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Encumbered Ontology:
An Intimate Foray into the Sociality of Human Organs

Pinaki Roy
Assistant Professor in Sociology
Govt. General Degree College, Mangalkote; Email:
pinaki.roy88@gmail.com

Abstract: *Appadurai's (1986) "social life of things" approach helps conceptualize human organs as not merely biological but deeply embedded in complex social relationships, and implicated in the associated hierarchies within which they acquire significance. Disputes in the interpersonal realm in immediate, everyday contexts of ailment, disease and its management foregrounds the encumbered ontology of bodies and organs – their entanglement in relational disputes articulated in and through the ailing body and failing organ. Drawing on unanticipated moments in the life-trajectory of the researcher – an essentially unconventional source of data in now canonized practices of sociological and anthropological research, this paper demonstrates that people who are ill or afflicted with some disease which requires personalized care and group attention, physical involvement and financial expenses, often become objects of dispute over issues of care, support and responsibility. Such discourses reaffirm the social – the responsibility of the family and friends or the wider kin group towards the ill, as much as they are discourses of contention over issues like who is ideally responsible for taking care of the ill and dependent? How the responsibility is to be shared or distributed within the family or amongst immediate kin members? And if the responsibility is not to be divided equally, what are the plausible grounds for waiving or discounting one over another? Engagement with unanticipated yet immediate situations of kidney failure and its familial management reveals that such disputes need not always seamlessly centre on the question of ownership of property of the ailing beyond death, but around the failing or afflicted organ itself, in that it serves as the*

material-symbolic locus of disputes which frames the human organ as encumbered property.

Keywords: Social life, sociality, human body, human organs, encumbrance, ontology, dispute, property, kidney failure, dialysis.

Introduction: Tracing the sociality of the non-social

Sociologies of natural entities enable to trace their unthought-of mundane trajectories and embeddedness within the social (see Foucault 1976; Rabinow 2005; Franklin 2007). At deeper philosophical level, such studies facilitate a rethinking of the ontology of natural entities by relocating them within social, cultural and historical discourses, generating interest in what has been called the "social life of things" (Appadurai 1986) – an investigation into the complex societal embeddedness of entities conceived as non-social.

From the scientific point of view, the ontology of natural entities derives from the inherent regularity of their movements and courses of action and reaction, as if some inherent rationality runs through these movements, unrestricted by forces beyond the natural. In short, scientific discourses posit the ontology of things as unencumbered, which is not to say that they deny the cellular or molecular dynamics of things, but in some way point to the essential lack of continuity of this dynamics beyond "thingness" of the thing and the immediate world of things around (see Heidegger 1967; Das 2010). This constitutes the denial of the everyday social life or societal life-trajectory of not only things and objects but their constituent elements, for in such discourses nothing beyond the "thingness" of the thing and the proximate world of things impinges upon its ontology (see Heidegger 1967; Das 2010).

The expression encumbered from which I derive the concept of encumbered ontology to think of a possible reconceptualization and recontextualization of Appadurai's (1986) "social life of things" derives from a typically financial and legal vocabulary, deployed in contexts where there is dispute over a property – characterized by claim by a party which is not its owner, yet functions as an effective restriction or resistance to its conveyance. The expression is useful to grapple with the disputes that may happen over the human body and its constituent organs, which are, empirically speaking, the property of right-bearing citizens, yet there are claims to it by a party that is not its owner or proprietor, but no less significant in that it has the capacity to impinge on it by virtue of proximate and asymmetrical embeddedness in the immediate network of interpersonal relationships. Thinking of human bodies and organs as encumbered involves rethinking

their ontology in terms of how purportedly pure materiality may emerge as the site of material-semiotic contestations in general (Haraway 1988; Butler 1993; Grosz 1994; Kirby 1997) and disputes and contestations in particular empirical situations.

