford it, in order to avoid long waits, out-of-stock pharmacies, and care that could be notoriously brusque. Deeply flawed but also deeply necessary as the primary source of health care for the majority of Mexicans, the IMSS was regarded by many as one of the last remnants of the largely abandoned hopes of the Revolution, representing a national commitment to at least the promise (if not the reality) of health care as a universal right of the people.[20]

At the time of this study, the IMSS Centro Médico de Especialidades (Specialty Medical Center) in Guadalajara housed the country's most active kidney transplant program. Although the hospital's first successful kidney transplant was carried out in 1976, until the mid-1990s transplant activity remained sporadic at best, and in some years not a single transplant was performed. While the demonstrated ability to do transplants was valued as a mark of scientific achievement, any sizable expansion was thought to be unrealistic. In 1995, however, a nephrologist fresh from training in the United States took over with an ambitious vision for dramatically building the transplant program and growing the yearly transplantation rate. His plans, which leaned heavily on the wooing of donations from multinational pharmaceutical companies, were deemed so outrageous by his IMSS colleagues that he was dubbed "MonteAlbán" in a derisive play on his own name that cheekily invoked both the massiveness of the famous pre-Columbian archaeological site in southern Mexico and the Mexican actor, Ricardo Montalbán, who played host on the old American television program *Fantasy Island*. Over the next five years however, those monumental, fantastical goals were achieved, and at the time of this research, the program was performing approximately two hundred kidney transplants per year and was beginning to build a liver transplant program as well. Worthy of a study all its own, this growth involved the complex interplay of dogged determination, politics both institutional and personal, the costly economics of kidney therapies, surgical charisma, and the glamorous media-grabbing cachet of transplantation, among a host of other factors.

Downloaded from http://read.dukeupress.edu/books/book/chapter-pdf/582098/9780822374633-001.pdf by guest on 04 October 2024

The IMSS transplant program was housed in the tall hospital tower of the IMSS Centro Médico, a stark concrete landmark in the generally low-slung cityscape of Guadalajara. The scale and the scuffed marble floors of the building reflected a former grandeur that has been slowly worn down by day-to-day use and the unending passage of the sick and their families. Upstairs, the transplant program occupied the better part of an entire floor, sharing space with the dialysis and hemodialysis programs that served the hospital's kidney patients. Patients, family members, and staff bustled their way in and out of patient rooms and staff offices, frequently crowding the hallway as they lay in wait hoping to catch an elusive physician or the constantly-in-motion transplant coordinator. Patients and their families were a varied lot, ranging from urban factory workers and small-business people to rural campesinos (farmers) to the occasional well-heeled housewife. There was constant activity as patients came in and out of the coordinator's and doctors' offices, clutching charts and X-rays, setting up appointments, seeking information, bureaucratic forms, and reassurance. As patients interacted with transplant staff, there was also occasional emotional chaos—tears, anger, fear, recrimination, but also laughter, joy, and fervent gratitude.

More loosely organized than the IMSS, the largely state-run SSa system was essentially a public charity system designed to care for the most vulnerable members of society. Estimates suggest that approximately 10 to 15 percent of the population depended primarily upon the SSa for health care (INEGI 2000). Patients in the SSa system paid "quotas" for their care, based on a sliding scale assessment of income, and many paid nothing at all. Though patients required neither the ability to pay nor an outside referral to access the SSa system, interminably long waits for hospital beds and services greatly restricted access, sometimes catastrophically so. Regarded by many as a "poor people's hospital" where those without hope go to die, the SSa hospital's university affiliation meant that it was also a site for academic teaching and research, as well as for sometimes cutting-edge medical care such as transplantation.

The SSa hospital's transplant program was also under the direction of a U.S.-trained nephrologist. Although the program was officially launched in 1988, the first kidney transplant was not carried out until December 1990—a delay characteristic of this perpetually resource-strapped hospital. Subsequent growth was halting, never quite achieving the goal of one transplant per month. A major limitation of growth was the hospital's

Downloaded from http://read.dukeupress.edu/books/book/chapter-pdf/582098/9780822374633-001.pdf by guest on 04 October 2024

inability to provide patients with the immunosuppressive drugs required after transplant surgery, due to the SSa mandate to provide coverage for in-patient care only. All too aware of the lifelong and extremely expensive commitment these drugs represent, the program director was reluctant to transplant patients without a plan to guarantee ongoing medication access. Such plans ranged from cobbling together money from private benefactors to brokering discounts with the pharmaceutical companies to finding post-transplant employment for patients that would entitle them to access to the IMSS system and its drug benefits. Despite such limitations, however, the SSa hospital not only maintained an active kidney transplant program but was also the site of the country's only successful liver transplant program during the study period.

