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Of Debt and the Spectrality of the Donor Organ: Tracing the Dynamics of Market and Morality in Organ Donation

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Abstract: *Myriad possibilities can be traced into the situated narratives of individuals who are exposed to the experiences characteristic of organ failure, donation and transplantation. Such narratives are replete with meanings which offer alternative possibilities of tracing the parallel co-existence or mutual inter-implication of the forces of moral and market valuation of human bodies and organs in the context of organ donation and transplantation. Ethnographic encounter with the suffering of individuals with organ failure and their care-givers, and the quest for remedy through organ transplantation, foregrounds the impossibility of thinking empirical instances of subjective, bodily experiences of suffering irrespective of the dynamic presence of human body and organs across multiple registers of valuation – the market and the moral-ethical, the economic and the non-economic, the utilitarian and the experiential. The category of debt (riin in Bengali), as it pervasively emanates from the ethnographic context of organ failure and donation and the discursive milieu or locale of the study, to be more specific, renders this dynamic more prominent and serves as the conceptual and methodological lynchpin in the analysis.*

Keywords: Human organs, organ donation, organ transplantation, economic valuation, moral valuation, debt, indebtedness, spectrality, donor organ.

Introduction: Beyond economic valuation of human organs

Studies of kidney transplantation in developed countries suggest that transplantation in the case of end-stage kidney failure is a cost-effective[1] alternative to long-term dialysis (see Garcia et al., 2012). While developed countries invest in cost-benefit analysis[2] of kidney transplantation over long-

term dialysis (see Axelrod et al., 2018; Held et al., 2016; Senanayake et al., 2020), for most people suffering from end-stage kidney failure in the developing world, kidney transplantation is not an option. Transplantation is not only not offered for free through the public health service institutions, but donor organs are also scarce in most developing countries owing to poor ODR[3], misconceptions about cadaveric organ donation and weak infrastructural facilities available to retrieve brain-stem death-related organs (Espitalie & Saha, 2014). This is particularly true of India, where organ and body donation rates have improved only recently in a few states through higher brain-stem death declarations, greater public awareness and promptitude on the part of health personnel (Kute et al., 2020). The lower rate of supply of donor organs in India has been attributed to socio-psychological, socio-cultural and medical-infrastructural barriers as much as to illegal organ trade or trafficking – as a result of which many donor organs are likely to make their way into the transnational black market (Espitalie & Saha, 2014), with meagre or no compensation to the vulnerable donor (see Scheper-Hughes, 2000, 2001, 2004, 2007). Real or manufactured – the scarcity of donor organs has a decisive impact on transplantation practices worldwide. In countries like India, only a minor fraction of the total population suffering from end-stage-organ-failure can contemplate transplantation as a remedy (Espitalie & Saha, 2014), for the majority, it is a matter of perennially negotiating the fear of impending death and financial insolvency – a continuous struggle for survival against manifold odds.

Economic analysis of organ scarcity emphasises incentivization of organ donation (Held et al., 2016). Such analysis involves determining the incentive for the donor based on the costs incurred when the latter donates an organ, which is proposed as the basis of determining a 'regulated' market value of human organs (Crooker et al., 2008; Matas, 2015). Not that those advocating incentivization of organ donation do not take ethical issues into account while attempting to determine the market value of human organs and the incentive for the donor. Policy recommendations derived from such analysis, however, tend to conceive of human organs through the lens of market mechanisms, thereby prioritising their market value over moral value.

When the practitioners of hard social sciences advocate incentivization of organ donation and, in doing so, convert the socially embedded discourse of organ donation into a de-moralised market discourse, they disavow the fact that human bodies embody profoundly moral meanings and are embedded

in semiotic systems. To oppose the market valuation of human organs, legal discourses step in to remoralise the body as a safeguard against both the formal and regulated, and other informal and deviant forms of the market. The THOA 1994 in India is a good instance of this. Universal monetisation opens up the field of the body to newer possibilities, sometimes corrupt. Nevertheless, complacent reliance on any grand formulation about the indomitable powers of the market undermines necessary engagement with the parallel counter-forces of moral valuation of human bodies. When one engages individual narratives of end-stage-kidney-failure experiences, one confronts the fact that forces of moral and market valuation of bodies are *always already* in conversation. These are specific but not exclusive or exhaustive registers. For instance, organised organ trade and trafficking by white-collar professionals – the so-called *rogue* doctors and hospital personnel – widely reported in print and digital media is an instance of how authorities and agencies involved in legal moralization of human bodies exceed their discursive limits to transact with the market forces. Myriad possibilities of conversation can be traced by recourse to the experiential narratives of individuals who are exposed to experiences characteristic of organ failure, donation and transplantation. Such narratives are replete with meanings which offer alternative possibilities of tracing the parallel co-existence or mutual inter-implication of forces of moral and market valuation of human bodies and organs in the context of organ donation and transplantation.