A look at the contexts of organ failure, donation and transplantation demonstrates how such contexts are not merely biological or biomedical but deeply implicated in the complex weave of social structures and relationships, and the associated hierarchies and ideologies within which they acquire significance. It is through disputes and contestations in the immediate interpersonal relations in mundane contexts of everyday life and living that one encounters the encumbered ontology of bodies and organs. The incident of organ failure and how such contexts are rife with relational disputes over issues which flow beyond the ailing body and failing organ empirically located in it, yet deeply connected to and centered on it, foreground the encumbered ontology of bodies and organs.

My tryst with the problem at hand began in mid-2015 as a research student and in the March of 2017 my *boro jethu*[1] passed away after months of struggling with end-stage-kidney-failure[2]. My encounter with his suffering, and his immediate family's struggle to ensure his survival brought me closer to the set of experiences I was trying to narrativize through my research. Of course, the encounter was unfortunate – something I did not anticipate but shaped my perception of the field I was trying to engage as a research student in fundamental ways.

A tragic foray into the field

In an early winter morning of February 2017, my uncle was admitted to the S.S.K.M. hospital[3] in South Kolkata, with breathing trouble and fluid retention in his body. He was suffering from kidney ailment for last seven-eight years. The situation became more critical towards the end of 2015 when a nephrologist[4] told my brothers that his kidneys are severely damaged and will soon be requiring dialysis.[5] The kidney ailment was aggravated by his post-retirement alcoholism and diabetes.[6] My aunt and brothers were extremely worried as a consequence.

Although my uncle was employed in a well-known private firm, he was not financially solvent in the post-retirement phase. There was no solid financial support available that would take care of his hospitalization expenses in case of emergency. The monthly medical expenses were already huge. Much of the money that he had received at retirement got exhausted in last seven-eight years owing to medical expenses and recurrent blood works.

His initial treatment began at the out-patient department of a private hospital in South Kolkata, which was manageable at that point. When towards the end of 2015, the doctor said that total kidney failure was imminent and dialysis will eventually be the only resort, worries aggravated within the family. The issue was two-pronged: money and time. On the one hand, my aunt and brothers were worried that they will not be able to continue treatment in the private facility because dialysis there is too expensive. On the other hand, they could not finalize on a government hospital for dialysis, where the treatment is offered for free or at highly subsidized rates but there is a huge waiting list[7], and patients are asked to come to the dialysis centre at odd hours. Since my brothers are employed in the private sector, they were worried they would not get recurrent leaves for accompanying my uncle for dialysis.

The sense of imminent crisis continued for close to another year and towards the end of 2016, averting dialysis became impossible. My aunt and brothers decided to get my uncle enrolled for dialysis at the M. R. Bangur hospital in South Kolkata, which is close to their residence. In the government facility, the modality of dialysis was such that the patients were informed about their turn ahead of time and the patient party[8] was required to arrive at the dialysis centre on time to get the procedure done. The patient's attendant was required to wait until the procedure is completed. Initially I had no idea about the odd schedules of dialysis appointments at government hospitals. In one occasion, when I asked my aunt about a forthcoming appointment to consider whether I could substitute my brothers who were already alternatively accompanying my uncle for dialysis, I was shocked to learn that the next dialysis session was scheduled at 3.00 a.m. the day after. A connected problem was that of arranging a vehicle every time my uncle went for dialysis. A vehicle and a driver had to be arranged for in advance, ready to respond to their call, as there was no fixed schedule for dialysis. Whether the slot was allotted in the morning or at night, in the absence of privately owned car, a pre-arranged vehicle was necessary as my uncle by then was too feeble to keep up with the waiting time specifications of app cabs.[9]