The SSa transplant program in Guadalajara was housed in the Antiguo Hospital Civil (Old Civil Hospital). Itself a hybrid structure, one half of the hospital consisted of the "old wing"—a structure built by the Spanish bishop of the city nearly two hundred years before. This older section of the hospital combined graceful open courtyards with long, echoing, grim hospital wards lined with narrow cots and makeshift curtains. In a dense layering of histories of suffering and stigma, the ward that had once served as the leprosy wing in the hospital had become, during my time there, the AIDS unit. This original structure was connected to a newer medical tower, a dingy concrete structure with overcrowded waiting areas and perennially out-of-service elevators. The SSa transplant program was somewhat splintered between these sections of the hospital, and transplant program staff, patients, and their families shuttled constantly between the nephrology floor, the transplant program office, hemodialysis, and the intensive care unit. Like the IMSS patient population, the SSa patients were also a mixed lot, although Mexicans with various markers of both rural life and Indian ethnicity were much more common than in the IMSS hospital—cowboy hats and boots on the men, women with shawls drawn carefully and demurely over their heads, and the stature, skin tone, and facial structure of indigenous Mexicans were ubiquitous. Urban, working-class mestizos also abounded, however, and occasionally there appeared patients or family members whose clothes, cell phones, and style of speech signaled a more prosperous economic stratum. Patients and their families waited propped up against walls, or, if they were lucky, in flimsy plastic chairs, to be called into staff offices and consultation rooms. Many people brought blankets, food, even pillows, knowing from experience that the wait could be a long

Downloaded from http://read.dukeupress.edu/books/book/chapter-pdf/582098/9780822374633-001.pdf by guest on 04 October 2024

one. A certain camaraderie often grew up among them as they waited or wandered the halls, sharing information and frustrations, hope, and the occasional piece of fruit.

Though sketched out here as separate entities, any neatly drawn distinctions between the social security setting of the IMSS, the public charity setting of the SSa, and even the presumably privileged setting of the private health-care system proved hard to maintain once on the ground. Both physicians and patients were mobile elements within the matrix of health-care options, constantly and strategically shifting back and forth between different institutional settings as they tried to maximize the relative advantages of each. Physicians often juggled jobs in the public and private sector—holding positions in the government hospitals for the prestige and access to more advanced technology and equipment but needing a private practice as well in order to make ends meet.[21] Patients too, across the socioeconomic range, moved—sometimes deftly, sometimes haltingly—across the complex health-care landscape, making use of a mix of private and various public health care services, and often combining biomedicine with homeopathy, naturalism, and/or *curandería* (folk healing) in ways that to them felt complementary rather than contradictory. Such constant interconnections between institutional settings, as well as the relatively small size of the still-in-formation local transplant endeavor, created a degree of social intensity and often face-to-face interaction best captured by the notion of transplant community I use throughout this book. Indeed, it was precisely these interconnections that surely made the story of the más mexicana German mother so widely shared among so many of those I first met as I began this work. Ultimately, this was the complex, shifting institutional ground upon which the complex nexus of relations entailed in what Lesley Sharp so usefully terms "organ transfer" has come to matter in Mexico (Sharp 2006: 3).

Tracking Transplantation

In approaching a topic as layered with fantasies, fears, embodied desperation, and institutional complexity as organ transplantation, I was committed to the familiar anthropological approach of staying put, convinced that long-standing strategies of showing up, hanging out, riding the daily rhythms, and sharing meals, frustrations, emergencies, tedium, and endless conversations with the same group of people for an extended period could produce a richness of data and insight hard to come by otherwise.

Downloaded from http://read.dukeupress.edu/books/book/chapter-pdf/582098/9780822374633-001.pdf by guest on 04 October 2024

And so, employing the classic ethnographic methods of participant observation and in-depth interviewing, I devoted much of my time in Mexico to the IMSS and the SSa hospitals, ensuring that I was an ongoing presence in both throughout the course of my fieldwork. Observations took place everywhere I could think to go in the complex social world of the hospital, in the perpetually overcrowded offices of transplant coordinators and physicians, in patient rooms and operating rooms, at nurses' stations and pharmacy lines, in clinic rooms and waiting rooms, and at patient support groups and staff meetings. Time spent around the transplant wards allowed me to develop a nodding acquaintanceship with patients that often grew into conversations and, when they were willing, formal interviews. Often, in fact, patients approached me first, full of curiosity about what such an obvious gringa was doing hanging around in the hospital all the time—the little notebook that served as my constant companion frequently prompted initial assumptions that I was a reporter. The relationships that grew out of those early interactions allowed me, in many cases, to follow patients, families, and the clinicians who cared for them out of the hospital and into their lives, spending time with them in their homes, workplaces, favorite restaurants, nearby parks, and even a local bowling alley where a group of us met on Sunday afternoons for a few games and lots of laughter.