This paper looks at the dual processes of moral valuation and monetisation of human bodies and organs. In contemporary times, bodies and organs, although predominantly made sense of via biomedical sciences, have a strong presence in religious and legal discourses. While the body within the territory of biomedical and legal discourses is taken for granted, and that it inhabits the religious discourses is pervasively acknowledged, its trespassing into the territory of the market is frowned upon by society at large and academia in particular. This is where the problematic of the paper begins to unfold as it asks: *Is it tenable to assume that body and organ discourses could be safely contained by morality or kept immune from market forces? Is it possible to conceive of an autonomous critique of the marketisation of human bodies by the moral forces?* Ethnographic encounter with the everyday suffering of individuals with organ failure and their caregivers, and the quest for remedy through organ transplantation, foregrounds the impossibility of thinking empirical instances of subjective and bodily experiences of suffering, irrespective of market discourses on bodies and

organs. Taking into account market forces does not amount to a devaluation of the moral force of bodily pain and suffering. Rather, such gesture points to the dynamic presence of human body across multiple registers of valuation – the market and the moral-ethical, the economic and the non-economic, the utilitarian and the experiential (see for instance Granovetter, 1985; Granovetter & Swedberg, 1992; Graeber, 2001; Joralemon, 2001; Joralemon & Cox, 2003). The category of debt (*riin* in Bengali), as it emanates from the ethnographic context of organ failure and donation or the ethnographic milieu or locale to be more specific, renders this dynamic more prominent and is the situated conceptual and methodological lynchpin in the analysis.

This paper, however, can speak only spectrally of the experiences of suffering of the others – the ailing persons, and their caregivers, and represent them only by way of mere approximation. The argument derived from the singular empirical narrative presented below only tentatively represents the dynamic presence of the human body across contending registers of valuation. This narrative or fragment about the characteristic experiences related to organ failure, donation and transplantation helps us ruminate on the moral burden of debt involved in receiving a donor organ – leading to an ethnographically grounded rethinking of exclusivity and exhaustiveness of morality and money in the context of organ donation and transplantation.

During my fieldwork, I had the opportunity to converse with people about their encounters with kidney failure and the struggle for finding a donor kidney or waiting for one to be provided by the government hospital while undergoing dialysis.[4] A common theme that inscribes all the experiential narratives is indebtedness in the context of kidney donation. Debt (*riin*) is an objective economic category, but indebtedness is a subjective experience which is nonetheless socially embedded. Therefore, in the experiential narratives, the perception of indebtedness acquires varied trajectories depending upon the context and the nature of debt incurred or to be potentially incurred in the context of kidney donation. All appear in one way or the other to resist the moral weight of accepting a donor kidney, for it binds the recipient and immediate caregivers in a relationship of perpetual indebtedness to the donor. Even when there are organ donors available from within the immediate network of kin relations, purportedly willing to donate a kidney as a way of repaying a previous debt, for instance, recipients and caregivers conceive of it as a new debt – an unprecedented burden, with the implication of a perpetual moral obligation. Receiving a purportedly free kidney via the

government hospital or a kidney from an individual immediately responsible for the ailing person appears as the predominantly accepted mode of negotiation against *organ donation as bodily repayment of a previous debt*. In extreme circumstances, monetary compensation for a donor kidney with its baggage of illegality, rather than a new debt, appears as a more acceptable mode of negotiation, even when, in legal parlance, it involves exceeding the limits of the legal. Socially formulated and legally determined moral value of a donor organ generates the spectral effect of a perpetual debt on the recipient and the caregivers, which can never be repaid. The experiential narrative provided below presents a particular or single trajectory of indebtedness from a specific subject-position – the paralysing sense of perpetual obligation, even a potential organ donation generates, the spectral effect it has, and the negotiations it brings forth in the context of organ failure, donation and transplantation.