This first round of dialysis, consisting of treatment sessions with two-day gap in-between, was an immensely draining period for them. I earnestly wanted to help them by substituting one of my brothers for at least a couple of sessions but could not do so owing to my professional obligation. I however made an attempt to help them in ways that would at least take care of associated crises at the home front. My aunt, who was already a senior citizen by then, always accompanied my uncle for the dialysis sessions

which sometimes lasted for four hours or more, with a resting period before he was discharged. However, she could not accompany my uncle if the session was scheduled at mid-night or very early morning, as she had to attend to my elder brother's sons, of whom the elder one was seven years of age and the younger was barely five, who were left at the disposal of my aunt after their parents separated. We – I and my mother, were more than eager to take care of the children when my aunt accompanied my uncle for the day-time sessions. She eagerly accepted our proposal, as she too wanted to substitute and help, at least partially, one of her sons, who had decided to accompany my uncle as the main attendant for that particular day. We even volunteered to take care of the children during the night, in case my aunt had to accompany my uncle for the night-time sessions but she chose not to bother us. This continued for one month and after the first round of dialysis at this South Kolkata government hospital, they were informed that the gap between two sessions could be increased to three days. However, by appearance, there was clear indication that my uncle's overall health condition had deteriorated. He looked exhausted and emaciated.

Dialysis is no easy a process, especially if the patient has resorted under compulsion to the government facility for the procedure. There is not only a challenge of collectively working out the logistics for receiving dialysis service from a government hospital, a whole lot of caution and care is required at the home front owing to manifold restrictions on food and fluid intake. Where employing a twenty-hour attendant is not possible due to financial constraint, there are tangible pressures of managing pre and post-dialysis care. My aunt was worst hit in this regard. My uncle had become too feeble to go the toilet himself. Under such circumstances, my aunt had to attend to his calls, dispose his urine, and clean his lower body. Dialysis in general improves a patient's overall health. In my uncle's case, there were clear signs of discomfort, may be due to the age-factor because he was already mid-70s by then.

In the winter of 2017, towards the end of January, a week more than a month after the completion of his first round of dialysis that complications began to reappear. He had severe breathing issues, his haemoglobin levels dropped drastically, protein and albumin levels too, and there was abnormal fluid retention in his lower limbs. My brothers realized that hospitalization was unavoidable. Admitting him in a private hospital was no option; therefore, they decided to admit him to the S.S.K.M. hospital in Kolkata.

A week had elapsed in between when due to a couple of holidays I was relatively free and called up my aunt to inquire whether I could be of some help. My aunt readily agreed saying that the day after a dialysis session was scheduled and both my brothers had important responsibilities at office. She requested me to reach the hospital by seven in the morning – to be present when my elder brother would leave so that I can accompany my uncle to the dialysis centre where his turn was scheduled at 8.00 a.m. She also gave me the phone number of Debu (name changed), a hospital staff with whom my younger cousin brother had developed a good relationship, in case I needed help.

Dis-ease at the vicinity of suffering

That day, I reached the hospital a bit earlier. Seeing me reach early, my elder brother was relieved that he would be able to get back home early, freshen up and report to office. I had met my uncle after many days. He was awake by then. I inquired whether he could sleep properly at night. He replied in affirmative. But he added that my elder brother could not sleep properly. There is a wooden bench on the other side, he pointed out, where attendants usually take rest by turn. The next person in queue woke him up within two hours. My uncle told me in a faint voice that my elder brother prefers sitting on the stool the entire night rather than having an interrupted sleep.

I was waiting beside my uncle's bed, when two men arrived with an over-sized trolley containing stainless steel plates with a couple of bread slices, bananas, boiled eggs and milk. But the food was not meant for him uncle said, because he had a dialysis session scheduled. He had an early breakfast. Initially the dialysis was carried out through an incision in his hand but the doctors had informed that a *fistula*[10] would be required if dialysis became necessary beyond two weeks. Over time long-term dialysis recipients learn to live with the *fistula* and corporeally bear the tactile mark of that trauma throughout.