The field notes I took by hand each day and recorded and expanded on my laptop each evening eventually accrued observational and interview data on 323 transplant patient cases, and on 74 potential cadaveric organ donation cases. These qualitative data were augmented by quantitative statistics shared with me by each transplant program from its own patient databases. I conducted in-depth, taped interviews with 50 transplant patients, divided between the IMSS and the SSa programs, and including patients already transplanted, patients awaiting transplantation with a live donor, and patients on the waiting list for a cadaveric transplant. In all, I formally interviewed 22 female patients and 28 male patients, with ages ranging from seventeen to sixty-two. Patient socioeconomic status varied widely, and interview participants ranged from college-educated upper/middle-class (engineer, small business owner) to high school–educated working-class (factory worker, food vendor) to grade school–educated marginalized poor (farm laborer, unemployed single mother). In addition, I interviewed key transplant professionals in both hospitals, including physicians, surgeons, transplant coordinators, and nurses, as well as administrators responsible for policy and budget decision-making. I pursued questions of

Downloaded from http://read.dukeupress.edu/books/book/chapter-pdf/582098/9780822374633-001.pdf by guest on 04 October 2024

policy outside the hospital walls as well, through interviews with regional government officials involved in transplant-related policy, including members of the nascent statewide Consejo Estatal de Trasplante de Organos y Tejidos (State Council on Organ and Tissue Transplantation), a politically contentious body still in formation at the time.

Another tactic for tracing the movement of people, practices, and ideas outside of the hospitals themselves was attending a number of conferences and training courses (some for the general public, some for various types of medical personnel) on organ donation and transplantation. Other public-education events were also important sources of ethnographic experience and information, including several publicity stunts planned by patients to draw attention to their plight. Toward the end of my main fieldwork stint, I was invited to present two papers on my research at a national conference on transplantation held for medical professionals from around the country, an opportunity that allowed me to reflect some of my preliminary findings back to the local transplant community and opened up further avenues of discussion.

And finally, I sought to extend my research outside of the transplant community itself—beyond the countless conversations with friends, street vendors, taxi drivers, and random acquaintances in which all anthropologists engage. Such efforts included systematically monitoring the popular media for news stories about transplantation in particular and health care more generally, a task greatly aided by the IMSS hospital's news media clipping service.[22] I also conducted a small series of interviews with Catholic priests—including the bishop of the main cathedral in Guadalajara—about the Church's attitudes toward transplantation and donation and about priests' own experiences and beliefs in dealing with such issues in their own congregations. Another window into a wider point of view was provided by a new state initiative in Jalisco to record willingness to serve as an organ donor on drivers' licenses—a program that generated data on donation attitudes of upward of 120,000 new license recipients.

Doing anthropology entails not just collecting all of these variegated forms of data, of course, but deciding how to make sense of and represent them. At a practical level, I have followed anthropological convention in protecting the identities of research participants. The names of all patients, family members, transplant professionals, and government officials have been changed throughout, and in some cases individual details have been combined, elided, or altered in order to disguise distinguishing

Downloaded from http://read.dukeupress.edu/books/book/chapter-pdf/582098/9780822374633-001.pdf by guest on 04 October 2024

characteristics. Although individual identity is protected, the identity of the city and primary institutional sites where this research was conducted clearly has not been. This was a decision made in consultation with the directors and other staff members of the transplant programs I studied, who agreed that because of the programs' elite status in Mexico the location of this research would be difficult to disguise. Such pragmatic considerations aside, however, my interlocutors also made it quite clear that their interest in promoting awareness about the existence of successful transplantation in Mexico outweighed their understanding that the study goal was not to present the programs in a promotional or even necessarily flattering light (nor, I should note, was it a goal to present them in an *un*flattering light). This was a decision we came to together toward the end of my main fieldwork stint, after months of ongoing contact and conversation had increased their confidence that they understood both me and my project better, and after I had the opportunity to present some preliminary research findings to them. Throughout the book, direct quotations are cited (and translated by me) from either individual taped interviews or from my field notes, and quotes and individuals are identified by name, a brief occupation descriptor (e.g., engineer, street vendor, surgeon) and main institutional affiliation (e.g., IMSS, SSa, private hospital). These identifiers are intended to provide some approximate markers of socioeconomic status and class positioning, and to help the reader track individuals as they appear in different places throughout the text.