Toward an alternative trajectory: Donor organs as a free good and entitlement

Rajesh Ganguli's (name changed) elder brother, Dinesh Ganguli (name changed), who was sixty when I was doing my fieldwork, had his kidneys damaged due to chronic hypertension and diabetes, and was undergoing dialysis at the government hospital for the last two years. While not many people see transplantation as an alternative, even when counselled by the doctors, Rajesh Ganguli and Dinesh Ganguli's only son, Akash (name changed), who was then in his early twenties, said that they were from the very beginning prepared for kidney transplantation, and had got Dinesh Ganguli enrolled in the waiting list of potential recipients. But they knew that getting a kidney officially would be difficult if they depended only on formal procedures. Arranging for a kidney donor all by themselves would be an equally challenging task, they acknowledged.

During my conversations with Rajesh Ganguli and Akash, the issue of the scarcity of donor kidneys came up recurrently. Rajesh Ganguli was a highly opinionated person with substantial exposure to the field and had a lot of information to share. Although in our dialogues he harped mostly on the complexity of getting a kidney transplantation and their conviction that they would have to get it done somehow, thinking that I was primarily researching that particular dimension of the problem. I chose not to intervene much, thinking of not imposing any external structure on his mode of narrating the

experience.

Rajesh Ganguli told me that they knew from the very beginning that they had to find a donor because they could not perpetually wait for their turn to come. But he added that they did not want anybody from the family to donate a kidney. Since they could afford to compensate the donor kidney, they collectively resolved, Rajesh Ganguli said, that the best option would be to find a willing donor, compensate the person well, if such a person is at all found, rather than push somebody on filial grounds into the brink of perpetual illness – of living with one kidney until death. He told me in a rather disgusted tone, '... but it is not at all easy to find a donor and above all, finding one is illegal according to the laws of this country, even if a near one die ....' From whatever I could gather from the opinion of Rajesh Ganguli on the matter, the latter's decision to opt for a government hospital for dialysis and transplantation was to economize on the expenses, because kidney failure and dialysis, and eventual transplantation, if at all the option is available, is lengthy and expensive, which could exhaust all finances and create problems of continuing the treatment later on. So, there was a combination of rational decision to economise and constraints induced by huge treatment expenditure, which made Rajesh Ganguli take the decision to get the treatment done at the government facility, although they had the capacity to avail treatment at any private hospital in the city. He was, however, dissatisfied with the orientation of the doctors at the government hospital, who he found not taking enough initiative or risk to carry out more transplantations. There is an inherent complacency in them in his view, which gets further concretised because of legal constraints. Rajesh Ganguli opined that legal constraints result in an ethical orientation where doctors counsel the patient parties by saying that the organ was for free or not to be paid for, which, for him, is a contradiction because donor organs are not easily available. Critiquing this farcical emphasis on the free organ at the government hospitals like other free goods, Rajesh Ganguli stated:

> In the government hospitals, the doctors say that the organ is free, and the patient party would only have to pay nominally for the transplantation cost, or the cost may even be waived in some cases. In reality, no organ is available in these hospitals. Only a few transplantations are carried out, that too, when brain death is declared in some private hospital, or when one or two organs come here for transplantation. They are even jittery about declaring brain death.

> You have to wait for years and see your dear one gradually perish. Transplantation cost is nominal or waived in the government hospitals, which is why we are here. The doctors are qualified, too, but they never help you find an organ. The transplantation cost here is far less compared to the private hospitals, but you do not know when your patient will finally get the organ. Doctors in private hospitals earn a lot when they carry out transplantation, both money and fame. They are willing to take the risk. Private hospitals have everything arranged in advance if you can pay for it. Paperwork is not a major hurdle. Here, doctors claim they have the best resources but are unable to deliver. Their practice is bound by law. But you tell me; don't you think it is a contradiction to say that organs are free but unavailable?

What came across very powerfully in his argument is the purported nonchalance of the doctors towards the suffering of the ailing persons and their caregivers. In some sense, Rajesh Ganguli was of the view that doctors appropriated the strict laws to justify their lack of involvement insofar as finding an organ is concerned. From my exposure to the field, I noticed that many people who are exposed to the characteristic experiences of the field identify a fundamental difference in how government hospitals and private facilities orient themselves to the problem of finding an organ. None actually undermines the laws of the land, unless they are involved in organised crime with middlemen targeting vulnerable donors. While the government hospitals conceive of law as defining the limit of their practice, those in private hospitals devise varied means of cushioning the adverse effects of limiting laws on the patient and their families. In short, the latter go a few steps ahead, whereas the former chooses not to inch closer to the limits of law or harness the possibilities in the legal provisions. This is probably the reason why Rajesh Ganguli appears profoundly dissatisfied with the state of affairs at the government hospital and attributes the lack of initiative to them. Describing how his desperation began turning into hopelessness, Rajesh Ganguli shared with me:

> Frankly speaking, we never imagined that *Dada* (referring to his elder brother in Bengali) would finally get an organ. We had given up all hope and had come to terms with the fact that he would live the rest of his life like this, and all resources would get exhausted. Our business too suffered due to Dada's illness. But we had to

> balance everything to ensure the flow of money necessary for treatment. For years, we two have struggled to make our catering business what it is today. Now, everyone in Birati (their place of residence and business) knows us. For the last few years, Dada could not contribute much to maintaining the business. Since Akash has finished his twelfth grade, he has been helping me sincerely. Earlier, I used to tell him not to worry about the business at all. It is important to be at least a graduate. Now he is doing B.Com. and helps me in the business during the wedding season. These days, I don't refrain from taking his help. I, too, am getting old and can't manage everything by myself. He is young and more agile than me. But I have asked him not to compromise on his studies. Dada was well into the catering business when we were young. He never allowed us to feel the absence of our father, who died at a young age. I have tried my best to support my nephew in this crisis. To save Dada, we fight together. All we want to ensure is that he survives.

This long passage introduces us to Rajesh Ganguli's indebtedness to his elder brother, who took care of him in their father's absence. It depicts how he attempts to reproduce the element of duty his elder brother showed towards him and other siblings in the relationship he has with his nephew. Like his elder brother, he too tries to shield his nephew from the adversities of life. And at the same time, thinks of him as a comrade in the life-struggles and acknowledges that he needs him as a support system now that he, too, is getting old and cannot manage everything alone. The interaction with Rajesh Ganguli was revealing because there was a double-bind of indebtedness and duty, and a trenchant critique of structural and legal constraints which hindered the realisation of his dutifulness towards his dada. He kept on referring to what the doctors at the government facility told them during the counselling session, and is particularly intrigued by the contradictory claim that the donor organ is for free or not to be paid for, but is unavailable. I do not know whether this is the general perception about the donor organ in the public hospitals or if it is the perception of a particular doctor, but the expression, "the organ is for free," became the locus of Rajesh Ganguli's critical discourse. At one point, he and Akash had started considering the option of shifting to a private hospital, because such facilities do not claim that the organ or the service is free, rather attempt to make things work in favour of the patient and have no qualms in asking money for

the service they provide. They had even started thinking of a probable donor who would be willing to donate a kidney, in case the private hospital could make all other arrangements. Rajesh Ganguli told me:

> When we were counselled before the transplantation, we were told by the doctors that the organ was free. But it is not free. We have incurred huge financial loss for years waiting for Dada to get a kidney. We even thought of shifting him to a private hospital. We even planned to arrange for a kidney. A distant relative even volunteered. He is our grandson, and his family too like me, is indebted to my dada. They volunteered on their own. There was absolutely no compulsion. According to the law, we cannot compensate the donor. But he is our grandson. We decided we will take care that he is compensated well. He has his entire life ahead. We can't be selfish. We were ready to spend the money, also, however risky it may be. But finally, Dada got a kidney from the hospital, which was unanticipated.

Rajesh Ganguli thought that his elder brother would perish if they waited for his legitimate turn to receive a donor kidney. He said that at the government hospital, they knew the situation was not under their control. Therefore, they thought that if they arranged for a donor and resorted to a private hospital, then probably things would get sorted fast, unlike the government hospital, where the transplantation got delayed. But who the distant relative was – the potential kidney donor, Rajesh Ganguli, did not disclose. I did not even cajole him much as I realised that the conversation was gradually being pushed to the limits of the legal, to a point where any further intervention would frustrate the project of gaining knowledge. Spontaneity is what I relied on as an ethnographer. The invocation of the "distant" unidentified relative and the history of indebtedness of the family of the young relative to Rajesh Ganguli's elder brother, however, generated curiosity. Not that I was sure that there was some illegality involved, for they did not have to ultimately proceed that way. The stated indebtedness of the potential donor and his family, however, lingered, making a perturbed appearance in my face towards the end of the conversation that day, when the question of shifting to a private hospital came up. Rajesh Ganguli gauged my doubts. On another occasion, in an attempt to justify his contemplating of arranging for an organ donor who is a 'distant' relative and indebted to them, and could easily be shown through documentation by the private hospital that

the donor is Dinesh Ganguli's grandson and is willing to donate out of pity, he told me:

> You can tell me that this is illegal. Even the law says that. If you follow newspapers closely, you will find advertisements urging prospective donors to contact the caregivers of persons with failing kidneys and livers. If buying and selling of kidneys is illegal, then by the same logic, advertising for them should also be illegal, isn't it? Why should popular newspapers even allow such advertisements? And if they are allowed, this means the law of the land is not the same for all. Those who respect the law of the land are bound to die then. And those who disregard it will survive. Is this what you will call equality? (Pauses for a while) …When we pay for the electricity we use, when we pay tax for the water we use or the land we buy, then why can't we buy a kidney faced with death? Not only that, but many people die of hunger, but by selling a kidney, they can earn money and survive!

I interacted with Rajesh Ganguli for some four to five days intermittently. I met him on several occasions, but could interact with him only for a few days when someone else came to meet Dinesh Ganguli, and Rajesh Ganguli waited outside to speak to the doctor about his recovery. Unless Dinesh Ganguli's wife came to see him or Akash went inside the ward, I could not manage to speak to him. He would always appear absent-minded if he had to speak to the doctor or get some information from the nurse. I found it perturbing to speak to him when he had other worries. I could speak to him on three occasions, and each time he would reveal and conceal a lot at the same time, saying: 'There are many stories. I will share with you later', which he never returned to the next day. I, too, lacked the finesse of a skilled ethnographer who could push for further information and remained content with whatever came my way.

What I have presented above bears no chronology, rather speaks of how Rajesh Ganguli narrated his encounter with kidney failure and transplantation when I asked him a question as simple as: 'How did you come here?' I do not know whether he understood my project. I did not either try to explain to him the conceptual issues I intended to deal with, but it seemed that his perception that I was an educated man and the research will help me progress in my career, pushed him to maintain a congenial approach towards

me and help gather information from others with the same experience of having to anxiously see their near ones gradually recover inside the kidney transplantation ward or plunge into uncertainty at the dialysis center. With hindsight, I also realised that he spoke vociferously about legal constraints because he probably thought of me as a medium of communication with the larger public via my research, in which he got involved. Not that it was a well-thought-out plan, but it seemed that in trying to convince me about the validity of his decision to arrange for a donor kidney, he was also communicating with other stakeholders in the field about what it means to conform and see a near one suffer at the brink of death.

In Conclusion: Moral debt and the spectrality of the donor organ

Indebtedness has both economic/monetary and moral/non-monetary aspects. The dominant way of conceiving indebtedness derives from a typically economic point of view. In such thinking, indebtedness derives from the empirical act of incurring a debt, for instance, borrowing money. Incurring a debt, however, may not necessarily amount to a sense of indebtedness. Moreover, the perception of indebtedness is individual and context-specific, and could vary in nature and magnitude. When one borrows from an institutional source or lending agency like a bank, against a collateral security or based on professional credentials, involving a contract between the lender and the borrower, the nature and magnitude of indebtedness of the borrower to lender is bound to vary in comparison to a situation where a relative or friend has lent money on request based on the promise that the amount will be returned as soon as possible. The former is institutional, based on a formal agreement between the lender and the borrower, where the lender is not a person but an institution, involving formal procedures and a legal contract elaborating the conditions of loan sanction, repayment and penalties for failure. The latter is an informal verbal agreement based on the interpersonal relationship between friends or relatives, with conditions of repayment more flexible and contingent, sometimes working in favour of the borrower. The latter generates a greater sense of indebtedness because it is non-contractual and driven by a discourse of magnanimity of the lender, and the moral impact of such debt for the borrower as a consequence is more pressing. Nevertheless, moral evaluation, though compelling, may have individual interpretations, and therefore non-contractual lending could be riskier for the lender, because morality is not enforceable (and there are

deviant possibilities which are not easily punishable), whereas a legal contract is.

Indebtedness is the linchpin of the narrative presented above. Other narratives, which are constituent of the larger project, also point to the wariness of individuals to incur debt that may have moral implications – the debt involved in receiving a donor organ, especially from a distant relative, a known person or an acquaintance. Society moralises all debts, even when they are typically monetary and based on a legal contract. For example, even when a contract-based, legally binding debt is incurred by a borrower, if the borrower declares himself bankrupt – unable to repay the loan in the face of financial insolvency, under no circumstances can the institutional funder compel the borrower to repay the debt in ways that may undermine the well-being of the borrower. Debts of all kinds bind the lender and the borrower in an abstract moral relationship, beyond the immediate legal contract or anthropological modes of relatedness. Thus, society not only moralises all debts, debts also binds the individual parties in an abstract moral relationship, which may have longitudinal implications beyond the life-trajectory of empirical individuals, and this is best realised in the case of debts incurred in non-contractarian and non-institutional modes, especially in immediate realms of interpersonal relationships.