When the breakfast of other patients was about to come to an end, a man came towards us with a file in his hand, and asked whether my uncle has completed his breakfast at least an hour ago? When we replied in affirmative, the man asked me to take my uncle to the dialysis centre. He also told me to seek help of any available hospital personnel. I knew I could always seek Debu's help, as told to me by my aunt, but thought of resorting to the available personnel. However, even before I could call him up, he suddenly appeared and asked my uncle: "How are you feeling today?" Seeing my

anxious face, Debu told me in an assuring voice: "Don't worry. Patients under dialysis too have a long life. Only that people around have to be more patient." I confessed to him that as my aunt and brothers were not around, and my uncle was too feeble, I would not feel relieved until he safely reaches the dialysis centre.

Soon Debu helped me take my uncle to the dialysis centre. In the meanwhile, Debu's phone started ringing. From the conversation that ensued I understood it was a call from either of my cousin brothers. After the phone call ended, Debu confirmed to me that it was my younger brother's phone call, and told me he would take my leave, and disappeared. When all this was happening, my uncle was already inside the dialysis unit. By then it was 8.35 a.m. on my phone clock and I made a call to my aunt informing her about the beginning of the procedure, to which she responded and told me that my younger brother's wife will be reaching the hospital soon. I may stay back in case I want or leave if I have some other work.

I was browsing my phone leaning against the handrail of the broad staircase leading to the floor above – the kidney transplantation unit. Many people came in between with their patients. Not all patients looked emaciated but there were definite marks of wear-and-tear in the words and visages of people who appeared and disappeared to reappear soon at the scene, and some lingered with anxious faces, some looking curiously at others, trying to strike a conversation or a casual chat, faced with boredom and disorientation. I understood that I was an object of attention because I was not a familiar face to the stable yet shifting public that appeared at regular intervals in the waiting area for the dialysis of their relatives. Although I tried feigning ignorance – as if I was not aware that others were gazing at me, trying to give an appearance that I am too engrossed in my phone, I knew I had become an object of speculation, ever since I had stepped out of the elevator with Debu and my uncle. This was particularly owing to Debu's – a hospital personnel's cordial demeanour towards me. Some of them recognized my uncle immediately but I understood from their speculating gaze that they were wondering who I was, because most of them had not seen me before as my uncle's attendant. Those who entered the scene after my uncle was already inside the dialysis unit, thought of me as the attendant of some new patient they were yet to know. A lean man in his late fifties, wearing a pale yellow shirt and a pair of black trousers, soon came inquisitively towards me, asking why I was waiting there. I told him that my uncle was inside. When I told him that my brother's wife would soon arrive, he immediately recognized who my uncle was, and referred to him as the "fair, old man." He told me that he is familiar with my aunt and

brothers. At one point it appeared he knew more about my uncle and his condition than I did, which caused me embarrassment. When I asked him about his relative as gesture of reciprocation, he told me that his wife, who is in her late forties, is undergoing three dialysis sessions every week. He is regular at the hospital and has been doing so for the last six months. Some of his family members substituted him during the three weekly visits to the dialysis centre. He added in a slightly smiling face: "Your aunt knows everything. I speak to her and your sister-in-law often when I get bored. We share our problems. We know a lot about each other."

He appeared to be a good man but his insistence that he knows my extended family and their crises better, perhaps as an innocent way of foregrounding familiarity and as a way of seeking companionship, made me feel an outsider to their inter-subjective experience of encountering and managing the kidney failure of a most immediate relative – which caused me dis-ease and made me feel I have not been enough dutiful towards my uncle.

"Serendipity" and its discomforting epistemic potential

Around 10.30 a.m. my younger cousin's wife arrived. Although she told me that I could leave but she had a lot of things to share with me about how she was managing her household work, her responsibilities as a mother of a seven-year-old, as a wife and daughter-in-law. I too assured her that she was doing a commendable job. Soon she started sharing her grievances about my uncle and aunt, and especially my elder cousin brother. I felt awkward because she was speaking in her characteristically loud voice. Everything she said was audible to others. They looked at us with inquisitiveness. I could immediately deduce from her behaviour how others who frequented the dialysis centre developed considerable familiarity with my extended family. My sister-in-law however did not bother and continued sharing her grievances. She started narrating how difficult it has become for my younger brother to manage everything. Not only did he not have enough money for purchasing the medicines and continuing the treatment, for which they had to take the decision of availing free dialysis at a government hospital. He was also finding it difficult, she told me, to be present every alternate day to function as the day's attendant. Spending a sleepless night and then reporting to office the next day was taking a toll on his health, she worryingly said. That is why; she said she was putting as much effort as possible to share his part of the responsibility.