Such familiar anthropological writing conventions help both to protect those who participated in this research and to orient those who will read it. With similar goals in mind I also provide markers throughout the book of my own presence as an actor in the field I aim to describe. Doing so is meant to serve as a recurring reminder that what I can offer here is but one possible story of the way things stand. This account of organ transplantation in Mexico at the turn of the millennium is a story that—like all forms of knowledge—is situated, fundamentally conditioned by the storyteller herself (Haraway 1991; Harding 1991). My own ethnographic gaze is shaped in ways I can mark and challenge and try to expand but can never fully escape: I remain female, white, well educated, a person raised in the middle-class suburban world of late-twentieth-century North America (among many other identifications). So too did the gazing back of those I sought to study—those who spoke and interacted with me, as well as those who chose not to—inevitably apprehend and respond to me in their own situated ways

Downloaded from http://read.dukeupress.edu/books/book/chapter-pdf/582098/9780822374633-001.pdf by guest on 04 October 2024

that I can strive to comprehend, but for which I can never fully account. What I can do is try to frame the ethnographic stories I have to tell in terms of the conditions under which I learned them, attending throughout the book to questions of context as well as content, to how and when and by whom certain narratives, certain kinds of experiences were made available to me in the field.

Also worth marking are the conditions under which I produced this account from those field experiences, for this book has had a long gestation. Since I first began this research transplant medicine, Mexico, and anthropology itself have continued to move through time and change of various kinds. Though some sense of those changes is surely, necessarily incorporated into the book, the central story I have to tell is unabashedly focused on a particular moment, just at the turn of the twenty-first century, when organ transplantation was truly coming to matter in Mexico in clinical, ethical, and political terms. This is, of course, an ongoing story, some dimensions of which are now being picked up by Ciara Kierans, who has been studying the course of kidney patients specifically without IMSS access in Guadalajara more recently (see, for example, Kierans 2015). My own account—like all ethnography—is thus particular to a time and place, but it also speaks to a larger set of processes of biotechnical emergence, proliferation, and incorporation (into both individual and national bodies) that we are bound to see recur in the ongoing march of medicine as scientific endeavor, clinical practice, and capitalist enterprise. Organ transplantation is neither the first nor the last example of medicine's interventions into bodies, selves, politics, and ideas urgently calling for anthropological attention.

How I have come to think about that millennial moment in Mexican transplantation has been shaped by the fact that I too have hardly remained static since those first, heady days of fieldwork. In the process of conducting this project so unavoidably engaged with the politics of families and the bodies of mothers, I have extended my own forms of embodied experience and familial attachment, becoming both a wife and a mother myself. I have also become a professional, not just in anthropology, but in medicine as well by virtue of the hybrid academic appointments where I have made my institutional homes. In the process, I have experienced the sometimes unexpected, uneasy ways that being an observer of transplantation can pull one into being a participant—even a form of professional—in the transplant endeavor. I have had to pick and choose my way carefully among invitations not just to share my research, but to collaborate with or even (in

Downloaded from http://read.dukeupress.edu/books/book/chapter-pdf/582098/9780822374633-001.pdf by guest on 04 October 2024

a move I chose not to make) to become wholly institutionally assimilated with the transplant clinicians that I study. In thinking through such charged choices, as well as through the material that my time in Mexico yielded, I have been immeasurably aided by the growing community of scholars in the anthropology of transplant that has emerged over the past decade, providing evocative, provocative comparative examples against which to sharpen my own ethnographic observations, as well as cherished intellectual companionship along the way. All of these expanding forms of attachment, familial, professional, and intellectual, have deepened the resources available to me for thinking through the complex pull of emotion, obligation, desperation, and aspiration on those who need organs, those who are called to give them up, and those who work to make such organ transfers possible. Though the years elapsed since I began this work have rendered this book less timely in a journalistic sense, they have also, I hope, produced an account much richer than I would otherwise have been able to tell.