The dominant economic explanation is that people incur debt when they do not have enough money to partake in a venture or mitigate a crisis. Debt in such circumstances involves a rational orientation on the part of the individual toward future gains or for solving a crisis. But what does the study of economic behaviour say about individual attempts not to incur any further debt or rule out possibilities of being mired in moral debt or attempts to neutralise debts with inter-generational implications by way of actions which suspend or circumvent indebtedness?

In the long narrative presented above, although it appears that Rajesh Ganguli is at the brink of committing an illegality by getting a 'distant' indebted relative donate a kidney in return of compensation, in actuality, he is more interested in getting a free organ as an entitlement from the government hospital as that would not involve incurring any moral debt to any individual relative or family member. His decision to compensate the donor in case of donation by a 'distant' indebted relative as the last resort, if a free organ is not available, is a contemplation of potential illegality, but involves subtle

attempts to neutralise the moral debt that would bind them (him and his family) perpetually to the donor, even when a handsome compensation is provided. The moral obligation of the recipient and the family members or the immediate care-givers appear more pressing in its tangible and intangible spectral effects from the point of view of Rajesh Ganguli, and thus he attempts to de-moralize the potential debt by bringing money within the frame of exchange, in the absence of a free organ, which does not involve indebtedness to any particular individual relative or family member.

The moral value of a donor organ haunts the recipient, actual or potential, in response to which Rajesh Ganguli resorts to the plan of offering monetary compensation to the potential donor, to minimise the humbling effects of the moral value of a donor organ and suspend indebtedness. It could be deduced, though not safely, that economic analysis or monetary valuation of human organs overlooks their moral value – a valuation which entails surreptitious spectral effects and intangible moral obligations in opposition to tangible monetary debts, which is why Rajesh Ganguli ideates monetary compensation as a mode of negotiation.

Rajesh Ganguli navigates the situation of crisis based on instrumental reasoning across registers of valuation, moral and monetary, until he *prioritises monetary over moral debt*, unless incurring a moral debt is inescapable. His actions embody a rational orientation to debt, which does not deny the moral value of human organs, but rather decides through rational calculation in favour of monetary debt or monetary resolution of debt over moral debt in organ donation, particularly because the donor is a relative, though distant. Yet this rational calculation is mired in moral considerations and involves value judgments on the part of the recipients or their family members, which is why receiving an organ through bureaucratic procedures of official allotment appears safer, as it is perceived as an entitlement and involves incurring no personal debt to an individual or family or collectivity. The donor in the case of official allotment is diffused in the list of cadaveric donors or is a person who has already received or is about to receive an organ, in return for the one provided by the hospital through organ swapping, with no immediate and tangible moral obligations whatsoever.

Such a conception of the rational individual partaking in making decisions regarding what is less morally burdening is not a gross reduction of morality to calculative rationality (Weber, 1978). This rather points to the varied

moral trajectories of negotiation with the standardised market valuation of human organs, which absolves buying or selling of organs of morality (see Granovetter, 1985; Granovetter & Swedberg, 1992; Graeber, 2001). The fact that rationality itself gets embroiled in acts of moral valuation, weighing decision in favour of the impersonal, state-sponsored, free provisioning over moral obligation to an immediate other – attempting to circumvent moral debt, with its spectral effects in live donation (considered more spectral than cadaveric donation and the cadaveric organ) from a distant relative demonstrates that the marketization of spheres of embodiment cannot completely absolve human action of moral considerations. The subjective decision not to collapse into perpetual moral indebtedness that the receipt of the donor organ brings in its wake shows how debilitating a discourse of moral valuation is in such spheres of corporeal exchange, mediated by money or not.

Notes

1. The extent to which a business venture is effective in relation to the cost incurred.
2. Weighing of estimated costs and projected outcomes of a business venture to decide whether it is lucrative.
3. Organ Donation Rate.
4. The ethnographic material presented here for analytical purposes is mainly derived from field notes and memories of conversations with people in the field. Anonymity of the respondents has been maintained throughout the presentation and analysis of the field data.

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