Her object of contention was my elder brother, who, according to her, has a problematic life-history. No point denying the fact that this conception is

also a part of the familial common sense or wisdom. My elder brother got married against the wish of his parents. He moved out and resorted to his in-laws with his wife after their sudden marriage. He lost his job, and it was not the first time that this happened. What exactly unfolded thereafter is not known to us but his wife left him soon after, leaving behind two children with him. He then returned to his parents, he was jobless then too, making an old, ailing private company pensioner and an aging householder responsible for him and his two kids, who were at a very nascent stage of life then. Within the extended family this is more of a narrative of parental indulgence combined with individual eccentricities and its aftermath. The main complaint my younger brother's wife had was that, my uncle and aunt did not take strict stance against by elder brother when he suddenly came back. If they had not allowed him in, on the ground of sympathy, they could have saved money which could have been used now for his treatment at some better hospital. Despite being the reason behind such unnecessary drain of funds, "he too will get an equal share of the parental property," she said. During this period when my uncle was undergoing dialysis, my elder brother was employed in a petty private firm. There is no point demonizing the daughter-in-law for she had rational arguments to place. I obviously did not have any overt sympathy for my elder brother. At an objective distance, what appeared significant was that both were struggling hard to ensure my uncle's survival. After some time, I somehow escaped the scene, assuring her that we would meet and speak again.

When I looked at my phone's clock after reaching downstairs, it was close to twelve noon. Suddenly I saw one woman struggling with a wheel chair, with a young emaciated man sitting on it, trying to push it towards the elevator. I immediately recognized the woman as one of the two whom I saw the last time when I came to see my uncle and had to wait outside the dialysis unit for a long time. However, she was not the one with whom my aunt interacted with quite often but I remembered she was there in the waiting area during my last visit. She was the other woman, who appeared timid, exhausted and disengaged, squatting haplessly on the floor in the waiting area. Having recognized her, and on seeing her struggle with the wheel chair, I offered help. She hesitated at first, but accepted my proposal. She told me to help her station the wheelchair on the elevator, after which she will be able to manage alone. I did my bit, without pushing too much, and returned. I was about to reach the main exit of the Nephrology building when I suddenly noticed the husband of the woman who had a long conversation with my aunt the other day. I could not immediately sense any stark dis-junction in what was unfolding but was wondering why the

woman was trying to manage everything alone when her elder sister's husband is present in the hospital premises. But this wonder transformed into intellectual curiosity when I overheard the man saying to the person on the other side of the telephone:

> I have reached a bit late today. After reaching the ward, I found that Kartik (name changed, I had noticed the real name of the young man on the packet of reports the woman was carrying) was missing. They (possibly indicating the other patients and their attendants) told me that she (pointing to the woman I had encountered a few moments back) has taken him for dialysis.... (Then there was a pause for some time) I don't know what Saraswati (name changed) wants? She has been abandoned by her husband and now she is interfering in her paternal family. Everybody knows Kartik will die today or tomorrow. We can't afford kidney transplantation. From where will the kidney come? Who will donate the kidney? Who will fund the surgery, the treatment? If you ask her for a kidney she won't give but she is after Kartik's property. What about my wife's right? Isn't she the elder sister?