Mapping the Chapters

This book explores how organ transplantation gets caught up in particular ways of imagining both individual and national selves and how such imaginings materialize transplant in locally specific ways that have crucial consequences in clinical, social, and political terms. More broadly, the book takes up the way that organ transplantation is so often made to stand for something—or for many things—larger than itself, not only in millennial Mexico, but in anthropology itself. Seen in turn as a triumphal example of modern medicine's death-defying powers, as miraculous proof of God's work in the world, and as the horrifying extension of capitalism's voracious commodification of the human body, I argue that transplantation serves as a kind of icon, as a site where many different—and sometimes conflicting—commitments, claims, and anxieties are condensed and instrumentalized.

The book is divided into three sections, each containing a set of paired chapters. The first section explores the question of what kinds of bodies were—and were not—made available in Mexico to transplantation's demand for organs. Chapter 1 examines the dependence on living related organ donation in Mexico, delving more deeply into the questions of gender, risk, and responsibility first raised in the story of the German mother, and arguing that the feminization and familialization of transplantation in Mexico produced a powerful effect of familiarization. Framing this as a kind of

Downloaded from http://read.dukeupress.edu/books/book/chapter-pdf/582098/9780822374633-001.pdf by guest on 04 October 2024

ethical domestication of the transplant endeavor as a whole, this chapter traces out some of the resulting material, political, and ethical effects on the way transplantation has come to matter as both practice and idea in Mexico. Chapter 2 turns from the abundant bioavailability of living donors in Mexico to explore the relative bio*un*availability of brain-dead donors, interrogating both the conditions and consequences of this scarcity of cadaveric organs in terms of an all-too-familiar politics of blame that we might see as its own form of ethical domestication. I argue that beneath easy indictments of "superstitious ignorance" and "family refusals" as the barriers holding back further flourishing of the transplant endeavor lies a much more unruly story about the situated difficulties of materializing brain death both *as* a slippery state, rife with conceptual ambiguities and practical difficulties, and *in* a slippery State, where institutional and interpersonal trust may be hard to come by.

The next section moves from the donors who provide organs to the patients who need them, exploring the lived experiences, institutional politics, and symbolic dimensions of seeking and (for some) of living over the long term with a transplant. Chapter 3 focuses on the complex ways in which certain patients came to be deemed worthy of transplantation and others did not, attending in the process to the representational powers and pressures exerted by transplant's iconic status. Such decisions about who should (and should not) be transplanted are also, critically, decisions about what kind of clinical and moral enterprise transplant itself should be. Chapter 4 picks up the story of posttransplant life, resisting the romance of transplantation's standard salvationary narrative to examine the lived challenges of posttransplant health, productivity, and reproductivity over the longer term. These challenges produce for many transplant recipients what we might call a form of persistent patienthood, a state-of-being much more contingent than the familiar happily-ever-after story of transplantation. Eliding this more complex and uneasy lived reality in the iconic story line of transplantation is, I argue, another form of strategic simplification—indeed a domestication—of the transplant enterprise itself.

The last section moves away from the iconic dyad of organ donor and organ recipient to consider two other key nodes in the set of relations through which transplantation comes into being. Taking up in turn the figure of the kidney itself and of the transplant professional who works to make it move between bodies, these last two chapters engage—and also question—some of the iconic analytic frames that anthropology has brought to the study of

Downloaded from http://read.dukeupress.edu/books/book/chapter-pdf/582098/9780822374633-001.pdf by guest on 04 October 2024

transplantation. Chapter 5 delves into the social life of the kidney, examining and complicating the moral and affective politics (as well as the analytic effects) of the gift/commodity frame and arguing for a more expansive temporal and relational approach to tracking the complex, unstable meanings of organ transfer. Chapter 6 explores the dense intermingling of notions of the sacred and the profane and of insiders and outsiders in how the iconic figures of scientist, saint, and monster persistently haunt not only the professionals who enact transplantation, but also those of us who study them. Drawing on but also stepping back from the ethnographic specificity of Mexico, these final chapters together explore a set of broader conceptual questions regarding how transplant has come to matter in anthropology itself and how, conversely, anthropology comes to matter in particular ways through its engagement with the transplant endeavor. A brief Coda looks back to the figure of the German mother become más mexicana with whom we began in order to look forward to an emerging biopolitics of global health that we might frame as also, in a sense, más mexicana in its growing dependence on the intimate resources of body, family, and culture to fuel the survival of some at the risk of others.

Downloaded from http://read.dukeupress.edu/books/book/chapter-pdf/582098/9780822374633-001.pdf by guest on 04 October 2024