Overhearing this, I immediately realized I had unknowingly and unintentionally become witness to an extremely disturbing fragment of some larger narrative and hurriedly walked past the main exit of the Nephrology building towards my way back home. Merton (1968) has emphasized on the significance of serendipity or accidental encounters in scientific inquiry and how such encounters are disavowed or overlooked in the presentation of scientific data in order to conform to the canonical stylistics of scientific research. Serendipitous possibilities loom large in every stage of sociological and anthropological research and such information widens the horizon of knowledge in the intellectual treatment of the problem at hand.

Conclusion: Human organs as encumbered property

I began this first-person narrative arguing how human organs are deeply embedded in the complex weave of social relationships, which I have tried to demonstrate through an intimate, narrative foray into the experiences of kidney failure and its familial management within the government hospital setting, with reference to: firstly, my significant others – my *boro jethu*, my extended family, and secondly, few unknown people, the family members of the young man with chronic kidney disease whom had I encountered at the waiting area of the dialysis centre at the S.S.K.M. hospital. Here my

contention is, however disturbing it may appear from an ethical-moral point of view – writing about a very close relative or some acquaintance behind his or her back or waiting to witness, at least, the partial completion of an overheard, curiosity-inciting fragment of conversation, if one undertakes the project of depicting the sociality of human organs, foregrounding that among many other important features, under particular circumstances, human organs exhibit characteristics of encumbered property, one has to somehow negotiate and navigate such disputed terrains or morally reprehensible situations. This encumbrance derives from the inherent sociality of human bodies and organs, even though they may appear to have no autonomous sociality or semiotic existence apart from the biomedically-defined material bodies in which they are empirically located.

One can trace the sociality of human bodies and organs by recourse to the complex, oft-unrecognized relational and semiotic topography human organs traverse, as is the case with the two pivotal narrative moments I have provided in this first-person account. The recognition of the material-symbolic hybridity (Haraway 1988) of human bodies and organs does not involve denying their natural materiality – their biological constitution. Rather it involves the gesture of recognizing that human bodies and organs are as much natural or biological as they are social, cultural, historical and political. A study of the sociality of human organs therefore ought to take into account the social ontology of human organs – an ontology that has been categorically obscured by biomedical and technomedical discourses in particular and the universalistic discourses of life sciences in general which reifies the human body as essentially non-social.

This paper is profoundly intimate in that it speaks at length about the personal trajectory of an institutionalized journey called research. In this intimate narrative, two moments count as pivotal in crystallizing my conception of social ontology of the non-social. One moment is extremely intimate in that it relates to the immediate interpersonal and familial set of experiences associated with kidney failure of my uncle – my *boro jethu*. The other moment is not intimate *per se*, but has implications for what I see as intimate in that it is associated with my unintended or rather accidental exposure to information relating to an unfamiliar set of relationships. By way of a combination of individual and situational factors, I ended up bearing witness to a disturbing fragment of telephonic conversation relating to the latter set of relationships. This bearing of witness in this narrative does not happen only via exposure to the experiences of unknown or unfamiliar others – the unintended witnessing of a telephonic conversation about issues however distant, discomforting and awkward they may be, but also through the person

of my sister-in-law while waiting in front of the dialysis unit, when she began sharing with me her grievances about my elder brother and his role in the weakening of my uncle's financial condition.

How I became witness to these fragments of larger narratives of relational disputes, and what implications they have for my study of the sociality of human organs does not only work by way of revelation. Those embedded in family, neighbourhood and social life at large will recognize that people who are ill or afflicted with some disease which require personal support or group attention and care, and mental and physical involvement and financial expenses, often become objects of discussion and dispute over issues of care, support and responsibility. Such discourses reaffirm the social – the responsibility or duty of the family and friends, and the kin group towards the ill, ailing or feeble, as much as they are discourses of contention and dispute over many issues like who is ideally responsible for taking care, both physically and financially, of the ill and the dependent? How the responsibility is to be shared or distributed within the family or amongst those kin members immediately responsible for taking care? And if the responsibility is not to be shared equally, what are the plausible grounds for justifying why one is discounted or waived and whose lesser contribution is seen as legitimate and whose is not?

These are just few questions from an infinite range. Contextual specificity and situational reference may add more dynamics to the issues stated above. Beyond all these, what draws my attention as an ethnographer of the social is how the question of property figures in these discourses. The property question seamlessly is not only associated with who owns or inherits the property of the ill or the ailing beyond death, it is also a question of how the failing human organ becomes the material-symbolic locus for discourses pertaining to proprietorship, which becomes evident in both the narrative instances. In this concluding section, I take up the second instance for symptomatic analysis, while the first acts as the conceptual-empirical point of take off – the intimate edifice for conceptual engagement with the second. Not that I could gather enough information from what Saraswati's elder brother-in-law was communicating over phone. I have attempted to reconstruct through the overheard utterances as sonic resources, the ways of conceptualizing human organs as encumbered property. Towards this end, I will proceed by pointing out the two key insights that I derive from the enunciations or utterances of Saraswati's elder brother-in-law, which will lead to final argument.

Firstly, when I saw Saraswati taking her brother to the dialysis centre all alone from the ward, it poked my sociological curiosity, but it did not occur to me as pointing to any possible dispute over the legitimate right to take care of the ailing brother. But only when I overheard the elder brother-in-law accusing Saraswati for her wrong approach to life – for having been deserted by her husband, for not having a child and a family of her own, and for needlessly interfering in a domain where he thinks he and his wife legitimately have greater prerogative to act and intervene, that I realized that the right to legitimately act – to partake in decision-making and executing the responsibilities for taking care of the ill or dependent, does have some solid connection in some perceptions with the character-traits particular individuals have – how they have managed their own life-trajectory and how such management has put them in troubled life-conditions. This is also true of my elder brother. In short, one does not have sufficient legitimate reasons to partake in decision-making or getting involved in the life of an endangered person, if he or she has mismanaged his or her own life. And because, Saraswati, despite having failed to secure her own life and establish herself, according to societal expectations, from the point of view of her elder brother-in-law, was trying to make a significant claim to decide and act, and was trying to execute the claim with sincerity, she immediately entered into a conflictual relationship with her elder sister and her husband. Her tendentious claim to the body of the ailing brother was not acceptable to her brother-in-law, for he conceives of such claim to proprietorship as illegitimate, given her purportedly disputed life-trajectory.

Secondly, although the conflict is apparently between the elder sister or elder sister's husband and the younger sister or younger sister-in-law, i.e., Saraswati – a dispute pertaining to whether the latter has any legitimate claim to the ailing body of the brother. But beyond this conflict, there are issues relating to legitimate claim to property, of which Kartik has the socially ascribed, if not legally, immediate right to inheritance and ownership for his parents are too old, but due to his severe illness, Kartik is unable to assert the claim, which renders the paternal property open to contestations claims. The elder sister's supposedly legitimate claim to paternal property by virtue of her age-related seniority is communicated through the voice of her husband, but one does not necessarily have enough reason to believe what Saraswati does or how she acts in this fragment of the narrative is a claim to control or own the paternal property of which her ailing brother is the supposed heir, but it is nonetheless an act performing a claim to the ailing body of the brother – a person prematurely rendered incapable by the severity of kidney. Her elder brother-in-law however smells foul in this

serious involvement of Saraswati. He says that she knows her brother will perish but will not donate her kidney to save her brother. Saraswati's claim to the right to own and control paternal property in the enunciations or utterances of the elder brother-in-law is cast in a language that frames such claim as legitimate and acceptable only if the claimant is willing to part away with a part of her body. In this case her kidney. The inalienability of a woman's right to control or own paternal property is called into question by asking her to prove how worthy and deserving she is of the right by promising to donate or by actually donating her kidney to her ailing brother. An immediate equivalence is thus assumed between Saraswati's right to own and control paternal property and corporeal self-alienation by Saraswati by giving away an inalienable part of her body – a kidney – in donation to her ailing brother. Saraswati's elder brother-in-law does not think of women's right to paternal property as dispensable, for he is emphatic about his own wife's right to paternal property. But his wife's claim to paternal property is communicated in a language which posits her age-related seniority, her impeccable character and undisputed life-history viz-a-viz Saraswati, who is younger and has a purportedly disputed one, which is posited as the legitimate ground for discounting her claim to the right to own and control paternal property.

But how does then one demonstrate, on the basis of the above reading, that human organs are encumbered property or exhibit features of encumbered property. In the above analysis, kidneys of two individuals begin to make marked material-semiotic appearance in the utterances or enunciations, the first is that of Kartik, whose kidneys have failed and is dialysis-dependent for rest of his life and the second is that of Saraswati, whose healthy kidneys are invoked in the fragment of the larger narrative presented by her elder brother-in-law, who sees in Saraswati a potential kidney donor for her brother but assumes at the same time that Saraswati is not good enough a human person to donate a healthy kidney to her ailing brother. Both the organs – the kidneys belonging to Kartik and Saraswati, which are part of the discourse at hand, display properties of encumbrance in that although they are owned by discrete individual bodies or distinct right-bearing citizens, empirically located in three-dimensional spatial site of the body, to invoke Das (2010), and therefore, legitimately belonging to these citizens both empirically and ethically in non-negotiable terms, but it is derivable from the fragment of the narrative under scrutiny that such non-negotiable belongingness is compromised by encumbrances from external agents.

In Kartik's case, there is a claim to his ailing body and the associated care-function towards the failing kidneys by both of his sisters, where the

purportedly legitimate claim of the elder sister is communicated in and through what the elder brother-in-law of Kartik has to say, while the young sister remains silent, unlike her elder sister on whose behalf her husband speaks vociferously, yet she makes her presence felt by reaching the hospital on time to execute the disputed care-function. Kartik's failing kidneys therefore get encumbered by conflicting claims to control and care by his significant others – his elder sister and her husband on the one hand and his young sister on the other, yet distinct from his own right-bearing body. The encumbrance is particularly felt in Kartik's case because he is ill, feeble, wheel-chair bound and dependent on others for care. In short devoid of agency both literally and by material implication. In Saraswati's case, although her body and organs are not failing, her kidneys are forcibly inserted into the disputed discourse by her elder brother-in-law who presumes that Saraswati will not donate a kidney to her ailing brother, but is interfering in how they are managing his treatment. Saraswati's kidneys here get implicated in the acts of encumbrance which impose an external restriction on her kidneys through her brother-in-law who presumes that she will not donate a kidney to save her brother, for she is assumed to be more interested in owing and controlling paternal property, for which she will immediately lay her tendentious claim the moment Kartik succumbs to kidney failure.

Kartik's and Saraswati's kidneys, ontologically speaking, exhibit features of encumbered property in the overheard fragment of conversation presented above, in that there are conflicting claims to and about them, and there are restrictions imposed upon them, symbolic or semiotic, with material or concrete implications, by tangible empirical individuals and transcendental societal forces.

Notes

1. Bangla expression for father's elder brother.
2. End-stage-kidney-failure is a medical condition where the kidneys have stopped functioning irrevocably.
3. The full form of S.S.K.M. Hospital is Seth Sukhlal Karnani Memorial Hospital. Presently it is called Institute of Post-Graduate Medical Education.
4. A nephrologist is a doctor specializing in kidney diseases.
5. Dialysis is an artificial way of eliminating waste and fluid from the body when kidneys stop functioning properly.

6. Diabetes is a disease related to higher glucose level in blood.
7. Waiting list in case of dialysis refers to the long list of patients with chronic kidney disease enrolled in a hospital for periodic dialysis.
8. Patient party is an expression common in hospitals in West Bengal, referring to family members, relatives and attendants of the patients.
9. App cabs are cab hire facilities available on smart mobile phone applications.
10. Fistula is a surgically constructed connection between artery and vein necessary for dialysis.

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